Leicestershire Partnership NHS Trust

Public Meeting of the Trust Board
9.30 am Tuesday 3rd March 2020
Venue: NSPCC Conference Room
AGENDA

Public meeting			
Timing		**Item**	**Lead**
09.30	1	Apologies for absence Welcome to meeting: Dr Walid Sorour, Dr Lynn Snow, Brendan Daly – Armed Forces Lead, Rob Melling – Head of Community Development	Chair
9.35	2	Step into Health – Signing The Pledge	Chair
09.40	3	Patient voice	HT
09.50	4	Staff voice	HT
10.20	5	Declarations of interest in respect of items on the agenda	Chair
	6	Minutes of the previous public meeting: 14th January 2020 *(Paper A)*	Chair
	7	Matters arising *(Paper B)*	Chair
	8	Chairman's Report *(Paper C)*	Chair
	9	Chief Executive's Report *(Paper D)*	AH
		Governance and Risk (G Well-governed, T Trustwide Quality Improvement)	
10.40	10	Organisational Risk Register *(Paper E)*	CO
10.50	11	Corporate Governance Update *(Paper F)*	CO
		Strategy and System Working (T Transformation, E Environments, A Access to Services)	
11.00	12	Service Presentation – FYPC *(Presentation)*	HT
11.25	13	Step Up To Great Progress/Milestones/KPIs *(Paper G)*	DW
11.40	14	Break	
		Quality Improvement and Compliance (T Trustwide Quality Improvement, P Patient Involvement, A Access to Services, S High Standards)	
11.50	15	Quality Assurance Committee Highlight Report 18.02.20 *(Paper H)*	LR
11.55	16	Director of Nursing's Report including AHP report *(Paper I)*	AS
12.00	17	Care Quality Commission (CQC) progress Report *(Paper J)*	AS
12.10	18	Safer Staffing - Monthly Report December 19 and January 20*(Paper Ki & Kii)*	AS
12.15	19	Six Monthly Safe and Effective Staffing Review Report *(Paper L)*	AS
12.25	20	Guardian of Safe Working Hours (Junior Doctors Contract) Quarter 3 Report *Paper M)*	SE
12.30	21	Patient and Carer Experience and Involvement (including Complaints) Quarterly Report Q3 *(Paper N)*	AS

12.40	22	Patient Safety Incident and SI Learning Q3 Report *(Paper O)*	AS
12.45	23	Learning from Deaths Report Q2 and Q3 *(Paper P)*	SE
		**Performance and Assurance**	
12.50	24	Staff Survey *(Paper Q)*	SW
1.00	25	Finance and Performance Committee Highlight Report 21.01.20 & 18.02.20 *(Paper Ri & Rii)*	FH
1.05	26	Finance Monthly Report – Months 9 & 10 *(Paper Si & Sii)*	DC
1.10	27	Performance Report – Months 9 & 10 *(Paper Ti & Tii)*	DC
1.15	28	2020/21 Financial Plan *(Paper U – To Follow)*	DC
1.25	29	Review of risk – any further risks as a result of board discussion? *(Oral)*	Chair
	30	Board Performance Pack	Chair
	31	Any other urgent business	Chair
	32	Public questions on agenda items	Chair
1.30	33	**Date of next public meeting** **27th May 2020 venue TBC**	Chair

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 3rd March 2020
Venue: NSPCC Conference Room
AGENDA

Confidential Agenda			
Timing		**Item**	**Lead**
2.00	1	Apologies for absence:	Chair
2.00	2	Declarations of interest in respect of items on the agenda	Chair
2.00	3	Minutes of the previous confidential meeting 14th January 2020 *(Paper AAi)* Minutes of the Board Development 4th February 2020 *(Paper AAii)*	Chair
2.00	4	Matters arising *(Paper BB)*	Chair
2.05	5	Chief Executive's report *(Oral)*	AH
		Governance and Risk	
2.20	6	Section 75 Agreement 0-19 *(Paper CC)*	DW
2.35	7	New Care Models *(Paper DD)*	DW
		Strategy and System Working	
2.50	8	LLR Contract Sign off *(Oral)*	DC
		Performance and Assurance	
3.00	9	Transfer of the Mental Health Facilitators Service from Nottingham Healthcare *(Paper EE)*	GK
3.15	10	Review of risk – any further risks as a result of board discussion?	Chair
	11	Confidential Board Performance Pack	Chair
	12	Confirmed minutes from all committee meetings available to Board members on request.	Chair
	13	Any Other Business	Chair
3.20	14	Close	

UNCONFIRMED

Leicestershire Partnership NHS Trust

Trust Board

A

Minutes of the Public Meeting of the Trust Board
Tuesday 14th January 2020 9.30am

Sparkenhoe Committee Room, County Hall

Present:

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

In Attendance:

Ms Rachel Bilsborough, Director of Community Health Services
Mr Gordon King, Interim Director of Mental Health
Ms Helen Thompson, Director, Families, Young People & Children Services & Learning Disability Services
Mrs Sarah Willis, Director of Human Resources & Organisational Development
Mr Chris Oakes, Director of Corporate Affairs Governance and Risk
Mr David Williams, Director of Strategy and Business Development
Ms Emma Wallis, Associate Director of Nursing and Professional Practice
Ms Cathy Geddes, NHSI
Ms Kimberly Kingsley, NHSI Observer
Mr Oliver Newbold, NHSI Observer
Ms Kamy Basra, Head of Communications
Ms Julie Shepherd, NHFT Director of Nursing
Mr Mark Farmer, Healthwatch
Ms Millie Weston, LPT Graduate Scheme
Mr Frank Lusk, Trust Secretary
Mrs Kay Rippin, Corporate Affairs Manager (Minutes)

TB/20/001	**Apologies and Welcome:** The theme of today's meeting is Community Health Services.

	The Chair invited all attendees to introduce themselves and welcomed the following individuals to the meeting: Mr Chris Oakes, Director of Corporate Affairs Governance and Risk and Mr David Williams, Director of Strategy and Business Development - both in shared Director roles with LPT and NHFT. Emma Wallis Associate Director of Nursing and Professional Practice (deputising for Anne Scott); Cathy Geddes and the NHSI observers Kimberly Kingsley and Oliver Newbold; Mark Farmer from Healthwatch; Kamy Basra Head of Communications; Millie Weston attending as part of the LPT Graduate Scheme and Julie Shepherd NHFT Director of Nursing. Also for the staff voice item TB/20/003 the chair welcomed members of the MHSOP Memory Service Team: Simon Guild the MHSOP Memory Service Manager; Stuart Kennedy the Clinical Lead and Rob Snow the Team Administrator. Apologies for absence were received from Professor Kevin Harris and Ms Anne Scott. Emma Wallis is deputising for Anne Scott today.
TB/20/002	**Patient Voice Film:** CHS MHSOP Memory Service The patient voice film features Sheila and her two sons David and Michael who care for Sheila's day to day needs. Sheila was referred to the Memory Service after a memory diagnosis from her GP. The Memory Service have helped the family access adaptions including a clock which shows the days allowing Sheila to independently know what day it is; a wrist alarm allowing Sheila to safely sleep in her bed rather than the chair downstairs which she had been doing previously and also audio books which increase the quality of life for both Sheila and her son David. Michael explained how having the support of the Memory Service has helped them to structure their lives and helped them to prepare for what may come next. He felt their quality of life had improved and they feel that they now manage well on a day to day basis, knowing they can access support and advice from the Memory Service if needed. It was agreed by the Board that the message from the film was very positive. The Chair had contacted the team prior to the meeting to ask if there were any learnings for the Trust from the family's feedback. There were none as they were happy with the service they had received. Ruth Marchington enquired as to whether the service offered support to the carers, and it was confirmed that carers are always an integral part of the service offer. Discussions were held around other services involved in patient care and the development of Integrated Care Pathways within LPT. Sue Elcock commented that it was helpful from a clinical point of view that the interviewer raised with the patient if having a diagnosis had made a difference to her. Darren Hickman wondered if any other services were involved with the family as we moved into a more integrated model of care. Angela Hillery confirmed that integrated care within this Leicester, Leicestershire

	and Rutland is further forward than many systems especially with social care services. The Board agreed that the positive nature of the family and their strength based approach embracing self-care was important and clearly made a difference.
TB/20/003	**Staff Voice Presentation:** CHS MHSOP Memory Service attended to present to The Board. Rachel Bilsborough Director of Community Health Services; Simon Guild MHSOP Service Manager; Stuart Kennedy Clinical Lead and Rob Snow Team Administrator discussed the service and the recent changes in structure they have undergone. Simon Guild and Stuart Kennedy described the two strands to the service – those aged 65 and over with a suspected dementia illness and adults aged under 65 with a suspected dementia illness. 50% of the referrals into the Mental Health Service for Older People (MHSOP) were into the Memory Service, averaging around 240 per month. There are around 740 patients on the pathway in any given month. The service has seen a restructure over the last year with the two teams – East and West moving to share a single service lead since October 2019. This has led to less variation within the teams and an increased peer support network but also the need to manage expectations from staff as they adjust to having only one staff lead to support them and as they begin to work more remotely. A centrally located single team would be a solution for the future but there are challenges around securing a location for this. The team have been working closely with primary care and the voluntary sector and this has seen a number of positive results including increased compliance with the 18 week Referral To Treatment (RTT) rates. In 2017 the RTT compliance rates were at 71% rising to 80% (averaging at 85%) by the end of 2019. Other news from the team included the introduction of Job Plans for staff to ensure roles mirror each other across the county; a focus on the 6 week pathway group – where pathway targets can depend on University Hospitals Leicester (UHL) providing scanning services; regular meetings with the stakeholder group; reducing Did Not Attend (DNA) rates to 10.8% by introducing text messaging reminders and the consideration of a joint tender with The Alzheimer's Society to provide the post diagnostic support service that is currently provided by The Alzheimer's Society. The team have also embraced student placements and have developed strong links with research. Rob Snow Team Administrator shared with the Board his experiences of dealing with resolving issues with backlogs within the team by looking at processes and tasks and reprioritising leading to more efficient ways of working and targets being met with letters now produced in real time or within 5 working days. The team have worked hard to prepare for the migration from Rio to SystmOne with staff booked on training and super users identified. They are in a good place to migrate. The next steps for the team include looking at the cohort of patients who require

	ongoing maintenance and the impact this has on core business and working towards supporting advanced care planning. Faisal Hussian raised the issue of how wait times for the Memory Service could be particularly distressing for that group of people and it was confirmed that there were procedures in place to signpost people to support services during the wait period. Sue Elcock made the Board aware that the team's waiting list management procedures had been shared with other teams as a beacon of excellence. Ruth Marchington was interested in how the service reaches the diverse communities in Leicester and the team described their accessibility with the use of interpreters and a new cognitive assessment tool which will be introduce shortly which is more conducive to non-English speaking patients. David Williams reflected with regards to the Step Up To Great Strategy (SUTG) this service is a great example of looking at all areas where improvement can be made and Helen Thompson asked if the Job Plans could be used as shared learning across teams for consistency. Angela Hillery commented that as remote working is the direction of travel we need to consider how we support the staff in this and manage the challenges that arise. The team was thanked by the Board for attending. **Action – Dani Cecchini/Estates – consider the possibility of a facility for a centrally located single team for the East and West Teams as part of the Estates Strategy.**
TB/20/004	The Chair introduced the meeting by stating : This is a meeting held in public. We welcome members of the public and have allowed an opportunity to ask any questions on the agenda items at the end of the agenda. It is assumed that all papers have been read in advance in order to avoid lengthy introductions, but asked authors to highlight any new developments or significant implications arising since the paper was written. Please avoid using NHS acronyms. **Declarations of Interest in Respect of Items on the Agenda:** The Chair reminded all Board members to record any declarations or a nil return on the Self Service LPT Declare. The Board members confirmed that they had no conflicts of interest in relation to the agenda items.
TB/20/005	**Minutes of the Previous Public Meeting:** Paper A The minutes of the previous public meeting held on 3rd December 2019 were

	agreed subject to an amendment to the section on the Quality Assurance Committee (QAC) Highlight Report which makes it unclear which meeting a paper was seen at – it was the QAC meeting. This will be amended.
TB/20/006	**Matters Arising Actions:** Paper B. The Board agreed that all matters that were listed as green were completed and could now be closed. Item 903 has now been resolved with a clearer and more accurate methodology being employed to produce the data. However 903 will remain amber until a report has gone to Finance and Performance Committee (FPC) to confirm this. Item 906 was to be raised with the next Audit Committee. **Action: Dani Cecchini - 903 remains amber until a report has gone to Finance and Performance Committee (FPC) as detailed above.**
TB/20/007	**Chair's Report:** Paper C was presented to the Board. It covers the period 3rd December 2019 to 14th January 2020. The Chair's Report aligns with the Step Up To Great priorities and details boardwalks to the Evington Centre wards where Winter pressures were evidenced being managed with strong leadership. The report also describes how Non-Executive Directors have carried out 5 boardwalks across services during this period. The Chair has attended recent events including giving the opening speech at the Medical Trainees Awards and also attending the CQC engagement meeting which had a very informative pharmacy presentation. The Chair joined a staff group discussing the new leadership behaviours at a Café Conversation at Coalville Hospital and remarked on how engaged the staff were in the Our Future Our Way initiative. Mark Farmer, Healthwatch raised the issue of Charnwood Community Mental Health Team and anecdotal evidence that recruitment is an issue and patients are suffering with a lack of consistency in consultant contact. Ruth Marchington confirmed that during her recent visit this was raised as an issue by a member of staff. Sue Elcock confirmed that they are aware of the recruitment difficulties and that the roles need to be made as attractive as possible. The strategy of overseas recruitment is being considered with the use of Skype interviews and the promotion of word of mouth recruitment through the consultant network.
TB/20/008	**Chief Executive's Report:** Paper D ensures that the Board is updated on national and local developments with the Health and Social care sector. Within this paper, the Board was asked to support the national pledge to reduce plastic waste within the NHS.

	The NHS Midlands Pledge to Reducing Plastic Waste was discussed and presented as an appendix to this paper for the Board to consider. The Chief Executive asked that as a Board we support this scheme and sign up to the pledge. The Board agreed. This piece of work will be monitored through the Sustainability Champions Group which reports into the Estates Group. It will be brought back to Board by Dani Cecchini who is the Executive Lead. Angela Hillery discussed LPT's Buddy work with Northamptonshire Healthcare Foundation NHS Trust and stated that she was encouraged to read, hear and see from staff the growing opportunities for us both to learn from each other. Angela Hillery welcomed officially the two shared executive director roles with NHFT that do not currently exist within LPT, confirming that these shared roles reflect the approach that many NHS trusts now adopt to strengthen, build capacity and resilience, whilst ensuring value for money too. The Chief Executive welcomed Chris Oakes as shared Director of Corporate Governance and Risk and David Williams as shared Director of Strategy and Business Development. Angela Hillery raised the issues around the Flu Vaccination take up rates remaining low and confirmed that this will be discussed later in the meeting. Other news included the Recruitment to the Director of Mental Health role which took place yesterday and was successful; the Better Care Together work which continues to be successful and the news that Boards are starting to work together in partnership which is important in terms of integrated care systems – our Board is meeting with other local NHS Boards on 28th January 2020. The recent Infection Prevention and Control (IPC) re visit (7th January 2020) is now a strong amber which is very encouraging. Angela Hillery also confirmed that LPT are an accelerator site for the Ageing Well Integrated Care Model and more on this will feature later in this meeting. Mark Farmer, Healthwatch raised the issue of Personal Health Budgets for those patients not under a section. Angela Hillery confirmed that there is a national direction of travel to support Personal Health Budgets for patient groups and there was a lot of work going on nationally which includes how commissioning needs to transform. This will be important to support this overall direction. The Board was recommended to receive the Chief Executive's Report and to approve the Plastic Waste Reduction Pledge detailed in the report and attached as an appendix to this report. **Resolved: The Board approved the Plastic Waste Reduction Pledge.**
TB/20/009	**Organisational Risk Register (ORR):** Paper E - The Chair asked The Board to note the organisational risk profile, including the changes made since the last risk report and the action being undertaken to support maturity of the risk system. The Organisational risk register Report was presented by Chris Oakes.

	Chris Oakes confirmed that the key changes following the risk review completed in December 2019 by the Executive Team, QAC and FPC were listed in the paper and the Board is to note the two new risks raised. It was confirmed that there have been improvements over the last few months but that the process is a continuous journey. A new internal audit on risk was due to begin. Discussions were held around the usefulness of stepping back from the detail and looking at gaps and themes. This issue was raised by Geoff Rowbotham who felt this may be a useful activity to ensure that we don't miss any risks. Geoff Rowbotham also suggested benchmarking with other Trusts to help see the bigger picture. Ruth Marchington suggested that we may want to record where our risks and risk appetite differ. Ruth Marchington highlighted that the residual score risk 11 on the current estate configuration stands above the Trust's risk appetite – despite mitigating action. Liz Rowbotham added that intelligence from elsewhere could be used and that the auditors have given us useful comparative information from other Trusts that we could use. Chris Oakes confirmed that the risks were more developed now and that once the executive 1:1 reviews of their risks are complete this will be the right time to step back and assess. The Chair asked the Board to agree the changes – in sections 2.1 and 2.2 in the report. She highlighted that risks would be captured during the meeting from the papers that followed and would be considered at the end of the meeting. **Resolved: The Board agreed the above changes to the Risk Register.**
TB/20/010	**Community Health Services:** **Community Services Redesign go-live update – oral presentation by Rachel Bilsborough.** Rachel Bilsborough gave the Board an overview of the last 12-18 months' working collaboratively to redesign the model of care. This pre work part of the journey is important to ensure that we are using resources in the most effective way as the scale of the redesign is internally very large with the realignment of community nursing and therapy services and establishment of eight community hubs aligned to the primary care networks. 6 weeks post implementation the safety and quality metrics show no significant change; there has been a decrease in patient complaints and also they have received encouraging feedback from stakeholders including GPs. Rachel Bilsborough confirmed that the Home First offer has so far been a positive experience for patients and GPs. The changes for staff have been quite significant and that there is more work to do around this and around acute colleagues accessing services in a timely manner. However, therapy staff agreed that the therapy offer now available at weekends is leading to improved outcomes. . During the first four weeks there were 838 referrals into the Home First Service. Following a question raised by Mr Farmer, it was confirmed that after 6 weeks

local authority support funding ceases whilst most have met their reablement goals in this time, those who haven't will be transferred into an alternative appropriate health or care service. The Local Authority is currently re tendering their domiciliary contract which will strengthen the reablement offer.

It was confirmed that the risk of failing to implement the service (risk number 7) detailed on the ORR had been reviewed and was in the process of being closed.

Angela Hillery confirmed that the engagement work undertaken with staff did pick up on concerns and these were quickly responded to. The Chair confirmed that this had been the case for the staff she had met during a recent Boardwalk. Rachel Bilsborough confirmed that they continue to respond to and work with staff who have concerns and acknowledged that there is more work to do to to refine and embed the new model post implemention.

Resolved : The Board confirmed that risk 7 will be closed and any new emerging risks are being managed locally and will be escalated to the ORR if the residual risk is significant.

Ageing Well strategic update – oral presentation by Rachel Bilsborough.

This was presented as a PowerPoint presentation to the Board. The presentation aimed to give clarity in terms of delivery plans. It discussed the national Ageing Well programme and Community Services Accelerator sites – the purpose of the accelerator site programme is to co-develop a national approach to achieve the 2 hour/ 2 day standard and to deliver a nationally defined operating model.

The three areas discussed were:

- Urgent Community Response (UCR) – 2 hour standard for UCR and 2 day standard for reablement on a single point of access for UCR utilising 111
- Enhanced Health in Care Homes – enhanced support and better coordinated care, reablement and rehabilitation.
- Anticipatory Care – helping people with complex needs stay healthy and functionally able.

The presentation detailed how the sites will work tightly together to determine a national operating model that will deliver the national standards 365 days a year. The programme will set out what must be standardised and what is for local adaptation and will codify the data detail behind the national standards and work with NHSX and NHS Digital to implement changes to the national data set.

The accelerator sites aim to develop a workforce model that can be adopted across England to support each area to scale up their local teams including sharing good practice with all systems across England. This will also give areas the option to buddy with a neighbouring non-accelerator system to support them in meeting the national standard.

This system aims to provide the evidence and knowledge that will lead to a set of recommendations on the thresholds and achievement of the national standards. This will be applicable to the whole of England and build delivery confidence through their own early delivery against these standards.

	Rachel Bilsborough was confident that the pre work done to support this was thorough and that the new Home First offer aligns well with the Ageing Well intentions. It can be framed as a continuation along the pathway. Geoff Rowbotham confirmed that on his recent Boardwalks he was very impressed at how ready everything is for what is emerging. Darren Hickman agreed that this was a big step in the Leicester, Leicestershire and Rutland (LLR) Systems work and a significant achievement for LPT. The Board was informed that there is a large piece of work being undertaken on data and the problem that non-integrated units on SystmOne presents in causing double counting of referrals. It was agreed that the risk around data quality would need to be reviewed and possibly increased due to this. Sarah Willis also raised the matter of risk around recruitment and the need to ensure this recruitment drive was different to be successful. Rachel concluded by stating that the National Team for Ageing Well will be visiting LPT on 12 February 2020. **Resolved : The Board agreed that the Ageing Well project was aligned to the Leicester, Leicestershire and Rutland (LLR) systems plan and supported the accelerator site plan.**
TB/20/011	**System Flow – Winter Plan and Current Pressures:** Oral presentation from Rachel Bilsborough, Gordon King and Helen Thompson to inform the Board about current system pressures. Rachel Bilsborough stated that we cannot underestimate the local and national significant pressures that have been very challenging and had pathway impacts. Rachel Bilsborough confirmed that there had been a 96-97% acute regional bed occupancy during this period with a 6% increase in admissions and a 5% increase in A&E attendances. The focus of regional dicussions with NHSI/E were centered on quality and safety. Regionally we had seen over the Christmas period UHL, LPT, East Midlands Ambulance Service (EMAS) and transport providers all at OPEL 4 which is highly unusual with community providers operating at the same pace as acute providers. All of LPT's 222 beds were open. The Board were informed that during this period a number of strategies were employed to assist: A safer flow pathway was implemented in the community hospitals; the Diana Team Children's Nurses were placed in UHL to assist with flow difficulties in paediatrics and Home First nurses were deployed to in-reach at UHL and to the respiratory rapid response department in the Glenfield Hospital to support. This week has seen a de-escalation to OPEL 3. Helen Thompson informed the Board about the Winter Pressure Money which will be used to support children's mental health services including positive behavior support and community support for children with difficulties; a crisis café offer for children and young people and also supporting the mental health triage team.

	Gordon King added that LPT have been successful in identifying resources to support 8 different aligned schemes across the CCG, UHL and the Police to increase hours; provide nurses 24/7 from April 2020 as part of the Core 24 offer; for admin support between the hours of 12 midnight and 7am and for a new triage nurse and consultant in the Emergency Department. Also for additional housing enablement support and return to home support in the Bradgate Unit and additional capacity for the mental health triage car working with the police. All this forms part of the Crisis Pathway. The Chair thanked the team for the update. Faisal Hussain commented that it was reassuring to see a patient safety focus on the winter pressures and asked if there was any evidence to demonstrate that it was working. Rachel Bilsborough confirmed that she sits on the A&E delivery Board where all providers' data is collected for review and assurance. Ruth Marchington raised the issue of staff support during this pressured time it was confirmed that a close eye was kept on staffing levels and agency workers used as needed, resulting in there not being a reduction in the agency spend trajectory, but safety must come first. During periods of OPEL 4 all services are in close contact with several scheduled calls each day and the OPEL system clearly maps out steps needed to be taken to mitigate risk for each provider. This is detailed in the Winter Plan. **Resolved: The Board received an update on current system pressures.**
TB/20/012	**Quality Assurance Committee Highlight Report:** Paper F - the Highlight Report from the meeting held on 10th December was presented to the Board by Liz Rowbotham who confirmed that the new governance structure for QAC is 90% complete. There is around 10% of the total work left to do which included improving the flow of papers up to QAC and on to the Board. The Board was asked to note that the final paragraph of the CQC report stated that great progress had been made and highlighted the spot checks as a remaining concern in terms of embedded improvement. The Quality Forum is focusing on this issue of spot checks. It was raised in the report that there are concerns around the prolonged difficulty in terms of capacity in the patient safety team, which was being reviewed by Anne Scott, Interim Director of Nursing, AHPs and Quality.. The Health and Safety flash reports to the Board around fire safety improvements have been very useful and Liz Rowbotham thanked Dani Cecchini and the team for these. The report showed two low assurances, seven medium assurances and one high assurance detailed on the Highlight Report. Darren Hickman asked why the Learning from Deaths Report remains at amber and Sue Elcock confirmed that it was due to the period of transition for the report style and it will remain amber until this is properly embedded.

	QAC had received a presentation on Seclusion with a further deep dive planned. Anne Scott and Julie Quincy working closely to improve this. Angela Hillery reminded the Board that spot checks are useful tools as they help us to gauge embedding. **Resolved: The Board was recommended to receive assurances raised in the Quality Assurance Committee Meeting of 10th December 2019 and detailed in the Highlight Report presented today.**
TB/20/013	**Director of Nursing, AHPs and Quality Report:** The report Paper G was presented to the Board for assurance by Emma Wallis deputising for Anne Scott. The Board were asked to note the content of the report. The report detailed a summary of events since the last Trust Board meeting in December. It also detailed the current position on the flu vaccination The Trust's flu vaccination uptake for front line staff currently stands at 56% and it was recognised that this is one of the lowest rates of uptake for NHS Trusts in the country. Emma Wallis confirmed that the up to date position stood at 56.5%, with a planned twilight flu vaccination shift planned at 3 sites (Bradgate, Bennion and Evington) to target bank staff. The Board were informed that LPT had benchmarked their actions against the top performing Trusts and confirmed that we are doing everything that other Trusts do to increase the level of take-up. Geoff Rowbotham requested assurance on what is actually planned to ensure LPT meet the Flu targets. Angela Hillery confirmed that what we are doing is comparable with other Trusts and that success is often through local ownership so we need to look at how we can build this into teams across the Trust. Sarah Willis added that the message needs to encourage staff to want to do it rather than staff being told to do it. The NHSI Infection Prevention & Control (IPC) re-visit which took place on 7th January 2020 as a follow up visit from the August 2019 visit had now taken place. The result of this is that LPT remain within the Amber rating as determined at the last visit and that a revisit will take place in May 2020 to see further developments. It was made clear that this is now a strong Amber moving towards the Green as opposed to an Amber nearly Red following the visit last year and so progress is evident. The inspectors were pleased with the improvements and they were very complimentary about the evidenced engagement and enthusiasm of our staff. Faisal Hussain raised the matter of toy cleaning reported in Paper G stating that he report says that issues had been resolved but it wasn't clear what issues they were. Emma Wallis confirmed that the issue had been around whether toys were considered to be therapeutic equipment and therefore the responsibility of the staff to clean and this has mostly be resolved with staff with a couple of staff members still being supported in this. **Resolved: The Board received the report for assurance.**
TB/20/014	**Care Quality Commission (CQC) Progress Report:**

	Paper H. The progress report was presented to the Board by Emma Wallis for assurance. It was confirmed that this report had been to QAC. The report summarised the progress against actions so far and confirmed that overall the Trust has completed 91% of the actions. The 'warning notice and must do' actions are 97% complete (with two 'warning notice / must do' actions continuing) and the 'should do' actions are 77% complete (with six 'should do' actions on-going). The report concluded that 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. Emma Wallis updated the Board on a change since this report was written – action S11 – the capacity for assertive outreach training – this has now been resolved and Kate Dyer has confirmed that the capacity is there. Mark Farmer, Healthwatch raised the issue of shared rooms on the Bradgate wards and asked for any developments. It was confirmed that this matter would be addressed in this afternoon's confidential meeting, that a three year plan to eliminate dormitory accommodation across LPT's mental health services (including older people's services) had been formulated for approval. **Resolved: The Board is recommended to receive the report for assurance over CQC activity to deliver the actions identified in the 2018/19 inspection report.**
TB/20/015	**Safer Staffing Monthly Report:** Paper I. The monthly report was presented to the Board by Emma Wallis for assurance.. The report detailed how 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. The Interim Director of Nursing, AHPs and Quality confirmed in the report that she is assured that there is sufficient resilience across the Trust (not withstanding some hot spot areas) to ensure that every ward and every community team is safely staffed. Emma Wallis confirmed that in relation to the hot spot areas additional tools are being used to collect acuity and dependency data and assist with triangulation. There will be an in-depth review of hot spots included in the 6 monthly Trust Board paper. The first data is due on 21st January 2020 and the narrative will be delivered after this date. Angela Hillery enquired if we were capturing the information around bank and

	agency staff and if we are able to identify those bank/agency staff that are used regularly in the community hospitals. Sarah Willis confirmed that this data is collected as LPT are always keen to turn bank and agency staff into permanent staff. It was pointed out by Rachel Bilsborough that some bank staff want to choose their hours and this is why they remain on the bank. Dani Cecchini added that it was critical that we understand the staffing needs on our wards in order to help us prioritise. Congratulations were extended to Emma Wallis who had successfully become a Safer Staffing Fellow after being recruited by the Chief Nursing Officer in the 1st cohort of twelve. The Chair asked that the narrative around the recurring hot spots come back to Board. **Resolved: the Trust Board was 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.**
TB/20/016	**Freedom to speak Up Guardian 6 monthly Report:** Paper J. The chair welcomed Pauline Lewitt, Freedom to Speak Up Guardian to the meeting to present Paper J. The 6 monthly report was presented to the Board by for approval following the work on the self –assessment at the Board development meeting on 20th December 2019. Angela Hillery confirmed that Pauline Lewitt now attends the Strategic Executive Board meetings which helped with triangulation of the data. The report detailed both national and local guardian work including discussion of themes and numbers of contacts made to the FTSUG. Pauline Lewitt confirmed that there had been 63 staff concerns raised in the period either by individuals or groups. These concerns raised did not have specific themes or come from a particular service. The Board was informed how the Freedom to Speak Up agenda is building an environment where staff know that their concerns, feedback and commentary are taken seriously and indeed welcomed as an opportunity to guide service improvement and transformation. Pauline Lewitt discussed how feeling free to speak up is a significant culture change across the whole of the NHS. Faisal Hussain commented that he had indeed noticed a positive change when meeting staff with regards to their willingness to raise matters with him. The Board agreed this was a very positive progression and great to see. Angela Hillery commented that it is important as a Board that we recognise that we have an open culture encouraging more speaking up and that more speaking up is a really good thing. The Chair asked about the increase in CHS concerns raised from 11 in the first six months to 22 in the second six months and whether this had correlated with the

	Community Services Redesign. Pauline Lewitt advised that there was no correlation with the change programme and that these were individual issues. **Resolved: The Trust Board was recommended to approve the completed NHS England and NHS Improvement self-review tool which was presented at Appendix 1 - including actions and review dates which was sent in the Board papers. They were also requested to support the current mechanisms and activities in place for raising awareness of the FTSU agenda, thereby supporting the significant impact speaking up can have in supporting our Trust vision of 'Creating high quality, compassionate care and wellbeing for all'.**
TB/20/017	**Patient Safety Quarterly Report Q2:** Paper K - the quarter 2 report was presented to the Board by Emma Wallis to assure the Trust Board that information is being monitored in order to identify where action is required and where action is taken; that this action is both effective and is taking place in a coordinated way across the three directorates thus ensuring patient safety. The report had been to QAC prior to the Board. Emma Wallis updated the Board on the Serious Incident (SI) report performance section of the report – to confirm that Tracy Ward has been asked to work with Northampton Foundation Trust (NHFT) Head of Patient Safety harmonizing processes. Liz Rowbotham added that the QAC had noted that the new way of working around the SIs demonstrated that we are moving towards a changed culture. Angela Hillery observed that the transition into quality governance had been created and now there is a requirement to challenge learning and adapt and scale it – this will be done through QAC. Rachel Bilsborough asked the Board to note the change in pressure ulcer reporting – numbers have increased due to reporting all pressure ulcers not just those that were developed in LPT care. The Board was asked to note that the data around SIs will also change moving forward due to neck of femur fractures caused by falls being reported as an SI. Sue Elcock requested the Board to note that there had been a delay in recruiting a Learning from Deaths nursing post but that this is now resolved. **Resolved: The Trust Board was recommended to receive assurance from this report and note the additional work identified as required that will begin when staff come into post via the work of the Patient Safety Improvement Group and the Serious Incident Group. The Board are also asked to note the change in the reporting requirements of Serious Incidents and this has resulted in showing out of control. The reason for this is detailed in section 4.**
TB/20/018	**Finance and Performance Committee Highlight Report:** Paper Li. The FPC Highlight Report from the meeting held on 10th December 2019 was

	presented to the Board by Geoff Rowbotham. The Board was asked to note the improvement in assurances since the previous report in November. There were now three low assurances (waiting times, financial position and estates); five medium assurances and one high assurance all detailed in the report. **Resolved:The Board was recommended to receive assurances raised in the Finance and Performance Committee Meeting of 10th December 2019 and detailed in the Highlight Report**
TB/20/019	**Joint Meeting of Finance and Performance Committee and Quality Assurance Committee Highlight Report:** Paper Lii. The joint FPC and QAC Highlight Report from the meeting held on 10th December 2019 was presented to the Board by Liz Rowbotham. There was one low assurance, two medium assurances and no high assurances detailed on the joint Highlight Report. The Board was asked to note a change in the CIP Quality Impact assurance following a review which took place in January. This was now high assurance. **Resolved: The Board was recommended to receive assurances raised in the joint meeting of the Finance and Performance Committee and the Quality Assurance Committee Meeting held on 10th December 2019**
TB/20/020	**Finance Monthly Report:** Month 8 - Paper M - the paper was presented by Dani Cecchini for assurance. The report presented the LPT financial position for the period ending 30th November 2019 (month 8). Dani Cecchini confirmed that despite continued challenges, we remain on plan at month 8 It was confirmed that considering the still unsettled OPEL3/4 and the winter pressures along with higher agency usage it is becoming increasingly unlikely that we will meet the revised year end financial plan. Dani Cecchini confirmed that if LPT were to change the forecast outturn at month 9 there is protocol for this to be followed regarding discussing with the NHSI finance team and the Board. Angela Hillery confirmed that it is a nationally challenging period and it is important that we differentiate between safety first and financial grip. If there is a deviation from our financial plan we need to be clear what is a response to safety pressures rather than grip. This will need to be explained to NHSI and other regulators. Dani Cecchini confirmed that LPT was ensuring that it was operating at the most efficient and effective whilst remaining safe. A Quality Impact Assessment of the Financial Turnaround will be completed and QAC will look at this in detail. Mark

	Farmer, Healthwatch commented that as well as looking at the safety of patients and the well-being of staff it's important to consider the impact on patients. The Chair concluded that the range of forecast from best case to worst case as detailed in appendix F has now narrowed leading to more certainty around the likely position. Dani Cecchini confirmed that all options are being considered and confirmed that month 9 protocol is to be fully transparent and FPC will receive the detail in their meeting. **Action: Dani Cecchini - A Quality Impact Assessment of the Financial Turnaround will be completed and presented at QAC** **Resolved: The Trust Board was recommended to accept the reported financial position(s), and to support any further actions designed to improve the year end forecast as agreed or discussed during this Trust Board meeting.**
TB/20/021	**Performance Report:** Paper N was presented to the Board by Dani Cecchini. Dani Cecchini introduced this report as the new style performance report with the old format Integrated Quality Performance Report (IQPR) report being in the Board Information pack. The Executive team, the Strategic Executive Board and the Finance and Performamce Committee have worked hard to develop the new format and requested feedback on this report. Liz Rowbotham whilst supporting the new format requested a timeline on the quality measures that had been agreed that are missing from the report – it was confirmed that this information would be reported back to the Finance and Performance Committee's next meeting. Sarah Willis made the Board aware that with regards to workforce indicators (vacancies, agency costs and sickness) a senior leadership team session (which is held every 6 weeks with over 140 leaders) is addressing this. The Chair raised the issue that matters relating to CQUIN that are outstanding from the December IQPR are not referred to in this report so a way to track this will need to be established. The Board members had a discussion around the length of the report, what should and shouldn't go into the report and if the old format report (IQPR) should continue to be issued with the Board Information pack. It was confirmed that there are no financial penalties in respect of the delivery of CQUIN but the board agreed that they should still be sighted on it because often the measures impact patient experience It was agreed that the IQPR was not clear and did not allow prioritisation which is key moving forward. The Board should not see everything as there will be a hierarchy of reports that pass through the new governance and escalation processes.

	The Chair referred to appendix one in the report relating to harm and waiting times. Sue Elcock confirmed that work is progressing in this area and that waiting list concerns are largely around a particular waiting list (Refugee Trauma) and there is a Harm Assurance meeting on 16th January 2020 where this will be discussed. The Chair highlighted areas where performance had improved, notably gatekeeping and CPA 7 day and 12 month targets. **Resolved: the Trust Board was recommended to receive assurance with regards to the areas of quality and performance**
TB/20/022	**Performance Management and Accountability Framework:** Paper O was presented to the Board by Dani Cecchini for approval. Dani Cecchini confirmed that the report may need to be reframed in the future but that this was a good start point. There was a review meeting booked for 27th January 2020 to look at the month 9 data and that this would come back to the next Board. Feedback on the report and its content was given. Issued raised were: • Sub-committees roles – are they detailed enough? It doesn't refer to deep dives or KPIs for QAC. Perhaps more words are needed? (Ruth Marchington) • More detail on how it's going to work could be helpful and a reference to Estates and Facilities escalation routes is important as it's a big risk for LPT (Geoff Rowbotham) Angela Hillery welcomed the challenge the Board had presented. Dani Cecchini confirmed that the LPT Performance Framework will be reviewed after six months in June 2020. **Resolved: The Trust Board approved the new Trust Performance Management Framework, subject to the above mentioned changes which will give more clarity.**
TB/20/023	**Charitable Funds Committee Highlight Report:** Paper P was the Charitable Funds Committee Highlight Report from the meeting held on 17th December 2019. It was presented to the Board by Cathy Ellis for assurance. There were no low assurances reported, one medium assurance and eleven high assurances detailed on the Highlight Report. The Board were informed that the 360 Assurance end of year Audit was very positive and had given significant assurance of the charity's financial controls and processes. Lindsey Woodward our Fundraising Manager is currently reviewing the strategy for the charity to explore the next stage of its journey. The Board were asked to note that the Asset Based Community Development project (ABCD) has been moved into core NHS funding and therefore £100k of funds has been returned to the charity which is being used for gyms/equipment at Stewart House and the Willows and gardens at the Evington Centre and Bradgate Unit.

	Cathy Ellis requested support from the Board in a future development session, possibly April, to help shape the direction of the charity. **Resolved: The Board were asked to receive assurance from the Charitable Funds Committee Highlight Report.**
TB/20/024	**Audit and Assurance Committee Highlight Report:** Paper Q - the Audit and Assurance Committee Highlight Report from the meeting held on 6th December 2019 was presented to the Board by Darren Hickman. There was one low assurance reported, four medium assurances and six high assurances detailed on the Highlight Report presented to the Board. Darren Hickman confirmed that the three audits that were at a standstill in the process were now progressing so assurance will improve at the next Audit and Assurance Committee Meeting. **Resolved: The Board were requested to receive assurance from this highlight report.**
TB/20/025	**Review of Risk:** The chair asked the board if any further risks had emerged as a result of Board discussion. Risks highlighted by the Chair were both from item 10 on the agenda (Ageing Well): • Recruitment into Ageing Well • Data quality impact A further risk raised was consultant recruitment in relation to staffing levels – an assessment is needed. **Action: Rachel Bilsborough – risk around recruitment into ageing well to be considered.** **Action: Sue Elcock – risk around consultant recruitment to be considered.** **Action: Chris Oakes – to consider the inclusion of the new risks raised.** **Resolved: These risks will be considered by the Executive team for inclusion in the ORR**
TB/20/026	**Board Information Pack:** The Board members confirmed receipt of the following documents: • Documents Signed Under Seal (Quarter 3) • Integrated Quality Performance Report • Organisational Risk Register
TB/20/027	**Any Other Urgent Business:** No other urgent business was raised.

UNCONFIRMED

TB/20/028	**Feedback on the Meeting:** The Chair requested feedback from the Board members on today's meeting. Comments were: • Lots of positive change happening in LPT, especially involving patients and carers – people need to hear about it (Mark Farmer) • References to risk in the reports – would like to see more reference to quality of care and patient experience (Mark Farmer) • Connecting the patient voice and staff voice is better(Geoff Rowbotham) • The patient Voice video could show less positive experiences to offer more learning (Dani Cecchini)
TB/20/029	**Public Questions on Agenda Items:** There were no public questions at this meeting. The Chair invited the visitors Julie Shepherd, Kamy Basra and Millie Weston to share their experience of the Board meeting and they confirmed that it had been positive and informative. Julie Shepherd confirmed that she was working with Anne Scott on the Serious Incident process and sharing best practice from NHFT. Kamy Basra reminded the Board members that the Celebrating Excellence Awards was open for nominations.
TB/20/030	**Date of next Meeting:** The next public Trust Board meeting will be held on Tuesday 3rd March 2020, venue to be confirmed.

B

Leicestershire Partnership NHS Trust

TRUST BOARD 3rd March 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	3rd March 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 – Report to go to FPC

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.			to confirm this has occurred.
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. Action CLOSED
905	December TB/19/215	Explore the possibility of strategic links with DNRS (the national facility being proposed for rehabilitation)	David Williams	3rd March 2020	In progress
906	December TB/19/217 January TB/20/006	Standing Orders and Standing Financial Instructions. Approved at December Trust Board subject to Audit Committee review again for adequacy for appropriate capital authorization limits.	Dani Cecchini	3rd March 2020	Next Audit committee 6 March 2020 Action CLOSED
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 April 2020, is completed.	Helen Thompson	27th May 2020	Report to May Board.
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	Next Audit committee 6 March 2020 Action CLOSED

Action No	Meeting month and minute ref	Action/issue	Lead	Due date	Outcome/evidence (actions are not considered complete without evidence)
909	January TB/20/003	DC/Estates to consider the possibility of a central facility for the East and West located MHSOP hubs – request arising from the Staff Voice Presentation.	Dani Cecchini	3rd March 2020	Will be incorporated in the Estates prioritisation meeting 18 March 2020. Action CLOSED
910	January TB/20/020	Quality Impact Assessment of the Financial Turnaround to be sent to QAC meeting.	Dani Cecchini	3rd March 2020	
911	January TB/20/025	Consider the risk around recruitment for Ageing Well.	Rachel Bilsborough	3rd March 2020	This has been incorporated into the OOR recruitment risk Action CLOSED
912	January TB/20/025	Consider the risk around recruitment of consultants.	Sue Elcock	3rd March 2020	
913	January TB/20/025	Following the consideration of the 911 and 912 consider the need to add these risks to the risk register.	Chris Oakes	3rd March 2020	

C

Trust Board 3rd March 2020

LPT Chair's report summarising activities and key events
From 14th January 2020 to 3rd March 2020

Hearing the patient and staff voice	Chair and Non-Executive Directors 12 boardwalk visits to: • **FYPC** – Diana service; Children's speech and language; Paediatric phlebotomy • **CHS-** Mental Health Services for Older People Unscheduled care team; St Lukes Hospital Ward 1 stroke unit • **AMH** – Bradgate Unit Ashby Ward; Hershel Prins Griffin Ward Female PICU; Liaison & Diversion team; 4 Community Mental Health Teams in City Central, City West, County South and County North West
Connecting for Quality improvement	• CQC engagement meeting featured updates from the CQC and LPT's progress against actions and themes from the last inspection. Tim Sayers and Lydia Towsey gave a presentation on Arts in Mental Health. • Attended 2 Foundations for Great Patient Care meetings with deep dives on seclusion, restraint, ligatures and smoking. • Site visit to the Beacon Unit, our new inpatient building for CAMHS. Thank you to Glenfield Parish Council for presenting us with a £5,000 cheque for our charity fundraising appeal to buy sensory equipment and sports equipment.
Promoting Equality Leadership & Culture	• Attended the launch of the national Workforce Race Equality Standards (WRES) pilot programme. LPT are one of 6 trusts selected for the national pilot to accelerate the cultural changes necessary to improve the working environment for all staff. This is important because it impacts our staff satisfaction, patient care and efficiency. • Cohort one of the LLR-wide BAME Reverse Mentoring programme has now completed. We held a celebration event for mentors and mentees to share their experiences. Personally, the time I spent with my mentor has given me much greater insight and we have written up our story as a reflection to share with cohort 2. • Attended the race and cultural understanding training along with 30 other staff, there are further sessions running throughout the year for our staff to sign up. Thank you to Asha Day who talked about her life experiences. • Participated in Celebrating Excellence staff awards shortlisting panel to assess 220 nominations across 13 categories. The awards will be presented on 1st May. • Quarterly meeting with Freedom to Speak up Guardian to discuss themes, concerns and national developments. LPT now have 20 Freedom to Speak up Partners amongst our staff
Building strong Stakeholder relationships	• Board to Board meeting with our Buddy Trust board members from NHFT to explore the mutual benefits from our current collaborations and the potential for further opportunities to work together. • Board to Board meeting for LLR organisations: LPT, UHL and three CCGs. The agenda included our vision for the Integrated Care System, contracting and

	financial plans and good governance. • Attended the Police and Crime Commissioner awards for safer communities • Monthly NHSI System Improvement & Assurance Meeting in January and February to review LPT performance • University of Leicester meetings including a 1:1 with Prof Phil Baker Pro-Vice Chancellor and Head of College of Life Sciences; the University Court annual meeting; University Council Awayday; and Finance committee
Good Governance	• Board development session on 4th February with work on: Culture and the new leadership behaviours; Well-Led corporate governance; Restraint, seclusion & ligatures; Workforce Race Equality Standard national programme; stakeholder strategy; and LLR contracting for 2020 • Non-Executive Director timeout session focusing on Well-led corporate governance changes, including feedback from NHSI on the Board and committee observations that took place in December and January. • Conducted the annual appraisals for 3 Mental Health Act Managers who sit on our panels that hear renewals and appeals for detained patients • Attended January and February Finance & Performance Committees to support with the embedding of governance changes

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 NHS Foundation Trust; **CCG** – Clinical Commissioning Group; **FYPC –** Families Young Persons and Children's services**; CHS –** Community Health Services**, AMH –** Adult Mental Health Services; **CAMHS** – Children's and Adolescents Mental Health Services; **LD** - Learning Disability

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 3rd March 2020
Paper number	D

Name of Report: CEO Report

For approval		For assurance		For information	x

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

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

Coronavirus

The Trust continues to follow national guidance released regarding coronavirus and we are communicating regularly with staff to ensure they are well informed of the latest developments. The Trust has established a Covid-19 Management Group led by the Director of Nursing and AHPs who is the Trust Executive lead.

New guidance on mental health in integrated care systems

The Royal College of Psychiatrists (RCPsych) has published recommendations for local and national health and care leaders to support the prioritisation of mental health as local areas develop into integrated care systems (ICSs). RCPsych state the move to ICSs brings opportunities for mental health services to be incorporated more fully with the wider health and care system and for patients to benefit from more joined up care. However, challenges may be thrown up around the viability of mental health trusts, and how their comparatively smaller voices can be heard. RCPsych's recommendations focus on the following areas: establishing and maintaining clear purpose, engaging and collaborating during planning, making use of population health management, data and outcomes, using new contractual models to deliver high quality care, funding, whole population budgets and incentives, and leadership and governance.

Your mind matters – NHSE/I & Age UK

In conjunction with Age UK, NHSE/I have launched an awareness campaign to highlight the benefit of talking therapy for older people. In this open letter, they have asked GPs and IAPT services for help in increasing referrals to talking therapies for older people to better support older people's mental health.

NICE is changing the way it produces and presents guidance

NICE Connect is a multi-year project to transform the way NICE guidance is produced and presented, making it easier to use and ensuring people receive evidence-based high quality care in the right place at the right time. For further information or to get involved please follow this link.

Recent publications:

NHS Operational Planning & Contracting Guidance 2020/21:

NHSE/I published the operational planning and contracting guidance for 2020/21 on 30 January. This overarching document sets the delivery task for both NHS providers and commissioners for the coming financial year, covering system planning, finances, operational performance, and workforce. It details what the service will be expected to deliver in the second year of the long term plan period, including moving towards financial balance and improving access to services.

For a greener NHS

The NHS has launched For a greener NHS, to work with staff, hospitals and patients to help the health service become net zero as soon as possible. Ideas are welcome from anyone with an interest in healthcare or carbon reduction.

Consultation on requirements for patient safety specialists

NHSE/I will shortly be consulting with providers to identify patient safety specialists to oversee and support patient safety activities across their organisation, as stated in the NHS Patient Safety Strategy. Responses will help shape the final requirements providers will use to identify their patient safety specialists by June 2020.

Launch of the Gram-negative toolkit

Alongside stakeholders, NHSE/I have developed a Gram-negative toolkit for infection prevention and control staff, which includes a template action plan for a system approach to Gram-negative sepsis reduction. The toolkit contains examples of implementation from systems across England.

Local Developments

CQC Routine Provider Information Request (RPIR)

We have now received, completed and submitted our information for the CQC Routine Provider Information Request (RPIR). The CQC will use the information we supply in our RPIR to help them decide on their inspection approach. This request contains a mixture of quantitative and qualitative questions, as well as a list of documents.

A thank you to all staff involved in this for their hard work in populating this request in a timely manner. Regular communication will be available to all staff to guide them through the CQC journey and outline the processes involved in more detail.

National Ageing Well team visit LLR

On 12 February 2020, the national Ageing Well team led by Kath Evans, Director of Urgent Community Response for the Ageing Well Programme, undertook a site visit to LLR supported by a local team of CCG commissioners, Local Authority partners and LPT staff. The purpose of the visit was to understand our new model of care and our ambition and system trajectory to achieve the 2 hour/2 day national standards. Following a helpful and informative discussion in the morning about our model, our learning and our key risks and challenges, the group visited the Neville Centre to talk to our City integrated health and care staff who deliver Home First. They had a demonstration and were impressed by our SystmOne auto- planner functionality. The afternoon was spent discussing plans for investment in 2020/21, and feedback from the other Ageing Well accelerator sites who have also had a recent site visit. Key messages from the visit include:

- Definition and clarity with regard to the 2 hour/2 day national standard is on-going;

- All health and care providers delivering urgent community response are expected to input via CDSD v1.5, technically this will be very challenging for social care partners and a solution is sought through accelerator sites;
- Accelerator sites will be expected to invest time and commitment to deliver a 'support offer' nationally enabling other systems to deliver the national standards;
- An expectation that commissioners will recurrently invest in workforce to deliver the national standards from 2022/23 and beyond, thus enabling non recurrent Ageing Well funds to be committed recurrently.

Staff Survey

Our 2019 National NHS staff survey results were recently published, thank you to all 2,422 staff who completed the survey and shared their views. There are no significant variations in what was shared the previous year, which highlighted some real improvements in staff experience. However there is a slight decrease in three of the eleven indicators: staff morale, staff engagement and quality of appraisals. There are also variations in results across the directorates and services, for which we will receive more detail to help assess what local action is required.

Through the Our Future Our Way programme we are addressing the feedback and there is a significant focus and programme of work already underway, including nine priorities which will pick up these elements. A key part of this work is the leadership behaviours framework that all staff have had the opportunity to contribute to.

AHPs

LPT has recently led on a funding bid to Health Education England (HEE) on behalf of the Allied Health Professions' (AHP) Council for Leicester, Leicestershire and Rutland to enhance AHP apprenticeships locally, and I am delighted to tell you that our bid was one of six selected for the East Midlands region. HEE announced in early December that it would be making a number of regional funding awards to support the development of AHP 'Faculty Test Beds' – money to develop and train the local AHP workforce in line with the objectives set out in the NHS Long Term Plan and Interim People Plan. As the lead organisation for the bid, we already have a proven record of AHP apprenticeships at level 4 and level 6 across speech therapy, occupational therapy and physiotherapy. The additional funding (which runs until the end of March 2020) will be used to further extend the existing apprenticeship programme to more of the allied health professions, creating a toolkit to enable other areas and organisations across system to support apprentices within their teams, and provide a quality experience for them. This is in line with the local AHP Council's strategic plan, and will facilitate successful recruitment and retention.

Leicester Homelessness Charter

The Trust will be signing up to the Leicester Homelessness Charter and working in partnership with other providers and representative groups to ensure that healthcare is represented for the homeless population we support. The charter has 150 signatories and includes 36 organisations working together, further details of the charter can be found here.

Leicester, Leicestershire and Rutland (LLR Better Care Together Update)

The latest edition of Partnership Update, the Leicester, Leicestershire and Rutland (LLR) Health and Social Care Better Care Together (BCT) newsletter can be found here and includes updates on LLR's local response to the NHS Long Term Plan, the new governance arrangements for system working across Health and Social Care and progress on the IM&T services priorities over the next 12 months from a system point of view.

Recent events

LGBT history month

LPT have been busy celebrating LGBT history month during February with LGBT+ staff sharing their stories so that we can better understand our LGBT+ colleagues and highlighting the importance of this campaign. Victim First will be delivering a special workshop on LGBT+ history to encourage understanding of LGBT+ history and of issues that LGBT+ people face today. The work being undertaken is support by the Trusts LGBT+ staff support network Spectrum. More details on LGBT+ can be found here.

Recognition awards for Recovery College students

In January 2020 Leicestershire Recovery College hosted a special celebration event for a group of 'star' students nominated by tutors and staff for a variety of reasons, from recognising fantastic progress to acknowledging their support for fellow students and the difference they make for others. Over the last year, tutors from LPT and our partner organisations have delivered more than 132 courses at 12 venues across Leicester, Leicestershire and Rutland.

Executive Team Update

I am pleased to confirm that Gordon King was successful in his application for the position of Director of Adult Mental Health Services.

Leadership Behaviours

I'm sure you will have seen that we have now agreed the wording to describe each of the five behaviour themes that will make up our new Leadership Behaviour Framework. They are:

- Taking personal responsibility; *We give our best at work to deliver the highest standards.*
- Recognising and valuing people's differences; *We respect everyone equally by helping to create a community that demonstrates unconditional positive attitudes; where people feel they belong, are valued, empowered and proud to work at LPT.*
- Valuing one another: *We communicate with kindness and respect, valuing everyone's contribution.*
- Working together: *We are supportive, appreciative and encouraging of each other, enabling a positive team spirit which gives the best outcomes for colleagues and patients*.
- Always learning and improving: *We embrace change and actively seek opportunities to keep improving.*

Further details and supporting guidance to explain how it will be used across the organisation will be communicated out to staff.

Beacon Appeal

We were delighted to accept a cheque for £5,000 from Councillor Richard Bowers, chair of Glenfield Parish Council. The parish council has made this generous donation to the Beacon Appeal, which is fundraising for specialist sensory and sporting equipment to enhance inpatient care at the new mental health facility for young people in Leicester which is due to open in the early Autumn.

National Apprenticeship Week

It was great to see our apprentices being celebrated during National Apprentice Week (3-7 February 2020) at the Apprentice Workshop on 7 February 2020. It was also a fantastic opportunity to promote the accredited qualifications available to all staff.

Brew Monday & Time to Talk Day

It was good to see and read about staff backing the recent national "Brew Monday" and "Time to talk day" campaigns to get together with loved ones, friends and colleagues to talk about problems and encourage everyone to be more open around Mental Health.

Reverse Mentoring Success

We have recently marked the end of a 6 month reverse mentoring programme which aimed to match junior black and minority ethnic (BME) staff with white senior staff. BME junior staff led the mentor-mentee relationship providing insights on discrimination and disadvantages they faced. BME colleagues have helped senior white staff gain knowledge and skills on how to actively address race inequality, actively becoming involved in removing barriers and empowering junior BME staff. Reverse mentoring is one of a number of actions to ensure we create a more inclusive workplace that nurtures our BAME staff and addresses workforce race inequalities.

The programme was a great success and work is taking place to arrange the second cohort of reverse mentoring.

Awards news

Continence pilot in national awards

An LPT project to improve patient access into the continence service has been highly commended in a national awards scheme. The project was highly commended (runner up) in HTN (The Health Tech Newspaper)'s "Excellence in Implementation" category. The project involved introducing the Autoplanner module of SystemOne to the continence nurses working in the community in the Melton, Syston and Rutland areas. LPT and LHIS worked with software suppliers TPP to develop the Autoplanner module, initially with planned community nursing. It is now being rolled out across other community services within LPT.

The original project, involving LPT and Autoplanner, has been shortlisted for a HSJ Partnership Award. At that time the project was part of a wider transformation project for the community nursing service, which also included upskilling staff, eliminating unnecessary paperwork, and streamlining those forms which were essential to good patient care. The same project was shortlisted by the Nursing Times last year.

Cavell Award

Congratulations to Beverley Sharman, staff nurse at Stewart House, who has received a Cavell Star Award for her outstanding work as a nurse.

Relevant External Meetings attended since last Trust Board meeting

Service visits by Executive Directors since last Trust Board

Jan/Feb/March 2020
Stewart House
Occupational Therapists, Loughborough Hospital
Charnwood Hub – DN Team
Listening Meeting – DN teams
Phlebotomy Team *
CAHMS: Ward 3
PIER Team
Staff Support Group

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

Executive Directors: external meetings since last Trust Board

Jan/Feb/March 2020	
A&E Delivery Board	LPT/NHFT Board to Board
Ageing Well Recruitment Group	LPT System Improvement and Assurance Meeting
Andy Williams (AO for LLR CCG)	LLR - STP System Review Meeting & Pre-meet
NHFT tour of Bradgate Unit	LLR STP Integrated Community Board
Buddy Forum	LLR Site visit with Ageing Well National Team
COO Breakfast Meeting	LTP Workforce Task and Finish Group
Community Transformation Group	LLR Workforce Meeting
Commissioning oversight of health visitors and school nursing meeting	Launch of WRES Culture Change Pilot
Community Network Board Meeting	Leicester City Council/NHS meeting
CQC Engagement Meeting	Meeting with LAMP (independent mental health advocacy service)
Chief Officer Form	Midlands and East Mental Health and Learning Disability CEOs meeting
Division of Psychiatry Meeting	MH Programmes Delivery Board
East Midlands CEO Meeting	MH Collaborative Board
Health & Well Being Scrutiny Commission	Midlands UCR Accelerator Meeting
Health a& Wellbeing Board	Peter Davis (County Council)
Healthwatch	Paul Hindson (PCC)
Joint meeting with Healthwatch Leicester/Leicestershire	PCC Safer Community Celebration
John Sinnott (County Council)	Review of solutions to support urgent care flow
Leicester CCG – Future in Mind Commissioning Steering Group	Research Envoy Scheme (Launch day)
Leicestershire HOSC Meeting	Tamsin Hooton – West Leicestershire CCG
LLR System Board to Board	Tim Sayers/Lydia Towsey (BrightSparks)

**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.

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board – 3 March 2020
Paper number	E

Name of Report: Organisational Risk Register

For approval		For assurance	✓	For information	

Presented by	Chris Oakes, Shared Director of Corporate Governance and Risk	Author	Kate Dyer, Head of Quality Governance

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

Report previously reviewed by	
Committee / Group	Date
QAC	18.02.20

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
The Strategic Executive Team is asked to: • note the organisational risk profile, including changes since the last risk report • and agree the recommendations **The Quality Assurance and Finance and Performance Committees are asked to:** • note the organisational risk profile, including changes since the last risk report • Provide an assurance rating for any risks reviewed **Trust Board is asked to;** • note; the organisational risk profile, decisions made by the Operational Executive Team, and the level of assurance provided by QAC and FPC through their highlight reports.

Organisational Risk Register February 2020

1 Introduction

1.1 The Organisational Risk Register (ORR) is presented as part of a continuing risk review process. The paper includes a summary of the current risk profile, the risk appetite statement approved by the Trust in November 2019, and the rational for risk scoring.

2 Discussion

2.1 There have been a limited number of updates to the ORR this month due to a focus of attention on responding to the CQC routine provider information request (RPIR). Notes for action to be rolled over into February 2020, for reporting in March 2020 are noted below:

- Completion of the approved new risk regarding cultural resistance to the Bare Below the Elbow Initiative
- Further additions to risk 26 - Insufficient staffing levels to meet capacity and demand and provide quality services to include;
  - Recruitment for ageing well
  - Recruitment of Consultants
- Addition of a new risk regarding the STP and the management of the LPT budget
- Addition of a new risk regarding the Trust's ability to meet the community health services dataset requirements
- Addition of a new risk to address phase 2 of the community service re-design
- The two access risks (29 and 30) will be closed and a new, merged risk will be opened.

2.2 Revision of the Organisational Risk Register

The table below provides an update on those risks which have been reviewed in the last month. The update column captures any new, escalated, de-escalated or closed risks and any changes to risk oversight or scoring. It also highlights any new controls, sources of assurance or actions; or any identified gaps in controls and assurance.

Risk No	Risk Descriptor	Update as at 30.01.20
QAC		
12	There is a risk that the Trust does not positively impact on the experience of services users, carers and families that use our service	An additional control has been included; - Three year patient experience and involvement delivery plan 2019/2022 now in place Two additional gaps in control have been identified; - Friends and Family Test system currently being used is not fit for purpose and results in poor feedback received by patients and carers - No strategic lead for carers or carers strategy in place A number of additional sources of assurance, and gaps in assurance have been provided. New actions have been detailed.
13	The Trust does not increase the number of service users that are positively participating in their care, treatment and service improvement	Three additional controls have been included on the ORR: - Three year patient experience and involvement delivery plan 2019/2022 now in place - Collaborative Care Programme now in place - Recovery Café Programme in place An additional gap in control has been identified; - No central funding to support involvement activities or delivery of Delivery Plan A number of additional sources of assurance, and gaps in assurance have been provided. New actions have been detailed.
14	Patients do not always find it easy to share their experiences and the Trust does not as a result receive feedback	An additional control has been included; - Three year patient experience and involvement delivery plan 2019/2022 now in place Two additional gaps in control have been identified; - Lack of IT infrastructure to deliver an effective FFT programme. - No strategic lead or strategy for carers to support response to LLR Carers Strategy
24	Failure to delivery workforce equality, diversity and inclusion	Additional actions have been detailed.
25	Failure to create a culture of collective leadership that empowers staff to improve the services we provide	An additional control has been included; - Vision co designed and live

26	Insufficient staffing levels to meet capacity and demand and provide quality services	An additional control has been included; - Flexible working guidance launched Two additional gaps in control have been identified; - CSR and ageing well staffing requirements and demand - Medical consultant capacity concerns in AMH/CAMHS Additional actions have been detailed.
27	Failure to improve the health and well-being of our staff	An additional action has been detailed.
34	The Trust may 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.	External assurance has been sought by undertaking benchmarking of initiatives undertaken by other Trusts.
Joint QAC / FPC		
28	Failure to deliver timely access to assessment and treatment which could impact on patient safety and outcomes (for the priority services)	A gap in control has been identified: - Harm Review process approved at joint FPC/QAC (September 2019) but is not yet in place across the Trust
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	A number of additional controls, and gaps in control have been identified, this has led to a re-scoring of this risk. The current risk level has reduced from 20 to 12, and the residual risk score has reduced from 15 to 6. An additional internal assurance has been included, along with an additional action.
FPC		
17	Failure to meet financial plan and statutory breakeven duty	Risk 17 has been closed and separated into two new risks (numbers 37 and 38)
37	Failure to meet the 2019/20 Control Total surplus (£2.1m)	New risk. Included for approval by the Strategic Executive Team.

38	Failure to meet statutory duties in 2019/20- breakeven on I & E, External Financing Limit (cash) and Capital Resource Limit	New risk. Included for approval by the Strategic Executive Team.

3. Operational Executive Team

3.1 The Operational Executive Team is asked to note the organisational risk profile, including changes since the last risk report. It is also asked to approve the following actions:

- Closure of risk 17 and the addition of two new risks in its place:
    - Risk 37 Failure to meet the 2019/20 Control Total surplus (£2.1m)
    - Risk 38 Failure to meet statutory duties in 2019/20- breakeven on I & E, External Financing Limit (cash) and Capital Resource Limit

4. Quality Assurance Committee / Finance and Performance Committee

4.1 The Committees are asked to note the updates provided in section 2 above which highlights any recent risk activity, and any new sources of control and assurance provided on the ORR. All risks, including those which have not been updated during the month should be considered alongside information from any other relevant papers received by the Committees.

4.2 The Finance and Performance Committee should note that the Operational Executive Team has been asked to approve the closure of risk 17 and the addition of two replacement risks (numbers 37 and 38) which provide more clarity over each distinct area of risk. Any additional comments from the Operational Executive Team meeting about these two new risks will be provided to the Finance and Performance Committee as part of a verbal update.

5. Trust Board

5.1 The Trust Board is asked to;

- note the revisions to the ORR
- take assurance from the information provided by the QAC and FPC to the Trust Board following its discussion of risk; and
- note the decision made by the Strategic Executive Team regarding the closure of risk 17, and the addition of risks 37 and 38.

6. Organisational risk register summary: February 2019

6.1 The table below provides a summary of the risks included in the Organisational Risk Register, including the two additional risks that were added this month. The Quality Assurance Committee and the Finance and Performance Committee have been identified as responsible committees for these risks and will therefore review these at their meetings.

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	5	16	12
2	The Trust's safeguarding systems do not fully safeguard patients	DoN	QAC	High Standards	5	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	5	15	10
4	Services do not have the right number of staff with the right skills at the right time	DoN	QAC	High Standards	5	12	8
5	Capacity and capability to deliver KLOEs	DoN	QAC	High Standards	5	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	5	16	12
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	5	16	12
9	Failure to maintain the level of cleanliness required within the Hygiene Standards	DoF	QAC	Environment	5	16	12

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	5	16	12
11	The current estate configuration is not fit for the delivery of modern mental health, community and LD services	DoF	FPC	Environment	5	12	12
12	The Trust does not positively impact on the experience of service users, carers and families that use our services	DoN	QAC	Patient Experience	5	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	5	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	5	12	9
15	Risk of disruption to service and detrimental impact on patient safety as a result of EU exit	DoN	FPC	Well Governed	5	15	12
16	The Leicester/Leicestershire/Rutland system is unable to work together to deliver an ICS by April 2020	CEO	FPC	Well Governed	5	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	5	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	5	12	12
20	Performance management framework is not fit for purpose	DoF	FPC	Well Governed	5	20	16

22	Financial, reputational or service delivery harm or loss resulting from information breaches and attacks on information systems	DoF	FPC	Well Governed	5	16	12
23	Failure to deliver the EPR system and realise the benefits of the system	MD	FPC	Single Patient Record	5	16	8
24	Failure to deliver workforce equality, diversity and inclusion	DoHR	QAC	Equality, Leadership and Culture	5	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	5	16	12
26	Insufficient staffing levels to meet capacity and demand, and provide quality services	DoHR	QAC	Equality, Leadership and Culture	5	16	12
27	Failure to improve the health and well-being of our staff	DoHR	QAC	Equality, Leadership and Culture	5	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	5	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	QAC/FPC	Access to Services	5	12	6
30	Unmitigated demand may result in patients being unable to access services in clinically appropriate timescales	DoF / DDs	QAC/FPC	Access to Services	5	16	16

31	Projects will not deliver sufficiently to embed a consistent QI framework	MD	QAC	Trust-wide Quality Improvement	5	9	9
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	3	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	2	16	12
35	There is a risk that we have poor data quality due to a lack of an overarching data and information control framework. This may impact on our ability to make decisions and account for our activities	DoF	FPC	Well Governed	2	16	12
36	There is a risk that we are not compliant with Bare Below the Elbow	DoN	QAC	High Standards	1	16	12
37	Failure to meet the 2019/20 Control Total surplus (£2.1m)	DoF	FPC	Well Governed	1	12	8
38	Failure to meet statutory duties in 2019/20- breakeven on I & E, External Financing Limit (cash) and Capital Resource Limit	DoF	FPC	Well Governed	1	4	4

7. Heat Map

7.1 The heat maps below illustrate the current and residual risk levels of all risks on the Organisational Risk Register.

Current risk levels given the existing set of controls.

Consequence	5			3		
	4	*38*		4, 11, 18, 19, *29*, 32, 32, *37*	1, 6, 8, 9, 10, 16, 22, 23, 25, 26, 28, 30, 33, 34, 35, *36*	20
	3			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.

Consequence	5		3			
	4	*38*	4, 18, 23, 32, *37*	1, 6, 8, 9, 10, 11, 16, 19, 22, 25, 26, 33, 34, 35, *36*	20, 28, 30	
	3		12, 27, *29*	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)

Risk No: 1	High Standards	Date included:	01.10.19
Risk Title:	There is a risk that the Trust's systems and processes for the management of patients may not be sufficiently effective and robust to provide harm free care on every occasion that the Trust provides care to a patient.		
Risk Owner:	Director of Nursing, AHP and Quality (QAC)	**Date Last Reviewed:**	04.12.19
Review frequency:	Monthly		

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12

Controls

Description:

- Learning from incidents
- Thematic reviews and QI approach adopted by the Trust
- IPC policies
- Quality Strategy
- Mortality reviews
- Quality framework
- Patient safety plan
- People strategy
- Patient safety group
- Patient Safety Survey
- MHA reviews
- Accreditation in MHSOP wards and developing Trust wide
- Pressure Ulcers Group
- Falls Group
- Sexual Safety Work
- Violence and aggression Group

Gaps:

- External report on quality governance systems requires improvements to the systems to be made
- Developing an agreed set of clinical and professional standards and values

Assurances

Internal:	**Source:** • Quality report information being reviewed within the Trust • Quality Assurance Committee • All associated policies • Professional standards group • Revised quality governance structure being embedded • Revalidation and registration process in place • Associate Director of Nursing in place who leads on professional practice	**Evidence:** Use of polices Training Professional standards reports Revalidation /Registration reports Introduction of new governance reporting routes	**Assurance Rating**
External:	**Source:** • CQC inspection • NMC • Professional council (NMC, GMC) • Contract with CCG	**Evidence:** Requirement that no one can act as a nurse without a pin number	**Assurance Rating**

Gaps:

- Quality governance including SI system to be made
- Implementation of recommendations from external Quality Governance Report
- Learning from Deaths processes to be improved
- Suicide strategy to be developed

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Aug19	Implementation of the actions identified in the external quality governance report	T Ward H McCallion	Operationalise the actions identified from the Quality Governance Report. Revised quality governance structure in place, review of capacity to undertaken SI and other investigations to be undertaken. Appointment made to lead manager for learning from deaths and interviews for trust wide accreditation senior nurse to be held in December.	
Aug 19	Lead manager for learning from Death system	T Ward		
Aug 19	Appointment of a Trust wide accreditation senior nurse	A Scott		

Risk No: 2	High Standards	Date included:	01.10.19
Risk Title:	There is a risk that the Trust's safeguarding systems do not fully safeguard patents		
Risk Owner:	Director of Nursing, AHP and Quality (QAC)	**Date Last Reviewed:**	07.11.19
Review frequency:	Monthly		

	Conseq-uence	Likeli-hood	Combined
Current Risk	3	4	12
Residual Risk	3	3	9

Controls

Description:

- Lessons learnt
- Investigations and reviews
- Safeguarding Committee (to be included in Legislative Committee under new Quality Governance Framework)
- S42 enquires lessons learnt are disseminated
- Identified Safeguarding Nurse and Doctor
- Internal governance structure to manage safeguarding in place
- Members of 4 local safeguarding Board
- Adult and children's safeguarding team in place

Gaps:

- Lack of consistent approach to how lessons are learnt and how they are disseminated across the clinical directors through to front line staff
- Review of capacity of the safeguarding team

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Safeguarding Committee (to be included in Legislative Committee under new Quality Governance Framework) • Quality Assurance Committee • Annual Quality Account	Safeguarding report to Trust Board Annual Safeguarding Report	
External:	• CQC inspection • Commissioner meetings • Membership 4 local safeguarding Boards	• Minutes and reports produced	

Gaps:

- New processes to be embedded into the organisation including s42 conducted by safeguarding team

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Aug 19	Implementation of the actions identified in the external SI report			
	Review of capacity of safeguarding team	Anne Scott	External review to start in November 2019	

Risk No: 3	High Standards	**Date included:**	01.10.19		**Consequence**	**Likelihood**	**Combined**
Risk Title:	There is a risk that the Trust does not demonstrate learning from incidents and events and does not effectively share that learning across the whole organisation.			**Current Risk**	5	3	15
Risk Owner:	Director of Nursing, AHP and Quality (QAC)	**Date Last Reviewed:**	05.12.19	**Residual Risk**	5	2	10
Review frequency:	Monthly						

Controls

Description:

- SI system
- Investigations
- Complaints and claims
- Clinical Audit
- Patient survey
- Risk Management
- External Quality Governance Report
- Learning from Deaths
- Learning lessons exchange group

Gaps:

- Implementation of the actions from the external Quality Governance Report

Assurances

Internal:	**Source:** Quality Assurance Committee Quality Forum (to be introduced November 19)	**Evidence:** Regular reports and minutes from meetings Highlight information and escalation processes	**Assurance Rating**
External:	**Source:** • CQC inspection • Commissioners • Coroners • 360 Assurance internal audit of clinical audit – DRAFT limited assurance	**Evidence:**	**Assurance Rating**
Gaps:			

Key actions

Date:	**Actions:**	**Action Owner:**	**Progress:**	**Status:**
Aug 19	Implementation of the actions identified in the external Quality Governance report	Tracy Ward Hillary McCallion	Implementation plan being developed	

Risk No: 4	High Standards	Date included:	01.10.19
Risk Title:	There is a risk that services do not have adequate workforce cover through substantive bank and agency to ensure we have safe staffing levels		
Risk Owner:	Director of Nursing, AHP and Quality (QAC)	**Date Last Reviewed:**	04.12.19
Review frequency:	Monthly		

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	3	12
Residual Risk	4	2	8

Controls

Description:

- Monthly safe staffing reports with oversight and triangulation of fill rates, skill mix, temporary worker utilisation, vacancies, CHPPD, core clinical and mandatory training, patient experience feedback and Nurse Sensitive indicators
- 6 monthly establishment reviews include workforce planning, new and developing roles and recruitment and retention
- All reviews are in line with the NQB guidance for safe sustainable and productive staffing and the NHSI Developing Workforce Safeguards policy.
- Hot spot areas are escalated weekly to the Director of Nursing AHPs & Quality and monthly within the safe staffing report with actions to mitigate the risks.

Gaps:

- Trust wide safe staffing safeguards SOP
- Evidence based acuity and dependency data daily and for establishment reviews

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Workforce Planning capacity - funded establishments and 6 monthly reviews • Analysis of NSIs, outcomes and patient experience feedback • Analysis of CHPPD and fill rates • Analysis of temporary worker utilisation • Detailed reports on rostering effectiveness are provided to services each month to measure the impact of different initiatives and to help identify areas for improvement.	• **Trust Workforce Plan** • **Monthly and 6 monthly safe staffing reviews** • Analysis of the CHPPD has not identified variation at service level, indicating that staff are being deployed productively across services. • **Analysis of NSIs has not identified correlation between staffing and impact to quality, safety and patient outcomes**	
External:	NHSE Safe staffing trends – monthly submission The Department of Health and Social Care's group annual governance statement - NHSI Single Oversight Framework	Unify and Healthroster	

Gaps:

- Evidence based acuity and dependency data for all in-patient areas

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
	• To adopt the MHOST tool for review of patient acuity and dependency in all mental health adult and children's inpatient wards	Emma Wallis	License obtained for MHOST Staff training in October 2019 Data collection November 2019 Analysis – next 6 monthly review January 2020	
	• To identify an evidenced based tool for acuity and dependency measurement – Community Hospitals		November 2019	
	• To develop a Trust wide safe staffing safeguards SOP			
	• To procure and implement Allocate SafeCare.to monitor actual patient demand at key points during the day and accurately align staffing to match	Amrik Singh	May 2020 – Allocate SafeCare	

Risk No: 5	High Standards	Date included:	01.10.19
Risk Title:	Capacity and capability to deliver KLOEs		
Risk Owner:	Director of Nursing, AHP and Quality (QAC)	**Date Last Reviewed:**	04.12.19
Review	Monthly		

	Conseq-uence	Likeli-hood	Combined
Current Risk	3	4	12
Residual Risk	3	3	9

Controls

Description:

- Quality Improvement Work stream targeting
- CQC progress meetings
- Roll out of core standards training
- Local and Directorate risk registers

Gaps:

- Knowledge of organisational understanding and ownership of KLOEs
- inconsistent coverage of targeted core standards work (ie membership of the progress meeting, training coverage)

Assurances

Internal:	**Source:** • CQC fortnightly meetings with key staff • Level 3 groups • Quality forum • QAC • Walk arounds by the Director and Deputy Director of Nursing, AHP's and Quality	**Evidence:** Assurance papers Minutes Reports	**Assurance Rating** Amber
External:	**Source:** • CQC inspection and engagement meetings / discussions • Regulator discussions (SIAM / informal discussions with NHSEI)	**Evidence:** Inspection report Minutes of CQC engagement and SIAM meetings	**Assurance Rating** Amber
Gaps:	• Third line assurance over compliance (outside of the CQC)		

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
	Link to the High Standards QI programme **In addition:** Roll out of core standards training Development of a core standards toolkit Progress meetings to have a standing agenda item linked to KLOEs. To review membership to ensure it provides consistency across the Trust Explore the potential for a reference to the relevant KLOE in assurance reports	**Anne Scott** **Anne Scott / Mia Morris**	**QI project status Amber** Ad hoc training has started, with more scheduled Progress meetings already include core standards but an explicit agenda item will be included from 21 November 2019 To discuss feasibility of introducing a link in assurance reports during Q4 2019/20 with the level 3 governance work stream	Amber

Risk No: 6	Transformation		
Risk Title:	The co-produced future model for all age mental health services does not deliver the required transformation to meet population needs		
Risk Owner:	Director AMH (FPC/transformation Board and QIB)	**Date Last Reviewed:**	07.01.20
Review frequency:	Monthly		

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12

Controls

Description:

- Healthier in Mind campaign and co-design surveys and workshops generated principles which underpin future model of delivery
- Proven methodology , timeline and bespoke support package from NTW Trust
- Project Initiation Document
- Project Management Team
- Business plan and delivery plan
- Directorate Management Team (operationally and clinically steering)
- Stakeholder commitment to the programme through the Better Care Together plan and MH collaborative board

Gaps:

- Sufficient stakeholder ownership and engagement of the future model
- Effective balance of conflicting short term priorities, with the development of the longer term vision and plan
- System financial sustainability and mental health investment standard

Assurances

Internal:

Source:	Evidence:	Assurance Rating
• Large scale co-production events • Project Initiation Document • Directorate governance meetings • LPT Trust Board quarterly updates • Directorate Management Team (DMT)	• Communication products including website pages • Minutes of meetings • Transformation highlight reports	

External:

Source:	Evidence:	Assurance Rating
• Health and Wellbeing Board scrutiny • STP Better Care Together Plan – Mental Health work stream • System MH Partnership Board governance • City MH partnership Board scrutiny • MH Clinical Forum monthly updates • CPM monthly progress updates • MH collaborative	• Highlight reports • Progress updates	

Gaps:

- Signed off clinical model
- Affordable workforce model

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Oct-Dec	• Developing business plan and delivery plan to set out how to deliver outputs of AAT	J Edwards	Draft business plan developed and received at DMT	
Dec-Jan	• Communicating business plan to trust board, overview and scrutiny committees and staff	J Edwards	Plan presented to city HOSC, Trust board and events booked for new year	
19/20				
Jan 20	• Agree business plan with commissioners	J Edwards	Presentation planned at MH collaborative in new year	
Jan 20	• Set up workstreams for delivery plan	J Edwards	Briefs for each workstream currently being drafted	
Mar 20	• Develop financial plan for 2020 delivery plan	J Edwards / M White		

Risk No: 8	Transformation
Risk Title:	Failure to deliver LPTs 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
Risk Owner:	Operational Directors of LD, FYPC and AMH (FPC/transformation board and QIB)
Date Last Reviewed:	07.01.20
Review frequency:	Monthly

Transformation	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12

Controls

Description:

- Multi-agency LD and Autism Executive Board - *reports directly into the STP SLT, and is one of the Workstreams of the STP.*
- LLR weekly review of TCP cohort
- Clinical leadership and ownership
- Risk of Admission Register (ROAR)
- Care and Treatment Reviews
- SDIP for LD Rehab at the Agnes Unit
- Develop LD Forensic Community Network
- LD Outreach team offer alternative to admission
- 12 point discharge plan is utilised and monitored via discharge planning meetings
- There is an Accountable Officer (LPT CEO), an SRO and an Exec Lead
- LD forensic training package for health and social care staff

Gaps:

- LD Forensic training package for health and social care staff
- Treatment and support for ASD only diagnosis (without LD)
- Comprehensive service user led Risk Assessments and Care Plans
- Workforce Plan
- Timely LeDeR reviews

Assurances

Internal:	**Source:** • SOP for in hours and out of hours CTRs and CETRs to reduce risk of admission • ROAR • RCAs on all admissions	**Evidence:** SOP List of people at risk of admission Learning from RCAs to reduce risk of future admissions	**Assurance Rating**
External:	**Source:** • Adult Case Managers • RCA's on all admissions • External review from Moorhouse December 2019 priority recommendations made relating to : Programme governance Operational oversight and resource across the programme Inpatient data tracking and discharge Provision and commissioning strategy Capability and engagement and ways of working	**Evidence:** Learning from RCAs to reduce future admissions	**Assurance Rating**

Gaps:

- Case Managers for children
- Support for effective discharge of MOJ cases into the community

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Jan 2020	Deliver LD Rehab SDIP within agreed timescales	Helen Thompson	SEB 10.01.20	
	Mobilise All Age CRHTT offer to include response to LD and ASD		in progress	
	Configure Outreach services to support Crisis Bed accommodation Develop workforce plan		Waiting for crisis bed to be identified	
	Improvement plan for RA's and collaborative Care Plans Senior programme manager being LPT to appoint a project manager		Plan in place	
	Develop improvement plan from Moorhouse report with partners			
	Increasing the number of LeDeR reviewers by 2			

Risk No: 9	Environment
Risk Title:	Failure to maintain the level of cleanliness required within the Hygiene Standards
Risk Owner:	Director of Finance (QAC)
Date Last Reviewed:	06/01/2020
Review frequency:	Monthly

	Consequence	Likelihood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12

Controls

Description:

- PLACE Audits
- Contract management with NHSPS for provision of soft facilities management (including cleaning standards)
- Collaborative agreement in place with UHL for provision of soft facilities management (including cleaning standards)
- Use of the Hygiene standards
- Appropriately trained estates team in place
- Backlog maintenance controls
- Estates Strategy
- Hygiene Code gap analysis undertaken – Aug 2019
- Estates rep sits on/reports into IPC Group (cleaning/water/waste/decontamination)

Gaps:

- Lack of reporting against Hygiene standards

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Estate and Medical Devices Committee • Finance and Performance Committee • IPC Group • Bi-monthly cleaning forum (estates/IPC/NHS PS/UHL)	• Reporting against the delivery of the Estates Strategy • Monthly reports to FPC (Estates) and QAC - (IPC) • Regular cleaning audits and KPI score monitoring • Regular assurance information from UHL • IPC Bi-Annual report to Trust Board	
External:	**Source:** • NHSI IPC audit • CQC inspections • PLACE audits	**Evidence:** Reports from audits from independent sources	**Assurance Rating**

Gaps:

- Assurance information not being received from NHSPS
- Lack of assurance that the Trust is compliant with the cleaning standards
- NHSI re-visit in Jan 2020 identified gaps – risk re-scored to reflect current and residual risk

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
	Identify assurance routes for NHSPS to report to the Trust Confirm and where necessary strengthen reporting against Hygiene standards To audit all cleaners rooms against expected standards of cleanliness. To include trolley, schedules and equipment Develop key responsibility cards for domestic staff and supervisors	Emma Wallis	Draft FM SLA and performance KPIs received (Dec 2019) tbc	

Risk No: 10	Environment
Risk Title:	Failure to implement planned and reactive maintenance of the estate leading to an unacceptable environment for patients to be treated in
Risk Owner:	Director of Finance (FPC)
Date Last Reviewed:	09.01.2020
Review frequency:	Monthly

Environments	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12

Controls

Description:

- Contract management with NHSPS for provision of facilities management
- Collaborative agreement with UHL for provision of facilities management
- Appropriately trained estates team in place
- Health and Safety Reviews
- Backlog maintenance controls
- P21 partners in place
- Revenue and capital budget setting process in place
- Condition survey for the inpatient estate completed 2018
- Approved Estates Strategy
- Planned and preventative maintenance plan held by UHL
- New FM Oversight Group – weekly meetings to track FM risks/issues (Dec 2019 onwards)
- FM Transformation Board (Jan 2020 onwards)

Gaps:

- Lack of systematic process for identify high risk areas requiring maintenance
- Planned and preventative maintenance plan not share with the Trust by UHL – PPM schedules now received from UHL (Dec 2019)
- Unsatisfactory delivery against our facilities management agreement
- Maintenance is not always undertaken in a timely way

Assurances

Internal:	**Source:** • Estates and Medical Devices Committee • Finance and Performance Committee • Initial review to identify high risk areas of the estate that require maintenance completed – on going tracking of this via the FM oversight group.	**Evidence:** • Reports demonstrating implementation of the Estate Strategy • Reporting of FM KPIs to FPC • Estates risk register • Audit action plan – track via FM Oversight Group	**Assurance Rating**
External:	**Source:** • NHSI • CQC • HSE • Fire service • 360 Assurance internal audit of estates maintenance - Limited Assurance	**Evidence:** Audits and reports	**Assurance Rating**

Gaps:

- Lack of assurance on information received from UHL due to inconsistent audits
- Assurance information not being received from NHSPS
- Poor performance against set KPI resulting in lack of assurance

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Mar 2020	Reviewing options for delivery of FM services including planned and preventative maintenance plan	Sarah Ost	Business case with detailed options by Mar 2020 FM Transition Board and Working Groups established Letter of Intent issued to UHL	
	Escalation and governance process being developed that will include issue raising of inconsistent information	Andy Donoghue	Escalation via Oversight Group to Chief Exec as required	
	Identify assurance routes for NHSPS to report to the Trust managing contractors/ subcontractors	Andy Donoghue	Will be via performance reporting to EMEC – draft report format received for agreement (end Jan 2020)	
		Andy Donoghue		

Risk No: 11	Environment			Environments	**Conseq-uence**	**Likeli-hood**	**Combined**
Risk Title:	The current estate configuration is not fit for the delivery of modern mental health, community and LD services			**Current Risk**	4	3	12
Risk Owner:	Director of Finance (FPC)	**Date Last Reviewed:**	05.12.19	**Residual Risk**	4	3	12
Review frequency:	Monthly						

Controls

Description:

- A dedicated estates team in place
- Estates Strategy approved by the Trust Board in Oct 2019.
- Capital resource prioritisation framework
- Annual PLACE inspections
- Condition surveys have been completed in priority areas (in-patient estate)
- All age Mental Health Acute Inpatient Crisis and Outpatient Services Strategic Outline Case – Approved in principle at Trust Board – Oct 2019
- Health and Safety Risk Assessments in place
- Clinical risk assessment to mitigate re privacy and dignity

Gaps:

- Lack of derogation process to the Board
- Premises Assurance Model to be updated
- Challenges around availability of capital funding
- Approved Strategic plan for the elimination of dormitory accommodation

Assurances

Internal:	**Source:** • Strategic Estates and Medical Equipment Committee • Finance and Performance Committee • Health and Safety Committee • Directorate Health and Safety Action Groups • Building of new CAMHs Unit	**Evidence:** • Monthly report to FPC on progress against the Estate Strategy • Health and Safety Reports and confirmation of compliance with actions	**Assurance Rating**
External:	**Source:** • PLACE audits • NHSI • CQC • HSE • Fire service • KPMG audit of financial and quality accounts	**Evidence:** Audits and reports	**Assurance Rating**

Gaps:

- Premises Assurance Model is out of date

Key actions

Date:	**Actions:**	**Action Owner:**	**Progress:**	**Status:**
Mar 20 Jan 20 **22/23**	Premises Assurance Model to be updated SOC – follow up project – option to reduce 3 sites to 1 site Business case for interim dormitory solution Implementation of plan for the dormitories (20/21 to 22/23) Delivery of the SOC implementation plan (10 year phased delivery)	A Donoghue	Timescales to be confirmed – if new model not confirmed (by NHSE) by end Jan 2020, a desktop review of previous LPT version will be undertaken Work to finalise '3 sites to 1 site' to complete Jan 2020 Update report to Trust Board – Jan 2020 for decision on how to proceed	

Risk No: 12	Patient Involvement
Risk Title:	There is a risk that the Trust does not positively impact on the experience of services users , carers and families that use our service
Risk Owner:	Director of Nursing, AHP and Quality (QAC)
Date Last Reviewed:	07.11.19

	Conseq-uence	Likeli-hood	Combined
Current Risk	3	4	12
Residual Risk	3	2	6

Controls

Description:

- Patient Involvement Experience Team
- RIO system
- Use of SystemOne
- Patient surveys
- Friends and Family Test
- Envoy Patient Experience portal commissioned and in place
- Equality and diversity work
- Consultation and engagement with patients/ families/ carers
- Annual Quality Account
- Care planning audit programme
- Three year patient experience and involvement delivery plan 2019/2022 now in place

Gaps:

- Challenges in working between RIO and SystemOne
- Lack of use of carer assessments to develop better understanding of the link between incidents and concerns when introducing new pathways
- Friends and Family Test system currently being used is not fit for purpose and results in poor feedback received by patients and carers
- No strategic lead for carers or carers strategy in place

Assurances

Internal:

Source:	Evidence:	Assurance Rating
~~Patient involvement Experience Team report~~	~~Regular update reports~~	
~~Quality Assurance Committee~~	~~Carer Strategy~~	
Patient and Carer Experience Group established	Monthly Highlight Reports from PCEG to Quality Forum	
Equality Diversity and Inclusion Patient Experience and Involvement Group established	Three year patient experience and involvement delivery plan in place	
Complaints Review Group established	Service User Involvement Group established	
Quarterly Patient Experience and Involvement Reports	Friends and Family Test feedback	
Quality Forum	Compliments, concerns and complaints feedback received	
Quality Assurance Committee		

External:

Source:	Evidence:	Assurance Rating
~~Patient Experience Survey~~	Community Mental Health Survey Report and supporting improvement plan	
~~CQC inspections~~	CQC Reports	
~~MHA visits~~	Ward Accreditation programme in place	
~~Joint Strategic Needs Assessment~~	Step up to Great monthly reports	
Community Mental Health Survey		
CQC inspections		
MHA visits		
Joint Strategic Needs Assessment		
Healthwatch		

Gaps:

- ~~Lack of central assurance to Executive~~
- ~~Not sufficient involvement of carers~~
- No carers lead or strategy in place
- FFT system not fit for purpose - funding investment required for new system

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Aug 19	RIO will stop being used as part of the implementation of EPR project	Sue Elcock	Quality Governance framework being approved by the Trust Board 1 October 2019. The framework was approved in principle on 30 August 2019	
Aug 19	Governance systems are being developed to ensure proper oversight and assurance from Executive Directors	Frank Lusk	Presentation to the Trust Board 20 August 2019 where the Board supported the actions being taken	
Aug 19	Programme in place to develop increased engagement and empowerment of carers, service users and families	Alison Kirk	Delivery plan in place and reported monthly through Quality Improvement Board	
Jan 2020	Three year Patient Experience and Involvement Delivery Plan in place for 2019-2022	Alison Kirk	Co-design taking place to inform implementation of patient involvement framework	
	Patient Involvement Co-Design Group in place		Testing commenced with patients in January 2020	
	Patient Experience survey currently being developed with patients and carers for piloting in March 2020		Draft rollout plan to be discussed at PCEG in February 2020	
	FFT re-launch will take place in March 2020			
	Carers Option Paper to be discussed at Quality Forum in February 2020			

Risk No: 13	Patient Involvement					
Risk Title:	The Trust does not increase the number of service users that are positively participating in their care, treatment and service improvement					
Risk Owner:	Director of Nursing, AHP and Quality (QAC)	**Date Last Reviewed:**	29.01.20			
Review frequency:	Monthly					

	Conseq-uence	Likeli-hood	Combined
Current Risk	3	4	12
Residual Risk	3	3	9

Controls

Description:

- Patient Involvement Experience Strategy
- Patient Involvement Experience Team
- Experts by Experience programme
- Patient experience involved in training
- Patient surveys
- Equality and diversity work
- Consultation and engagement with patients/ families/ carers
- Annual Quality Account
- Care planning audit programme
- Range of communication to informed staff of engagement work
- Three year patient experience and involvement delivery plan 2019/2022 now in place
- Collaborative Care Programme now in place
- Recovery Café Programme in place

Gaps:

- Challenges in working between RIO and SystemOne
- Lack of use of carer assessments to develop better understanding of the link between incidents and concerns when introducing new pathways
- No central funding to support involvement activities or delivery of Delivery Plan

Assurances

Internal:

Source:	Evidence:	Assurance Rating
• Patient involvement Experience Team	• Regular update reports	
• Quality Assurance Committee	• ~~Carer Strategy (not in place)~~	
• PALs	• Patient involvement Experience Team report	
• **Patient and Carer Experience Group established**	• Monthly Highlight Reports from PCEG to Quality Forum	
• **Equality Diversity and Inclusion Patient Experience and Involvement Group established**	• Three year patient experience and involvement delivery plan in place	
• **Complaints Review Group established**	• Service User Involvement Group established	
• **Quarterly Patient Experience and Involvement Reports**	• Friends and Family Test feedback	
• **Quality Forum**	• Compliments, concerns and complaints feedback received	

External:

Source:	Evidence:	Assurance Rating
• ~~Patient Experience Survey~~	• ~~Outcome of patient conference~~	
• CQC inspections	• Planning of services	
• MHA visits	• Impact assessment	
• Joint Strategic Needs Assessment	• CQC Reports	
• ~~Patient conference~~	• Ward Accreditation programme in place	
• Healthwatch	• Step up to Great monthly reports	
	• Patient and Carer Involvement Group established	

Gaps:

- ~~Lack of central assurance to Executive~~
- Not sufficient involvement of carers, service users and families

Risk No: 14	Patient Involvement
Risk Title:	Patients do not always find it easy to share their experiences and the Trust does not as a result receive feedback
Risk Owner:	Director of Nursing, AHP and Quality (QAC)
Date Last Reviewed:	29.01.20
Review frequency:	Monthly

	Conseq-uence	Likeli-hood	Combined
Current Risk	3	4	12
Residual Risk	3	3	9

Controls

Description:

- FFT
- Patient survey
- Complaints
- Experts by experience
- Patient experience involved in training
- Equality and diversity work
- Consultation and engagement with patients/ families/ carers
- Annual Quality Account
- Care planning audit programme
- Range of communication to informed staff of engagement work
- Three Year Patient Experience and Involvement Delivery Plan in place

Gaps:

- Lack of use of carer assessments to develop better understanding of the link between incidents and concerns when introducing new pathways
- Lack of IT infrastructure to deliver effective FFT programme.
- No strategic lead or strategy for carers to support response to LLR Carers Strategy

Assurances

Internal:

Source:	Evidence:	Assurance Rating
• Patient involvement Experience Team report • Quality Assurance Committee • Quality Forum • Patient Carer and Experience Group • Equality, Diversity & Inclusion for Patients Group • Complaints Review Group • Quarterly Patient Experience and Involvement Reports	• Patient Experience Improvement Framework • Regular update reports • ~~Carer Strategy~~ • Patient involvement Experience Team report • Monthly Highlight Reports from PCEG to Quality Forum • Three year patient experience and involvement delivery plan in place • Service User Involvement Group established • Friends and Family Test feedback in placce • Compliments, concerns and complaints feedback received • Trust-wide patient experience survey implementation in 2020	

External:

Source:	Evidence:	Assurance Rating
• Patient Experience Survey • CQC inspections • MHA visits • Joint Strategic Needs Assessment • ~~Patient conference~~ • Healthwatch – regular meetings in place	• ~~Outcome of patient conference~~ • Planning of services • Impact assessment • CQC Reports • Ward Accreditation programme in place • Step up to Great monthly reports • Patient and Carer Involvement Group established	

Gaps:

- ~~Lack of central assurance to Executive~~
- Not sufficient involvement of carers, service users and families

Risk No: 15	Well - Governed
Risk Title:	Risk of disruption to services and detrimental impact on patient safety as a result of EU exit
Risk Owner:	Director of Finance (FPC)
Date Last Reviewed:	07.11.19
Review frequency:	Monthly

	Conseq-uence	Likeli-hood	Combined
Current Risk	3	5	15
Residual Risk	3	4	12

Controls

Description:

- National guidance
- Executive Lead and Senior Manager SRP appointed
- Brexit mitigation plan in place
- Members of local resilience forum
- Participate in the LLR
- MDT Brexit forum in place
- Brexit no deal action plan in place
- Membership of the Local resilience forum working group

Gaps:

- Lack of clarity on Government Brexit Strategy

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Monitoring against the Trust's Brexit plan	Reports presented to Board	
External:	• National planning being undertaken • Review of Brexit risks nationally • Support from DHSE and NHSI	National publications	

Gaps:

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Aug 19	Actions taken as required by the National planning directives Programme in place to update FPC and Board	D Cecchini Frank Lush		

Risk No: 16	Well - Governed					
Risk Title:	The Leicester/Leicestershire / Rutland system is unable to work together to deliver an ICS by April 2020					
Risk Owner:	Chief Executive (FPC) (? David Williams)	**Date Last Reviewed:**	04.12.19			
Review frequency:	Monthly					

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12

Controls

Description:

- LPT to play our role in system meetings and the development of the ICS proposal, through honest and trusting discussions.
- A consistent agreed objective and system narrative that is used and tested in all system meetings, with all partners.
- Regular discussion and engagement with our Senior Leadership Team.
- Chief officers meeting fortnightly
- Chief officers have signed up to working together to resolve and deliver system issues and transformation
- Shared purpose agreed with chief officers

Gaps:

- Inability of individual organisations to priorities investment capacity for the ICS
- The system is introducing a governance process for the partnership board, which will include, shared purpose, risk sharing and how a provider alliance system will operate.
- We are introducing a governance process for the 2 way flow of information and engagement between our senor leadership team and our Directors.

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Formal updates from system meetings to Executive meetings, Board sub-committees and Trust Board. • Regular discussion at executive meetings and with senior leaders. • Work in progress to develop greater partnership working between organisations which enable the provider alliance concept to be tested.	• Minutes from Executive meetings, Board sub-committees, Trust Board and SLT meetings	
External:	**Source:** • System assessment against the ICS maturity matrix • NHS E & I assessment of system maturity • System meetings and system performance dashboards • Assessment of the System's Long Term Plan Submission	**Evidence:** • Joint shared document of our system assessment • Summary of NHS E/I assessment of the system • Papers and minutes from system meetings • Formal feedback on our LTP from NHS E/I	**Assurance Rating**

Gaps:

- There is no national blue-print to follow for the system, there are a number of options and the preferred way forward is subject to local discussion. The LLR system is meeting with NHS England and NHS Improvement to agree our plans and proposals for our 5 year plan. This will enable us to develop and transform with regulator support.

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Sept 19 **Oct 19**	Initial assessment of current position and confirmation that controls are in place, all gaps have been identified and assurances are in place. Clear action plan to be in place for how LPT and other stakeholder's role in supporting the system becoming an ICS by April 2020. Current and residual risk to be reviewed in October 2019 once our assessment is complete. Further update on progress to follow.	Rachel Bilsborough & David Williams David Williams	Initial assessment ongoing, work in progress to develop greater partnership working between organisations which will enable the provide alliance concept to be tested. Expecting to be able to update on progress at the end of January 2020. Paper to FPC Jan/Feb 2020. Further update January 2020	

Risk No: 17	~~Well - Governed~~				
Risk Title:	~~Failure to meet statutory duties in 2019/20 breakeven on I & E, External Financing Limit (cash) and Capital Resource Limit~~				
Risk Owner:	~~Deputy Director of Finance (FPC)~~	**Date Last Reviewed:**	~~24.01.20~~		
Review frequency:	~~Monthly~~				

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	1	4
Residual Risk	4	1	4

Controls

Description:

- ~~CIP plans and schemes in place agreed by Executive Team and monitored by Financial Turnaround Committee~~
- ~~Divisional engagement and leadership of CIPs through project teams, directorate business planning and directorate finance committees~~
- ~~Financial plan includes CIP plans with monthly profile to allow monthly monitoring and reporting of CIP delivery against target~~
- ~~Quality Impact Assessment process including review and sign off by Chief Nurse and Medical Director~~
- ~~Monthly Director of Finance report~~
- ~~Financial governance and control framework in place through Standing Financial Instructions with reporting to the Audit Committee~~
- ~~Trust objectives established~~
- ~~Capital Management Committee's oversight of capital planning and agreed governance processes; Capital Financing strategy~~
- ~~Treasury management policy , cash flow forecasting and management~~

Gaps:

- ~~Non delivery costs savings~~
- ~~Focus on CQC remedial actions may detract from financial management and vice versa~~
- ~~Commissioner approach to investment and contract funding~~

Assurances

	~~Source:~~	~~Evidence:~~	Assurance Rating
Internal:	~~Finance and Performance Committee report includes I & E, cash & capital reporting~~ ~~Quality Assurance Committee~~ ~~Audit Committee~~ ~~Financial turnaround Committee and delivery of documented plan~~ ~~CCG/LPT contract income triangulation & DoF level discussion~~ ~~Capital management committee review & agreement of capital bids, in year plan delivery & annual development of capital plans.~~	~~Formal scheme level monthly CIP , cash & capital monitoring~~ ~~Quality Impact Assessment documentation~~ ~~Standing Financial instructions~~ ~~Monthly forecast I & E run rate reporting to FPC~~ ~~Agreement of Balances year end process~~ ~~Highlight report~~	
External:	~~Source:~~ ~~Commissioner discussions~~ ~~KPMG audit of annual accounts and value for money conclusion~~ ~~Internal audit review of key financial systems~~	~~Evidence:~~ ~~Inclusion of CIP plan in overall formal Trust Annual Financial Plan approved by NHSI and CCG confirm and challenge~~ ~~Significant assurance opinions issued~~	Assurance Rating
Gaps:			

Key actions

Date:	~~Actions:~~	Action Owner:	~~Progress:~~	Status:
	~~Reduce bank and agency spend back to 2018/19 levels~~	SM	~~Spend has decreased in some areas, unlikely to achieve target~~	
	~~Exercise to reduce management costs~~	ASc	~~Back office costs analysis completed December 2019~~	
	~~Full programme of engagement and communication of turnaround plan~~	SM	~~Initial comms in newsletter & in SLT meetings. Myth busting~~	
		SM	~~campaign agreed with comms team~~	

Risk No: 18	Well Governed				**Conseq-uence**	**Likeli-hood**	**Combined**
Risk Title:	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			**Current Risk**	4	3	12
Risk Owner:	Anne Scott / Chris Oakes (QAC)	**Date Last Reviewed:**	05.12.19	**Residual Risk**	4	2	8
Review frequency:	Monthly						

Controls	**Description:**	• Action plans and programmes of work following last CQC inspection • Governance structure to manage the achievement of the actions and provide evidence • Regular meetings with NHSI and CQC to discuss progress • Leadership from the Director of Nursing, AHPs and Quality • Use of regulator standards • QI methodology being implemented across the Trust • Commissioning of external reviews of governance and SI management] • IPC inspection and action plan
	Gaps:	• Outstanding actions from the CQC inspections • Outstanding actions from independent governance reviews • Outstanding actions from IPC inspection

Assurances	**Internal:**	**Source:** • Engagement from Trust Board and Board Committees • Quality Forum • Health and Safety Committee	**Evidence:** • External reports on governance and SI management • Revised quality governance framework	**Assurance Rating**
	External:	**Source:** • CQC inspection • NHSI SIAM meetings • Regulator inspections including HSE, NHSIPC • KPMG value for money conclusion • 360 Assurance internal audit – seclusion rooms: Limited Assurance	**Evidence:** **Reports and recommendations from regulators following inspections**	**Assurance Rating**
	Gaps:	• Oversight of assurance processes		

Key actions	**Date:**	**Actions:**	**Action Owner:**	**Progress:**	**Status:**
	Aug 19	Implementation of the actions identified in the external Quality Governance report Ensuring quality and consistency of evidence	Tracy Ward Hillary McCallion	Implementation plan being developed	

Risk No: 19	Well Governed		
Risk Title:	There is a risk that inaction or failure to deliver on agreed plans results in a persistent and detrimental impact on LPT's reputation.		
Risk Owner:	Chief Executive / David Williams(QAC)	**Date Last Reviewed:**	07.11.19
Review frequency:	Quarterly		

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	3	12
Residual Risk	4	3	12

Controls

Description:

- There is a need to understand the view of our key stakeholders and understand what is driving their beliefs about LPT performance.
- The Quality Improvement Programme will monitor performance and delivery of key action plans and must ensure that any areas of failure are escalated to Directors.
- Establish a clear and consistent narrative about LPT, the actions in place and the improvements being delivered is key. This narrative must be developed and shared across the organisation.
- Weekly media monitoring and day to day media enquiries log
- Check FOIs from journalists
- Enquiries log from MPs and other senior stakeholders recently created
- High profile media statements are signed off by CEO and/or relevant exec director

Gaps:

- LPT is lacking a current formal assessment of reputation, the views of key stakeholders and an action plan to address this.
- Demonstration that quality improvement plan is delivering
- Reputational risks and issues log is not routinely shared with exec team. Separate issues are highlighted as appropriate.
- Senior stakeholder meetings – currently not central overview of messages being shared or materials. This is being worked towards
- Stakeholder bulletin (reflecting good news) is sent out on ad hoc basis and needs to be created more regularly. ET need to feed in to this.
- Other patient information such as discharge cards needs to follow our patient information policy and branding guidelines
- New website goes live in September, which aims to provide easier navigation and clearer information for our patients.

Assurances

Internal:	**Source:** Outcomes and issues from contract review meetings, executive meetings, discussions in board sub-committees and Trust Board. Reputational risk and issues log held centrally by the communications team Daily rota to check all social media channels (Twitter, Facebook, Instagram and YouTube)	**Evidence:** Written evidence will be available from these meetings. • Emails sent every week • Accessible to the communications team • Daily conversations with right ET members • Narrative is signed off by ET members or CEO • Accessible to the communications team	**Assurance Rating**
External:	**Source:** Feedback in ICS and system meetings will be evident, alongside feedback from NHS E&I in formal system meetings. Feedback to the CQC from our stakeholders	**Evidence:** Written evidence will be available from these meetings.	**Assurance Rating**

Gaps:

- This is an emerging area of work. This will be reviewed as the work commences. The residual risk and current risk remain currently the same until we complete the initial assessment. This should then result in them being different.
- Reputational risks and media log to be shared as a monthly update to all ET

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Sept & Oct 19	Speak with key stakeholders about their view of LPT. Identify key areas of LPT's reputation to address and develop a consistent narrative to share across the organisation. Confirm governance is in place to identify when agreed actions and improvements are not being delivered.	David Williams	Action to commence in September 2019	

Risk No: 20	Well - Governed
Risk Title:	Performance management framework is not fit for purpose
Risk Owner:	Director of Finance (FPC)
Date Last Reviewed:	07.11.19
Review frequency:	Monthly

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	5	20
Residual Risk	4	4	16

Controls

Description:

- Information asset owners in place
- SIRO in place
- Clinical system training in place
- Schedule of regular reports
- SOP in place
- 360 data quality audits
- Quality Account audit
- Nationally submitted data
- Information team in place

Gaps:

- No monitoring solution available to measure timeliness of data input
- Challenges in the system to ensure information is timely and appropriate
- Lack of system that allows validated data on a consistent basis at directorate level
- Strategy refresh to be undertaken
- Consideration of skill mix and need to address any capability and capacity challenge
- Inability to progress at pace due to competing priorities and lack of capacity in the corporate Information team.

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	Finance and Performance Committee Quality Assurance Committee Information management strategy	Information management strategy update quarterly report Quarterly data quality information plan updated	
External:	Contract monitoring of quality indicators by Commissioners Finance, Technical and Performance monitoring of contracted performance indicators NHSI CQC inspections	360 data quality audits	

Gaps:

- Current performance framework not providing the level of assurance needed

y actions

Date:	Actions:	Action Owner:	Progress:	Status:
Aug 19	Development of Performance Management Framework	Daniella Cecchini	Framework to be aligned to NHFT and implemented by Q3	
Aug 19	Progress data consistency and integrity work including kite marks for quality assurance.	Daniella Cecchini/ Laura Hughes	Review and strengthen existing data governance arrangements - including data dictionary by Q3	
Aug 19	Revised Trust level IQPR – Dash Board –immediate	Laura Hughes	Develop clear performance on a page as integrated dashboard. SPC reporting for priority waiting time improvement services. First draft September 2019.	
Aug 19	Introduction of revised IQPR	Laura Hughes	Establish task and finish reporting group and revise IQPR **Q3**	

Risk No: 22	Well-Governed
Risk Title:	Financial, reputational or service delivery harm or loss resulting from information breaches and attacks on information systems
Risk Owner:	Director of Finance (FPC / Data privacy committee)
Date Last Reviewed:	05.12.19
Review frequency:	Monthly

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12

Controls

Description:

The Trust has worked with an NHS Digital commissioned supplier to review and evaluate our Cyber Resilience through the Unified Cyber Risk Framework (UCRF) programme which is embedded into the Trusts Cyber and Information Security Programme

Further control improvements are being deployed across LLR such as Anti-malware for mobile devices, changes to password parameters, revised telephone password reset procedure, mobile phone lockdown, Windows 10 rollout with revised security controls, etc. These changes are required to comply with national security standards and to further improve our cyber security posture.

LHIS has amended the approved/whitelisted applications that are available to install on mobile devices and a number have been removed so as to increase our cyber resilience on mobile apps

LHIS in conjunction with the Data Privacy function are conducting Cyber Security Awareness Training which is also being delivered into a number of LHIS partners.

Security incidents and data breaches scrutinised by the Data Privacy Committee and lessons learned shared with LHIS Customers and the community

Gaps:

- Similar data breaches occurring but in different services suggesting that shared learning across the Trust is not taking place

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• LHIS re-accreditation of the secure email system (DCB1596). • Review and testing disaster recovery processes.	• Accreditation report • Outputs of Disaster Recovery Testing in remediation action plan	
External:	360 Assurance internal audit of data security standards – Complete December 2019 Advisory Exploration of Cyber Resilience by NHS Digital Consultants through UCRF		

Gaps:

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
13/11/2019	**LHIS Cyber Security Services are evaluating a SIEM (Security Information and Event Management) system to evaluate whether such a system would improve the current technical security posture of the whole LHIS community.**	**Chris Biddle**		
13/11/19	**Outputs from the UCRF included in a Remediation Plan which will be reviewed with the NHS D Consultants in later January 2020**	Sam Kirkland		
	LHIS working towards Cyber Essentials Plus accreditation during 2019	Chris Biddle		
	LHIS Cyber Security Service seeking further accreditation to enhance skill sets and provide technical support into customer organisations. This includes acquisition of 'Certified Ethical Hacker' accreditation	Chris Biddle		
	Development of Robust data breach governance process through Data Privacy Committee	Sam Kirkland		

Risk No: 23	Single Patient Record		
Risk Title:	Failure to deliver the EPR system and demonstrate the benefits of the system		
Risk Owner:	Medical Director (FPC)	**Date Last Reviewed:**	05.12.19
Review frequency:	Monthly		

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	2	8

Controls

Description:

- The training demands for the system could disrupt services leading to an increase in waiting times
- The data migration could not improve the quality of the clinical records
- Reporting requirements could not be possible to meet

Gaps:

- No comprehensive training plan in place currently
- Data migration is a large and complex task
- The reporting functions can not yet be tested until configuration completed which is on track

Assurances

Internal:

Source:

- Development of the training plan involving Learning and Development and Nursing
- Staff appointed to support the data migration and cleansing work and the EPR Project Board will continue to work at least 6 months post full transfer to support ongoing data improvement
- If there are any safety issues the transfer from our existing EPR can be delayed or board can be asked to consider what risks it is willing to tolerate re reporting.

Evidence:
Reports to Finance and Performance
QIB monthly

Assurance Rating

External:

Source:
360 Assurance internal audit – patient records EPR – due Q4

Evidence:

Assurance Rating

Gaps:

- The system is not implemented

Key actions

Date:	**Actions:**	**Action Owner:**	**Progress:**	**Status:**
Aug 19	• Complete the comprehensive training plan • Complete implementation of plan	Sue Elcock	Due to next EPR Group – signed off Reviewed by EPR steering Group monthly Any variation reported to FPC	

Risk No: 24	Equality, Leadership, Culture		
Risk Title:	Failure to delivery workforce equality, diversity and inclusion		
Risk Owner:	Director of HR & OD (QAC)	**Date Last Reviewed:**	07.11.19
Review frequency:	Monthly		

	Conseq-uence	Likeli-hood	Combined
Current Risk	3	4	12
Residual Risk	3	3	9

Controls

Description:

The Trust has embarked on a programme of work to improve the experience of BAME staff.

- Independent focus groups run and led by national WRES team
- Delivery of key actions from focus group
- Electronic system controls to support identification of staff who want to progress in their careers
- Staff survey results
- WRES /WDES data and action plans
- Staff support groups
- Annual Report on WRES
- Appraisal
- Continued listening events with staff
- Reverse mentoring
- Cultural ambassadors
- Equality and Diversity Inclusion Group
- ~~Balanced interview panels process in place~~

Gaps:

- Delivery against outcome measures
- Delivery against WRES and diversity metrics
- Staff survey performance
- Limited representation of BAME staff at senior levels
- Lack of career development for BAME staff at all levels
- Experience of bullying and harassment of BAME staff

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	Equality Diversity and Inclusion group Strategic Workforce Committee Quality and Assurance Committee Trust Board	Trust board equalities report Annual Equalities Action Plan – to SWG and Trust Board WRES Action plan	
External:	• Staff survey • National WRES metrics • Engagement with national WRES team	Results of staff survey WRES Report and Findings Wres delivery action plan	

Gaps:

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Aug 19	WRES Delivery action plan ~~Developing process for balance interview panels~~ • Unconscious bias training • Race and cultural understanding training • Interview skills attaining for BAME staff • Reverse mentoring • Invite WRES TEAM back in LPT invited to be part of WRES cultural pilot programme 2yrs	**Haseeb Ahmed** **Kathryn Burt**	Range of action consolidated into a single plan Newly formed EDI group BAME interview panel members recruitment underway Training courses developed EDI system conference 31dt March 2020 Attending launch of WRES cultural pilot programme	

Risk No: 25	Equality, Leadership, Culture
Risk Title:	Failure to create a culture of collective leadership that empowers staff to improve the services we provide
Risk Owner:	Director of HR & OD (QAC)
Date Last Reviewed:	07.11.19
Review frequency:	Monthly

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12

Controls

Description:

Our Future Our Way is LPT's Culture, Inclusion and Leadership programme. Our staff are telling us that LPT is not a great place to work, our BAME staff do not feel supported and there are incidents of bullying, our bank staff also feel undervalued. Our CQC well lead rating is Inadequate. And our vison is not clear.

- Change champions identified from existing staff and appointed
- Training provided to all change champions
- Monthly report to SWG and Exec team
- Line Management pathway
- Leadership and Team development programme
- Learning and development annual plan
- Communications strategy in place supporting engagement with staff
- Vision co designed and live

Gaps:

- ~~Synthesis feedback to be given to Board~~
- Capacity of OD team
- Transformation support
- CSR OD Support

Assurances

Internal:

Source:	Evidence:	Assurance Rating
• Staff survey results • Board approval of change champion programme • Programme plan in place and approved by Trust Board • 92 change champions engaged • Focus groups	Leadership Survey Focus group Synthesis work themed against 5 elements of culture	

External:

Source:	Evidence:	Assurance Rating
• Staff survey • Staff Friends and family test • External recognition of initiatives • Well led external review demonstrated need for culture and leadership programme • CQC well led inspections • NHSI Support on the culture and leadership programme	National results Pulse survey NHS review Cqc report	

Gaps:

- Design and implementation phases yet to be completed

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
June 19	Our Future our way leadership and culture programme Discovery, design, implementation Present synthesis feedback work to Trust Board and wider workforce Develop key priorities Communications plan linked to step up to great Co- design of Trust vision Developing leadership behaviours	Dir of HR & OD	~~Arranged for 1 October 2019~~ Trust board sign off complete ~~Change champions developing priorities Sep~~ Change champions developed Priorities ~~Vison co-design commencing 10th Sep~~ Vison Complete	

Risk No: 26	Equality, Leadership, Culture
Risk Title:	Insufficient staffing levels to meet capacity and demand and provide quality services
Risk Owner:	Director of HR & OD (QAC)
Date Last Reviewed:	07.11.19
Review frequency:	

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12

Controls

Description:

- Recruitment action plan in place
- Service level workforce groups with action plans in place
- E rostering in place across inpatient services
- Auto planner within CHS
- Safer staffing reports with oversight of staff levels
- Centralised temporary staff service
- Regular recruitment conferences and schedule of events
- Recruitment and retention schemes in place
- Growing our own workforce
- LLR System and LWAB working together on system initiatives
- Flexible working guidance launched

Gaps:

- Workforce Planning capacity
- Impact of removal of nursing bursary
- National workforce nursing supply challenges
- National medical workforce challenges within CAMHS
- Community Services Redesign
- Full utilisation rostering
- CSR and ageing well staffing requirements and demand
- Medical consultant capacity concerns in AMH/CAMHS

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Third cohort of nurse associate roles • Further development of other roles • Reengineering of clinical roles • SWG , Directorate Workforce groups , retention working group • WWB	Recruitment and retention papers to SWG Workforce reports to Directorate workforce groups	
External:	National NHS people plan NHS retention support and benchmarking data	SWG progress reports SWG Dashboard, recruitment retention, agency , bank, Benchmarking data	

Gaps:

- National gap in detail around NHS people plan as published in June 2019

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
	Respond to interim people plan waiting for final publish Increasing out nursing placement capacity working with universities Consideration of overseas recruitment Re WRES linking actions around workforce ~~Recruitment website to be improved~~ ~~Launch flexible working arrangements~~ Develop a proposal for super enhancing recruitment and attraction campaign	**Director HR & 0D**	Growing our own group progressing on role development Retire and return & Flexible working launch CSR workforce group taking forward actions Overseas recruitment considered at lead nurses Recruitment website updated	

Risk No: 27	Equality, Leadership, Culture		
Risk Title:	Failure to improve the health and well being of our staff		
Risk Owner:	Director of HR & OD (QAC)	**Date Last Reviewed:**	07.11.19
Review frequency:			

Equality, Leadership, Culture	Conseq-uence	Likeli-hood	Combined
Current Risk	3	3	9
Residual Risk	3	2	6

Controls

Description:

- Occupational health service wellbeing strategy and implementation plan
- Workforce and wellbeing group
- Wellbeing calendar – including a range of wellbeing events
- Counselling service
- 1:1s, Supervision, Appraisal
- Focus on wellbeing, sickness management policy
- Anti bullying harassment and advice service
- Bullying and harassment sub group
- Annual Health and Wellbeing event
- Health and wellbeing champions
- Staff Physiotherapy scheme
- MH first aid training
- Mindfulness programmes

Gaps:

- High level of workplace stress reported
- High number of MSK health issues reported
- High level of sickness in some clinical areas
- Post incident psychological support for staff

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Monitoring sickness reports workforce reports • Sickness reviews within divisions • Wellbeing element of appraisal • Wellbeing conferences	**Appraisals above 90%** **Workforce reports – includes sickness performance**	
External:	**Source:** • NHSI reporting, • NHSI wellbeing initiatives	**Evidence:** **Provided monthly**	**Assurance Rating**

Gaps:

- Ongoing implementation of action plan associated with Health and Well being Approach.
- Review Health and Well being Approach in Nov 2019

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
	Continue to progress the health and wellbeing approach and action plan Refreshed health and wellbeing approach for 2020 ongoing review at senior leaders forum ~~Developing a business case to support mental health referrals for employees~~ Post incident psychological support for staff	**Kathryn Burt**	NHS long terms people plan well being event attending in Nov LPT health and wellbeing conference in Nov Developed a business case to support mental health referrals for employees-waiting for final sign off Additional sickness monitoring HR support	

Risk No: 28	Access to Services		
Risk Title:	Failure to deliver timely access to assessment and treatment which could impact on patient safety and outcomes (for the priority services)		
Risk Owner:	Divisional Directors / Medical Director (QAC and FPC)	**Date Last Reviewed:**	07.01.20
Review frequency:	Monthly		

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	4	16

Controls

Description:

- Strategic approach to waiting time management approved by Trust Board
- A risk based approach to prioritisation of waiting times approved by the Executive Team
- Weekly patient tracking list sessions operational in all services
- NHSI demand and capacity management training complete
- Trajectories and improvement plans in place for priority services
- Access Group operational
- System Improvement and Assurance meeting oversight of Trust waiting times
- ~~Harm Review process approved at joint FPC/QAC (September 2019) and has commenced~~

Gaps:

- Demand and capacity analysis of priority services with long wait times
- Dialogue with commissioners on the management of capacity shortfalls
- Lack of updated access policy and 52 week descriptor
- Lack of embedded harm review process
- Lack of SPC reporting
- Harm Review process approved at joint FPC/QAC (September 2019) but is not yet in place across the Trust

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Directorate performance reports • Waiting time performance reported to Finance and Performance Committee monthly	Papers and minutes of meeting Papers and minutes of meeting Highlight report to Board	
External:	• Finance, Technical and Performance meetings with commissions with escalation of issues to contract performance meeting • NHSI system improvement and assurance meeting (SIAM) • NHS Improvement Support Team review of CAMHs • CQC inspection process	• Minutes of meeting • Minutes of meeting • Report on CAMHS • Published report	

Gaps:

- Lack of performance management framework

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Aug 19	Demand and capacity analysis to be completed for all high risk waiting times	Graham McKay	**Delivery Mar 2020**	
Aug 19	Review of Access Policy including definition of 52 week access and treatment waits	Anne Senior	**Completion of document Nov /Dec 19**	
Aug 19	Monthly escalation to CPM via by Finance , Technical and Performance Group	Anne Senior		
Aug 19	Use of SPC to report high risk waiting times failing to meet access targets	Laura Hughes		
Aug 19	Development of performance management framework	Dani Cecchini		
Jan 20	Revising ToR for waiting times group and strengthen clinical representation	Anne Senior		

Risk No: 29	Access to services				**Conseq-uence**	**Likeli-hood**	**Combined**
Risk Title:	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			**Current Risk**	~~5~~ 4	~~4~~ 3	~~20~~ 12
Risk Owner:	Director AMH (QAC and FPC)	**Date Last Reviewed:**	23.01.20	**Residual Risk**	~~5~~ 3	~~3~~ 2	~~15~~ 6
Review frequency:	Monthly						

Controls

Description:

- Clear protocol for patients who are identified as 'suitable for assessment for rehab' are transferred 'under bed management, when additional bed capacity at the BMHU is needed
- ~~Discharge facilitators (3.0WTE) to support seven acute wards with actions required to facilitate discharge barriers~~ Investment in CRHT to enhance home treatment offer, increase EDP and prevent further admissions
- Move to open access for Crisis by July 2020
- Red2Green meetings set up on all seven acute wards. Barriers to discharge are identified and ~~allocated for action to the Red2Green co-ordinators~~ and length of stay has reduced
- No longer moving patients to Progress (treatment) beds ~~commissioned and in place (from 6th May 2019) to support patient flow and free up acute beds~~ and work underway to discharge patients to home, supported accommodation or AHP
- Daily Safety Huddle established to consider staffing and flow
- 6 bed Crisis House provided by Turning Point available for those patients who are identified via the Crisis team as requiring an informal temporary admission to manage their mental health during a short up to 7 day period.
- Crisis House also provides 24 hr helpline and crisis cafes
- 5 Moving-On beds procured
- Enhancement to Housing Enablement Team through winter funding and clear 'No Fixed Abode' flow chart for staff on wards
- In depth performance data analysed to develop understanding of driving factors impacting on flow and capacity.
- Acute Mental Health OAP Recovery Plan agreed with system leaders (see separate plan – updated Jan 2020)

Gaps:

- Demand for rehab beds exceeds availability of local rehab bed stock and no current community rehab offer in place
- Flow out of PICU has restricted bed availability for patients requiring step up to PICU.
- AHP approval and placement timescales causing delays in the movement of patients out of general psychiatry , rehabilitation and PICU beds
- Patients who do not wish to move to an OAP progress bed at the end of the pathway away from their family.
- Lack of ~~capacity from private provider, as progress beds are not block booked but are secured via an individual referral system~~ necessary capacity for senior medical psychiatric support for robust gatekeeping over evenings and weekends
- ~~Grip over sustainability~~
- Housing stock availability and bidding process causing significant delays to discharge. Average length of stay in move on accommodation now exceeds 20 weeks (target is 12 weeks)

Assurances

Internal:

- **Source:**
- Regular monitoring through Acute and Forensic Operational meetings, Directorate meetings and ET
- 3 times daily bed management meetings
- ~~Executive level authorisation for OAPs~~ Director on call out of hours authorisation
- Clinical Discharge Meeting weekly
- DTOC tracker supported by clinical discharge nurses
- OAPs clinically managed through RIO OOA Virtual Ward with minimum weekly clinical conversation with OAP
- Total bed stock and the numbers of patients who are OOA are SITREP each day through the 3 times daily bed state.
- Early involvement of HHET for referral to the Move On accommodation
- Contract review meetings with the CRHT and Turning Point to ensure facility is being used according to service specification
- Daily Red2Green reporting
- Standard SOP guidance for progress beds. Patients who are moved to a progress bed will have an individual clinical treatment plan which is monitored weekly by the CCG Case Managers and LPT Discharge Nurses

- **Evidence:**
- Bed management reports to QAC, AMH SitRep daily and reported to commissioners twice weekly
- Electronic bed state is circulated to key individuals
- DTOC tracker
- RIO OOA Virtual Ward
- Discharge Facilitators complete the daily Red2Green reporting templates
- Live reporting dashboards through Qlikview

Assurance Rating

Risk No: 30	Access to services
Risk Title:	Unmitigated demand may result in patients being unable to access services in clinically appropriate timescales
Risk Owner:	Divisional Directors/Finance Director (QAC and FPC)
Date Last Reviewed:	05.12.19
Review frequency:	3 monthly

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	4	16

Controls

Description:

- Contract discussions with commissioners
- Business planning process
- Financial planning and budget setting processes
- Staff trained in demand and capacity analysis
- Budget setting process in place
- Outsourcing arrangement s where appropriate (eg CAMHs)
- Staff productivity and efficiency programmes in place via service transformation
- Flow improvement plans in place eg Red to Green in AMH
- Winter planning/OPEL framework/daily escalation tool/calls in place

Gaps:

- Lack of internal approach to prioritisation of funding requests
- Nature of block contract arrangements
- LLR financial sustainability plan
- Lack of funding to match growth in population / prevalence / demand

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Internal strategic waiting times approach • FPC regular waiting times report • Daily OPEL escalation template	• Paper approved at Trust Board • Waiting times report	
External:	• Contract Performance Meetings and monthly returns • SIAM meetings • AEDB • NHSI Regional Escalation oversight of 4 hr performance • 360 Assurance internal audit of waiting times - due Q4	• Minutes of meetings • Minutes of meetings • Minutes of meeting	
Gaps:			

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Sept 19	• Develop approach to prioritise funding requests • Strengthen approach to demand management through FT&P	Sharon Murphy Anne Senior		

Risk No: 31	Trust wide Quality Improvement					
Risk Title:	There is a risk that projects will not deliver sufficiently to embed consistent QI framework and framework					
Risk Owner:	Medical Director (QAC)	**Date Last Reviewed:**	05.12.19			
Review frequency:	Monthly					

	Conseq-uence	Likeli-hood	Combined
Current Risk	3	3	9
Residual Risk	3	3	9

Controls	**Description:**	• Listening to action embedded into the organisation • Implementation of QI methodology • QSIA training being delivered • Use of QSIA practitioner • QI Board in place
	Gaps:	• Lack of project management support including administration • No formal QI lead

Assurances	**Internal:**	**Source:** • QI Board meeting monthly • Quality Assurance Committee	**Evidence:** **Reports**	**Assurance Rating**
	External:	**Source:** 360 Assurance internal audit – quality improvement due Q4	**Evidence:**	**Assurance Rating**
	Gaps:			

Key actions	**Date:**	**Actions:**	**Action Owner:**	**Progress:**	**Status:**
	Aug 19	• Recruitment of project management support to be completed	S Elcock		

Risk No: 32	Quality Improvement Plan		
Risk Title:	Failure to secure the resources and develop a PMO to support the delivery of the Trust QI Plan		
Risk Owner:	Director of Nursing, AHP and Quality (QAC)	**Date Last Reviewed:**	07.11.19
Review frequency:			

Trustwide Quality Improvement

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	3	12
Residual Risk	4	2	8

Controls

Description:	Monthly Quality Improvement Board Support from NHSE/I Improvement Director Administration Support Executive Leads for Workstreams identified Draft reporting template in place
Gaps:	• Lack of current PMO • Limited capacity with workstream leads to oversee and monitor delivery of plans

Assurances

Internal:	**Source:** KPI's for each workstream in draft Monthly highlight reports from QIB to QAC/FPC and escalation report to Board	**Evidence:** Paper to QIB 10/09/19 Monthly reports	**Assurance Rating**
External:	**Source:** Progress on delivery of the Quality Improvement Plan will be reported to the System Improvement and Assurance Group CQC Well Led inspection	**Evidence:** Monthly reports to the SIAM CQC Report	**Assurance Rating**
Gaps ..	• Lack of formalised reporting established due to lack of established PMO • KPIs not signed off and robustness of data collection unclear at present		

Key actions

Date:	**Actions:**	**Action Owner:**	**Progress:**	**Status:**
Aug 19	Secure funding for Head of PMO	CG	Head of PMO in post	G
Aug 19	Write JD for Head of PMO	CG/SW		
Aug 19	Interview for Head of PMO	SW		

Risk No: 33	Well - Governed				**Conseq-uence**	**Likeli-hood**	**Combined**
Risk Title:	Insufficient executive capacity (including Joint Chief Executive role) to cover demand and impacts on LPT ability to achieve it's strategic aims			**Current Risk**	4	4	16
Risk Owner:	Director of HR & OD/Chief Executive	**Date Last Reviewed:**	21.11.19	**Residual Risk**	4	3	12
Review frequency:	**At Performance Committee/ RemCom committee**						

Controls

Description:

- Part time Chief Executive appointed with NHFT (NHFT rated outstanding overall and outstanding for well –led domain)
- Overall Well-led inadequate rating from CQC
- No Vacant Executive team posts / Additional temporary supernumerary support from external sources, e.g. Governance
- Buddy arrangements with NHFT / Supportive oversight from NHSI/E
- Deputy Chief Executive position created strengthening executive capacity for LPT
- Business manager /LPT Programme Lead role for NHFT working closely with the Chief Executive across both organisations
- Lead LPT Director for the Buddying Programme – DoN
- Resources identified to support buddy programme via NHFT directors
- Set days/working pattern for CEO role allowing shared resource time spent each week to be auditable with exceptions according to needs
- Regular review of buddy work programme and impacts
- Discussion at Board of Directors Nominations and Remunerations Committee
- MOU between LPT and stakeholders (NHFT, NHSEI) setting out the capacity and resource requirements for each organisation for the buddying programme
- Agreed funding with NHSEI and NHFT
- Shared Director posts with NHFT from January 2020 – Governance & Strategy

Gaps:

- Temporary additional support undertaking main stream work
- Deputy CE in process to support the CEO
- Director of Nursing, AHP and Quality to leave the Trust in December. Acting arrangements have been put in place with Chief nurse support identified via buddy programme
- Monitoring mechanisms part of transition to new governance arrangements

Assurances

Internal:

Source:

- Regular governance meetings to maintain oversight
- Review at SEB and Exec. boards
- Review at Performance Committee/ Rem comm
- Regular monitoring of LPT KPI's/ strategic priorities
- Review at Trust Board
- 1:1's CEO with Directors to monitor impact
- 1:1's Directors with direct reports to monitor impact
- DMT's/Corporate management team meetings monitor and assess impact on operational and project performance
- Positive outcomes/benefits from exec. involvement with NHFT including innovations from joint learning and development of directors and deputies through inclusion in programme

Evidence:

Strategic Executive Board
Executive Operational meeting
Revised governance structures
ORR and QIB

Meeting minutes

- Ongoing reports
- Remcom paper on exec capacity
- Buddy programme meeting minutes

Assurance Rating

External:

Source:

- Support from NHSI/E
- Buddying support from NHFT / Ongoing support from NHSI / Engagement meetings CQC
- Perspectives on CQC/NHSI support of shared role
- Regional and national recognition of effective joint working across the Trusts

Evidence:

- Regular contact and positive feedback from NHSI
- Positive feedback at assessment
- CQC inspection

Assurance Rating

Gaps:

Key actions

Date:	**Actions:**	**Action Owner:**	**Progress:**	**Status:**
	• Discussions with NHSI/E on the joint appointment of some key roles	CEO		
	• Appointment of a deputy CEO / new Director of Nursing, AHP and Quality	CEO		
	• Development of ORR risk through regular review at Performance Committee	CEO		
	• LPT update to Board committees and board	SW/CEO		
	• LPT Recruiting to a substantive Director of Adult Mental Health position			

Risk No: 34	High Standards					
Risk Title:	The Trust may 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.					
Risk Owner:	DoN (QAC / IPC)	**Date Last Reviewed:**	23.01.20			
Review frequency:	**Monthly**					

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12

Controls	**Description:**	• Strategic flu group meets throughout the year to enable strategic and oversight of trust wide flu action plan. All directorates invited. • Minutes of meeting • Trust Clinical Lead (Senior Infection Control Nurse) and Specialist Practitioner in Occupational Health Nursing. • Dedicated communications plan to launch September 2019. • Increased flexible approach to peer vaccine training to enable cohort • Enhanced data (compared to previous flu campaigns) from Occupational Health Service will enable to reallocate resources to provide clinics and vaccination opportunities • Trust wide operational / service peer vaccinators trained to deliver the vaccination programme • Bank representative on Flu Group • Trust wide Infection Prevention and Control Policy in place and followed • A more enhanced data collection will be used to inform areas that need additional support in vaccination program
	Gaps:	• Inconsistent representation of directorates at strategic flu group.

Assurances	**Internal:**	**Source:**	**Evidence:**	**Assurance Rating**
	External:	**Source:** Networking with similar trusts to identify and implement where possible any actions that have been identified as improving uptake (and does not currently take place within in LPT)	**Evidence:**	**Assurance Rating**
	Gaps:			

Key actions	**Date:**	**Actions:**	**Action Owner:**	**Progress:** / **Status:**
		Dedicated vaccinator to set up LLR wide clinics and advertise in the flu eSource, Facebook, trust talk and flu calendar 29/02/2020 until end of the season.	Amanda Hemsley	
		Updated plan with remedial actions generated which highlights gaps and concerns that have a direct impact on the 31/01/2020 reasons why the figures are not as expected or anticipated.	Amanda Hemsley	
		Twilight sessions provided for staff who work outside of 'regular hours'		

Risk No: 35	Well Governed
Risk Title:	There is a risk that we have poor data quality due to a lack of an overarching data and information control framework. This may impact on our ability to make decisions and account for our activities.
Risk Owner:	DoF
Date Last Reviewed:	
Review frequency:	**FPC**

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12

Controls

Description:

- Kite mark
- Annual record keeping audit
- data quality policy

Gaps:

- Overarching control framework for data and information includes the patient record.
- Compliance with a control framework
- Process for testing compliance (2nd line of defence)
- Robust approach to responding to 3rd line assurance
- No assurance framework
- Non compliance with the policies listed above
- Lack of capacity and capability
- Lack of resource to deliver the changes

Assurances

Internal:	**Source:** • Clinical audit	**Evidence:**	**Assurance Rating**
External:	**Source:**	**Evidence:**	**Assurance Rating**
Gaps:			

Key actions

Date:	**Actions:**	**Action Owner:**	**Progress:**	**Status:**

Risk No: 36	Well Governed
Risk Title:	There is a risk that we are not compliant with Bare Below the Elbow
Risk Owner:	DoN
Date Last Reviewed:	
Review frequency:	**QAC**

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12

Controls	**Description:**			
	Gaps:			
Assurances	**Internal:**	**Source:**	**Evidence:**	**Assurance Rating**
	External:	**Source:**	**Evidence:**	**Assurance Rating**
	Gaps:			

Key actions	**Date:** **February**	**Actions:** Fully draft the risk / actions	**Action Owner:** Amanda Hemsley	**Progress:**	**Status:**

Risk No: 37	Well - Governed
Risk Title:	Failure to meet the 2019/20 Control Total surplus (£2.1m)
Risk Owner:	Deputy Director of Finance (FPC)
Date Last Reviewed:	24.01.20
Review frequency:	Monthly

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	3	12
Residual Risk	4	2	8

Controls

Description:

- CIP plans and schemes in place agreed by Executive Team and monitored by Financial Turnaround Committee
- Divisional engagement and leadership of CIPs through project teams, directorate business planning and directorate finance committees
- Financial plan includes CIP plans with monthly profile to allow monthly monitoring and reporting of CIP delivery against target
- Quality Impact Assessment process including review and sign off by Chief Nurse and Medical Director
- Monthly Director of Finance report
- Financial governance and control framework in place through Standing Financial Instructions with reporting to the Audit Committee
- Trust objectives established
- Introduction of formal turnaround reporting
- Executive leadership on turnaround schemes
- Agreed 2019/20 Control Totals for services
- Trust has followed NHSI protocol to advise that the £500k stretch target unlikely to be delivered in 2019/20

Gaps:

- Non delivery costs savings (unidentified CIP of £1.2m)
- Focus on CQC remedial actions may detract from financial management and vice versa
- Turnaround action delivery is variable
- Agreed control totals do not currently address the whole financial gap
- Commissioner approach to investment and contract funding

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Finance and Performance Committee • Quality Assurance Committee • Audit Committee • Financial turnaround Committee and delivery of documented plan • Control Totals agreed with Service Directors • CCG/LPT contract income triangulation & DoF level discussion	• Formal scheme level monthly CIP monitoring report • Quality Impact Assessment documentation • Standing Financial instructions • Monthly forecast run rate reporting to FPC • Signed Control Total summaries • Agreement of Balances year end process	
External:	Commissioner discussions KPMG audit of annual accounts and value for money conclusion	Inclusion of CIP plan in overall formal Trust Annual Financial Plan approved by NHSI and CCG confirm and challenge	
Gaps:			

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
	Reduce bank and agency spend back to 2018/19 levels		Spend has decreased in some areas, unlikely to achieve target	
	Exercise to reduce management costs	SM	Back office costs analysis completed December 2019	
	Full programme of engagement and communication of turnaround plan	SM	Initial comms in newsletter & in SLT meetings. Myth busting campaign agreed with comms team	

Risk No: 38	Well - Governed
Risk Title:	Failure to meet statutory duties in 2019/20- breakeven on I & E, External Financing Limit (cash) and Capital Resource Limit
Risk Owner:	Deputy Director of Finance (FPC)
Date Last Reviewed:	24.01.20
Review frequency:	Monthly

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	1	4
Residual Risk	4	1	4

Controls

Description:

- CIP plans and schemes in place agreed by Executive Team and monitored by Financial Turnaround Committee
- Divisional engagement and leadership of CIPs through project teams, directorate business planning and directorate finance committees
- Financial plan includes CIP plans with monthly profile to allow monthly monitoring and reporting of CIP delivery against target
- Quality Impact Assessment process including review and sign off by Chief Nurse and Medical Director
- Monthly Director of Finance report
- Financial governance and control framework in place through Standing Financial Instructions with reporting to the Audit Committee
- Trust objectives established
- Capital Management Committee's oversight of capital planning and agreed governance processes; Capital Financing strategy
- Treasury management policy , cash flow forecasting and management

Gaps:

- Non delivery costs savings
- Focus on CQC remedial actions may detract from financial management and vice versa
- Commissioner approach to investment and contract funding

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Finance and Performance Committee report includes I & E, cash & capital reporting • Quality Assurance Committee • Audit Committee • Financial turnaround Committee and delivery of documented plan • CCG/LPT contract income triangulation & DoF level discussion • Capital management committee review & agreement of capital bids, in year plan delivery & annual development of capital plans.	• Formal scheme level monthly CIP , cash & capital monitoring • Quality Impact Assessment documentation • Standing Financial instructions • Monthly forecast I & E run rate reporting to FPC • Agreement of Balances year end process • Highlight report	
External:	Commissioner discussions KPMG audit of annual accounts and value for money conclusion Internal audit review of key financial systems	Inclusion of CIP plan in overall formal Trust Annual Financial Plan approved by NHSI and CCG confirm and challenge Significant assurance opinions issued	
Gaps:			

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
	~~Documented turnaround plan developed~~	SM	~~Approved by the Board 30 August 2019~~	
	~~Financial Turnaround Group fully established~~	SM	~~Committee established and operating~~	
	~~Efficiency and productivity strategy~~	SM	~~Approved by FPC September 2019~~	
	Reduce bank and agency spend back to 2018/19 levels	SM	Spend has decreased in some areas, unlikely to achieve target	
	Exercise to reduce management costs	ASc	Back office costs analysis completed December 2019	
	Full programme of engagement and communication of turnaround plan	SM	Initial comms in newsletter & in SLT meetings. Myth busting campaign agreed with comms team	
		SM		

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 3rd March 2020
Paper number	F

Name of Report: Corporate Governance Update

For approval	X	For assurance		For information	

Presented by	Chris Oakes, Director of Governance and Risk	Author	Chris Oakes, Director of Governance and Risk

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	Dates
Executive meetings ((Workshop/Away Day), Board Workshop February, QAC and FPC briefings	January and February 2020

Assurance : What assurance does this report provide in respect of the Organisational Risk Register?	Links to ORR risk numbers
There is a risk that the Trust does not routinely achieve regulatory standards.	18

Recommendations of the report
The Trust Board is asked to approve the revised approach to Trust Governance and support the further implementation and development.

Step up to Great LPT Governance
Board Meeting 3rd March 2020

Purpose of the report

As part of CQC and Well Led the Governance structures and processes within the Trust have been subject to a major review. This has included an exploration of the current organisational model within the Trust and an agreement as to the most appropriate model moving forward. In summary this can be described as a strategy to move from a model based on independent Strategic Business Units to a model encompassing a single organisational role structure.

The review also explored the approach to Directors' roles and accountabilities across both corporate and operational directorates. It has developed the committee structures their focus, role and relationship with the Board. The timetabling and processes to support committees and flow of information was also explored.

This report sets out the approach followed and the future proposed governance model for the Trust.

Analysis of the issue

As a result of initial work on governance a number of meetings took place to develop the Trust's overall approach to governance.

- Executive Team held a workshop in November 2019 which considered organisational design and Corporate and Operational Director roles
- Executive Team away day in December 2019 agreed the future approach to committee structures
- Non-Executive team timeout –Jan 2020
- Consultation with Extended Executive on the developmental proposals – Jan 2020
- Board supported new proposals at their development day– Feb 2020
- Detailed planning with NEDs who Chair level one committees – supported by relevant Exec Directors – Feb 2020
- Consideration by level one board committees and Board – Feb, March 2020

In its analysis the Executive Team and Board committees considered the three common types of organisational structure. The entrepreneurial approach, often described as a club culture or as having a web design, a role or system approach and a model using Strategic Business Units (SBU).

The key characteristics of each model are described below (Diagrams illustrating the models are set out in appendix one);

CLUB CULTURE / WEB DESIGN

- Centred around entrepreneurial enterprises
- Smaller organisations
- Personal connection to leader
- Culture emanates from leader
- Decisions vested in the leader
- Can do – speed – clear outcomes
- Starts to struggle as organisation grows

ROLE/ SYSTEM CULTURE

Classic definition

- Led by the Board and Executive
- Structured approach
- Clear rules
- Clear accountabilities
- Systematic plans
- Objectives and KPIs

Developmental approach

- Can be shaped to many styles and approaches
- Leadership determines approach and culture
- Culture used to create flexibility and innovation
- Model used by nearly all Healthcare organisations

DELEGATED AUTHORITY TO SBUs

- Usually designed for a group structure; SBU is accountable for all elements
- Usually adopted to enable significant growth and management of that growth
- Inherently commercial model – clear outcomes ("Get it done")
- Very tight and clear culture
- Loose tight (Peters and Waterman)
- Command and control management style
- Regular Executive monitoring meetings
- Managing Director (MD) or Director of SBU – fully accountable for performance
- MD accountable to Exec and Corporate Directors
- MD not a member of the Exec
- SBUs easily collated for organisational performance
- Strict adherence to specified corporate guidelines
- Co-production is very problematic

The discussion and analysis identified the environments to which each model is best suited. It also drew out a key point that each model was coherent so that the most challenging approach which results in significant challenges to effectiveness is when the models are mixed together.

The Executive team's analysis and discussion led them to identify that the Trust had been adopting an SBU model with each of the Directorates expected to function as an SBU. They also identified that it felt like there had not been clarity on accountability and there had not been a clear process to summarise issues and reports from Directorates to then collate a cohesive corporate whole organisation view.

In addition to have achieved this there would have needed to be a clear command and control approach necessary for the model to work. This however had not been in place. To further complicate the position it was unclear who was responsible for key issues within the organisation whether it was the corporate Director or the operational directors.

The overall view from the Executive Team was that had not supported effective Governance.

The Executive team also felt that a command and control culture was not one they would wish to adopt for the future.

LPT future approach

To develop a more effective approach to governance and to ensure that the Trust can function both effectively and efficiently the Executive team took account of a number of issues. There was a recognition that the Trust is working in an environment where cost control rather than expansion is the key focus. A command and control culture is not a preferred option and the Trust wants to develop an empowering culture. The organisation design needs to enable a whole organisation corporate approach. That the model most often used in the NHS is a role culture because of the benefits described.

On this basis the desired approach identified is for the Trust is to adopt a role culture and to have divisional teams who are accountable for operational performance and collaborate with the specialist Corporate Directors who will take the lead role for the Trust corporate strategies. This approach was also supported by the Non-Executive Directors and hence the whole board.

The agreed focus for the Trust is on high performance and high quality compassionate care through a collaborative culture

Proposal

To develop a role culture and to ensure the Trust's governance works effectively and efficiently to support the delivery of the Trust's strategy the following supporting arrangement has been agreed. These set out the arrangements for the Corporate Directors and their teams, their function and in addition the arrangements for committees and their various levels and their role and function.

The role of Corporate Director's and their teams

-

- The corporate director sets the strategy for their corporate discipline
- All strategies will support the Trust's overall strategic strategy framework
- The corporate function is led by a corporate director
- The allocated resources are directly accountable to the corporate director or there is a strong dotted line to them
- The corporate director is accountable for the strategic delivery of the area of control
- The function will provide effective and efficient delivery of support services to the operational directorates to the highest standard

The Committee Structures

The level one and level two committees within the Trust had already been agreed and as a result of the review were confirmed. These are detailed below and are also described in appendix two.

Level one

- Board
- Finance and Performance
- Audit
- Nominations and Remuneration Committee
- Quality Assurance Committee

Level Two

Quality Forum -
Transformation Committee
Workforce Committee
Trust policy Committee
IM and T
Health and Safety
Capital
Waiting List and Harm
Financial Turnaround
Transformation Committee

The proposals for supporting committees were considered in depth. It had been proposed that there would a level 2ii such as Learning from Deaths, Clinical Effectiveness Group, Workforce and Wellbeing Group and level three would be defined as the equivalent groups in each of the Directorates. The analysis suggested this would create considerable bureaucracy and would not support the role culture model. In effect there would be four level three committees to report into each level 2ii. It was therefore determined that level 2ii committees would become the Trusts level three committees.

The corporate level three committees would be the workhorses of strategy delivery each of the Directorate Management Teams would input to the level three committees and nominate appropriate representatives.

This was seen as an important way to develop the single organisation focus and militate against "silo working" and support the development of the Trust's culture.

Roles of level one committees and their relationship to Board

The Board and level one committees Finance and Performance Committee (FPC) and Quality Assurance Committee will meet Bi- Monthly on alternate months. The Audit Committee and Nominations and Remunerations will follow their own agreed timetable for meetings.

In the case of all committees where issues are delegated from Board the committee will fulfil the board's role and raise concerns by exception. Other matters will be dealt with by the committee and reported through the assurance report. If delegated issues are of sufficient concern then an emergency board can be called.

A work plan and items to be considered by each level one committee is already in place. These will be further reviewed to continue to improve their effectiveness.

In this new governance model the same papers will not be considered by the level one committee and board. Some items designated by board will be considered directly in addition the level one committee will report issues through assurance reports or through specific subject reports including the committee's considerations.

In exceptional circumstances some papers which are considered by a level one committee will also need to be considered by the Trust Board. This will be determined by the Chair of the level one committee in consultation with the Chair of the Trust Board and the Director of Corporate Governance and Risk.

A key focus of FPC and QAC as standing items will be the Organisational Risk Register for allocated risks and the Performance and Quality Dashboard covering performance, quality, workforce and Finance (this is proposed to be the same for both committees but they will review it through the lens of the focus of their committee)

To illustrate the Information flow two examples are described below;

- The finance report will be considered by FPC who will challenge and gain assurance (if there are any serious issues that require an emergency board this could be actioned)
- The board the following month would receive the report for the current month and the assurance report from FPC on the previous month
- Business cases will be considered by FPC in detail and then presented to board for final approval based on feedback and information prepared by FPC

Processes to Support Committees

To ensure that each committee functions effectively there has been discussion and agreement on a range of key principles and processes that will be adopted in the new governance approach.

- The Operational and Strategic Executive meetings will review level one board committee agendas to ensure key items are progressed
- An Executive Director will be identified as responsible for each item considered at a level one committee
- Directors will be required to sign off level one committee reports
- All reports will be sent out five working days before the meeting and will need to be submitted to corporate governance six days before.
- If a report is late the responsible Director will need to speak to the chair of the committee to explain the reasons for late submission and either confirm the paper can be submitted late or will be deferred
- The level three committees will provide assurance highlight reports to level two committees who will in turn do this to the level one committees
- Strategies and policy decision will be developed at each level and progress through the governance framework as appropriate
- Using the new **innovation of Governance on a page**, alongside TORs, each committee will summarise its role and the key risks and KPIs they will focus on. This will be developed as a project over a specified period.
- A new standard approach to board reports and committee reports will be adopted
- To gain greater connectivity it is proposed that the Trust explores the possibility, dependent on workload, of three NEDs attending each committee, allowing some NEDs to attend more than one committee (the reduced number of meetings should facilitate this approach)

The function of level three committees

The level three committees will be led by members of the corporate teams overseen by the Corporate Directors and the approach to support them is described below;

- Committees will draw their membership from each of the three operational directorates and the corporate directorates
- Divisional Management Teams will put their own structures in place and will determine which issues they need to bring to Level three groups to be progressed.
- Policy and strategy development will come either as a bottom up development from Directorates or from strategic discussion of the board or in response to national developments

- The joint working will promote the development of the single organisation and militate against any potential from silo working.

New Governance Approach

The approach described above sets the Governance framework the Trust will now adopt.

As part of business as usual within this new approach to governance there will be an ongoing focus on improving processes.

Some examples of the key questions which will feature as part of ongoing, business as usual, improvement are;

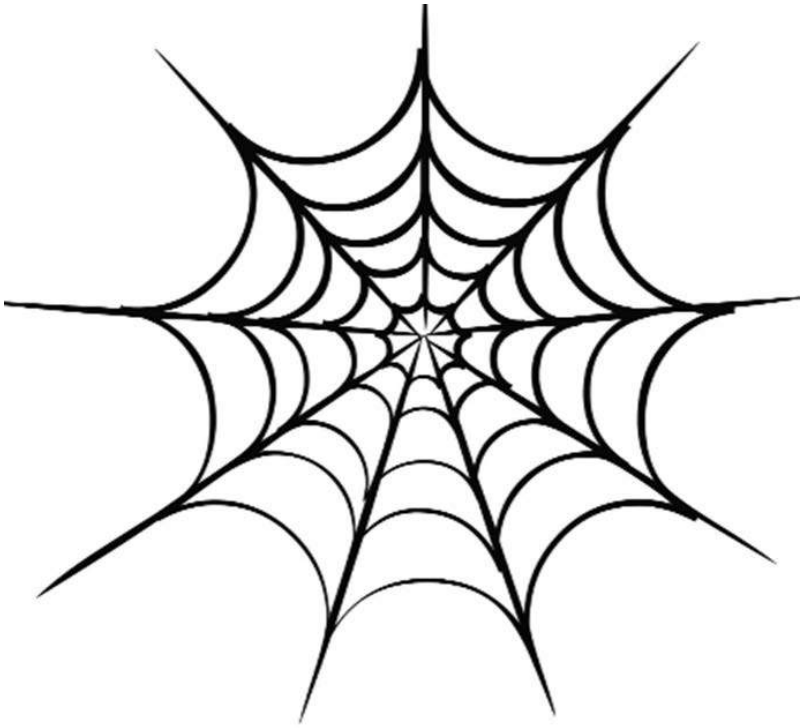
- Why have we got the group?
- What does it broadly aim to achieve?
- Can they be consolidated?
- Do any groups need to be disaggregated to focus on specific issues?
- Can an individual lead this area, replace the group?
- Can a group transform to a project - report to a group?

Decision Required

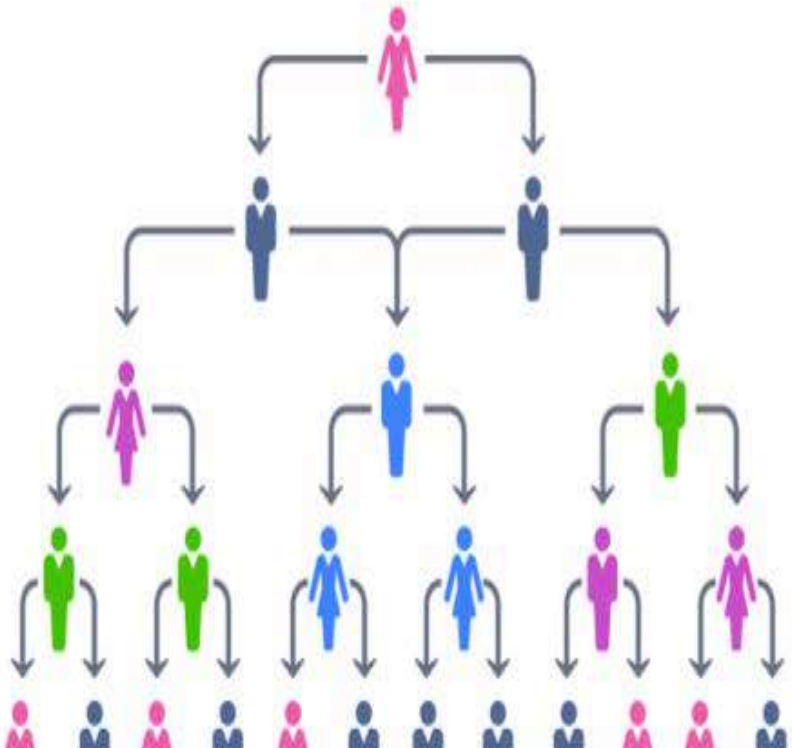
The Trust Board is asked to approve the revised approach to Trust Governance and support the further implementation and development.

Appendix one

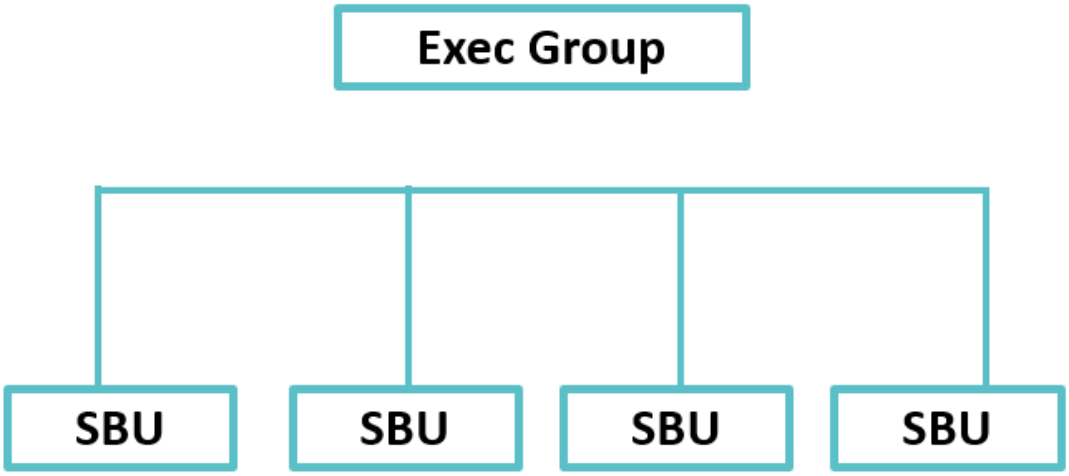
CLUB CULTURE / WEB DESIGN



ROLE CULTURE



DELEGATED AUTHORITY TO SBUs


Exec Group
SBU
SBU
SBU
SBU

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 3rd March 2020
Paper number	G

Name of Report Step up to Great quarterly programme update

For approval		For assurance	x	For information	

Presented by	David Williams	Author (s)	Kat Macann

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
Deputy CEO	21/02/20
Transformation Committee	21/02/20

Assurance : What assurance does this report provide in respect of the Organisational Risk Register?	Links to ORR risk numbers
The report summarises progress against all Step up to Great priority programmes, which impact on various organisational risks	Various – see report

Recommendations of the report
To receive assurance that processes are in place to monitor the delivery of priority programmes sitting under the Step up to Great Quality Improvement Plan.

1. Introduction/Background

The nine STEP up to GREAT priorities are supported by a range of trust-wide work and directorate specific projects and workstreams. The delivery of priority change programmes are monitored via the Quality Improvement Programme Board (QIPB), which has met monthly since August 2019. Since the QIPB was established work has been underway to develop a programme management framework to underpin delivery, including elements such as monthly reporting against delivery milestones, risks and performance indicators relevant to delivery.

In January 2020 the QIPB agreed, in addition to the Quality Assurance Committee receiving a highlight report, the Trust Board should receive a quarterly update summarising progress with delivery against programme milestones, to enable strategic oversight.

2. Aim

The aim of this report to provide an update regarding progress with the delivery of change programmes sitting under the Trust's STEP up to GREAT Quality Improvement Plan.

3. Recommendations

The Board is asked to note the report and to receive assurance that processes are in place to monitor the delivery of priority programmes sitting under the Step up to Great Quality Improvement Plan.

4. Discussion

The report is attached below and presented as a series of slides, with a narrative slide for each of the nine priorities summarising key achievements to date, followed by a snapshot of delivery milestones and KPIs for each programme covering the following information:

<u>Summary</u>

An overall delivery status RAG rating is given for each programme with brief supporting comments. The RAG rating is based on the following factors:

On track / high assurance	Delivery is on track against major milestones. A programme structure is in place, with clearly assigned roles.

Some issues / delays – medium assurance	Delivery is not on track however is under control. Some elements of a programme structure is in place but the programme needs strengthening.
Significant issues – low assurance	Delivery is not on track and is blocked. There are significant issues with the programme structure, such as key roles unassigned or missing key documentation.

Where there are risks on the Organisational Risk Register relevant to a programme, a note has been made of the relevant risk numbers to enable cross referencing to more detailed risk reports.

Delivery milestones

- The status of delivery milestones from the last quarter (October-December 2019)
- Upcoming delivery milestones and whether these are on track

Measures

- Shows the latest position of selected KPIs for each programme – this includes delivery progress measures where relevant alongside performance and quality measures which will be the focus for benefits realisation as change programmes are delivered

Programme and workstream reports with more detail on delivery progress and risks are reviewed monthly by the Quality Improvement Programme Board.

The key areas for further focus and action (the coming quarter) in each *brick* are:

1. High Standards – complete CQC action plan including clear plan for eradicating dormitory accommodation.
2. Transformation – develop community service patient outcome measures, and address and improve Transforming Care provision.
3. Environments – finalise backlog maintenance plan and capital programme
4. Patient Involvement – deliver real time patient feedback & our new complaints and investigator model.
5. Well-Governed – confirm directorate governance structures
6. Single Patient Record – continue and deliver with plan for June 2020
7. Equality, leadership and culture – continue and build on the progress we have made to date.
8. Access to services – improve waiting times
9. Trust-wide quality improvement – continue with our trust wide approach to quality

5. Conclusions

The Board is asked to note the report.

Leicestershire Partnership NHS Trust

Step up to Great Programme Delivery Update

LPT Trust Board
March 2020

WeAreLPT
compassion respect
integrity trust

www.leicspart.nhs.uk

NHS
Leicestershire Partnership
NHS Trust

Our Vision

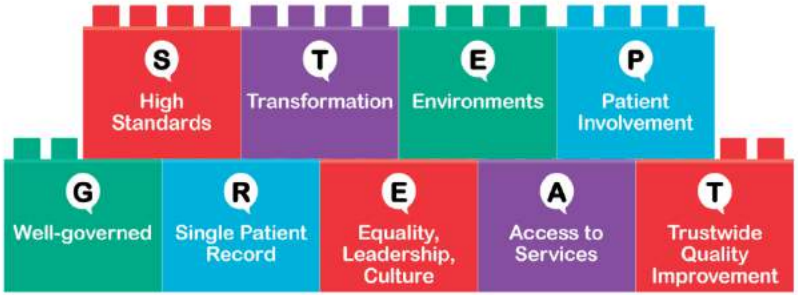
"Creating high quality, compassionate care and wellbeing for all"

Our Values

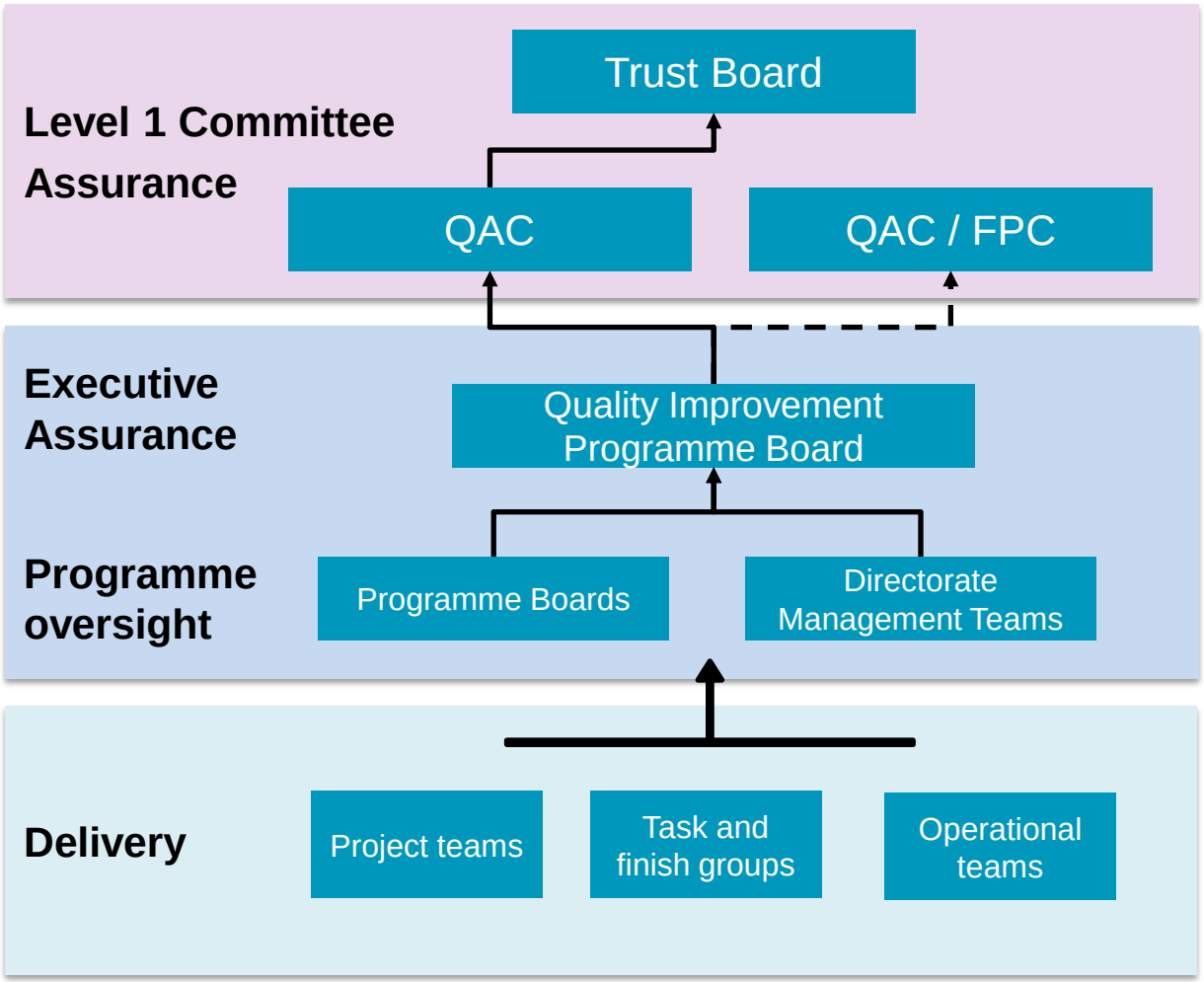
WeAreLPT
compassion respect
integrity trust

Our Strategy

STEP up to GREAT



Programme Governance and Assurance



Committee reporting:

- Quarterly report to Trust Board
- Bi-monthly highlight report to Quality Assurance Committee

Programme reporting:

- Monthly programme + workstream reports to QIPB
- DMTs oversee directorate-led programmes, with summary reporting to QIPB
- Establishing dedicated programme boards or using existing committees to oversee trust-wide programmes

Workstream or project level reporting – varies by programme

- Workstream reports to the programme board
- Updates via operational management

High Standards

Improve standards of safety and quality

We will know we're Great when we are receiving positive feedback, other accreditations, good CQC ratings and other regulatory feedback for everything we do.

Some examples of how we are Stepping Up:

We said we would…	Where are we at?
Develop an agreed set of clinical and professional standards for safe, high quality person-centred care	• **We have met 97% of CQC must do actions** in our action plan, with the exception of eliminating dormitory accommodation, for which we have developed a strategic outline case to address, and a longer term plan to address seclusion paperwork. • **Accreditation is being embedded** in inpatient areas which incorporates 13 CQC core standards, NMC and RCN professional principles of Nursing practice and the Trust clinical priorities. Other external accreditation schemes will continue.

High Standards

Improve standards of safety and quality

Summary		
Delivery Status	Comments	ORR alignment
Some issues / delays – medium assurance	Some workstreams have been defined and are progressing, however further work is needed to clarify improvement objectives for trust-wide work and define delivery plans where changes to 'business as usual' are required.	Risk nos 1-5

Delivery Milestones				
Workstream	Last quarter – Oct-Dec 2019	Status	Next quarter – Jan-Mar 2020	Status
CQC action plan	Complete actions on CQC Action plan	On track	100% of actions on CQ have a plan by March 2020. 97% complete now.	On track
Accreditation	Appoint a trust-wide Accreditation Matron	Complete	Develop and pilot accreditation tool for FYPC, MHSOP, LD and AMH inpatient wards	On track
Core Standards	n/a		Privacy and dignity review against core standards	On track

How we will measure the impact?			
Measure	Target	Impact start date	Position at Dec 19
% of community hospitals through a second accreditation cycle	100% by March 2021	Oct 2019	25%
AMH/LD and FYPC inpatient wards through one accreditation process	100% by March 2021	April 2020	n/a
Improve CQC rating for Safe domain from requires improvement (RI) to Good (G)	Improved CQC rating following next inspection	March 2020	Requires Improvement

Transformation

Transform our mental health and community services

We will know we're Great when patients and staff share positive experiences, demonstrating patient-centred care, and staff experience of working here are good.

Some examples of how we are Stepping Up:

We said we would…	Where are we at?
Implement a new model of care in our community nursing and therapy services – ensuring patients are cared for in the most appropriate place by health and social care.	• Integrated community neighbourhood Teams **(Home First**), co-designed by staff and patients, were launched on 1 December 2019 • We have been successful in selection as one of 7 providers in the country for the **Ageing Well** transformation – building on what we've already done to improve the urgent community response offer.
Transform all-age mental health services by co-designing a new mental health services model with service users and staff – ensuring people can access the right support in a timely way through high quality services.	• We have launched the **Step up to Great Mental Health** co-designed model for adult mental health and mental health services for older people. A 30-month phased implementation plan, including public engagement, will be part of the business plan. • A network of **peer support workers** recruited
Support people with learning disabilities and Autism to remain in their home. Where admission is essential this is for the shortest time needed and is also the closest possible location to home, facilitating the person to maintain links with family, friends and the local community.	We are supporting the local **Transforming Care Partnership to reduce hospital beds** (15 CCG-funded and 15-community specialist beds) by March 2020, with: • LD rehabilitation capability and capacity at Agnes Unit • Development of a forensic network and learning disability forensic training for health and social care staff

Transformation – Community Services Redesign

Transform our community services

Summary		
Delivery Status	Comments	ORR Risk Reference
On track / high assurance	Phase one of the programme has been completed, with the new Community Services model implemented in December. The programme is now moving into the next phase – Ageing Well.	Risk no 7 (now closed)

Delivery Milestones				
Workstream	Last quarter – Oct-Dec 2019	Status	Next quarter – Jan-Mar 2020	Status
Community Services Redesign	Implement new community services redesign model 1 December 2019	Complete	Develop patient outcome measures (CHS)	On track
			SystemOne configuration of one integrated unit	On track

How we will measure the impact?			
Measure	Target	Impact start date	Position at Dec 19
Increase in therapy productivity – average contacts per day	Increase to 5.0 average contacts/day by October 2020	October 2019	2.2 contacts/day
New national target: Percentage of people who receive 2 hour crisis response	95% by March 2021	January 2020	n/a
New national target: Percentage of people who receive rehabilitation within 48 hours	95% by March 2021	January 2020	n/a

Transformation – Transforming Care

Transform our learning disability services

Summary		
Delivery Status	Comments	ORR Risk Reference
Some issues / delays – medium assurance	A programme structure is in place for the Transforming Care recovery plan. There have been some delays to the proposal for rehabilitation beds in the Agnes unit.	Risk no 8

Delivery Milestones				
Workstream	Last quarter – Oct-Dec 2019	Status	Next quarter – Jan-Mar 2020	Status
Transforming Care Recovery Plan	Costed proposal to develop LD rehabilitation capacity and capability at the Agnes Unit to CCG Executive Leadership Team	Delayed	Develop a forensic network and LD forensic training materials for health and care staff working in LLR	On track

How we will measure the impact?			
Measure	Target	Impact start date	Position at Dec 19
Reduction of admissions for assessment and treatment	Reduce admissions by 4 by Q4 2020	Apr 2020	n/a
Train Health and Social Care staff in the effective management of forensic patients	200 staff trained by March 2020	Dec	72 staff trained

Environments

Environments will be welcoming, clean and safe

We will know we're Great when we have welcoming, clean and safe buildings that reduce risk of harm to patients and improve their privacy and dignity.

Some examples of how we are Stepping Up:

We said we would…	Where are we at?
Improve the quality of our buildings and ensure they are safe, clean and welcoming	• **We are building a new CAMHS unit** (child and adolescent mental health), co-designed by children and young people, due for completion August 2020 • We have developed a **strategic outline business case to create a purpose-built mental health acute inpatient unit** for adults and older people, with a view to eliminating all dormitory style accommodation by 2030. • We have improved communications to ensure **reporting and escalation** arrangements are understood • To improve **facilities management oversight and response times** we are reviewing our existing facilities management arrangements to scope bringing them back in house. • We are reviewing our **estates strategy** to ensure our use of estate is fit for purpose for modern community, mental health and learning disabilities services

Environments

Environments will be welcoming, clean and safe

Summary		
Delivery Status	Comments	ORR Risk Reference
On track / high assurance	All workstreams are on track with delivery of key milestones. While there are still significant outstanding risks and ongoing performance issues related to facilities management, actions have been identified to address these.	Risk nos 9, 10, 11

Delivery Milestones				
Workstream	Last quarter – Oct-Dec 2019	Status	Next quarter – Jan-Mar 2020	Status
Facilities Management Transformation	Board decision on preferred option	Complete	Approval of outline business case for implementation of the preferred option	On track
Estates Strategy	Bradgate Strategic Outline Case signed off at board	Complete	Bradgate Strategic Outline Case - finalise site selection	On track
	Estate backlog maintenance plan - 3 year plan approved	Delayed	Finalise approval of overall Trust capital programme	On track

How we will measure the impact?			
Measure	Target	Impact start date	Position Dec 19
Statutory PPM (Planned, Preventative Maintenance)	100%	Ongoing performance issues to be addressed through FM transformation workstream – new service model to be implemented from April 2021	100%
Non Statutory PPM	>=95%		80%
Improve performance against urgent response time within 8 hours	>=95%		49%
Improve performance against urgent rectification within 7 days	>=95%		76%

Patient Involvement

Involve our patients, carers and families

We will know we're Great when patient involvement is at the core of everything we do and our patient satisfaction, and feedback reflects this.

Some examples of how we are Stepping Up:

We said we would…	Where are we at?
Make it easier for patients to share their experiences	• We have **recruited volunteers and a Youth Advisory Board** to help collect feedback and will be purchasing an **new computerised system**. • Our **website information and patient information** about making a complaint and giving feedback has been improved • We are forming a **People's Council by March 2020**
Increase numbers of people who are positively participating in care and service improvement.	• We have co-produced a **new Patient Experience and Involvement strategy** and introduced an **involvement training programme**, use of volunteers, collaborative care planning offer, and a **quality improvement framework for patient involvement.**
Improve the experience of people who use services	• Patient experience and involvement **champions** are in place • A **complaints review group and complaints training** has been established, with Peer Reviews to commence in 2020 • A **Patient Experience and Involvement Group** has been set up to provide strategic direction and assurance on patient experience and improvement plans and actions.

Patient Involvement

Involve our patients, carers and families

Summary		
Delivery Status	Comments	ORR Risk Reference
Some issues / delays – medium assurance	A three year delivery plan has been developed and a programme structure is in place. The programme is rated as 'amber' in terms of delivery due to some initial delays and a risk regarding resourcing for delivery.	Risk nos 12, 13, 14

Delivery Milestones				
Workstream	Last quarter – Oct-Dec 2019	Status	Next quarter – Jan-Mar 2020	Status
Make it easy for people to share their experiences	N/A		Implement real time patient experience questions pilot	Risk of delay
Increase participation	Start co-design of 'Experts by experience' programme	Complete	Launch People's Council and Experts by Experience programme	On track
Improve experience	Implement a patient satisfaction survey for complaints	Complete	Finalise complaints and incident investigator model	Risk of delay

How we will measure the impact?			
Measure	Target	Impact start date	Position at Dec 19
Improve Community FFT response rate	>= 4% by 31 Mar 2020	Jan 2020	2%
Improve Mental Health FFT response rate	>= 3% by 31 Mar 2020	Jan 2020	1%
Reduce clinical complaints by 10%	<= 18 by March 2020	Dec 2019	Achieving target
Increase in annual patient and carer satisfaction	3 out of 5 by Dec 2020	Jan 2020	2.8

Well-governed

Be well-governed and sustainable

We will know we're Great when we feel clear and confident about how we are governed and we use these practices consistently across the Trust

Some examples of how we are Stepping Up:

We said we would…	Where are we at?
Ensure the Trust's positive achievement of external regulatory body inspections and introduce effective governance arrangements across the Trust to maintain ward to board	• **Revised corporate governance arrangements and structures** are now in place, alongside strengthened risk management and performance management .
Deliver our statutory financial duties and financial plan	• **A Financial turnaround plan** is in place including an agreed cost improvement plan to ensure we meet our financial duties. • Next year's financial plan will be aligned to our Trust's strategy.
Together with our Leicester, Leicestershire and Rutland (LLR) partners and stakeholders we will develop the LLR Integrated Care System (ICS) by 2021	• We are a **proactive partner** in the local health and social care system, developing a local plan that responds to the **NHS Long Term Plan**. We are operating a number of system roles to support the long term plan. • Health leaders from UHL, LPT and CCGs have agreed to a system approach to contracting, through an **aligned incentive contract**

Well-governed

Be well-governed and sustainable

Summary		
Delivery Status	Comments	ORR Risk Reference
Some issues / delays – medium assurance	Well Led: Most identified actions completed or due to complete soon. Objectives for this workstream need to be refreshed and the next phase of work defined. Performance workstream: On track to complete end of March 2020 Finance workstream: Further work needed on business processes to manage financial turnaround.	Risk nos 15-22

Delivery Milestones				
Workstream	Last quarter – Oct-Dec 2019	Status	Next quarter – Jan-Mar 2020	Status
Well Led	New corporate governance structure established	Delayed	Directorate governance structures aligned to new corporate structure	Risk of delay
Performance	External review to be completed	Complete	Revised IQPR/performance report implemented	On track
	Approve and implement Performance Framework & Performance management approach	Complete	Final external review report	On track
Finance	Introduction of Control Totals by service	Complete	Monthly reporting of run rates and turnaround plan delivery	Ongoing

How we will measure the impact?			
Measures	Target	Impact start date	Current position
Audit assurance measure against Head of Internal Audit Opinion from Moderate (M)	Significant assurance by May 2020	May 2020	Moderate
CQC Well Led rating from inadequate (I) to requires improvement (RI)	Improved CQC rating following next inspection	March 2020	Inadequate

Single Patient Record

Implement single patient record

We will know we're Great when all staff are trained and proactively using our single patient record to improve our communications and ultimately ensure safer patient care.

Some examples of how we are Stepping Up:

We said we would…	Where are we at?
Implement SystmOne as a replacement for the current RiO Electronic Patient Record, including the successful migration of RiO clinical data accessible for all staff.	We have **a robust project plan** to ensure implementation of SystmOne across the Trust, including plans for safe data migration. A training programme for staff has begun.

Single Patient Record

Implement single patient record

Summary		
Delivery status	Comments	ORR Risk Reference
On track / high assurance	The project is on track: Go live is currently planned for June 2020 with further dates planned if needed until November 2020 as a contingency plan.	Risk no 23

Delivery Milestones			
Last quarter – Oct-Dec 2019	Status	Next quarter – Jan-Mar 2020	Status
Confirm configuration requirements for MHSDS	Complete	Completed and sign-off system designs	On track
Complete design phase (as-is and to-be process mapping	Partially complete	Complete pre Go Live system configuration and sign-off	On track

How we will measure the impact?			
Measures	Target	Impact start date	Position at Dec 19
Reduce data quality errors from baseline	Reducing trend by Go-live (Jun 2020)	August 2019	0.8% - reducing trend
Train identified staff prior to go-live	>=85% by Go-live (Jun 2020)	TBC	n/a
Remove deceased patient records as part of data transfer	Target 0 by Go-live (Jun 2020)	July 2019	137

Equality, leadership and culture

Improve culture, equality and inclusion

We will know we're Great when we value inclusive, compassionate behaviours and show pride in our collective leadership and in our Trust.

Some examples of how we are Stepping Up:

We said we would…	Where are we at?
Embed a culture of inclusion, engagement and collaboration, where all staff and patients feel valued and recognised as we Step up to Great – through the launch of a WRES improvement programme, codesigned by BAME staff.	• Introduction of training to ensure we have **diverse interview panels** and training to address **unconscious bias** • A **reverse mentoring programme** is being tested • We launched a **Zero tolerance campaign** to support staff against abuse, including racist abuse
Co-create a culture of collective leadership that engages staff and empowers them to improve the services we provide – using the 'Our Future, Our Way' programme.	• Through '**Our Future, Our Way**', led by 80 plus change champions, we are co-designing solutions to our barriers together so that our staff feel more valued, supported and empowered. • Nine key themes have been identified for us to address. We have begun by co-designing a **new vision** for the Trust, which is now in place, and co-designing a **new leadership behaviours framework** to support all staff to undertake collective leadership to make improvements.

Equality, leadership and culture

Improve culture, equality and inclusion

Summary		
Delivery status	Comments	ORR Risk Reference
On track / high assurance	Both workstreams are on track with delivery	Risk nos 24, 25, 26, 27

Delivery Milestones				
Workstream	Last quarter – Oct-Dec 2019	Status	Next quarter – Jan-Mar 2020	Status
Equality	Identify and ensure training for staff to sit on diverse panel	Complete	Evaluation of reverse mentoring programme	On track
Culture and Leadership	New Trust Vision created	Complete	Launch Leadership behaviour framework	On track
			Launch the People Strategy	On track

How we will measure the impact?			
Measures	Target	Impact start date	Position at Dec 19
Equality: Uptake of race and cultural understanding training	Target >=360 by March 2021	Sept 2019	85
Equality: Rate of BAME staff receiving interview skills training	Target >=30 by March 2020	Sept 2019	3
Culture and Leadership: Staff sickness rate	Target <=4.5% by March 2020	TBC	5.1%
Culture and Leadership: Maintain/improve staff survey results	>=7.0 by 2019/20 Q4 >=7.1 by 2020/21 Q4	TBC	7.0

Access to services

Make it easy for people to access our services

We will know we're Great when we are delivering improved access to services that meets patient needs as well as local and national targets.

Some examples of how we are Stepping Up:

We said we would…	Where are we at?
Make it easier for people to access our services by reducing our waiting times	• We have achieved significant reductions in our CAMHS waiting lists. Their demand and capacity management model was sited as a national example of good practice by NHS Improvement. • We have undertaken demand and capacity modelling across our services to support commissioning decisions
Ensure equality of access for all our patients	• We are reviewing our patient information systems to improve the accuracy and robustness of data collection, to help us better identify our patients' diverse needs.

Access to services

Make it easy for people to access our services

Summary		
Delivery status	Comments	ORR Risk Reference
Some issues / delays – medium assurance	Delivery of previously identified trust-wide actions is nearly complete, however the programme objectives and governance need review. Outstanding action for executive leads to review terms of reference and membership of the Waiting Times group.	Risk nos 28, 29, 30

Delivery Milestones				
Workstream	Last quarter – Oct-Dec 2019	Status	Next quarter – Jan-Mar 2020	Status
Waiting Times Group	Review, amend and implement LPT Access Policy	Delayed	Refresh scope and objectives for Waiting Times group	Risk of delay

How we will measure the impact?			
Measures	Target	Impact start date	Position at Dec 19
Meet all national access targets - RTT (ASD/ ADHD), EIP, Diagnostics, CAMHS ED(x2)	100% by Sept 2019	March 2019	83%
Reduction in over 52 week waits to treatment	Declining trend by 30 Apr 2020	March 2019	Declined month to month from July 19 – Nov 19 but increase Dec 19
Compliance to planned trajectories in priority services	100% by Sept 2019	March 2019	38%

Trust-wide quality improvement

Implement a trust-wide approach to quality improvement

We will know we're Great when quality improvement, learning and action is embedded in everything we do, and our services are high quality, safe and constantly improving.

Some examples of how we are Stepping Up:

What we said we'd do	Where are we at?
We will design and implement a Trustwide programme of Quality Improvement that equips staff with the skills and resources to drive improvements	• We have launched **WeImproveQ** – a new co-designed model of shared principles and approach to support staff to make improvements • New virtual **Improvement Knowledge hub** of advisors and a **QI champions network** is in place to support staff, alongside communities of practice • Advisors are undertaking **QSIR training** and a training programme is being developed for staff

Trust-wide quality improvement

Implement a trust-wide approach to quality improvement

Summary		
Delivery Status	Comments	ORR Risk Reference
On track / high assurance	The programme is on track with delivery and work is underway to look at resources and capacity to ensure sustainability.	Risk 31

Delivery Milestones			
Last quarter – Oct-Dec 2019	Status	Next quarter – Jan-Mar 2020	Status
Establishment and 'go live' of Improvement Knowledge Hub and Teams and conference	Complete	QI Community of Practice and Masterclasses established at NSPCC	On track
IKH Advisers and Quality Improvement Coaches training programme initiated	Complete	Completion of QI Life interim evaluation at the end of Year 1	On track
		4 tier development and training programme written and dates established for roll out	Delayed

How we will measure the impact?			
Measures	Target	Impact start date	Position at Dec 19
Number of Improvement Advisors trained	15 advisors trained by March 2020	July 2019	15 trained
IKH advisers to receive QSIR training	80% of advisors trained by October 2020	July 2019	47% trained
Number of QI projects	>= 30 by end 2019/20 >=70 by end 2020/21	Sept 2019	45 live projects

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Leicestershire Partnership NHS Trust

QUALITY ASSURANCE COMMITTEE – DATE 18th February 2020

HIGHLIGHT REPORT

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

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

Report	Assurance level*	Committee escalation	ORR Risk Reference
Organisational Risk Register	Medium	QAC accepted assurance from discussions re work in progress on the ORR – assurance given that this will be completed by the end of March. However QAC do not have assurance on the specific risks not updated on the ORR with the exception of Patient Experience which is up to date.	All
Update of New Governance Structure	High	Following the presentation delivered QAC approved the revised approach and supported further implementation and development of this new Governance Structure feeling confident that processes were being improved.	20
Director of Nursing, AHPs and Quality Update.	High	The Report confirmed that the seclusion and segregation work was moving at pace and that we now have a dedicated lead Nurse. The SIAM and CQC Relationship meetings recently both were very positive. The buddy forum work is progressing with a funding discussion to be had shortly. The flu vaccine rate is59% and the focus is now on a final push and what can be done differently for next year's campaign.	18
CQC report	Medium	The CQC report and the 2 outstanding 'Must Do' actions and 5 'Should Do' actions were discussed. The CQC Progress committee has been renamed the Foundation for Great Patient Care Forum to change the focus beyond when	18

Report	Assurance level*	Committee escalation	ORR Risk Reference
		the CQC visit and to focus on the delivery of Great Patient care. A project officer has been employed for the preparation work for the pending CQC visit – Julie Rubenza. The peer review programme is underway with each executive lead being given an area of focus in core services..	
Clinical Quality Strategy QIP Update including CQUINS and Quality Schedule.	Medium	. It was confirmed that the clinical strategy will support the Step Up To Great Strategy and in turn that QAC supports this strategy.	18
Safer Staffing Report	Medium	The Safer Staffing report detailed 15 in-patient areas of note for December. One of these was the Diana Service but this was amber only due to absence.. The care hours per day is an issue relating to calculations only and not an area of significance from a patient safety perspective. The decline in supervision detailed on the report has improved since December and was discussed in the Executive meeting on 17th February The issues around medication errors were linked with changes in medication storage areas and were not detrimental to patients and cause no patient harm.	4 18
Patient Experience Q3 Report	Medium	There has been work going on around revising the Trust's complaints procedure to mirror NHFT's. The FFT work for devices bid has been submitted.	1 3 14 18
Patient Safety Q3 Report	Medium	The report is currently being changed and will include more SPC information in the future. Key issues in the report – a notable reduction in grade 4 pressure ulcers; an increase in deaths by suicide; and increase in self harm and an increase in harm related to falls in MSOP and community hospitals. The issue of increased suicide will be reviewed by the Suicide Prevention Group.	1 3 18
Learning from Deaths Quarterly report Q2 and Q3	High	This report has now been streamlined with a consistent approach across the directorates. The report evidenced that the structures, processes and learning are in place and therefore high assurance received on the progress made to date. Next steps to include embedding and sharing of lessons learnt through the new governance structures	3 18
Serious	High	QAC agreed that the Serious Incidents Executive	NA

Report	Assurance level*	Committee escalation	ORR Risk Reference
Incidents Executive Summaries		Summaries did not need to be presented to QAC as the learning will be received through the revised serious incidents report	
Consultant Appraisal and Revalidation – 6 Monthly update	High	QAC agreed that the Consultant Appraisal and Revalidation Report did not need to be presented to QAC from this point and will be sent to SWC with the annual report going to Board	NA
Performance Report	Medium	It was confirmed that KPIs and QI indicators are being set for 2021. Graham Jones is working on Level 2 Committee Dashboards. In future QAC will receive the Performance Report and QAC Dashboard – this is currently being developed. Concerns were raised over missing metrics in the Performance Report that QAC have agreed should be included and it was confirmed that the QAC dashboard will include additional metrics. The missing metrics that QAC would like to see in the Performance Report are falls; prone restraints; seclusions and pressure ulcers. It was confirmed that the data is available , it is just not in the correct format yet. QAC requested that the Neurological Development Pathway Children's Service wait times are clear in the Performance Report.	20
Health & Safety Report	Medium	The Health & Safety Report was presented and raised no significant issues. The matrix for the minimum training requirements for all roles will come back to H&S in March.	18
Quality Forum Report	Medium	The committee had been running for 3 months now and has full engagement from members. The committee had some concerns raised including concern around duplication of the same reports to various committees. The Quality Forum is the biggest committee and has a large number of committees reporting in to it – it needs to be allowed to develop and with the work around governance it was hoped that paper flow will improved. The areas of concern raised are included in the specific reports detailed above including increased suicide numbers, FFT rates, flu performance.	12 13 14
QIB	High	The highlight report was presented and no issues were raised.	8
Strategic Workforce Committee Report	High	The highlight report was presented and no issues were raised.	8

Report	Assurance level*	Committee escalation	ORR Risk Reference
Privacy and Dignity and Dormitories Deep Dive	NA	Postponed to 17th March QAC due to time restrictions	NA

Chair	Liz Rowbotham

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 3rd March
Paper number	I

Name of Report: January/February Director of Nursing AHPs and Quality Update report

For approval		For assurance	x	For information	

Presented by	Dr. Anne Scott Acting Director of Nursing AHP's and Quality	Author (s)	Dr. 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
QAC in part – paper has been updated since QAC.	Feb 2020

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 the Quality Assurance Committee

Introduction

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

Key Messages

1. Mapping Level 3 Governance Structures

Discussions between the shared Director of Governance and Risk and the other executive directors have started to formulate a plan for the development of the governance arrangements between operational governance and corporate governance.

2. Seclusion and Segregation

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'* (DoH 2014).

The Positive and Safe Group is the level 3 governance group within our quality governance structure, reporting into the Quality Forum, which monitors our Seclusion and Segregation practices and develops improvements in practice.

This group continues to look at the agreed 4 focus areas for 2019/20 which are:

1. Full implementation of less restrictive practice models - Safewards
2. Move from two types of training (MAPA and SCIP) to a programme that meets multiple service and patient needs.
3. Improving seclusion and segregation and recording in line with the MHA Code of Practice.
4. Developing use of Positive Behaviour Support Care Plans for patients and enhanced patient and carer involvement. It is important to note that the focus has been on 3rd phase of the Quality Improvement Programme adopted to support this work in order to embed the changes made to the Seclusion Policy and recording documentation. This has included: a revised training pack and competency document which is being rolled out to every area across AMH/LD and FYPC; building a quality surveillance tool for Seclusion and Segregation documentation using an electronic audit tool known as AMAT; the implementation of a simplified flow-chart of nursing and medical staff roles and responsibilities during seclusion and segregation episodes in care. We also have planned an internal re-audit of Seclusion and Segregation

practices in March 2020; this will be reported in April 2020.

3. January SIAM Meeting

We provided an update on our plans to eradicate dormitory accommodation over the next three years. Michelle Churchard-Smith, head of Nursing for AMH presented a deep dive into our work to address Privacy and Dignity for patients in dormitory accommodation, which was well received.

We discussed a number of issues including;

- Risks around workforce, retention, attraction and sickness.
- Performance management framework and Month 8 performance report; there was focussed discussion on 52 week waits in CAMHs.
- Wait times for adult services, specifically focusing on psychological services and our harm minimisation plan.

We proposed the following deep dive schedule;

- February: Seclusion
- March: Governance
- April: Meds Management
- May: Estates

4. January CQC relationship meeting

There was a presentation from Tim Sayers on Arts therapy which was well received. The attendees were really impressed with the recovery work this service compliments. The meeting took place at the Evington Centre and our CQC colleagues like the fact that we choose different venues for the meeting. Often this includes a visit around the clinical areas which they really enjoy. It gives our staff a great opportunity to showcase what they do. We discussed a wide range of issues, including progress with the CQC action plan, our work with the sexual safety pilot, and an update on the CAMHS construction unit.

5. NHFT and LPT Buddy Forum

Chaired by our CEO, in attendance are the two Trust chairs, the DON's, the two communication leads, the two chairs of the quality committees and the two buddy support leads. Gordon King is now in post as Director of Adult Mental Health. David Williams is supporting two days a week as strategic lead for new care models and the alliance; also

Chris Oakes has joined LPT for two days a week as shared Director for Governance and Risk. Julie Shepherd, Chief Nurse at NHFT is supporting the Interim Director of Nursing/AHPs and Quality at LPT during the 'Acting up' period. The ongoing buddy support for LPT after the 31st March 2020 from NHSE/I, is subject to national discussion and an update can be shared after 31st March 2020. NHSI have congratulated both Trusts on the positive buddy relationship which has been nationally acclaimed as good practice.

6. Flu Vaccination

As of 21st Feb 2020 the total LPT frontline healthcare worker uptake to date is **59.2.% requiring 36 more front-line staff before the end of February to achieve 60%.**
The Trust position remains one of the lowest rates of uptake for NHS Trusts in the country. To date we have offered over 140 clinics at 61 locations, at flexible hours, the key challenges and themes from declination feedback are; needle phobias, it's a personal choice and I don't want it and veganism. There are also a number of clinical leaders who personally do not choose to have the vaccine and this is role modelled in teams.

Planned actions:-

- Dedicated Peer Vaccinator to continue in-patient and community hub 'floor walks' until the end of February 2020 to pick up any final staff uptake
- 2 further flu induction clinics for all new starters
- Attendance/ clinic at safeguarding training event

7. NHSI Infection Prevention & Control (IPC) re-visit – update following visit

Following the visit from Dr. Debra Adams (NHSI) we remain within a strong Amber rating and we are planning a further revisit for 26th May 2020.
Progress with areas noted for improvement and/or immediate actions taken:-

- Opportunity offered to LPT - one of our IPC nurses offered and accepted a place on the National Infection Prevention Leadership Programme – national profile.
- Reviewed NHSI material and producing key responsibility action cards for all staff roles from domestic staff, Ward Sister to Chief Executive so we have a clear line of responsibility, accountability and expectations.
- Matron/Ward Sister Charge Nurse IPC masterclass programme in development and all expected to attend.
- IPC session at the In-patient professional meeting for FYPC, AMH, LD and MHSOP – completed 21 January 2020
- Programme of IPC team visits to all in-patient areas supported with CCG colleagues.
- Processes being developed to strengthen reporting, feedback and assurance systems.
- Revised the highlight report template from the Directorates to the IPC Group mapped

to the Hygiene Code assurance frameworks

- Audit of cleaners rooms and equipment to be completed by facilities in mid-March 2020
- Mattress checking audit added to AMAT for a pilot

8. Wuhan novel coronavirus briefing, situation as at 27th January:

On 31 December 2019, the World Health Organization (WHO) was informed of a cluster of cases of pneumonia of unknown cause located in Wuhan City, Hubei Province, China. On 12th January 2020 it was announced that a novel coronavirus had been identified in samples obtained from cases and that initial analysis of virus genetic sequences suggested that this was the cause of the outbreak. PHE is currently using the name Wuhan novel coronavirus (WN-CoV), in the absence of internationally accepted names for the virus and the disease/syndrome it causes. There are currently two confirmed cases of Wuhan novel coronavirus in the UK. Health partners have been carefully monitoring the situation in Wuhan for some time and have put in place proportionate, precautionary measures. The risk to the UK population is currently assessed as moderate. In preparedness and response the Trust has;

- Reviewed PHE guidance at the Trust Infection Prevention and Control (IPC) group, the group recommended a Trust Coronavirus Emergency Preparedness Resilience and Response Group to co-ordinate and lead the Trust response and actions, chaired by Emma Wallis, Deputy DIPaC, operational leadership; Mike Ryan (Emergency Planning Manager) and Amanda Hemsley (Lead IPC nurse). First meeting took place on Monday 3 February 2020 next meeting 7 February 2020 and weekly thereafter.
- Current policies to support response plans;
    - LPT Major Incident Plan
    - LPT Pandemic Influenza Plan – elements of this plan will support response
    - LPT Infection Prevention Control Policy
    - PHE Communicable Disease Outbreak Management Plan
    - Site / Service Business Continuity Plan
- Trust coronavirus assurance submitted to the Strategic Data Collection System (SDCS) 31 January 2020.
- PHE posters sent to all in-patient and community hubs, patient areas and receptions 31 January 2020
- Daily SITREP from the PHE Incident Control Centre (ICC). This contains the modelling strategy, global figures as at 29 Jan, the national risk assessment, communications plan and next steps accessed and shared by Mike Ryan.
- Attendance at the Local Health Resilience Partnership (LHRP) by Mike Ryan

- Preparedness measures; equipment;

    - FFP3 respirator mask – ordered 31.1.20 expected delivery 11 February 2020
    - IPC team leading on mask fit test training priority areas; Community Hospitals, MHSOP, AMH/LD and community nursing
    - Gloves with long fitting cuffs and gowns with full sleeve gowns ordered 31 January 2020 expected delivery 11 February 2020
    - All other equipment procured and currently in the in-patient emergency boxes at Community Hospitals

- Actions post coronavirus meeting on 3 February 2020;

    - Develop a local SOP in line with PHE guidance how to manage a suspected case of coronavirus presenting in our services
    - Comms update to all staff and message with link to PHE on websiteConfirm preparedness of tenants in LPT buildings, such as Derbyshire Healthcare United (DHU), Alliance and UHL. and to ensure our communication pathway is aligned
    - Link with local Universities to share preparedness plans and ensure plans are aligned.

9. CQC Provider Information Request (PIR) received

We received the Provider Information Request from the CQC on the 24th January 2020 and the following actions have been taken to date:-

- All exec team, heads of nursing/service, the nominated section leads and the governance teams were immediately notified and guidance and the workbooks shared.
- A series of drop-in sessions to discuss the approach and guidance held.
- Agreed on the timeline for initial data completion with the information team..
- NHFT have shared their approach and project lead Julie Rubenzer has also been employed to work with LPT to support the enactment of the CQC plan in readiness for the inspection.
- CQC and QI Hub in Bridge Park Plaza being set up.
- Timeline for completion : -
    - Internal deadline 5th Feb to section leads.
    - Full validation on the 6th/7th Feb
    - Director of nursing review on the 9th.
    - Director of Nursing LPT and Chief Nurse NHFT and Head of Quality Governance LPT further review 12th Feb
    - CEO review 12th – 14th Feb 2020
    - Submit 14th Feb 2020.

10. Agnes Unit Quality Summit -January

The Director of Nursing, AHP's and Quality co-led a SWOT analysis of the Agnes Unit with a diverse range of staff from within the unit, members of the FYPC&LD leadership team and quality and governance leads. Engagement was supported in advance of the session with a comprehensive portfolio of evidence including training, finance, complaint, incident, accreditation review outcomes and performance data. Discussion was open and engaging and has been positively reported by the staff involved. A detailed record of the outputs has been captured and the local leadership team and unit staff involved on the day are currently running follow-up sessions with colleagues working in the unit to confirm challenge and build on the analysis. At the end of February the data will inform a Service Development Plan for the coming year, progress against which will be assured through the Adult Learning Disability Service's Improvement Plan with oversight from the Head of Nursing and Assistant Director.

11. CAMHS Ward 3 Quality Review meetings – February

The Director of Nursing, AHP's and Quality led two Quality Review meetings: one on the 7th February 2020 and one on the 20th February 2020 with a diverse range of clinical and managerial staff from the Unit, including Executive Directors of Operations and an Associate Medical Director. These meetings were held to ensure a proactive approach was taken clinically and managerially to develop robust and safe care plans for the children and ensure the safety of our staff. Ward 3 has been significantly challenged over the last few weeks with the level of acuity of some of the children inpatients being very high, with severe complex needs and escalating behaviours; awaiting placement within a national PICU bed.

Nationally, PICU beds for the under 18's is currently challenging and at times on Ward 3 there have been 3 children awaiting this level of care and placement. This has resulted in Ward 3, recently, at times becoming a very challenging environment, with a significant level of risk and complexity. In order to manage this level of risk, the Unit has been closed, at times, through this period to admissions, which has resulted to one young lady of 17yr 5 months old, being admitted into the Bradgate Unit, safely and clinically well managed and subsequently also impacted on UHL ED where at times there has been 1-2 children waiting to be admitted.

This has also impacted on the level of staffing required for the Unit and to care for the children within UHL, so there has also been an increase in the usage of agency staffing in order to safely staff the Unit.

12. International Year of the Nurse and Midwife 2020

This year, 2020 has been declared as the Year of the Nurse and Midwife as Florence Nightingale's bicentennial year, designated by World Health Organisation as the first ever global Year of the Nurse and Midwife.

Nurses and midwives make up the largest numbers of the NHS workforce. They are highly skilled, multi-faceted professionals from a host of backgrounds that represent our diverse communities.

2020 is our time to reflect on these skills, the commitment and expert clinical care they bring, and the impact they make on the lives of so many. This year is also an opportunity to say thank you to the professions; to showcase their diverse talents and expertise; and to promote nursing and midwifery as careers with a great deal to offer.

A few of the ways the LPT is celebrating this year is our planned International Nurses Day conference on the 12th May 2020. We have submitted bids to secure places for the Florence Nightingale bicentennial celebration at Westminster Abbey on 12 May 2020, places will be confirmed in April 2020. Theme the NHS Big Tea Party celebration on 5 July 2020 linked to Year of the Nurse, to be launched at the conference on 12 May 2020.

Introducing the **DAISY (Diseases Attacking the Immune System)** award scheme for extraordinary nurses. This initiative is in partnership with the DAISYFoundation.org set up in memory of J.P Barnes in 1999 in the USA.

Over 4,000 healthcare facilities and schools of nursing internationally are committed to honoring their nurses with The DAISY Award

- 136,000 nurses honored
- Over 1,600,000 nominations written

Registered Nurses are nominated by patients, families, colleagues, other staff and every nomination tells a *story* of extraordinary care and compassion. A complimentary award scheme is also being considered for AHPs.

Task and finish group has been set up to look at implementation with a view to launching in March/April 2020.

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 3rd March 2020
Paper number	J

Name of Report: Care Quality Commission Report

For approval		For assurance	X	For information	

Presented by	Anne Scott, Interim Director of Nursing, AHP's and Quality	Author (s)	Kate Dyer, Head of Quality Governance

Alignment to CQC domains:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):		Any equality impact (Y/N)	N
Safe	X	S – High Standards	X		
Effective	X	T - Transformation	X		
Caring	X	E – Environments	X		
Responsive	X	P – Patient Involvement	X		
Well-Led	XX	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
QAC	18.02.20

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 and preparedness for the 2019/20 inspection.

Care Quality Commission

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. Discussion

2.1 2018/19 Inspection

The CQC report published in February 2019 relates to the inspection dated 19th November 2018 to 13th December 2018. The Trust compiled an action plan in response to the warning notice, must and should do's recommended within the report (see appendix 1 for outstanding actions, also summarised below):

2.1.1 Two 'warning notice and must do' actions are on-going:

- 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, and is currently at 469 (a decrease from 490 in December 2019) against a target of 345 (as at 13/01/2020).

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

  A strategic plan for the elimination of dormitory accommodation has been approved by the Trust Board. The phased implementation of this plan will be monitored by the Estates Committee. The privacy and dignity of patients continues to be managed by clinical risk assessments and health and safety risk assessments.

2.1.2 There are five ‘should do’ actions that remain ongoing. Two of these actions relate to recruitment which is being progressed, the remaining include;

- S11 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.
  Training is currently being delivered and a trajectory for completion of the training programme is being determined.

- S12 to ensure that the requirements for undertaking physical health checks on children and young people in mental health services are met.
  The CAMHS service will be producing a formal written standard operating guidance for physical health monitoring within CAMHS by 28th February 2020.

- S25 to review the Trust Smoke Free Policy to ensure that there is clear guidance to staff regarding the escorting of patients who want to smoke whilst on escorted leave.
  This was the subject of a deep dive at the Foundation for Great Patient Care forum in February 2020. Further work will be targeted to determine a trust-wide way forward.

2.2 2019/20 Inspection

2.2.1 PIR

The CQC Routine Provider Information Request (PIR) was received on the 24 January 2020. This is currently being collated and validated in readiness for the sign off process on the 12th and 13th February, ahead of submission on the 14 February 2020. A verbal update on the final submission will be provided at the Committee.

2.2.2 CQC related activity

- The Foundation for Great Patient Care Sharing and Learning Forum replaces the former CQC progress meeting; it formally feeds into the Quality Forum. The agenda for the meeting is driven by our step up to great priorities, and feedback from the CQC. The quality surveillance tracker feeds into the agenda; this includes outstanding actions from last year’s CQC inspection and any ongoing feedback from staff. The meeting on the 10th February 2020 included a de-brief on the PIR, discussing next steps for preparedness for the imminent inspection, and a deep dive into our Trust wide work around supporting the smoke free agenda.

- We have recruited an interim CQC project lead, Julie Rubenzer, to support our preparation for the next inspection which we anticipate will be within the next three months. Julie will be providing a next steps session at the Senior Leadership Team meeting on the 11th February 2020.
- The Trust has implemented a peer review programme following learning from NHFT where this provided support to their improvement journey. Within LPT each Director and their Deputies have been assigned to a core service. This will involve providing support, challenge and opportunities to share learning and best practice.
- The Trust has an on-going list of evidence mapped to the Well Led key lines of enquiry. An action plan is being developed for further targeted improvement.
- The Trust has regular contact with the CQC, including a quarterly engagement meeting. The last meeting was held on the 31st January 2020. We provided an update on progress against our action plan, and a number of SI's were discussed. The Arts in Mental Health Team were in attendance to present an overview of the work they do, and the positive impact this has for patients.

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

The ratings poster has been updated by the CQC and is displayed at each of our locations where regulated activity is being delivered (including our main place of business and our website).

4. Conclusion

The Trust is collating the PIR and is on track for delivery by the 14 February 2020 deadline. Any issues arising from the data and information are being captured on a tracker for action, and a project lead is in place to support the PIR process, and preparation for the core service inspection and well led review.

Appendix 1 – CQC action plan (excerpt of on-going actions)

Ref No:	Warning Notice/Should Do/Must Do	Theme	Improvement/ Objective	Action	Action Taken (phase 1 or 2)	RaG Rating	Timeline
W1	Warning Notice	Access to treatment for specialist community mental health services for children and young people	Ensure patient waiting times for assessment and treatment meet commissioned targets and the NHS constitution for children and young people.	Agree a trajectory and resourcing model to deliver significant improvement and increase capacity for assessment and treatment including neurodevelopmental specialist assessment	Access Waiting List: - Number of Patients Waiting for Assessment as at 23/09/19: 103 (target for sustainable position achieved - now managed within tolerances 80 to 150) waiting list is at 124 (18/11/19) – 224 on 30/12/19, 246 on 13/01/20 - Treatment (excluding ND) waiting list is at 464 (18/11/19) - 440 on 30/12/19, 456 on 13/01/20 - Neurodevelopmental Waiting List is at 504 (18/11/19) – 462 on 30/12/19, 469 on 13/01/20 - Access- 4 week urgent performance. October - 90.2%% Due to patient choice (5 out 51 patients choosing appt outside target) – November 88.9%, December 94.6% - Access-13 week routine performance. June 74.7%, July 97.2%, August 97.3%, Sept 98.1%, Oct 99.5% November – 99.3%. December 99.3%	R	June 2020 approved trajectory. Long term action

S1	Should Do	Access to services	The trust should ensure patients have access to psychological therapy and this is delivered and recorded in line with best practice guidance	To review psychological therapies provision, i.e. offering different therapies to meet the needs of the patient group.	Northumberland Tyne and Wear Foundation Trust (NTW) have completed an independent external review of psychological interventions provided in the Directorate. The report has now been received, factual accuracy checked and the recommendations considered by the Adult Mental Health (AMH) Directorate Management Team (DMT). A number of recommendations have been identified to ensure that appropriate therapies are being offered in line with nationally recognised treatment plans, which include the following: - Development and implementation of a Personality Disorder pathway - Roll out of Structured Clinical Management (SCM) training for generalist mental health practitioners The AMH DMT have agreed that in light of this review and the planned structural and clinical changes that will be taking place within the psychological therapies services, it would not be prudent at this time to recruit to a Senior Consultant Clinical Psychologist for Inpatient services as originally planned. In order to ensure access to psychological therapies for inpatient services, two Band 8a Clinical Psychologists will be appointed, one of which will be a research post and take part in the TULIPS study (Talk, Understand and Listen for Inpatient Settings), for which LPT have been confirmed as a study site. https://sites.manchester.ac.uk/tulips/ A job description is already available for this post and the two posts will be advertised before the end of January, pending approval by the Executive Team.	R	1. Complete 2.End January 2020 delayed by banding panel
M3	Must Do	estates and premises	The trust must ensure it reviews arrangements of dormitory accommodation with a view to eliminating this in line with national guidance.	Dormitory accommodation to be reviewed as part of the work to look at the re-provision of the four older wards	A strategic plan for the elimination of dormitory accommodation has been approved by the Trust Board (December 2019). The 3 year, phased implementation of this plan will be monitored by the Estates Committee. The privacy and dignity of patients continues to be managed by clinical risk assessments and health and safety risk assessments.	R	Plan approved December 2019. Long term action over three year period.

S25	Should Do	Fire Safety Issues	Trust to provide clear guidance to staff regarding the escorting of patients who want to smoke whilst on escorted leave.	To review the Trust Smoke Free Policy to ensure that there is clear guidance to staff regarding the escorting of patients who want to smoke whilst on escorted leave.	The Smoke Free Group has nominated a lead for this action and potential solutions are currently being reviewed. The Director of Mental Health will be attending the smoke free group to support the way forward, and a deep dive will be undertaken at the Foundation for Great Patient Care forum in February 2020.	R	full plan to be produced by smoke free group
S11	Should Do	CTO (Community Treatment Order)	To ensure that all patients who are subject to a CTO receive their Section 132 rights.	1. To audit the number of patients subject to a CTO who receive their Section 132 rights. 2. To develop a training programme to support staff's knowledge and understanding of CTO and the implications for care delivery.	1. A monthly audit programme commenced from November 2019 to identify service compliance regarding Section 132 rights. This showed improvement in December as service managers shared the information with staff. 2.A training package regarding Community Treatment Orders has been developed and continues to be delivered to staff.	R	update to Legislative committee February 2020
S12	Should Do	Physical Healthcare	The Trust should review how they assess and monitor patient's physical health needs in children and young people.	Ensure that the requirements for undertaking physical health checks on children and young people in mental health services are met.	Steps taken within CAMHS to ensure compliance with NICE Guidelines: * All clinicians to record past medical history/allergies as part of the core mental health assessment if there are any current physical health concerns. Then to take appropriate actions in partnership of other providers. * All patients on ADHD/antipsychotic medications have their clinical observations (height, weight and BP pulse done) as per NICE recommendations by clinicians within the service. Currently in the process of ensuring it is recorded systematically in SystmOne so that it is easily accessible to all when required. Training for relevant clinicians 03/12/19. * Currently not compliant with metabolic monitoring for patients on antipsychotics. There is a set centralised process in place within AMH and we are looking at the option of CAMHS being part of this. FYPC are collating patient names who are on the said medication and verifying this before enrolling them on the register which will ensure systematic recall at the correct time and so improve timely monitoring.	R	Jan-20

					A paper looking at the 3 areas - roles and responsibilities for physical health monitoring in CAMHS, monitoring aligned to medication, metabolic monitoring and the requirements/actions has been presented to the FYPC Business day. This includes a number of actions which includes a commitment to produce a formal written standard operating guidance for physical Health monitoring within CAMHS by 28th February 2020.		
S15	Should Do	Workforce	The trust should ensure staffing requirements of 136 services do not adversely affect those of acute wards for adults of working age	The rostering team will work with operational managers to review the rosters and staffing requirements.	Additional funding identified of £160K for Band 5 RGN 24/7. Job will be advertised in January 2020 interview date set for 14th February 2020. In the interim, a member of staff from the wards is covering PSAU on a rota basis and their post will be backfilled by bank or agency staff.	R	Jan-20

Meeting Name and date	Trust Board – 3 March 2020
Paper number	Ki

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

For approval		For assurance	X	For information	

Presented by	Anne Scott	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 – Trust wide Quality improvement	
Any equality impact (Y/N)	N		

Report previously reviewed by		
Committee / Group	Date	
Quality Assurance Committee	18.2.20	

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

QUALITY ASSURANCE COMMITTEE – 18 FEBRUARY 2020

TRUST BOARD – 3 MARCH 2020

SAFE STAFFING – DECEMBER 2019 REVIEW

Introduction/Background

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

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

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

Aim

4 The aim of this report is to provide the Quality Assurance Committee and 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 Quality Assurance Committee and 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 December 2019

Right Staff

- Overall the planned staffing levels were achieved across the Trust.
- Temporary worker utilisation rate decreased overall this month 0.3%; reported at 30.2% and Trust wide agency usage increased this month by 0.9% to 4.9%.

- 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 ten of the fifteen are due to agency utilisation above 6%. Five areas did not meet the planned levels of staffing 100% of the time; analysis has shown that staffing was maintained within safe parameters on those occasions, detailed in Annexe 2.
- There are nine community hot spots teams. The Diana service is a new hot spot this month rated at Amber escalation due to staff on phased return from long term sickness, leavers and maternity leave. 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 January 2020 Trust wide;
    - Appraisal sustained at 93.0% GREEN
    - Clinical supervision decreased 4.5% to 81.7% AMBER
    - There are 11 core and clinical mandatory topics for substantive and bank staff.
    - Some training topics are made up of more than one course e.g. safeguarding, and these are reported separately.
    - Substantive staff; most are GREEN with the exception of five courses that are AMBER.
    - Bank staff; most courses are GREEN with the exception of eight courses; four at RED (change from last month for ALS and Safeguarding children training) and four at AMBER.

Right Place

- Fill rates for actual HCSWs over 100% reflects the high utilisation and deployment of additional temporary staff due to increased levels of therapeutic observation to maintain safety of all patients. High utilisation will be considered in the establishment reviews.
- The total Trust CHPPD average (including ward based AHPs) is reported at 10.46 CHPPD in December 2019, with a range between 5.2 (Skye Wing and Ashby Ward) and 35.9 (Agnes Unit) CHPPD. Variation reflects the diversity of services, complex and specialist care provided across the Trust.
- Analysis of CHPPD has identified slight variation for the acute AMH In-patient service, the service CHPPD average is 6.5, there are two outliers; Ashby and Watermead Wards at 5.2 and 8.4 CHPPD respectively. Analysis has shown that Watermead Ward HCSW fill rate/staffing levels for both days and nights was higher than the other wards (229% fill rate on days and 422% fill rate on nights) . Levels were increased to support patient acuity this increased the CHPPD. Ashby Ward fill rate levels were at the lower average point; 126.6% days and 145.2% nights in comparison with all service wards resulting in a lower CHPPD average. No impact to patient experience or outcomes.
- There is no other 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 December 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%
Oct 19	102.1%	199.4%	108.7%	186.4%	29.6%
Nov 19	104.2%	201.7%	108.7%	187.9%	30.5%
Dec 19	**103.0%**	**204.1%**	**111.9%**	**186.2%**	**30.2%**

Table 1 - Trust level safer staffing

7 Temporary worker utilisation rate decreased overall this month 0.3%; reported at 30.2% and Trust wide agency usage increased this month by 0.9% to 4.9%.

8 The following wards utilised above 6% agency staff; Belvoir, Griffin, Beechwood, Clarendon, Feilding Palmer, St Lukes Ward 3, Coalville Ward 2, Coalville Ward 3 (CAMHS) East and North Wards. These are the wards with high vacancy factors, increased acuity and dependency and or hard to fill bank shift areas.

Summary of staffing hotspots – Inpatients

Hot spot wards	Oct 2019	Nov 2019	Dec 2019
Hinckley and Bosworth - East Ward		X	X
Hinckley and Bosworth – North Ward		X	X
Beechwood	X	X	X
Clarendon	X	X	X
Feilding Palmer	X	X	X
St Lukes Ward 3	X	X	X
Coalville Ward 1		X	
Coalville Ward 2			X
Short Breaks - The Gillivers	X	X	X
Short Breaks – The Grange			X
Mill Lodge			
Coleman	X	X	X
Gwendolen			X
Belvoir		X	X
Heather	X	X	
Griffin	X	X	X
Watermead		X	
Agnes Unit		X	X
Langley			
Ward 3 Coalville (CAMHS)	X	X	X

Table 2 – In-patient staffing hotspots

9 Coleman, Gwendolen, East, Feilding Palmer, Grange 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.

10 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

11 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	Oct 2019	Nov 2019	Dec 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 only)	X	X	X
Healthy Together – East	X	X	
Health Together - West	X	X	X
CAMHS County - FYPC	X	X	X
CAMHS Crisis - FYPC			
Diana service			X
City West CMHT - MHSOP	X	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. East Central has seen an improving staffing position. Hinckley and Bosworth Hub remains a hotspot as they have four registered nurses on maternity leave, due to return from leave by the end of January 2020. To support management of the risk, where there is a cross border area, the hubs have taken care homes from the teams under pressure to support where staffing is a concern

15 Healthy Together City (School Nursing only), West Healthy Together, County Outpatient and Diana 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.

The Diana service is a new hot spot; it is rated at Amber escalation due to staff on phased return from long term sickness, leavers and maternity leave.

Mitigation plans are in place across the wider service and Amber teams for moving staff internally to cover high risk areas. A number of strategies are being used to mitigate staffing gaps and including paid overtime, ongoing advert for vacant posts. Locum support recruited to and additional hours in place for existing substantive staff where possible to increase capacity. Risks continue to be monitored internally on a weekly basis.

16 City west, CMHT, MHSOP remains a hot spot due to sickness and a vacancy; in conjunction with internal moves clinical risk and activity are supported and managed.

17 There are no community hot spots in December 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 commenced in December 2019 with a fifth cohort commencing in March 2020 (a total of 20 trainee Nursing Associates in cohorts 4 & 5). Nine trainees (Cohort 2) finish their academic programme in January 2020 due to register with the NMC in March/April 2020.

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: Anne Scott – Acting Director of Nursing, AHPs and Quality

Author: Emma Wallis – Associate Director of Nursing and Professional Practice

December 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	90.8%	126.6%	100.0%	145.2%			79.6%	23.4%	22.5%	0.9%	5.2
	Aston	19	19	82.8%	178.2%	95.2%	290.3%			60.2%	38.5%	34.9%	3.6%	6.7
	Beaumont	22	22	100.0%	172.6%	101.6%	335.5%			89.2%	30.3%	29.5%	0.9%	6.4
	Belvoir Unit	10	10	113.9%	353.7%	183.9%	375.0%			95.7%	54.6%	42.3%	12.3%	21.2
	Bosworth	20	19	81.7%	183.1%	96.8%	245.2%			58.1%	33.2%	33.0%	0.2%	6.5
	Heather	18	17	88.4%	146.0%	100.0%	158.1%			73.1%	26.8%	22.1%	4.6%	6.2
	Thornton	20	18	81.0%	166.9%	100.0%	104.8%			63.4%	35.3%	34.9%	0.4%	6.3
	Watermead	20	19	90.7%	229.0%	98.4%	422.6%			71.0%	48.5%	44.8%	3.7%	8.4
	Griffin Female PICU	6	6	186.4%	291.4%	200.0%	154.8%			95.7%	50.8%	30.0%	20.8%	17.6
AMH Other	HP Phoenix	12	11	101.6%	143.5%	112.9%	150.0%			94.6%	12.5%	11.3%	1.2%	9.5
	SH Skye Wing	30	27	114.5%	162.4%	203.2%	145.2%			98.9%	37.5%	37.5%	0.0%	5.2
	Willows Unit	35	34	150.4%	180.5%	122.6%	208.1%			93.5%	16.8%	16.5%	0.3%	8.3
	ML Mill Lodge (New Site)	13	10	100.0%	191.9%	98.4%	145.2%			87.1%	38.4%	37.1%	1.3%	12.0
CHS City	BC Kirby	23	21	81.9%	206.3%	96.8%	124.2%			62.4%	24.8%	23.3%	1.5%	5.9
	BC Welford	24	16	90.4%	176.6%	93.5%	101.6%			78.5%	10.0%	9.1%	0.9%	7.1
	CB Beechwood	20	19	81.9%	213.0%	100.0%	116.1%	102.1%	109.6%	64.5%	25.7%	14.5%	11.2%	6.2
	CB Clarendon	23	21	86.5%	246.4%	101.6%	106.5%			72.0%	15.2%	8.4%	6.8%	6.6
	EC Coleman	20	17	69.5%	320.2%	88.7%	201.6%			49.5%	25.6%	25.3%	0.3%	9.7
	EC Gwendolen	19	16	77.9%	306.2%	98.4%	200.0%			65.6%	38.6%	34.0%	4.6%	10.5
CHS East	FP General	10	9	137.8%	75.4%	106.9%	-	96.8%		66.7%	32.4%	17.1%	15.3%	7.0
	MM Dalgleish	16	15	101.6%	123.8%	100.0%	161.3%	102.9%	102.0%	93.5%	14.2%	10.3%	3.9%	6.3
	Rutland	15	13	100.0%	115.2%	95.2%	148.4%			92.5%	11.8%	7.4%	4.5%	6.7
	SL Ward 1 Stroke	17	14	117.6%	186.3%	98.4%	96.8%	100.9%	101.3%	96.8%	15.6%	13.6%	2.0%	8.9
	SL Ward 3	12	11	106.5%	113.8%	193.5%	93.5%	106.7%	100%	86.0%	30.6%	18.6%	11.9%	7.2
CHS West	CV Ellistown 2	18	16	100.0%	204.8%	200.0%	100.0%	103.1%	100%	98.9%	18.3%	8.8%	9.6%	7.3
	CV Snibston 1	16	14	105.4%	185.0%	100.0%	108.1%	102.4%	101.9%	92.5%	8.6%	6.0%	2.6%	8.3
	HB East Ward	20	19	75.3%	226.6%	98.4%	143.5%	102.0%	94.2%	50.5%	18.2%	11.6%	6.7%	7.2
	HB North Ward	19	18	117.7%	173.4%	100.0%	112.9%			100.0%	34.3%	21.5%	12.8%	6.7
	Lough Swithland	24	22	101.6%	215.3%	100.0%	203.2%	97.5%	107.0%	95.7%	13.9%	8.3%	5.6%	5.7
FYPC	Langley	13	12	88.1%	161.2%	112.9%	116.1%	97.8%		79.6%	37.5%	37.5%	0.0%	7.1
	CV Ward 3	10	8	178.6%	408.6%	197.0%	412.1%			100.0%	48.0%	32.0%	16.0%	19.0
LD	3 Rubicon Close	4	2	91.9%	140.3%	83.9%	161.3%			74.2%	31.4%	30.5%	0.9%	22.0
	Agnes Unit	11	8	220.5%	639.8%	197.3%	902.7%			94.6%	51.7%	47.4%	4.4%	39.2
	The Gillivers	5	2	91.9%	140.6%	45.2%	138.7%			69.9%	20.6%	20.6%	0.0%	21.9
	The Grange	5	2	-	152.4%	-	212.9%			97.8%	31.0%	31.0%	0.0%	20.2
Trust Total				**103.0%**	**204.1%**	**111.9%**	**186.2%**			**81.2%**	**30.2%**	**25.3%**	**4.9%**	

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

Trust thresholds are indicated below;

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

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

Acute Inpatient Wards

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers%	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
Ashby	20	90.8%	126.6%	100.0%	145.2%	23.4%	5.2	14.7%↓	0	1↓	0	100%
Aston	19	82.8%	178.2%	95.2%	290.3%	38.5%	6.7	10.4%↑	0	1	0	100%
Beaumont	22	100.0%	172.6%	101.6%	335.5%	30.3%	6.4	4.9%↓	3↑	0↓	0	nil
Belvoir Unit	10	113.9%	353.7%	183.9%	375.0%	54.6%	21.2	40.7%↑	0↓	0	2↑	nil
Bosworth	19	81.7%	183.1%	96.8%	245.2%	33.2%	6.5	16.6%↑	2↑	3↓	0↓	nil
Heather	17	88.4%	146.0%	100.0%	158.1%	26.8%	6.2	17.7%	0↓	2↑	0	nil
Thornton	18	81.0%	166.9%	100.0%	104.8%	35.3%	6.3	12.9%↑	1↑	1	0	100%
Watermead	19	90.7%	229.0%	98.4%	422.6%	48.5%	8.4	17.5%↑	2	11↑	2	100%
Griffin F PICU	6	186.4%	291.4%	200.0%	154.8%	50.8%	17.6	26.8%↑	1↑	0	1↓	nil
TOTALS									**9↑**	**19↑**	**5↓**	

Table 3 - Acute inpatient ward safe staffing

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

Temporary worker utilisation is Red for Belvoir and Griffin Units at 54.6% and 50.8% 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. The ward has completed successful recruitment to RN and HCSW vacancies.

Analysis of the NSIs has shown an increase in falls on Watermead in December 2019 these were all related to one patient who has mobility issues and epilepsy which are affected by the persons mental health. The ward team have fully reviewed physical health and behaviour to reduce the falls/ seizures. One of the complaints relates to the care for this lady and understanding falls.

There was an increase in medication errors on Beaumont Ward related to storage and administration of controlled drugs, there has been no harm to patients, staff are receiving additional training.

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	2	91.9%	140.3%	83.9%	161.3%	31.4%	22.0	30.0%↑	0	0↓	0↓	nil
Agnes Unit	8	220.5%	639.8%	197.3%	902.7%	51.7%	39.2	10.0%↓	0	5↑	0	nil
The Gillivers	2	91.9%	140.6%	45.2%	138.7%	20.6%	21.9	15.0%	0	0	0	nil
The Grange	2	-	152.4%	-	212.9%	31.0%	20.2	21.9%↓	0	0↓	0	100%
TOTALS									**0**	**5↓**	**0↓**	

Table 4 - Learning disabilities safe staffing

Rubicon, Short Breaks and the Agnes Unit met the thresholds for RN and HCSW planned staffing in December 2019.

Gillivers and Grange short breaks did not meet the planned RN level on days and nights at the Grange and on nights at the Gillivers. The skill mix of staff 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 Grange and Gillivers site as the homes are situated next to each other.

The 5 falls at the Agnes Unit relate to one patient, care plans and risk assessments identify behaviour in relation to anxiety however further investigations are taking place to ascertain whether there is any epilepsy, risk mitigations are in place until the investigations are concluded.

Low Secure Services – Herschel Prins

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers%	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
HP Phoenix	11	101.6%	143.5%	112.9%	150.0%	12.5%	9.5	8.3%	0	0	0	57.10%

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	114.5%	162.4%	203.2%	145.2%	37.5%	5.2	1.6%	1↓	2↑	0	80%
Willows Unit	34	150.4%	180.5%	122.6%	208.1%	16.8%	8.3	8.2%	0	1↑	0	83.3%
Mill Lodge	10	100.0%	191.9%	98.4%	145.2%	38.4%	12.0	14.2%↓	0	0↓	0	nil
TOTALS									**1↓**	**3↓**	**0**	

Table 6 - Rehabilitation service safe staffing

All ward/units met the planned staffing thresholds for all shifts in December 2019; 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	137.8%	75.4%	106.9%	-	32.4%	7.0	35.0%↓	0↓	4	0	100%
MM Dalgliesh	15	101.6%	123.8%	100.0%	161.3%	14.2%	6.3	-14.01%	0	7↑	0	nil
Rutland	13	100.0%	115.2%	95.2%	148.4%	11.8%	6.7	16.5%	1↑	4↓	0	100%
SL Ward 1	14	117.6%	186.3%	98.4%	96.8%	15.6%	8.9	15.2%	0↓	3↑	0	100%
SL Ward 3	11	106.5%	113.8%	193.5%	93.5%	30.6%	7.2	26.7%↓	1	3	0↓	80%
CV Ellistown 2	16	100.0%	204.8%	200.0%	100.0%	18.3%	7.3	6.6%	0	6↑	0	100%
CV Snibston 1	14	105.4%	185.0%	100.0%	108.1%	8.6%	8.3	17.2%↑	0	3↓	0	100%
HB East Ward	19	75.3%	226.6%	98.4%	143.5%	18.2%	7.2	4.0%↓	1↓	5↑	0	100%
HB North Ward	18	117.7%	173.4%	100.0%	112.9%	34.3%	6.7	19.4%	0	5↑	0	87.5%
Swithland	22	101.6%	215.3%	100.0%	203.2%	13.9%	5.7	20.9%↓	0	4↓	0	90.5%
CB Beechwood	19	81.9%	213.0%	100.0%	116.1%	25.7%	6.2	14.6%	1↓	7↑	0↓	100%
CB Clarendon	21	86.5%	246.4%	101.6%	106.5%	15.2%	6.6	13.9%	2↑	8↑	0	100%
TOTALS									**6↓**	**59↑**	**0↓**	

Table 7 - Community hospital safe staffing

All wards met the thresholds for RN and HCSW planned staffing in December 2019 with the exception of Feilding Palmer on days for HCSW and East Ward on days for Registered Nurses. Feilding Palmer HCSW staffing was adjusted in line with bed occupancy and patient need, East 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 Dalgleish Ward, Beechwood, Clarendon, East, North and Ellistown Ward. 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	21	81.9%	206.3%	96.8%	124.2%	24.8%	5.9	24.5%↓	0	15↑	0	nil
BC Welford	16	90.4%	176.6%	93.5%	101.6%	10.0%	7.1	19.2%	1↓	2↑	0	nil
Coleman	17	69.5%	320.2%	88.7%	201.6%	25.6%	9.7	16.2%	2↑	6↑	0↓	nil
Gwendolen	16	77.9%	306.2%	98.4%	200.0%	38.6%	10.5	17.3%↑	0↓	15↑	0	50%
TOTALS									**3↓**	**38↑**	**0↓**	

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

Coleman and Gwendolen are hot spots as they only met the threshold for RN planned staffing on days 69.5% and 77.9% respectively. Analysis has shown that Coleman ward had one registered nurse on six day shifts and Gwendolen ward on nineteen day shifts. Both wards were supported by the charge nurses and Gwendolen ward by a Medication Administration Technician.

Analysis has shown that the increase in falls on both Kirby and Gwendolen Wards is not linked to staffing numbers.

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

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers%	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
Langley	12	88.1%	161.2%	112.9%	116.1%	37.5%	7.1	-13.0%	1↑	2↑	1↑	100%
CV Ward 3 - CAMHS	8	178.6%	408.6%	197.0%	412.1%	48.0%	19.0	20.1%↑	0↓	1↑	0	nil
TOTALS									**1↓**	**3↑**	**1↑**	

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

Both wards met the thresholds for RN and HCSW planned staffing in December 2019, the wards continue to utilise an increased number of temporary workers to manage increased patient acuity and maintain patient safety.

There was an increase in NSIs on Langley Ward in December; analysis has not identified any correlation between staffing and impact to quality and safety of patient care/outcomes.

Meeting Name and date	Trust Board – 3 March 2020
Paper number	Kii

Name of Report - **SAFE STAFFING - JANUARY 2020 REVIEW**

For approval		For assurance	X	For information	

Presented by	Anne Scott	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 – Trust wide Quality improvement	
Any equality impact (Y/N)	N		

Report previously reviewed by		
Committee / Group	Date	

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

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

Leicestershire Partnership NHS Trust

TRUST BOARD – 3 MARCH 2020

SAFE STAFFING – JANUARY 2020 REVIEW

Introduction/Background

1 This report provides an overview of nursing safe staffing during the month of January 2020, triangulating workforce metrics, quality and outcomes linked to Nurse Sensitive Indicators (NSIs) and patient experience feedback.

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

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

Aim

4 The aim of this report is to provide the Trust Board with assurance that arrangements are in place to safely staff our services with the right number of staff, with the right skills at the right time. Including an overview of staffing areas to note, 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 January 2020

Right Staff

- Overall the planned staffing levels were achieved across the Trust.
- Temporary worker utilisation rate decreased overall this month 0.3%; reported at 30.2% and Trust wide agency usage decreased this month by 1.1% to 3.8%.
- There are eleven inpatient 'areas to note' 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 five of the eleven are due to agency utilisation above 6%.

- There are eleven community team 'areas to note' with three new areas identified in January 2020; East Leicester CMHT, Charnwood CNLD and Outreach LD. 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 February 2020 Trust wide;
    - Appraisal improved at 93.8% GREEN
    - Clinical supervision increased 1.3% to 83.0% AMBER
    - There are 11 core and clinical mandatory topics for substantive and bank staff.
    - Some training topics are made up of more than one course e.g. safeguarding, and these are reported separately.
    - Substantive staff; most are GREEN with the exception of five courses that are AMBER all with improved compliance in January 2020
    - Bank staff; most courses are GREEN with the exception of eight courses; two at RED (change from last month ALS and safeguarding children training moved from RED to AMBER) 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 11.2 CHPPD in January 2020, with a range between 4.8 (Skye Wing) and 36.5 (Agnes Unit) CHPPD. Variation reflects the diversity of services, complex and specialist care provided across the Trust.
- Analysis of CHPPD has not identified 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 January 2020 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%
Nov 19	104.2%	201.7%	108.7%	187.9%	30.5%
Dec 19	**103.0%**	**204.1%**	**111.9%**	**186.2%**	**30.2%**
Jan 20	**102.8%**	**207.8%**	**111.2%**	**189.5%**	**30.0%**

Table 1 - Trust level safer staffing

7 Temporary worker utilisation rate decreased overall this month 0.3%; reported at 30.2% and Trust wide agency usage increased this month by 0.9% to 4.9%.

8 The following wards utilised above 6% agency staff; Belvoir, Griffin, Beechwood, Feilding Palmer and Coalville Ward 3 (CAMHS) Wards. These are the wards with high vacancy factors, increased acuity and dependency and or hard to fill bank shift areas.

Summary of inpatient staffing areas to note

Wards	Nov 2019	Dec 2019	Jan 2020
Hinckley and Bosworth - East Ward	X	X	
Hinckley and Bosworth – North Ward	X	X	X
Beechwood	X	X	
Clarendon	X	X	
Feilding Palmer	X	X	X
St Lukes Ward 1			X
St Lukes Ward 3	X	X	X
Coalville Ward 1	X		
Coalville Ward 2		X	
Short Breaks - The Gillivers	X	X	X
Short Breaks – The Grange		X	X
Coleman	X	X	X
Gwendolen		X	
Belvoir	X	X	X
Heather	X		
Griffin	X	X	X
Watermead	X		
Agnes Unit	X	X	
Langley			X
Ward 3 Coalville (CAMHS)	X	X	X

Table 2 – In-patient staffing areas to note

9 Coleman, Langley, Feilding Palmer, the Grange and Gillivers did not meet the threshold for planned staffing across all shifts; on these occasions staffing was reported to be within safe parameters.

10 Feilding Palmer, St Lukes Ward 1 and Ward 3 and North Ward are 'areas to note' associated with increased temporary workforce usage due to vacancies, maternity leave and sickness.

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 'areas to note' as reported by the lead nurses is detailed in the table below;

Community team	Nov 2019	Dec 2019	Jan 2020
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	
Healthy Together – City (School Nursing only)	X	X	X
Healthy Together – East	X		
Health Together - West	X	X	X
CAMHS County - FYPC	X	X	X
Diana service		X	X
City West CMHT - MHSOP	X	X	X
East Leicester CMHT			X
Charnwood CNLD			X
Outreach LD			X

Table 11 – Community areas to note

14 There remain a number of vacancies across community planned care nursing hubs with City East, West and East Central carrying the largest number. Where there is a cross border area, hubs have 'taken' care homes from the teams under pressure to support management of the risk, patient care and staffing. Hinckley and Bosworth hub staffing has improved with staff returned from maternity leave and improved availability of bank staff fill rates.

There are three Band 5 rolling adverts; one aimed at newly qualified nurses, one for City hubs with a recruitment and retention premia, and one for the County hubs to support the ageing well agenda. Interviews scheduled for early March 2020 to date there are four RN candidates.

15 Healthy Together City (School Nursing only), West Healthy Together, County Outpatient and Diana teams are rated to be at Amber escalation level due to only 70% of the established team being available to work. A number of strategies are being used to mitigate staffing gaps including paid overtime, ongoing advert for vacant posts. Locum support recruited to and additional hours in place for existing substantive staff where possible to increase capacity. Risks continue to be monitored within the Directorate on a weekly basis.

16 City west, CMHT, MHSOP remains a hot spot due to sickness, the team is currently supported by a regular agency nurse and a new starter commences in February 2020. The team have operated on the minimum local agreed staffing levels and there is an established process of reviewing the waiting list and any risks acted upon accordingly.

17 East Leicester CMHT, Charnwood CNLD and Outreach LD are rated to be at Red escalation level with Charnwood CMHT, City LD, East LD, Hinckley & NW LD, Autism rated at Amber escalation level. Teams have been rated reviewing staff available to work, vacancies, sickness and case load complexity. A number of strategies are in place to support areas of note, risks and impact to patient care and waiting lists continue to be monitored within the services and Directorate.

Recruitment and Retention

18 Rolling adverts for all RN posts including implementation of Trust incentivised schemes for hard to recruit areas.

19 Accessing recruitment fairs at local universities, schools and colleges including the recent partnership (UHL and LPT) careers event for DMU pre-registration nursing students in February 2020 aimed at recruiting and retaining nursing students in their final year.

20 Increased work experience placements and increased recruitment of clinical apprentices.

21 Cohort 4 of trainee Nursing Associates commenced in December 2019 with a fifth cohort commencing in March 2020 (a total of 20 trainee Nursing Associates in cohorts 4 & 5). Nine trainees (Cohort 2) finish their academic programme in January 2020 due to register with the NMC in March/April 2020.

22 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

23 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.

24 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: Anne Scott – Acting Director of Nursing, AHPs and Quality

Author: Emma Wallis – Associate Director of Nursing and Professional Practice

January 2020

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	93.5%	124.2%	96.8%	167.7%			86.0%	25.5%	23.9%	1.6%	5.2
	Aston	19	19	84.9%	152.4%	100.0%	167.7%			69.9%	27.3%	25.6%	1.7%	5.9
	Beaumont	22	22	89.8%	121.0%	101.6%	235.5%			80.6%	18.8%	18.3%	0.4%	5.0
	Belvoir Unit	10	10	121.0%	353.9%	171.0%	418.0%			97.8%	58.9%	45.8%	13.2%	22.2
	Bosworth	20	19	89.1%	179.0%	98.4%	254.8%			71.0%	30.4%	29.7%	0.8%	6.6
	Heather	18	18	89.8%	151.6%	98.4%	283.9%			76.3%	36.3%	31.9%	4.4%	6.8
	Thornton	20	18	99.4%	159.7%	100.0%	111.3%			88.2%	34.9%	34.5%	0.4%	6.7
	Watermead	20	20	86.0%	208.9%	93.5%	338.7%			65.6%	49.0%	43.8%	5.2%	7.1
	Griffin Female PICU	6	6	197.0%	302.9%	193.5%	171.0%			97.8%	43.1%	25.9%	17.3%	18.4
AMH Other	HP Phoenix	12	11	108.1%	139.4%	100.0%	146.8%			95.7%	10.6%	9.7%	0.9%	9.0
	SH Skye Wing	29	27	116.9%	143.3%	200.0%	127.4%			97.8%	35.9%	35.4%	0.5%	4.8
	Willows Unit	36	35	148.0%	195.9%	125.0%	209.7%			100.0%	16.3%	16.3%	0.0%	8.5
	ML Mill Lodge (New Site)	13	11	103.2%	221.3%	90.3%	162.9%			83.9%	38.9%	38.7%	0.2%	12.5
CHS City	BC Kirby	24	23	80.6%	225.0%	95.2%	121.0%			62.4%	30.5%	29.2%	1.3%	5.7
	BC Welford	24	21	80.6%	208.1%	98.4%	111.3%	100%	100%	62.4%	15.8%	15.0%	0.8%	6.0
	CB Beechwood	21	20	87.7%	204.9%	98.4%	100.0%			72.0%	15.8%	9.3%	6.5%	7.1
	CB Clarendon	23	21	92.3%	235.2%	100.0%	119.4%			77.4%	15.0%	9.1%	5.9%	6.8
	EC Coleman	20	19	65.6%	317.7%	95.2%	230.6%			33.3%	34.1%	32.3%	1.8%	9.1
	EC Gwendolen	20	12	88.6%	362.6%	98.4%	290.3%			81.7%	41.6%	37.3%	4.3%	15.7
CHS East	FP General	9	9	143.5%	78.7%	109.1%	-	100%	100%	72.0%	38.7%	31.0%	7.7%	7.9
	MM Dalgleish	16	15	100.8%	131.5%	93.5%	200.0%	100%	100%	95.7%	17.4%	12.0%	5.4%	8.4
	Rutland	15	14	98.4%	120.8%	96.8%	116.1%			95.7%	17.9%	14.1%	3.7%	6.1
	SL Ward 1 Stroke	18	15	100.7%	208.1%	98.4%	112.9%	100%	100%	84.9%	20.7%	17.7%	3.0%	9.9
	SL Ward 3	12	11	94.4%	168.5%	196.8%	119.4%	100%	100%	89.2%	33.5%	28.8%	4.7%	9.2
CHS West	CV Ellistown 2	18	16	100.0%	193.5%	200.0%	100.0%	100%	100%	100.0%	16.8%	11.5%	5.3%	8.9
	CV Snibston 1	16	14	101.4%	157.1%	92.1%	112.9%	100%	100%	86.0%	9.2%	8.8%	0.4%	10.3
	HB East Ward	22	21	84.4%	207.3%	100.0%	103.2%		100%	68.8%	8.9%	6.1%	2.8%	6.5
	HB North Ward	19	18	108.9%	184.7%	101.6%	127.4%			100.0%	33.2%	28.3%	4.9%	6.9
	Lough Swithland	24	23	100.0%	221.8%	100.0%	200.0%	100%	100%	100.0%	12.2%	9.4%	2.9%	6.1
FYPC	Langley	11	11	74.0%	171.8%	132.3%	127.4%	100%		69.9%	37.9%	37.2%	0.7%	8.1
	CV Ward 3	10	9	135.1%	355.3%	143.5%	356.5%			97.8%	50.7%	36.9%	13.7%	19.6
LD	3 Rubicon Close	4	2	130.0%	160.0%	120.0%	80.0%			66.7%	12.8%	12.8%	0.0%	29.3
	Agnes Unit	12	8	211.5%	790.8%	144.2%	739.5%			100.0%	47.9%	45.3%	2.6%	36.5
	The Gillivers	4	2	108.1%	165.7%	77.4%	158.1%			74.2%	19.9%	19.9%	0.0%	28.2
	The Grange	5	2	-	156.7%	-	171.4%			95.7%	21.9%	21.5%	0.4%	33.1
Trust Total				**102.8%**	**207.8%**	**111.2%**	**189.5%**			**81.2%**	**30.0%**	**26.2%**	**3.8%**	

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	93.5%	124.2%	96.8%	167.7%	25.5%	5.2	11.5%↓	3↑	2↑	1↑	100%
Aston	19	84.9%	152.4%	100.0%	167.7%	27.3%	5.9	10.4%	1↑	2↑	1↑	nil
Beaumont	22	89.8%	121.0%	101.6%	235.5%	18.8%	5.0	4.4%	1↓	0	1↑	nil
Belvoir Unit	10	121.0%	353.9%	171.0%	418.0%	58.9%	22.2	36.2%↓	1↑	1↑	0↓	nil
Bosworth	19	89.1%	179.0%	98.4%	254.8%	30.4%	6.6	20.3%↑	1↓	2↓	0	nil
Heather	18	89.8%	151.6%	98.4%	283.9%	36.3%	6.8	17.7%	1↑	3↑	0	nil
Thornton	18	99.4%	159.7%	100.0%	111.3%	34.9%	6.7	4.9%↓	1	2↑	0	nil
Watermead	20	86.0%	208.9%	93.5%	338.7%	49.0%	7.1	25.6%↑	2	11	0	nil
Griffin F PICU	6	197.0%	302.9%	193.5%	171.0%	43.1%	18.4	32.5%↑	0↓	0	0↓	nil
TOTALS									**11↑**	**23↑**	**3↓**	

Table 3 - Acute inpatient ward safe staffing

All wards met the thresholds for RN and HCSW planned staffing in January 2020.

Temporary worker utilisation is Red for Belvoir Units at 58.9%. 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. The Unit has recently successfully recruited to both RN and HCSW vacancies; this is reflected in the reduced vacancy factor this month.

Watermead and Griffin continue to utilise additional staff required to meet enhanced levels of observation, this is reflected in the higher fill rates and temporary worker utilisation.

The increased falls on Watermead ward relate to one patient who has mobility issues and epilepsy both affected by the persons mental health. The ward team fully review physical health and behaviour to try to reduce the falls/ seizures.

Analysis of the NSIs has not identified any correlation between staffing and impact to quality and safety of patient care/outcomes.

Learning Disabilities (LD) Services

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers %	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
3 Rubicon Close	2	130.0%	160.0%	120.0%	80.0%	12.8%	29.3	82.9%↑	0	1↑	0	nil
Agnes Unit	8	211.5%	790.8%	144.2%	739.5%	47.9%	36.5	12.8%↑	0	12↑	0	88.9%
The Gillivers	2	108.1%	165.7%	77.4%	158.1%	19.9%	28.2	3.4%↓	0	1↑	0	nil
The Grange	2	-	156.7%	-	171.4%	21.9%	33.1	1.5%	0	0	0	nil
TOTALS									**0**	**14↑**	**0**	

Table 4 - Learning disabilities safe staffing

Short Breaks and the Agnes Unit met the thresholds for RN and HCSW planned staffing in January 2020.To note Rubicon Close, closed on 5 January 2020. The majority of staff from Rubicon Close were redeployed to the Gillivers or the Grange; this is reflected in the reduced vacancy factor and temporary worker utilisation for short breaks.

Gillivers did not meet the planned RN level on nights and the Grange did not meet the planned levels on days or nights. The skill mix of staff 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 Grange and Gillivers site as the homes are situated next to each other.

Analysis of the NSIs has not identified any correlation between staffing and impact to quality and safety of patient care/outcomes.

Increased falls on the Agnes Unit are all attributed to one patient; there is a known risk related to behaviour – placing self on floor. The patient has a falls assessment and care plan in place and a helmet to reduce potential head injury as a result of falls, the patient will not always wear the helmet.

Low Secure Services – Herschel Prins

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers%	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
HP Phoenix	11	108.1%	139.4%	100.0%	146.8%	10.6%	9.0	8.3%	0	0	0	66.7%

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	116.9%	143.3%	200.0%	127.4%	35.9%	4.8	2.8%↑	0↓	1↓	0	100%
Willows Unit	35	148.0%	195.9%	125.0%	209.7%	16.3%	8.5	7.7%↓	3↑	3↑	0	62.5%
Mill Lodge	11	103.2%	221.3%	90.3%	162.9%	38.9%	12.5	10.9%↓	0	2↑	0	nil
TOTALS									**3↑**	**6↑**	**0**	

Table 6 - Rehabilitation service safe staffing

All ward/units met the planned staffing thresholds for all shifts in January 2020; 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. The medication errors on the Willows Unit were self-administration errors not nursing errors. Falls linked to a patient; post illegal substance misuse whilst AWOL.

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	143.5%	78.7%	109.1%	-	38.7%	7.9	37.4%↑	2↑	3↓	1↑	100%
MM Dalgliesh	15	100.8%	131.5%	93.5%	200.0%	17.4%	8.4	-0.3%	0	4↓	0	nil
Rutland	14	98.4%	120.8%	96.8%	116.1%	17.9%	6.1	28.9%↑	1	4	2↑	100%
SL Ward 1	15	100.7%	208.1%	98.4%	112.9%	20.7%	9.9	15.2%	3↑	3	0	100%
SL Ward 3	11	94.4%	168.5%	196.8%	119.4%	33.5%	9.2	26.7%	3↑	2↓	0	100%
CV Ellistown 2	16	100.0%	193.5%	200.0%	100.0%	16.8%	8.9	6.6%	2↑	7↑	0	96%
CV Snibston 1	14	101.4%	157.1%	92.1%	112.9%	9.2%	10.3	14.7%↓	3↑	3	0	100%
HB East Ward	21	84.4%	207.3%	100.0%	103.2%	8.9%	6.5	4.8%↑	2↑	6↑	0	100%
HB North Ward	18	108.9%	184.7%	101.6%	127.4%	33.2%	6.9	29.7%↑	0	6↑	1↑	100%
Swithland	23	100.0%	221.8%	100.0%	200.0%	12.2%	6.1	19.1%↓	0	4	0	100%
CB Beechwood	20	87.7%	204.9%	98.4%	100.0%	15.8%	7.1	18%↑	1	2↓	0	nil
CB Clarendon	21	92.3%	235.2%	100.0%	119.4%	15.0%	6.8	11.1%↑	4↑	3↓	1↑	100%
TOTALS									**21↑**	**47↓**	**5↑**	

Table 7 - Community hospital safe staffing

All wards met the thresholds for RN and HCSW planned staffing in January 2020 with the exception of Feilding Palmer on days. Feilding Palmer HCSW staffing was adjusted in line with bed occupancy and patient need.

Feilding Palmer, St Lukes Ward 1 and Ward 3 and North Ward are 'areas to note' associated with increased temporary workforce usage due to vacancies, maternity leave and sickness.

A review of the NSIs have identified a reduction in the number of falls for January 2020, however Ward 2 CCH, North and Swithland wards had a number of repeat patient fallers relating to their acuity.

There has been an increase across the wards of medication related errors; analysis has shown that 8 of the errors recorded were near misses. A review of the errors has identified prescribing and procedural related medication errors. Review of the increased incidences has not identified any direct correlation between staffing and the impact to quality and safety of patient care.

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	23	80.6%	225.0%	95.2%	121.0%	30.5%	5.7	28.1%↑	0	5↓	0	100%
BC Welford	21	80.6%	208.1%	98.4%	111.3%	15.8%	6.0	22.3%↑	0	4↑	1↑	nil
Coleman	19	65.6%	317.7%	95.2%	230.6%	34.1%	9.1	10.3%↓	1↓	8↑	0	nil
Gwendolen	12	88.6%	362.6%	98.4%	290.3%	41.6%	15.7	13.7%↓	1↑	15	1↑	nil
TOTALS									**2↓**	**32↓**	**2↑**	

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

Coleman only met the threshold for RN planned staffing on days 65.6% of the time. Analysis has shown that Coleman ward had one registered nurse on five shifts; four night and one day shift. At these times Coleman ward was supported by Gwendolen ward registered staff and staffing was within safe parameters.

Analysis has shown that the increase in falls on both Welford and Coleman Wards is related to patient factors and has not identified any direct correlation between staffing and the impact to quality and safety of patient care/outcomes.

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

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers%	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
Langley	11	74.0%	171.8%	132.3%	127.4%	37.9%	8.1	-12.7%	2↑	0↓	0↓	nil
CV Ward 3 - CAMHS	9	135.1%	355.3%	143.5%	356.5%	50.7%	19.6	16.9%↓	2↑	0↓	0	nil
TOTALS									**4↑**	**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 January 2020, the wards continue to utilise an increased number of temporary workers to manage increased patient acuity and maintain patient safety.

There was an increase in drug errors on both wards in January 2020; analysis has not identified any correlation between staffing and impact to quality and safety of patient care/outcomes.

Leicestershire Partnership NHS
NHS Trust

Meeting Name and date	Trust Board – 3 March 2020
Paper number	L

Name of Report	**Six Monthly Safe and Effective Staffing Review**

For approval		For assurance	X	For information	

Presented by	Anne Scott	Author (s)	Emma Wallis with input from; Heads of; Nursing, Workforce Support, Employment services and Education, Training & Development

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 – Trust wide Quality improvement	
Any equality impact (Y/N)	N		

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

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.

Six monthly Safe and Effective Staffing review

1. Introduction

1.1 All NHS Trusts are required to deploy sufficient, suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively, National Quality Board (NQB) [1], *Safe sustainable and productive staffing.*

1.2 In line with NQB guidance and NHSi Developing Workforce Safeguards policy [2] the Trust six monthly safe and effective staffing review includes; overview of right staff, right skills, right place; establishment reviews, workforce planning, new and developing roles and recruitment and retention.

1.3 The six monthly review is supported by the monthly safe staffing reports.

2. Aim

2.1 This paper aims to provide an update following the July 2019 safe and effective staffing review and six monthly analysis of right staff, right skills, right place; establishment reviews and workforce planning including new and developing roles, recruitment and retention.

3. Recommendations

The Trust Board is asked to;

Receive and consider the information within the report and assurance that actions are in place to review safe staffing in line with NHSi Developing Workforce Safeguards policy and NQB guidance.

Discussion

4. National Overview

4.1 NQB (2016) guidance states that providers must deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively, with a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service keeping them safe at all times.

4.2 The number of full-time equivalent (FTE) staff working in the NHS in England increased in 2018/19 by 2.8% (approx. 30,000 extra staff), the fastest rate of increase in the NHS workforce this decade, however there are marked variations for different staff groups [3] The Health Foundation (2019).

4.3 The 2018/19 workforce statistics confirm that nursing remains the key area of shortage and pressure across the NHS. The number of FTE nurses employed in children's nursing grew by 2.7% however mental health by just 0.6% and

community nursing (excluding health visitors) by just 0.7%. In 2018/19 the number of school nurses fell by a further 3.1% [3] The Health Foundation (2019).

4.4 The government set out intentions to grow nursing undergraduate places by 25%. This year the number of applicants to nursing courses in England increased the first time since the bursary was removed, total number accepted on to nursing courses in 2019 will not be known until the Universities and Colleges Admissions Service (UCAS) release end of cycle data. Attrition rates remain high, one in four nurses expected to graduate in 2018 did not do so, this was highest for learning disabilities nursing [4] The Health Foundation (2019).

4.5 Recently medical practitioners, occupational therapists, psychologists and speech and language therapists have been added to the Shortage Occupation List by the government [5] NHS Employers (2019).

5. LPT overview - 'Right staff, Right Skills, Right Place'

Right Staff

5.1 The overall trust wide summary of planned versus actual hours by ward for registered nurses (RN) and health care support workers (HCSW) in the last six months is detailed in the table below;

	DAY		NIGHT		
Trust wide	% of actual vs total planned shifts RN	% of actual vs total planned shifts care HCSW	% of actual vs total planned shifts RN	% of actual vs total planned shifts care HCSW	Temp Workers%
July 19	104.2%	205.9%	109.3%	187.9%	33.9%
Aug 19	103.0%	200.2%	110.3%	193.8%	34.1%
Sep 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%
Dec 19	103.0%	204.1%	111.9%	186.2%	30.2%
Averag	**102.7%**	**202.2%**	**109.3%**	**186.9%**	**31.7%**

5.2. Overall the planned staffing levels were achieved across the Trust on a monthly basis. Over the last six months; East and Coleman Wards, Feilding Palmer, Mill Lodge and Short Breaks did not meet the threshold for planned staffing across all shifts consistently; due to adjusted skill mix and moving staff across services, also linked to bed occupancy. On these occasions staffing was reported to be within safe parameters.

5.3 Increased utilisation of additional HCSWs remains high in Mental Health Services for Older People (MHSOP) wards, Adult Mental Health (AMH) wards, CAMHS Ward 3, Families Young People and Children's (FYPC) and Learning Disabilities (LD) services. Additional HCSWs are deployed to support increased patient acuity and high levels of patients requiring increased levels

of observation within these areas. The evidence based acuity and dependency tools have built-in FTE multipliers for enhanced levels of care to ensure establishments can be reviewed to reflect increased acuity and dependency and deployment of additional staff.

5.4 The Trust average percentage use of temporary workers is 32.1% over the last six months; utilisation of temporary workers is to support vacancies, sickness and increased patient acuity and dependency. The majority of temporary workers are Trust bank only staff, who work regularly across our services and within service areas.

5.5 The Trust safer staffing 'areas to note' are presented to Trust Board in the monthly staffing paper; the areas remain predominantly unchanged over the past six months for both in-patient wards and community teams. Further analysis of 'areas to note' is provided in the directorate updates.

5.6 'Areas to note' are determined by analysis of the fill rates, caseload complexity, utilisation of temporary workers and triangulation with Nurse Sensitive Indicators (NSIs) and patient experience feedback.

Right Skills

5.7 In consideration of ensuring staff have the 'right skills', a high level overview of clinical training, appraisal and supervision for triangulation is presented in the monthly safe staffing reports for both substantive and bank only staff.

5.8 In order to bring us in line with national streamlining; agreed at the Trust Strategic Workforce Committee, the below compliance topics were reclassified from Mandatory Training to Role Essential Training from 1st December 2019.

- Anaphylaxis - 2 Years
- Display Screen Equipment (DSE) – Once
- Medicines Management - 2 Years
- Mental Health Act for Nurses - 3 Years
- Mental Health Act for Doctors - 3 years
- Management and Prevention of Falls - 2 Years
- Record Keeping & Care Planning - 2 Years

5.9 For substantive staff during the last six months;

- Appraisal sustained GREEN end of December 2019 position 93.0% (improved compliance position from previous six month review)
- Clinical supervision AMBER end of December 2019 position 81.7% (improved compliance position from previous six month review)
- There is no change in trend of the AMBER rated core and clinical mandatory compliance subjects in the last six months. All subjects rated AMBER have seen improved compliance.

5.10 The Trust has a bank only workforce of around 977 individuals working across a wide range of professions, roles and services. Compliance with mandatory training for bank staff has historically been lower than that of substantive staff.

This raises challenges particularly in areas where bank use is high and assurance is required that bank workers who are actively working in our services have the right skills.

5.11 Following targeted support and action we continue to see an overall improvement in bank staff compliance for mandatory training. Four of the consistent AMBER or RED compliance subjects have improved in the last six months.

Right Place

5.12 Care Hours Per Patient Day (CHPPD) is a measure of workforce that is most useful at ward level to compare workforce deployment over time, with similar wards in the trust or at other trusts. This measure should be used alongside clinical quality and safety outcome measures to reduce unwarranted variation and support delivery of high quality, efficient patient care.

5.13 CHPPD is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing the total by every 24 hours of in-patient admissions (approximating 24 patient hours by counts of patients at midnight).

5.11 NHS Improvement national nursing CHPPD data was reported in November 2019 from 206 Trusts including LPT.

5.14 The national nursing average is reported at 9.13 CHPPD (an increase from December 2018 reported as 8.91 CHPPD).

5.15 The Trust nursing average has increased from 8.61 CHPPD in December 2018 to 9.24 CHPPD in November 2019. This reflects the increase nationally.

5.16 It should be noted that the Trust monthly CHPPD reporting includes ward based AHPs and nurses. Analysis of the CHPPD has not identified variation at service level, indicating that staff are being deployed productively across services.

6.0 Establishment reviews – In-patient Wards

6.1 An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.

6.2 The Mental Health Optimal Staffing Tool (MHOST) has been developed by the Shelford Group © Imperial College Innovations to measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce for mental health settings. The tool, when triangulated with Nurse Sensitive Indicators (NSIs) and professional judgement will offer a reliable method against which to deliver evidence-based work force plans to support

existing services or to develop new services. The tool is based on five acuity and dependency levels for each mental health in-patient specialty.

6.3 The Learning Disability Optimal Staffing Tool (LDOST) is currently in development by the Shelford Group © Imperial College Innovations to measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce for learning disability settings. The Associate Director of Nursing and Professional Practice as a Chief Nursing Officer (CNO) Safe Staffing Fellow was granted permission to use the draft tool (not to be shared outside the team/organisation).

6.4 In previous Community Hospital reviews we have used an adapted Safer Nursing Care Tool (SNCT) to measure acuity and dependency of patients. The tool is not validated for use. As a CNO Safe Staffing Fellow permission is granted to use an evidenced based Activities of Daily Living (ADL) tool to collate acuity and dependency with a FTE multipliers tool (not to be shared outside the team/organisation).

6.5 Twenty days data collection commenced across all in-patient wards, through November and December 2019 to January 2020 with a plan to convert the data to FTE establishments using the multiplier tools to be presented in this six monthly report. There has been a delay in some in-patient areas data collection process and data is currently being quality assured and checked with workforce systems and data inputted to the three FTE multiplier tools.

6.6 As a result the establishment reviews and data will be presented to the Trust Board in April 2020.

7.0 'Areas to note' six month overview

FYPC

Ward 3 CAMHS inpatient unit

7.1 Ward 3 has consistently met the planned staffing levels required for the unit over the last six months. As a result of increased patient acuity and caring for children who are repatriated to other areas (such as adult provision) staffing is increased to ensure all service user needs are met safely and appropriate safeguards are in place.

7.2 The risk in having to utilise an increased temporary workforce to support additional areas and increased acuity is being felt by Ward 3 as it is necessary to move substantive staff from the Ward to ensure the appropriate level of expertise is available to deliver safe, consistent care to all patients including those who have been repatriated to other areas.

7.3 Increased acuity has resulted in high levels of increased observations and numbers of staff required to provide safe observation e.g. 2/3/4 staff to one

patient. The potential impact to the quality and effectiveness of patient care and patient and staff experience are monitored by the FYPC service line.

Langley

7.4 The ward has seen consistently high levels of acuity over the last 6 months and this is reflected in the utilised higher than normal numbers of largely bank and agency workers to cover increased levels of therapeutic observations. The potential impact to the quality and effectiveness of patient care and patient and staff experience are monitored by the FYPC service line.

CHS

Community Hospitals

7.5 Over the last six months the main 'areas to note' have been Ward 3 St Lukes Hospital, Feilding Palmer, Beechwood and North Ward, largely due to higher numbers of RN vacancies resulting in consistent utilisation of temporary workers above 20% over the last six months.

7.6 Substantive staff are moved daily across all wards to maintain safe staffing and skill mix across the service. The Matrons work closely with the centralised staffing team to source block booking of temporary workers to support continuity of care.

7.7 Beechwood , Clarendon and East Wards have not consistently met planned RN staffing, planned staffing is to have three RNs during the day; however the ward operates with a minimum of two RNs on occasion with support from nursing assistant practitioners and or medicines administration technicians to ensure this meets safe staffing parameters.

7.8 The number of vacancies across the twelve community hospital wards has remained high; above 45 FTE band 5 RNs between July and December 2019. There has been a noticeable usage of off framework agency staff for the community hospitals linked to both the vacancy rate and increase in sickness rates greater than 4.80% average across the wards.

7.9 Challenges with recruitment of RN staff continue, the service continues to look at new roles and are supporting further training of Nursing Associates, review of recruitment and retention premiums for hard to fill areas, attendance at recruitment fairs and using social media to support advertising of posts.

7.10 The service is supporting four further trainee Nursing Associates across December 2019 and March 2020 cohorts.

7.11 Following successful implementation of the Quality Accreditation scheme, all twelve community hospital wards have now received accreditation supporting a culture of continuous quality improvement, accountability and responsibility at ward level.

Mental Health Services Older People (MHSOP)

7.12 All four MHSOP wards have periodically not achieved the planned RN levels on day shifts. The wards have worked within safe staffing parameters of a minimum of two RNs per shift and when required flex the skill mix across the unit dependant on patient acuity and dependency.

7.13 Welford and Coleman wards have Medication Administration Technicians (MATs), MATs are band 5 professionals that administer prescribed medication, provide medication education and medicines management. The role enhances the skill mix of the ward staffing profile and releases time to care for ward RNs. These posts are continuing to develop their practice through action learning, broadening knowledge and skill base and increasing their activity on the ward. The MATs are in addition to the two minimum RNs per day shift.

7.14 Across the service there is an increase in temporary workforce utilisation due to long term sickness, vacancies and increased acuity and the requirement for level 1 mental health observations.

7.15 Gwendolen and Coleman wards have seen a significant peak in acuity which has required a high number of patients requiring level 1 and at times 2:1 staffing to manage episodes and potential episodes of violence and aggression. Levels of observations are reviewed daily; as a result there has been a significant increase in bank and agency use.

7.16 Challenges with recruitment of staff and permanent RN cover remains. The directorate continues to look at a range of options to reduce the use of agency across the service and Trust including block booking of temporary staff and implementation of recruitment and retention premiums. Rolling adverts, attendance at national and local recruitment fairs and open days and the development of peripatetic team.

7.17 Introduction of a Mental Health Practitioner on Kirby ward project is due for review in April 2020 and if successful to be rolled out across inpatients.

7.18 Introduction of a Physician Associate as a pilot project on Kirby ward to support with physical health assessment and care in place.

7.19 Active recruitment to a peripatetic team to support acuity with a permanent workforce. This will provide consistency of care to patients and reduce the temporary workforce with the aim of improving care

AMH/LD

7.20 Over the last six months Griffin PICU and Belvoir Unit are consistent ‘areas to note’ due to concerns relating to increased acuity, high risk patients and self-harm, high vacancy factor, staff sickness, ability to fill additional shifts and the potential impact to safe and effective care.

7.21 Safe staffing is supported through block booking regular bank staff where possible, and increased utilisation and deployment of HCSWs to support increased levels of observation. Staff are moved across the service on a daily basis to support skill mix and ensure there are staff with the right skills in the right place.

7.22 The service continues to review and implement measures to increase recruitment and retention on the PICU's including premias, and there is evidence that the areas are retaining staff for longer on the units. With a constant recruitment drive in place, both Belvoir and Griffin have started to recruit to posts with 11 applications in receipt for posts closed recently.

7.23 Vacancies have remained high across inpatient areas with high use of bank and agency staff over the last six months; in the last few months staffing has improved considerably with focused recruitment, a robust induction and initial supernumerary status for all new staff.

7.24 In acute services, physical health nurses are now fully recruited to and have been deployed to support patient physical health assessments.

7.25 As part of new roles to support skill mix, Bosworth Ward at the Bradgate Unit has a Medicines Administration Technician working Monday to Friday within the ward establishment. The impact of the role is being reviewed by the Pharmacy Manager and Matron.

7.26 The Directorate continues to support the release and funding of HCSWs to undertake Nursing Associate training to support and enhance skill mix.

7.27 The Grange and Gillivers have not consistently met the thresholds for planned RN staffing in the past six months. The skill mix of staff is adjusted according to patient needs, utilising HCSWs who are trained to administer medication and carry out delegated health care tasks. The Gillivers and the Grange support each other with RN cover, shared across the site as the homes are situated next to each other in conjunction with utilisation of additionally trained HCSWs.

8.0 Community reviews

FYPC

CAMHS Crisis and Home Treatment team (CRHT)

8.1 The CRHT team currently has 3.0 FTE band 6 vacancies. Two of the Band 6 vacancies are being backfilled with agency nurses on mid-term fixed contracts to support and maintain service provision. The team have recently recruited to band 3 and 5 nursing posts and a psychologist, due to commence in March 2020.

PIER Team

8.2 The current caseload size is exceeding recommended guidance; a capacity and demand review is to be undertaken when the service is aligned with AMH. Currently to support practitioners, caseloads are reviewed in Multi-Disciplinary Team (MDT) meetings and in management and clinical supervision.

8.3 Over the last six months the team has rated itself at GREEN prioritisation.

Looked After Children (LAC) Health Nursing Team

8.4 The LAC team cover all three local authorities with approximately 1,000 LAC in LLR. The team comprises of 1.6 FTE Band 7, 4.55 FTE Band 6s and 3.0 FTE Band 5s. The service core hours are 8am-6pm, Monday-Friday.

8.5 Reconfiguration of SystmOne continues to reflect staffing and caseload alignment. The team is now divided as follows:

- Foster care team
- Unaccompanied Asylum Seeking Children
- Residential homes
- 16+ semi-independent

8.6 Monthly staffing reports are provided and sickness is at a minimum. The LAC team adhere to a draft Standard Operating Procedure (SOP) to support the delivery of safe, effective and responsive care. The SOP is currently under review.

8.7 Capacity and demand work is progressing well. This programme will help the team maximize service user flow through the LAC healthcare system. It will also support the team to be more resourceful (for example planning the number of clinics that would be required to meet demand), as well as supporting a case for additional clinical practitioners in the future.

Paediatric Phlebotomy

8.8 The phlebotomy service operates Monday to Friday 08.00am till 16.00pm. The team have 7.8 FTE paediatric phlebotomists and 3.0 FTE Play Support workers.

8.9 The service level agreement is currently being finalised for agreement and completion by 1st April 2020. The service has negotiated the Blood Born Virus contract this will increase referral rate by an approximate 175 additional referrals per year. The additional referrals have been negotiated into the new SLA to ensure there is adequate capacity to accommodate the increase.

School aged immunisations

8.10 The current staffing establishment has enabled service delivery over the last 6 months without any cancellations of sessions. When the service sees peaks in activity due to fluctuating programme needs, any risks are mitigated with the use of core bank staff that support delivery of the service.

Healthy Together

8.11 Healthy Together operates a prioritisation model to support business continuity of the service. The focus of the model is to ensure that standards for safeguarding and Healthy Child Programme assessment are delivered to those most in need. The model highlights priority contacts with the template supporting flexible and safe service delivery during periods of reduced staffing.

8.12 The prioritisation model has recently been updated to give practitioners options that can be considered on a scale to meet the individual needs of the neighbourhood, and the staffing available. The model is now being supported by a bespoke capacity and demand tool for the 0-5 Healthy Together workforce, and the 5-19 capacity & demand toolkit is in the process of being developed.

8.13 The tool triangulates multiple data sources to support informed decision on workforce capacity and activity. The tool continues to be evaluated and validated.

8.14 In order to respond to challenges faced by the service, school nursing teams are working more closely together and we have implemented a cluster wide approach across the County. Supporting each other across neighbouring areas and timely allocation of referrals.

8.15 To support cover across teams the service has explored a full range of additional options including; temporary movement of substantive staff, incentivised payments, additional hours and regular bank staff.

8.16 With the local school nursing workforce challenges that reflects the national decline the service is primarily prioritising safeguarding work only and exploring options to fill vacant posts with 0-19 Band 5 nurses and or Band 6 Emotional Health and Wellbeing nurses.

Redesign of Healthy Together Services

8.17 Due to Leicestershire County Council implementing a reduction in the Healthy Together contract the service is currently being redesigned. The current areas of redesign are as following:

- A revised antenatal contact offer that will still offer all first time mothers, and those identified as vulnerable, a face to face contact. All other prospective mothers will be offer an enhanced digital offer.
- Bumps to Babies will no longer be offered a group session. Instead, a new digital offer will be offered to prospective parents.
- 6-8 week contacts will primarily be delivered in a clinic setting rather than the previous model of home visiting.
- The 3-4 month group contact will cease and be replaced by targeted face to face contacts for universal plus babies and a digital offer for other all other parents.
- 2-2.5 year development checks will continue to receive two opportunities to attend. However, the second appointment will be an opt- in service for parents.
- School Nursing will no longer offer a drop in service for primary schools and instead offer an e-referral system.
- Public Health campaigns will reduce to three per year; health profile will be time intensive as local epidemical data is sources from the local authority and Health Fairs will only be school nurse led in conjunction with the Health and Wellbeing Questionnaire.

8.18 Leicester City Healthy Together is currently in negotiations with commissioners from the local authority regarding the redesign proposals.

Use of financial Incentive scheme for staff

8.19 Due to a combination of long term staff sickness, a high number of practitioners on maternity leave and continued difficulties with retaining and recruiting practitioners, a staff incentive scheme was implemented. Recruit and Retain Scheme 8 was implemented at the beginning of October 2019 and have been utilised in the following areas:

- Leicester City Area 4 Health Visiting where Health Visitor staffing was at 63% in October 2019 and has recovered to 74% in November.
- County East School Nursing Oadby & Wigston was staffed at 16% in December 2019. However, as of February 2020 this has recovered to 66%, with staff movement and successful recruitment of a Band 5 School Nurse. We anticipate that this will increase to 91% by April 2020, following the successful recruitment of an additional Band 5.

DIANA Children's Community Services

8.20 The Diana service moved to Wakerley Ward at the Evington Centre. The building still requires further refurbishment including an on site clinic to facilitate a proportion of home visits to be moved to a clinic setting, reducing travel and increasing capacity. In addition to this the service now has all

equipment and supplies on site making stock rotation more efficient and cost effective.

8.21 A patient acuity and dependency evidence based tool is being developed in collaboration with commissioners and the workforce to support the ability to prioritise the workload and implement auto roster in the future.

8.22 The service has developed a new post in response to service demand; an Equipment Lead that will be dedicated to managing equipment and consumables ordered for families to improve service delivery and efficiency.

CHS

Community Nursing

8.23 LPT Community Services has implemented the Community Service Review (CSR) transformation work. , The new clinical and operational model now delivers Core Community Nursing, Therapy, Rapid Response and Home First.

8.24 The overarching aim includes ensuring that the right people, with the right skills, are in the right place at the right time. To reduce transfer of patients across services, maintaining and improving opportunities for working in an integrated way with Social and Primary Care, to improve patient pathways and the overall quality of care provided to patients. The programme also supports a transformation of the mind-set, culture and behaviours of the workforce and supporting systems and structures into a culture of excellence, continuous improvement, innovation and creativity.

8.25 Patient caseloads, capacity versus demand continues to be reviewed alongside re-modelling plans. Within community nursing an electronic planning and work allocation tool is embedded that is aligned to signed-off staff skill sets, to support safe allocation of work.

8.26 The electronic tool supports visibility of staff's workload and enables a daily view of the caseload pressures against agreed skill mixes for each Hub. This is supported by an escalation process to the Lead Matron via the Situation Report, who will review capacity and demand across all the areas and then take any appropriate actions.

8.27 A safer staffing dashboard is under development and will take into account the changes that result from the CSR transformation work.

8.28 In the last six months the community nursing 'areas to note' are the city areas due to vacancy factor of between 15% and 30% and Hinckley due to high levels of maternity leave, this is reducing as staff are returning to work.. The fill rate for bank and agency shifts shows an improving picture over the last few months from 56% fill rate to between 72-92% across the hubs.

8.29 A rolling cycle of recruitment remains in place, bolstered by responsive interviewing processes, this has been further supported in the city area, by the implementation of the band 5 Retention Prema.

8.30 A robust induction programme for all new starters continues to be embedded with role specific workbooks, to support staff to transition in to their new role and teams.

8.31 Staff mandatory training, clinical and appraisal rates show an improved position across the planned care service line. The community nursing hubs are developing quality improvement plans in relation to their supervision levels.

8.32 There are a slightly higher number of complaints, concerns and incidents with the two city hubs, which is monitored monthly through the service line governance meetings.

MHSOP – CMHTs

8.33 City west CMHT has been an 'area of note' for the last six months due to unprecedented levels of sickness, the team and staffing has been supported by block booking an agency nurse and support from city east CMHT.

8.34 City East and City West CMHTs are piloting one band 7 per team. The band 7 will have both operational and clinical leadership and management. The pilot is due for review in December 2020.

8.35 Currently the service is reviewing Occupational Therapy staffing in the CMHTs and considering moving to a 'locality' model for Occupational Therapy across all CMHTs.

AMH/LD

Adult Mental Health and Learning Disability Community Services

8.36 Over the last six months, the main 'areas to note' for AMH/LD community services have been Charnwood AMH, Charnwood LD, North West Leicester and City East CMHTs. Challenges included leavers as well as sickness, secondments, maternity leave and staff not being available to work clinically. The teams have taken a number of approaches to covering the shortfalls, including block booking of bank staff, supporting retire and return options for experienced staff and more creative approaches such as the introduction of band 5 development roles and Nursing Associates.

8.37 Vacancies have varied from around 22 to 34 WTE RNs and 7 to 13 WTE HCSWs across all teams. The CMHTs have successfully recruited ten new HCSWs (which accounts for the significant variation in healthcare support worker vacancy numbers) and these additional workers provide clinical

support for registered staff to support recent work undertaken on caseload sizes and flow through the services.

8.38 Three members of staff are studying to be Advanced Nurse Practitioners (ANPs) due to qualify at various points throughout 2020. Two further students plan to start ANP studies this year. Work is underway to look at new roles for these advanced practitioners.

Learning Disability Community Teams

8.39 Two HCSWs have been supported to undertake Nursing Associate training; one from County West CLDT and one from the Autism Team. The two workers will qualify early in 2021, and work is underway to consider their new roles.

8.40 A Community Learning Disability Nurse from the city team remains seconded for three days per week for one year to work as CPA Lead for the Trust.

8.41 Within the Learning Disability Community teams, a 12 month pilot of a Forensic Network is underway following review of the community caseload. The review looked at cases where the individual patient had either come into contact with the criminal justice system, or would have come into contact if they had not received intensive support. The overall aim of the service is to maintain individuals in the community.

8.42 It has been made possible by £200K received from NHS England through Transforming Care. The team consists of two WTE Band 6 seconded staff and 0.8 WTE clinical psychology input with additional psychiatry support as required. The network has three aims:

- To develop and deliver a training package for 200 staff across health and social care to enhance the skills of staff in identifying and managing risk of offending behaviours.
- For a core group of staff to be trained in HCR-20 to further enhance the risk assessment and management of patients.
- For the central team of staff to case manage the most complex patient cohort.

Community Mental Health Teams

8.43 In 2017, the CQC identified that community nurses in CMHTs held caseloads that were too high. This concern has been placed on the risk register and a quality improvement programme across AMH community services, overseen by a steering group that meets monthly, has undertaken an extensive programme of work. This work is directly linked to the all Age Transformation Project.

8.44 In order to sustain improvements achieved by the programme, there is a need to ensure a consistent and fully recruited staffing establishment as high

nursing vacancy rates will impact on caseload numbers and complexity of caseloads.

8.45 The national picture of high vacancy rates within community mental health still exists, however, locally vacancies have stabilised due to the implementation of robust recruitment monitoring, rolling recruitment and the introduction of innovative new posts.

An overview of progress is as follows:

- Caseload reviews have been completed in all of the CMHTs. This was a labour intensive but very valuable exercise and as a result, supervision in the teams is much more focused on discharge and discharge planning.
- Work has been undertaken to increase the numbers of Non-Medical Prescribers (NMPs) across the teams in order to improve flow of service users through the service. Several staff have now been identified to train, and a peripatetic NMP CPN has been recruited to run outpatient clinics to help reduce the overall waiting lists.
- A RAG rating tool has been developed to robustly manage waiting lists. This has been successfully trialled in City East and City Central and rolled out across the other teams. A review is underway to ensure consistent practice across all CPN caseloads within clinical supervision.
- A Caseload Complexity Monitoring Tool has been developed by the Aneurin Bevan Continuous Improvement (ABCi) team at Aneurin Bevan University Health Board, and in 2017/2018, West Leicestershire Adult CMHT participated in a pilot project of the tool. As the pilot progressed, a number of concerns about the tool emerged, and a detailed evaluation of the project was produced by Lyn Williams, Head of Service, MHSOP. The tool is not currently in use in either AMH or MHSOP. Further plans include ongoing liaison with the team in Wales with a view to improving the ease of use and efficacy of the tool.
- Job plans have been developed for band 7 CPNs – this will link in with the need to ensure band 7 team leaders have some capacity to undertake clinical leadership and support team managers with performance in the CMHT. This process is now being cascaded to other staff within the teams.
- Design and recruitment of band 5 development posts has taken place, which has offered a supported pathway to band 6 and improved the appeal of the posts to external candidates. A framework to support this process has been developed by the matron, and this has been widely shared as a good practice initiative.
- The recruitment of additional healthcare support worker roles at band 3 into each team with a newly developed role has been undertaken, which supports both the out-patient caseloads and CPN caseloads by providing metabolic monitoring and discharge facilitation. These workers will also undergo training in collaborative conversations and motivational interviewing to support the co-production of care plans. Each CMHT has two WTE posts and one WTE Peer Support Worker plus 0.5 WTE of a Mental Health Employment Support Advisor.
- One community worker is due to qualify as a Nursing Associate in January 2020.

Perinatal Mental Health Team

8.46 Towards the end of 2018, the Trust secured £460,000 from NHS England to double the size of the Perinatal Mental Health Team. The new funding is from the second wave of a £365 million national package of additional funding from NHS England to improve access to mental health care.

8.47 The new funding has enabled the Trust to enhance the service to meet national staffing standards. The team establishment has increased from 9.5 to 19.75 WTE roles. As well as increasing nursery nursing, community mental health nursing and medical staffing, the service has recruited occupational therapists and psychologists and there are plans to expand its peer support and recovery worker roles.

Crisis Resolution and Home Treatment Team

8.48 Staffing has been challenging over the past six months and the teams have taken a number of approaches to cover the shortfalls including; block booking of bank staff, improved staff support, clinical supervision and the introduction of registered Nursing Associates.

8.49 The CRHT has supported the development the Nursing Associate role and two team members participated in the first cohort and are now registered. Work was undertaken to liaise with the students, clinicians and senior leaders in the team and the duties and responsibilities were clarified. Nursing Associates' duties include running clinics for physical health observations, updating care plans, carrying out home visits for CRT and crisis house patients and joint visits for patients already open to services such as community mental health teams.

9.0 Workforce Planning

9.1 NHSi Developing Workforce Safeguards policy recommends a two-step approach to workforce planning. First, to take account of actual staffing levels and second, understand the gaps and what is required to close them, supported by a workforce planning model.

Grow Our Own

9.2 Grow our own is the programme of support for the development of our existing workforce to meet our future knowledge and skills requirements, particularly focusing on two categories:

- Roles that impact on the establishment
- Roles that need specific (predetermined) education

Roles that impact the establishment	Roles that need specific education
Nursing Associates	Health Visitor
Medicine Administration Technicians	School Nurse

Physicians Associate	District Nurse
Advanced Clinical/Nurse Practitioner	Physiotherapy
Medical Assistants	Occupational Therapy
Peer Support Worker	Nursing
Assistant Practitioner	Nursing Associate
	Clinical Apprentice
	Non-Medical Prescriber
	Clinical/Medical Psychology
	Advanced Clinical Practitioner

9.3 The following was developed with each directorate workforce group; approved plan for new starts in 2019-20.

Education/ Training	**Approved Nos**	**Additional funding support**	**Recruitment progress**	**Comments**
Health Visitor	FYPC - 7	HEE approved Salary Support approx. £27,260 pp	Recruited 7	1-year programme- Sept 2019 at DMU
School Nursing	FYPC - 2	HEE expenses contribution £2,00 pp	In progress	1-year programme -Sept 2019 at DMU
District Nurse	CHS - 9	HEE approved Salary Support approx. £27,260 pp	Recruited 5 Out to recruit 1 more place	1-year programme starting Sept 2019 at DMU
Nursing Associate	17 trainees 7 – Dec 2019 10 – March 2020	HEE fund approx. £7,200 pp for 2019 starts	3 pending tbc	2-year part-time programme with UHL/DMU/ LPT
Nurse Graduate Entry	0	n/a	0	2-year programme with Derby University
Nurse Apprenticeship	CHS – 2 FYPC – 1 AMH – 2	Course fees Levy funded	3 confirmed 1 pending placement 1 MH nurses 2 Adult nurses	4-year part-time programme with Open University
Physiotherapy Apprenticeship	CHS-5 FYPC - 1	Course fees Levy funded	Recruited 6	4-year part-time programme with Coventry University
Occupational Therapy Apprenticeship	FYPC – 1 AMH – 1 CHS – 1	Course fees Levy funded	Recruited 3	4-year part-time programme with Coventry University
Advanced Clinical Practitioner	4	HEE funding course fees	Recruited 3 commenced Jan 2020	2 year programme at various universities
Non-Medical Prescriber	35	HEE Workforce Development Fund covers course fees. **Available funds will only cover 12 places**	9 candidates commenced in Sept 2019	6 – 9 month programme. HEI to be confirmed.
Clinical Apprentice	18	Course feed Levy funded	In process of recruiting to 12 post in AMH	18 month programme with UHL

9.4 The GOO working group continues to drive all steps, documents and processes from pre recruitment to training, support during the training and commitment to recruit to substantive posts once our staff have qualified.

9.5 In January 2020, the second cohort of trainee nursing associates in LLR complete their academic programme. The nine trainees are due to register with the NMC in March/April 2020 and will commence a Trust preceptorship programme.

9.6 The Trust currently has three further cohorts of trainee NAs; cohort 3 (seventeen trainee NAs) due to finish in January 2021 and 17 trainees recruited to cohorts 4 & 5 December 2019 & March 2020.

eRoster

9.7 LPT uses Allocate HealthRoster to manage the deployment of substantive, bank and agency staff for around one third of the Trust. All inpatient wards use HealthRoster as well as some community teams.

9.8 Using recommendation from the Carter Review, the focus is supporting services to make the best use of staff time by:

- Improving timeliness of rosters being published (minimum 6 weeks before they are due to be worked)
- Reducing unused hours (hours staff have been paid for but not yet worked)
- Reducing accrued time off in lieu (TOIL) (hours that have been worked but not paid for)
- Effective planning of annual leave to avoid pressure points at certain times of the year

These actions will help services to better plan their workforce and manage staffing levels on a shift by shift basis.

9.9 Detailed reports on rostering effectiveness are provided to services each month to measure the impact of different initiatives and to help identify areas for improvement.

Safe care

9.10 This year the Trust plans to procure and implement Allocate Safe Care, work is on-going through a regional procurement and workforce group.

9.11 Safe Care integrates fully with HealthRoster and offers the ability to monitor actual patient demand at key points during the day and accurately align staffing to match. The objective data identifying actual staffing requirement also helps avoid habitual temporary staff use and allow informed decision making as to when temporary staff are required. The user interface is accessible and easy to use and provides live user-friendly dashboard reporting.

9.12 Safe Care also has a positive impact on improving accuracy of rosters through contemporaneous updating of changes which further informs

decision making and visibility. The net result of the above is an improved utilisation of substantive staff and reduction in temporary staff requirement.

10.0 Recruitment and Retention

10.1 The graph below outlines the number of RN vacancies, staff recruited and in the pipeline and residual posts over the last six months.

10.2 The graph below outlines the number of HCSW vacancies, staff recruited and in the pipeline and residual posts over the last six months

10.3 Collaborative work to address nursing vacancies continues, including; joint working with both Leicester and DeMontfort University to retain newly registered nurses at the point of completion of training, participation in local and national recruitment fairs, rolling adverts, internal and UHL rotation programmes and continued development of new roles and 'grow our own' strategy.

10.4 Other Recruitment actions include

- Attendance at the RCN recruitment fair in November 2019
- An active member of the Y/Our Future campaign working with LLR healthcare partners to promote LLR as a destination for healthcare roles.
- Refreshed recruitment webpages on new LPT website launched
- To hold a Trust wide recruit fair in 2020
- Work to attract student nurses and other medical/health students to the bank during their studies
- Collaborative work with DMU to increase recruitment to mental health and learning disabilities fields of practice for pre-registration nursing
- Review of HEI provider engagement outside of LLR including Birmingham, Nottingham, Sheffield, Lincoln and Warwick
- Continue to advertise on Facebook/social media with plans to conduct an exercise in January 2020 across the organisation to produce compelling media/stories to support this approach
- Resourcing directly from CV library
- Engaged with permanent recruitment agencies for hard to recruit areas- mainly HPC wards
- Focus on rationalising recruitment process to get people started earlier and reduce risk of drop out. Time to recruit consistently within SLA
- Focus on engagement with recruits both during recruitment process and on boarding stages. 90 days toolkit developed and in place to support managers during the new starters first three months.
- Refer a friend scheme
- Return to Practice
- International recruitment to be explored and scoped fully
- Recruitment and retention financial schemes in place, and further schemes have been developed

10.5 Retention actions

- Our Future Our Way leadership and culture work underway including 90 plus change champions working to identify 9 key priorities and leadership behaviours framework being developed
- Launched the refreshed one day induction session for new starters
- NHSI cohort 3 invited to share our work on nursing pathways
- Development and launch of the nursing career pathways and AHP and A&C
- We Nurture 3rd Cohort underway and cohort 4 to commence
- New starter breakfast meetings across the Trust now taking place and providing positive feedback
- Reviewed and changed appraisal to reflect a career conversation to be had in appraisal
- Nurse turnover has reduced and we have achieved the target agreed
- Living our values video launched trust wide and Zero Tolerance campaign launched
- Health and well-being programmes
- Established Preceptorship programme for all newly registered staff

- leadership and professional development programmes; new band 7 and band 7 development programme to be launched in line with Year of the Nurse
- Time out days
- Career development opportunities
- To launch the DAISY award to recognise excellence in nursing and a complimentary award for non nursing staff.

11.0 Conclusion

11.1 The Trust continues to maintain compliance with the NQB reporting expectations. The safe staffing data is regularly monitored and scrutinised for completeness and performance by the Director of Nursing, AHPs and Quality.

11.2 Ongoing changes through the service transformation plans are considered alongside the regular staffing reviews that are undertaken on a monthly basis. All services continue to work to safe staffing risk escalation procedures and safe staffing risks are reviewed on a regular basis.

11.3 This report provides the Board with assurance that processes are in place to ensure compliance with the NQB and Developing Workforce Safeguards policy to deliver high quality care through safe and effective staffing; by combining evidence based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time.

References

1. National Quality Board (July 2016): Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time*. Safe sustainable and productive staffing.*

2. NHS Improvement (October 2018) Developing Workforce Safeguards *Supporting providers to deliver high quality care through safe and effective staffing.*

3. The Health Foundation (2019) *Falling short: the NHS workforce challenge.* The Health Foundation.

4. NHS Employers (2019) *Shortage Occupation List changes now implemented (webpage)* NHS Employers www.nhsemployers.org/news/2019/10/shortage-occupation-list-may-2019

5. Shelford Group (2019) *Mental Health Optimal Staffing Tool: Implementation Guidance for Mental Health Inpatient Wards,* Shelford Group, © 2019 Imperial College Innovations Ltd.

Leicestershire Partnership NHS Trust

Meeting Name and date	**Trust Board 3rd March 2020**
Paper Reference	**M**

Name of Report: Guardian of Safe Working Hours (Junior Doctors) Quarter 3 Report

For approval		For assurance	x	For performance	

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

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

Report previously reviewed by	
Committee / Group	Date

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 safeguards working hours	All

Recommendations of the report
The Trust Board is recommended to accept the report for assurance.

M

Leicestershire Partnership NHS Trust

TRUST BOARD – 3rd March 2020

Guardian of Safe Working Hours Quarterly Report
November 2019 to January 2020

1. Introduction

The Report:

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

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

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

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

2. Recommendations

The Report is to provide assurance to the Board.

3. Work Schedules

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

4. Exception Reports

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

Three exception reports have been received in this quarter. All of the exception reports raised were in relation to breaches in trainees on the CDR rota covering the A&E Department at LRI in getting 5 hours continuous rest between 10pm-7am.

Following an engagement event with medical trainees, led by the Medical Director, a consultation was launched to change the working pattern in A&E. There has been a subsequent meeting with medical trainees to consider feedback and an adjusted working pattern is now being prepared for review at the next Junior Doctors Forum on 6th March 2020.

5. Rota Gaps and re-design

Gaps in the current rotation (February 2020 – April 2020);

- FY2 x2 no cover
- CT x3 1 post no cover, 2 posts covered by LAS
- StR Adult x6 no cover
- StR OA x3 no cover
- StR CAMHS x2 no cover
- StR LD x 2 no cover

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

6. Terms and Conditions of Services for Doctors in Training (England) 2016

There has been a number of revisions to the Terms and Conditions of Service (TCS) since implementation. The latest version (8) was published in December 2019. There has been some changes to pay allowances which have been implemented. The breaches that attract a Guardian fine have been clarified to include when a doctor breaches the maximum 13 hour shift length and where 5 hours continuous rest is not achieved between 22.00 to 07.00 during non-resident on call shifts.

A new section has been added to the TCS about the requirements to appoint a Champion of Flexible Training. We have tried to recruit to this post previously and will make a further attempt shortly.

7. Facilities and Fatigue Funding

We received £60k through the Facilities and Fatigue Charter to improve the working conditions of junior doctors. Discussions have taken place with trainees to develop a list of priorities and following consultation, laptops have been purchased for Core Trainees and two rest rooms at the Bradgate are being refurbished for on call doctors.

8. Engagement

The last Junior Doctor Forum took place on 21st February 2020 and was well attended. The next is arranged for 6th March 2020 and will focus on the review of the working pattern for doctors working in A&E.

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

Appendices

Appendix A	Locum Hours – Internal Bank and Agency (1st November 2019 – 31st January 2020)
Appendix B	12 month summary data Exception reports

Appendix A

Locum Hours (Internal Bank and Agency)
1st November 2019 – 31st January 2020

Locum bookings by Rota				
Rota	Number of shifts vacant	Number of shifts filled by Internal Bank	Number of shifts given to agency	Number of shifts filled by agency
Bradgate / Bennion	33	33	Nil	
Evington	24	24		
Central Duty Rota	14	14		
StR East	7	7		
StR West	21	21		
Total	99	99		

Locum bookings by reason				
Reason	Number of shifts vacant	Number of shifts filled by Internal Bank	Number of shifts given to agency	Number of shifts filled by agency
Vacancy *	58	58	Nil	
Sickness	25	25		
Maternity / Paternity	1	1		
Special Leave				
Temporary removal of trainee from rota**	15	15		
Total	99	99		

* includes Less Than Full Time (LTFT)

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

Appendix B

Summary Data

Exception Reports

Reason for exception report	Jan'19 – Apr'19	May'19 – July'19	Aug'19 – Oct'19	Nov'19 – Jan'20
Working Hours	1 (rest, TOIL)	2	6	3
Training issue	0	0	0	0
Other reason	0	1	1	0
Total	1	3	7	3

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board – 3rd March 2020
Paper number	N

Name of Report: Patient and Carer Experience and Involvement (PCEI) Quarterly Report (including Complaints) Quarter 3, year-end 2019/20

For approval		For assurance	X	For information	

Presented by	Anne Scott, Director of Nursing, AHP's and Quality	Author (s)	Alison Kirk, Head of Patient Experience and Involvement

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

Report previously reviewed by	
Patient and Carer Experience Group	4 February 2020
Quality Forum	6 February 2020
Quality Assurance Committee	18 February 2020

Assurance :	Links to ORR risk numbers
• There is a risk that the Trust does not positively	12

impact on the experience of services users , carers and families that use our service • Patient do not always find it easy to share their experiences and the Trust does not as a result receive feedback • The Trust does not increase the number of service users that are positively participating in their care, treatment and service improvement	14 13

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

Quality Assurance Committee –

Patient and Carer Experience and Involvement (PCEI) Quarterly Report (including Complaints) Quarter 3, year-end 2019/20

1. Introduction

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

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

- Frequent Feedback – comments, enquiries and concerns
- NHS Choices Feedback
- Friends and Family Test (FFT)
- Complaints
- Compliments

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

2. Aim

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

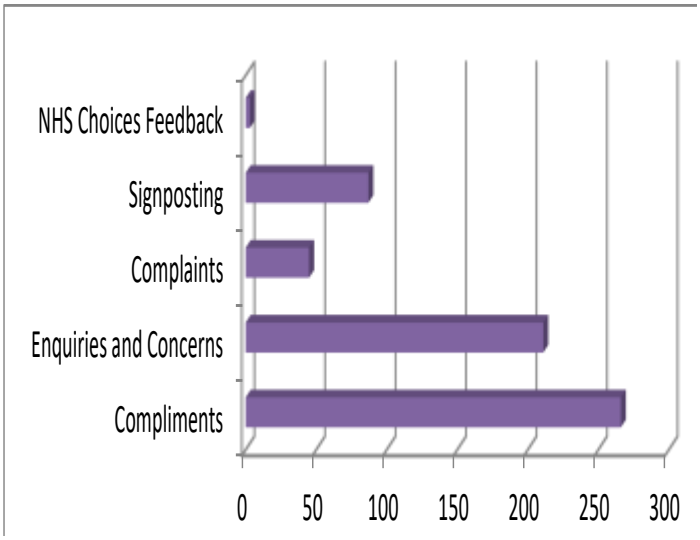
3. Recommendations

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

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

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

Feedback Overview shows that the Trust received 609 individual pieces of feedback in relation to complaints, comments, enquires, concerns, signposting and compliments. This is compared to 724 in Q2. 44% (n=266) were to provide positive feedback captured through compliments, which is an improvement from Q1. The remaining 56% of feedback received related to comments, concerns and enquiries (35%), complaints (7%) and the remaining 14% in relation to signposting to services both internal and external to the Trust.



The most reported concern across complaints and concerns, comments and enquiries is a repeat of Q2 where 17% of all concerns received where in relation to appointments this included cancelled, delays and length of wait for an appointment. Again, consistently with the previous quarters 1 and 2 for 2019/20 poor experience in relation to communication has been reported by patients and carers. Communications will be one aspect of a training and development programme for staff which is being developed to support the delivery of the Patient Experience and Involvement 3 year delivery plan. The training programme is currently being designed with patients and carers and will look to use different approaches such as role play and how to have positive conversations.

Positive feedback in the form of compliments demonstrated that patients and carers were most happy with the attitude of staff towards them with 30% (n=81) compliments received however this is a drop of 10% from Q2. 26% (n=70) of compliments received related to good customer service which is an increase of 6% from Q2 with happy with care and treatment receiving the third highest number of compliments 19% and increase of 12% from Q2.

As with Q2 this feedback demonstrates that patients and carers reported the highest satisfaction on the emotional elements of their care, whereas those who reported poor experience in relation to appointments demonstrated dissatisfaction with the rational elements of care e.g. processes and systems that impacted on their care.

NHS Choices patient feedback

During the period 3 comments were received through NHS Choices. All contacts were made anonymously however our Patient Advice and Liaison Service (PALS) did respond to the comment and offered to take the concern forward. All concerns have been shared with the service areas involved which were:

2	Bradgate Mental Health Unit
1	Coalville Hospital

Complaints

The Trust received 45 new complaints between 1 October and 31 December 2019 which included multi-agency complaints where we were asked to investigate specific elements of the complaint that relates to a person's care and treatment. This is a reduction of 15 complaints compared with those received in Q2 and an overall reduction of 54% (n=83) complaints received in Quarter 1 this year.

For this quarter 100% of complaints were acknowledged within 3 working days; 60% of all complaints were investigated with the timescale agreed with the complainant. Of this 60% 27% (n=12) complaints were investigated within 25 working days, 33% (n=15) complaints were investigated within the timescale negotiated with the complainant, the negotiation may be impacted by a number of things including the complexity of the complaint which may require longer than 25 days for investigation or the fact that the complainant as requested that the investigation is paused for a personal reason.

The 1 October 2019 saw the implementation of a revised Trust complaints procedure and work that had been undertaken to streamline our processes for managing and responding to complaints. The changes were made with a view to improving the experience to our complainant and provide a more person centred approach. The new process was supported by workshops delivered to Trust staff to help with their understanding and revised expectations of managing a complaint. The Complaints Service will continue to support staff with delivery of a further 5 workshops into Q4.

Two important changes were the timeframe to respond which is now 25 working days and all complaint responses will be signed by the Chief Executive. This was introduced to provide complainants with more timely responses and also to provide a greater level of assurance and oversight to the responses that we provide. It must be acknowledged however, that there has been a drop in the Trusts compliance with the number of complaints responded to within the timeframe in Q3 but this was to be expected whilst the new process was embedded and a fluid process established.

December saw the introduction of the newly created Complaints Review Group. The group was created to provide a forum where complaints could be discussed and our management, actions and learning from investigations could be constructively scrutinised. The Group will meet on a monthly basis going forward and will provide assurance to the Quality Forum and subsequently the Quality Assurance Committee.

Recruitment to a Senior Complaints Officer in the Corporate Complaints Team has been completed and interviews for a Complaints Facilitator will take place on 2 February 2020. Additional capacity has also been sourced within our Adult Mental Health Directorate to support the management and flow of concerns across services. The additions to the

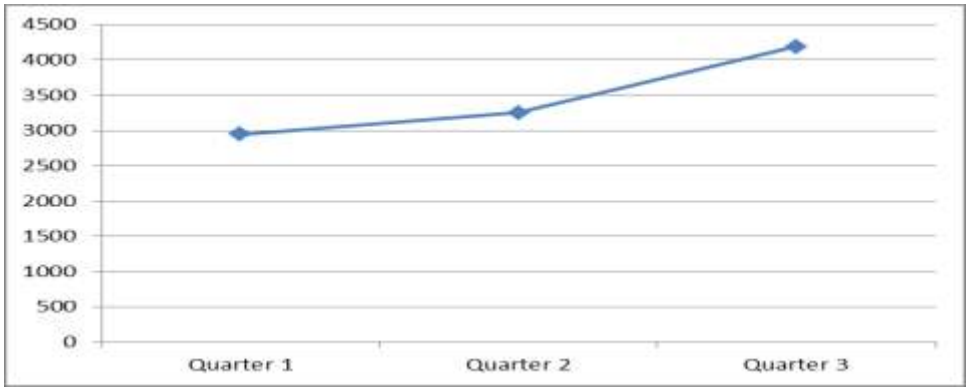
complaints function will strengthened the support that the Complaints Team can offer trust wide and to our complainants.

In Q4, the complaints Team will continue to work hard on embedding its new processes and supporting staff with the management of complaints. Training to medics in scheduled for February 2020 to educate them on how they could play a vital role with assisting patients and relative to resolve any issues informally and as quickly as possible but also their part to play in the complaints process.

A full breakdown of complaints data is available in Appendix 2

Friends and Family Test

4,184 responses to the Friends and Family Test (FFT) were received in Quarter 3. This is an increase of 22% across the Trust compared to Quarter 2. This increase follows three workshops on FFT delivered in Q3 setting out the new FFT guidance and to encourage staff to push efforts to collect FFT within their service areas for ongoing improvement. For the first three quarters of 2019/20 there has been a trend in increased responses which is set out below:



The current response rates for FFT across Mental Health Services in England is 3%, the Trust is currently reporting a 1.4% response rate. In relation to Community Health Services the national average across England is 4% with the Trust achieving a 1.8% response rate.

During the quarter the breakdown of ratings were 95.37% in relation to positive/recommendation scores and 1.54% negative/not recommend scores.

Work continues to improve the Trust's FFT performance in a number of areas. In relation to the current FFT infrastructure an options appraisal has been completed which has included reviewing a number of similar Trust's across the county in terms of their approach and systems. The options appraisal found that the current in-house system is not fit for purpose and is not currently receiving any new development monies, also that the paper-based approach to collecting responses is very staff reliant and through this approach of staff handing out card, results in a positive bias in terms of responses. This resulted in a submission of a capital bid to commission an automated system using SMS text messages and IVM, individual voice messages to compliment the current paper-based system. Unfortunately the bid did not meet capital requirements so a subsequent application for growth monies has been submitted for 2020/21. In addition to the automated system a proposed recall and reconfiguration of 300 IPads which are currently out across services

which will allow all IPads to be reconfigured and updated with the new FFT question and broaden the accessibility on the IPads to capture wider patient feedback. Through the Listening into Action sponsor group work with volunteers through a Listen and Talk volunteer role will be piloted. It is hoped that the introduction of volunteers to support the capture of patient feedback will be an effective approach and will compliment and support front line teams to capture patient experience.

A programme of FFT relaunch is currently in development. The proposed approach will consist of a year-long programme of themed activities and support for staff to help them in their implementation of FFT and wider feedback. This programme will be split across four quarters and will cover the following areas:

Quarter 1 CAPTURE - Relaunch with new materials and training for staff with focused training and support in capturing feedback

Quarter 2 ANALYSE – Training and support for staff to use their data effectively, this will include tools, materials and data analysis support

Quarter 3 IMPROVE – Using data, identifying areas for improvement, adopting a Quality Improvement approach to using feedback for improvement and working with patients and carers

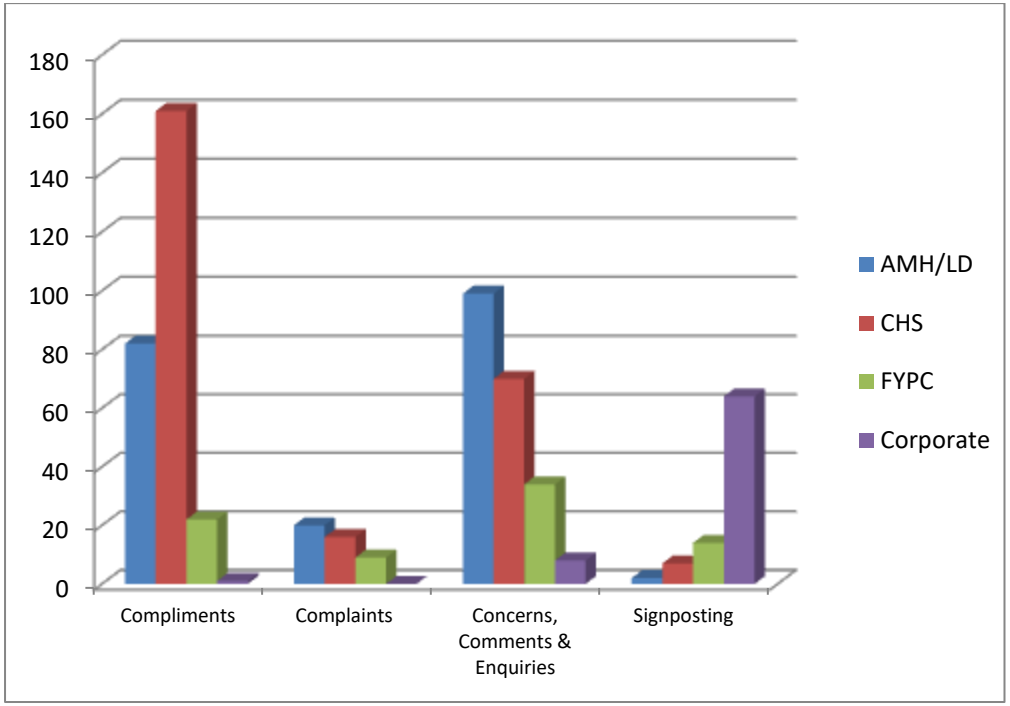
Quarter 4 SPREAD AND ADOPT – Connecting improvement projects and teams to support the spread and adoption of good practice in using patient experience for improvement

A full breakdown of FFT data is available in Appendix 3

Directorate Feedback Breakdown

Appendix 1

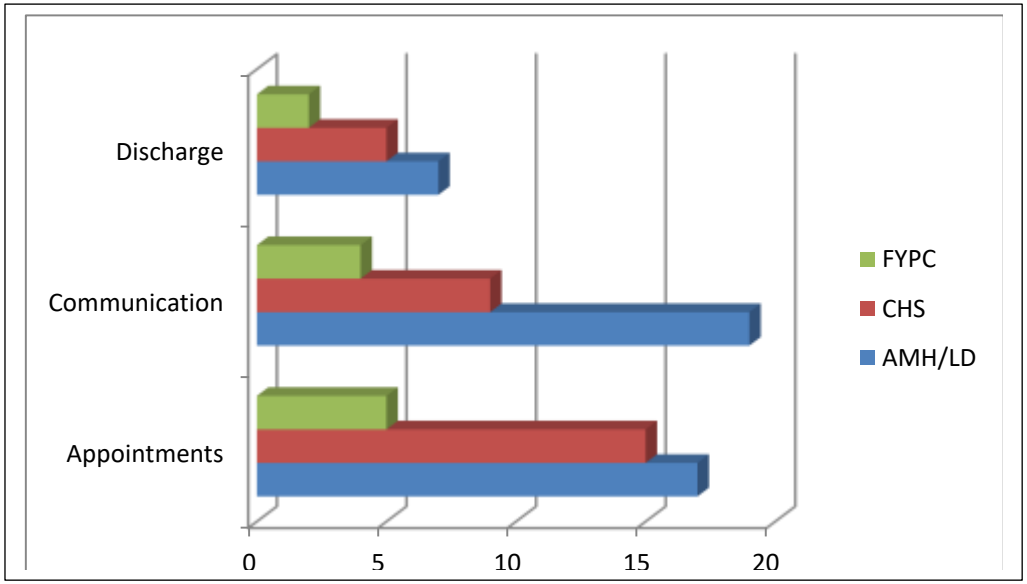
Individual Feedback Received Across All Directorates



During Q3 609 individual pieces were captured and recorded, of this feedback 44% was positive and 56% related to comments, concerns, enquiries and signposting.

Both graphs show all feedback received through website feedback and comments, concerns, enquiries received by directorate. Each comment can cover a range of themes and the analysis below is based on the themes covered in individual comments. During the period October 2019 to December 2019, 211 comments, concerns, enquiries were received.

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



Complaints

Appendix 2

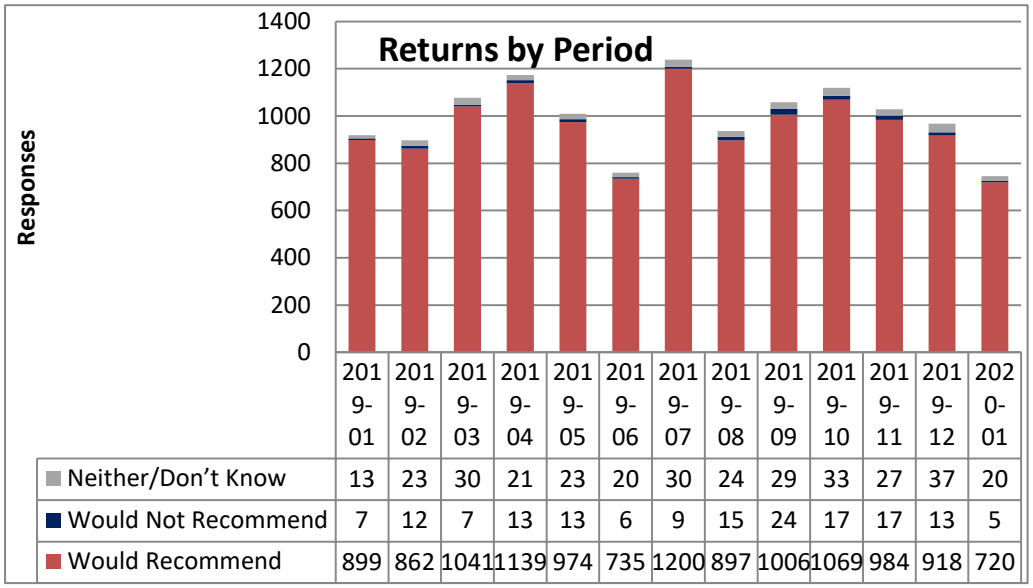
Complaints Activity for Q3 – 1 October – 31 December 2019

	Q1	Q2	Oct 2019	Nov 2019	Dec 2019	Total Q3	Total 19/20
Adult Mental Health and Learning Disabilities	35	24	8	7	5	20	79
Community Health Services	27	24	7	6	3	16	67
Families, Young People and Children	21	10	1	3	5	9	40
Corporate/Facilities	0	2	0	0	0	0	2
Total Received	**83**	**60**	**16**	**16**	**13**	**45**	**188**
Complaints vs Patient Activity (Complaints Rate as a %)*	0.04	0.03					
% of complaints acknowledged within three working days	99.3	100	100	100	93	97.6	98.8
Number of complaints responded to within the negotiated timescale****	36	23	5	6	4	15	74
Number of complaints responded to in 25 working days	25	16	3	5	4	12	53
Number of complaints upheld or partly upheld in quarter	54	42	6	9	3	18	114
Number of complaints ongoing after 3 months**	19	5	5	5	6		
Number of complaints ongoing after 6 months***	3	0	0	0	0		
Number of reopened complaints	14	11	3	4	2	9	34
Number of complaints reported to the PHSO	2	1	1	0	0	1	4
Number of complaints upheld or partly upheld by the PHSO	0	1	0	0	0	0	0

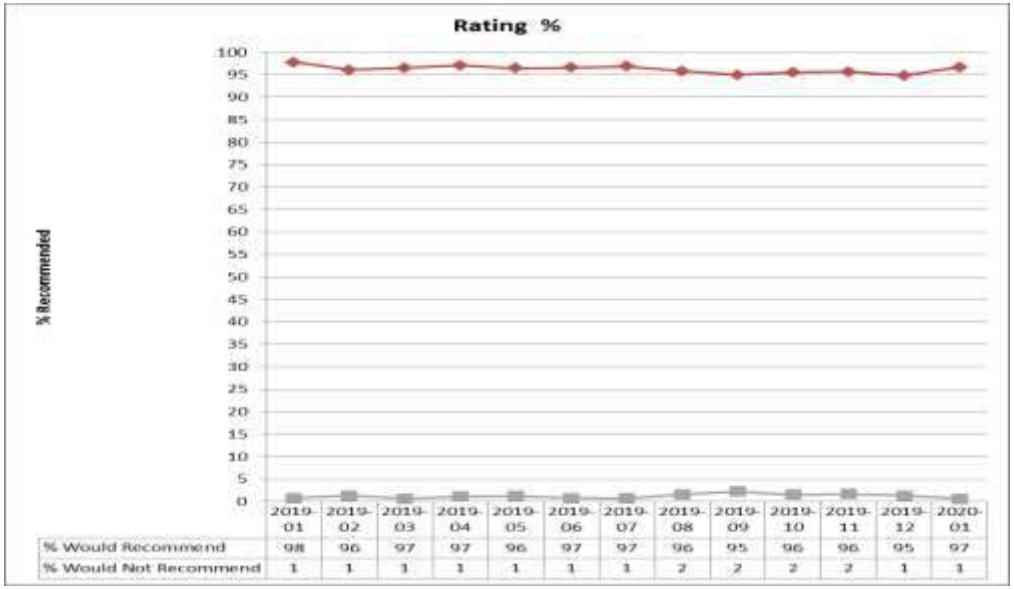
*Patients attended and seen

**Complaints ongoing after 3 months at the end of Q1
***Complaints ongoing after 6 months at the end of Q1. These include those also included in the ongoing after 3 months section.
****Position statement as responses still under investigation

Trust-Wide Returns trend analysis

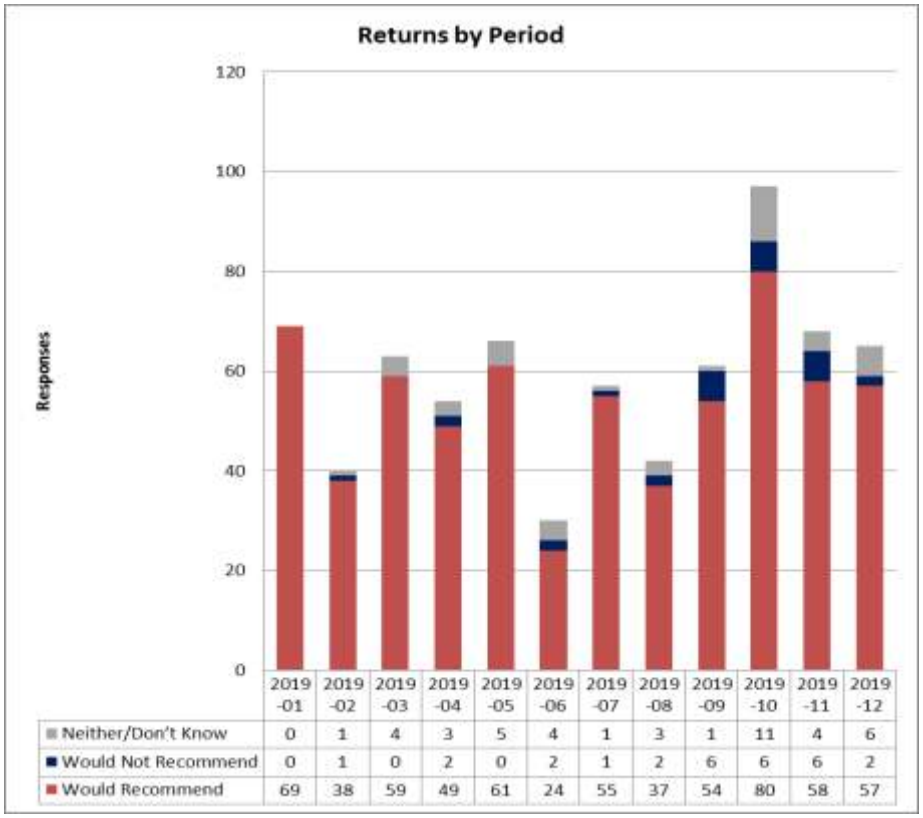


	2019-01	2019-02	2019-03	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01
Neither/Don't Know	13	23	30	21	23	20	30	24	29	33	27	37	20
Would Not Recommend	7	12	7	13	13	6	9	15	24	17	17	13	5
Would Recommend	899	862	1041	1139	974	735	1200	897	1006	1069	984	918	720

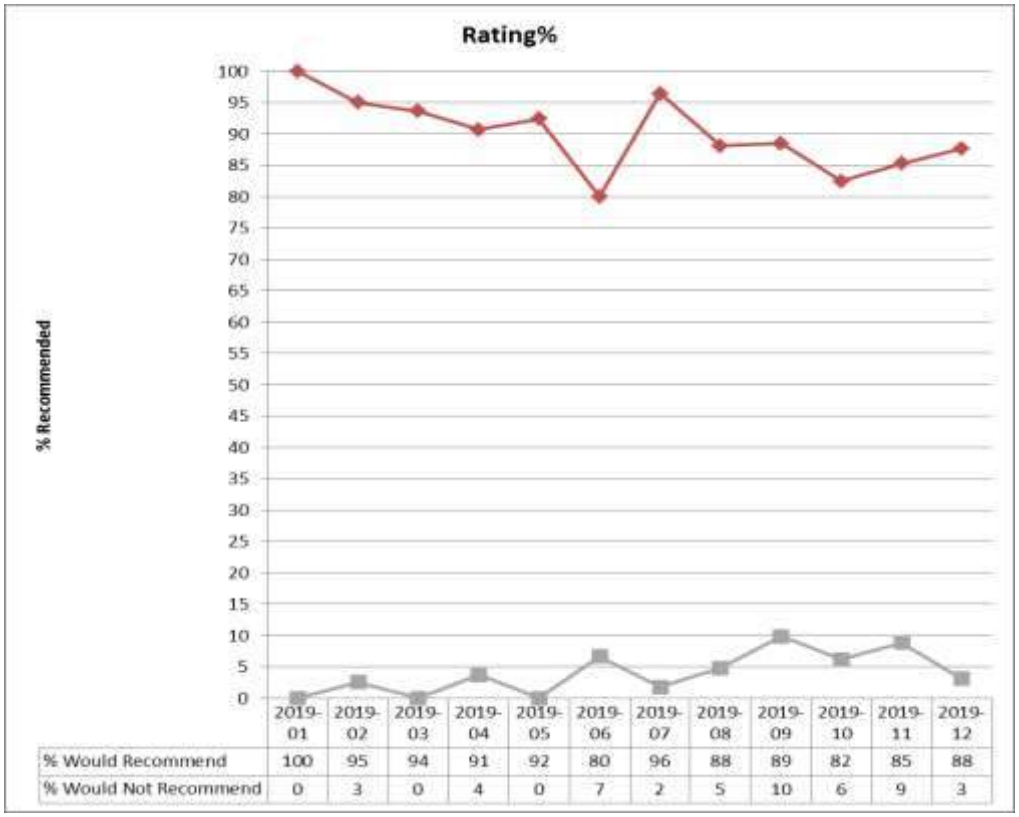


Friends and Family Test (FFT) Comparable Data

Adult Mental Health and Learning Disabilities

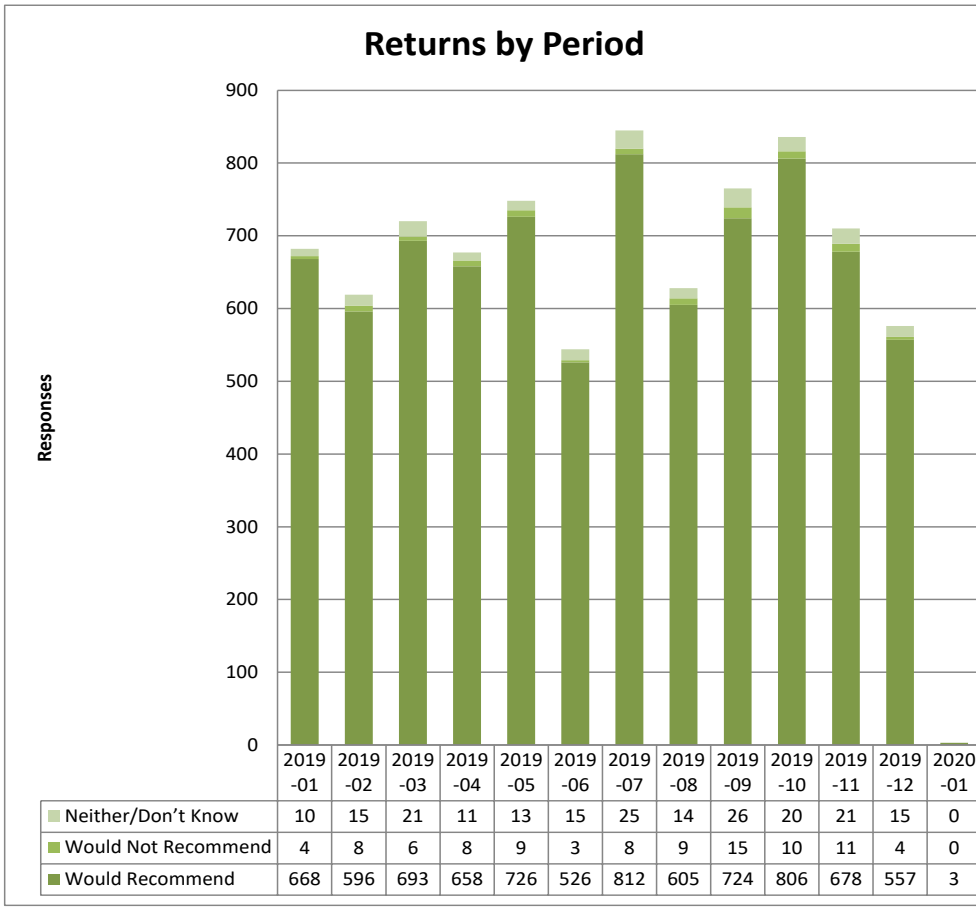


	2019-01	2019-02	2019-03	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12
Neither/Don't Know	0	1	4	3	5	4	1	3	1	11	4	6
Would Not Recommend	0	1	0	2	0	2	1	2	6	6	6	2
Would Recommend	69	38	59	49	61	24	55	37	54	80	58	57

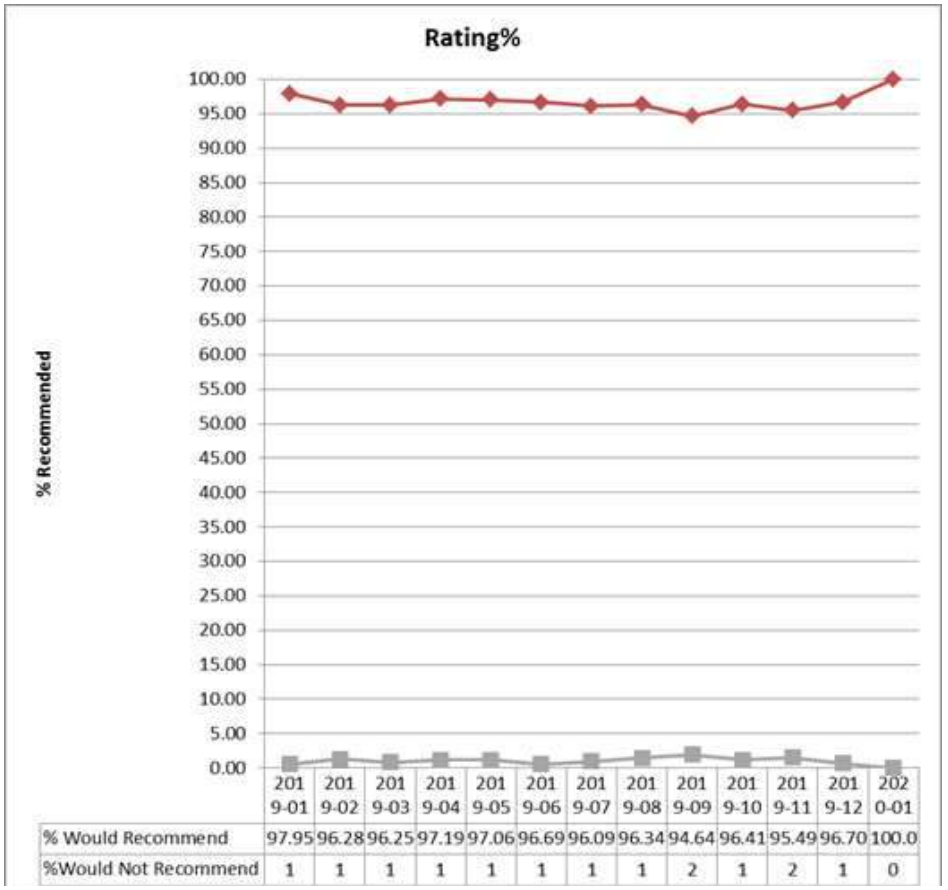


	2019-01	2019-02	2019-03	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12
% Would Recommend	100	95	94	91	92	80	96	88	89	82	85	88
% Would Not Recommend	0	3	0	4	0	7	2	5	10	6	9	3

Community Health Services

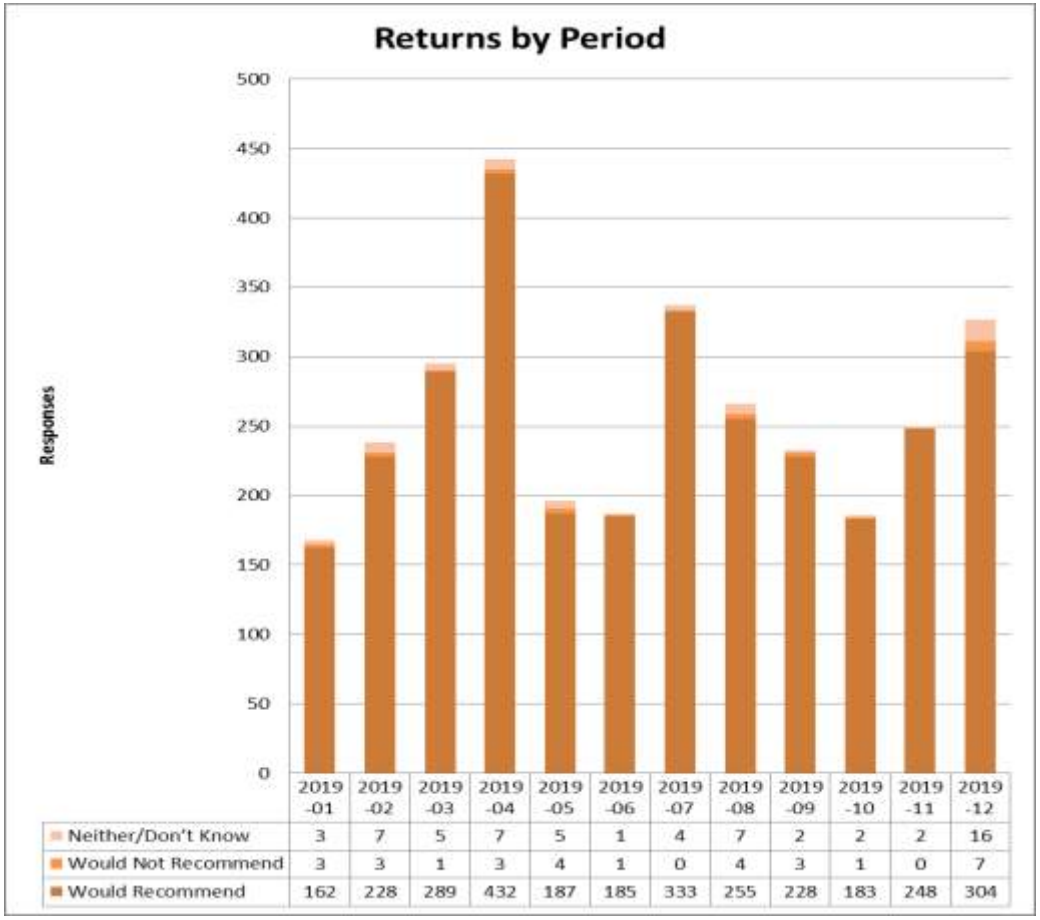


	2019-01	2019-02	2019-03	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01
Neither/Don't Know	10	15	21	11	13	15	25	14	26	20	21	15	0
Would Not Recommend	4	8	6	8	9	3	8	9	15	10	11	4	0
Would Recommend	668	596	693	658	726	526	812	605	724	806	678	557	3

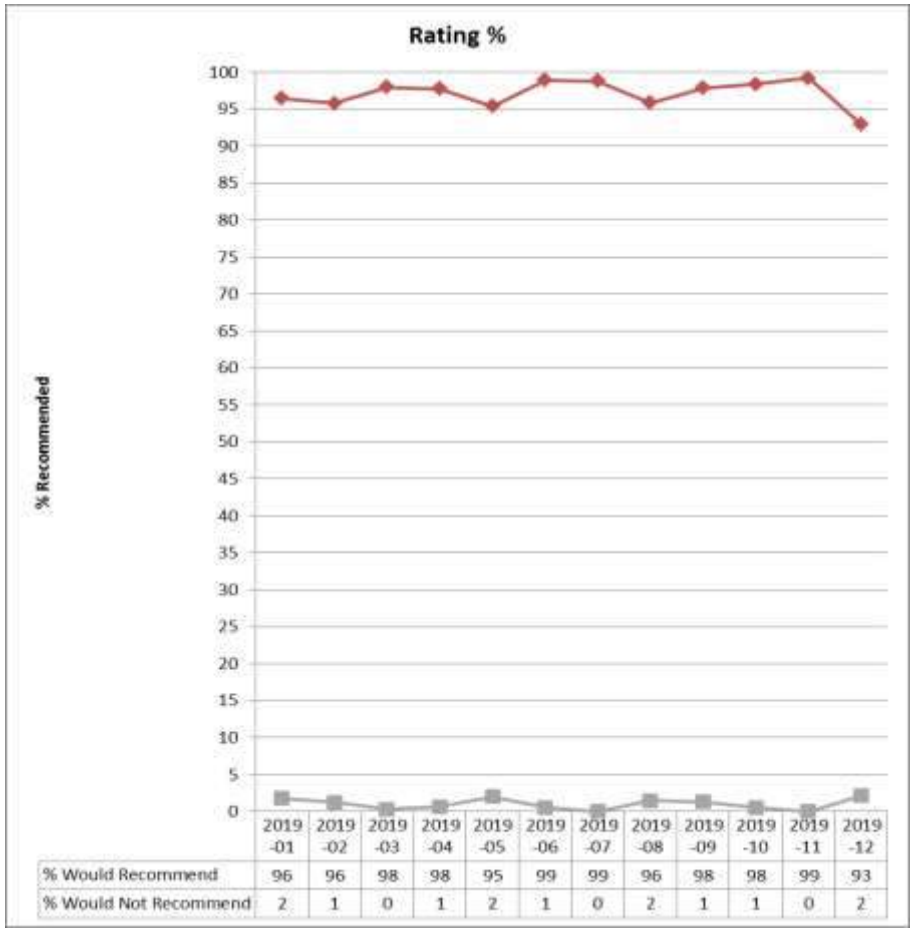


	2019-01	2019-02	2019-03	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12	2020-01
% Would Recommend	97.95	96.28	96.25	97.19	97.06	96.69	96.09	96.34	94.64	96.41	95.49	96.70	100.0
%Would Not Recommend	1	1	1	1	1	1	1	1	2	1	2	1	0

Families Young People and Children



	2019-01	2019-02	2019-03	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12
Neither/Don't Know	3	7	5	7	5	1	4	7	2	2	2	16
Would Not Recommend	3	3	1	3	4	1	0	4	3	1	0	7
Would Recommend	162	228	289	432	187	185	333	255	228	183	248	304



	2019-01	2019-02	2019-03	2019-04	2019-05	2019-06	2019-07	2019-08	2019-09	2019-10	2019-11	2019-12
% Would Recommend	96	96	98	98	95	99	99	96	98	98	99	93
% Would Not Recommend	2	1	0	1	2	1	0	2	1	1	0	2

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 3rd March 2020
Paper number	O

Name of Report: Patient Safety Incident and Serious Incident Learning Assurance Report for Q3 2019/20

For approval		For assurance	x	For information	

Presented by	Dr Anne Scott Interim Director of Nursing/AHP's & Quality	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	x	T - Transformation	
Caring	x	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	
		T – Trust-wide Quality improvement	x
Any equality impact (Y/N)		N	

Report previously reviewed by	
Committee / Group	Date
Quality forum (old format)	6/02/20
Quality Assurance Committee (old format)	18/02/20

Assurance: What assurance does this report provide in respect of the Organisational Risk Register?	Links to ORR risk numbers
That incidents are reported and escalated for appropriate investigation. Investigations are robustly undertaken and learning identified and shared.	1 and 3

Recommendations of the report
Review and confirm that the content and presentation of the report of the incident provides assurance around all levels and categories of incidents. Acknowledge that development of reporting is on-going and the presentation of the report may change as this develops. • Be assured on the performance of SI report completion and the work to improve • Be assured on the compliance with 'Being Open' and Duty of Candour'.

- Be assured systems and processes are in place to ensure effective investigations are undertaken that identify appropriate learning.
- Be assured that the quality assurance of these processes is continually reviewed.

Patient Safety Incident and Serious Incident Learning Assurance Report for Q3 2019/20

Purpose of the Report

This report is presented to the Trust Board Quarterly at this submission; bi-monthly going forward, to provide assurance of the efficacy of 'Patient safety Incident Management', learning identified and Duty of Candour compliance processes. Incident reporting supporting this paper has been reviewed and refreshed to assure that systems of control continue to be robust, effective and reliable, thus underlining our commitment to the continuous improvement of incident and harm minimisation, and ultimately patient safety.

The report will also provide assurance around 'Being Open', numbers of serious incident (SI) investigations and the themes emerging from recently completed investigation action plans, a summary of recent Ulysses patient safety incidents and associated lessons learned.

Analysis of Patient Safety Incidents reported

The top 4 patient safety incidents reported via Ulysses (by volume, not harm) were reviewed using the Statistical Process Control (SPC) Tool utilising the NHSI Toolkit.

Appendix 1illustrates the total number of incidents reported which is showing an increase; which is positive as reporting of incidents and near misses is encouraged. However there is also an increase in the level of harm; which can be directly correlated to a focus on ensuring accuracy with the description of harm as a result of an incident and a change in the way pressure ulcers are reported; this will continue to be monitored using the SPC Tool.

Appendix 1 reports the following:

- All incidents reported via LPT Incident reporting system Ulysses

Appendix 2 reports the following:

- Pressure Ulcers 2, 3 and 4, unstageable and deep tissue injury and moisture associated skin damage
- Self-harm 'Patient Suicides'
- Self- harm by numbers and harm
- All patient falls by numbers and harm
- All violence, assault and aggression by numbers and harm

Appendix 3 reports the following:

- Medication Errors/incidents

Appendix 4 reports the following:

- Serious Incidents reported

Appendix 5 reports the following:

- Trust Wide overall Serious Incidents Action Plan status

Appendix 6 reports the following:

- Lessons Learned/Learning

Review of Top 4 Patient Safety Related Incidents

1) Pressure Ulcers

Patients affected Pressure Ulcers developed whilst in LPT Care.

Considering incident in relation to learning rather than blame is best practice in incident management. Since April 2019, NHSE have required organisations to think differently in relation to Pressure Ulcers and consider learning as opposed to avoidability/lapses. Grade 4 pressure Ulcers meet the criteria for 'Severe' harm and have been reported as 'Serious Incidents' since April 2019 and the care considered to identify learning.

There have been no 'hospital acquired' Grade 4 pressure ulcers in Q3. The reported Grade 4's have been classed as acquired or deteriorated in the community.

Learning identified:

- The importance of the 'Tissue Viability Team' continuing to review all Grade 4's to provide advice and confirm grading. They provide advice and support in relation to all aspects of pressure ulcer prevention and management.
  Patient and family information to support them in making choices and understanding the importance of preventing pressure ulcers.
- The reliability of scheduling Registered Nurse Visits and the need to find a way of prompting a review of risk when the patient's condition changes.
- The group is developing a 'your skin matters' improvement plan. This will be reviewed as each incident is considered and any new learning included in this overarching plan.

Appendix 2 outlines the numbers of New Pressure Ulcers of all types and demonstrates that there is not a significant reduction in other categories as yet. As part of this improvement plan, it was identified for a local addition of two new Categories of Pressure Ulcers; 'unstageable' and 'New Moisture Associated Skin Damage - Non Continence'.

Appendix 2 also shows a downward trend in patients affected by Grade 4 pressure Ulcers; should this continue through Q4 this will be considered a sustained improvement.

Pressure Ulcers on Admission not attributable to LPT

The data is showing an increase in reporting and it can be surmised that this is due to the focus and training becoming embedded since the process changed in April 2019.

Guidance released in April 2019 by NRLS, "Implementing the Revised 2018 Pressure Ulcer Framework in Your Local Reporting System" requires that Pressure ulcers identified on admission should also be reported to the NRLS with their associated degree of harm (even though this may affect the organisations harm profile)

2) Self–Harm including Patient Suicide

Analysis has identified three wards that have a much higher number of patients reported to have self-harmed; totalling 319 incidents during October to December 2019:

- Beaumont
- Heather
- Ward 3 CAMHS

11 were not caused by “repeat” incidents, assuming that repeat in this case refers to those patients who self-harmed on at least 2 occasions during the 3 months.

Significant contributors were:

- Beaumont had 3 patients with above 10 incidents (one with 64, one with 18, and one with 11)
- Heather had 2 patients with above 10 (one with 20, one with 17)
- Ward 3 CAMHS had 5 patients with at least 10 incidents (one with 48, one with 20, two with 14, and one with 10).

Action: The Deputy Head of Nursing AMH has been asked to undertake a review of these incidents and if necessary; undertake an Internal Investigation and identify any learning to be shared across the Trust. The Head of Nursing for FYPC is undertaking a targeted piece of work for Ward 3. Both of these pieces of work will be reviewed through the directorate governance route and shared at the Suicide Prevention and Self Harm group.

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 2019/20

NHSE have worked with NHS Trusts to support them to develop a zero approach to in-patient suicides resulting with a Trust-wide 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 governed by the Suicide Prevention Group and monitored against progress by the Learning from Deaths Group.

The self-harm policy has also recently been reviewed; a lack of Clinical leadership and a need for a Trust wide approach for this agenda has been identified. This will be considered by the Suicide Prevention Group.

A positive example of how we are driving forward our commitment to ‘Learning from Deaths’ and suicides is the success of the business case for a new Learning from Deaths and Suicide Prevention Lead practitioner. Unfortunately recruitment to this role has been slightly delayed; however this is now back on track.

This data is shared by the Corporate Patient Safety Team to support the ‘Suicide and Self-Harm Prevention Group’.

3) Falls

Data has identified an increase in ‘inpatient falls’ in ‘Mental Health in-patient Wards for Older People’ and Community Hospitals in December 2019. There is also an increase in ‘Moderate Harm’ or above as a result of these incidents.

The increase in falls in December was due in part to a small number of patients who had repeated falls (e.g. Kirby 1pt fell 8 times, Dagleish 1pt fell 4 times, Gwendolen + Beechwood 3 pts fell 3 times). However as a percentage of total falls, repeat falls has fallen slightly

Falls Huddles have been put in place to reduce repeat falls. Delivery of huddles is improving but further work to be done re consistency and effectiveness.
The Falls Steering Group asks directorates to feedback the actions/learning particularly from these repeat fallers.
The Falls Group reviews the data and produces a thematic review based on completed SI Investigations for patient falls causing 'moderate harm' or above.

4) Violence, Assault and Aggression

The numbers remain stable around reported Violence and Aggression. During July 2019 the Patient Safety Team held two open sessions for staff to attend to share their experiences of working on the wards in relation to managing Violence and Aggression. The purpose of these sessions was to identify learning and areas where staff identified improvements that could be made, that would assist in the management of Violence and Aggression on a day- to-day basis.

All Other Patient Safety Incidents including Medication Incidents

The Patient Safety Team has only recently been involved in the review of Trust wide medication incidents. This has previously been part of the Medicines Management and Risk Reduction Group.

SPC reveals that overall reporting of medication incidents has been increasing month on month for the last five months. There has also been an increase in the number of Moderate Harm and above reported incidents since December 2019, however, not all of these incidents have been reviewed by local managers, so the harm rating hasn't been confirmed.

As part of our improved incident management processes, the initial review of incidents will be conducted locally by directorate managers in the area with support where required from the Patient Safety Team. Directorate managers work to a ten day timeframe to sign incidents off and confirm the harm rating. It is acknowledged that the transition will take time to embed and the Patient Safety Team also review the incidents to ensure robustness.

Serious Incident Review and Compliance Process

The detail around numbers reported of Serious Incidents and compliance with deadlines is included in appendix 4 and 5.

Queries Raised by Commissioners / Coroner / CQC on SI Reports Submitted

Q3 identified some difficulty with the 'sign off' process from the CCG resulting in some delays in final sign off and feedback position; this in turn has contributed to delays in information sharing with CQC, families and other stakeholders in Serious Incident investigation process.

The CQC have expressed a concern that they do not always receive timely notification of serious incidents and completed action plans. A meeting has been held with the CQC to understand their expectations and internal processes have been put in place to strengthen this including regular engagement meeting's with the CQC and the Head of Patient Safety.

The Trust was not issued with any ‘Prevention of Future Deaths’ (PFD) Regulation 28 in Q3.

There are currently two action plans for previous PFD’s; these are progressing and are being monitored by the Patient Safety Improvement Group.

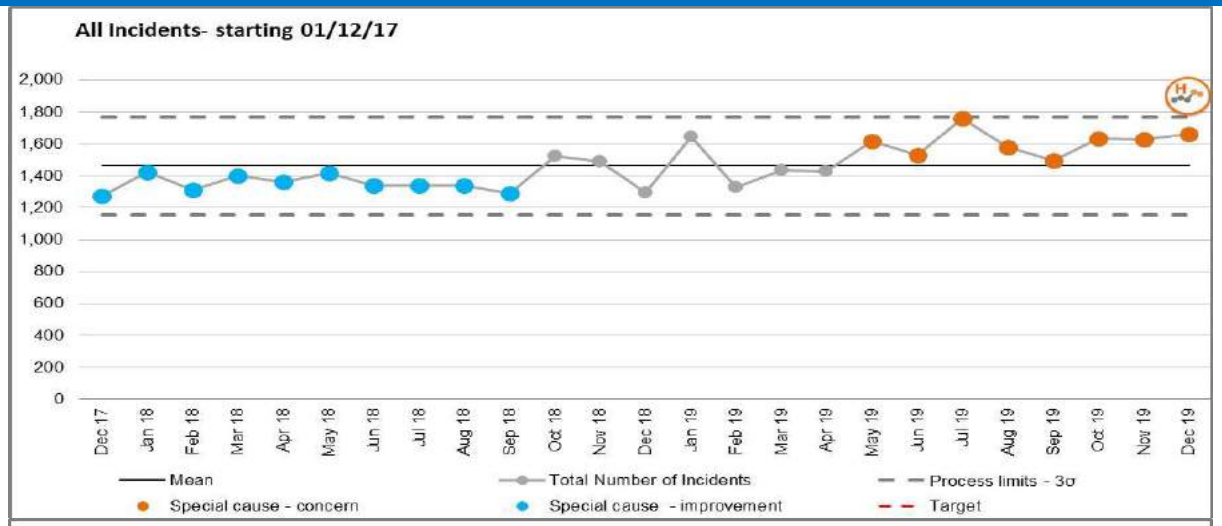
Duty of Candour

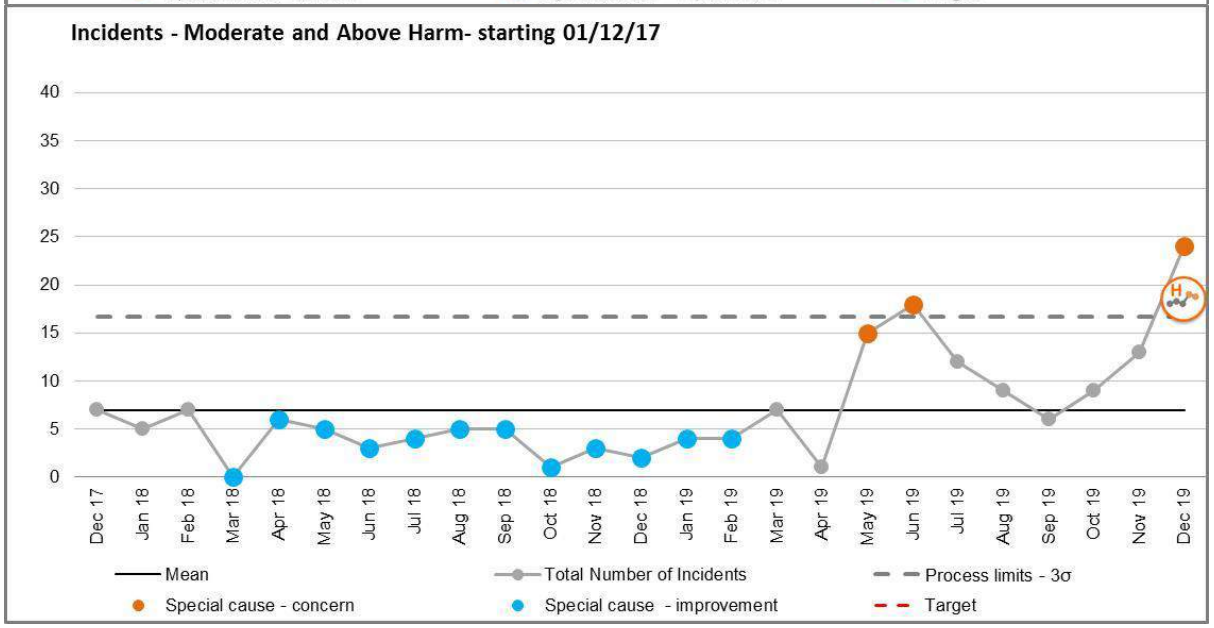
There have been no confirmed breaches of ‘Duty of Candour’ during Quarter 3. The policy has been rewritten to ensure the process is clearer and the Patient Safety Team offer support in terms of training where required. The process for reviewing all incidents is being strengthened to ensure that incidents are reviewed in a timely way and the degree of harm considered in relation to the incident to ensure appropriate level of investigation and compliance with the formal ‘Duty of Candour’ process. Staff are encouraged and supported to follow the principles of ‘Being Open’ with all incidents.

Serious Incident process

The Patient Safety Team have benchmarked and mapped SI processes with NHFT’s and, where possible, these processes are being harmonised. Phase one of this piece of work includes the robustness of the decision making in relation to level of investigation. This involves a weekly meeting where all potential serious incidents are considered. Phase two will focus on the investigation processes.

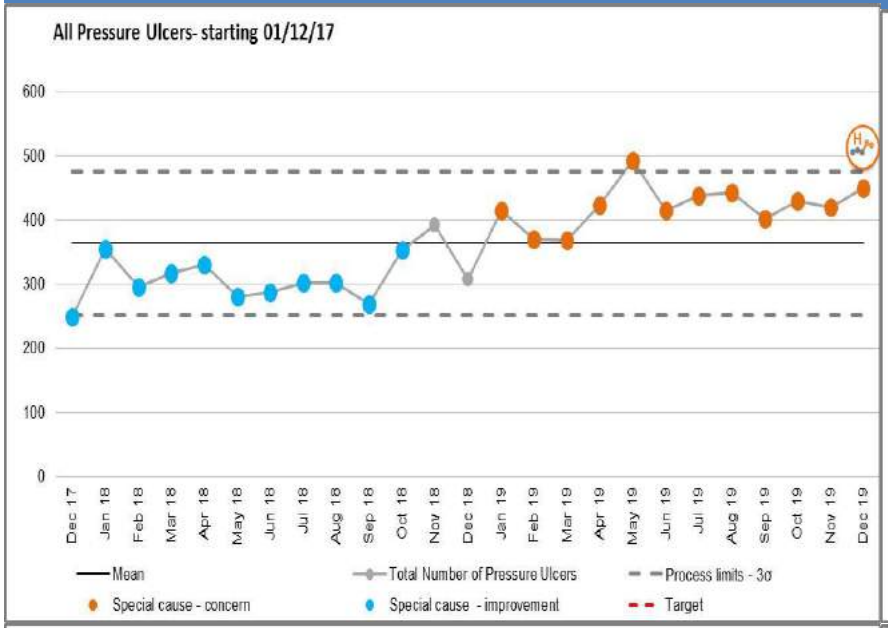
Appendix 1 - All Incidents Reported

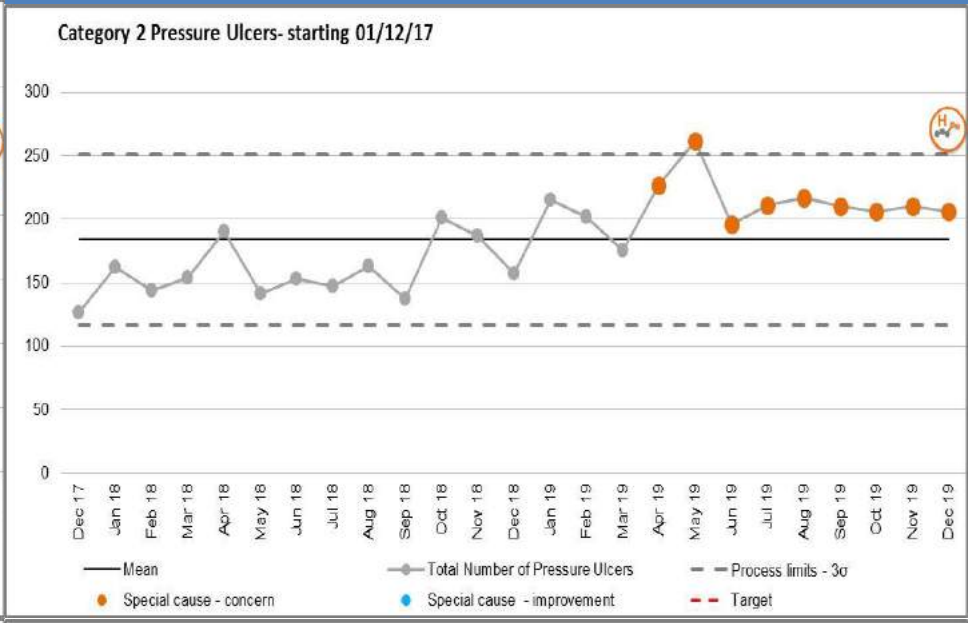


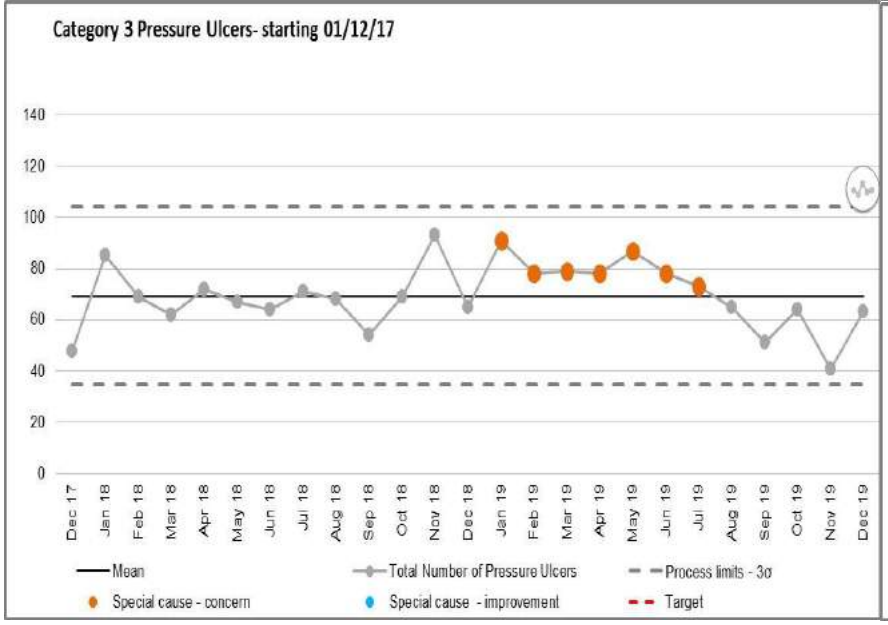


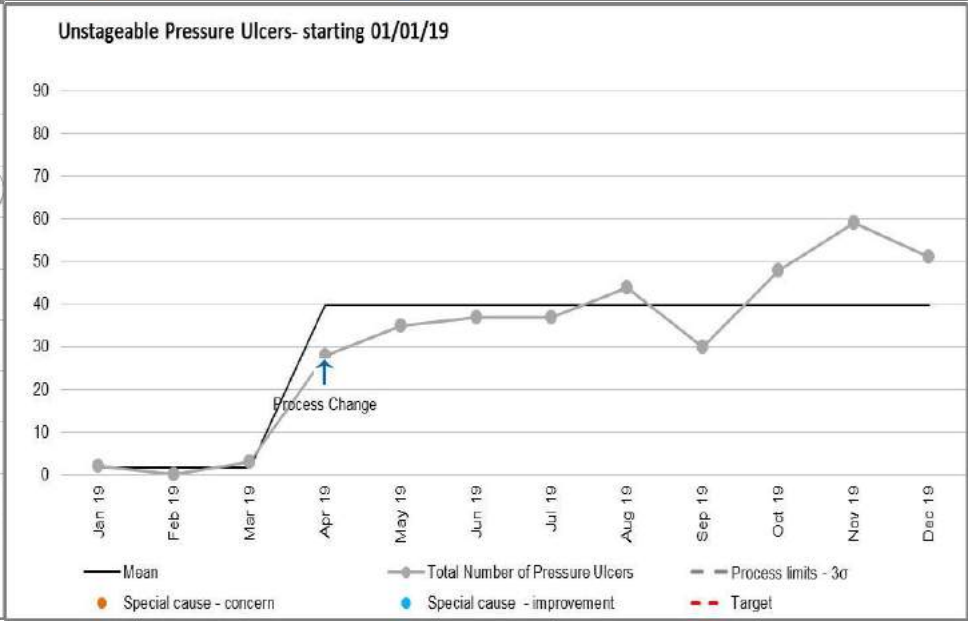
Appendix 2 Top Reported Incidents – by numbers not harm

Pressure Ulcers – all categories



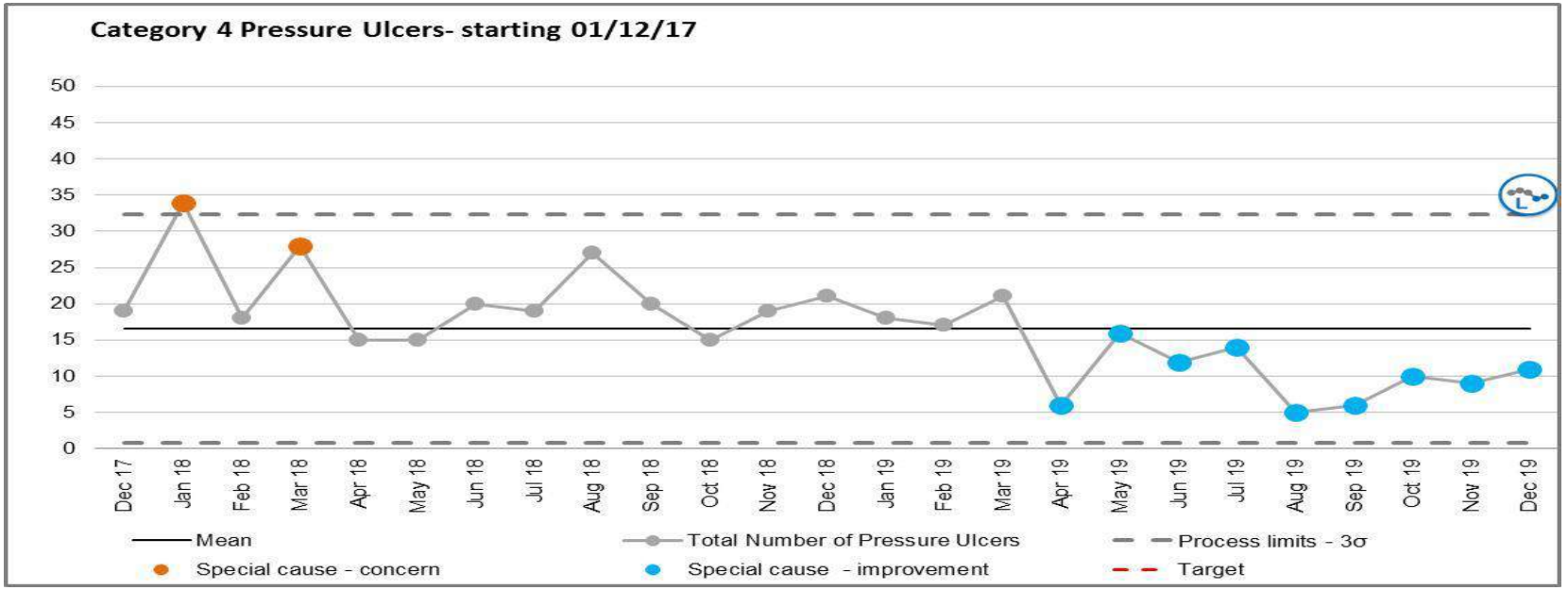


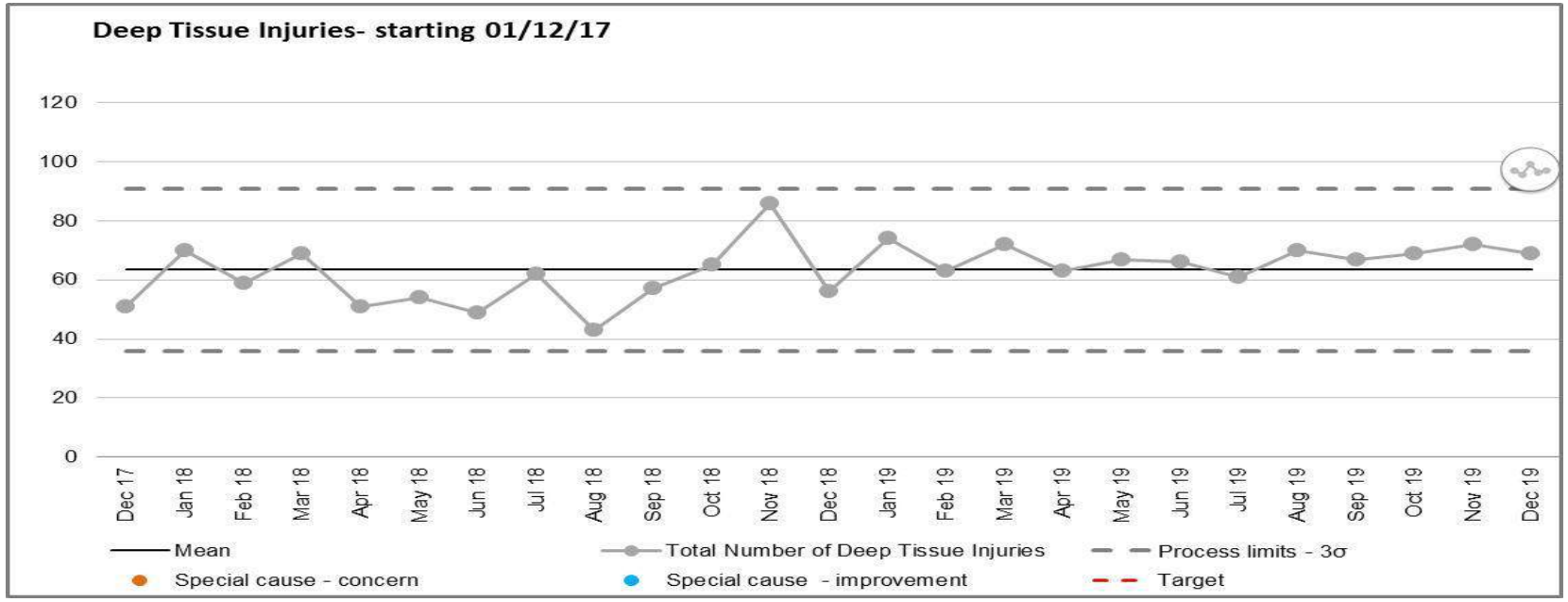




Appendix 2 - Top Reported Incidents – numbers not harm

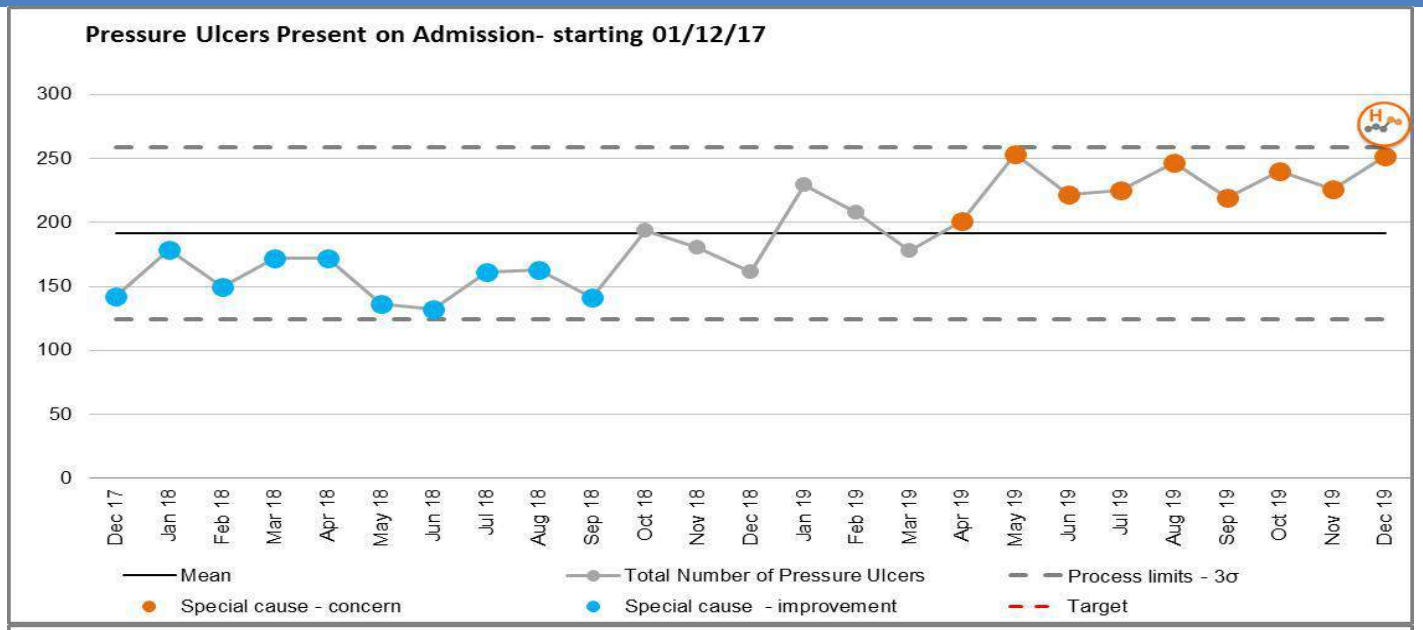
Pressure Ulcers

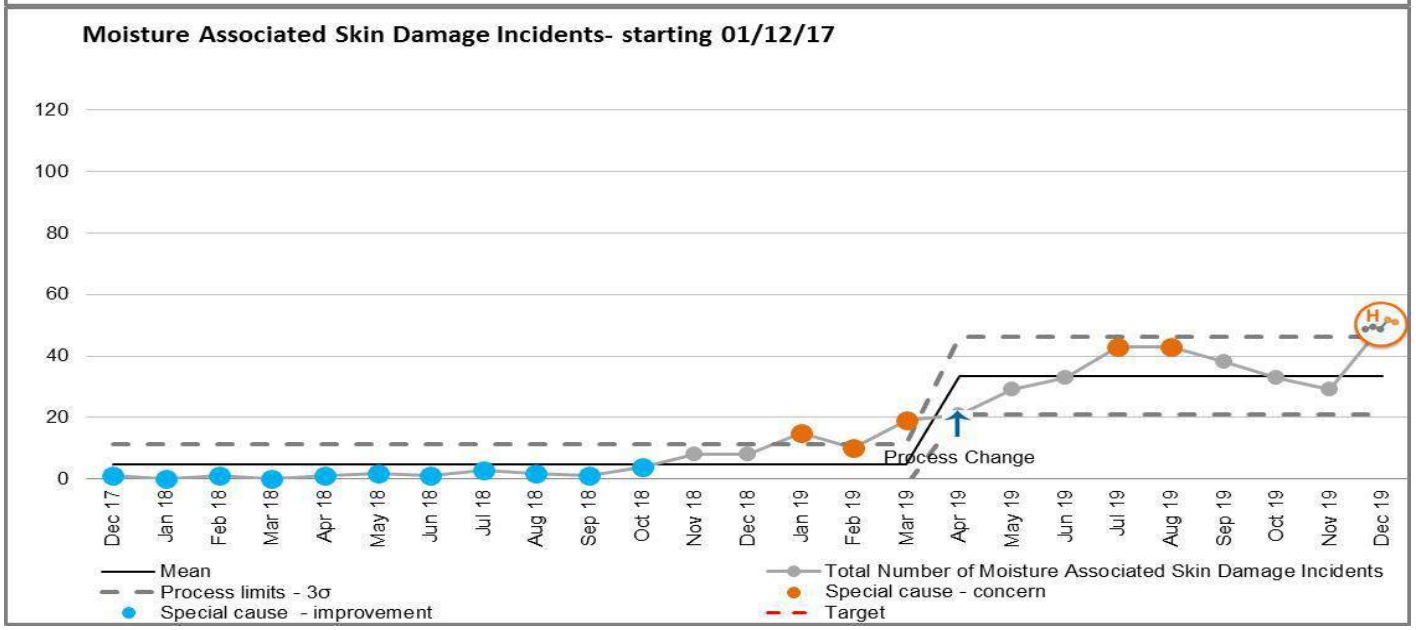




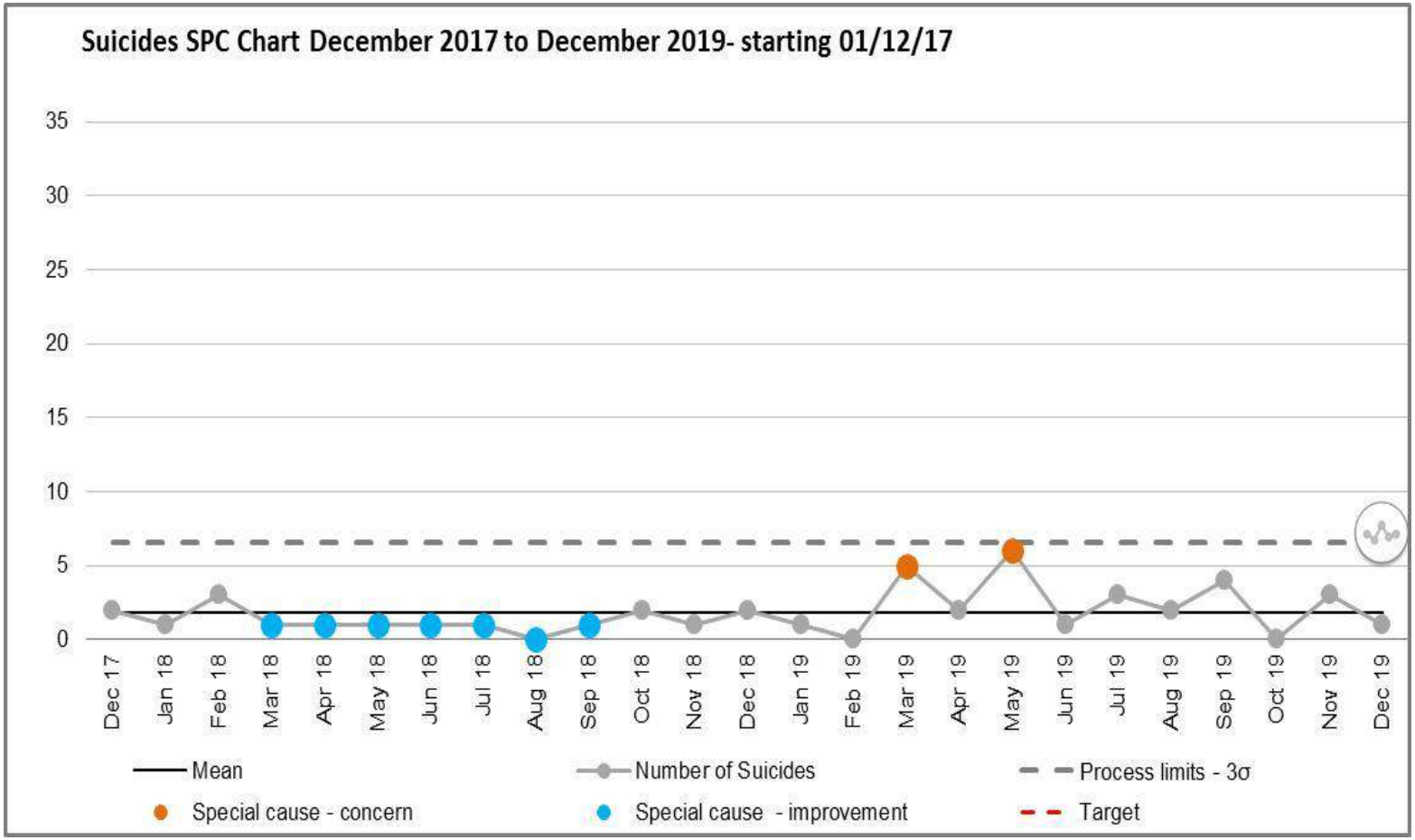
Appendix 2 Top Reported Incidents by numbers not harm

Reported Pressure Ulcers 'Present on Admission' and Reported Moisture Associated Skin Damage



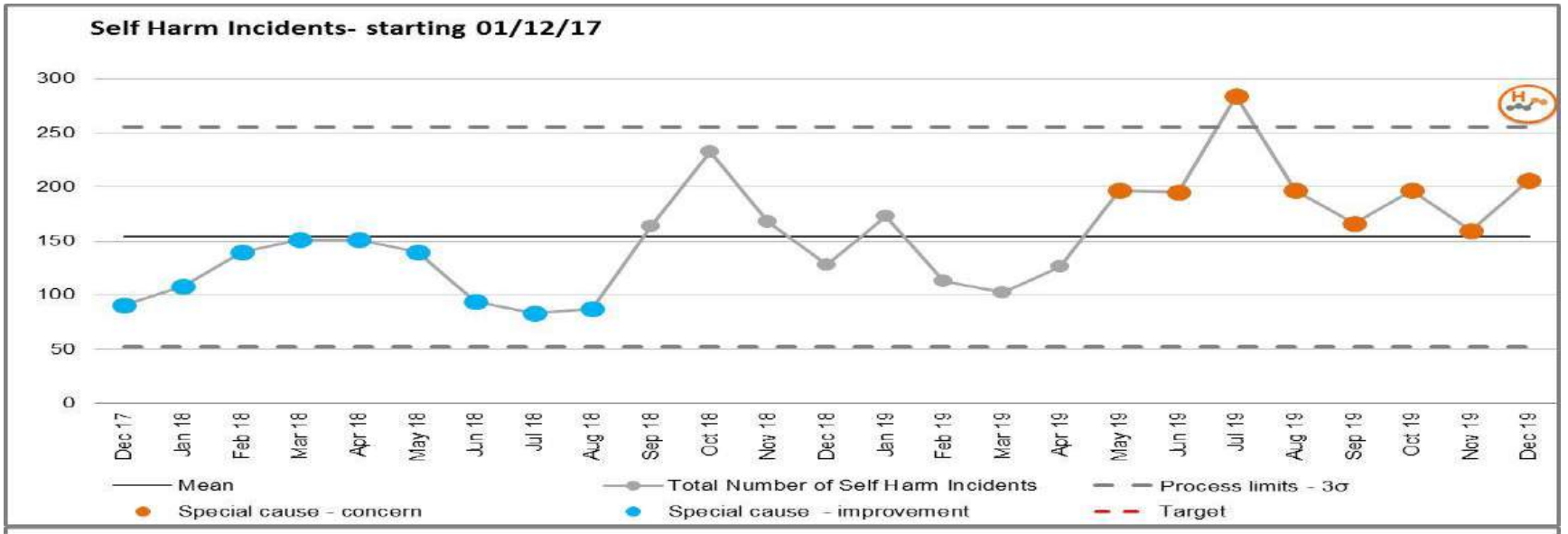


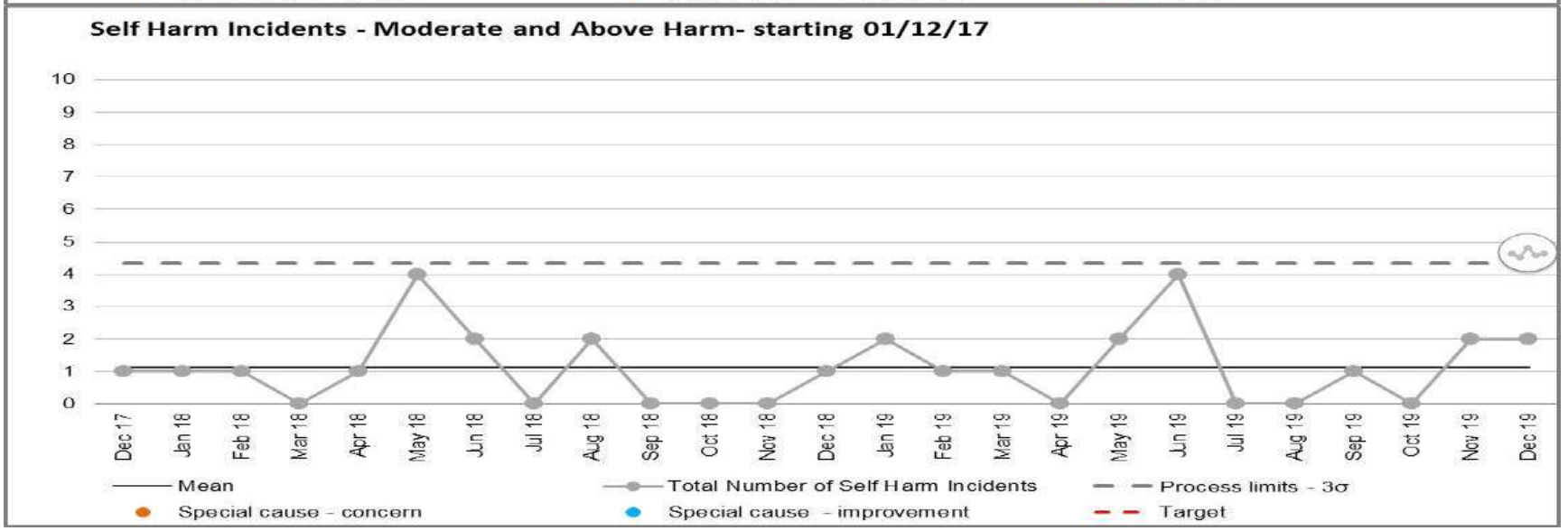
Appendix 2 - Top Reported Incidents by numbers
Patient Suicides



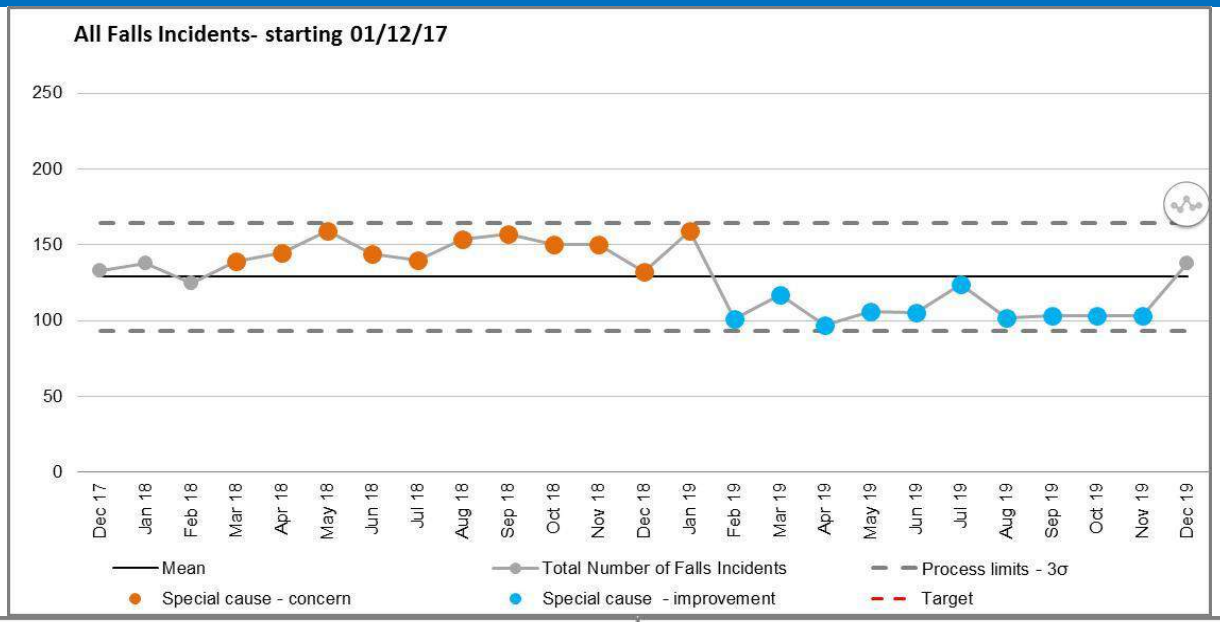
Appendix 2 Top Reported Incidents by harm

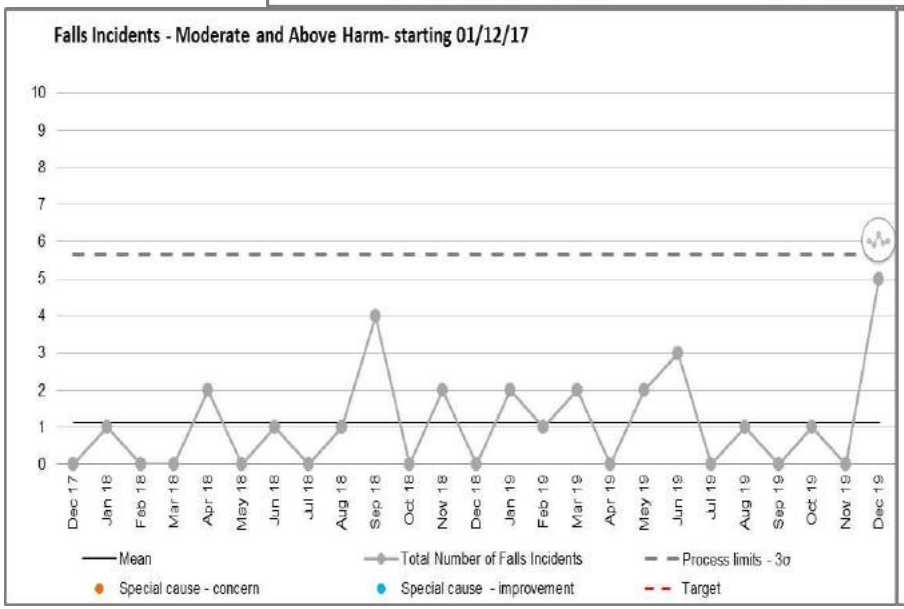
Self - Harm

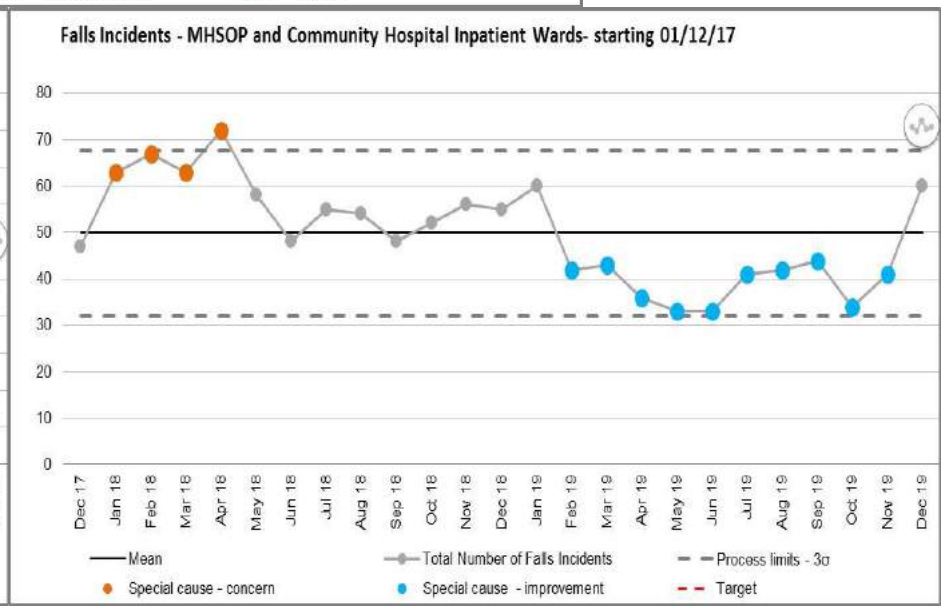




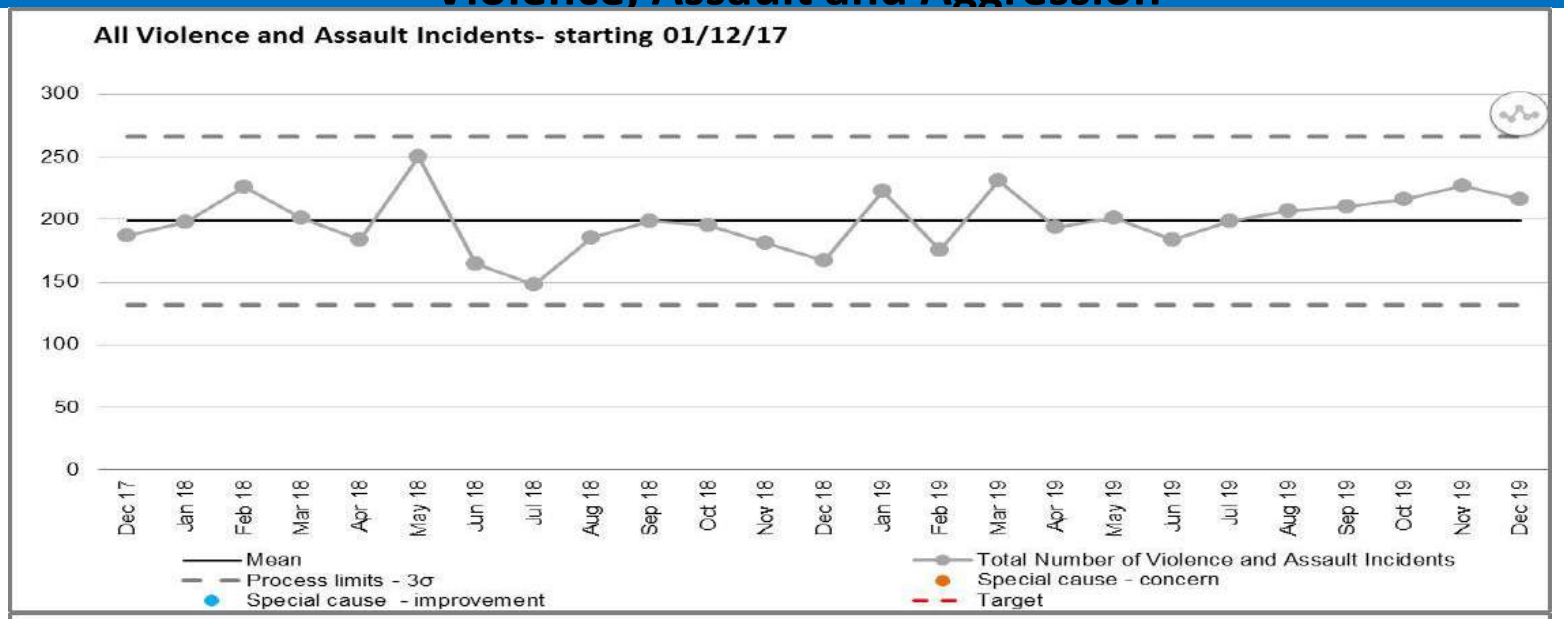
Appendix 2 -– All Falls

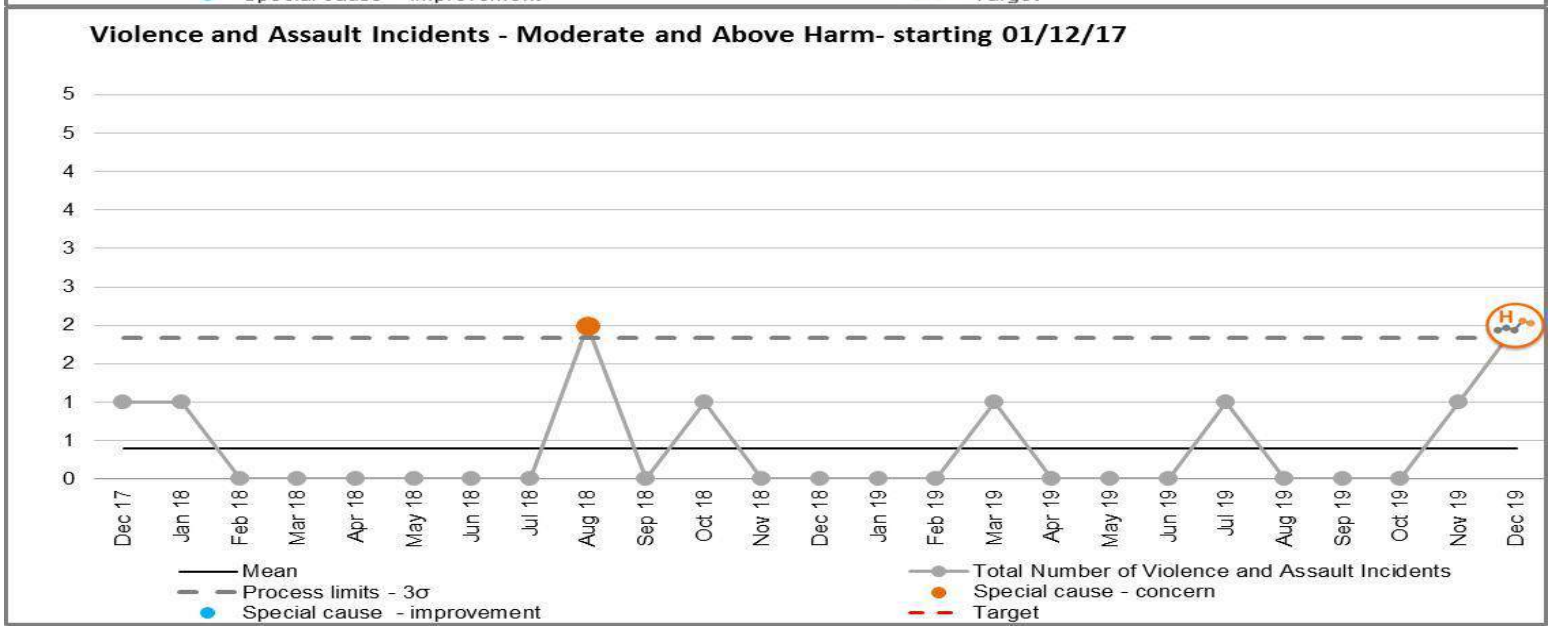




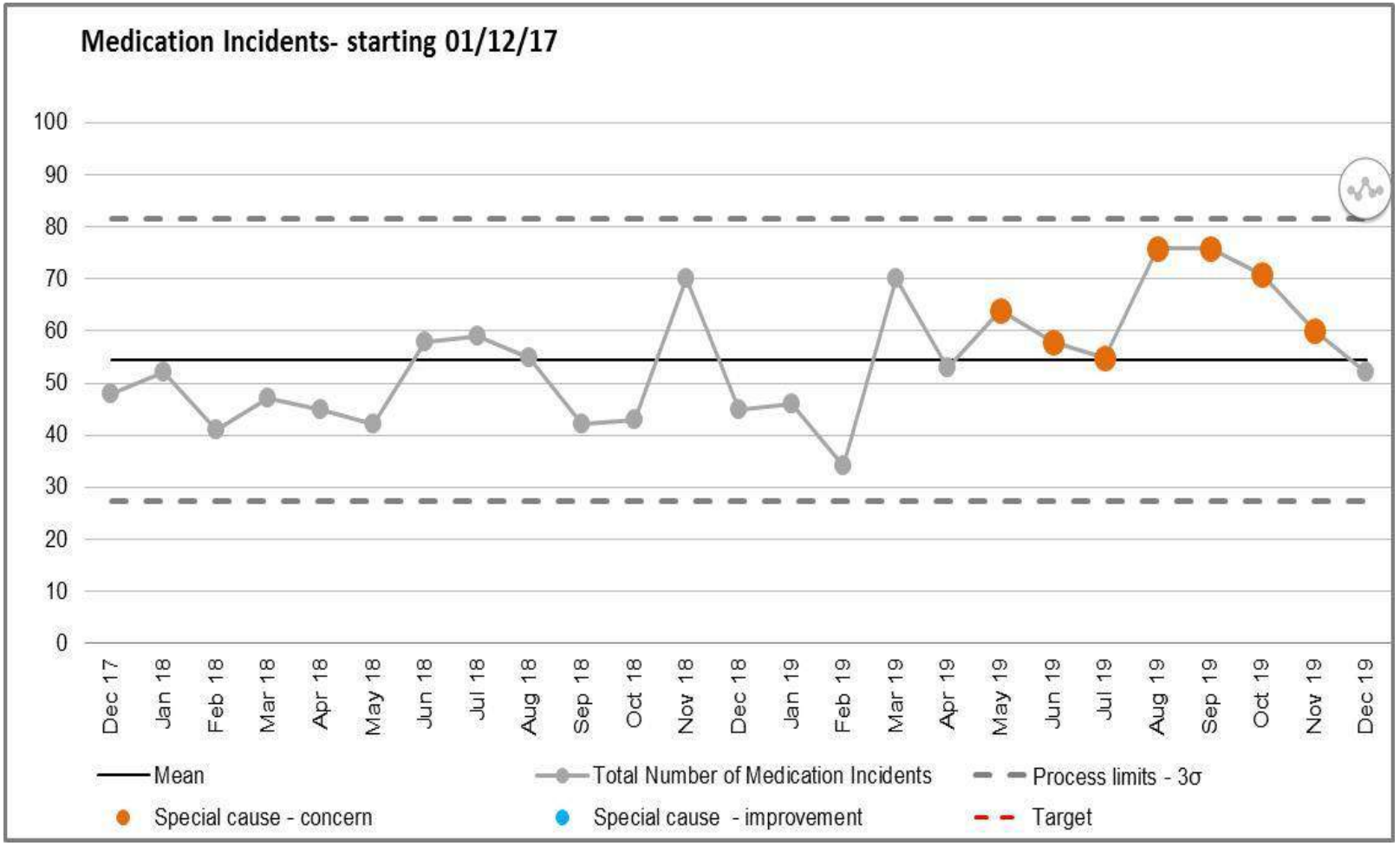


Appendix 2 -’
Violence, Assault and Aggression





Appendix 3– Medication



Appendix 4 - StEIS Reported Serious Incidents (SI's)

		StEIS Notificatio	SI INVESTIGATIONS							Internal Root Cause Analysis Investigations				
		Downgrade & removal requests	SIs declared AMH/LD	SIs declared FYPC	SIs declared CHS	Signed off within month	Within original deadline	SI Downgrade requests	Confirmed DoC breaches	AMH/LD	FYPC	CHS	Signed off within month	Within original deadline
2019/20 Q1	April	0	3	0	0	3	*	0	0	9	4	1	*	*
	May	0	7	2	4	3		0	0	2	4	0		
	June	0	3	1	10	3		0	0	4	2	0		
2019/20 Q2	July	0	6	0	11	2		0	0					
	August	0	2	0	4	7		0	0					
	September	0	3	1	22			2	0					
							31%							
2019/20 Q3	October	0	2	2	4	5		0	0	0	0	0		
	November	1	10	1	4	9		1	0	0	0	0		
	December	1	4	4	1	9		1	0	1	0	1		
							32%							
2019/20 Q4	January													
	February													
	March													
YTD		2	40	11	60	41		4	0	16	10	1	0	#DIV/0!
2020/21 Q1	April													
	May													
	June													
2020/21 Q2	July													
	August													
	September													
2020/21 Q3	October													
	November													
	December													
2020/21 Q4	January													
	February													
	March													

Appendix 5 – Trust Wide Overall SI's Action Plan Status 2019/20

	Trust Wide Overall SI Action Plans 2019/20					
	Total SI (Other) Action Plans due to be Implemented	Total SI (Other) Action Plans Implemented	Total SI (Pressure Ulcer) Action plans due to be Implemented	Total SI (Pressure Ulcer) Action plans Implemented	% Total SI Action Plans Implemented by Month	% Total SI Action Plans Implemented YTD
Apr-19	3	3	0	0	100.00%	100.00%
May-19	3	3	0	0	100.00%	100.00%
Jun-19	4	4	0	0	100.00%	100.00%
Jul-19	9	9	0	0	100.00%	100.00%
Aug-19	33	30	0	0	90.91%	94.23%
Sep-19	6	6	0	0	100.00%	94.83%
Oct-19	0	0	0	0	-	94.83%
Nov-19	3	0	0	0	0.00%	90.16%
Dec-19	0	0	0	0	-	90.16%
Jan-20	15	0	0	0	0.00%	72.37%
Feb-20	0	0	0	0	-	72.37%
Mar-20	0	0	0	0	-	72.37%
Total YTD:	76	55	0	0	72.37%	72.37%

Appendix 6 – Lessons Learned/Learning

Lessons Learned/Learning Identified Included:

- **Pressure Ulcer Themes/Trends**

The new 'Pressure Ulcer Scrutiny' Template enabled the Tissue Viability Group to capture themes for all pressure ulcers developed/deteriorated in our care. There were 345 completed templates in total identifying 2 the below key themes:

- Evaluation of prevention strategies (15%)
- Patient education/information (15%)
- Substantial improvement in the completion and review of SSKIN

Falls Themes/Trends and Learning

- Greater focus required on Skills and Competency to deliver physical health care/management of risks e.g. hypertension
- 2 Near misses regarding lack of escalation of changing condition not recognised
- No full holistic or falls assessment undertaken/completed
- Lack of a risk assessment for the use of low beds

Self Harm

- The need for a strong 'in patient' approach to self harm

Community Suicide

- The need to provide continuity of carer for patients under the care of crisis. For continuity for patients to build relationships and for staff to identify subtle changes in patient presentation

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 3rd March 2020
Paper number	P

Name of Report	Learning from Deaths Q2 and Q3

For approval		For assurance	X	For information	

Presented by	Dr S Elcock	Author (s)	J Nicholls, T Ward, S Elcock

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

Report previously reviewed by	
Committee / Group	Date
QAC	18/02/20

Assurance : What assurance does this report provide in respect of the Organisational Risk Register?	Links to ORR risk numbers
This demonstrates how learning is shared across the Trust.	3 There is a risk that the Trust does not demonstrate learning from incidents and events and does not effectively share that learning across the whole organisation.

Recommendations of the report
For the board to be assured that there is a robust process in place for learning from deaths.

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Learning From Deaths Report Q2+3 to Board of Directors

1. Introduction

The trust's Learning from Deaths process was developed in line with the July 2017 NHS Improvement document, "Implementing the Learning from Deaths Framework: key requirements for trust boards". We have also joined a regional peer group and included shared learning in our approach. A recent internal audit report made some key recommendations which have now been fully implemented.

The purpose of this report is to share key data and highlight any trends along with highlighting learning to the Board. Due to timings, the report shows data for the reporting quarter and learning from the previous.

The report format will be changed for the next Q4 report further to reviewing other Trust's Learning from Deaths Board reports. This will standardise and streamline the information presented to Board.

2. Mortality Data

Mortality Figures 2019/2020

Number of patients in scope who have died during 2019/20					
	Q1	Q2	Q3	Q4	Rolling total
Expected	67	71	84		222
Unexpected	35	21	38		94
Totals	102	92	122		316
Number of Child Death Overview Panel (CDOP)					

Totals	8	8	10		26
The number of deaths subjected to a case record review					
Numbers completed Total	CHS – 58 AMH – 21 FYPC – 2 81	CHS -40 AMH-9 FYPC-3 52	CHS -47 AMH-14 FYPC-2 63		145 34 7 196
Numbers outstanding	CHS 58 AMH – 0 FYPC – 0	CHS – 19 AMH – 0 FYPC – 5	CHS 30 AMH – 4 FYPC – 0		CHS – 30 AMH – 4 FYPC – 0
The number of unexpected deaths subjected to an SI investigation					
Numbers completed	8	12	7		27
The number and percentage of deaths subjected to an SI and case record review					
Numbers completed	0	2	1		3
The number of deaths more likely than not to have been due to problems in the care provided					
	0	0	0		0

The Learning from Deaths Policy has clear parameters for inclusion for case reviews. Given the demographics of our clinical services, CHS has a significantly larger proportion of expected deaths (on average total deaths of 22 per month) but we are clear that we want all opportunities to learn so all deaths are included and will be reviewed. The timescales to do this will be reviewed to balance the need.

3. Key Learning (Case Reviews, SIs, CDOPS, LEDR)

Themes & issues identified as part of the review/investigation including examples of good practice	Actions taken in response to identified themes & issues; actions planned and an assessment of the impact of actions
AMH/LD MSSG prioritises reviews of those deaths for which a detailed investigation has not yet been commissioned.	Issues identified (including good practice) are shared with specific teams involved. Additional mechanisms for wider sharing (in addition to via AMH&LD Quality & Safety (Q&S) meetings) are being considered.
DNA policy & procedure not always being followed.	Communication shared and RESPECT being implemented.
CHS EOL paperwork was initiated in 99% of all deaths considered this quarter There has been a 28% drop is SDA to UHL GSF standards adhered to in over 90% of cases Risk taking by decisions made by OOH provider clinicians still resulting unnecessary admissions to acute sector (UHL)	SDA accountability has increased through better escalation plans and discussions with OOH providers EOL champions working in better coordination with ward staff NerveCentre application escalated to higher Board level work up

Learning from FYPC

Themes and issues identified as part of the review/investigation including examples of good practice and Actions taken in response to identified themes and issues, actions planned and an assessment of the impact of actions
1. To set up a regular supervision/ case review process for wound care management in the Diana team. 2. To explore the use of hand held records for joint care packages. 3. To share the system findings regarding the 3 year funding cycle with CDOP for wider investigation. 4. To share the learning points with the family. 5. To share with the Diana Team that equipment can be loaned when funding is a delaying factor. The feedback from the group was that the process was supportive and helpful. The learning was shared with
1. The record keeping of medical staff to be included in systematic record keeping audits. 2. On transition from RIO to the SystmOne Electronic Record in 2020, regular systematic reporting of care planning and risk assessments should be carried out 3. Review guidance and protocols in line with commissioning arrangements and NHSEI expectations for supporting inpatients in an acute hospital known to LAEDS and Langley Ward. 4. Service to complete the pathway for patients with SEED. 5. A review of processes and systems relating to funding including escalation routes when seeking voluntary admissions out of area for patients with Eating Disorders. 6. Discharge planning and the functioning/membership of the MDT ward rounds to be considered to ensure that the following elements have a timely opportunity to be reviewed leading up to discharge • CPA status • Involvement of the community team • Consideration of safeguarding factors both as a potential perpetrator and as a vulnerable adult.

4 Recommendations

To assure the Board that there are robust mechanisms in place with regards Learning from Deaths across the 3 Directorates.

To note the mortality data. There has been no evidence of any significant changes or trends to be noted or to highlight concerns.

To note that learning has been identified and that the Trust wide Learning From Deaths Group facilitates the sharing of this learning across services and directorates.

Dr Sue Elcock

Jo Nicholls

Tracy Ward

21 February 2020.

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Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 3rd March 2020
Paper number	Q

Name of Report: Staff Survey 2019

For approval		For assurance		For Quality Improvement	x

Presented by	Sarah Willis	Author (s)	Sarah Willis Kathryn Burt

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

Report previously reviewed by	
Committee / Group	Date
CEO	
Transformation Committee	21/02/20

Assurance : What assurance does this report provide in respect of the Organisational Risk Register?	Links to ORR risk numbers
The 2019 NHS Staff Survey was conducted between October and November 2019. In addition to enabling LPT to understand the views of staff, the national survey enables LPT to benchmark performance against another 31 Mental Health/LD/Community Trusts.	24 25

Recommendations of the report
1. Consider the results of the 2019 NHS Staff Survey 2. Support a more detailed analysis being undertaken, priority areas identified and actions agreed by the Strategic Workforce Committee (SWC)

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Leicestershire Partnership NHS Trust

TRUST BOARD
3 March 2020

2019 NHS Staff Survey Results

1. Introduction / Background

The 2019 NHS Staff Survey was conducted between October and November 2019. In addition to enabling LPT to understand the views of staff, the national survey enables LPT to benchmark performance against another 31 Mental Health/LD/Community Trusts. A full benchmark report is attached at appendix A and a Directorate report is attached at appendix B. 2422 staff completed the survey which is a response rate of 46%.

Changes to the way that the results are presented were introduced in 2018 with a focus on 10 key themes. An additional theme of team working has been added in 2019. Scale scores are standardised against a 10 point scale and trend data, where available, is provided from 2015 or 2016 which shows progress over an extended period of time.

The 11 key themes are:

- Equality, diversity and inclusion
- Health and wellbeing
- Immediate managers
- Morale
- Quality of appraisals
- Quality of care
- Safe environment – Bullying and harassment
- Safe environment – Violence
- Safety culture
- Staff engagement
- Team working

2. Aim

To provide an overview of the 2019 Staff Survey results and highlight priority areas for further attention and action.

3. Recommendations

Trust Board members are recommended to:

1. Consider the results of the 2019 NHS Staff Survey

2. Support a more detailed analysis being undertaken, priority areas identified and actions agreed by the Strategic Workforce Committee (SWC)

4. Findings

4.1 Themes

Table 1 provides a comparison of results for the 11 themes between 2018 and 2019. There are a three statistically significant variations against what staff shared with us the previous year, which had highlighted some real improvements in staff experience. The slight decrease in three of the eleven indicators are staff morale, staff engagement and quality of appraisals.

2019 has been a year of significant change, where staff have been encouraged to share their views and speak up through the Our Future Our Way culture, leadership and inclusion programme.

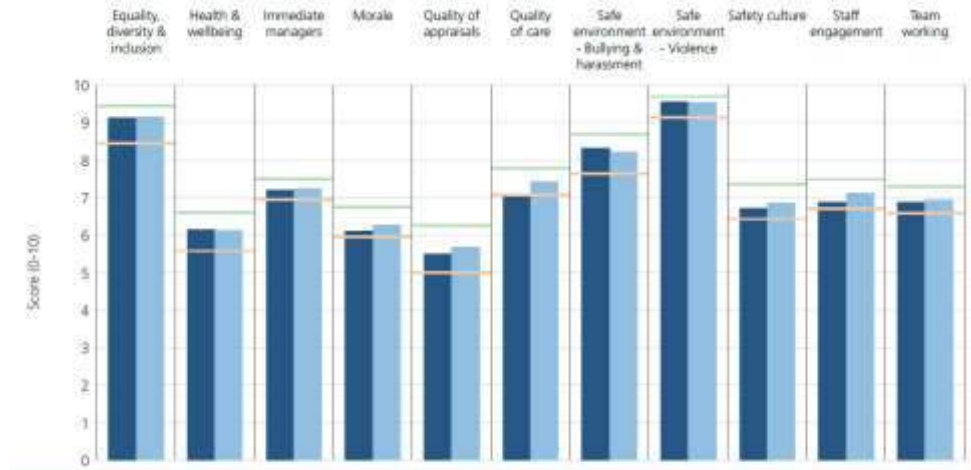
Table 1 - Themes – comparison between 2018 and 2019

Theme	2018 score	2018 respondents	2019 score	2019 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.2**	2557	**9.1**	2383	Not significant
Health & wellbeing	**6.3**	2565	**6.1**	2397	Not significant
Immediate managers	**7.2**	2573	**7.2**	2402	Not significant
Morale	**6.2**	2551	**6.1**	2384	↓
Quality of appraisals	**5.7**	2391	**5.5**	2286	↓
Quality of care	**7.0**	2135	**7.1**	1970	Not significant
Safe environment - Bullying & harassment	**8.4**	2556	**8.3**	2388	Not significant
Safe environment - Violence	**9.6**	2556	**9.5**	2387	Not significant
Safety culture	**6.8**	2561	**6.7**	2389	Not significant
Staff engagement	**7.0**	2596	**6.9**	2418	↓
Team working	**7.0**	2542	**6.9**	2371	Not significant

4.4 Benchmark

In terms of our comparison with similar Trusts – table 2 - we remain the same or better than our comparators on 6 of the 11 themes and are below the benchmark average for 5.

Table 2 – Benchmark 2018



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.6	7.5	6.7	6.3	7.8	8.7	9.7	7.4	7.5	7.3
Your org	9.1	6.1	7.2	6.1	5.5	7.1	8.3	9.5	6.7	6.9	6.9
Average	9.1	6.1	7.2	6.3	5.7	7.4	8.2	9.5	6.8	7.1	6.9
Worst	8.5	5.6	6.9	6.0	5.0	7.1	7.6	9.1	6.4	6.7	6.6
Responses	2,383	2,397	2,402	2,384	2,286	1,970	2,388	2,387	2,389	2,418	2,371

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5.0 Discussion

The staff survey results have been published and we have communicated with staff to confirm that, as a Trust, we have listened and heard what they are saying. We have also acknowledged that the feedback in this survey is reflective of what staff have shared with the change champions in the discovery phase of the Our Future Our Way programme. We already have significant focus and a programme of work underway including the nine priorities which will pick up these elements.

There are variations in results across the directorates and services as detailed in the Directorate report and work will be undertaken to assess assess what local action is required.

We have also surveyed our bank staff at the same time as the national staff survey and are in the process of analysing the results. 49% of our bank staff have responded to this survey which is very encouraging in term of engagement.

5.1 Step up to Great – Actions underway

Staff have been encouraged to speak up and share their experiences both through the Our Future Our Way culture leadership and inclusion programme and through the work that we undertook with the national Workforce Race Equality Standard (WRES) team in the early part of 2019. Work that is already underway to improve the experience of staff includes:

Our future Our way

Identification of 9 priority areas as part of discovery phase of Our Future Our Way leading to:

- Co-design of vision
- Development of leadership behaviours for all – currently being rolled out and embedded
- No-Bullying workstream – LiA supplemented by Survey Monkey and response 'drop boxes' to identify improvements

WeImproveQ – clearly identifiable routes for staff to have and implement great ideas.

Senior Leadership Forum / Leading Together conferences – meeting regularly

Workforce Race Equality Standard (WRES)

- Selected to participate in cultural change pilot with national WRES team – 2 year programme
- Representative interview panels
- Race and Cultural Understanding training

6.0 Next steps

Clinical directorates and services have been provided with directorate/service reports and Quality Health will provide a further breakdown to team level during March. Comments have also been shared. Directorates have been asked to review the results for their own areas and identify specific actions they will be taking to engage staff in identifying actions/solutions or making links to

existing programmes of work. The results of the bank staff survey will be reviewed and incoprated into the local plans.

Work will also be undertaken to triangulate areas for priority in relation to the Our Future our Way nine priorities and additional targeted focus provided where required.

7.0 Conclusion

The Trust board has made significant commitment to working with staff on our culture, leadership and inclusion work and our step up to great journey, and it is acknowledged that change can affect morale. It is noted that we have recently received more feedback from staff that reflects increased positivity in their teams which is encouraging, however it is acknowledged there is still more to do. Changing culture takes time and there is confidence that we are moving in the right direction.

Appendix A: LPT 2019 NHS Staff Survey Benchmark Report
Appendix B: LPT 2019 NHS Staff Survey Directorate Report

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Leicestershire Partnership NHS Trust

FINANCE AND PERFORMANCE COMMITTEE – 21 JANUARY 2020

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 	**High**	NHSE/I had published the draft NHS standard contract for 2020/21 and a consultation on the changes would run until 31 January 2020. FPC was updated on the key changes in relation to LPT. The Trust had been asked to step down Brexit arrangements for the time being. SEB had agreed to progress the business case to develop four inpatient LD rehabilitation beds, this would create significant savings to the system. FPC was fully assured on the issues highlighted.	17 15
Organisational Risk Register 	**Medium**	A detailed review of three risks was undertaken; 10 (maintenance of the estate); 11 (estate configuration) and 17 (failure to meet financial plan and statutory breakeven duty). FPC asked that residual score levels for risk 20 (Performance Management Framework) and risk 29 (out of area placements) were reviewed. Updating of risk 23 (single EPR) was also requested. FPC was reasonably assured as a risk process was in place but it was still being embedded in sub-committees.	All
Committee Governance 	**Medium**	FPC received an update in respect of the new governance arrangements, an updated timetable for the review and implementation of new level 2 committees was presented. FPC was reasonably assured as its revised governance arrangements were on track. Evidence of the embeddedness across sub-committees was still to be established.	11

Report	Assurance level*	Committee escalation	ORR/Risk Reference
STP Long Term Plan 	**Medium**	FPC received an update on key planning assumptions and messages. The LLR high level 5 year plan had been agreed and LPT needed to put this into its own Trust wide plans. The system financial gap was not yet resolved and therefore the plan would need to be flexible. FPC was reasonably assured as a process was in place but the underpinning detail was not yet agreed.	17
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 30 November 2019. **Priority Services** • CAMHS Access was maintaining its high performance. • Liaison Psychiatry and CAMHS ED complete met targets. • The remaining targets were not met. **52 week waits** • No patients were waiting more than 52 weeks for first appointment. • In non-consultant led services the improvement continued, 289 patients were waiting for referral to second appointment/treatment. **National Targets** • Three of the four targets were being met. • 18 week RTT – consultant-led services continued not to be met for Adult ADHD for incomplete pathways. This would become a local target rather than national. • The Children's Audiology 6 week target would not be met in January for the first time, recovery plans were being progressed. The Committee was not assured as despite there being improved processes in place, evidence including SPC analysis highlighted they were not sufficient to deliver the present outcomes in a sustainable way. FPC agreed to receive in March a proposed set of outcomes and trajectories for waiting times for 2020/21.	28
Performance Management Framework 	**Medium**	FPC agreed the terms of reference for the Directorate Performance Review meetings which had been established bi-monthly and would commence on 27 January. Discussion focused on the reporting timeline, concern was raised about the overall journey time of reporting to Board once committees meetings went bi-monthly. It was agreed a wider discussion was required on the appropriate level of monthly information circulated. FPC was reasonably assured as there was a good process in place, it would be fully assured once the DPR meetings had started and appropriate levels of information had been agreed.	20

Report	Assurance level*	Committee escalation	ORR/Risk Reference
Performance Report 	**Medium**	Performance headlines from November data were presented. KPIs for clinical supervision, flu and safe staffing were now included. Discussion focused on the format of the new report. FPC was reasonably assured, it acknowledged the report format was still being developed with colleagues. FPC would continue its review with committees as part of establishing the version for the new financial year.	20
Finance Report Month 9 2019/20 	**Low**	An update on the financial position for the period ended December 2019 was received, key points were; • The month 9 operational overspend of £3,193k represented a negative movement of £184k compared to month 8. • AMH was slightly off their run rate plan but moving in the right direction and should be on target for month 10. CHS and FYPC were continuing to deliver against their control total trajectory. LD's control total had now been agreed at £587k overspend however, LD had its largest monthly overspend in month 9 of £154k which meant their forecast had increased to £887k overspent. • Estates and Enabling were delivering as expected. • As a result of the LD movement, the forecast outturn gap had increased to £951k and there was currently no I&E solution for the gap. If this position continued towards year end, LPT would deliver a £1.7m surplus, lose Q4 PSF and be in underlying deficit of £451k excluding Q1-3 PSF receipts. • Cash and capital continued to be delivered as expected against target. • All BPPC targets were now being met. • Agency spend had increased in month 9 as expected, the causes of this were understood in some areas. • Trust Board had agreed LPT would declare in its month 9 submission to NHSI on 23 January outlining the external pressures/support that had resulted in it not meeting the stretch target of £500k. It would meet its original control total and statutory break even position, FPC agreed the process for actioning this. FPC was not assured, it was satisfied with the process in place, whilst recognising the continued ongoing risks and pressures.	17, 22
Electronic Patient Record Project 	**Green**	The project was reported on track and meeting all key milestones ahead of the 'go live' date 9 June 2020. FPC requested more detail on key elements on the ORR given that this was currently one of the Trust's biggest financial investments. An update would be received in April covering the key areas requiring assurance to meet the 'go live' date. FPC was fully assured the project was on track for delivery of the single EPR for 9 June 2020.	23

Report	Assurance level*	Committee escalation	ORR/Risk Reference
IM&T Committee	**Medium** **Low**	A highlight report from the meeting 19 December 2019 was received. Concern was raised about the low level of assurance in respect of the community services dataset as the Trust was an accelerator site. An update on the three red areas would be received at the next FPC meeting. FPC was not assured because of the concerns but was reasonably assured on other elements of the report.	
Estates and Facilities Management Update	**Low**	Key points to note were; • Elimination of dormitory accommodation programme had been agreed by the Board and in the capital programme. • Design work for the Bennion Centre - completed by April. • SOC final piece of work - completed by 22 January. • The Estates Oversight Group continued to meet to review job tracking and management of risk. • CAMHS scheme - slightly delayed due to bad weather. • Revenue budget for replacement of items in terms of patient safety and experience to be included in 2020/21. • Interim improvement plan for FM services was now in place. • Delay in progress in agile, disposal, HQ options, training and pharmacy accommodation. • Internal Audit report actions progressing but risk of slippage. FPC was reasonably assured around estates' projects but was still not assured on facilities management as improvement in performance had not yet been seen.	9, 10, 11
Information Governance Six Monthly Report	**Medium**	Key points to note were; • Data Security and Protection Toolkit - progressing well. • Internal Audit review had been split into two stages, stage one did not highlight any issues. • No concerns - compliance with information rights. • Significant work was taking place around cyber information security and Unified Cyber Risk Framework. FPC was reasonably assured. Good progress was being made, risks /gaps identified and actions proposed.	22
EPRR Q3 Report	**High**	FPC received an update on the actions taken following the incident at Coalville Hospital in May. The post incident review with stakeholder partners LPT, UHL and Alliance staff was being shared across.	3, 12, 15, 22
360 Assurance Six Monthly Review	**High**	Key points to note were; • The budget deficit agreed by the Consortium Board for 2019/20 of £13k had increased to £20k because of significant investment into workforce and service development. To be funded through the 2018/19 surplus. • Shortlisted finalist for the HFMA Good Governance Award. • Bank staff resources totaled 545 days, c£145k December 2019. • Trust performance targets had been largely sustained. • Client satisfaction surveys and client surveys continued to provide a positive view toward 360 Assurance.	

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

Rii

Leicestershire Partnership NHS Trust

FINANCE AND PERFORMANCE COMMITTEE – 18 FEBRUARY 2020

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 		Agreement had been reached at the Strategic Executive Board meeting to progress towards the establishment of a Section 75 Agreement with Leicester City Council for the delivery of the 0-19 Healthy Together Service. The development of 2020/21 key performance and quality indicators was underway as part of the planning process and would be available for review by FPC at its meeting in March. The annual update on Model Hospital had been released, updated to reflect 2018/19 costs. This would be used to support the Trust's efficiency and productivity strategy.	
Committee Governance  FPC Governance	**High**	A presentation was received on Step up to Great LPT Governance. Discussion focused on embedding the process of reporting for level 2 and 3 committees. FPC supported the move to a role culture approach and recommended approval by Trust Board. FPC received for information an update in respect of the next steps in the development of its governance arrangements. The focus would be on the clarification of assurances required from the level two committees, the "governance on a page" had been developed for each level two committee.	11
Organisational Risk Register 	**Medium**	A full review of all risks was currently being undertaken and a significantly improved risk register was expected to be presented to the March meeting. FPC agreed an in-depth review of the ORR would be done at that meeting. FPC was reasonably assured as good progress was being made but improvements were still being made to the ORR.	All

Report	Assurance level*	Committee escalation	ORR/Risk Reference
NHS Planning Guidance and Next Steps Draft LPT 2020/21 Financial Plan 	**Low**	FPC received a summary of key points contained in the NHS Planning Guidance issued on 31 January 2020; • Specific emphasis was on environment and sustainability; • The system would only be signing off a system plan; • LPT had submitted its finance plan but it was unlikely to be signed off as it did not currently meet NHSE/I requirements for control total. • There would be no reduction in bed capacity; • LPT was expected to sustain winter 2019/20 peak capacity in 2020/21. FPC also received the draft LPT 2020/21 financial plan, the committee acknowledged that the final plan was dependent on the LLR system plan and was to be agreed with NHSE/I. There was still a system gap and control total of c£30m. The actual level of CIP for LPT had not yet been agreed. FPC was not assured as there was still uncertainty about the level of LPT's control total and CIP and what would be included in the contract.	17
Business Case for Mental Health Facilitators 	**Green**	FPC received the business case which had previously been presented to SEB as the value was greater than £1m income. The committee acknowledged that not all costs had been identified however; it was a very positive development for the Trust. The recommendation to Trust Board would be to approve the business case subject to this being delivered within the commissioner financial envelopment. FPC was assured as all risks had been identified and mitigated.	
Counter Fraud, Bribery & Corruption Policy		FPC approved the content of the updated policy which had been presented to the Audit and Assurance Committee (AAC) in December 2019. The committee acknowledged the policy would be formally approved by the Policy Group.	
Treasury Management Policy		The Committee noted the revised Treasury Management Policy activities in 2019/20 and approved the changes made subject to confirmation of the narrative on the 2020/21 position.	
2019/20 Accounting Policies and SFI/SORD changes		The Committee agreed the accounting policies for the preparation of the 2019/20 accounts, and noted they would be reviewed again by the AAC prior to Trust Board approval. The key change that would have an impact on this year's accounts related to land valuations. FPC also agreed the proposed changes to the SFIs and SORD however; concern was raised about the approval levels for the Capital Management Committee as there was inconsistency with the scheme of delegation for current budget virements. This would be reviewed and amended prior to submission to AAC and Trust Board for final sign off.	

Report	Assurance level*	Committee escalation	ORR/Risk Reference
Performance Report 	**Medium**	Performance headlines from December data were presented. Key points to note were; • The out of area placement trajectory was being met and good feedback had been received from NHSI. • The Trust had delivered the seven-day CPA standard in November and continued to deliver the gatekeeping measure in December. A positive position in terms of receiving limited assurance for the Quality Account was noted. • The Trust performance against the Referral to Treatment 18-week incomplete standard for ASD would no longer be reported in January data. • The national audiology incomplete target had been met in January although it had not been expected to be. • KPI setting was currently being carried out with executive directors for 2020/21. FPC received an update on the new CHS two-week and two-day waiting time targets linked to the national Ageing Well programme. The Committee noted this was national trail blazing work to build a unit that captured an integrated service offer across health and social care. There were some known data quality issues but by May the expectation was the data should be more accurate. The national standard was not due to be delivered until 2023/24 but as an accelerator site, LPT was looking to deliver it by March 2021 subject to the level of investment it received. FPC was reasonably assured, it acknowledged there were still some issues identified to be addressed.	20
Waiting Times Report 	**Low**	A highlight report from the meeting on 20 January 2020 was received. The Waiting Times and Harm Reduction Groups were to merge to ensure momentum of work to date was not lost and focus on strategic improvement was sustained. 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 December 2019. **Priority Services** • Significant improvement was seen for those services that were green. • There was also a significant improvement in achieving local targets. **52 week waits** • There had been an increase in patients who were waiting more than 52 weeks for first appointment. The Committee was not assured.	28
Capital Committee	**Medium**	A highlight report from the meeting on 15 January 2020 was received. Discussion had focused on diverting any slippage in 2019/20 to ensure there was no underspend on capital. The draft capital allocation for 2020/21 had been reviewed.	17

Report	Assurance level*	Committee escalation	ORR/Risk Reference
Finance Report Month 10 2019/20	**Low**	An update on the financial position for the period ended January 2020 was received, key points were; • The Trust was reporting a surplus of £1,820k at the end of January 2020 and achievement of the statutory break-even duty by the end of the year was fully expected. However, FPC noted there were some significant pressures still to be taken account of. • Concern was raised about aged creditors and aged debtors as a significant number were greater than 90 days and provision may need to be increased. FPC was not assured, it was satisfied with the process in place, whilst recognising the continued ongoing risks and pressures.	17, 22
Directorate Finance Summaries	**Low**	**AMH** - The current position was approximately £112k off plan, planned crisis income (£110k) included in the control total was not recognised in the position. The main issues related to out of area placements, inpatient areas, high consultant vacancies and CMHT vacancy rate. FPC noted an increasing grip around the main financial pressures.	
		LD - The forecast currently stood at £797k adverse. Acuity was very high but a plan was in place.	
		FYPC - The agreed control total was £125k over, a breakeven position was expected but Ward 3 was in a very challenged position currently.	
		CHS - The directorate was reporting an overall underspend of £51k at month 10, and was confident it would achieve its control total.	
Estates and Facilities Management Update	**Medium**	Key points to note were; • A site selection workshop had taken place for the adult mental health SOC and the Bradgate Unit had been identified as the preferred option, NHSI approval was still required. • The Internal Audit follow up report had been re-submitted, there were still some red risks. • The PLACE scores were a little disappointing, an action plan would be developed in conjunction with colleagues at Northamptonshire Healthcare NHS FT. FPC was reasonably assured around estates' projects but was still not assured on facilities management.	9, 10, 11
IM&T Committee	**Medium**	A highlight report from the meeting on 16 January 2020 was received. FPC noted the issue regarding the Community Services Data Sets currently RAG rated red related to the specialist skill set required for two high profile projects. In-depth discussion would be held at the next meeting to try and resolve the issue.	22

Chair	**Faisal Hussain, Non-Executive Director**

Leicestershire Partnership NHS Trust

Meeting Name and date	**Trust Board 3rd March 2020**
Paper Reference	**Si**

Name of Report:	**Month 9 Trust Finance Report**

For approval		For assurance		For Performance	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	21 January 2020

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

Recommendations of the report

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

Leicestershire Partnership NHS Trust

Finance Report for the period ended **31 December 2019**

For presentation at the **Trust Board meeting 4 February 2020**

Leicestershire Partnership NHS Trust

Contents

Executive Summary and overall performance against targets

Introduction

1. This report presents the financial position for the period ended 31 December 2019 (month 9). The report shows a £1,585k surplus, which is in line with plan.

2. Operational budgets are currently overspending by £3,193k. The run-rate overspend for month 9 was £184k. The overspend rate has worsened again slightly this month (it was £159k in month M8 and £275k in month 7). Whilst Central reserves are now exhausted, further fortuitous assumptions have provided enough benefit to balance the position. Such gains cannot be relied upon going forwards and it remains imperative that the operational position is brought into financial balance as a matter of urgency.

3. Adult Mental Health and Estates directorates both show overspends of £1.2m. Other overspends include Learning Disabilities (£0.7m), FYPC (£0.2m) and Hosted (£0.4m). Community Health Services are now broadly breaking even against budget. Enabling is the only directorate which is reporting an underspend (£474k).

4. Closing cash for December stood at £11.3m. This equates to 15.4 days' operating costs, and is above the planned cash level of £6.4m for December.

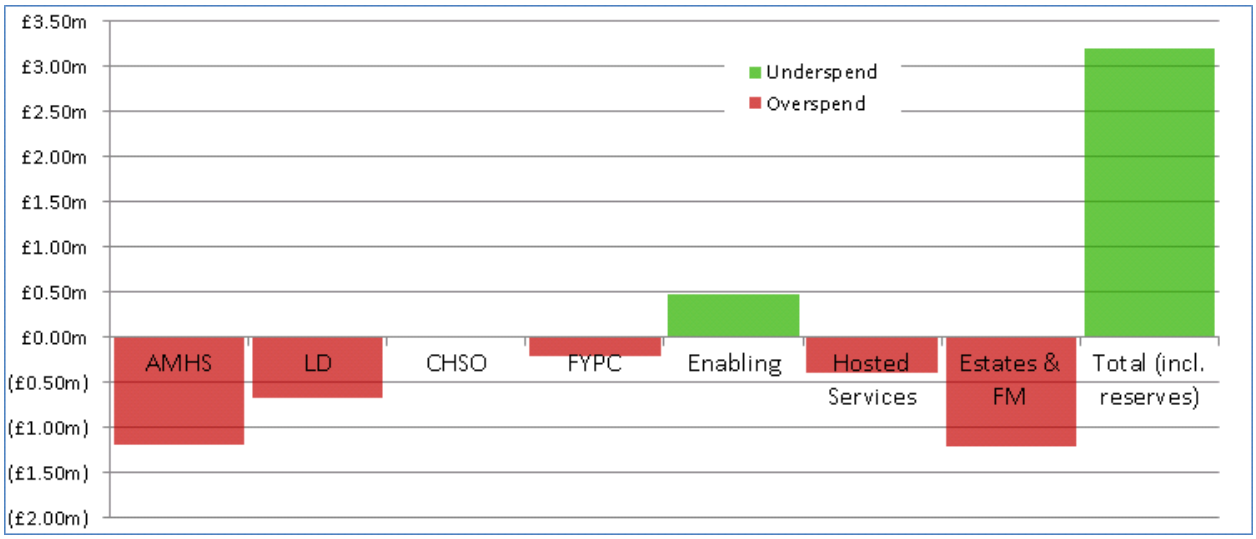
NHS Trust Statutory Duties	Year to date	Year end f'cast	Comments
1. Income and Expenditure break-even.	G	G	The Trust is reporting a surplus of £1,585k at the end of December 2019. This is in line with the Trust plan. Despite the year end risks to the planned surplus, achievement of I&E break-even is now expected **[see 'Service I&E position' and *Appendix A*]**.
2. Remain within Capital Resource Limit (CRL).	G	G	The capital spend for December is £6.8m, 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 £11.3m are currently above target. The forecast year end cash balance will deliver the EFL requirement.

Secondary targets	Year to date	Year end f'cast	Comments
5. Comply with Better Payment Practice Code (BPPC).	G	G	The target is to pay 95% of invoices within 30 days. Cumulatively the Trust achieved all of the 4 BPPC targets in December. 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 £1,965k achieved compared to a £2,852k year to date target (equating to 69% delivery) at the end of month 9. The year end forecast (for operational schemes) currently shows 72% 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 £1,585k has been reported in month 9, 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 Plan and 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 £11.3m was achieved at the end of December 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 £6,759k at the end of month 9; £644k (9%) below plan. **[See 'Capital Programme 2019/20']**

Income and Expenditure position

The month 9 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.



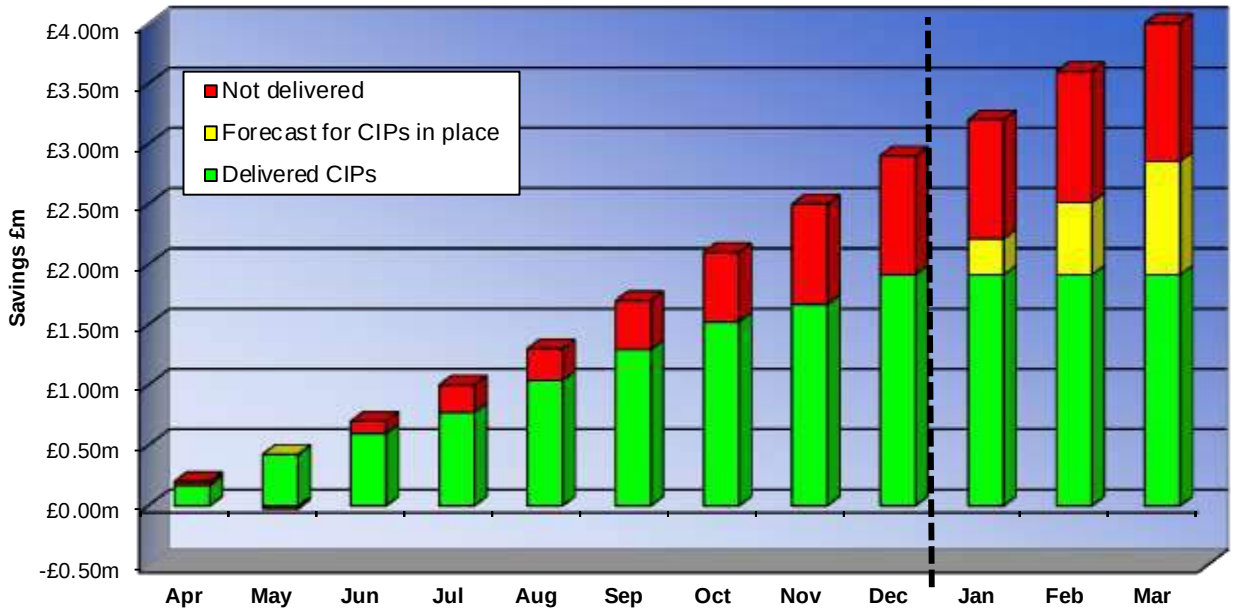
Income and expenditure forecast

The month 9 operational overspend of £3,193k represents a negative movement of £184k compared to month 8 (£3,009k). The central reserves budgets which are offsetting this overspend 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.

Appendix F (risks, pressures and mitigations) provides details of the risk-adjusted year end forecast. The Learning Disabilities position forecast has worsened by almost £0.3m since last month, increasing the requirement for additional solutions to almost £1m if the year end planned surplus is to be achieved. A verbal update on this position will be provided during the meeting.

Directorate Efficiency Savings Programme

CIP performance (directorate schemes) as at month 9



	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	1,965	1,965	1,965	1,965
Forecast achieved	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*298*	*601*	*941*
Total savings:	**169**	**474**	**648**	**824**	**1,089**	**1,345**	**1,575**	**1,719**	**1,965**	**2,263**	**2,565**	**2,906**
Variance:	**(43)**	**47**	**(24)**	**(143)**	**(217)**	**(321)**	**(485)**	**(737)**	**(887)**	**(986)**	**(1,082)**	**(1,141)**

At the end of December, CIP delivery amounted to £1,965k, against an overall year to date target of £2,852k. This equates to 69% delivery.

The year end forecast predicts performance significantly lower than plan by the end of March 2020 (72% 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: December 2020	2018/19 31/03/19 Audited £'000's	2019/20 31/12/19 December £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	200,260	201,510
Intangible assets	1,909	1,691
Trade and other receivables	653	653
Total Non Current Assets	**202,822**	**203,854**
CURRENT ASSETS		
Inventories	319	392
Trade and other receivables	13,802	15,842
Cash and Cash Equivalents	8,357	11,324
Total Current Assets	**22,478**	**27,558**
Non current assets held for sale	**0**	**0**
TOTAL ASSETS	**225,300**	**231,412**
CURRENT LIABILITIES		
Trade and other payables	(14,856)	(18,765)
Borrowings	(220)	(220)
Capital Investment Loan - Current	(190)	(190)
Provisions	(1,202)	(395)
Total Current Liabilities	**(16,468)**	**(19,570)**
NET CURRENT ASSETS (LIABILITIES)	**6,010**	**7,988**
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**	**199,342**
TAXPAYERS' EQUITY		
Public Dividend Capital	83,675	85,263
Retained Earnings	48,288	49,873
Revaluation reserve	64,205	64,205
TOTAL TAXPAYERS EQUITY	**196,168**	**199,342**

Non-current assets

- Property, plant and equipment (PPE) amounts to £202m. This balance will continue to increase as capital spend accelerates in the final quarter of the year.

Current assets

- Current assets of £27.6m include cash of £11.3m and receivables of £15.8m.

Current Liabilities

- Current liabilities amount to £19.6m and mainly relate to payables of £18.8m
- Net current assets / (liabilities) show net assets of £8m.

Working capital

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

Taxpayers' Equity

- December's year to date surplus of £1,585k is reflected within retained earnings.

Cash and Working Capital

12 Months Cash Analysis Apr 18 to Mar 19

Cash – Key Points

December's closing cash balance is £11.3m and equates to 15.4 days' operating expenses - this is £4.9m above the planned cash balance of £6.4m.

The £4.9m 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 M9, the debt owed from customers is less than expected and the amount the Trust owes to its suppliers continues to be 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 £15.8m.

Receivables	Current Month (December 2019)					
	NHS	Non NHS	Emp's	Total	% Total	% Sales Ledger
	£'000	£'000	£'000	£'000		
Sales Ledger						
30 days or less	1,438	399	7	**1,844**	**11.4%**	**24.3%**
31 - 60 days	1,499	98	5	**1,602**	**9.9%**	**21.1%**
61 - 90 days	548	121	3	**672**	**4.1%**	**8.9%**
Over 90 days	2,652	640	165	**3,457**	**21.3%**	**45.6%**
	6,137	1,258	180	**7,575**	**46.8%**	**100.0%**
Non sales ledger	5,958	2,309	0	**8,267**	**51.0%**	
Total receivables current	**12,095**	**3,567**	**180**	**15,842**	**97.8%**	
Total receivables non current		360		360	**2.2%**	
Total	**12,095**	**3,927**	**180**	**16,202**	**100.0%**	**0.0%**

Debt greater than 90 days amounts to £3.5m, an increase of £45k since last month. Receivables over 90 days should not account for more than 5% of the overall total receivables balance. The proportion at Month 9 is 21.3% (last month: 20.3%).

Aged debts > 90 days

Based on the RAG ratings below (see key), £3.5m (491 invoices) are greater than 90 days old. Work is continuing with clearing the red rated debts; the value and number of invoices have increased by £158k (14 invoices) during the month. The Accounts Receivable (AR) team focus on the green and amber debts, whilst the red debts are passed to Service areas once all general debt recovery processes have been exhausted. The majority of 'red' invoices relate to disputed AMH out-of-area (OOA) recharges; the monthly increase relates to outstanding Derbyshire CCG OOA invoices.

RAG	M6		M7		M8		M9		Diff	
	£000	No	£000	No	£000	No	£000	No	£000	No
Green	1,733	325	2,039	331	1,979	331	1,869	325	(110)	(6)
Amber	1,134	105	1,271	112	869	100	866	109	(3)	9
Red	564	45	564	44	564	43	722	57	158	14
Total	3,431	475	3,874	487	3,412	474	3,457	491	45	17

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

The red rated debts of £722k comprise of NHS (£483k) and Non-NHS (£239k) debts. The current bad debt provision of £374k can only support Non-NHS debt (NHS rules do not allow us to provide for NHS debt); therefore the financial risk only relates to the NHS debt of £483k. Work is ongoing with Derbyshire CCG to help resolve their total disputed OOA invoices of £350k - at this stage we are relooking into the activity data to help resolve the queries from the CCG. The remaining NHS debt of £133k relates to other OOA recharges and UHL invoices.

There has not been any movement in the general bad debt provision of £374k since the start of the financial year. Any debt write-offs will be undertaken as part of the year end accounts process.

Payables

The current payables position in Month 9 is £18.8m, an increase of £689k 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 December 2019				
	NHS £'000	Non NHS £'000	Total £'000	% Total	% Purchase Ledger
Purchase Ledger					
30 days or less	2,011	1,258	**3,269**	**17.4%**	**50.1%**
31 - 60 days	21	2	**23**	**0.1%**	**0.4%**
61 - 90 days	915	4	**919**	**4.9%**	**14.1%**
Over 90 days	2,258	60	**2,318**	**12.4%**	**35.5%**
	5,205	1,324	**6,529**	**34.8%**	**100.0%**
Non purchase ledger	2,709	9,527	**12,236**	**65.2%**	
Total Payables Current	**7,914**	**10,851**	**18,765**	**100.0%**	
Total Payables Non Current	0	0	**0**		
Total	7,914	10,851	18,765	**100.0%**	

Better Payment Practice Code (BPPC)

The specific target is to pay 95% of invoices within 30 days. Cumulatively the Trust achieved all of the 4 BPPC targets in December.

The Finance team introduced additional invoice monitoring processes in November, which have facilitated the delivery of all cumulative BPPC targets. In addition to this the Finance team will continue to meet with any non-complying departments to help improve the position further.

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

Capital Programme 2019/20

Capital expenditure totals £6.8m at the end of month 9, £644k (or 9%) below plan. The monthly spend is forecast to increase in the final quarter 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.

Approval of our CRL uplift has now been received. In addition to the £1.6m increase from internally generated cash (from previous year's I&E surplus), new funding has also been granted for energy efficient LED lighting (£174k). The Trust is also in the process of finalising 2019/20 new national capital funding for IM&T initiatives.

The 2020/21 capital plan is in the process of being finalised; the Estates and IM&T strategy groups have reviewed capital requirements for next year and the Capital Management Committee is now in the process of prioritising bids in line with Trust priorities.

	Annual Plan	Dec YTD Plan	Dec YTD Actual	Dec YTD Variance	Year End Forecast	Revision to Plan
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Depreciation	7,179	4,673	3,965	(708)	7,179	0
PDC capital for CAMHS	5,102	2,730	2,730	0	5,102	0
PDC capital for Digital Hub	0	0	64	64	435	435
PFI Agnes Unit capital lifecycle replacement	100	0	0	0	100	0
I&E Surplus (CRL confirmed)	1,576	0	0	0	1,576	0
Asset Sales	0	0	0	0	0	0
Total Capital funds	**13,957**	**7,403**	**6,759**	**(644)**	**14,392**	**435**
Application of Funds	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Estates & Innovation						
Service Improvements	(7,138)	(3,791)	(3,651)	140	(7,139)	(1)
Estates & Equipment	(2,911)	(1,699)	(751)	948	(2,539)	372
Sub-total:	**(10,049)**	**(5,490)**	**(4,402)**	**1,088**	**(9,678)**	**371**
IT Programme	**(3,908)**	**(1,913)**	**(2,357)**	**(444)**	**(4,714)**	**(806)**
Total Capital Expenditure	**(13,957)**	**(7,403)**	**(6,759)**	**644**	**(14,392)**	**(435)**
(Over)/underspend against resource available	**0**	**0**	**0**	**0**	**0**	**0**

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 31st December 2019	YTD Actual M9 £000	YTD Plan M9 £000	YTD Var. M9 £000	Year end forecast £000
Revenue				
Total income	213,834	208,915	4,919	278,567
Operating expenses	(206,913)	(201,995)	(4,918)	(268,805)
Operating surplus (deficit)	**6,921**	**6,920**	**1**	**9,762**
Investment revenue	27	27	(0)	36
Other gains and (losses)	0	0	0	0
Finance costs	(747)	(747)	0	(996)
Surplus/(deficit) for the period	**6,200**	**6,200**	**0**	**8,802**
Public dividend capital dividends payable	(4,615)	(4,615)	(0)	(6,154)
I&E surplus/(deficit) for the period (before tech. adjs)	**1,585**	**1,585**	**(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	**1,585**	**1,585**	**(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:	**1,585**	**1,585**	**(0)**	**2,648**
Trust EBITDA £000	**12,600**	**12,599**	**1**	**17,336**
Trust EBITDA margin %	**5.9%**	**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	480	674
	Actual / *Forecast*	0	141	10	12	48	18	-40	-125	-24	30	34	68	39	172
	Variance	-25	116	-47	-49	-13	-43	-103	-188	-87	-34	-31	3	-440	-502
	Cumulative Variance	-25	91	44	-5	-18	-62	-165	-353	-440	-474	-505	-502		
	Cuml. % delivered	0%	280%	141%	97%	92%	79%	53%	15%	8%	13%	17%	25%	8%	25%
FYPC	Plan	49	49	49	49	49	49	49	49	49	49	49	49	440	586
	Actual / *Forecast*	49	49	49	49	49	49	49	49	49	49	49	49	440	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	653	870
	Actual / *Forecast*	73	73	73	73	73	73	73	73	73	73	73	73	653	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	416	555
	Actual / *Forecast*	45	38	38	38	46	46	46	45	45	44	44	46	387	521
	Variance	-1	-8	-8	-8	0	0	0	-1	-1	-2	-2	0	-29	-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	559	862
	Actual / *Forecast*	2	5	5	5	5	5	38	38	38	38	38	40	141	257
	Variance	-17	-17	-17	-61	-61	-61	-61	-62	-62	-62	-63	-62	-418	-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%	25%	30%
Trust-wide savings	Plan	0	0	0	0	45	65	65	65	65	65	65	65	305	500
	Actual / *Forecast*	0	0	0	0	45	65	65	65	65	65	65	65	305	500
	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	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	100%
Total	Plan	**212**	**215**	**246**	**295**	**340**	**360**	**394**	**396**	**396**	**397**	**399**	**400**	2,852	4,047
	Actual / *Forecast*	**169**	**305**	**174**	**176**	**265**	**255**	**230**	**144**	**245**	**298**	**302**	**341**	1,965	2,906
	Variance	**-43**	**91**	**-72**	**-118**	**-74**	**-104**	**-164**	**-251**	**-150**	**-99**	**-96**	**-59**	-887	-1,141
	Cumulative Variance	-43	47	-24	-143	-217	-321	-485	-737	-887	-986	-1,082	-1,141		
														69%	72%
Cumulative Delivered		**80%**	**111%**	**96%**	**85%**	**83%**	**81%**	**76%**	**70%**	**69%**	**70%**	**70%**	**72%**		

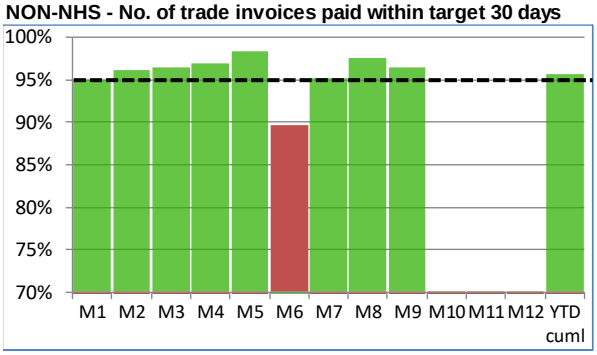
APPENDIX C – BPPC performance

Trust performance – current month (cumulative) v previous

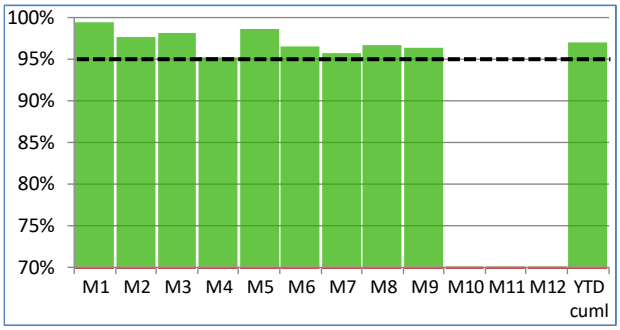
Better Payment Practice Code	December (Cumulative)		November (Cumulative)	
	Number	£000's	Number	£000's
Total Non-NHS trade invoices paid in the year	21,178	77,586	18,994	68,670
Total Non-NHS trade invoices paid within target	20,280	75,337	18,172	66,735
% of Non-NHS trade invoices paid within target	**95.8%**	**97.1%**	**95.7%**	**97.2%**
Total NHS trade invoices paid in the year	635	38,446	584	34,915
Total NHS trade invoices paid within target	604	38,218	554	34,698
% of NHS trade invoices paid within target	**95.1%**	**99.4%**	**94.9%**	**99.4%**
Grand total trade invoices paid in the year	21,813	116,032	19,578	103,585
Grand total trade invoices paid within target	20,884	113,555	18,726	101,433
% of total trade invoices paid within target	**95.7%**	**97.9%**	**95.6%**	**97.9%**

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

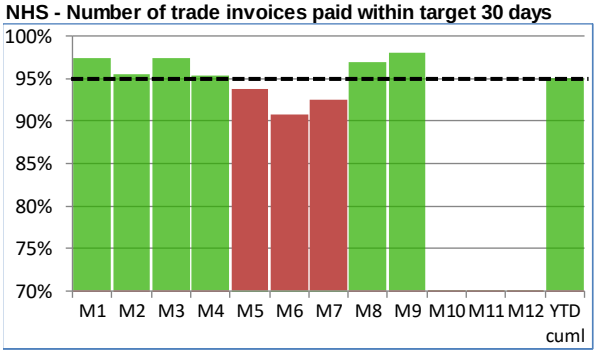
NON-NHS - No. of trade invoices paid within target 30 days



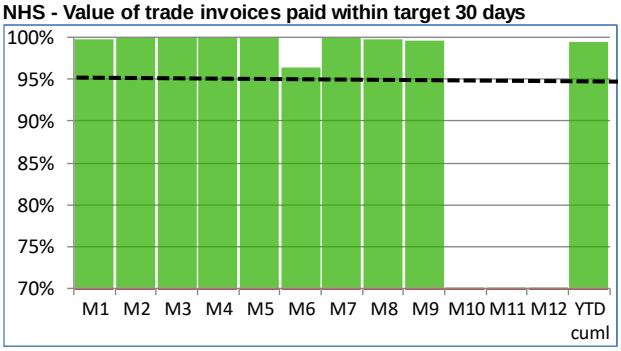
NON-NHS - Value of trade invoices paid within target 30 days



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 Actual	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	-77	-95	-95	-75	-751	-1,016
Agency Nursing	-1,528	-127	-122	-142	-158	-173	-157	-214	-144	-147	-166	-150	-140	-145	-1,256	-1,857
Agency Scient, Therap. & Tech	-232	-19	-33	-18	-21	-26	-23	-12	-22	-15	-16	-18	-18	-18	-170	-241
Agency Non clinical staff costs	-409	-34	-48	-43	-31	-14	-25	-38	-7	-16	-5	-10	-10	-10	-222	-257
Sub-total	**-2,778**	**-231**	**-264**	**-267**	**-303**	**-273**	**-280**	**-350**	**-292**	**-295**	**-264**	**-273**	**-263**	**-248**	-2,324	**-3,372**
CHS																
Agency Consultant Costs	-182	-15	-15	-15	-12	-13	-11	-15	-18	-12	-13	-7	-7	-7	-110	-144
Agency Nursing	-3,579	-298	-306	-243	-305	-332	-302	-279	-298	-252	-345	-290	-250	-240	-2,317	-3,442
Agency Scient, Therap. & Tech	-644	-54	-54	-41	-47	-53	-49	-39	-30	-28	-28	-45	-45	-45	-341	-504
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**	**-386**	**-342**	**-302**	**-292**	-2,768	**-4,091**
FYPC																
Agency Consultant Costs	-429	-36	-42	-12	-29	-30	-41	-28	-37	-67	-37	-45	-45	-45	-287	-459
Agency Nursing	-521	-43	-118	-160	-163	-94	-96	-160	-132	-137	-89	-50	-30	-30	-1,060	-1,259
Agency Scient, Therap. & Tech	-26	-2	-4	-7	-11	-16	-5	-9	-10	-4	-6	-4	-3	-3	-67	-83
Agency Non clinical staff costs	-32	-3	-8	-15	-15	-28	-3	-8	-5	-5	1	-3	-2	-2	-88	-94
Sub-total	**-1,007**	**-84**	**-172**	**-194**	**-218**	**-168**	**-145**	**-205**	**-185**	**-214**	**-131**	**-102**	**-80**	**-80**	-1,502	**-1,895**
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	-6	0	0	0	29	23
Agency Scient, Therap. & Tech	-42	-4	-7	-4	-8	-10	-8	-5	-10	-23	-20	-9	-9	-9	-75	-122
Agency Non clinical staff costs	-623	-52	-22	-31	-24	-27	-19	-33	-36	-42	-68	-25	-25	-25	-233	-376
Sub-total	**-714**	**-60**	**-28**	**-6**	**-32**	**-38**	**-27**	**-38**	**-46**	**-65**	**-94**	**-34**	**-34**	**-34**	-279	**-475**
TOTAL TRUST																
Agency Consultant Costs	-1,220	-102	-117	-90	-136	-103	-126	-130	-174	-196	-127	-147	-147	-127	-1,198	-1,619
Agency Nursing	-5,676	-473	-546	-516	-626	-599	-556	-653	-574	-536	-606	-490	-420	-415	-5,210	-6,535
Agency Scient, Therap. & Tech	-944	-79	-99	-71	-87	-105	-85	-65	-72	-70	-71	-76	-75	-75	-725	-951
Agency Non clinical staff costs	-1,107	-92	-78	-89	-70	-70	-47	-79	-48	-63	-72	-38	-37	-37	-616	-728
Total	**-8,946**	**-746**	**-839**	**-766**	**-918**	**-877**	**-814**	**-926**	**-868**	**-865**	**-876**	**-751**	**-679**	**-654**	-7,749	**-9,833**
Agency ceiling (£8,122k)			-675	-677	-677	-677	-677	-677	-677	-677	-677	-677	-677	-677	-6,091	-8,122
Variance (+better/-worse)			**-164**	**-89**	**-241**	**-200**	**-137**	**-249**	**-191**	**-188**	**-199**	**-74**	**-2**	**23**	-1,658	**-1,711**
Trust financial plan			-710	-681	-680	-678	-677	-675	-674	-670	-673	-675	-673	-656	-6,118	-8,122
Variance (+better/-worse)			**-129**	**-85**	**-238**	**-199**	**-137**	**-251**	**-194**	**-195**	**-203**	**-76**	**-6**	**2**	-1,631	**-1,711**

At month 9, total Trust agency costs were £7,749k. This is higher than year-to-date planned spend of £6,118k, and also higher than the year-to-date agency spend ceiling of £6,091k 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 9, the revised forecast for the year is £9.8m against the plan / NHSI ceiling of £8.1m.

APPENDIX E – Cash flow forecast

APPENDIX E: 2019/20 CASH-FLOW FORECAST	DEC FORECAST £'000	DEC ACTUAL £'000	DEC VARIANCE £'000	JAN FORECAST £'000	FEB FORECAST £'000	MAR FORECAST £'000	YTD ACTUAL £'000	19/20 FORECAST £'000
OPENING BALANCE	**10,189**	**10,189**	**0**	**11,324**	**10,945**	**12,705**	**8,356**	**8,356**
INCOME								
CCG Block Contracts	17,995	17,995	**0**	18,196	17,995	17,995	161,951	216,137
NHS England Specialist Commissioning Contracts	623	350	**(273)**	623	623	735	5,562	7,543
Health Education England Medical Training Contracts	716	716	**0**	710	708	715	6,842	8,975
Local Authorities	1,437	2,117	**680**	1,437	1,437	2,157	12,288	17,319
UHL Contracts	200	200	**0**	200	200	400	1,600	2,400
Non Contract Activity (NCA) re service provision for Non- Leicester patients	198	382	**184**	325	325	574	2,248	3,472
Health Informatics Service (HIS)	1,187	885	**(302)**	940	950	1,236	2,972	6,098
360 Assurance Audit Services	453	226	**(227)**	420	242	323	1,457	2,442
Property income for rents and service charges	1,134	0	**(1,134)**	126	1,260	126	0	1,512
STP Funding 19/20	322	430	**108**	357	0	608	752	1,717
STP Funding 18/19 - Q4 plus incentive and bonus allocation	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
HMRC VAT reclaims	259	190	**(69)**	259	259	259	2,467	3,244
Property disposals	0	0	**0**	0	0	0	0	0
Capital Loan	0	0	**0**	0	0	0	0	0
Other income receipts and recharges (including PDC)	830	568	**(262)**	2,390	673	2,265	6,218	11,545
PDC capital funding support	1,476	0	**(1,476)**	0	1,476	2,472	1,589	5,537
Income receipts relating to previous year	98	58	**(40)**	98	98	98	6,234	6,528
Total Receipts	**26,928**	**24,117**	**(2,811)**	**26,081**	**26,246**	**29,963**	**215,360**	**297,649**
PAYMENTS								
Payroll	16,990	17,148	**158**	17,250	16,990	17,050	153,575	204,865
Capital	2,419	1,000	**(1,419)**	1,525	1,164	2,569	5,634	10,892
Non pay general expenditure	5,157	3,665	**(1,492)**	4,700	4,200	6,466	34,570	49,936
UHL - Estates & FM Services	827	0	**(827)**	827	827	1,654	5,789	9,097
UHL - Other contracts	352	176	**(176)**	176	176	352	1,412	2,116
Rents and Service Charges (NHS Properties & Community Health Partnership)	1,143	94	**(1,049)**	1,282	329	425	1,912	3,948
HCL Agency Nursing Costs	388	577	**189**	400	500	531	3,712	5,143
Out of Area (OOA) costs for patients placed in private hospitals	396	322	**(74)**	300	300	300	2,753	3,653
Public dividend capital payment (PDC)	0	0	**0**	0	0	3,077	2,798	5,875
Other finance costs (inc loan interest and principal repayments)	0	0	**0**	0	0	0	237	237
Total Payments	**27,672**	**22,982**	**(4,690)**	**26,460**	**24,486**	**32,424**	**212,392**	**295,762**
CLOSING CASH BOOK BALANCE	**9,445**	**11,324**	**1,880**	**10,945**	**12,705**	**10,244**	**11,324**	**10,244**
Plan	**6,436**	**6,436**	**0**	**7,383**	**8,711**	**8,000**	**7,216**	**8,000**
Variance to plan	**3,009**	**4,888**	**1,880**	**3,562**	**3,994**	**2,244**	**4,108**	**2,244**

APPENDIX F – Risks, Pressures and Mitigations

Risk adjusted estimated year end position as at month 9

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	(496)	(1,382)	348	559	**(971)**	(742)	(971)	(1,390)
Learning Disabilities	(100)	(887)	100	0	**(887)**	(872)	(887)	(987)
Community Health Services	(700)	0	349	451	**100**	300	100	(100)
Families, Young People and Childrens Services	0	(2,110)	1,650	335	**(125)**	0	(125)	(500)
Enabling Services	0	(386)	763	100	**477**	577	477	400
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)	(700)
Service Delivery - total	**(1,696)**	**(7,871)**	**4,403**	**1,445**	**(3,719)**	**(2,787)**	**(3,719)**	**(5,490)**
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			951	0	**951**	1,400	951	500
Trustwide/Corporate total:	**(2,490)**	**(770)**	**6,979**	**0**	**3,719**	**5,277**	**3,719**	**873**
Budget variance after net risks, pressures and mitigations	**(4,186)**	**(8,641)**	**11,382**	**1,445**	**(0)**	**2,490**	**(0)**	**(4,617)**
Trust plan surplus (includes additional £500k NHSI target)					**2,648**	**2,648**	**2,648**	**2,648**
Net I&E performance					**2,648**	**5,138**	**2,648**	**(1,969)**

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**

Leicestershire Partnership NHS Trust

Meeting Name and date	**Trust Board 3rd March 2020**
Paper Reference	**Sii**

Name of Report:	**Month 10 Trust Finance Report**

For approval		For assurance		For performance	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	18 February 2020

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

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

Leicestershire Partnership NHS Trust

Finance Report for the period ended **31 January 2020**

For presentation at the **Trust Board meeting** **5 March 2020**

Leicestershire Partnership NHS Trust

Contents

Executive Summary and overall performance against targets

Introduction

1. This report presents the financial position for the period ended 31 January 2020 (month 10). The report shows a £1,820k surplus, which is under plan by £102k. This is the first time that the Trust has reported an adverse variance, reflecting a revised year end forecast that anticipates non-delivery of the additional stretch surplus target of £0.5m. While we have informed NHSI of our changed trajectory, the formal plan against which we are monitored remains as submitted at the start of the year.

2. Operational budgets are currently overspending by £3.3m. The operational overspend run-rate for month 10 was £89k. The overspend rate has improved this month (it was £184k in month M9 and £159k in month 8). Central reserves underspends are sufficient to offset the year-to-date operational overspend. However, these reserves are now fully committed, so no additional central mitigation is available should there be any further unexpected deterioration of directorate positions.

3. Adult Mental Health and Estates directorates both show overspends of £1.3m. Other overspends include Learning Disabilities (£0.6m), FYPC (£0.2m) and Hosted (£0.4m). Community Health Services are now broadly breaking even against budget. Enabling services are reporting an underspend (£606k).

4. Closing cash for January stood at £11.4m. This equates to 15.4 days' operating costs, and is above the planned cash level of £7.4m for January.

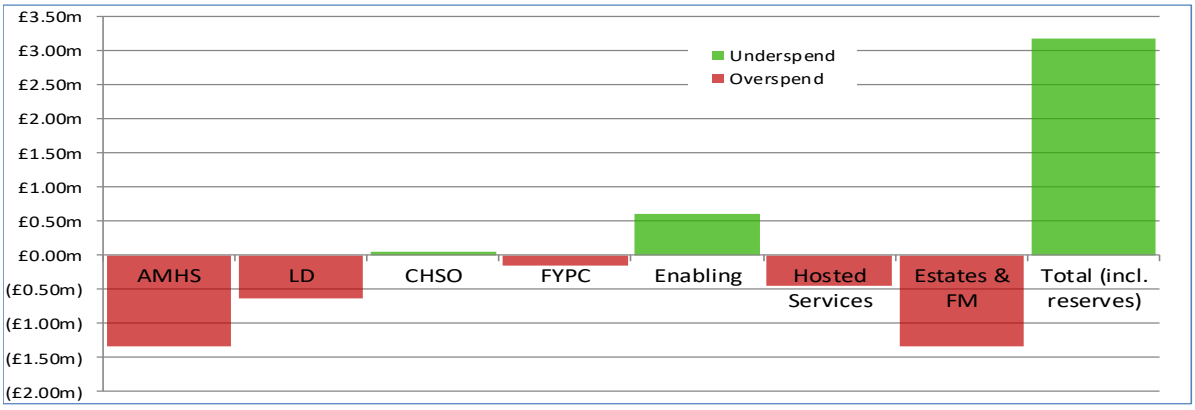
NHS Trust Statutory Duties	Year to date	Year end f'cast	Comments
1. Income and Expenditure break-even.	G	G	The Trust is reporting a surplus of £1,820k at the end of January 2020. Achievement of the statutory break-even duty by the end of the year is fully expected **[see 'Service I&E position' and *Appendix A*]**.
2. Remain within Capital Resource Limit (CRL).	G	G	The capitalspend for January is £8.6m, 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 £11.4m 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	R	The target is to pay 95% of invoices within 30 days. Cumulatively the Trust achieved 3 of the 4 BPPC targets in January. The achievement of all 4 targets is now unlikely by the end of the year.
6. Achieve Cost Improvement Programme (CIP) targets.	R	R	CIP schemes are currently under delivering, showing £2,142k achieved compared to a £3,249k year to date target (equating to 66% delivery) at the end of month 10. The year end forecast (for operational schemes) currently shows 57% 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 £1,820k has been reported in month 10, which is £102k under plan. The plan for the year assumed an overall surplus of £2.6m, incorporating a £0.5m stretch target set by NHSI. A revised forecast now assumes that the Trust will not meet the £0.5m stretch.
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 revised forecast showing non-delivery of the 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 £11.4m was achieved at the end of January 2020. 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 £8.6m at the end of month 10; £780k (8%) below plan. **[See 'Capital Programme 2019/20']**

Income and Expenditure position

The month 10 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 10 operational overspend of £3.3m represents a negative movement of £89k compared to month 9. Central reserves budget underspends are offsetting this overspend, however these reserves are now fully committed.

A revised year end forecast has been prepared which now assumes that the Trust will deliver a surplus of £2.1m against the £2.6m plan. The £0.5m shortfall represents non-delivery of the additional stretch target (built into the £2.6m plan surplus). The Trust's NHS control total (delivery of which secures the Provider Sustainability Fund income) did not incorporate the stretch element, and was therefore set at £2.1m. On this basis, despite the shortfall against plan, the control total target is still expected to be achieved.

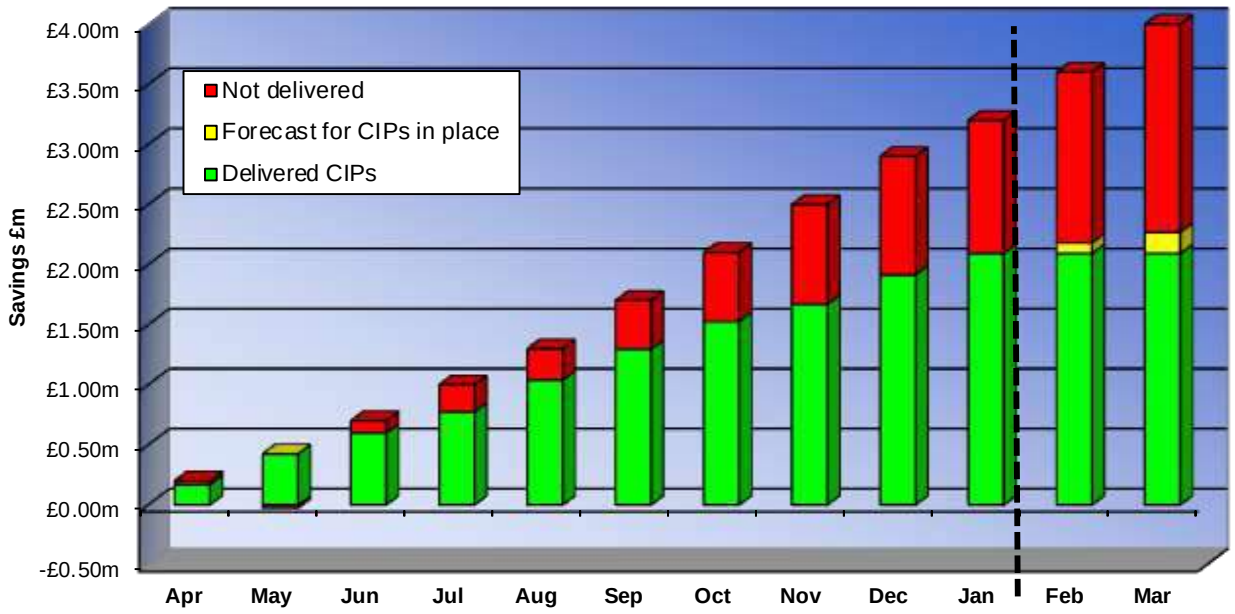
Appendix F (risks, pressures and mitigations) provides details of the risk-adjusted year end forecast. This shows performance against the £2.6m plan and the £2.1m control total.

Run-rate variances

Appendix G provides an analysis of the monthly income and expenditure run-rate of each directorate (actuals, and forecasts for the remaining 2 months). As with ***Appendix F,*** the run-rate analysis shows performance against both the £2.6m plan and the £2.1m control total. Note that, whilst the year-to-date position shows a £102k shortfall against plan, it also shows a year-to-date over-achievement of £318k against the control total target. This over-achievement against the year-to-date control total has occurred throughout the year whilst we have been achieving plan, due to the control total being lower than our planned surplus. This is demonstrated in the 'control total performance' section at the end of ***Appendix G***. Based on the current forecast, by the year end this will change to a £500k shortfall against plan and a break-even against the control total. Essentially this reflects the utilisation of central reserves, and their exhaustion after month 9.

Directorate Efficiency Savings Programme

CIP performance (directorate schemes) as at month 10



	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	1,965	2,142	2,142	2,142
Forecast achieved	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*87*	*175*
Total savings:	**169**	**474**	**648**	**824**	**1,089**	**1,345**	**1,575**	**1,719**	**1,965**	**2,142**	**2,229**	**2,317**
Variance:	**(43)**	**47**	**(24)**	**(143)**	**(217)**	**(321)**	**(485)**	**(737)**	**(887)**	**(1,107)**	**(1,418)**	**(1,730)**

At the end of January, CIP delivery amounted to £2,142k, against an overall year to date target of £3,249k. This equates to 66% delivery.

The year end forecast predicts performance significantly lower than plan by the end of March 2020 (57% delivery). The year end forecast has worsened compared to month 9, due to the recognition of the non-delivery of the £0.5m stretch target. This had been reflected as an additional CIP when the stretch target was set by NHSI in May.

Statement of Financial Position (SoFP)

PERIOD: January 2020	2018/19 31/03/19 Audited £'000's	2019/20 31/01/20 January £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	200,260	202,690
Intangible assets	1,909	1,667
Trade and other receivables	653	718
Total Non Current Assets	**202,822**	**205,075**
CURRENT ASSETS		
Inventories	319	391
Trade and other receivables	13,802	16,772
Cash and Cash Equivalents	8,357	11,394
Total Current Assets	**22,478**	**28,557**
Non current assets held for sale	**0**	**0**
TOTAL ASSETS	**225,300**	**233,632**
CURRENT LIABILITIES		
Trade and other payables	(14,856)	(21,021)
Borrowings	(220)	(263)
Capital Investment Loan - Current	(190)	(189)
Provisions	(1,202)	(345)
Total Current Liabilities	**(16,468)**	**(21,818)**
NET CURRENT ASSETS (LIABILITIES)	**6,010**	**6,739**
NON CURRENT LIABILITIES		
Borrowings	(8,025)	(7,761)
Capital Investment Loan - Non Current	(3,510)	(3,347)
Provisions	(1,129)	(1,129)
Total Non Current Liabilities	**(12,664)**	**(12,237)**
TOTAL ASSETS EMPLOYED	**196,168**	**199,576**
TAXPAYERS' EQUITY		
Public Dividend Capital	83,675	85,263
Retained Earnings	48,288	50,108
Revaluation reserve	64,205	64,205
TOTAL TAXPAYERS EQUITY	**196,168**	**199,576**

Non-current assets

- Property, plant and equipment (PPE) amounts to £203m. This balance will continue to increase as capital spend accelerates in the last two months of the year.

Current assets

- Current assets of £28.6m include cash of £11.4m and receivables of £16.8m.

Current Liabilities

- Current liabilities amount to £21.8m and mainly relate to payables of £21.0m. This balance will reduce when the PDC of c£3m is paid in March.
- Net current assets / (liabilities) show net assets of £6.7m.

Working capital

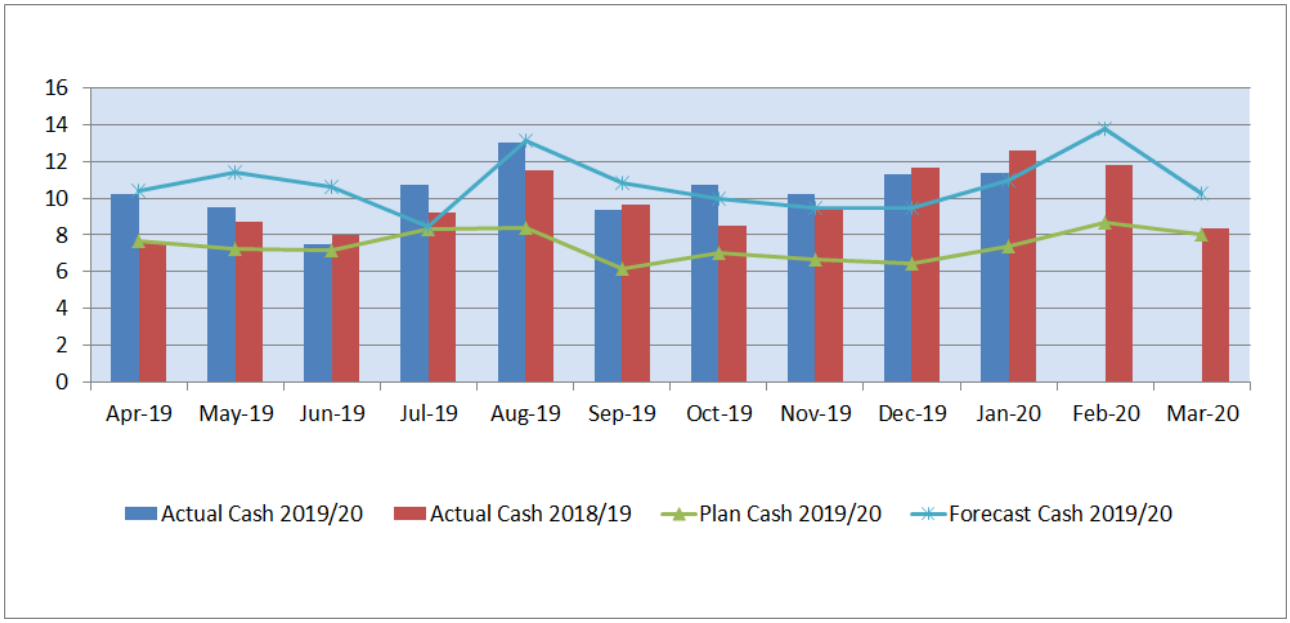
- Cash and changes in working capital are reviewed on the following pages.

Taxpayers' Equity

- January's year to date surplus of £1,820k is reflected within retained earnings.

Cash and Working Capital

12 Months Cash Analysis Apr 19 to Mar 20



Cash – Key Points

January's closing cash balance is £11.4m and equates to 15.4 days' operating expenses - this is £4.0m above the planned cash balance of £7.4m.

The £4.0m cash over-achievement against plan continues to relate to favourable working capital balances. As at M10, the debt owed from customers is less than expected and the amount the Trust owes to its suppliers continues to be higher than planned. Invoice disputes with NHS Property Services and UHL are contributing towards the increased payables balance.

The cash balance will reduce in March following payment of c£3m to the Department of Health for Public Dividend Capital (PDC), payments to capital suppliers for projects completed in the final quarter of the financial year, and part-payment (if appropriate) to those suppliers whose invoices are currently in dispute.

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 £16.8m.

Receivables	Current Month (January 2020)					
	NHS £'000	Non NHS £'000	Emp's £'000	Total £'000	% Total	% Sales Ledger
Sales Ledger						
30 days or less	1,830	1,093	3	**2,926**	**17.1%**	**34.1%**
31 - 60 days	782	190	2	**974**	**5.7%**	**11.3%**
61 - 90 days	616	68	8	**692**	**4.0%**	**8.1%**
Over 90 days	3,077	753	166	**3,996**	**23.3%**	**46.5%**
	6,305	2,104	179	**8,588**	**50.1%**	**100.0%**
Non sales ledger	6,138	2,046	0	**8,184**	**47.8%**	
Total receivables current	**12,443**	**4,150**	**179**	**16,772**	**97.9%**	
Total receivables non current		360		360	**2.1%**	
Total	**12,443**	**4,510**	**179**	**17,132**	**100.0%**	**0.0%**

Debt greater than 90 days amounts to £4.0m, an increase of £539k since last month. Receivables over 90 days should not account for more than 5% of the overall total receivables balance. The proportion at Month 10 is 23.3% (last month: 21.3%).

Aged debts > 90 days

£4m (528 invoices) are greater than 90 days old. The overall value has increased by £539k due to a number of UHL and Leicester City Council invoices now being over 90 days.

The red rated invoices have reduced by £158k (14 invoices) due to a reclassification of ratings from red to green during the month – this is mainly due to the resolution of several Derbyshire CCG OOA invoice disputes nearing completion; credit notes will be raised to clear these debts. A large number of low valued amber debts have been paid during the month, however several higher valued invoices have moved into the amber category offsetting any overall reduction in value.

Red debts are passed to Service areas once all general debt recovery processes have been exhausted by the Accounts Receivable team. The majority of 'red' invoices relate to disputed AMH out-of-area (OOA) recharges.

RAG	M8		M9		M10		Diff	
	£000	No	£000	No	£000	No	£000	No
Green	1,979	331	1,869	325	2,539	397	670	72
Amber	869	100	866	109	893	88	27	(21)
Red	564	43	722	57	564	43	(158)	(14)
Total	**3,412**	**474**	**3,457**	**491**	**3,996**	**528**	**539**	**37**

RAG ratings reflect ability to resolve debt, either through payment of invoices or raising of credit notes following invoice dispute resolution

The red rated debts of £564k comprise of NHS (£325k) and Non-NHS (£239k) debts. The current bad debt provision of £374k can only support Non-NHS debt (NHS rules do not allow us to provide for NHS debt); therefore the financial risk only relates to the NHS debt of £325k. Work is ongoing with resolving disputed OOA invoices which represent the majority of the red rated NHS debt.

There has not been any movement in the general bad debt provision of £374k since the start of the financial year. Any debt write-offs will be undertaken as part of the year end accounts process.

Payables

The current payables position in Month 10 is £21.0m, an increase of £2.3m during the month. Payables will reduce significantly in March following the PDC payment of £3m to the Department of Health, payments to capital suppliers for projects completed in the final quarter of the financial year and part-payment (if appropriate) to those suppliers whose invoices are currently in dispute. £3.2m of the £3.3m 90 days supplier debt relates to two suppliers - UHL (£0.48m) and NHS Property Services disputed invoices (£2.7m). Work is ongoing to resolve specific old year invoice disputes.

Payables	Current Month January 2020				
	NHS £'000	Non NHS £'000	Total £'000	% Total	% Purchase Ledger
Purchase Ledger					
30 days or less	1,221	1,652	**2,873**	**13.7%**	**43.7%**
31 - 60 days	192	218	**410**	**2.0%**	**6.2%**
61 - 90 days	23	2	**25**	**0.1%**	**0.4%**
Over 90 days	3,209	62	**3,271**	**15.6%**	**49.7%**
	4,645	1,934	**6,579**	**31.3%**	**100.0%**
Non purchase ledger	3,965	10,477	**14,442**	**68.7%**	
Total Payables Current	**8,610**	**12,411**	**21,021**	**100.0%**	
Total Payables Non Current	0	0	**0**		
Total	8,610	12,411	21,021	**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 January. The target not achieved during the month related to the number of NHS invoices paid within 30 days.

The Finance team introduced additional invoice monitoring processes earlier in the year which resulted in an improvement in monthly performance. However due to staff sickness in January, several departments were late in authorising invoices (of the 71 NHS invoices processed, 11 were paid after 30 days). The Finance team will continue to meet with any non-complying departments to help improve the position further. With only two months remaining it is now unlikely all four targets will be achieved by the end of the financial year. Further details are shown in ***Appendix C***.

Capital Programme 2019/20

Capital expenditure totals £8.6m at the end of month 10, £755k (or 8%) below plan. The monthly spend is forecast to increase in the final two months of the financial year due to payment of Interserve invoices for the construction of the CAMHS unit, Bradgate ward refurbishments, Trust-wide backlog maintenance works and IM&T expenditure.

New PDC funding of £435k has been received this month to support IM&T digital investment. Capital spend has been reviewed in detail this month. Any identified expenditure slippage will be used to support current project overspends or new schemes that can be completed by the end of the financial year. The Capital Committee will agree any changes to the capital programme at its meeting in February and an update will be provided in next month's finance report.

The 2020/21 capital plan is in the process of being finalised; the Estates and IM&T strategy groups have reviewed capital requirements for next year and the Capital Management Committee has prioritised bids in line with Trust priorities.

	Annual Plan	Jan YTD Plan	Jan YTD Actual	Jan YTD Variance	Year End Forecast	Revision to Plan
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Depreciation	7,179	5,983	5,544	(439)	7,179	0
PDC capital for CAMHS	5,102	3,007	3,007	0	5,102	0
PDC capital for Digital Hub	0	0	0	0	435	435
PDC LED Lighting efficiencies	0	0	0	0	174	174
PFI Agnes Unit capital lifecycle replacement	100	0	0	0	69	(31)
I&E Surplus (CRL confirmed)	1,576	336	0	(336)	1,576	0
Asset Sales	0	0	0	0	0	0
Total Capital funds	**13,957**	**9,326**	**8,551**	**(775)**	**14,535**	**578**
Application of Funds	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Estates & Innovation						
Service Improvements	(7,138)	(4,535)	(4,541)	(6)	(7,264)	(126)
Estates & Equipment	(2,911)	(2,253)	(922)	1,331	(2,747)	164
Sub-total:	**(10,049)**	**(6,788)**	**(5,463)**	**1,325**	**(10,011)**	**38**
IT Programme	**(3,908)**	**(2,538)**	**(3,088)**	**(550)**	**(4,524)**	**(616)**
Total Capital Expenditure	**(13,957)**	**(9,326)**	**(8,551)**	**775**	**(14,535)**	**(578)**
(Over)/underspend against resource available	**0**	**0**	**0**	**0**	**0**	**0**

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 31st January 2020	YTD Actual M10 £000	YTD Plan M10 £000	YTD Var. M10 £000	Year end forecast £000
Revenue				
Total income	237,663	232,137	5,526	278,567
Operating expenses	(229,915)	(224,287)	(5,628)	(269,305)
Operating surplus (deficit)	**7,748**	**7,850**	**(102)**	**9,262**
Investment revenue	30	30	0	36
Other gains and (losses)	0	0	0	0
Finance costs	(830)	(830)	0	(996)
Surplus/(deficit) for the period	**6,948**	**7,050**	**(102)**	**8,302**
Public dividend capital dividends payable	(5,128)	(5,128)	(0)	(6,154)
I&E surplus/(deficit) for the period (before tech. adjs)	**1,820**	**1,922**	**(102)**	**2,148**
IFRIC 12 adjustments	0	0	0	0
Donated/government grant asset reserve adj	0	0	0	0
Technical adjustment for impairments	0	0	0	0
NHSI I&E control total surplus	**1,820**	**1,922**	**(102)**	**2,148**
Other comprehensive income (Exc. Technical Adjs)				
Impairments and reversals	0	0	0	0
Gains on revaluations	0	0	0	0
Total comprehensive income for the period:	**1,820**	**1,922**	**(102)**	**2,148**
Trust EBITDA £000	**14,059**	**14,161**	**(102)**	**16,836**
Trust EBITDA margin %	**5.9%**	**6.1%**	**-0.2%**	**6.0%**

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	544	674
	Actual / Forecast	0	141	10	12	48	18	-40	-125	-24	-39	24	58	0	83
	Variance	-25	116	-47	-49	-13	-43	-103	-188	-87	-103	-41	-7	-543	-591
	Cumulative Variance	-25	91	44	-5	-18	-62	-165	-353	-440	-543	-584	-591		
	Cuml. % delivered	0%	280%	141%	97%	92%	79%	53%	15%	8%	0%	4%	12%	0%	12%
FYPC	Plan	49	49	49	49	49	49	49	49	49	49	49	49	488	586
	Actual / Forecast	49	49	49	49	49	49	49	49	49	49	49	49	488	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	725	870
	Actual / Forecast	73	73	73	73	73	73	73	73	73	73	73	73	725	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	463	555
	Actual / Forecast	45	38	38	38	46	46	46	45	45	44	44	46	431	521
	Variance	-1	-8	-8	-8	0	0	0	-1	-1	-2	-2	0	-31	-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	659	862
	Actual / Forecast	2	5	5	5	5	5	38	38	38	38	38	40	179	257
	Variance	-17	-17	-17	-61	-61	-61	-61	-62	-62	-62	-63	-62	-480	-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%	27%	30%
Trust-wide savings	Plan	0	0	0	0	45	65	65	65	65	65	65	65	370	500
	Actual / Forecast	0	0	0	0	45	65	65	65	65	13	-140	-178	318	0
	Variance	0	0	0	0	0	0	0	0	0	-52	-205	-243	-52	-500
	Cumulative Variance	0	0	0	0	0	0	0	0	0	-52	-257	-500		
	Cuml. % delivered	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	100%	0%
Total	Plan	**212**	**215**	**246**	**295**	**340**	**360**	**394**	**396**	**396**	**397**	**399**	**400**	3,249	4,047
	Actual / Forecast	**169**	**305**	**174**	**176**	**265**	**255**	**230**	**144**	**245**	**177**	**87**	**88**	2,142	2,317
	Variance	**-43**	**91**	**-72**	**-118**	**-74**	**-104**	**-164**	**-251**	**-150**	**-220**	**-311**	**-312**	-1,107	-1,730
	Cumulative Variance	-43	47	-24	-143	-217	-321	-485	-737	-887	-1,107	-1,418	-1,730		
														66%	57%
Cumulative Delivered		**80%**	**111%**	**96%**	**85%**	**83%**	**81%**	**76%**	**70%**	**69%**	**66%**	**61%**	**57%**		

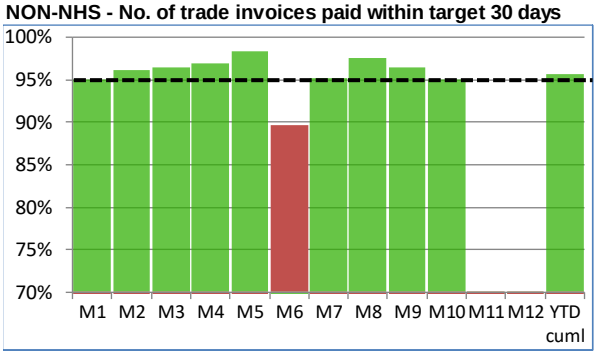
APPENDIX C – BPPC performance

Trust performance – current month (cumulative) v previous

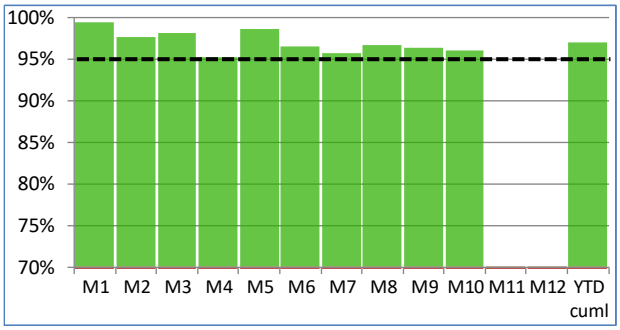
Better Payment Practice Code	January (Cumulative)		December (Cumulative)	
	Number	£000's	Number	£000's
Total Non-NHS trade invoices paid in the year	23,436	85,521	21,178	77,586
Total Non-NHS trade invoices paid within target	22,425	82,963	20,280	75,337
% of Non-NHS trade invoices paid within target	**95.7%**	**97.0%**	**95.8%**	**97.1%**
Total NHS trade invoices paid in the year	706	43,757	635	38,446
Total NHS trade invoices paid within target	664	43,409	604	38,218
% of NHS trade invoices paid within target	**94.1%**	**99.2%**	**95.1%**	**99.4%**
Grand total trade invoices paid in the year	24,142	129,278	21,813	116,032
Grand total trade invoices paid within target	23,089	126,372	20,884	113,555
% of total trade invoices paid within target	**95.6%**	**97.8%**	**95.7%**	**97.9%**

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

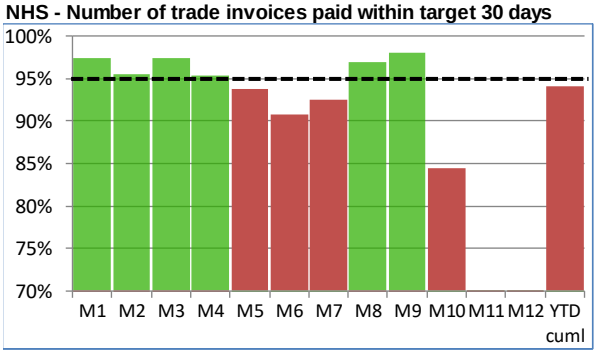
NON-NHS - No. of trade invoices paid within target 30 days



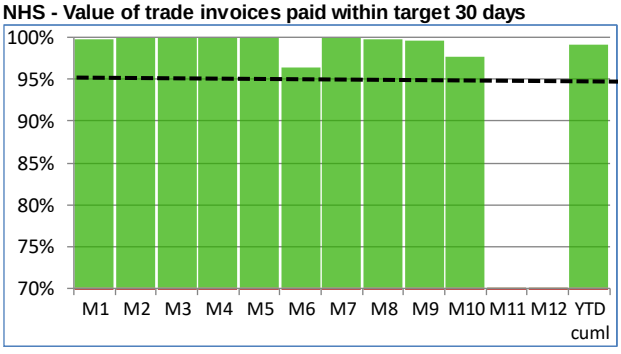
NON-NHS - Value of trade invoices paid within target 30 days



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 Actual	2019/20 M10 £000s Actual	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	-77	-76	*-95*	*-75*	-828	*-998*
Agency Nursing	-1,528	-127	-122	-142	-158	-173	-157	-214	-144	-147	-166	-143	*-135*	*-150*	-1,566	*-1,851*
Agency Scient, Therap. & Tech	-232	-19	-33	-18	-21	-26	-23	-12	-22	-15	-16	-10	*-18*	*-18*	-197	*-233*
Agency Non clinical staff costs	-409	-34	-48	-43	-31	-14	-25	-38	-7	-16	-5	-4	*-5*	*-5*	-231	*-241*
Sub-total	**-2,778**	**-231**	**-264**	**-267**	**-303**	**-273**	**-280**	**-350**	**-292**	**-295**	**-264**	**-234**	***-253***	***-248***	-2,822	***-3,323***
CHS																
Agency Consultant Costs	-182	-15	-15	-15	-12	-13	-11	-15	-18	-12	-13	5	*0*	*0*	-119	*-119*
Agency Nursing	-3,579	-298	-306	-243	-305	-332	-302	-279	-298	-252	-345	-286	*-250*	*-240*	-2,948	*-3,438*
Agency Scient, Therap. & Tech	-644	-54	-54	-41	-47	-53	-49	-39	-30	-28	-28	-32	*-40*	*-40*	-401	*-481*
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**	**-386**	**-314**	***-290***	***-280***	-3,468	***-4,038***
FYPC															0	
Agency Consultant Costs	-429	-36	-42	-12	-29	-30	-41	-28	-37	-67	-37	-50	*-45*	*-45*	-374	*-464*
Agency Nursing	-521	-43	-118	-160	-163	-94	-96	-160	-132	-137	-89	-80	*-60*	*-60*	-1,229	*-1,349*
Agency Scient, Therap. & Tech	-26	-2	-4	-7	-11	-16	-5	-9	-10	-4	-6	-8	*-7*	*-7*	-81	*-95*
Agency Non clinical staff costs	-32	-3	-8	-15	-15	-28	-3	-8	-5	-5	1	0	*0*	*0*	-87	*-87*
Sub-total	**-1,007**	**-84**	**-172**	**-194**	**-218**	**-168**	**-145**	**-205**	**-185**	**-214**	**-131**	**-138**	***-112***	***-112***	-1,772	***-1,996***
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	-6	6	*0*	*0*	29	*29*
Agency Scient, Therap. & Tech	-42	-4	-7	-4	-8	-10	-8	-5	-10	-23	-20	-9	*-9*	*-9*	-104	*-122*
Agency Non clinical staff costs	-623	-52	-22	-31	-24	-27	-19	-33	-36	-42	-68	-36	*-25*	*-25*	-337	*-387*
Sub-total	**-714**	**-60**	**-28**	**-6**	**-32**	**-38**	**-27**	**-38**	**-46**	**-65**	**-94**	**-39**	***-34***	***-34***	-412	***-480***
TOTAL TRUST																
Agency Consultant Costs	-1,220	-102	-117	-90	-136	-103	-126	-130	-174	-196	-127	-122	*-140*	*-120*	-1,320	*-1,580*
Agency Nursing	-5,676	-473	-546	-516	-626	-599	-556	-653	-574	-536	-606	-504	*-445*	*-450*	-5,713	*-6,608*
Agency Scient, Therap. & Tech	-944	-79	-99	-71	-87	-105	-85	-65	-72	-70	-71	-59	*-74*	*-74*	-784	*-932*
Agency Non clinical staff costs	-1,107	-92	-78	-89	-70	-70	-47	-79	-48	-63	-72	-40	*-30*	*-30*	-656	*-716*
Total	**-8,946**	**-746**	**-839**	**-766**	**-918**	**-877**	**-814**	**-926**	**-868**	**-865**	**-876**	**-724**	***-689***	***-674***	-8,473	***-9,836***
Agency ceiling (£8,122k)			-675	-677	-677	-677	-677	-677	-677	-677	-677	-677	*-677*	*-677*	-6,768	*-8,122*
Variance (+better/-worse)			**-164**	**-89**	**-241**	**-200**	**-137**	**-249**	**-191**	**-188**	**-199**	**-47**	***-12***	***3***	-1,705	***-1,714***
Trust financial plan			-710	-681	-680	-678	-677	-675	-674	-670	-673	-675	*-673*	*-656*	-6,793	*-8,122*
Variance (+better/-worse)			**-129**	**-85**	**-238**	**-199**	**-137**	**-251**	**-194**	**-195**	**-203**	**-49**	***-16***	***-18***	-1,680	***-1,714***

At month 10, total Trust agency costs were £8,473k. This is higher than year-to-date planned spend of £6,793k, and also higher than the year-to-date agency spend ceiling of £6,768k 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 10, the revised forecast for the year is £9.8m against the plan / NHSI ceiling of £8.1m.

APPENDIX E – Cash flow forecast

APPENDIX E: 2019/20 CASH-FLOW FORECAST	JAN	JAN	JAN	FEB	MAR	YTD	19/20
	FORECAST	ACTUAL	VARIANCE	FORECAST	FORECAST	ACTUAL	FORECAST
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
OPENING BALANCE	**11,324**	**11,324**	**0**	**11,394**	**13,787**	**8,356**	**8,356**
INCOME							
CCG Block Contracts	18,196	18,196	**0**	18,528	18,528	180,147	217,203
NHS England Specialist Commissioning Contracts	623	639	**16**	639	767	6,201	7,607
Health Education England Medical Training Contracts	710	1,305	**595**	734	740	8,147	9,621
Local Authorities	1,437	757	**(680)**	1,437	2,157	13,045	16,639
UHL Contracts	200	0	**(200)**	200	200	1,600	2,000
Non Contract Activity (NCA) re service provision for Non- Leicester patients	325	208	**(117)**	325	574	2,456	3,355
Health Informatics Service (HIS)	940	382	**(558)**	800	1,086	3,354	5,240
360 Assurance Audit Services	420	146	**(274)**	516	323	1,603	2,442
Property income for rents and service charges	126	0	**(126)**	0	641	0	641
STP Funding 19/20	357	0	**(357)**	357	608	752	1,717
STP Funding 18/19 - Q4 plus incentive and bonus allocation	0	0	**0**	0	0	3,180	3,180
HMRC Mill Lodge VAT refund for construction works	0	0	**0**	0	0	0	0
HMRC VAT reclaims	259	286	**27**	259	259	2,753	3,271
Property disposals	0	0	**0**	0	0	0	0
Capital Loan	0	0	**0**	0	0	0	0
Other income receipts and recharges (including PDC)	2,390	1,377	**(1,013)**	1,423	2,265	7,595	11,283
PDC capital funding support	0	0	**0**	2,085	2,037	1,589	5,711
Income receipts relating to previous year	98	19	**(79)**	98	98	6,253	6,449
Total Receipts	**26,081**	**23,315**	**(2,766)**	**27,401**	**30,283**	**238,675**	**296,359**
PAYMENTS							
Payroll	17,250	16,937	**(313)**	17,090	17,180	170,512	204,782
Capital	1,525	364	**(1,161)**	815	3,279	5,998	10,092
Non pay general expenditure	4,700	3,554	**(1,146)**	4,700	6,669	38,124	49,493
UHL - Estates & FM Services	827	1,654	**827**	827	827	7,443	9,097
UHL - Other contracts	176	0	**(176)**	352	352	1,412	2,116
Rents and Service Charges (NHS Properties & Community Health Partnership)	1,282	0	**(1,282)**	424	1,612	1,912	3,948
HCL Agency Nursing Costs	400	463	**63**	500	531	4,175	5,206
Out of Area (OOA) costs for patients placed in private hospitals	300	273	**(27)**	300	300	3,026	3,626
Public dividend capital payment (PDC)	0	0	**0**	0	3,077	2,798	5,875
Other finance costs (inc loan interest and principal repayments)	0	0	**0**	0	0	237	237
Total Payments	**26,460**	**23,245**	**(3,215)**	**25,008**	**33,827**	**235,637**	**294,472**
CLOSING CASH BOOK BALANCE	**10,945**	**11,394**	**450**	**13,787**	**10,243**	**11,394**	**10,243**
Plan	**7,383**	**7,383**	**0**	**8,711**	**8,000**	**7,383**	**8,000**
Variance to plan	**3,562**	**4,011**	**450**	**5,076**	**2,243**	**4,011**	**2,243**

APPENDIX F – Risks, Pressures and Mitigations

Risk adjusted estimated year end position as at month 10

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	(373)	(1,453)	122	559	**(1,145)**	(1,009)	(1,145)	(1,422)
Learning Disabilities	(70)	(796)	70	0	**(796)**	(773)	(796)	(853)
Community Health Services	(700)	0	349	451	**100**	300	100	(350)
Families, Young People and Childrens Services	0	(2,110)	1,775	335	**0**	40	0	(250)
Enabling Services	0	(501)	1,058	100	**657**	700	657	550
Estates - from M8 includes additional risk £400k relating to NHSPS charges	(400)	(2,092)	679	0	**(1,813)**	(1,700)	(1,813)	(2,213)
Hosted Services	0	(1,000)	471	0	**(529)**	(450)	(529)	(600)
Service Delivery - total	**(1,543)**	**(7,952)**	**4,524**	**1,445**	**(3,526)**	**(2,892)**	**(3,526)**	**(5,138)**
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	0
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**	300	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.			365	0	**365**	365	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			258	0	**258**	350	258	0
Trustwide/Corporate total:	**(2,490)**	**(770)**	**6,286**	**0**	**3,026**	**3,432**	**3,026**	**1,265**
Plan/Budget variance after risks, pressures and mitigations:	**(4,033)**	**(8,722)**	**10,810**	**1,445**	**(500)**	**540**	**(500)**	**(3,873)**
Trust budget/plan surplus (includes £500k stretch target):					**2,648**	**2,648**	**2,648**	**2,648**
Net I&E performance (actual I&E surplus/(deficit):					**2,148**	**3,188**	**2,148**	**(1,225)**

Control total target:	**2,148**
Control Total variance after net risks, pressures and mitigations:	**0**

Leicestershire Partnership NHS Trust

Meeting name and date	Trust Board 3rd March 2020
Paper reference	**Ti & Tii**

Name of Report Performance Report – Month 9 and Month 10

For approval		For assurance	X	For information	

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

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
Operational Executive Team meeting (M9)	20 January 2020
Strategic Executive Board (M9)	7 February 2020
Finance and Performance Committee (M9)	18 February 2020
Operational Executive Team meeting (M10)	17 February 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 Finance and Performance Committee is recommended to receive assurance with regard to areas of quality and performance where performance improvement action is being undertaken.

Ti

Leicestershire Partnership NHS Trust

Trust Board Performance Report (Month 9)

Strategic Executive Board – 7th February 2020
Finance and Performance Committee – 18th February 2020
Trust Board – 3rd March 2020

Version 3

Performance headlines – February 2020

Key standards being delivered/improving

1. NHS Oversight

- The Trust continues to deliver the **EIP standard** which will see an upward movement in the national threshold in 2020/21. The Trust is already delivering the higher threshold of 60%.
- 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 92 in December).
- The Trust continued to deliver the **6-week diagnostic standard for Audiology** services although this will dip in the January performance figures due to a cancelled clinic. This is expected to be recovered in February.

2. Access

- The plans and investment to improve performance in the **CAMHS Eating Disorder** service have been delivered ahead of the original trajectory. The four-week standard was delivered in December 2019 at 100% and is expected to be sustained from April 2020.
- All four of the key national access targets for **CAMHS Eating Disorders and Children and Young People's Access** are being delivered by the Trust (three of the standards at 100%).

3. 52 Week waits

- The plans and investment to reduce **long waits in the CAMHS service** have seen a significant improvement in the number of long waits, reducing from 138 in June 2019 to under ten at the time of the Performance Review in January 2020. Is expected that these will be eradicated by the end of March 2020.
- The **Community Health Services** directorate have delivered improvements in longer waits (the directorate does not have any 52 week waits) through the delivery of agreed improvement plans.
- There has been a further reduction in the total number of **long waits (one year plus)** at the Trust. However, the Trust remains an outlier in the volume and length of excessive waits particularly for Adult General Psychiatry – CMHT and Outpatients and Psychological Therapies (Cognitive Behaviour Therapy, Dynamic Psychotherapy and Personality Disorder).

4. Patient Flow

- The Trust has delivered the seven-day **Care Programme Approach** standard in November and continued to deliver the **Gatekeeping** measure in December.
- There was an improvement in delivery against the **Delayed Transfer of Care** target in December although the Trust remains above the 3.5% target.

7. Workforce/HR

- The Trust continues to deliver the key **equality and diversity**, **turnover**, **mandatory training and annual appraisal** targets.
- There was an improvement in the overall Trust **vacancy rate and sickness absence rates** in December and November respectively, although both remain above the agreed targets.

Performance headlines – February 2020

Key standards not being delivered and/or deteriorating

1. NHS Oversight

- The Trust performance against the **Referral to Treatment 18-week incomplete** standard deteriorated again in December. Improvement will be supported by a new Multi-disciplinary team approach to ADHD. Recruitment has been successful with new staff in post from February to April.

2. Access

- The Trust has failed to deliver the **CMHT access standards.** Improvement plans are being developed.

4. Patient Flow

- The Trust is not delivering some of the agreed key **patient flow standards – occupancy and length of stay (Mental Health beds).**
- The target for **Community bed occupancy** is not being delivered although this is by agreement with the wider health system. The standard needs to change in 2020/21 to reflect the goals of the system.

6. Data Quality

- All the key **data quality measures** are not being met. Improvement plans are being developed but have been delayed until March 2020.

7. Workforce/HR

- The Trust is not delivering the targets agreed for **agency costs**. A focus on agency spend forms part of the financial turnaround processes introduced in the Trust.
- There has been a drop in the percentage of **staff who have undertaken clinical supervision** within the last three months. The 85% was delivered in October and November but fell to 81.7% in December. Discussions took place with each service directorate on the need to deliver improvement and of the actions to achieve that improvement.
- The Trust is well short of the **staff flu vaccination** target of 80% and has been identified as an outlier by NHS Improvement.

Improvement Plans

- The improvement plans for **CAMHS Eating Disorders** and to reduce **CAMHS long-waits** have been delivered.
- The **Community Health Service** directorate have developed and are implementing longer wait improvement plans for three service areas.
- An improvement plan is in place for **ADHD RTT** (new staff in post from February).
- An improvement plan focusing on data recording and a new breach validation process has been introduced in **CMHT** with improvements expected in January. A medium-term improvement plan to improve the 6-week routine performance will be in place by the end of February.
- Improvement plans for the **data standards** were not completed in January and will now be implemented from March onwards.
- **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.
- Each directorate is taking action to improve **Clinical Supervision**.
- An improvement plan is in place for the PIER service to improve **CPA compliance** in relation to the 12 months standard.
- The FYPC team will develop a plan to address the significant reduction in target time for the **Initial Health Assessment checks** from one month to 19 days.
- The FYPC directorate will develop plans to address the expansion of **Therapy Services** to 16 to 18-year olds and the transfer of **Community Paediatric** patients that have already had a long wait from 1 April.

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>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr>
<tr><td>81.8%</td><td>81.3%</td><td>65.2%</td><td>66.7%</td><td>72.0%</td><td>66.7%</td></tr>
</table>
</td><td>This target is consistently being delivered.</td></tr>
<tr><td>Inappropriate Out of Area bed days for Adult Mental Health services (excluding progress beds)

Target is 0 by end March 2021</td><td>
<table>
<tr><td></td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr>
<tr><td>Total Inappropriate OAPs bed days</td><td>1260</td><td>764</td><td>604</td><td>508</td><td>464</td></tr>
<tr><td>Total Inappropriate OAPs bed days (excluding progress beds)</td><td>1038</td><td>513</td><td>269</td><td>154</td><td>92</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>An improvement plan is being developed 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>An improvement plan is being developed 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>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr>
<tr><td>94.3%</td><td>92.4%</td><td>92.6%</td><td>86.2%</td><td>79.9%</td><td>78.9%</td></tr>
</table>
</td><td>ADHD has a new MDT model. Additional staff recruited to start between February and April.</td></tr>
<tr><td>6-week wait for diagnostic procedures

Target is 99%</td><td>
<table>
<tr><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr>
<tr><td>100.0%</td><td>100.0%</td><td>100.0%</td><td>99.7%</td><td>100.0%</td><td>100%</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>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>60%</td><td>0%</td><td>100%</td><td>66.7%</td><td>100%</td><td>100%</td></tr></table></td><td>The Trust delivered this standard in November and December.</td></tr>
<tr><td>CAMHS Eating Disorder – four weeks (complete pathway)

Target is 95%</td><td><table><tr><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>33.3%</td><td>40%</td><td>60%</td><td>62.5%</td><td>62.5%</td><td>100%</td></tr></table></td><td>The funded interim improvement plan has delivered the agreed improvement.</td></tr>
<tr><td>Children and Young People’s Access – four weeks (incomplete pathway)

Target is 92%</td><td><table><tr><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>62.5%</td><td>94.7%</td><td>100%</td><td>94.4%</td><td>96.7%</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>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>98.6%</td><td>99.1%</td><td>100.0%</td><td>100.0%</td><td>99.5%</td><td>100%</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>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>18.2%</td><td>50.0%</td><td>66.7%</td><td>66.7%</td><td>66.7%</td><td>n/a</td></tr></table>
‘n/a’ denotes no patients to measure as at last day of the month</td><td>Improvement plan focusing on data recording and a new breach validation process introduced with improvements expected in January.</td></tr>
<tr><td>Adult CMHT Access Six weeks routine (incomplete pathway)

Target is 95%</td><td><table><tr><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>60.5%</td><td>59.6%</td><td>56.4%</td><td>50.0%</td><td>50.0%</td><td>43.7%</td></tr></table></td><td>Service redesign is required to consistently deliver this six-week standard. Plans for an improved service model 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 or between their first to second appointment (post-access waits). The following services have 52 week waits within their service:

Service	Number of 52 week waits	Longest wait (Nov 19)	RAG and comments on recovery plan position
Adult General Psychiatry - Community Mental Health Teams and Outpatients – Treatment	Jun -19: 31; Jul -19: 70; Aug -19: 76; Sep -19: 89; Oct -19: 89; Nov-19: 76	100 weeks	Audit of each patient taking place. Plan for improved service model by end of February.
Liaison Psychiatry	Jun -19: 1; Jul -19: 7; Aug -19: 6; Sep -19: 15; Oct -19: 11; Nov-19: 9	80 weeks	Service will be subsumed into new Core 24 service from 1 April.
Cognitive Behavioural Therapy	Jun -19: 48; Jul -19: 42; Aug -19: 31; Sep -19: 30; Oct -19: 28; Nov-19: 33	104 weeks	Weekly MDT meeting is reviewing all long wait patients and developing an operational plan for a new model of Psychological Therapies.
Dynamic Psychotherapy	Jun -19: 62; Jul -19: 62; Aug -19: 56; Sep -19: 51; Oct -19: 47; Nov-19: 46	96 weeks	Weekly MDT meeting is reviewing all long wait patients and developing an operational plan for a new model of Psychological Therapies.
Personality Disorder	Jun -19: 71; Jul -19: 69; Aug -19: 62; Sep -19: 63; Oct -19: 59; Nov-19: 61	82 weeks	Weekly MDT meeting is reviewing all long wait patients and developing an operational plan for a new model of Psychological Therapies.

<table>
<tr>
<td>Medical/Neuro psychology</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>38</td><td>37</td><td>37</td><td>53</td><td>48</td><td>48</td></tr>
</table>
</td>
<td>77 weeks</td>
<td>Recruitment to vacant posts has been completed. Recovery is expected but has yet to be delivered.</td>
</tr>
<tr>
<td>CAMHS</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>138</td><td>131</td><td>115</td><td>51</td><td>19</td><td>16</td></tr>
</table>
</td>
<td>74 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>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>89.5%</td><td>90.4%</td><td>86.9%</td><td>86.2%</td><td>85.6%</td><td>85.9%</td></tr></table></td><td>The Trust has been successful in reducing occupancy since August despite increased demand.</td></tr>
<tr><td>Occupancy Rate - Community Beds (excluding leave)

Target is >=93%</td><td><table><tr><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>84.9%</td><td>84.7%</td><td>88.3%</td><td>89.7%</td><td>88.5%</td><td>89.2%</td></tr></table></td><td>The Trust is below the target rate of 93%. This is in line with the broader plans of the wider system and needs to be reflected in a revised KPI for 2020/21.</td></tr>
<tr><td>Length of stay (excluding leave) from acute Bradgate wards

Target is <=33 days (national benchmark)</td><td><table><tr><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>51.4</td><td>44.0</td><td>41.4</td><td>35.2</td><td>33.5</td><td>41.9</td></tr></table></td><td>Length of stay has reduced since July. Spike at Christmas which is expected to be recovered.</td></tr>
<tr><td>Length of stay in Community services

National benchmark is 25 days.</td><td><table><tr><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>17.7</td><td>18.5</td><td>19.9</td><td>17.7</td><td>19.9</td><td>17.9</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>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>3.7%</td><td>4.6%</td><td>4.1%</td><td>4.4%</td><td>4.6%</td><td>3.8%</td></tr></table></td><td>Improvement in December. Further meetings with social care colleagues to agree further joint actions.</td></tr>
<tr><td>Gatekeeping

Target is >=95%</td><td><table><tr><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>100.0%</td><td>100.0%</td><td>97.5%</td><td>98.8%</td><td>98.6%</td><td>98.5%</td></tr></table></td><td>The Trust is consistently delivering this standard.</td></tr>
</table>

<table>
<tr>
<td>Care Programme Approach – 7-day follow up

(reported 1 month in arrears)

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>93.7%</td><td>91.3%</td><td>92.6%</td><td>89.2%</td><td>97.8%</td><td>95.3%</td></tr>
</table>
</td>
<td>The Trust delivered this standard in October and November.</td>
</tr>
<tr>
<td>Care Programme Approach

12-month standard

Target is 95%</td>
<td>
<table>
<tr><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr>
<tr><td>91.9%</td><td>90.8%</td><td>89.0%</td><td>92.4%</td><td>94.8%</td><td>94.5%</td></tr>
</table>
</td>
<td>The Trust performance has improved against this standard in recent months.

PIER service improvement plan in place.</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>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>0</td><td>1</td><td>1</td><td>0</td><td>2</td><td>0</td></tr></table></td><td>Trust is below year to date ceiling. No new cases in December.</td></tr>
<tr><td>Serious incidents</td><td><table><tr><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>15</td><td>2</td><td>26</td><td>3</td><td>18</td><td>8</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>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>100.0%</td><td>90.9%</td><td>100.0%</td><td>100.0%</td><td>0.0%</td><td>No plans</td></tr></table></td><td></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>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>3</td><td>4</td><td>3</td><td>1</td><td>6</td><td>3</td></tr></table></td><td>Medium term recruitment and retention plans. Immediate mitigating actions are put in place when these issues arise.</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><th>Apr-19</th><th>May-19</th><th>Jun-19</th><th>Jul-19</th><th>Aug-19</th><th>Sep-19</th></tr>
<tr><td>84.8%</td><td>84.6%</td><td>90.6%</td><td>88.0%</td><td>91.1%</td><td>92.5%</td></tr>
</table>
</td><td>The Trust is failing to deliver the 95% target. Improvement plan required. Revised date of March for the data quality improvement plan and for implementation to begin.</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>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>8.7%</td><td>8.5%</td><td>8.7%</td><td>8.8%</td><td>8.8%</td><td>9.3%</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>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>8.6%</td><td>8.9%</td><td>9.6%</td><td>8.8%</td><td>8.6%</td><td>8.5%</td></tr></table></td><td>Performance has improved since September. A vacancy control process is now in place.</td></tr>
<tr><td>Health and Well-being Sickness Absence (1 month in arrears)

Target is <=4.5%</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>4.7%</td><td>4.7%</td><td>4.9%</td><td>5.0%</td><td>5.2%</td><td>5.1%</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>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>£876,966</td><td>£813,941</td><td>£926,375</td><td>£867,920</td><td>£864,714</td><td>£875,918</td></tr></table></td><td>Increased controls over agency spend have been put in place. Some of the over-spend is agreed as part of actions to reduce long waits ahead of substantive recruitment.</td></tr>
<tr><td>Core Mandatory Training Compliance for substantive staff

Target is >=85%</td><td><table><tr><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>95.1%</td><td>95.1%</td><td>95.2%</td><td>95.4%</td><td>95.3%</td><td>95.3%</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>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr>
<tr><td>92.9%</td><td>93.4%</td><td>93.1%</td><td>93.5%</td><td>93.5%</td><td>93%</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>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr>
<tr><td>22.1%</td><td>22.3%</td><td>22.6%</td><td>22.5%</td><td>22.5%</td><td>22.7%</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>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr>
<tr><td>N/A</td><td>N/A</td><td>N/A</td><td>22%</td><td>44%</td><td>55%</td></tr>
</table>
</td>
<td>The Trust is well below the 80% target rate.</td>
</tr>
<tr>
<td>% of staff who have undertaken clinical supervision within the last 3 months

Target is 85%</td>
<td>
<table>
<tr><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr>
<tr><td>81.5%</td><td>80.0%</td><td>84.5%</td><td>86.0%</td><td>86.2%</td><td>81.7%</td></tr>
</table>
</td>
<td>The Trust fell below the 85% target in December. Raised at the three service directorate review meetings.</td>
</tr>
</table>

8. Performance Framework - 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 taken place. The key areas of discussion and agreed action are set out below:

Community Health Services

- There was discussion of the actions to hold occupancy of community beds below the agreed 93% standard and the need to re-set that KPI for 2020/21 to reflect the system approach to community bed occupancy.
- The directorate does not have any 52 week waits. It has a focus on three service areas with waiting times that have been of concern – Specialist Continence; Neuro and Stroke; and, Community Therapies. All three areas have agreed improvement plans in place and the progress being delivered through these plans was noted.
- The new two-week and two-day waiting time targets linked to the national Ageing Well programme were discussed. The Trust is an early implementer of this programme and will need to work with commissioners to improve the measurement and recording of relevant data to capture an accurate picture of performance against these new measures.
- Discussions took place on the investment being made in Community Services, the mitigating actions put in place when Safe Staffing ratios cannot be met and the role of the directorate in delivering wider system targets.
- There was a broader discussion on the actions underway and planned throughout the Trust to improve staff engagement, staff retention and support to staff particularly when subject to change of work base.

Families, Young People and Children

- The CAMHS Eating Disorder improvement plan has delivered the achievement of the four-week waiting time standard in December. This is three months ahead of the original trajectory.
- The reduction in 52 week waits for CAMHS was discussed. These have reduced from 138 at the end of June to under ten in January 2020. The directorate expect these waits to be eradicated and for that improvement to be sustained from April onwards.
- On Therapy Services, the directorate are working with commissioners to agree how the 16 to 18-year-olds cohort are brought into the service and funded.
- Community Paediatrics - The directorate are working with commissioners and the Alliance to understand how many patients already over the 18-week wait standard will transfer to the Trust from 1 April.
- In relation to Audiology Services, it was noted that the Trust will fall below the 100% standard for diagnostic waits in January following the cancellation of one clinic. The performance should return to full compliance in February.
- An improvement plan is in place for the PIER service to improve CPA compliance in relation to the 12 months standard.
- The FYPC team will develop a plan to address the significant reduction in target time for the Initial Health Assessment checks from one month to 19 days.

- The higher than planned spend on Agency staff was noted. This has been largely due to the agreed additional investment to reduce long waits and allowed early action while substantive recruitment took place.
- There was a discussion of key estates issues for the directorate focusing on Westcote House and Mawson House.
- The Key Performance Indicator (KPI) setting process for 2020/21 will need to include KPIs for service areas that are not subject to national indicators. This will enable the Board, Finance and Performance Committee and the Executive team to monitor progress with some quite large service areas that do not have national indictors.
- There was a discussion on the learning that might be shared more widely on the successful delivery of improvement plans for areas of concern within the directorate.

Adult Mental Health and Learning Disabilities

- There was a discussion of the challenges over Christmas and in January linked to demand which impacted on Length of Stay and put pressure on the improvements made in reducing inappropriate Out of Area Placements. The improvement in OOAPs since August was noted as an example of improvement actions delivering a significant positive change for patients.
- Recruitment has been taking place to support the new service model for ADHD and to address the pressures in that service. New Peer Support Workers have been recruited to support planned changes to the CMHT and Assertive Outreach service models.
- A full longer-term operational plan for the CMHTs and Assertive Outreach teams will be in developed by the end of February.
- The Trust is an outlier in terms of the number and length of long waits for various Psychological Therapies. A discussion took place on the need to develop a model that can meet the needs and demand from the local population and eradicate all long waits. Some services currently have waits of over three years.
- A weekly MDT meeting is taking place to review all the long waits for Psychological Therapies (Cognitive Behaviour Therapy – 33 one-year plus waits including one at 104 weeks; Dynamic Psychotherapy – 46 one year waits including one of 96 weeks; and Personality Disorders – 61 one year waits including one of 82 weeks) and to inform the development of a medium-term operational plan.
- The introduction of a new Core 24 model from April will address the long waits for Liaison Psychiatry.
- Recruitment has taken place to address the long Neurological waits and improvement is expected.
- There has been a delay in developing a plan to address the data quality issues identified in this performance report. This is due to the range of pressures to develop and implement improvement plans. A plan will be developed by March.
- The directorate have actions in place to improve the Clinical Supervision indicators.
- The positive impact of the introduction to the directorate of an SBAR model to tackle HR and workforce issues was noted. Progress with some HR indicators (e.g. sickness) was also linked to closer management and oversight.
- The scale and breadth of the challenge facing the directorate was discussed. Future meetings will review improvement plans in more detail and discuss the application of corporate support to underpin successful implementation.

9. Regulatory meetings

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

NHS England/Improvement

- System Improvement and Assurance Meeting – 28th January 2020
    - Deep dive into privacy and dignity – included update on Elimination of Dormitory business case
    - IPC visit – confirmed strong amber
    - Flu – LPT national outlier
    - Month 9 FOT deterioration
- System Review Meeting – 29th January 2020
    - Urgent and emergency care – specifically impact on complex MH patients in A&E resulting in 12 hour breach
    - MH – given meeting previous day focus on IAPT recovery plan for CCG
    - Transforming care – concern raised around LLR position
    - Finance – deterioration in 2019/20 and remaining gap in 2020/21

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. Key Performance Indicators for 2020/21

The following process has been agreed to develop a set of KPIs for 2020/21 to bring to the Board for approval in early April. This is in line with the new Performance Framework that the Trust has adopted.

Purpose

1. To agree a set of measurable KPIs for the Trust for 2020/21.
2. To agree the level at which the KPIs will be reported – (e.g. to the Board, a level one or level two committee).
3. To support the work underway to clarify the relationship and links between committees and sub-committees.
4. To ensure that the KPIs set are SMART and can be monitored in year (including those in the Quality Account).
5. To check on duplication or gaps in the reporting of KPIs.
6. To agree which KPIs are only Trust wide and which are sub-divided by directorate, and the approach to any sub-division.
7. To give the lead directors and chairs of relevant committees, the Executive Team, Board sub committees and the Board an opportunity to comment on the proposed KPIs.
8. To ensure that the Trust is addressing all relevant national KPIs.
9. To agree local KPIs for service areas that are not subject to national KPIs.

Process

The suggested process to agree draft KPIs is:

- Process led by Finance, Business and Estates Director and overseen by F&P Committee
- Small group meets with directors and the chairs of level one
- Leads to bring their terms of reference, current KPI list and any new imposed or proposed KPIs
- Agree a manageable number of KPIs for each area of work.
- Agree any sub-division of KPIs, thresholds and check the mechanism to record and report KPIs
- KPIs presented to the Strategic Executive, the F&P Committee and then the Board for approval
- The Board performance report and those to Board sub committees are amended appropriately.

Timeline

13 February	KPI setting meetings
6 March	Strategic Executive Board consider full set of draft KPIs and the proposed level at which KPIs will be considered
17 March	Finance and Performance Committee consider full set of draft KPIs and the proposed level at which KPIs will be considered
7 April	Trust Board review and are asked to sign off the full set of KPIs and the proposed level at which KPIs will be considered

11. Recommendations

The Trust Board is asked to note:

a) the performance of the Trust on these key measures;

b) the improvements that have been made in developing and implementing improvement plans and the commitment to develop plans in other areas;

c) the discussions that took place in the first round of service directorate review meetings under the new Trust Performance Framework and the key points from the most recent regulatory meetings;

d) the process to develop a clear set of KPIs for the Trust for 2020/21 to bring to the Board for approval in early April. This will also include a wider set of KPIs to be reported to Board sub committees, new or amended national KPIs and new local KPIs for service areas without national KPIs;

e) the new targets for Community Services under the Ageing Well programme and the need for improvements in data capture and data quality;

f) the need to develop plans to address the expansion of Therapy Services to 16 to 18-year olds and the transfer of Community Paediatric patients that have already had a long wait from 1 April;

g) the scale and breadth of the challenges in the Adult Mental Health directorate and to agree to receive a broader update at a future Board time-out session.

Draft version 2

6 February 2020

Tii

Leicestershire Partnership NHS Trust

Trust Board Performance Report (Month 10)

Trust Board – 3rd March 2020

Performance headlines – January 2020

Key standards being consistently delivered and improving or maintaining performance

- Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral
- Inappropriate Out of Area bed days for Adult Mental Health services (inc progress beds)
- 6-week wait for diagnostic procedures
- Children and Young People's Access – 13 weeks (incomplete pathway)
- Length of stay - Community services
- Gatekeeping
- % Normalised Workforce Turnover *(Rolling previous 12 months)*
- Core mandatory training compliance for substantive staff
- Staff with a completed annual appraisal

Key standards being delivered but deteriorating

- none

Key standards being delivered inconsistently

- CAMHS Eating Disorder – four weeks - (complete pathway)
- Children and Young People's Access – four weeks (incomplete pathway)
- Occupancy rate – mental health beds (excluding leave)
- Occupancy rate – community beds (excluding leave)
- Delayed transfer of care (DToC)
- CPA 7 day
- CPA 12 month
- C Diff
- STEIS action plans completed within timescales
- Agency costs

Key standards not being delivered but improving

- Vacancy rate
- % staff from BME background
- Staff flu vaccination rate (frontline healthcare workers)
- % staff undertaken clinical supervision within the last 3 months

Key standards not being delivered but deteriorating/ not improving

- 18 week RTT
- CAMHS ED one week (complete)
- Adult CMHT Access five day urgent (incomplete)
- Adult CMHT Access six week routine (incomplete)
- Data quality maturity index
- Sickness absence

Key standard we are unable to assess using SPC

- Mental Health data submission - % clients in employment (not enough data for SPC)
- Mental Health data submission - % clients in settled accommodation (not enough data for SPC)
- 52 week waits (SPC due May 2020)
- Length of stay (excluding leave) from Bradgate acute wards (SPC due March 2020)
- Serious incidents (no target)
- Safe staffing (awaiting data)

Improvement Plans *(based on January 2020 directorate performance reviews)*

- Improvement plans are in place for CAMHS Eating Disorders (and on track) and for ADHD RTT (recruiting new staff in January and February 2020).
- Improvement plans for the data standards will be developed by the end of January 2020.
- 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 2020 and a plan to improve the 6-week routine performance by the end of February 2020.
- Vacancy control and agency spend are now subject to escalated processes and review as part of the financial turnaround process.
- The Strategic Workforce Group (SWG) are undertaking a review of staff sickness rates.

Performance Framework

- The first round of directorate performance review meetings that form the core of the **new Performance Framework** were completed in 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 2020 and to the full Board in early April 2020 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.

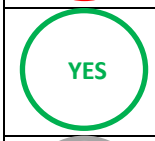
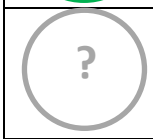
RAG rating against improvement plans

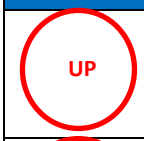
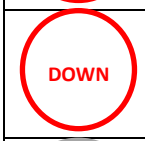
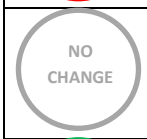
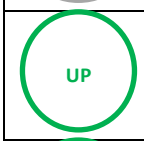
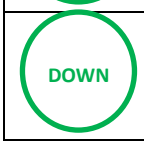
A simple RAG rating is used to assess compliance to the recovery plan:

- 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

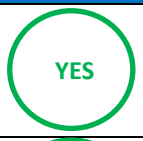
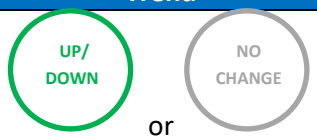
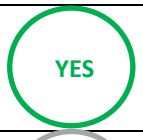
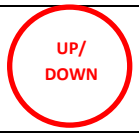
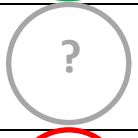
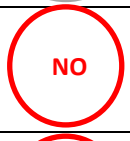
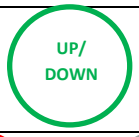
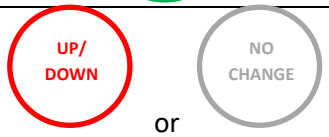
Statistical process control (SPC) ratings against performance

The Trust has introduced SPC icons to indicate assurance of whether the process is expected to consistently meet or fail the target; and if a process is in special cause or common cause variation.

Icon	Performance Description
	The system is expected to consistently fail the target
	The system is expected to consistently pass the target
	The system may achieve or fail the target subject to random variation

Icon	Trend Description
	Special cause variation – cause for concern (indicator where high is a concern)
	Special cause variation – cause for concern (indicator where low is a concern)
	Common cause variation
	Special cause variation – improvement (indicator where high is good)
	Special cause variation – improvement (indicator where low is good)

Useful icon combinations to understand performance:

Performance	Trend	Description
	 or	Key standards are being consistently delivered and are improving/ maintaining performance
		Key standards are being delivered but are deteriorating
	Any trend icon	Key standards are being delivered inconsistently
		Key standards are not being delivered but are improving
	 or	Key standards are not being delivered and are deteriorating/ not improving

1. NHS Oversight

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

<table>
<tr><th rowspan="2">Target</th><th rowspan="2">Trust performance</th><th rowspan="2">RAG/ Comments on recovery plan position</th><th colspan="2">SPC Flag</th></tr>
<tr><th>Assurance of Meeting Target</th><th>Trend</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>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr><tr><td>81.3%</td><td>65.2%</td><td>66.7%</td><td>72.0%</td><td>66.7%</td><td>72.2%</td></tr></table></td><td></td><td>YES</td><td>NO CHANGE</td></tr>
<tr><td colspan="3">Key standards are being consistently delivered and are maintaining performance</td></tr>
<tr><td rowspan="2">Inappropriate Out of Area bed days for Adult Mental Health services

Target is 0 by end March 2021</td><td rowspan="2"><table><tr><td></td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr><tr><td>Total Inappropriate OAPs bed days</td><td>1260</td><td>764</td><td>604</td><td>508</td><td>464</td><td>483</td></tr><tr><td>Total Inappropriate OAPs bed days (excluding progress beds)</td><td>1038</td><td>513</td><td>269</td><td>154</td><td>92</td><td>114</td></tr></table></td><td rowspan="2">The Trust has made significant improvements since August in reducing the number of inappropriate Out of Areas placements and continues to meet the reduction trajectory.</td><td>YES</td><td>NO CHANGE</td></tr>
<tr><td colspan="2">Key standards are being consistently delivered and are maintaining performance</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>Improvements are expected to be by 2020/21 Q2 following the SystmOne go live in June 2020</td><td>Not enough data to assess using SPC</td><td>Not enough data to assess using SPC</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>Improvements are expected to be by 2020/21 Q2 following the SystmOne go live in June 2020.</td><td>Not enough data to assess using SPC</td><td>Not enough data to assess using SPC</td></tr>
</table>

<table>
<tr>
<td>18-week Referral to Treatment (incomplete)

Target is 92%</td>
<td>
<table>
<tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr>
<tr><td>92.4%</td><td>92.6%</td><td>86.2%</td><td>79.9%</td><td>78.9%</td><td>73.3%</td></tr>
</table>
This data refers to the following services:

ADHD and ASD (Aug 2019 - Dec 2019)
ADHD (Jan 2020 onwards)

</td>
<td>The Trust performance against this standard has deteriorated significantly. ADHD has a new MDT model with appointments being made in January 2020 and February 2020.</td>
<td>NO
DOWN

Key standards are not being delivered and are deteriorating</td>
</tr>
<tr>
<td>6-week wait for diagnostic procedures (incomplete)

Target is 99%</td>
<td>
<table>
<tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr>
<tr><td>100.0%</td><td>100.0%</td><td>99.7%</td><td>100.0%</td><td>100%</td><td>99.5%</td></tr>
</table>
This data refers to the Audiology Service only
</td>
<td>This KPI is measured using patients waiting at the end of the month. Performance for complete pathways is 97.6% (10 breaches) in January 2020.</td>
<td>YES
NO CHANGE

Key standards are being consistently delivered and are maintaining performance</td>
</tr>
</table>

2. Access – wait time standards

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

<table>
<tr><th rowspan="2">Target</th><th rowspan="2">Trust performance</th><th rowspan="2">RAG/ Comments on recovery plan position</th><th colspan="2">SPC Flag</th></tr>
<tr><th>Assurance of Meeting Target</th><th>Trend</th></tr>
<tr><td>CAMHS Eating Disorder – one week (complete pathway)

Target is 95%</td><td><table><tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr><tr><td>0%</td><td>100%</td><td>66.7%</td><td>100%</td><td>100%</td><td>50.0%</td></tr></table></td><td></td><td>NO</td><td>NO CHANGE</td></tr>
<tr><td colspan="5">Key standards are not being delivered and are not improving</td></tr>
<tr><td>CAMHS Eating Disorder – four weeks (complete pathway)

Target is 95%</td><td><table><tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr><tr><td>40%</td><td>60%</td><td>62.5%</td><td>62.5%</td><td>100%</td><td>57.1%</td></tr></table></td><td>A funded interim improvement plan is in place and on track to deliver the agreed trajectory.</td><td>?</td><td>NO CHANGE</td></tr>
<tr><td colspan="5">Key standards are being delivered inconsistently and are not improving</td></tr>
<tr><td>Children and Young People's Access – four weeks (incomplete pathway)

Target is 92%</td><td><table><tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr><tr><td>94.7%</td><td>100%</td><td>94.4%</td><td>96.7%</td><td>96.7%</td><td>98.3%</td></tr></table></td><td></td><td>?</td><td>NO CHANGE</td></tr>
<tr><td colspan="5">Key standards are being delivered inconsistently and are not improving</td></tr>
<tr><td>Children and Young People's Access – 13 weeks (incomplete pathway)

Target is 92%</td><td><table><tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr><tr><td>99.1%</td><td>100.0%</td><td>100.0%</td><td>99.5%</td><td>100%</td><td>99.5%</td></tr></table></td><td></td><td>YES</td><td>NO CHANGE</td></tr>
<tr><td colspan="5">Key standards are being consistently delivered and are maintaining performance</td></tr>
<tr><td>Adult CMHT Access
Five day urgent (incomplete pathway)

Target is 95%</td><td><table><tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr><tr><td>50.0%</td><td>66.7%</td><td>66.7%</td><td>66.7%</td><td>n/a</td><td>66.7%</td></tr></table>'n/a' denotes no patients to measure as at last day of the month. There were two referrals made to the service in December 2019</td><td>Improvement plan for the five-day urgent standard will be in place by the end of January 2020.</td><td>NO</td><td>NO CHANGE</td></tr>
<tr><td colspan="5">Key standards are not being delivered and are not improving</td></tr>
<tr><td>Adult CMHT Access
Six weeks routine (incomplete pathway)

Target is 95%</td><td><table><tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr><tr><td>59.6%</td><td>56.4%</td><td>50.0%</td><td>50.0%</td><td>43.7%</td><td>46.8%</td></tr></table></td><td>Service redesign is required to consistently deliver this six week standard. Plan in place by the end of February 2020.</td><td>NO</td><td>NO CHANGE</td></tr>
<tr><td colspan="5">Key standards are not being delivered and are not improving</td></tr>
</table>

3. 52 week waits

No patient should wait for more than 52 weeks from referral to the start of their treatment. From March 2020, the Trust will merge the existing Wait Times Group and the Harm Assurance Group to improve the governance and confidence of harm reviews for long waiting patients.

The following services have 52 week waits within their service:

<table>
<tr><th rowspan="2">Service</th><th rowspan="2">Number of 52 week waits</th><th rowspan="2">Longest wait (latest month)</th><th rowspan="2">RAG/Comments on recovery plan position</th><th colspan="2">SPC Flag</th></tr>
<tr><th>Assurance of Meeting Target</th><th>Trend</th></tr>
<tr><td>Adult General Psychiatry - Community Mental Health Teams and Outpatients – Treatment (6 weeks)</td><td><table><tr><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>70</td><td>76</td><td>89</td><td>89</td><td>76</td><td>105</td></tr></table></td><td>100 weeks</td><td>No reduction in the number of 52 week waits. Audit of each patient taking place.</td><td>SPC icons due May 2020 when 12 months of data is available</td><td>SPC icons due May 2020 when 12 months of data is available</td></tr>
<tr><td>Liaison Psychiatry (13 weeks)</td><td><table><tr><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>7</td><td>6</td><td>15</td><td>11</td><td>9</td><td>14</td></tr></table></td><td>80 weeks</td><td>Service will be subsumed into new Core 24 service. No new referrals from December 2019.</td><td>SPC icons due May 2020 when 12 months of data is available</td><td>SPC icons due May 2020 when 12 months of data is available</td></tr>
<tr><td>Cognitive Behavioural Therapy (13 weeks)</td><td><table><tr><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>42</td><td>31</td><td>30</td><td>28</td><td>33</td><td>35</td></tr></table></td><td>104 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><td>SPC icons due May 2020 when 12 months of data is available</td><td>SPC icons due May 2020 when 12 months of data is available</td></tr>
<tr><td>Dynamic Psychotherapy (13 weeks)</td><td><table><tr><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>62</td><td>56</td><td>51</td><td>47</td><td>46</td><td>40</td></tr></table></td><td>96 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><td>SPC icons due May 2020 when 12 months of data is available</td><td>SPC icons due May 2020 when 12 months of data is available</td></tr>
</table>

Personality Disorder (13 weeks)	Jul-19: 69 Aug-19: 62 Sep-19: 63 Oct-19: 59 Nov-19: 61 Dec-19: 93	82 weeks	Long term plan is a review of Psychological Services. Shorter term plan is a case by case review of each long wait patient.	SPC icons due May 2020 when 12 months of data is available	SPC icons due May 2020 when 12 months of data is available
Medical/ Neuropsychology (18 weeks)	Jul-19: 37 Aug-19: 37 Sep-19: 53 Oct-19: 48 Nov-19: 48 Dec-19: 40	77 weeks	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.	SPC icons due May 2020 when 12 months of data is available	SPC icons due May 2020 when 12 months of data is available
CAMHS (13 weeks)	Jul-19: 131 Aug-19: 115 Sep-19: 51 Oct-19: 19 Nov-19: 16 Dec-19: 6	74 weeks	Significant improvement being delivered in line with improvement plan.	SPC icons due May 2020 when 12 months of data is available	SPC icons due May 2020 when 12 months of data is available

4. Patient flow

The following measures are key indicators of patient flow:

<table>
<tr><th rowspan="2">Target</th><th rowspan="2">Trust performance</th><th rowspan="2">RAG/ Comments on recovery plan position</th><th colspan="2">SPC Flag</th></tr>
<tr><th>Assurance of Meeting Target</th><th>Trend</th></tr>
<tr><td>Occupancy Rate - Mental Health Beds (excluding leave)

Target is <=85%</td><td><table><tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr><tr><td>90.4%</td><td>86.9%</td><td>86.2%</td><td>85.6%</td><td>85.9%</td><td>89.6%</td></tr></table></td><td></td><td>?</td><td>NO CHANGE</td></tr>
<tr><td colspan="3"></td><td colspan="2">Key standards are being delivered inconsistently</td></tr>
<tr><td>Occupancy Rate - Community Beds (excluding leave)

Target is >=93%</td><td><table><tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr><tr><td>84.7%</td><td>88.3%</td><td>89.7%</td><td>88.5%</td><td>89.2%</td><td>91.9%</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><td>?</td><td>NO CHANGE</td></tr>
<tr><td colspan="3"></td><td colspan="2">Key standards are being delivered inconsistently</td></tr>
<tr><td>Length of stay (excluding leave) from acute Bradgate wards

Target is <=33 days (national benchmark)</td><td><table><tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr><tr><td>44.0</td><td>41.4</td><td>35.2</td><td>33.5</td><td>41.9</td><td>36.9</td></tr></table></td><td>Length of stay has reduced every month since July 2019 although it remains above the 33-day national benchmark.</td><td>SPC icons due March 2020 when 12 months of data is available</td><td>SPC icons due March 2020 when 12 months of data is available</td></tr>
<tr><td>Length of stay

Community services

National benchmark is 25 days.</td><td><table><tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr><tr><td>18.5</td><td>19.9</td><td>17.7</td><td>19.9</td><td>17.9</td><td>20.4</td></tr></table></td><td>The Trust consistently is below the national benchmark of 25 days.</td><td>YES</td><td>NO CHANGE</td></tr>
<tr><td colspan="3"></td><td colspan="2">Key standards are being consistently delivered and are maintaining performance</td></tr>
</table>

<table>
<tr>
<td>Delayed Transfers of Care

Target is 3.5%</td>
<td>
<table>
<tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr>
<tr><td>4.6%</td><td>4.1%</td><td>4.4%</td><td>4.6%</td><td>3.8%</td><td>3.8%</td></tr>
</table>
</td>
<td>New specialist DTOC meeting with adult social care was introduced in January 2020.

Community services DToC is low and delivering the standard.</td>
<td>?
NO CHANGE

Key standards are being delivered inconsistently</td>
</tr>
<tr>
<td>Gatekeeping

Target is >=95%</td>
<td>
<table>
<tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr>
<tr><td>100.0%</td><td>97.5%</td><td>98.8%</td><td>98.6%</td><td>98.5%</td><td>95.6%</td></tr>
</table>
</td>
<td></td>
<td>YES
NO CHANGE

Key standards are being consistently delivered and are maintaining performance</td>
</tr>
<tr>
<td>Care Programme Approach – 7-day follow up (reported 1 month in arrears)

Target is 95%</td>
<td>
<table>
<tr><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr>
<tr><td>91.3%</td><td>92.6%</td><td>89.2%</td><td>97.8%</td><td>95.3%</td><td>98.1%</td></tr>
</table>
</td>
<td></td>
<td>?
NO CHANGE

Key standards are being delivered inconsistently</td>
</tr>
<tr>
<td>Care Programme Approach

12-month standard

Target is 95%</td>
<td>
<table>
<tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr>
<tr><td>90.8%</td><td>89.0%</td><td>92.4%</td><td>94.8%</td><td>94.5%</td><td>93.5%</td></tr>
</table>
</td>
<td></td>
<td>?
NO CHANGE

Key standards are being delivered inconsistently</td>
</tr>
</table>

5. Quality and safety

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

<table>
<tr><th rowspan="2">Target</th><th rowspan="2">Trust performance</th><th rowspan="2">RAG/Comments on recovery plan position</th><th colspan="2">SPC Flag</th></tr>
<tr><th>Assurance of Meeting Target</th><th>Trend</th></tr>
<tr><td>C difficile

Full year ceiling is 12.</td><td><table><tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr><tr><td>1</td><td>1</td><td>0</td><td>2</td><td>0</td><td>1</td></tr></table></td><td>Trust is below ceiling year to date with 7 cases in 10 months.</td><td>?</td><td>NO CHANGE</td></tr>
<tr><td colspan="3"></td><td colspan="2">Key standards are being delivered inconsistently</td></tr>
<tr><td>Serious incidents</td><td><table><tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr><tr><td>2</td><td>26</td><td>3</td><td>18</td><td>8</td><td>16</td></tr></table></td><td></td><td>N/A</td><td>UP</td></tr>
<tr><td colspan="3"></td><td colspan="2">Key standards are not improving</td></tr>
<tr><td>STEIS - SI action plans implemented within timescales

Target = 100%</td><td><table><tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr><tr><td>90.9%</td><td>100.0%</td><td>100.0%</td><td>0.0%</td><td>No plans</td><td>0.0%</td></tr></table>
Data from November 2019 is to be validated</td><td></td><td>?</td><td>DOWN</td></tr>
<tr><td colspan="3"></td><td colspan="2">Key standards are being delivered inconsistently and are deteriorating</td></tr>
<tr><td>Safe staffing No. of wards not meeting >80% fill rate for RNs

Target 0</td><td><table><tr><td></td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr><tr><td>Day</td><td>4</td><td>3</td><td>1</td><td>6</td><td>3</td><td>2</td></tr><tr><td>Night</td><td>2</td><td>2</td><td>1</td><td>1</td><td>1</td><td>1</td></tr></table>
SPC based on day shift</td><td></td><td>NO</td><td>NO CHANGE</td></tr>
<tr><td colspan="3"></td><td colspan="2">Key standards are not being delivered and are not improving</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 rowspan="2">Target</th><th rowspan="2">Trust performance</th><th rowspan="2">RAG/ Comments on recovery plan position</th><th colspan="2">SPC Flag</th></tr>
<tr><th>Assurance of Meeting Target</th><th>Assurance of Meeting Target</th></tr>
<tr><td>MH Data quality Maturity Index

Target >=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>84.6%</td><td>90.6%</td><td>88.0%</td><td>91.1%</td><td>92.5%</td><td>92.7%</td></tr></table></td><td>The Trust is failing to deliver the 95% target. Improvement plan required.</td><td>NO</td><td>NO CHANGE</td></tr>
<tr><td colspan="3"></td><td colspan="2">Key standards are not being delivered and are not improving</td></tr>
</table>

7. Workforce/HR

<table>
<tr><th>Target</th><th>Trust performance</th><th>RAG/Comments on recovery plan position</th><th colspan="2">SPC Flag</th></tr>
<tr><th></th><th></th><th></th><th>Assurance of Meeting Target</th><th>Trend</th></tr>
<tr><td>Normalised Workforce Turnover rate (Rolling previous 12 months)

Target is <=10%</td><td><table><tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr><tr><td>8.5%</td><td>8.7%</td><td>8.8%</td><td>8.8%</td><td>9.3%</td><td>8.8%</td></tr></table></td><td>The Trust is below the ceiling set for turnover.</td><td>YES</td><td>DOWN</td></tr>
<tr><td colspan="3"></td><td colspan="2">Key standards are being consistently delivered and are improving performance</td></tr>
<tr><td>Vacancy rate

Target is <=7%</td><td><table><tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr><tr><td>8.9%</td><td>9.6%</td><td>8.8%</td><td>8.6%</td><td>8.5%</td><td>8.8%</td></tr></table></td><td>Performance improved in October and November. A vacancy control process is now in place linked to financial turnaround.</td><td>NO</td><td>DOWN</td></tr>
<tr><td colspan="3"></td><td colspan="2">Key standards are not being delivered but are improving</td></tr>
<tr><td>Health and Well-being Sickness Absence (1 month in arrears)

Target is <=4.5%</td><td><table><tr><td>Jul-19</td><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td></tr><tr><td>4.7%</td><td>4.9%</td><td>5.0%</td><td>5.2%</td><td>5.2%</td><td>5.3%</td></tr></table></td><td>The Trust is not delivering the ceiling set for sickness absence. Subject to a SWG review.</td><td>NO</td><td>NO CHANGE</td></tr>
<tr><td colspan="3"></td><td colspan="2">Key standards are not being delivered and are not improving</td></tr>
<tr><td>Agency Costs

Target is <=£641,666 (NHSI national target)</td><td><table><tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr><tr><td>£813,941</td><td>£926,375</td><td>£867,920</td><td>£864,714</td><td>£875,918</td><td>£724,425</td></tr></table></td><td>Increased controls over agency spend is part of the financial turnaround process.</td><td>?</td><td>NO CHANGE</td></tr>
<tr><td colspan="3"></td><td colspan="2">Key standards are being delivered inconsistently</td></tr>
<tr><td>Core Mandatory Training Compliance for substantive staff

Target is >=85%</td><td><table><tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr><tr><td>95.1%</td><td>95.2%</td><td>95.4%</td><td>95.3%</td><td>95.3%</td><td>95.4%</td></tr></table></td><td></td><td>YES</td><td>NO CHANGE</td></tr>
<tr><td colspan="3"></td><td colspan="2">Key standards are being consistently delivered and are maintaining performance</td></tr>
</table>

<table>
<tr>
<td>Staff with a Completed Annual Appraisal

Target is >=80%</td>
<td>
<table>
<tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr>
<tr><td>93.4%</td><td>93.1%</td><td>93.5%</td><td>93.5%</td><td>93%</td><td>93.8%</td></tr>
</table>
</td>
<td></td>
<td>YES
UP
Key standards are being consistently delivered and are improving performance</td>
</tr>
<tr>
<td>% of staff from a BME background

Target is >= 22.5%</td>
<td>
<table>
<tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr>
<tr><td>22.3%</td><td>22.6%</td><td>22.5%</td><td>22.5%</td><td>22.7%</td><td>21.9%</td></tr>
</table>
</td>
<td></td>
<td>NO
UP
Key standards are not being delivered but are improving</td>
</tr>
<tr>
<td>Staff flu vaccination rate (frontline healthcare workers)

Target is >= 80%</td>
<td>
<table>
<tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr>
<tr><td>N/A</td><td>N/A</td><td>22.0%</td><td>44.0%</td><td>55.0%</td><td>58.7%</td></tr>
</table>
</td>
<td>The Trust has not yet achieved the 80% rate. Significant focus on this measure.</td>
<td>NO
UP
Key standards are not being delivered but are improving</td>
</tr>
<tr>
<td>% of staff who have undertaken clinical supervision within the last 3 months

Target is 85%</td>
<td>
<table>
<tr><td>Aug-19</td><td>Sep-19</td><td>Oct-19</td><td>Nov-19</td><td>Dec-19</td><td>Jan-20</td></tr>
<tr><td>80.0%</td><td>84.5%</td><td>86.0%</td><td>86.2%</td><td>81.7%</td><td>83.0%</td></tr>
</table>
</td>
<td></td>
<td>NO
UP
Key standards are not being delivered but are improving</td>
</tr>
</table>

8. Directorate performance reviews

The next 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 March 2020:

- Adult Mental Health – 23rd March 2020
- Families, Young People, Children and Learning Disabilities – 23rd March 2020
- Community Services – 23rd March 2020