Leicestershire Partnership NHS Trust

Public Meeting of the Trust Board
10.00am 5th May 2020 additional Covid-19 meeting
Microsoft Teams Meeting

AGENDA

1) Covid-19 2) Quality and Safety 3) Health and Wellbeing of Staff 4) Risk
5) Finance and Impacts on Performance 6) Statutory requirements

Public Meeting			
Time		**Item**	**Lead**
10.00	1	Apologies for absence and welcome to meeting: Welcome – Mark Farmer; Sally Camm	Chair
	2	Declarations of interest in respect of items on the agenda	Chair
	3	Minutes of the previous public meeting: 3rd March 2020 *(Paper A)*	Chair
	4	Matters arising *(Paper B)*	Chair
	5	Chair's Report *(Paper C)*	Chair
	6	Chief Executive's Report *(Verbal)*	AH
		Governance and Risk	
10.20	7	Covid-19 Risk – In depth review *(Paper D)*	CO/DC
10.30	8	Organisational Risk Register *(Paper E)*	CO/DC
10.40	9	ICC Governance Arrangements *(Paper F)*	CO
		Strategy and System Working – Covid-19	
10.50	10	Covid-19 Update *(Verbal)*	DC
11.05	11	Covid-19 Exit/Recovery Strategy *(Verbal)* • LLR System Wide & LPT	DC
		Quality Improvement and Compliance	
11.15	12	Quality Assurance Committee Highlight Reports – 17th March & 21st April 2020 *(Paper Gi & Gii)*	LR
		Performance and Assurance	
11.20	13	Finance and Performance Committee Highlight Reports – 17th March & 21st April 2020 *(Paper Hi & Hii)*	GR
11.25	14	Finance Report - Month 12 *(Paper I)*	DC
11.35	15	Performance Report - Month 12 *(Paper J)*	DC
11.45	16	Audit and Assurance Committee Highlight Report *(Paper K)*	DH
11.50	17	Review of risk – any further risks as a result of board discussion?	Chair
	18	Any other urgent business	Chair
	19	Public questions on agenda items	Chair
12.00	20	**Next public meeting: 27th May 2020 Microsoft Teams**	Chair

UNCONFIRMED

Leicestershire Partnership NHS Trust

Trust Board

A

Minutes of the Public Meeting of the Trust Board
Tuesday 3rd March 2020 9.30am

The Conference Hall, NSPCC

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
Professor Kevin Harris, 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 Governance and Risk
Mr David Williams, Director of Strategy and Business Development
Dr Anne Scott, Director of Nursing AHPs and Quality
Mr Mark Farmer, Healthwatch
Mr Frank Lusk, Trust Secretary
Mrs Kay Rippin, Corporate Affairs Manager (Minutes)

TB/20/031	**Apologies and Welcome:** The theme of today's meeting is Families Young People and Children's services. The Chair invited all attendees to introduce themselves and welcomed the following individuals to the meeting: Dr Walid Sorour (shadowing Dr Sue Elcock) Dr Lynn Snow Brendan Daly – Armed Forces Lead Darren Smith – Armed Forces Volunteer Kartik Bhalla - Communications

	Tracy Ward – Head of Patient Safety (shadowing Dr Anne Scott) Rebecca Taylor – Business Development Manager (member of the public) Also for the staff voice item TB/20/034 the chair welcomed members of the Diana Service team: Erica Johnson – Family Services Manager Corinne Hutton – Acute Operation Team Lead Tina Woodford – Training Lead Phillipa Harris – Nurse and Student Lead Jenny Doyle – Respiratory Physio Nurse Claire Fallen – Respiratory Physio Nurse Lauren Smith – Nursing Associate Helen Hughes – Health Care Worker No apologies for absence were received.
TB/20/032	**Step into Health – Signing the Pledge:** Brendan Daly, Armed Forces Lead and Darren Smith Armed Forces Volunteer attended with Kartik Bhalla from Communications to present the Step into Health signed pledge. The Board supported the pledge and its initiative. Brendan Daly explained how important the recruitment initiative is as ex-service personnel have transferable skills and the NHS can benefit from this. Brendon Daly offered thanks to Ruth Marchington for being the non-executive champion supporting the armed forces work.
TB/20/033	**Patient Voice Film:** The Diana Service was the focus of the patient voice film. The film described how The Diana Service had been invaluable in supporting a young family with a young child with a life limiting condition. The service had provided them with support throughout their journey from diagnosis. This support included emotional support and advice, and accessing a personal health budget so that the family could continue to live a fulfilling life. The family described the Diana Service as invaluable, flexible, approachable, family centered and proactive and are truly grateful for their continued support. The Board agreed it was a fantastic, emotional story and an invaluable service to support families. The team said it was both a privilege and a pleasure to work with these families and they support each other to remain resilient.
TB/20/034	**Staff Voice Presentation:** The Diana Service Team gave a brief history of the service: before 1997 there was no community children's service so children either had to be in hospital or visiting hospital often daily. In 1998 The Princess Diana Memorial Fund funded a small service. Since then the service has grown to having over 70 staff. The service aims to keep children out of hospital by visiting them in their homes or other settings to offer many services from taking bloods or removing stitches right through to end of life care. The team have varied roles and a varied skillset and recently one of their Health Care Workers has qualified as a Nursing Associate. The team work collaboratively with other services such as UHL and Rainbows. The team offer respite care and allow families to enjoy normal activities safe in the knowledge that their child is being cared for by the Diana Team. They offer training to other key workers involved in the child's care as many of the children

	they work with have very complex healthcare needs. This ensures the children receive the best care possible. The Service is currently supporting 145 children across the county and city all with life limiting/threatening illnesses in their own environments. This helps with flow and bed management and emergency care in hospitals. The Friends and Families test results testify what a highly valued and important service it is. The service needs to grow to continue to support the need across LLR and Helen Thompson confirmed that a business case has been built and that they are optimistic for the future. The Board agreed it was an invaluable service and enquired around the staff wellbeing in sometimes difficult circumstances and the team described 1 to 1 sessions, debriefs, monthly meetings and open door/phone policies within the team. The problems around transition to adult services were discussed with difficulties around no matched adult services being available and services following different guidelines around the definition of adult making transitions difficult at times. A Diana team member is looking at SOP development with regards to transitions but this is only one small part of the issue. Helen Thompson advised that the 18-25 wrap around care initiatives give us the opportunity to look more closely at this group and the provision available. Geoff Rowbotham raised the issue that the STP allows the opportunity to respond to these challenges and bridge these gaps. Angela Hillery confirmed that the STP allows us the opportunity to work differently and we need to look at where we add value by working together. We need to prioritise capacity modelling across the system to enable acute and community children's providers to deliver more integrated working. The Chair asked about the recent team move, the team confirmed that the relocation to Wakerley Ward had some initial teething problems but is now going well and offers huge opportunity for the team moving forward. It could increase the number of appointments and efficiency if the Diana team could hold clinics there.
TB/20/035	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, authors please highlight any new developments or significant implications arising since the paper was written. **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/20/036	**Minutes of the Previous Public Meeting- Paper A:** Paper A - The minutes of the previous public meeting held on 14th January 2020 were agreed. **Resolved: The Board agreed the 14.01.20 public Trust Board Minutes**

TB/20/037	**Matters Arising Actions – Paper B:** Paper B. The Board agreed that all matters that were listed as green were completed and could now be closed. The Chair followed up on amber rated actions 903, 905, 910, 912 and 913 and the action owners confirmed that the action had been completed. **Action: Paper B – the Action Log to be updated as discussed** **Resolved: The Board agreed to the Action Log updates.**
TB/20/038	**Chair's Report – Paper C:** Paper C was presented to the Board by Cathy Ellis. It detailed the work the Chair and Non-Executive Directors had been involved in since the last update. This included 12 boardwalk visits to The Diana Service, Children's speech and language, Paediatric phlebotomy (FYPC); Mental Health Services for Older People Unscheduled care team, St Lukes Hospital Ward 1 stroke unit (CHS) and The Bradgate Unit Ashby Ward, Hershel Prins Griffin Ward Female PICU, Liaison & Diversion Team and 4 Community Mental Health Teams in City Central, City West, County South and County North West (AMH). The Chair has attended a CQC engagement meeting, two Foundations for Great Patient Care meetings with deep dives on seclusion, restraint, ligatures and smoking and had a site visit to the Beacon Unit, our new inpatient building for CAMHS. The Chair also attended the launch of the national Workforce Race Equality Standards (WRES) pilot programme, attended the Race and Cultural Understanding training course and participated in Celebrating Excellence staff awards shortlisting panel. The Chair has held her quarterly meeting with Freedom to Speak up Guardian and attended two Board to Board meetings and the recent Board Development session. **Resolved: The Board accepted the update on activity.**
TB/20/039	**Chief Executive's Report – Paper D:** Paper D ensures that the Board is updated on national and local developments with the Health and Social care sector. Angela Hillery presented the Report. The Report details discussion on national developments including the Coronavirus, new guidance on mental health in integrated care systems and a new awareness campaign launched by Your mind matters in conjunction with NHSE/I & Age UK. Recent publications discussed in the report include the NHS Operational Planning & Contracting Guidance 2020/21, For a greener NHS, Consultation on requirements for patient safety specialists and the Launch of the Gram-negative toolkit. Local developments described within the report include that 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 and Angela Hillery thanked all staff involved in this for their hard work in populating this request in a timely manner. The CEO report also detailed the National Ageing Well team visit LLR which took place on the 12 February 2020 and confirmed that NHFT will be a fast follower in

	this initiative. The 2019 Staff Survey National NHS staff survey results that were recently published. Angela Hillery thanked all 2422 staff who completed the survey and shared their views. The report detailed that 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 Angela Hillery confirmed that she was delighted to advise that our bid was one of six selected for the East Midlands region. The report confirmed that 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 report concluded with recent events and awards news within the Trust and details of internal and external meetings Angela Hillery has attended. The CHS team have won the national HSJ award for workforce innovation – Angela Hillery congratulated them on this achievement. Malcolm Heaven has also been shortlisted for his 'Knead to Chat' initiative. Faisal Hussain questioned if we always clearly set out what success looks like – for example in the reverse mentoring initiative. It was confirmed that formal evaluation of the reverse mentoring programme was taking place and this and other initiatives should not be seen in isolation but as part of the cultural journey. SW confirmed that LPT remains committed to career development opportunities targeted at BAME staff and that a number of one day programmes to support this were being run. **Resolved: The Board accepted the CEO report.**
Governance and Risk	
TB/20/040	**Organisational Risk Register (ORR) – Paper E:** Paper E – Presented by Chris Oakes who described two aspects to the ORR – the current risk register and the risk register process. Chris Oakes has attended recent QAC and FPC meetings and described a process of how the ORR will continue to be improved as part of good practice and to ensure LPT continues to use the risk register in a dynamic way. Consultations with directors have been held and revisions are being made. The revised ORR will be presented at QAC and FPC on 17.03.20 and at the board on 7.4.20. The revision process has been very helpful and has really challenged our concept of active risk management and assurance. This work, the KPI work and the work around the clarity of the level 2 committees all together mean that wewill have robust processes going forwards.. Geoff Rowbotham commented that now the process is clear and that the outcomes are the priority. Liz Rowbotham commented that she hopes to have assurance at the next QAC meeting in this regard. Ruth Marchington expressed concern around the time lapse with the ORR not functioning as planned. Chris Oakes explained that QAC and FPC will have full clarity on the risks and some will will look very different which reflects the dynamic nature and development undertaken. It is a constantly moving tool so a process for regular meetings needs to be set with directors as the ORR is a live working document. Angela Hillery reminded the Board that these changes are dynamic and cultural –

	and have changed the way the organisation and Board approaches risk. Dani Cecchini added that the board must remember how much is being done to deliver the outcomes whilst these changes are taking place. The chair raised the issue of the number of high red rated risks on the register. It was confirmed by both Anne Scott and Chris Oakes that these were being be revised The Chair requested action to be taken on 3 of the high risks with scores that were not being mitigated – 28 and 30 – Waiting Times and Access to Services and 20 – Performance Management Report –it was confirmed that these 3 items will be reviewed by FPC at its next meeting. The Chair asked The Trust Board 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. The chair asked the Board to accept the changes in 2.2 of the ORR **Action: Dani Cecchini to look at risks 20, 28 and 30 at FPC 17.03.20.** **Resolved: The Board agreed to accept the ORR being presented in its most up to date format at the QAC and FPC meetings on 17.03.20**
TB/20/041	**Corporate Governance Update – Paper F:** Paper F was presented by Chris Oakes who described the review of the governance structures that had been taking place over the last 3 months. The presentation around this had been delivered at QAC and FPC. The changes will mean that LPT moves to operate under a role culture with the corporate directors to lead the functions and control the resources and divisions being accountable for operations. Within the review of the committee structures the 2.2 level committees have now become level 3 committees to support the level 2s. Work was now focused on describing the committees and their KPIs. Liz Rowbotham raised the matter of papers not being considered at both the committees and at the Board and required an exception to this rule – giving the example of SIs which would not be discussed by QAC if the papers didn't come to QAC. Geoff Rowbotham raised an issue with the wording around the role of corporate directors and their teams setting the agenda/strategy for their directorate. This needs to state that this will be part of the trusts overall strategic framework of Step Up To Great. The Chair noted that both QAC and FPC need 3 non-executive directors. QAC already has 3, but FPC only 2 so Liz Rowbotham and Ruth Marchington will share the role on FPC, providing additional objectivity and at the same time linking to QAC The Chair confirmed that The Trust Board is asked to approve the revised approach to Trust Governance and support the further implementation and development. **Action: Chris Oakes to amend wording in the corporate governance to include possible exception list for papers being presented to committee and Board and make clearer that strategies will support the Trust's overall framework.**

	Resolved: The Board approved the revised approach to Trust Governance and support its further implementation and development.
Strategy and System Working	
TB/20/042	**Service Presentation:** The Chair welcomed the team to the Trust Board Meeting and Helen Thompson introduced the item - FYPC Service Presentation – Ian Harratt Clinical Project Manager FYPC; Louise Evans – Service Group Manager FYPC and Helen Jones – Family Service Manager Paediatrics, OT and Physio FYPC. A PowerPoint presentation was delivered to the Board and will be circulated to the Board for information. In brief, the presentation described the diverse range of services within FYPC and the changes around governance and structure made over the last 18 months by this team. The focus today was on 2 services in particular. The 0-19 service had initiated a review because available funds in the County had been reduced by half a million pounds The area of service undergoing the redesign was the Healthy Together initiative serving over 237,000 children across LLR. Task and finish groups were set up in 2019 for 8 different redesign areas: Antenatal; Bumps to Babies; 6-8 Week Contract; 3-4 Month Contract; 2 Year Contract; 5-19; SystemOne Configuration and Enhancing Digital Offer. In total 360 staff were engaged in the review and the new service goes live on 1st April 2020. The County Paediatric service is transferring from the Alliance contract to LPT. A review had been initiated due to a disparity of services between the City and County leading to differing wait times. 8 Project work streams were detailed – Contract Finance; HR People Recruitment; Estates and Clinics; Comms; IMT/Data Transfer/ EPR; Performance; Governance and Clinical Model. The last 6 months has been the mobilisation period ready for delivery from 1st April 2020. The redesign has involved demand and capacity modelling; review of roles; involvement of service users; meetings with commissioners and stakeholders and developing measures of success for each redesign. Work has been carried out collaboratively to avoid duplication of work. Go live date is 1st April 2020 and there has been an increase in funding to increase capacity in order to reduce the 843 County waiting list. (There are 240 children waiting over 40 weeks and 41 waiting over 30 weeks). The service will increase its operation from 4 sites to 10 sites which should improve access for families. Data recording will initially remain separate to ensure that the County waiting list does not adversely affect the City wait times but this will be one single service moving forward. The Chair congratulated the team on the significant amount of transformation work they have done. Kevin Harris was interested if the learning had been captured and could be shared with other teams in the Trust. The team confirmed that they have tracked, planned and gathered lessons learned throughout. Dani Cecchini had attended the recent cascade session and said it was great to see the transformation to make financial savings in such a positive light. Helen Thompson confirmed that the Transformation Committee will be given the details around this project.

	David Williams suggested that April's RTT will be affected and therefore aa narrative to explain why within the performance pack will be required so everyone can understand why. The Chair commented that a clear trajectory of recovery is needed for the waits and this will be overseen at FPC. Helen Thompson confirmed that they have a recovery plan. Angela Hillery thanked the team and confirmed that this is the kind of model that we want to use in the LLR system and it's a great example to demonstrate that LPT not only want to take change on but also that they can successfully take change on.
TB/20/043	**Step Up To Great (SUTG) Progress/Milestones/KPIs – Paper G:** David Williams presented Paper G and confirmed that there was much going on and being achieved and still more to be done and that we all needed a good clear narrative around SUTG which the paper delivered. The Chair commented that the paper was excellent, giving a good clear narrative around each of the SUTG bricks. Geoff Rowbotham agreed that the paper contained SMART objectives, live triangulation and ORR referencing. Geoff Rowbotham raised the following queries – the details around the High Standards brick do not clearly indicate why this remains at amber; as it's a live document could we develop a RAG rating around the outcomes and then this could be linked to the Performance Report; could this model be used for the CQC as it is a great model. Mark Farmer, Healthwatch commented that he felt there was still more co-design work to be done with patients and carers who were involved at the beginning but not so much now. Gordon King described how the AMH have redesigned patient involvement and that there is a Patient and Carer Involvement Champion Day on 4.3.20. Anne Scott added that the People's Council Patient Involvement Experience is a 3 year delivery plan and that Alison Kirk is working on this and would like Mark Farmer to co-design it. In respect of TCP Angela Hillery reminded the Board that this is just LPT's part of the transformation there are wider aspects including housing and employment – the SUTG work reflects what LPT are doing in the System for TCP . Within high standards, Darren Hickman raised the matter of self-regulation on areas that were not inpatient areas and if any plans were in place to change this. Anne Scott confirmed that the inpatient accreditation programme was gaining pace and that accreditation in community was not done nationally and that a tool is being developed by LPT. Anne Scott confirmed that all quality self-regulation activity should now be called Quality Accreditation and not self-regulation, and this will be discussed at the March QAC meeting. Ruth Marchington raised the issue of Environments urgent response times for repairs being at 49% with a target of 95% and the narrative around how we will achieve this. The Chair confirmed that this will be covered at the Board Development day on 7.4.20 when we will receive a status report on FM services. The Chair noted that the BAME staff interview skills training remains off target and Sarah Willis confirmed that interview skills workshops will be run at the Inclusion

	Conference planned for the end of March. The Chair confirmed that The Board is recommended 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. **Resolved: The Board agreed to receive assurance as requested.**
Quality Improvement and Compliance	
TB/20/044	**Quality Assurance Committee Highlight Report – Paper H:** Paper H the Highlight Report from the meeting held on 18th February 2020 was presented to the Board by Liz Rowbotham. Liz highlighted the following points: No updates onspot checks on CQC Report; Clinical Quality Strategy – reiterated the fact that SUTG is our strategy so this is more an enabling strategy; Patient Experience Q 3 report came to QAC in its old style – the new style report is with the Board today; The Learning From Deaths Report has been amended for Board today following QAC feedback. Dani Cecchini confirmed that the Health and Safety report amber areas are due to actions needing to be followed through and not linked with the H&S Inspection. The Chair commented on the feedback from the Quality Forum and suggested that a review of the committee is conducted now that it has been running for 3 months. Liz Rowbotham confirmed that she felt confident it was starting to work well and Anne Scott added that she felt it will improve after the next quarter, that it is a very large forum and it is moving in the right direction. The Chair recommended the Board to receive assurances raised in the Quality Assurance Committee Meeting of 18 February 2020. **Resolved: The Board accepted the assurances from the QAC Highlight Report.**
TB/20/045	**Director of Nursing, AHPs and Quality Report – Paper I:** The report Paper I was presented to the Board for assurance by Anne Scott. Anne Scott updated the Board on changes since Paper I was written. The next SIAM Meeting would be held in May; the flu vaccine CQUIN target of 60% was achieved at 60.6%; there is a Deep Dive into the plans for next year's flu initiative at April's QAC; the NHSI Infection Control re-visit is due to take place on 13th May 2020 and there are coronavirus plans in place which change daily with Mike Ryan and Emma Wallis leading on this – currently preparing to staff a 3rd pod. Anne Scott commented that there has been good practice evidenced from staff during the recent challenges of high acuity on CAMHS Ward 3. 2020 is the International Year of the Nurse and Midwife and there is a conference being held on May 12th where the Daisy Award will also be launched. Angela Hillery commented that the Estates team responded superbly to the Ward 3 estates issues evidencing good team work. Faisal Hussain questioned how we would ensure the revised training around seclusion and segregation was embedded and how will we bridge the gap before audit/spot check? Anne Scott confirmed that there is an ongoing audit with a weekly report to execs and that the information feeds directly into the Positive and

	Safe Group. Also Deep Dives have been conducted at other committees/forums. Anne Scott confirmed that she continues to monitor the situation. **Resolved: The Board agreed to accept assurance from the report.**
TB/20/046	**Care Quality Commission (CQC) Progress - Report Paper J:** Paper J was presented to the Board by Anne Scott for assurance. Anne Scott confirmed matters addressed since this report – item "should do 11" CTO training action is complete and monthly audits are now in place. The dormitory accommodation "must do 3" – was raised at QAC and presented to Board, the action was to develop a plan and we have done this so this is now complete and removed. Rachel Bilsborough suggested that a wider communication was issued on dormitories to prevent confusion on this matter. Anne Scott confirmed that Julie Robenza was leading on the CQC matters and the Foundation to Great Patient Care meeting will be a forum to discuss lessons learned and good practice. Geoff Rowbotham raised the matter of the smoking policy and Angela Hillery advised the Board that this will be an ongoing piece and that collaborative work is being carried out with NHFT, the CQC are clear why our action plan stands at 97% and have been supportive of our approach. The Chair recommended the Board 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. **Resolved: The Board agreed to accept the report as assurance.**
TB/20/047	**Safer Staffing Monthly Report – December 2019 and January 2020 – Papers Ki & Kii:** The December 2019 and January 2020 monthly reports were presented to the Board by Anne Scott who confirmed that December's went to QAC; January's did not. Anne Scott confirmed that there were similar themes in both reports and that the Board should note the change in terminology from "hot spots" to "areas to note". There are 11 areas to note detailed in the report – a slight increase since December but not a significant variation. The Chair recommended that the Trust Board 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. **Resolved: The Board agreed to accept assurance from the report.**
TB/20/048	**6 Monthly Safe and Effective Staffing Review Report – Paper L:** Paper L was presented by Anne Scott who confirmed that whilst there is a national shortage, planned staffing levels had largely been achieved. The areas where it had not, was due to adjustment in skills mix and this remained within safe parameters. The trust's bank staff numbers are at 1000 and this increase helps us to comply with the mandatory staffing numbers. The data collection across inpatient wards was delayed but is ongoing and will come to the April Board.

	Faisal Hussain questioned how we manage quality of care whilst staff are working in a more pressured environment due to shortages and Anne Scott confirmed that the quality of care and harm is always captured and that this is a bigger issue than this paper would cover. Faisal Hussain sited the increase in falls on Coleman Ward and asked how we are mitigating this. Sue Elcock added that triangulation from the Safer Staffing report evidence with vacancy rates, turnover rates and sickness rates is carried out regularly adding another layer of assurance. Anne Scott confirmed that the Falls Group report into the Quality Forum and this is how this information would be received. The Chair was supportive of the teams being creative with new roles and the appropriate skills mix. Angela Hillery commented that supervision and mandatory training gives confidence around improvement trajectories. Liz Rowbotham raised the issue that temporary worker description is not enough – these could be our own regular bank staff as opposed to agency staff and would like to see this analysis. The Chair recommended that the Trust Board 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. **Resolved: The Board agreed to accept assurance from the report.**
TB/20/049	**Guardian of Safe Working Hours (Junior Doctors Contract) Quarterly Report Q3 – Paper M:** The Quarter 3 report was presented to the Board by Sue Elcock. There have been three exception reports in the last quarter which is not an increase although there are some concerns around trainees not completing the exception reports. In order to reduce this the 3 rotas are being combined to be 2 to improve the experience of junior doctors. The Board were asked to note that the new rules around safe working hours allow fines and this is a possibility for our Trust. The Chair recommended the Trust Board receive Paper M as assurance. **Resolved: The Board agreed to receive assurance from Paper M.**
TB/20/050	**Patient and Carer Experience and Involvement (including complaints) Q3 Report – Paper N:** Paper N was presented by Anne Scott who confirmed that the theme of complaints/ comments in Q2 was delays of appointments and length of waits. There has been a new Complaints review Group set up and new processes have now been put in place which will have a positive impact. The report provided details of how the patient involvement strategy is being worked through to increase patient feedback and co-design. The Chair noted that there has been a positive increase in the Friends and Family responses and that the reconditioned Ipads will also have a positive impact. The Chair advised that the Board 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. The Board was also recommended to 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. **Resolved: The Board agreed to receive assurance from Paper N.**
TB/20/051	**Patient Safety Incident and SI Learning Q 3 Report Paper O:** Paper O presented by Tracy Ward, Head of Patient Safety who attended the Board to shadow Anne Scott. This report was in the new style and now focused on looking for learning rather than blame. The report details an increase in self-harm on Beaumont, Heather and CAMHS Ward 3 and Deep Dives are planned into these areas. There have been some Post Fall Huddles looking at 2nd falls and this has highlighted that low beds are sometimes inappropriate and the cause of some falls. The risk assessment process around this is now being strengthened. The ECD process cause a spike in medicine problems around August 2019 but this has now been resolved. Tracy Ward is working hard to build a closer relationship with the CQC and is speaking with them directly now on all incidents. The mapping exercise on SI process with NHFT is complete and they are now working to harmonise the processes. The Chair commented that this new report is much improved and that the themes are clear now. Liz Rowbotham agreed and confirmed that a Deep Dive into The Duty of Candour will take place at April's QAC. The Chair commented that there was great feedback from the recent Compassion in Care day and that feedback on investigations included that a more centralised approach was desired with opportunities for staff to be seconded. Tracy Ward confirmed that this would be addressed in the second phase and a secondment into a centralised team would be considered.. The Chair confirmed that the Board is requested to review and confirm that the content and presentation of the report of incidents provides assurance around all levels and categories of incidents. The Board was also requested to acknowledge that development of reporting is on-going and the presentation of the report may change as this develops. **Resolved: The Board agreed to receive assurance from this paper.**
TB/20/052	**Learning From Deaths Report Q2 and Q3 – Paper P:** Paper P was presented by Sue Elcock who confirmed that the report had been to QAC previously and the board could be confident that both the numbers and the learning are being monitored. Sue Elcock asked the Board to note that within CHS services there are increased numbers of patients which is expected because of the nature of these services and patient cohorts and the policy around this may need to be adjusted to reflect the data more accurately. Liz Rowbotham confirmed that QAC were assured that progress was being made. The Chair recommended that the Board be assured that there is a robust process in place for learning from deaths. **Resolved: The Board agreed to receive assurance from this paper.**

Performance and Assurance	
TB/20/053	**Staff Survey – Paper Q:** Paper Q was presented by Sarah Willis who confirmed that 2019 was a year of significant change for all staff. Our Future, Our Way culture programme had listened to staff and their concerns. The feedback from the Staff Survey reflects what the Change Champions have heard and work is therefore underway on addressing these matters. The Bank Staff were surveyed at the same time – this report is currently in draft form but Sarah Willis confirmed that the respondent numbers doubled since the last Bank Staff survey. Work to address issues is underway and includes Our Future, Our Way; SUTG; Leadership Behaviours; The No Bullying LIA; Senior Leadership Forum; Leading Together conference and the 2 year pilot WRES programme. Angela Hillery commented on the increased Bank Staff responding to the survey highlighting that this shows significant progress and this describes a culture where people feel it's worth talking even if this highlights areas of improvement required . The Chair requested that equal profile is given to staff and bank staff results in the report produced and she would like to see it come to the Board meeting David Williams requested that analysis of the staff survey by teams is vital to encourage teams to discuss their own results and think about how they can use this in their teams. Ruth Marchington noted that the rate of return in 2019 was lower than that for 2018 and Sarah Willis suggested that there were a number of internal surveys in a short space of time and this may have had an impact. Sarah Willis also confirmed that they were looking at ways to make completing the survey easier for example not needing a username and password. NHFT are discussing their way with LPT. The Chair recommended that The Board consider the results of the 2019 NHS Staff Survey and support a more detailed analysis being undertaken with the priority areas identified and actions agreed by the Strategic Workforce Committee (SWC). **Resolved: The Board agreed to support the more detailed analysis required.**
TB/20/054	**Finance and Performance Committee Highlight Reports 21.01.20 & 18.02.20 – Papers Ri & Rii:** The FPC Highlight Reports were presented to the Board by Faisal Hussain who confirmed that there had been lots of challenge from FPC around waiting times improvement plans to ensure that there are robust. Faisal Hussian confirmed that most of the items on the Highlight Report will be discussed at Board today and that FPC have given technical approval to policies that do not go to The Policy Committee or to Board. The Chair recommended that The Board receive assurance raised in the Finance and Performance Committee meetings held on 21.01.20 and 18.02.20, Paper Ri and Rii.

	Resolved: The Board agreed to accept assurance from the FPC Highlight Reports.
TB/20/055	**Finance Monthly Report – Months 9 & 10 – Papers Si & Sii:** Paper Si & Sii were presented by Dani Cecchini who confirmed that great improvements are evident in operating positions in month 10. It was also noted that month 12 may present some challenges due to the acuity and increased staffing issues on Ward 3 CAMHS. In the report the cash position is higher than expected largely due to more PSF and improved debtors. The Cost Improvement Plan (CIP) achievement is at 66% for month 10 forecasted to be 57% at year end with agency costs above plan. The Chair recommended that the Trust Board 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. Months 9 & 10 - **Resolved: The Board agreed to accept the month 9 & 10 reports for assurance.**
TB/20/056	**Performance Report – Months 9 & 10 Papers Ti & Tii:** Months 9 & 10 - Papers Ti & Tii were presented to the Board by Dani Cecchini who confirmed that Month 9 includes the narrative at directorate meetings and also describes the KPI process. Month 10 shows new SPC indicators. Dani Cecchini confirmed that the definition of targets around seclusion and falls is still to be finalised. The key red areas are RTT and 18 week wait. Mandatory Training and Clinical Supervision are compliant Trust wide. The Chair thanked Laura Hughes for her work in developing this new format which was much clearer. Liz Rowbotham was concerned that the report still did not include the CQC plan and metrics for quality, indicating that without these it is not a balanced picture. Dani Cecchini confirmed that following consideration at March FPC and QAC, these metrics will be agreed at the next Board. Helen Thompson commented that the Learning Disability wait times should be back on plan shortly. Geoff Rowbotham commented that the work is coming on well but now needs a sense check – should that data be there. We need to take a common sense view. The Chair recommended that the Board receive assurance with regard to areas of quality and performance where performance improvement action is being undertaken. **Resolved: The Board accepted assurance from the Performance Report**
TB/20/057	**2020/2021 Financial Plan – Paper U:** Dani Cecchini presented Paper U to the board for approval. Hard copies were circulated to attendees so that the Board could receive the most up to date position. Dani Cecchini talked through the presentation and confirmed that the LPT plan was here in draft and the final plan would need to be signed off before

	submission. The LLR System Plan was submitted in February and has not yet been approved by NHS England. Discussions were held around the figures contained within the draft LPT plan and Dani Cecchini confirmed that the net surplus would be £1.9m based on 2.6% CIP savings which were needed to cover an underlying gap of £11.6m.Growth of £4.6m will be allocated and some of this was investment which would reduce the gap. With regards to the capital detailed in the report, IM&T and the Estates Group have looked at prioritizing this capital and this will be seen at Strategic Exec Board on 6th March and FPC on 17th March. The capital plan includes funding for year one of the dormitory business case and the completion of the new CAMHS Beacon Unit. There are two issues that are still being resolved – Digital and Agile – a strategy around these is being discussed. Dani Cecchini confirmed that within this plan, no CQUIN or other penalties are assumed and the LLR system risk share for LPT currently stands at 2%. A System approach to risk is currently being established. Dani Cecchini asked the Board to note that we need to have a balance view of what can be improved and what will need to be mitigated. The Quality Impact Assessments for all CIPS will be presented at the joint QAC and FPC on 17th March. Mark Farmer, Healthwatch asked how the patient voice fed into the financial position, continuing that he was aware of two areas where patients were keen to have more financial input and these were the Recovery College and The People's Council. Angela Hillery confirmed that the Board was now in a better position to know where we want to prioritise and that the patient voice/experience is explicit around waiting times so that we are clear where we prioritise and why. Anne Scott continued that the People's Council feeds into the Quality Improvement Board and the patient voice is heard there. Geoff Rowbotham commented that the public's perception of the NHS's financial position may not reflect the actual position so it is important to keep them up to date which the Chair confirmed will continue to happen through the public Board meetings. Dani Cecchini confirmed that there will be a phased approach to the release of plans and Angela Hillery confirmed that there is some positive within it but that demand and pressure is stronger than ever. The Chair recommended the Board approve the plan as it stands at this point in its draft form. It will then go back to FPC and the final version come back to Board – this allows it to function from April 1st 2020. **Resolved: The Board agreed to approve the plan in its current draft form and receive the final plan at the next Board meeting.**
TB/20/058	**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: (1) Coronavirus – a local risk – Anne Scott was adding this to the policy. (2) Junior Doctor breaches – confirmed that this was one to watch, not yet an organisational level risk.
TB/20/059	**Board Performance Pack:** The Board members confirmed receipt of the following documents: • Ratified SLT Minutes 19.12.19 • NHS Staff Survey 2019 - Full • NHS Staff Survey 2019 - Directorate • NHS Staff Survey 2019 – Summary
TB/20/060	**Any Other Urgent Business:** No other urgent business was raised.
TB/20/061	**Feedback on the Meeting:** The Chair requested feedback from the Board members on today's meeting. Comments were: good venue, very informative patient and staff voice items.
TB/20/062	**Public Questions on Agenda Items:** No questions at this meeting but comments came from Dr Lyn Snow who suggested that the changes in corporate governance were communicated well to all staff so that not only do they all understand it but that they all see it as a positive step. Mark Farmer also commented that the CQC had requested his opinion on the Trust Board and he will share what was discussed with Angela Hillery and the Chair.
TB/20/063	**Date of next Meeting:** The next public Trust Board meeting will be held on Wednesday 27th May 2020, Guthlaxton Committee Room County Hall.
TB/20/064	**Post meeting note dated 10 March 2020:** The flu vaccination rate was subsequently confirmed as 59.93% following data validation and data cleansing by the UHL Occupational Health team, which means that LPT are 0.07% short of the CQUIN target of 60%.

B

Leicestershire Partnership NHS Trust

TRUST BOARD 5th May 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)
903	November TB/19/200	Assurance sought that a solution had been found on the appropriate recording and monitoring of data for out of area beds.	Dani Cecchini	Completed - 3rd March 2020	SystmOne will sort this matter. FPC to monitor this moving forward. Action closed 3.3.20
905	December TB/19/215	Explore the possibility of strategic links with DNRS (the national facility being proposed for rehabilitation)	David Williams	Completed - 3rd March 2020	Completed and closed.
907	December TB/19/218	QAC to feed back to the Board once the Deep Dive into Transforming Care	Helen Thompson	27th May 2020	Update required

Action No	Meeting month and minute ref	Action/issue	Lead	Due date	Outcome/evidence (actions are not considered complete without evidence)
		which is due to be done in April 2020, is completed.			
910	January TB/20/020	Quality Impact Assessment of the Financial Turnaround to be sent to QAC meeting.	Dani Cecchini	Completed - 3rd March 2020	Action completed.
912	January TB/20/025	Consider the risk around recruitment of consultants.	Sue Elcock	Completed - 3rd March 2020	Action Completed and added to ORR
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	Completed - 3rd March 2020	Action completed.
914	March TB/20/040	ORR risks 20, 28 and 30 to be addressed at FPC 17.03.20.	Dani Cecchini	17th March 2020	Update required
915	March TB/20/041	Amend wording in the corporate governance document to include possible exception list for papers being presented to committee and Board and make clearer that strategies will support the Trust's overall framework.	Chris Oakes	17th March 2020	Update required

C

Trust Board 5th May 2020

LPT Chair's report summarising activities and key events From 3rd March 2020 to 5th May 2020

Thank you to all LPT staff who have stepped up to great during the Covid crisis – you have been incredible #ClapForCarers

Hearing the patient and staff voice	Chair and Non-Executive Directors made 7 boardwalk visits between 3rd March and 18th March 2020. (In order to comply with government Covid19 guidelines and visitor restrictions, Boardwalks were postponed from mid-March). • **FYPC** – Diana service • **CHS-** both wards at St Lukes Market Harborough, Dalgleish Ward at Melton hospital (included observation of 2 resuscitation training drills) • **AMH** – Bradgate Unit Aston ward, Bradgate Unit Beaumont Ward, Male PICU Belvoir Ward, Criminal Justice & Liaison Service
Connecting for Quality improvement	• The CQC inspection that was due in Spring 2020 has been postponed, but regular contact with the CQC is being maintained through engagement meetings. The April meeting featured updates from the CQC and LPT's progress against themes from the inspections in Nov 2018 and June 2019. Covid19 changes to governance and operational services were also discussed. .
Promoting Equality Leadership & Culture	• Visible leadership from Board members through "all staff" briefings, videos and Twitter during Covid period. • Quarterly meeting with Freedom to Speak up Guardian to discuss themes, concerns, national developments and particular focus on Covid19.
Building strong Stakeholder relationships	• Buddy Trust planning with NHFT for 2020/21 – to finalise targeted support areas for LPT around quality and safety, and wider collaborative opportunities for both trusts. • Leicester City Homelessness oversight Board meeting • NHS Partnership Board meeting with LLR health partners • Joining weekly NHS Confederation Mental Health Chairs network calls and NHSI Regional Director calls – focused on governance during Covid19 period • University of Leicester meetings : meeting with the Head of School of Allied Health Professionals and visit to the Physiotherapy department; University Council; University Finance committee
Good Governance	• The Board approved new interim governance arrangements in response to Covid19 on 30th March 2020. The Board and critical committee meetings focus on 6 areas: Covid19, quality &safety, health & wellbeing of staff, risk, finance & performance, statutory requirements. • Non-Executive Director weekly calls with Chair established on MS Teams to brief on COVID related matters and ensure alignment of committee governance.
LPT's Charity : Raising Health **"we say thank you"**	• Thank you to the public for their support of the NHS during the Covid period. LPT staff have received many gifts of food, handcreams and treats directly into their teams. • Raising Health has received financial donations from NHSCharitiesTogether, the public and local organisations which have enabled us to set up 34 "wobble" rooms across the trust and purchase single use activities for patients. The Charitable Funds committee are meeting regularly to ensure that decisions are taken on use of the funds and support gets to the frontline quickly.

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

Risk No: 40	High standards	Date included:	11.03.20
Risk Title:	The ability of the Trust to deliver high quality care may be affected during a Coronavirus COVID-19 pandemic		
Risk Owner:	Director of Finance, Business & Estates and Deputy Chief Executive	Date Last Reviewed:	24.04.20
Governance / Review:	Weekly Executive Team, QAC/FPC, Trust Board		

	Conseq-uence	Likeli-hood	Combined
Current Risk	5	4	20
Residual Risk	5	3	15
Risk Appetite	5	3	15

Controls

Description:

- National level 4 major incident led by COBR with national, regional and local resilience structures and policies in place
- COVID-19 Incident Management Team and Control Centre open 8 – 8 7days per week / Single point contact 24/7 email and dedicated phone
- LPT Gold, Silver and Bronze chain of command with role specific cells to support the ICC
- Approved, interim governance and risk management arrangements with focus on action, risk and decision logs
- Prioritisation of critical services and maintenance of business continuity plans
- Policy controls are in place for IPC, major incident place, Flu pandemic
- Participation in national and LLR health resilience forums
- National weekly Webinars / Communications for COVID-19 both internally and externally
- Communication of information – Staff Room and daily Email
- Staff guidance on Management of isolation and reporting / Agile home working policy / Occupational Health dedicated phone lines
- National guidance on workforce
- National and system updates including modelling on the development of the pandemic
- Procurement hub with PPE planning and distribution
- Impact of COVD-19 on existing ORR and local / Directorate risk registers
- Daily SitRep reports
- Established surge capacity in line with system requirements

Gaps:

- National shortages of PPE and inconsistent distribution of stock into LPT
- Full quality risk impact assessments for any full or partial service closures
- Capacity to address an influx of referrals post COVID
- An understanding of the impact of a likely surge in the number of legal challenges relating to decisions made during the coronavirus pandemic

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Weekly flash report to Executive Team • Communications structures to staff • 7-day per week COVID-19 major incident meetings • COVID related National Guidance reviewed daily • Monitoring of unintended consequences of rapid and high pressured decision making	• Weekly Flash report to Board of Directors 17th March 2020 • Monthly risk report to level one committees • Directorate highlight reports • Situation Reports (SitReps) • Regular staff and stakeholder briefings	Amber
External:	• Department of health / Public Health England / NHSEI / Cobra / Chief Medical Officer • LLR system advice and planning / Joint CEO exec daily (Mon-Fri) reporting structure • Gov.uk COVID-19 information email alerts / National webinars • Buddy relationship with NHFT	• Records of Joint CEO daily conference calls	Amber
Gaps:			

	Actions:	Action Owner:	Progress:	Status:
Ongoing May 20 May 20 Ongoing	• Procurement Hub to continue to respond to PPE concerns • Quality risk impact assessments to be signed off by the ICC • Establish the recovery cell to address post COVID referrals and legal challenges • COVID-19 action plan held by the ICC	Sarah H Dani C ICC ICC	• Procurement Hub have systems and processes in place to respond to PPE shortages • QIA for business critical services to be ready for sign off week beginning 27.04.20 • The Recovery cell is being scoped.	Amber

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 5th May 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 & FPC	21st April 2020

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
• Note the amendments made to the ORR and the Trust's current and residual risk profile.

Leicestershire Partnership NHS Trust

Organisational Risk Register April 2020

1 Introduction

1.1 The Organisational Risk Register (ORR) is presented as part of a continuing risk review process. At each meeting the Trust Board receives the summary ORR highlighting any risk changes and updates since the last Board. The Strategic Executive Board regularly considers the ORR, with the Quality Assurance Committee (QAC) and the Finance and Performance Committee (FPC) exercising their delegated responsibility from the Board to review, and gain assurance on their allocated risks. The ORR is then updated to reflect committee recommendations and the revised summary ORR presented to the following Trust Board.

1.2 This report outlines the current ORR

2. Discussion

Since the March 2020 ORR report two risks have increased, three have reduced, and there has been one de-escalation.

2.1 Current risk scores for two risks from the 'high standards' element of our strategy have increased due to the impact of the coronavirus and the additional pressure that services are currently under;

- Risk 1 'the Trust's clinical systems and processes may not consistently deliver harm free care' the level has changed from 12 (amber) to 16 (red).
- Risk 3 'the Trust does not learn from incidents and events and does not effectively share that learning across the whole organisation' the level has changed from 12 (amber) to 16 (red).

Current risk scores for three risks (one from the patient involvement and two from the well governed elements of our strategy) have reduced;

- Risk 12 'service users, carers and families do not have a positive experience of care, do not feel able to participate effectively and share their experiences'. The level has changed from 12 to 9 due to the progress made with launching the involvement framework and the agreement to fund FFT moving forward. There is a risk in relation to Covid-19 in relation to putting back the relaunch of FFT to May 2020, however this is in line with NHSE advice.
- Risk 20 'performance management framework is not fit for purpose' the level has changed from 16 (red) to 8 (amber) due to the level of progress achieved to date on designing and implementing a framework, with a new format performance

report approved the board and the first rounds of performance management reviews taking place.

- Risk 22 ‘information systems and processes are not robust enough to militate against cyber-attacks and information breaches’ the level has changed from 16 (red) to 12 (amber). This was changed following ongoing review of the cyber risk framework and the positive external assurances received.

2.2 There has been one de-escalation: Risk 36 ‘the Trust cannot ensure all staff adhere to Bare Below the Elbow recommendations’ has been de-escalated to Directorate level. It was agreed at the joint QAC/FPC in March 2020 that this risk related to a lack of cultural ownership which is covered in risk 25 ‘Staff do not fully engage and embrace the Trust’s culture and collective leadership’.

2.3 This month the ORR has introduced a new risk appetite component to the risk scoring; this will be reviewed by executive directors and updated during April 2020.

3. Analysis

3.1 Current risks scoring 20 or above

There are three risks rated 20;

- Risk 28 ‘Delayed access to assessment and treatment impacts on patient safety and outcomes’ (access to services). No change has been proposed to the risk level at this review.

- Risk 38 ‘Unable to deliver the operational plan due to financial pressures from the system and funding settlement’ (Well Governed). No change has been proposed to the risk level at this review.

Risk 40 ‘The ability of the Trust to deliver high quality care may be affected during a Coronavirus COVID-19 pandemic’ (High Standards). This risk has been reviewed by the joint QAC/FPC in March 20 and no change in risk level has been proposed. In addition to this overarching risk, an impact box has been included within other relevant risks on the ORR to allow for an understanding of the impact of coronavirus on other strategic risks. This primarily captures the reasons for any delays to the completion of actions, or any reduction in the current controls (for example due to the temporary changes in corporate governance).

4. Summary of the revised ORR April 2020

Risk No.	Title	Owner	Committee Group	SUTG	Months on ORR	Current risk	Residual Risk
1	The Trust’s clinical systems and processes	DoN	QAC	High Standards	6	16	8

	may not consistently deliver harm free care.						
2	The Trust's safeguarding systems do not fully safeguard patients and support frontline staff and services.	DoN	QAC	High Standards	6	12	8
3	The Trust does not learn from incidents and events and does not effectively share that learning across the whole organisation.	DoN	QAC	High Standards	6	16	8
4	Services are unable to meet safe staffing requirements	DoHR	SWC	High Standards	6	12	8
5	Capacity and capability to deliver regulator standards	DoN	QAC	High Standards	6	12	8
6	The step up to great mental health strategy does not deliver improved mental health services that meet quality, safety and contractual requirements and are sustainable.	DoAMH	FPC	Transformation	6	16	12
8	The transformation plan does not deliver improved outcomes for people with LD and/or autism.	DoLD	FPC	Transformation	6	16	12
9	Inability to maintain the level of cleanliness required within the Hygiene Standards	DoF / DoN	QAC/FPC	Environment	6	12	8
10	Failure to implement planned and reactive maintenance of the estate leading to an Unacceptable environment for patients to be treated in	DoF	FPC	Environment	6	16	12
11	The current estate configuration does not allow for the delivery of high quality healthcare	DoF	FPC	Environment	6	16	12
12	Service users, carers and families do not have a positive experience of care, do not feel able to participate effectively and share	DoN	QAC	Patient Involvement	6	9	6

	their experiences.						
16	The Leicester/Leicestershire / Rutland system is unable to work together to deliver an ICS	DoS/CEO	FPC	Well Governed	6	16	12
20	Performance management framework is not fit for purpose	DoF	FPC	Well Governed	6	8	4
22	Information systems and processes are not robust enough to militate against cyber-attacks and information breaches	DoF	FPC	Well Governed	6	12	8
23	Failure to deliver the EPR system and demonstrate the benefits of the system	MD	FPC	Single Patient Record	6	8	4
24	Failure to deliver workforce equality, diversity and inclusion	DoHR	QAC	Equality, Leadership, Culture	6	12	9
25	Staff do not fully engage and embrace the Trusts culture and collective leadership	DoHR	QAC	Equality, Leadership and Culture	6	16	12
26	Insufficient staffing levels to meet capacity and demand and provide quality services	DoHR	QAC	Equality, Leadership and Culture	6	16	12
27	The health and well-being of our staff is not maintained and improved	DoHR	QAC	Equality, Leadership and Culture	6	9	6
28	Delayed access to assessment and treatment impacts on patient safety and outcomes	DD and MD	QAC / FPC	Access to Services	6	20	16
29	The trajectory to achieve the out of area placement is not maintained	DoAMH	QAC / FPC	Access to Services	6	12	8
33	Insufficient executive capacity (including Joint Chief Executive role) to cover demand and impacts on LPT ability to achieve it's strategic aims	DoHR/CEO	Trust Board	Well Governed	4	12	8
35	The quality and availability of data reporting is not sufficiently mature to inform quality decision making	DoF	FPC	Well Governed	3	16	12

38	Unable to deliver the operational plan due to financial pressures from the system and funding settlement	DDoF	FPC	Well Governed	3	20	15
39	Failure to deliver CIP and manage our costs to enable the ongoing function of the business – maintain sustainability of the Trust.	DDoF	FPC	Well Governed	2	12	8
40	The ability of the Trust to deliver high quality care may be affected during a Coronavirus COVID-19 pandemic	DoN	QAC	High Standards	2	20	15

5. Heat Map

The heat maps below illustrate the current and residual risk levels of risks on the ORR in April 2020.

Current risk levels given the existing set of controls.

Consequence	5				38, 40	
	4		20, 23	2, 4, 5, 9, 22, 29, 33, 39	1, 3, 6, 8, 10, 11, 16, 25, 26, 3	28
	3			12, 27	24	
	2					
	1					
		1	2	3	4	5
		Likelihood				

Residual risk levels remaining once additional controls are implemented.

Consequence	5			38, 40		
	4	20, 23	1, 2, 3, 4, 5, 9, 22, 29, 33, 39	6, 8, 10, 11, 16, 25, 26, 35	28	
	3		12, 27	24		
	2					
	1					

	1	2	3	4	5
	Likelihood				

6 Recommendation

Agree the current ORR as detailed.

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:	The Trust's clinical systems and processes may not consistently deliver harm free care.		
Risk Owner:	Director of Nursing, AHP and Quality	**Date Last Reviewed:**	17.03.20
Governance / review:	PSIG, Quality Forum, QAC / monthly review		

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

Controls

Description:

- Staff Safety Huddles and Debrief
- Mandatory & Role Related Training available Clinical Supervision
- Thematic reviews of patient safety incidents and QI approach adopted by the Trust
- Infection Prevention & Control policies & the monitoring of
- Step up to Great Strategy
- Patient Safety Plan - aligned to the National Patient Safety Plan
- Patient Safety Improvement Group (PSIG)
- Accreditation in MHSOP wards and developing Trust wide
- Nutrition & Pressure Ulcers Prevention Group (quarterly)
- Falls Group – monitoring of incidents, themes, and national aligning to best practice
- Suicide Reduction Plan in keeping with National Confidential Enquires Report
- 'Freedom to Speak Up Guardian'
- Deteriorating Patient Group
- Accreditation Matron in post
- Harm assessment process
- Learning from Death and Suicide Prevention Clinician recruited 01/06/20

Impact of covid-19
reduced numbers of staff to investigate incidents and drive improvements forward.
Reduced governance forums and a likely increase in incidents. The impact on patients not diagnosed with COVID19 has reduced visibility.
There is a concern that deterioration of patients condition will be attributed to COVID19
some training suspended
All Leicester inquests suspended until 30/09/20)

Gaps:

- Implementation of recommendations from the External report on quality governance
- Developing an agreed set of clinical and professional standards and values
- Mandatory and role related training compliance across both substantive and bank staff

Assurances

Internal:

- Quality Forum / Quality Assurance Committee / Strategic Workforce 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
- Mental Health Act Reviews
- Mortality reviews & Learning from Deaths Process
- Trust wide Adult & Child Safeguarding
- Mandatory training reports
- Clinical supervision reports

Evidence:
Learning from deaths report to Trust Board
Performance dashboard to FPC and Trust Board
QAC assurance report to Board
Update on progress of local Quality Accreditation (QAC paper F 16.03.20)
Harm review paper (QAC 16.03.20)

Assurance Rating
Green

External:

- Patient/family and staff FFT / PALs feedback
- CQC inspection
- Professional Bodies e.g. NMC, GMC, HCPC
- Quality Contract and Monitoring with CCG & Specialised Commissioning
- Health watch Leicester
- Coroner feedback
- LLR Transferring Care Safely Group/LPT engaged (acute/secondary provider feedback)
- External review of quality governance

Evidence:
Patient experience report to QAC
CQC report and action plan to QAC

Assurance Rating
Amber

Gaps:

- Patient Safety Walk-rounds
- Compliance with mandatory & role related training, staff knowledge around physical health and speciality
- Staff vacancies across the professions and high bank /agency use. Increased use of redeployment and non familiar staff

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
July 20	Implementing external quality governance report supported by 'buddying' with NHFT – implement new SI process and structures	Exec Team	Review of SI and Complaint process complete Identified in transformation programmes.	Amber
Jun 20	Plan for a coordinated recruitment process			
Sept 21	Accreditation Matron to implement quality accreditation trust wide	T Ward		

Risk No: 2	High Standards	Date included:	01.10.19
Risk Title:	The Trust's safeguarding systems do not fully safeguard patients and support frontline staff and services.		
Risk Owner:	Director of Nursing, AHP and Quality	**Date Last Reviewed:**	01.04.20
Governance / Review:	Legislative Group, QAC / Monthly Review		

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

Controls

Description

- Safeguarding Team disseminate lessons learnt from investigations and reviews, Section 42 enquiries Care Act 2014) and through participation in multi-agency statutory reviews. processes (Child Safeguarding Practice Review [CSPR], Safeguarding Adult Review and Domestic Homicide Review .
- Legislative Committee oversight under new Quality Governance Framework.
- Identified Safeguarding Lead Nurses (Trust Lead, Child Lead, Adult Lead) and named Doctor for safeguarding children.
- Internal governance structure to manage safeguarding in place via Directorate oversight.
- Members of four local Safeguarding Boards, two Community Safety Partnerships and the Safeguarding Vulnerabilities
- Executive Committee.
- Adult and Children's Safeguarding Team in place.

Impact of covid-19
Lessons learned not being fully disseminated as fully.
Safeguarding Board on hold (only rapid reviews continue)
Team training postponed . Limited training in place for clinical staff,.
Work is continuing from the external review action plan, however this is proving to be challenging in terms of being able to fully implement.

Gaps:

- Lack of consistent approach to how lessons are learnt and how they are disseminated across the Clinical Directorates through to front line staff.
- The number of Multi Agency Reviews (CSPR, SAR and DHR) across Leicester, Leicestershire and Rutland (LLR) is above the national average for the number of reviews commissioned within a locality area the size of LLR (currently 37 active reviews).
- The safeguarding training offer from the LPT Safeguarding Team is not compliant with national standards and guidelines.
- Availability of training due to capacity
- Sufficient access to medical advice

Assurances

Internal:

Source:

- Legislative Committee
- Quality Forum provides oversight and challenge to the Legislative Committee.
- Quality Assurance Committee.
- Annual Quality Account.
- External review commissioned regarding safeguarding structures within LPT outlined 32 recommendations
- The identified Safeguarding Lead Nurses access safeguarding supervision external to the organisation.
- Annual Safeguarding Report.

Evidence:

- Safeguarding report presented to Trust Board.
- Key Performance Indicators for the Legislative Committee.
- Progress and update reports regarding the external review action plan.
- Action plan
- Safeguarding update (QAC paper D 16.03.20)

Assurance Rating
Amber

External:

Source:

- CQC inspections (contribution to CCG Safeguarding Inspections in addition to direct LPT CQC Inspection)
- Commissioner meetings, including completing a quarterly safeguarding assurance template (SAT) with face-to-face meetings with the CCG Safeguarding Team.
- Membership of four Local Safeguarding Boards, including the Boards' respective sub-committees , i.e. Performance Group, Policy Group and Review Group

Evidence:

- External review of safeguarding structures report
- CQC report
- Local Safeguarding Board reports and minutes

Assurance Rating
Amber

Gaps:

- Training figures
- Full implementation of the external review recommendations

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Jun 20 April 20	• Implement and embed the 32 recommendations from the external review. • Training capacity and offer to be reviewed as part of the external review recommendations • Recruit to vacant posts.	Neil King Neil King	• External review completed and report accepted by the Trust. Action plan developed for all 32 recommendations. • Recruitment to vacant posts is ongoing, some completed – awaiting one vacancy (recruited to) to commence employment.	Amber

Risk No: 3	High Standards	Date included:	01.10.19
Risk Title:	The Trust does not learn from incidents and events and does not effectively share that learning across the whole organisation.		
Risk Owner:	Director of Nursing, AHP and Quality	Date Last Reviewed:	17.03.20
Governance / Review:	Learning Lessons Exchange Group, Quality Forum, QAC / Monthly Review		

High Standards	Consequence	Likelihood	Combined
Current Risk	4	4	16
Residual Risk	4	2	8
Risk Appetite	4	2	8

Impact of covid-19
The opportunity for shared learning is reduced due to the reduction in governance forums.
Coroner feedback paused
Reduced feedback from patients / families

Controls

Description:

- Centralised process for identifying, processing, investigating, scrutiny and identifying Learning through the Serious
- Complaints process and PALs team
- Patient and Staff Safety Incident review via triage and directorate responsibility
- Outcomes from Clinical Audit & service evaluation
- Working towards a robust Risk Management Process for identifying and manging risks to enhance learning
- Learning from Deaths Group
- Learning lessons Exchange Group
- Patient Safety Improvement Group

Gaps:

- A robust Directorate level governance processes/systems

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Learning from deaths report • Patient safety quarterly report • Highlight report from Patient safety group • Highlight report from the Learning Lessons Exchange • Foundation for Great Patient Care • Escalation from Quality Forum to QAC • Incident review group weekly meet to review potential SI's and all COVID19 incidents +escalate to ICC	Regular reports and minutes from meetings Highlight information and escalation processes Reduction in harm , concerns, complaints/staff feedback	Amber
External:	• Feedback from patients/families • CQC statutory inspection framework • Quality and Serious Incident oversight by Commissioners & specialist commissioning • Coroner feedback • National Confidential Enquiries • Solicitor feedback learning points	Patient experience report to QAC CQC report	Amber

Gaps:

- Demonstrating changes based on learning
- Clarity and ownership of SI processes
- Triangulation with complaints and PALs

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
July 20	Implement the redesign of governance structures within directorates	Anne Scott	Implementation plan being developed	Amber
July 20	Reporting format for learning papers to include actions and progress against actions	Tracy Ward		
July 20	Triangulate with complaints and PALs	TW / AK		

Risk No: 4	High Standards	Date included:	01.10.19
Risk Title:	Services are unable to meet 'safe staffing' requirements		
Risk Owner:	Director of HR	Date Last Reviewed:	17.03.20
Governance / Review:	Learning and OD Group, Quality Forum, QAC / Monthly Review		

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	3	12
Residual Risk	4	2	8
Risk Appetite	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.
- MHOST tool for review of patient acuity and dependency

Gaps:

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

Assurances

Internal:	**Source:** • 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.	**Evidence:** • 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	**Assurance Rating** Green
External:	**Source:** NHSE Safe staffing trends – monthly submission The Department of Health and Social Care's group annual governance statement - NHSI Single Oversight Framework	**Evidence:** Unify and Healthroster data SOF / AGS	**Assurance Rating** Amber
Gaps:	• Evidence based acuity and dependency data for all in-patient areas • Plan for more centralised recruitment		

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Mar 20	• To identify an evidenced based tool for acuity and dependency measurement – Community Hospitals	Amrik Singh	Data collection November , December 2019 & Jan 2020 Analysis – next 6 monthly review May 2020	Green
May 20	• To develop a Trust wide safe staffing safeguards SOP	Laura Belshaw		
May 20	• To procure and implement Allocate SafeCare.to monitor actual patient demand at key points during the day and accurately align staffing to match		Allocate SafeCare	
May 20	• To review the DRA off-framework staffing process and deployment			

Risk No: 5	High Standards	Date included:	01.10.19
Risk Title:	Capacity and capability to deliver regulator standards		
Risk Owner:	Director of Nursing, AHP and Quality	Date Last Reviewed:	16.03.20
Governance / Review:	Foundation for GPC, Quality Forum, QAC / Monthly Review		

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

Controls

Description:

- Quality Improvement work programme / Quality accreditation
- Foundation for Great Patient Care with KLOEs driving the agenda / CQC project manager in post
- Quality Surveillance Tracker
- Core standards training
- 3 phased methodology
- NHFT buddy programme / Revised Governance structure
- Book of brilliance
- Step up to great strategy
- Senior Leadership and Extended Senior Leadership Team Meetings / Board development sessions
- Action plans and programmes of work following last CQC inspection
- IPC inspection and action plan
- Risk management strategy and ORR

Gaps:

- Organisational knowledge of the CQC key lines of enquiry
- Staff accountability and engagement
- inconsistent attendance at the Foundation for Great Patient Care
- Inconsistent attendance at Core standards training
- An understanding of the risks arising from the PIR
- Mock CQC inspection programme
- Full AMaT audit programme

Assurances

Internal:	• Audit and Quality Accreditation programmes • Quality forum • Foundation for great patient care • Walk arounds by the Director and Deputy Director of Nursing, AHP's and Quality • ORR Reporting • AMAT tool being used for meds management audits - monitored by pharmacy and showing significant improvement • NED boardwalks and feedback forms	**Evidence:** CQC update report and action plan to QAC Foundation for Great Patient Care report to Quality Forum ORR reports	**Assurance Rating** Amber
External:	• CQC inspection and engagement meetings / discussions • Regulator discussions (SIAM / informal discussions with NHSEI) • Third line assurance over compliance (outside of the CQC) • CQRG – discussions with Commissioners • Regulator inspections including HSE, NHSIPC • KPMG value for money conclusion • 360 Assurance internal audit – seclusion rooms: Limited Assurance	**Evidence:** Inspection report Minutes of CQC engagement and SIAM meetings 3rd party assurance reports (HSE, IPC, NHFT buddy visits) External reports on governance and SI management	**Assurance Rating** Amber
Gaps	·External mock CQC inspections		

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
April 20	Ongoing delivery of core standards training		**QI project status Amber**	Amber
April 20	Development of a training video to reach wider audience	Anne Scott	Ad hoc training has started, with more scheduled	
Mar 20	Foundation for great patient care to extend membership and invite list		To discuss feasibility of introducing a link in assurance reports	
Mar 20	Foundation highlight report to SEB	Julie Rubenzer	during Q4 2019/20 with the level 3 governance work stream	
Jun 20	Purchase of AMaT database			
	Mock CQC inspection / well led interview programme / Analysis of the PIR and Insight Report	Julie Rubenzer		

Risk No: 6	Transformation	Date included:	01.10.19
Risk Title:	The step up to great mental health strategy does not deliver improved mental health services that meet quality, safety and contractual requirements and are sustainable.		
Risk Owner:	Director AMH	Date Last Reviewed:	17.03.20
Governance / Review:	Transformation Committee, FPC / Monthly Review		

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12
Risk Appetite	4	2	8

Controls

Description:

- Step up to great system wide pathway redesign high level launch
- Developing delivery plan
- Resources identified to deliver plan
- Programme management in place with DMT oversight
- on-going engagement with staff, service users and carers

Gaps:

- Quality and timeliness of engagement with external partners
- 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
- Leadership development
- Robust stakeholder management and engagement plan
- QIA risk assessment process

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Large scale co-production events • Project Initiation Document • LPT Trust Board quarterly updates • Directorate Management Team (DMT) • Implementation plan	QIB update papers SUTG project delivery dashboard Out of area improvement	Amber
External:	• 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	External presentations SIAM minutes CQC engagement minutes	Amber

Gaps:

- Signed off clinical models
- Affordable workforce model
- Management of change and associated EIA and QIA
- Agreed internal governance pathways

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
May 20	• Formal sign off of detailed delivery plan	GK	Extensive engagement with mental health directorate	Amber
May 20	• Formal sign off of associated clinical model	GK	Confirmation of transformation programme and transformation committee	
June 20	• Set up workstreams for delivery plan	GK		
April 20	• Develop financial plan for 2020 delivery plan	GK		
May 20	• Determine the QIA risk assessment process	GK		

Risk No: 8	Transformation	Date included:	01.10.19
Risk Title:	The transformation plan does not deliver improved outcomes for people with LD and/or autism.		
Risk Owner:	Operational Director of LD	Date Last Reviewed:	10.03.20
Governance / Review:	Transformation Committee, FPC / Monthly Review		

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

Controls

Description:

- Multi-agency LD and Autism Executive Board - *reports into STP SLT, and is aWorkstreams 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
- System wide LeDeR reviews

Gaps:

- Treatment and support for ASD only diagnosis (without LD)
- System wide workforce plan
- Local LD rehab capacity
- Appropriate community placements in LLR

Impact of covid-19
Capacity to prioritise system improvement plan
Increased Nos of people on ROAR due to escalating behaviours / reduced community support / placement breakdown
Delayed discharges due to reduced provider resilience and staffing
Training: forensics and to AMH staff compromised by social distancing
Rehab proposal / forensics funding not agreed due to contract slippage and Q1 roll-over of budgets
CETRs taking place virtually and shortened

Assurances

Internal:

Source:

- SOP for in hours and out of hours CTRs and CETRs to reduce risk of admission
- Risk of admission register
- Root Cause Analysis for all admissions
- Project management
- Transformation Committee
- Improvement plan for AMH staff
- Business case for the treatment and support for ASD only diagnosis (without LD)

Evidence:
List of people at risk of admission
Learning from RCAs to reduce risk of future admissions
Report into transformation committee

Assurance Rating
Green

External:

Source:

- Adult Case Managers (CCGs / Specialised Commissioning)
- External input into Root Cause Analysis on all admissions
- External review from Moorhouse December 2019 priority recommendations
- System LD and Autism Executive

Evidence:
Learning from RCAs to reduce future admissions

Assurance Rating
Amber

Gaps:

- CCG Case Managers for children
- System based support for effective discharge of Ministry Of Justice cases into the community

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
May 20	Deliver LD Rehab SDIP within agreed timescales	HT		Amber
Dec 20	Implementation of improvement plan from Moorhouse report with partners	HT	Plan in implementation	
April 20	Full consideration of business case for funding (for the treatment and support for ASD)	HT	Business case developed	
May 20	Implementing plan to skill up health and social care staff in Forensic capability	HT		

Risk No: 9	Environment	Date included:	01.10.19
Risk Title:	Inability to maintain the level of cleanliness required within the Hygiene Standards		
Risk Owner:	Director of Finance / Director of Nursing	Date Last Reviewed:	06.03.20
Governance / Review:	IPCC, QAC and FPC / Monthly Review		

	Consequence	Likelihood	Combined
Current Risk	4	3	12
Residual Risk	4	2	8
Risk Appetite	4	2	8

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
- Hygiene Code gap analysis undertaken – Aug 2019
- Estates rep sits on/reports into IPC Group (cleaning/water/waste/decontamination)
- Infection control team / IPC quarterly report and annual report
- PLACE Audit action plan

Impact of covid-19
Potential impact from loss of (providers) cleaning staff
Possible need to withdraw cleaning from non-critical areas to backfill staff into critical areas
Possible difficulties in obtaining supplies & consumables

Gaps:

- Clear reporting process

Assurances

Internal:

Source:

- Cleaning report to the Estates Committee
- Finance and Performance Committee
- IPC Group to QAC
- Bi-monthly contractual cleaning forum (estates/IPC/NHS PS/UHL) - this goes to estates committee and FPC.
- Reporting against the delivery of the Estates Strategy
- Regular cleaning audits and KPI score monitoring
- Regular assurance information from UHL
- IPC Bi-Annual report to Trust Board

DMTs
Monthly reports to FPC (Estates) and QAC - (IPC)
PLACE scores and report for 2019

Assurance Rating
Amber

External:

Source:

- NHSI IPC audit
- CQC inspections
- PLACE audits

Evidence:
PLACE audit considered at SEB meeting (Mar 20) – action plan to be finalised by end Mar 20
NHSI audit received
National Guidance on C Diff
Premises Assurance Model

Assurance Rating
Amber

Gaps:

- Regular performance reports against hygiene standards and regular review at IPC
- 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:
May 20	Clear and agreed reporting mechanism against Hygiene standards	EW	Plan progressing	Amber
May 20	To audit all cleaners rooms against expected standards of cleanliness. To include trolley, schedules and equipment	EW		
May 20	Develop key responsibility cards for domestic staff and supervisors	EW		
May 20	Agree revised FM SLA and performance KPIs received	DC	Negotiation underway	

Risk No: 10	Environment	Date included:	01.10.19
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	Date Last Reviewed:	17.03.20
Governance / Review:	Estates Committee , FPC / Monthly Review		

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12
Risk Appetite	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)
- PPM schedules (12 month forward view) received from UHL Dec 2019 and assessed as adequate

Impact of covid-19
- Delay to estates workshop
- Potential impact from loss of (providers/contractors) maintenance staff
- Possible difficulties in accessing 'locked-down' areas
- Possible difficulties in obtaining parts/spares
- Possible issues with completing backlog schemes on the capital prog (due to reasons noted above)

Gaps:

- Lack of systematic process for identify high risk areas requiring maintenance
- Not complying with the KPIs
- Unsatisfactory delivery against our facilities management agreement
- Maintenance is not always undertaken in a timely way
- Clarity over the arrangements for managing risk with FM until April 2021

Assurances

Internal:

Source:
- Estates committee / FPC
- FM oversight Group
- Initial review to identify high risk areas of the estate that require maintenance completed Reporting of FM KPIs to FPC
- Estates risk register
- Audit action plan – track via FM Oversight Group
- Self assessment on premises assurance model
- Foundation for Great Patient Care quality surveillance tracker, deep dives and escalation process

Evidence:
- Report to the Estates Committee, and then to FPC which details performance
- PPM performance report (last 12 months) presented to EMEC (Feb 20)
- Reports demonstrating implementation of the Estate Strategy to the Estates Committee
- Reports to the FM oversight group.

Assurance Rating
Amber

External:

Source:
- NHSI / CQC / HSE / Fire service
- 360 Assurance internal audit of estates maintenance - Limited Assurance

Evidence:
Audits and reports
PLACE scores

Assurance Rating
Amber

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
- Report for property services

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Mar 20	Estates workshop	Sarah Ost	Business case with detailed options by Mar 2020	Amber
April 20	PMO for premises assurance model	AD	FM Transition Board and Working Groups established	
May 20	Decision on in-house to Board	AD		
May 20	Set of KPIs	AD		
	FM transformation plan	AD/SO		

Risk No: 11	Environment	Date included:	01.10.19
Risk Title:	The current estate configuration does not allow for the delivery of high quality healthcare		
Risk Owner:	Director of Finance	**Date Last Reviewed:**	17.03.20
Governance / Review:	Estates Committee , FPC / Monthly Review		

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

Impact of covid-19
- Availability of capital funding
- Delay to estates workshop

Controls

Description:
- A dedicated estates team in place
- Estates Strategy approved by the Trust Board in Oct 2019.
- Capital resource prioritisation framework
- Condition surveys have been completed in priority areas (in-patient estate)
- The mental health inpatient re-provision soc
- Health and Safety Risk Assessments in place
- Clinical risk assessment to mitigate re privacy and dignity
- Business case for interim dormitory solution approved by the Board Jan 20
- Approved Strategic plan for the elimination of dormitory accommodation

Gaps:
- Lack of derogation process to the Board
- Premises Assurance Model to be updated
- Challenges around availability of capital funding
- A plan to address weaknesses in the configuration
- An understanding of the full impact of coronavirus on progress of delivery of actions

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Monthly report to FPC on progress against the Estate Strategy • Health and Safety Reports and confirmation of compliance with actions • The soc was signed off by the Board in October 2019 • 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 • Annual PLACE inspections • 3 year plan to eliminate dormitory accommodation (AMH/MHSOP) agreed by Trust Board	• Monthly report to FPC on progress against the Estate Strategy • Health and Safety Reports and confirmation of compliance with actions • The soc was signed off by the Board in October 2019 • PLACE report for 2019	Amber
External:	• PLACE audits • NHSI • CQC • HSE • Fire service • KPMG audit of financial and quality accounts	CQC report 360 audit	Amber

Gaps ..
- Premises Assurance Model

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Mar 20	Workshop on the 18th March (postponed due to coronavirus)	A Donoghue	New PAM model released (Feb 20)	Amber
Jun 20	Overall transformation plan for estate	AD	Strategic case for Dormitory Accommodation supported by Trust Board	
Jun 20	Premises Assurance Model to be updated	AD		
Jun 20	SOC – follow up project – Preferred site (Bradgate) confirmed (Jan 20)	AD		
Jun 20	Implementation of plan for the dormitories (20/21 to 22/23)	AD		

Risk No: 12	Patient Involvement	Date included:	01.10.19
Risk Title:	Service users, carers and families do not have a positive experience of care, do not feel able to participate effectively and share their experiences.		
Risk Owner:	Director of Nursing, AHP and Quality	Date Last Reviewed:	06.04.2020
Governance / Review:	Patient and Carer Experience Group, Quality Forum, QAC / Monthly Review		

	Conseq-uence	Likeli-hood	Combined
Current Risk	3	3	9
Residual Risk	3	2	6
Risk Appetite	3	2	6

Controls

Description:

- Patient Involvement Experience Strategy and Team
- Patient surveys / Friends and Family Test
- Envoy Patient Experience portal
- Equality and diversity work
- Annual Quality Account
- Care planning audit programme
- Three year patient experience and involvement delivery plan 2019/2022
- Collaborative care programme
- Recovery café programme
- Patient Involvement Co-Design Group in place
- New Friends and Family Test Automated system being introduced in April 2020

Impact of covid-19
Delay to relaunch of FFT – launch to be delayed until May 2020

Gaps:

- 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
- No strategic lead for carers or carers strategy in place

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Patient and Carer Experience Group established • Equality Diversity and Inclusion Patient Experience and Involvement Group established • Complaints Review Group established • Quarterly Patient Experience and Involvement Reports • Quality Forum • Quality Assurance Committee	• 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 • Compliments, concerns and complaints feedback received	Green
External:	• Community Mental Health Survey • CQC inspections • MHA visits • Joint Strategic Needs Assessment • Healthwatch	• Community Mental Health Survey Report and supporting improvement plan • CQC Reports • Ward Accreditation programme being progressed • Step up to Great monthly reports	Green

Gaps:

- No carers lead or strategy in place
- FFT system not fit for purpose (new system planned for 2020/21)

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
April 20	Delivery against the three year Patient Experience and Involvement Delivery Plan in place for 2019-2022	Alison Kirk AK	Delivery plan in place and reported monthly through Quality Improvement Board	Amber
April 20	Pilot the Patient Experience survey Re-launch FFT	AK	Co-design taking place to inform implementation of patient involvement framework	
April 20	Carers Option Paper - way forward to be agreed	AK	Patient Involvement Framework launched with active patient and carer involvement in place	
May 20	People's Council to be launched	AK		
June 20	Embed the Trust wide reward and recognition policy	AK		
July 20	Deliver the complaints improvement programme			

Risk No: 16	Well - Governed	Date included:	01.10.19
Risk Title:	The Leicester/Leicestershire / Rutland system is unable to deliver the agreed plan for Integrated Care Systems		
Risk Owner:	David Williams / Chief Executive	Date Last Reviewed:	18.03.20
Governance / Review:	Transformation Committee , FPC / Monthly Review		

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

Controls

Description:

- LPT will 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
- Senior system staff (CEO, DoF & DoS for all organisations meet monthly)
- Risk sharing agreement
- System leader agreed conversations on new behaviours and agreement to a system control total now in place,
- will be formalised during the contractual process.

Impact of covid-19
The focus on delivery today will impact on the system plan for the future as resources are moved to managing immediate safety issues. There is likely to be a delay in the system delivering our Integrated care System plan.

Gaps:

- Ensuring individual organisations maintain commitment to the agreed priorities 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.
- Clear agreed transformation plan
- Clear strategy for bed based services within community hospitals

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	green
External:	• 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 • LLR Strategic Executive	• 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	

Gaps:

- No national blue-print
- Agreement with NHSEI on forward plan
- Confirm local authorities role in the ICS

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
April 20	Develop action plan for joint working arrangements, including VCS and council in Rutland	DW and RB	In development	
Mar 20	NHS system partnership board inc. CEOs, Chairs and NEDs commences 26 March 20 for system oversight	AH, DC & DW	Initial meeting undertaken	

Risk No: 20	Well - Governed	Date included:	01.10.19
Risk Title:	Performance management framework is not fit for purpose		
Risk Owner:	Director of Finance	Date Last Reviewed:	25.03.20
Governance / Review:	FPC / Monthly Review		

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	2	8
Residual Risk	4	1	4
Risk Appetite	4	1	4

Controls

Description:

- Information asset owners in place
- SIRO in place
- Clinical system training in place
- Board approved Performance management framework
- Board level performance dashboard
- Revised governance framework
- STUG plan
- SOP in place
- 360 data quality audits
- Quality Account audit
- Nationally submitted data
- Information team in place
- Simplified board reporting and an agreed set of KPIs for the Board
- Committee dashboards with KPIs owned by QAC/FPC
- Performance review meetings

Gaps:

- Embeddedness
- Reporting for each level
- Escalation criteria from QAC to the Trust Board
- Avoidable harm measures

Assurances

Internal:	**Source:** FPC / QAC Performance review meetings DMT meetings Trust Board	**Evidence:** Simple Dashboards to Finance and Performance Committee / QAC of KPIs that the committees own Simplified Board report ORR reports Performance report update on quality metrics / KPIs (QAC paper H 16.03.20). Agreement by QAC/FPC on the set of KPIs for the Board Performance review meetings in January 2020, and due 30 March and 1 April 2020	**Assurance Rating** Amber
External:	**Source:** Contract monitoring of quality indicators by Commissioners Finance, Technical and Performance monitoring of contracted performance indicators NHSI / CQC inspections SIAM External and internal audit	**Evidence:** Internal audit of performance scheduled for 2020/21	**Assurance Rating** Amber
Gaps	Fully embedded system Established regular cycle of reporting		

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Sept 20	Demonstration of consistent period of review (6 months)	DC	Evaluation of performance review meetings in Sept 20	Amber
Sept 20	6 monthly review led by level 1 committees	DC		
May 20	Consideration of avoidable harm measures	DC		
May 20	Determine escalation criteria from QAC to the Trust Board	DC		
May 20	Consider the introduction of avoidable harm measures	DC		

Risk No: 22	Well-Governed	Date included:	01.10.19
Risk Title:	Information systems and processes are not robust enough to militate against cyber attacks and information breaches		
Risk Owner:	Director of Finance	Date Last Reviewed:	26.03.20
Governance / Review:	Data Privacy Committee, FPC / Monthly Review		

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

Controls

Description:

Ongoing assessment of robustness of the cyber risk framework
LHIS together with their cyber security arrangements
Disaster recovery
Emergency Preparedness (EPRR)
IMT Committee
Data privacy committee
Password security policy
List of policies (see governance on a page)
Data Security and Protection Toolkit with Internal Audit report of Significant Assurance
SIRO structure
Guidance updates to support videoconferencing with service users and homeworking in light of COVID-19

Gaps:

- Similar data breaches occurring but in different services suggesting that shared learning across the Trust is not taking place
- New digital posts that are required - (we have Girish CIO) we have data quality champions missing
- IG training performance

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• LHIS re-accreditation of the secure email system (DCB1596). • Review and testing disaster recovery processes. • IG training compliance • Part of the Data Privacy Committee dashboard for 2020/21 • Reporting of it	• Accreditation report • Outputs of Disaster Recovery Testing in remediation action plan • GDPR reports to FPC • Self assessment paper to FPC 17.03.20 • Significant Assurance Internal Audit Report for DSPT	Green
External:	360 Assurance internal audit of data security standards – Complete December 2019 Advisory Assessment of Cyber Resilience by NHS Digital Consultants through UCRF NHS digital cyber training at Board	Report to data privacy IG report from 360 Assurance	Green

Gaps:

- Consideration of the UCRF report to the data privacy committee

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
May 20	Bring the UCRF through the committee structure and establish a regular report	Sam Kirkland	**Planning progressing**	Green
Jun 20	Learning from COVID-19 response	SK	**Planning progressing**	
Jul 20	Review of ICO reportable data breaches	SK	**Planning progressing**	

Risk No: 23	Single Patient Record	Date included:	01.10.19
Risk Title:	Failure to deliver the EPR system and demonstrate the benefits of the system		
Risk Owner:	Medical Director	Date Last Reviewed:	10.03.20
Governance / Review:	IM&T delivery group, FPC / Monthly Review		

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	2	8
Residual Risk	4	1	4
Risk Appetite	4	1	4

Impact of covid-19
Delayed roll out of training and potential delay to go live date

Controls

Description:

- Training plan for EPR implementation
- Data migration plan (6th cycle)
- Reporting and monitoring arrangements
- Implementation plan
- Communication plan
- Benefits

Gaps:

- Completion of final stage of data migration
- Formal contingency plan

Assurances

Internal:

Source:

- Training plan involving Learning and Development and Nursing
- Monitoring trajectory of training delivery
- Significant progress on data migration and cleansing work
- EPR Project Board in place and will continue for at least 6 months post full transfer to support ongoing data improvement.

Evidence:
Delivery reports to Finance and Performance
Monthly reports to QIB
EPR update to QAC 17.03.20

Assurance Rating Green

External:

Source:
360 Assurance internal audit – patient records EPR
SystmOne benchmarking inform project
Company providing SystmOne has track record of implementation and delivery
SystmOne is a market leader

Evidence:

Assurance Rating Green

Gaps:

- Accuracy of reporting function
- Contingencies not formalised with clear no / no go criteria defined
- Agreed plan for formal evaluation

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
April 20 April 20 May 20	• Compete the contingency plan • Board development day • Develop a plan for formal evaluation	Sue Elcock		Green

Risk No: 24	Equality, Leadership, Culture	Date included:	01.10.19
Risk Title:	Failure to deliver workforce equality, diversity and inclusion		
Risk Owner:	Director of HR & OD	Date Last Reviewed:	10.03.20
Governance / Review:	SWC, QAC / Monthly Review		

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

Impact of covid-19
Postponement of conference

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
- Our Future Our Way
- Leadership behaviours
- EDI Group

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

Internal:	**Source:** • WRES action plan • Diversity workforce dashboard • Trust board equalities report • Annual Equalities Action Plan • Staff support groups	**Evidence:** • Progress reports on WRES action plan 27th Jan • Staff survey report Trust Board 3rd March • EDI Bi annual report to EDI committee 27th Jan • EDI group 27th Jan • Annual meeting schedule across the year	**Assurance Rating** Amber
External:	**Source:** • Staff survey 2019 • National WRES metrics and report • Engagement with national WRES team	**Evidence:** • Trust Board reports on national WRES programme	**Assurance Rating** Amber
Gaps:	embeddedness		

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Aug 21	WRES Delivery action plan	Haseeb Ahmed	Newly formed EDI group	Amber
July 20	Reverse mentoring cohort 2	Kathryn Burt	BAME interview panel members recruitment underway	
Jan 20	Attend launch of WRES cultural pilot programme	SW	Pilot Launched 23rd Jan	
Aug 21	WRES cultural pilot programme plan developed and agreed	SW		
July 20	Programme of WeNuture OD sessions	SW	Commenced March 20	
Mar20	EDI system conference	SW	Scheduled 31st March	

Risk No: 25	Equality, Leadership, Culture	Date included:	01.10.19
Risk Title:	Staff do not fully engage and embrace the Trusts culture and collective leadership		
Risk Owner:	Director of HR & OD	Date Last Reviewed:	10.03.20
Governance / Review:	SWC, QAC / Monthly Review		

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

Impact of covid-19
Cancellations of SLT
Capacity to deliver

Controls

Description:

- Our Future Our Way is LPT's Culture, Inclusion and Leadership programme.
- 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
- 9 priorities identified and communicated as part of the Our Future Our Way
- Leadership behaviours

Gaps:

- Capacity of OD team
- Engagement plan
- Embedded appraisal system aligned to behaviours
- Leadership conferences
- Leadership programme aligned to behaviours
- OD input into transformation programmes
- Robust plans for addressing specific concerns around cultural ownership such as Bare Below the Elbow

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Staff survey results • Board approval of change champion programme • Programme plan in place and approved by Trust Board • 92 change champions engaged • Focus groups • Strategic workforce group	Staff survey report to Board 3rd March Board update on leadership behaviours progress Jan 20	Amber
External:	• Staff survey • Staff Friends and family test • External recognition of initiatives • NHSI Well led external review • CQC Well Led review • NHSI Support on the culture and leadership programme • WRES programme • People Plan	SIAM feedback CQC engagement meeting feedback	Amber

Gaps:

- Embedding new culture

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
	Step up to Great conference	SW	Plans progressed for SUTG conference 3rd April	Amber
Sept 20	Embedding senior leadership team	SW	Programme of SLT meetings 2020	
	Extended Exec team	SW	Begun a programme of extended SLT meetings bimonthly from Jan	
Jan 20	Leadership development programme linked to leadership behaviours Training programme	SW	Trained Change Champions to become workshop facilitators of our leadership behaviours framework 9th March	
Mar 20	Shaping OD input into service re-design	SW	OD support commissioned for CSR March 20	
	Robust plan for BBE	EW / AS		

Risk No: 26	Equality, Leadership, Culture	Date included:	01.10.19
Risk Title:	Insufficient staffing levels to meet capacity and demand and provide quality services		
Risk Owner:	Director of HR & OD	Date Last Reviewed:	10.03.20
Governance / Review:	SWC, QAC / Monthly Review		

	Conseq-uence	Likeli-hood	Combined
Current Risk	4	4	16
Residual Risk	4	3	12
Risk Appetite	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
- Consideration of a centralised trust wide approach to recruitment

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Third cohort of nurse associate roles • Further development of other roles • Reengineering of clinical roles • SWC , Directorate Workforce groups , retention working group • Workforce and Wellbeing Board • Transformation committee • HR Team • Electronic recruitment system • Staff staffing report	Progress reports to SWC Jan 16th Performance dashboard monthly Workforce reports monthly	Amber
External:	National NHS people plan NHS retention support and benchmarking data Internal audit Benchmarking reports	Engagement with development of NHS people plan	Amber

Gaps:

- National gap in detail around NHS people plan as published in June 2019
- National people plan not published
- National workforce supply

Key

Date:	Actions:	Action Owner:	Progress:	Status:
Sept 20	Transformation programme on centralised recruitment	Sarah Willis	Centralised recruitment agreed as a transformation committee	Amber
May 20	Consideration of overseas recruitment	SW	programme being developed	
May 20	Develop a proposal for super enhancing recruitment and attraction campaign	SW	Conversations with UHL on overseas recruitment taking plan	
July 20	Bespoke plan for integrated Ageing Well recruitment campaign	SW	Boosted social media support for hard to fill recruitment Feb 20	

Risk No: 27	Equality, Leadership, Culture	Date included:	01.10.19
Risk Title:	The health and well being of our staff is not maintained and improved		
Risk Owner:	Director of HR & OD	Date Last Reviewed:	10.03.20
Governance / Review:	SWC, QAC / Monthly Review		

	Conseq-uence	Likeli-hood	Combined
Current Risk	3	3	9
Residual Risk	3	2	6
Risk Appetite	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:

- Embedding of culture and leadership plan
- Embedding of WRES plan
- Leadership behaviours and appraisals linked to these
- post incident psychological support for staff

Assurances

Internal:	• Monitoring sickness reports workforce reports • Sickness reviews within divisions • Wellbeing element of appraisal • Wellbeing conferences • Occupational health department • Staff reps • Amica	**Evidence:** Performance management report monthly Staff side and management meetings Monthly SWC reports Occ health annual report Referrals to Amica	**Assurance Rating** Amber
External:	**Source:** • NHSI reporting, • NHSI wellbeing initiatives • People plan	**Evidence:** NHSI benchmarking reports Attendance at external NHSI wellbeing workshops	**Assurance Rating** Amber
Gaps:	• Ongoing implementation of action plan associated with Health and Well being Approach. • Review Health and Well being Approach in Nov 2019 • Embedding of National People Plan		

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Nov 20	Continue to progress the health and wellbeing approach and action plan	Kathryn Burt	NHS long terms people plan well being event attending in Nov	Amber
Nov 20	Refreshed health and wellbeing approach for 2020 ongoing review at senior leaders forum	SW	LPT health and wellbeing conference in Nov 20	
Nov 20	Post incident psychological support for staff	SW	Developed a business case to support mental health referrals for employees approved and now commencing implementation March 20	
Nov 20	Recruit / supply post incident psychological support for staff	SW		

Risk No: 28	Access to Services	Date included:	01.10.19
Risk Title:	Delayed access to assessment and treatment impacts on patient safety and outcomes		
Risk Owner:	Divisional Directors / Medical Director	Date Last Reviewed:	28.02.20
Governance /	Waiting List and Harm Prevention Committee , FPC and QAC / Monthly Review		

Access to Services	Conseq-uence	Likeli-hood	Combined
Current Risk	4	5	20
Residual Risk	4	4	16
Risk Appetite	4	3	12

Controls

Description:

- Strategic risk based approach to waiting time management approved by Trust Board
- Weekly patient tracking list sessions operational in all prioritised services
- NHSI demand and capacity management training complete
- Trajectories and improvement plans in place for priority services
- Joint waiting times group and harm assurance group in operation
- System Improvement and Assurance meeting oversight of Trust waiting times
- Business planning and contract discussions
- Outsourcing arrangements where appropriate (eg HEALIOS)
- Staff productivity and efficiency programmes in place via service transformation
- Winter planning/OPEL framework/daily escalation tool/calls in place
- Business cases to address high risk areas
- Demand and capacity analysis of priority services with long wait times
- Revised performance report with narrative

Gaps:

- Robust access policy
- Embedded harm review process
- LLR financial sustainability plan
- Lack of funding to match growth in population / prevalence / demand

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Directorate performance reports • Waiting time performance reported to Finance and Performance Committee monthly • Internal strategic waiting times approach • FPC regular waiting times report • Daily OPEL escalation template	Performance management dashboard Dashboards to DMTs Reports into waiting times group Harm review process update to QAC 17.03.20	**Amber**
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 • 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	Audit reports SIAM feedback CQC report	**Amber**

Gaps:

- Lack of overall assurance framework and performance management framework
- Sharing the learning

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
May 20 June 20 May 20 Aug 20	Review of Access Policy including definition of 52 week access and treatment waits Agreeing priorities for MHIS and growth with commissioners Merging access group and the harm free group Trajectories for all contractual targets	Divisional Directors	The terms of reference for the access and harm free group are being agreed	Amber

Risk No: 29	Access to services	Date included:	01.10.19
Risk Title:	The trajectory to achieve the out of area placement is not maintained		
Risk Owner:	Director AMH	Date Last Reviewed:	10.03.20
Governance / Review:	FPC and QAC / Monthly Review		

Access to Services

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

Impact of covid-19
Additional pressure on the system

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
- 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 length of stay has reduced
- Progress (treatment) beds usage ceased November 2019 – no longer part of out of area reporting
- Active discharge underway, 50% reduction
- Full discharge plan in place
- Bed meetings three times a day
- 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 café
- New 5 homeless beds developed in partnership with 3rd sector
- 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 in place with system leaders (see separate plan – updated Jan 2020)

Gaps:

- Continued pressure on rehab beds
- Community rehab team not yet developed
- Lack of capacity for CAMHS PICU impacts on adult out of area
- Lack of third sector partnership insufficient strength
- Limited crisis café capacity / Limited crisis house capacity
- Insufficiently robust demand management

Assurances

Internal:

Source:

- Monthly inpatient flow meeting
- Strong DMT oversight
- Regular monitoring through Acute and Forensic Operational meetings
- 3 times daily bed management meetings
- 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
- 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.

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
Green

External:

Source:

- Weekly DTOC patient tracker sent to Head of Service for AMH Social Care in City, County and Rutland. Copy is also sent to CCG for progressing any CHC / AHP placement funding requests
- Weekly DTOCs are shared with key managers from Social Care in City, County and Rutland
- Monthly meetings with Action Homeless, HHET and the City CCG to review service and KPIs
- Quarterly Contract meetings with Turning Point for contractual oversight
- Patients who are moved to a progress bed have an individual clinical treatment plan which is monitored weekly by the CCG Case Managers and LPT Discharge Nurses.

Evidence:

- Weekend bed state for AMH and LD (including Acute, Rehab and Crisis House) is shared to the LLR Urgent Care System.
- Standard SOP guidance has been produced to identify appropriate patients for progress beds.
- NHS E/I reporting
- come off level 1 reporting

Assurance Rating
Green

Gaps:

- Data inputting and reporting of Red and Green codes through the introduction of the Red2Green App
- Individualised contract and case management for patients in OAPs
- See Acute MH OAP Recovery Plan

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Aug 19	On-going delivery of Acute MH OAP Recovery Plan	S Wood		Green
Jan 20	Step up to great includes demand management and single referral point	S Wood		

Risk No: 33	Well - Governed	Date included:	01.10.19
Risk Title:	Insufficient executive capacity (including Shared Chief Executive role) to cover demand and impacts on LPT ability to achieve it's strategic aims		
Risk Owner:	Director of HR & OD/Chief Executive	**Date Last Reviewed:**	16.03.20
Governance / Review:	Strategic Exec Board, Trust Board / Monthly Review		

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

Controls

Description:

- Shared 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
- 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
- Deputy CEO in place
- Recruitment of substantive Director of Adult Mental Health

Gaps:

- Embedding deputy level support for shared Directors
- Formal embedding of portfolios of shared director roles
- Embedding new governance process

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• New governance process • Organisational risk register • 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	• Remcom paper on exec capacity • Buddy programme meeting minutes • SUTG update report • New governance process agreed • Leadership presentations to Board and senior management team • SLT meetings	**Green**
External:	• 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	• Regular contact and positive feedback from NHSI • Positive feedback at assessment • CQC inspection	**Green**

Gaps ..

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Feb 20	• Substantive Appointment of deputy CEO	CEO	Substantive appoint made	Green
Jan 20	• Appointment of interim Director of Nursing, AHPS and Quality	CEO	Substantive appoint made	
Mar 20	• Recruitment of a substantive Director of AMH	CEO	Substantive appoint made	
May 20	• Appointment of deputy infrastructure to support shared director posts	SW/CEO	Plans in development	
	• Future appointment of medical director			

Risk No: 35	Well Governed	Date included:	01.10.19
Risk Title:	The quality and availability of data reporting is not sufficiently mature to inform quality decision making		
Risk Owner:	Director of Finance	**Date Last Reviewed:**	11/03/2020
Governance / Review:	FPC / Monthly Review		

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

Controls

Description:

- Executive senior information risk officer (SIRO) sponsorship
- Performance management framework
- Performance reports
- Regular reporting of data quality maturity index in board reports
- Annual benchmark reporting against peers
- Contractual data quality improvement plans (DQIP)
- Experienced subject matter experts in the corporate information team
- National guidance
- Electronic patient records (EPR)

Gaps:

- Control framework for data and information
- Assurance framework
- Non compliance with policies
- Capacity to deliver the changes
- Accountability framework
- Complete data quality reports for local and national data sets
- Knowledge of data quality incidents
- Configuration of systems to support requirements of information standards and NHS data models
- Robust technical infrastructure to support timely and accessible use of data
- 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
- No monitoring solution available to measure timeliness of data input
- Challenges in the system to ensure information is timely and appropriate
- Inability to progress at pace due to competing priorities and lack of capacity in the corporate Information team.

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• FPC / Trust Board • Clinical audit • Annual record keeping audit • Data quality flag for priority KPIs	Quarterly DQIP report to FPC (last one 17.03.20) Data validation paper to Exec team 16.03.20	Amber
External:	• External audit • 360 Assurance audit • Benchmarking reports		Amber

Gaps:

- Internal process for testing compliance
- Process for responding to external feedback

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Apr 20 Jun 20 Dec 20	• Incorporate DQ into regular performance framework process • Create dedicated data quality group with long term vision to implement the strategy, define policy, promote and support the adoption of best practice, monitor compliance, identify emerging patterns in data quality related incidents in order to inform training and influence staff behaviour	Laura Hughes Dani Cecchini LHIS		Red

Risk No: 38	Well - Governed	Date included:	01.10.19
Risk Title:	Unable to deliver the operational plan due to financial pressures from the system and funding settlement		
Risk Owner:	Deputy Director of Finance	Date Last Reviewed:	25.03.20
Governance / Review:	Financial Turnaround Committee , FPC / Monthly Review		

	Conseq-uence	Likeli-hood	Combined
Current Risk	5	4	20
Residual Risk	5	3	15
Risk Appetite	5	3	15

Controls

Description:

- Governance arrangements established for LLR including arrangements for financial risk management and delivery of transformation schemes
- CIP plans and schemes in place agreed by Executive Team and monitored by transformation Committee
- Operational delivery through Directorate Management Team
- 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
- 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
- LLR transformation assurance group / LLR chief finance officers group
- Commissioners identified growth and investment funding in 2021
- Performance review meetings as part of tracking delivery

Gaps:

- Non delivery costs savings
- Fully established LLR governance framework
- Non delivery costs savings (unidentified CIP of £1.2m)
- Robust CIP plans
- Transformation action delivery is variable
- Agreed and signed off budget parameters including CIP
- Longer term transformational strategy
- Fully developed PMO function
- Signed contract for 20/21

Impact of covid-19
All planning activities paused
Block payment to be made 01/04/20 – 31/07/20; waiting for confirmation of value
Cash could be a short term issue – COVID cost reimbursement mechanism not yet clear
Financial governance needs to be maintained in fast moving environment
Counter fraud measures need to be robust in face of increased attempts
Annual accounts deadlines relaxed, but will still need to be delivered – need staff to be available

Assurances

Internal:

Source:

- Finance and Performance Committee report includes I & E, cash & capital reporting
- Quality Assurance Committee
- Audit Committee
- Transformation 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.

Evidence:

- 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
- Monthly Director of Finance report

Assurance Rating Amber

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 Red

Gaps:

- LLR plan not yet signed off by NHSI

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Mar 20	Sign contract	DC	Ongoing system discussions	Red
Mar 20	Finalise the plan and budgets	DC		
May 20	LLR plan sign off	DC		
Mar 20	Formally agree the transformation committee programme of work	DC		

Risk No: 39	Well - Governed	Date included:	01.10.19
Risk Title:	Failure to deliver CIP and manage our costs to enable the ongoing function of the business – maintain sustainability of the Trust.		
Risk Owner:	Deputy Director of Finance	Date Last Reviewed:	25.03.20
Governance / Review:	Financial Turnaround Committee, FPC / Monthly Review		

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

Controls

Description:

- CIP plans and schemes in place agreed by Executive Team and monitored by the transformation 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
- Step up to Great strategy
- Introduction of formal transformation reporting
- Executive leadership on transformation schemes
- Control Totals agreed with Service Directors

Impact of covid-19
Block payment 01/04/20 – 31/07/20 does not include any efficiency factor, so CIP plan will be different value from previous planning assumptions.
Finance leads will continue to work on CIP identification in the background but not expect clinician engagement until it's appropriate & has no impact on clinical service delivery.

Gaps:

- Non delivery costs savings (unidentified CIP of £1.2m)
- Robust CIP plans
- Transformation action delivery is variable
- Commissioner approach to investment and contract funding
- Agreed and signed off budget parameters including CIP
- Longer term transformational strategy
- Fully developed PMO function

Assurances

Internal:

Source:

- Finance and Performance Committee
- Quality Assurance Committee
- Audit Committee
- Transformation Committee and delivery of documented plan
- CCG/LPT contract income triangulation & DoF level discussion

Evidence:

- Bi monthly finance report
- Transformation committee highlight report – March 20
- 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

Assurance Rating
Amber

External:

Source:

- Commissioner discussions
- KPMG audit of annual accounts and value for money conclusion
- Model hospital

Evidence:
Agreement of the 20/21 contract value in the context of the system plan
Formal Trust Annual Financial Plan approved by NHSI and CCG confirm and challenge

Assurance Rating
Amber

Gaps:

- Established monitoring of CIP delivery
- Established monitoring of transformation plans
- Trust wide, embedded focus on productivity
- Assurance programme from transformation committee

Key actions

Date:	Actions:	Action Owner:	Progress:	Status:
Jun 20	Transformation plans for corporate and back office efficiencies to be established	SM	Spend has decreased in some areas, unlikely to achieve target	Green
Jun 20	Model hospital and benchmarking to inform clinical services productivity plan	SM	Back office costs analysis completed December 2019	
April 20	Finalise 20/21 CIP	DC		
July 20	Establish and recruit PMO team	DC		

Risk No: 40	High standards	Date included:	11.03.20
Risk Title:	The ability of the Trust to deliver high quality care may be affected during a Coronavirus COVID-19 pandemic		
Risk Owner:	Director of Nursing, AHPs and Quality (QAC)	Date Last Reviewed:	13.04.20
Governance / Review:	Covid19 Incident Control Centre, Strategic Exec Board , Trust Board / Weekly review		

	Conseq-uence	Likeli-hood	Combined
Current Risk	5	4	20
Residual Risk	5	3	15
Risk Appetite	5	3	15

Controls

Description:

- Local and national resilience structures and governance
- COVID-19 Incident Management Team and Plan
- Incident Control Centre open 8 – 8 7days per week / Single point contact 24/7 email and dedicated phone
- Prioritisation of critical services
- National COVID-19 coronavirus action plan
- Policy controls are in place for IPC, major incident place, Flu pandemic
- NHS England and NHS Improvement COVID-19 NHS preparedness and response
- Government, PHE communication, guidance and policies Infection Prevention and Control
- Participation in national and LLR health resilience forums
- Business continuity plans
- National weekly Webinars / Communications for COVID-19 both internally and externally
- Ward visiting times restricted(apart from EOL)
- Home working policy for Covid-19
- Occupational health team Covid -19
- Communication of information – Staff Room and daily Email
- Staff guidance on Management of isolation and reporting / Agile home working policy / Occupational Health dedicated phone lines
- National guidance on workforce

Gaps:

- Predicted development of pandemic
- Timely supply of Personal protective equipment - National procurement issues with PPE stock supply
- National modelling on workforce to inform local workforce

Assurances

Internal:	**Source:** Oversight by SEB and exec board. Internal governance structure for reporting and formally logging actions, risks and decision making . Communications structures to staff 7-day per week Covid -19 major incident meetings COVID related National Guidance reviewed daily Monitoring of unintended consequences of rapid and high pressured decision making	**Evidence:** **Flash report to Board of Directors 17th March 2020**	**Assurance Rating Red**
External:	**Source:** Department of health / Public Health England / NHSEI / Cobra / Chief Medical Officer LLR system advice and planning / Joint CEO exec daily (Mon-Fri) reporting structure Gov.uk Covid information email alerts / National webinars Buddy relationship with NHFT	**Evidence:** **records of Joint CEO daily conference calls** **HE**	**Assurance Rating Red**

Gaps ..

	Actions:	**Action Owner:**	**Progress:**	**Status:**
Ongoing	Staff training programme for Mask Fit Testing, PPE3 Donning and Doffing and hand hygiene	Emma Wallis	System response to community testing , decommissioned 13/3/20	Red
May 20	Review Business continuity plans and prioritisation of clinical services	Mike Ryan	Established incident control response	
Ongoing	supporting increasing discharges and prevent admissions	Anne Scott	System working on prioritisation of services and response to need	
April 20	Consider extending opening hours of ICC as demand increases	Anne Scott	to increase ITU beds	
May 20	IT increased VPN access, deployment of mobile devices and other required process to support home working	Ian Wakeford		

F

Incident Co-ordination Centre (ICC) Governance Framework

Introduction

The Trust Board is ultimately responsible for the effective and efficient management of the Trust and ensuring it adheres to the principles of Good Governance.

The Trust is currently working in the context of the Covid 19 pandemic.

In this context the Trust has identified that its strategic objective is "Preservation of life".

It has agreed an approach to maintain its overall governance during the pandemic and this framework describes the approach for the ICC element of the overall revised approach to governance.

The ICC is engine room of the Trust's response to the Covid pandemic.

The overall approach has been put in place to provide a streamlined approach to decision making which also describes clear accountabilities and processes which support Good Governance

The elements and processes of the Framework are described below;

Incident Co-ordination Centre

The ICC oversees the overall response to the Covid pandemic including for example staff deployment, staff health and wellbeing, quality and safety and finance.

The three pillars which support the management and governance of the ICC

- **The ICC action log**
- **The ICC risk register**
- **ICC decision log**

Issues and questions which arise though the day are placed on the action log and risk register as required and dates for the completion of tasks are agreed and monitored daily through the ICC.

The ICC uses conference calls and Microsoft teams to engage with the wider team with all key disciplines across the Trust represented (virtually) in the ICC team.

The **Director of Day** is responsible for making decisions as issues are raised whilst being supported by the ICC team.

The Deputy Chief Executive Officer (DCEO) or in their absence the Director of Governance and Risk identifies issues for communication to the Trust Board via a flash report sent by the Corporate Governance team for communication to the board.

A key restriction on decision making is that any policy decision within a specialist corporate area needs to have the agreement of the Director accountable for the particular discipline such as for example Finance, Nursing and Human resources. In addition certain decisions may need to be referred to the Clinical Senate.

All decisions will be registered on the decision log and all risks placed on the risk register.

The decision log will be overseen by the Executive and Director team through the Combined Strategic and Operational Executive Board.

Strategic / Operational Executive Board

The Combined Executive Board will have the decision log and the ICC risk register sent to them by the PMO team supporting the ICC at 8pm on the Sunday prior to the Monday Combined Executive Board.

The Deputy Chief Executive will present both the risk register and decision log and confirm that all decisions are supported or facilitate any discussion around concerns that are raised, enabling a conclusion to be agreed.

The Deputy Chief Executive will also virtually circulate a copy of the risk register to the executive team on the Monday when the executive team does not meet.

The DCEO or the Director of Governance and Risk in their absence will agree with Executive team if any items need to be communicated to the Trust Board following the review of the decision log and risk register.

Trust Board

The Trust Board will receive assurance on the ICC from the Chief Executive though their regular report to the Board.

Certain issues will need to be escalated from the ICC to the board for a decision these include as examples;

- **CQC must dos which may not be completed**
- **Potential breaches of safe staffing which present a clinical risk**
- **Financial Decision which exceed SFI limits and need board approval**
- **Significant changes to the Trust's strategy**

The DCEO or Director of Governance and Risk in their absence will escalate these through the exec team or direct to board through the corporate governance team if required.

The Trust Board supported by the corporate governance team will expedite decisions to support the overall response to the Covid pandemic.

There may be issues which will not exceed the thresholds described above and do not need a board decision. They may be still significant in terms of the criteria described and SEB may decide that a decision making rationale needs to be shared with the relevant level 1 committee for assurance.

Review

This framework will be reviewed every four weeks

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Leicestershire Partnership NHS Trust

QUALITY ASSURANCE COMMITTEE – DATE 17th March 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
Safeguarding - Update on the recommendation from the external review and 360 internal audit report	High	RM questioned the issue of the Adult and Child Safeguarding telephone advice line being replaced by emails. It was confirmed that this allows for a 24-48 hour turnaround and increases capacity. The advice provision will be improved as a result. It was confirmed that the capacity in the team was now significantly improved and all actions were either complete or underway. The Chair asked if the named Dr for adults' capacity was a gap and SE confirmed that this was not a national requirement. AS added that the Safeguarding Committee and Internal audit may cover this requirement and that the Legislative Committee will update QAC with the solution.	2
Update on progress of local Quality Accreditation	High	This is the Trust's chosen generic terminology that replaces and incorporates any quality review methodology that is currently being used to measure care standards within the Trust. This is an 18 month period to becoming business as usual and aligns directly to SUTG strategy within the Standards brick. It involves both a shift in language and in understanding. Internal Quality Accreditation does not replace external accreditation schemes; LPT will continue to	6, 6, 35

Report	Assurance level*	Committee escalation	ORR Risk Reference
		access external Accreditation programmes and these will align directly with our internal accreditation work.	
CQC update	High	All actions were now closed and the CQC are very pleased with the progress made. The Foundation for Great Patient Care Forum will now drive the operational and improvement work that needs to continue. This will feed to the Quality Forum. The PIR ran smoothly and was more accurate and robust than in previous years with limited queries received post submission. CQC have issued communication that inspections have been suspended for the time being due to Covid-19, however as a Trust we will continue to plan with our preparations for the inspection.	5, 20
Performance Report update on Quality Metrics/KPIs	Medium	Graeme Jones presented this item. The report provides clarity on each level of committee, where they report, and clarity on quality KPIs. Some targets had changed and some new targets and corporate KPIs had been introduced to try to measure the work the Trust does. A review date of September 2020 is set at which point new KPIs can be added or amended. A Dashboard Report should be a standard agenda item for all committees responsible for KPIs. GJ requested that all comments on the individual KPIs be sent to him direct via email.	All
Quality Forum Highlight Report	Medium	The hand hygiene audit showing as red is due to the number of audits conducted. This will form part of the Quality Account moving forward. The Positive and Safe Group were working well with weekly reports being received. Concerns remain around what the spot checks are revealing regarding seclusion practices however assurance given with the robust management in place. Following the data cleansing process the flu position fell below 60% (59.93%). Work has already begun around how to improve next year's rates and this will be placed back on the ORR at this time. The NICE Compliance 360 Limited Assurance Report Update had been deferred until the next QAC meeting.	1, 2, 3, 4, 5, 6, 40

Report	Assurance level*	Committee escalation	ORR Risk Reference
		The Covid-19 incident control centre was now operating 8am-8pm 7 days a week and a staffing rota was being developed.	
Community Mental Health Survey	High	The Community Mental Health Survey results highlight key areas where improvement can be made including Supporting Well-Being; Crisis Care and Planning Your Care. These actions are being integrated into the SUTG mental health action plan.	6
Draft Quality Account	Medium	It was recommended that the priority access/waiting and 52 week wait indicator was removed from the paper as it was a performance matter rather than a quality issue. It was considered that this could be replaced with a measure of harm and this is being considered for next year's report.	1, 4, 5
Policy Committee Highlight Report	Low	The issues around accessibility to the policies remain red on the report and a Deep Dive into this issue is planned for a future meeting. The Chair expressed concern around the length of time this accessibility matter has been outstanding and requested a report in relation to the progress made at the June QAC meeting.	20
Quality Improvement Board Highlight Report	High	The QIB Highlight report and a PowerPoint presentation was delivered to the committee – The Step Up To Great Progress Report (March 2020). Each slide showed the current status of each of the target areas (bricks).	All

Chair	Liz Rowbotham

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Leicestershire Partnership NHS Trust

QUALITY ASSURANCE COMMITTEE – DATE 21st April 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
New Governance Arrangements – Covid-19		Document has been well circulated it reinforces the 6 priorities which will be LPT's priorities moving forward.	All
Incident Control Centre Governance Arrangements		3 key areas – action log, risk register and decision log. The Director of the day leads and the governance is overseen by DC. Decisions made are reported to the Executives and escalated to The Board if needed. Any decisions needing an input from a Director will not be made without consulting them.	All
Organisational Risk Register		Changes in risks due to the impact of Covid-19 were detailed to the committee. 2 risks increased due to COVID-19 are Harm-Free Care and Learning from Incidents; increased due to the required work not being able to progress at this time. 3 risks have decreased due to the work completed prior to Covid-19. 3 risks are at the highest rating of 20, one of these is specifically titled Covid-19.	All
CQC Update		All CQC actions from the last inspection have been met; however some require ongoing development work. The Foundation For Great Patient Care forum continues to meet weekly in a virtual format. The team remain ready for the next CQC visit. KD confirmed that no Mental Health Act Reviews have been set but that they are	5, 20

Report	Assurance level*	Committee escalation	ORR Risk Reference
		likely to be virtual like the CQC.	
Director of Nursing, AHPs and Quality Summary Update in light of Covid-19.		An additional report (Safeguarding Briefing paper for HESCG) was circulated post meeting. Quality Account is out to stakeholders and will come back to QAC on 19.05.20 and to Trust board on 27.5.20. CQUINS are on hold until August following national guidance. The next NHSI IPC visit is postponed during COVID 19. Safeguarding will form part of the quality work within the recovery cell. Safeguarding Boards continue to meet virtually. The complaints team continue to work as business as usual and have an internally robust process in place to deal with complaints in a timely way during this period. The latest FFGPC meeting was well attended. The patient safety team continue to work as business as usual.	1, 2, 3, 40
Safer Staffing Update - Including Process for System Delivery - decision making for critical services		LPT continue to benchmark against other trusts and align themselves nationally. The nurse to patient ratio is 1-8 and QAC will continue to be updated on ward changes due to Covid-19. QAC was supportive of the Safer Staffing Report's new format. The Process for System Delivery - decision making for critical services process - a RAG rating has been developed and quality impact assessments are completed through the ICC and are signed off by AS and SE which ensures quality assurance.	1, 4, 26, 40
Privacy and Dignity Annual Declaration and Single Sex Accommodation Annual Declaration		Resolved: QAC approved this document on behalf of the Trust Board.	10, 11
Performance Report		QAC focused on the quality metrics at this meeting as this is being presented at FPC today. Discussions were held around the increasing trend of episodes of seclusion within this report and AS confirmed that this was likely related to 3 children on CAMHS Ward 3 who at the time were requiring significant increase in the level of observations and intermittent seclusion was required; all 3 of these children have now been more appropriately placed.	All

Report	Assurance level*	Committee escalation	ORR Risk Reference
Health & Safety Report including commentary on health and safety issues related to surge capacity		Following audits it was evidenced that the HSC action plan was being implemented. More audits are planned to ensure resilience moving forward. Work was happening around EPR arrangements with the highest risks being PPE and hand sanitiser in the previous week. There are robust arrangements around alternative stock coming into the Trust.	9, 10, 40
Quality Forum Report including Impacts of Covid-19 including appendices – Patient Safety Incident and SI Learning Report IPC Quarterly Report Q4		QF was held virtually on 02.04.20 and was well attended. At the point of this meeting the Governance paper had not been approved by the Trust Board – however since it was approved, matters have progressed significantly. The forum held a long discussion around safeguarding risks and can report that the Trust Head of Safeguarding has implemented changes to working in the current climate which are working well. The risk around a virtual inspection is being managed by FGPC meeting weekly to ensure mitigation is in place. It was noted that there has been a reduction in the number of SIs reported – and the Patient Safety team continue to encourage staff to report incidents so learning can be gained. Those incidents reported are reported well and decisions are being made quickly. Pressure ulcers and falls continue to be closely monitored. A position statement for QAC's information outlining the work of the IPC was presented. The IPC red areas including clinical waste and PPE have been superseded over the last 2 weeks and that moving forward the red PPE will be a national concern.	1, 2, 3, 4, 5, 6, 40
Strategic Workforce Committee Update including commentary on current health and wellbeing initiatives supporting staff during Covid-19		Both general absence and Covid absence rates are being monitored. Lots of work around health and well-being for staff at a divisional, system and national level in light of COVID -19 and SW is working with staff from AMH to develop a psychological offer of support. Staff supervision and mandatory training continues to take place but delays in uploading to the system may be affecting data. All staff are being supported and feedback comes from social media. The closed FB page now has over 2500 members and all posts are responded to.	24, 25, 27, 40
Policy Committee – feedback on policy approach during Covid-19		All policies' renewal dates had been put back to December 2020 and that this was supported by the Exec team.	20

Report	Assurance level*	Committee escalation	ORR Risk Reference
QIPB Report		Final report from QIPB. The information would be received from other committees moving forward. The Transformation Committee have now developed their processes for managing projects and most will transfer into there. The remaining projects will move either to the Strategic Workforce Committee or the Quality Forum.	All
Any Other Urgent Business: •R&D Activity		It was confirmed that this report had been deferred by LR, but that research staff were now prioritising research related to Covid-19.	

Chair	Liz Rowbotham

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Leicestershire Partnership NHS Trust

FINANCE AND PERFORMANCE COMMITTEE – 17th March 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
Matters Arising Well-governed		It was agreed to strengthen the governance of FPC and triangulation between QAC and FPC by an additional NED becoming a member of the Committee.	
Director of Finance Report Well-governed		LLR CEOs and Directors of Finance had attended an escalation meeting with NHSE/I's Joint Chief Financial Officer. It was not expected the financial plan would be approved before May 2020 given the current distance from the required system control total of £35.7m. Formal feedback was still awaited. The impact of COVID-19 on resources was discussed. The expectation was that costs would be covered by NHSE/I and were currently being collated, no restrictions were being placed on items staff needed to purchase. EPRR processes were in place and expected to run for a significant time. Assurance was requested and received around the integrity of the General Ledger and Financial reporting for 2019/20 supported by receipt of the Internal Audit report.	38, 40
Draft LPT 2020/21 Financial Plan Well-governed	**Low**	FPC received a summary of key points of 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. The actual level of CIP for LPT had not yet been agreed. A number of areas were still to be agreed and COVID-19 could further delay this. It was agreed to approve it as a working draft only and that the capital plan budgets should be released to directorates to minimise in year slippage. FPC was not assured as although there was a process in	17, 40

Report	Assurance level*	Committee escalation	ORR/Risk Reference
		place, a number of the working assumptions and timescales were still unclear.	
Performance Management Framework 	**Green**	Graeme Jones was in attendance to present the KPIs that had been developed for the Trust for 2020/21. Chairs of level two and three committees had agreed the upward reporting of KPIs to bring clarity and remove duplication in reporting lines. The draft KPI list had been reviewed by SEB and would be presented to Trust Board on 7 April, the Board would receive an updated Performance Report based on these KPIs at the May meeting onwards. FPC was fully assured as there was a good process and KPIs were in place.	20
Enterprise / Business Development Framework 	**Medium**	An update of the Business Development Pipeline as of 6 March 2020 was received, key points to note were; • The service transfer plan for the Mental Health Facilitators project was on track. • A joint bid with NHFT was being explored for learning disability and autism awareness training. • A tender for early support for people with dementia, their families and carers was being prepared. The service was currently provided by the Alzheimer's Society and commissioners were looking for a substantially changed model. The submission deadline was 31 March. FPC was reasonably assured.	19
Data Quality Improvement Plan 	**Medium**	FPC was informed the Trust had completed its objective to measure the data quality compliance for priority waits and priority KPIs. Work would continue throughout the 2020/21 financial year to embed the process into business as usual processes. FPC was reasonably assured as the process was being delivered but the outcome was not due to be seen until April.	20
Waiting Times / Harm Reduction Committee 		A highlight report from the first meeting of the merged group held on 4 March 2020 was received. Discussion had focused on two specific issues; compliance by services to the principles of waiting list management; and on how the Trust would learn from harm processes.	28
Waiting Times Report 	**Low**	**National Targets** Three out of four targets were being met, the target not being met was Adult ADHD but this target would be removed from national RTT reporting at the end of March. Non recurrent money would be available to target the backlog and recurrent money for meeting demand. Performance was expected to gradually improve delivery over the next eighteen months.	28

Report	Assurance level*	Committee escalation	ORR/Risk Reference
		Priority Services Three priority services had met its target, nine had not. **52 week waits** Three patients were waiting over 52 weeks for first appointment for the Personality Disorder Service and this was the first time it had happened for some time however, FPC acknowledged this may be due to an anomaly in reporting. FPC noted there was deterioration in the numbers and longest waits and that the situation was very challenging and not likely to improve quickly. The Committee was not assured. It recognised prioritised outcomes for 2020/21 had now been agreed from April 20.	
Finance Report Month 11 2019/20 G Well-governed	**Low**	An update on the financial position for the period ended February 2020 was received, key points were; • In terms of I&E, the run rate had deteriorated by £70k continuing the decreases seen in recent months. • AMH, LD and Estates continued to be above the run rate FYPC, CHS and Enabling were all improving. • One NHS Better Payment Practice Code target had not been achieved. • Capital was delivering as expected. • Some additional pressures had been raised by CCGs this month due to unexpected overspends. • Work was taking place to separate LD and AMH finances from 1 April. • Confirmation had been received that the Trust no longer needed to report progress beds in the national out of area reporting with immediate effect. FPC was not assured, it was satisfied with the financial position but recognised the £500k stretch would not be delivered.	17, 22
Estates and Facilities Management Update G Well-governed	**Low**	Key points to note were; • FM performance had worsened and to recover performance, work was continuing with UHL alongside identifying additional short term options. • An interim plan on managing FM services 2020/21 would be provided to the next meeting. • The new version of the PAM had been released. • The CAMHS accommodation project was slightly behind due to bad weather. No delay in opening was reported. • The Estates Team was in contact with UHL daily around preparedness for COVID-19. Issues related to staffing levels and maintenance of critical cleaning services • There was an emerging risk around full delivery of the capital programme next year due to COVID-19. • An engagement plan had been developed for the SOC, a meeting with NHSI had now been scheduled. FPC was not assured around estate projects and facilities management due to the performance of FM services.	9, 10, 11, 40

Report	Assurance level*	Committee escalation	ORR/Risk Reference
Data Privacy Committee		Highlight reports from the meetings held on 21 January and 10 March 2020 were received, no specific concerns were raised.	
Data Security and Protection Toolkit Well-governed	**High**	The Trust was able to demonstrate that it had attained full compliance with the DSP Toolkit requirements with a status of 'Standards Met' and this was supported by an Internal Audit report that reflected significant assurance in the governance, systems and processes supporting the Toolkit work. However, guidance received from the NHS Executive stated submission would be delayed because resources were currently being diverted elsewhere. FPC agreed the proposal to delay submission until later in the year but by the cut off date of 30 September 2020 as final training figures would be received by then and the impact of COVID 19 known. FPC was fully assured.	22, 40
Capital Committee		A highlight report from the meeting on 11 February 2020 was received, no specific issues had been raised.	
Transformation Committee		A highlight report from the meeting on 21 February 2020 was received, no specific issues were raised but FPC noted a significant amount of work still needed to take place around this committee.	
IM&T Committee		FPC received a highlight report from the meeting held on 20 February 2020, no specific issues were raised.	

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

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Leicestershire Partnership NHS Trust

FINANCE AND PERFORMANCE COMMITTEE – 21 APRIL 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 G Well-governed		ET was starting to consider COVID-19 in three specific phases. The first phase was the immediate response to the crisis and establishment of systems and processes, the second was the phase the Trust was now entering and related to how it was managing the crisis and starting to plan for the final recovery phase. Consideration was also being given to stepping up the recovery cell which would link into a system recovery cell and the wider system resilience forum. In terms of financial recovery, discussion was taking place between Directors of Finance and commissioners around arrangements from month 5 2020/21. The System Sustainability Group had changed to a Transformation Assurance Group to take this forward. The Internal Audit Financial Systems Review had received significant assurance opinion, congratulations were passed to Sharon Murphy and the Finance Team for this achievement.	
New Governance Arrangements & ICC Governance Arrangements G Well-governed	**High**	The key issue highlighted was the ICC structure and the process for the oversight of the ICC risk register, action log and decision log which were the three functions that supported the management and governance of the ICC. Discussion focused on the categorisation of meetings, FPC agreed, as a 'critical' meeting to continue to meet monthly until July and then to consider moving to bi-monthly meetings. A work plan for April to July would be presented to the next meeting as well as a proposal for the work plan August 2020 to March 2021. FPC was fully assured as good process was being made.	40

Report	Assurance level*	Committee escalation	ORR/Risk Reference
Organisational Risk Register 	**High**	Since the March 2020 ORR report, two risks had increased, three had reduced and there had been one de-escalation. All risk scores had been reviewed to reflect COVID, discussion focused on the impact COVID was having on all risks. Assurance had been received from the Head of LHIS that everything had currently been done to minimise the risk of cyber attack, although it was felt the NHS might be more vulnerable at the current time. FPC was fully assured, it acknowledged there were still some gaps but there were actions in place to mitigate them.	All
Major IT Outage 		A verbal update on the recent catastrophic power outage at Gwendolen House was provided. Although the power incident was resolved the next day, there were still some IT related issues during the following few days. FPC expected this major incident to be dealt with under the Serious Incident procedure and the outcome of the review would be reported to the committee at a point in the future. The Chair asked that thanks were passed to Ian Wakeford and his team on their work to resolve the issue.	40
Contracting – Interim System Approach for 2020/21		FPC was informed that contracting arrangements had ceased for the time being because of COVID. The work currently taking place was on how to proceed from month 5 of 2020/21 financial year when arrangements would need to recommence.	
Performance Report 	**High**	FPC received an overview on the process of producing the report. Discussion focused on what key COVID priorities should be reported over the next few months. The committee agreed the next report should contain an understanding of key COVID metrics, key performance figures affected by the metrics and the reasons for the stepping down of any reporting. FPC was fully assured on the process for reporting and acknowledged that gaps were in relation to COVID but there were actions in place to address them.	35
Summary of Draft Annual Accounts 2019/20 	**High**	Key points to note were; • All statutory duties were expected to be met this year. The national submission timetable had been amended in response to COVID and some dates had been pushed back, the accounts would now be submitted on 6 May. • The bottom line surplus delivery was £2.9m surplus which was better than expected. The increase was due to £700k mental health support funding received in late March which had to go into the bottom line. • No allocation of bonus PSF funding had been received for 2019/20 yet and the Trust was not now expecting to receive it. • Most services had broadly delivered I&E where	All finance risks

Report	Assurance level*	Committee escalation	ORR/Risk Reference
		expected, LD services were reporting a better position than expected. Estates had moved by £800k because of 2018/19 and 2019/20 charges from UHL FM services. • CIPs had achieved 57% delivery overall. • Agency spend was broadly in line with the forecast. • A bid for COVID-19 expenditure had been submitted and most funding requested had been provided. • In terms of the balance sheet, the only real movement was non recurrent assets due to land revaluation. • Cash and capital had delivered as expected. • BPPC had met all four targets which was a better position than expected.	
Month 1 – 4 2020/21 Financial Plan 	**High**	The key points of month 1 – 4 of the financial plan for 2020/21 were presented. • The Trust had been informed that all NHS billing had stopped for 2020/21 for non-clinical activity but this guidance had now been reversed and work was taking place to understand the impact of this change on the forecast position. • There were no current concerns around cash. • The key message from the Government was about keeping the wider economy going and making payments in the agreed timescales. • Budgets had been rolled forward from 2019/20. • The financial plan assumed a break even position would be achieved. • In terms of capital, a STP approach was expected. A lot of schemes would be impacted by COVID and the Capital Management Committee would be reviewing schemes at its next meeting. • Maintaining financial governance was a specific issue currently. • The main risk related to month 5 of 2020/21 onwards.	37, 38
Estates and Facilities Management During COVID-19 	**Medium**	Key points to note were; • Business as usual activities had ceased during the previous four weeks and engagement regarding the co-operation agreement and short term performance uplift had also stopped at present. • Work on the CAMHS construction site was three weeks behind schedule, two weeks previously noted due to poor weather and a further week due to COVID difficulties. The situation was being monitored closely. The contractors on the CAMHS site would be thanked for agreeing to work seven days a week to their original agreed fixed prices. • An update on the SOC was received, the next step would be to review the scope of the OBC and agree a source of funding. Consideration would be given to using the mental health funding to support this work. • The Estates Team was thanked for the work undertaken on preparation, equipping and commissioning of the surge wards in such a short time. FPC was informed that the response from UHL's front line staff had been excellent.	9, 10, 11 and 40

Report	Assurance level*	Committee escalation	ORR/Risk Reference
		FPC was reasonably assured, it was satisfied with the work taking place around COVID but acknowledged the facilities management work was ongoing	
Facilities Management Transfer Business Case		The Facilities Management Transfer Business Case was not presented to the meeting as it was felt it would be difficult at the current time to transfer services from UHL to LPT and the required data to develop a robust business case was not available because of COVID. A meeting had been arranged to discuss the next steps, an update was expected to be provided to either the May or June meeting.	
Capital Committee		A highlight report from the meetings held on 15 April 2020 was received, no specific concerns were raised.	
Joint QIB & Transformation Committee		A highlight report from the meeting held on 14 April 2020 was received. FPC was informed the joint committee was also likely to incorporate the Financial Turnaround Committee and some development programmes. FPC approved the terms of reference for the new combined committee.	
IM&T Committee		FPC received a highlight report from the meeting held on 19 March 2020. FPC noted the recommendation to defer the single EPR project was made at the last IM&T Committee meeting when all the existing projects were reviewed to consider whether any could be deferred because of COVID. The committee had felt it would not be possible to train staff and it would not be safe to change a clinical system in a pandemic situation. The recommendation had been approved by the ICC.	

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

Leicestershire Partnership NHS Trust

Meeting Name and date	**Trust Board meeting, 5th May 2020**
Paper Reference	**I**

Name of Report:	**Draft 2019/20 final accounts update**

For approval		For assurance	X	For information	X

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

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

Report previously reviewed by	
Committee / Group	Date
Finance & Performance Committee	21 April 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 draft 2019/20 accounts position, noting that further work (including the formal audit) is still required before the accounts can be finalised.

Leicestershire Partnership NHS Trust

Summary of draft annual accounts 2019/20

Trust Board Meeting

5th May 2020

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Headlines

Draft position

- Statutory duties achieved based on **draft** figures:
  - I&E surplus - achieved ✓
  - External Financing Limit duty - achieved ✓
  - Capital Resource Limit duty - achieved ✓

Timetable

- Key data submission to NHSI on 20th April ✓
- Draft accounts to be submitted to NHSI on 6th May (3 working days earlier than extended national deadline)
- Auditors begin their review on 11th May
- Final audited accounts to be submitted by Trust on 25th June

Changes to accounts timetable due to Covid-19 pandemic

In late March, the national final accounts deadlines were extended to take account of the additional workload and logistical pressures placed upon NHS organisations. This lead to a reworking of our internal timetable, with key changes as follows:

- Audit Committee review now 1st May (was 17th April)
- Draft accounts submission now 6th May (was 24th April)
- Commencement of Audit 11th May (no date change, but Audit will now be conducted remotely)
- Final audited accounts submission now 25th June (was 29th May)

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Draft Statement of Comprehensive income (SOCI)

Statement of comprehensive income - excluding impairments (draft accounts as at 28/04/2020)	Plan 31/03/2020 Year end £'000	Draft actual 31/03/2020 Year end £'000
Operating income from patient care activities	251,298	252,051
Other operating income*	27,269	41,740
Employee expenses*	(208,295)	(224,339)
Other operating expenses (excluding impairment charges)	(60,510)	(60,383)
OPERATING SURPLUS / (DEFICIT)	**9,762**	**9,069**
FINANCE COSTS		
Finance income	36	140
Finance expense	(996)	(1,002)
PDC dividends payable/refundable	(6,154)	(5,268)
NET FINANCE COSTS	**(7,114)**	**(6,130)**
Other gains/(losses) including disposal of assets	0	15
INITIAL SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**2,648**	**2,954**
Exclude provider Sustainability Fund residual bonus 2018/19 paid in 2019/20		(114)
Provider Sustainability Fund bonus 2019/20		0
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**2,648**	**2,840**

*Includes £9.3m notional cost and corresponding income for employers pension costs funded from central NHS budget

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Draft Statement of Comprehensive income (SOCI)

- Provisional year end surplus of £2.9m delivered.
- Surplus includes additional £0.7m mental health support funding awarded in March (this could only be used to increase bottom line surplus)
- Surplus does not deliver additional NHSI stretch target of £0.5m, but delivers our NHS Control Total
- NHSE/I initial notification suggests zero 19/20 PSF bonus (bonus is awarded on the basis of system performance in 19/20).

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Directorate I&E commentary

- 3 clinical services' final variances were broadly in line with the month 11 forecasts (AMH: £2.3m overspent; CHS £0.2m underspent; FYPC break-even)
- Enabling - £1.0m underspent, an improvement on the month 11 forecast chiefly due to additional income recoveries during month 12
- Estates - £2.6m overspend, a deterioration on month 11 forecast due to the reflection of additional UHL SLA & NHSPS charges
- Hosted - £0.9m overspend, representing a worsening of the month 11 forecast, mainly due to reduced income in March
- Reserves – significant improvement over the month 11 forecast mainly due to revised asset valuations as part of the capital charges calculation.

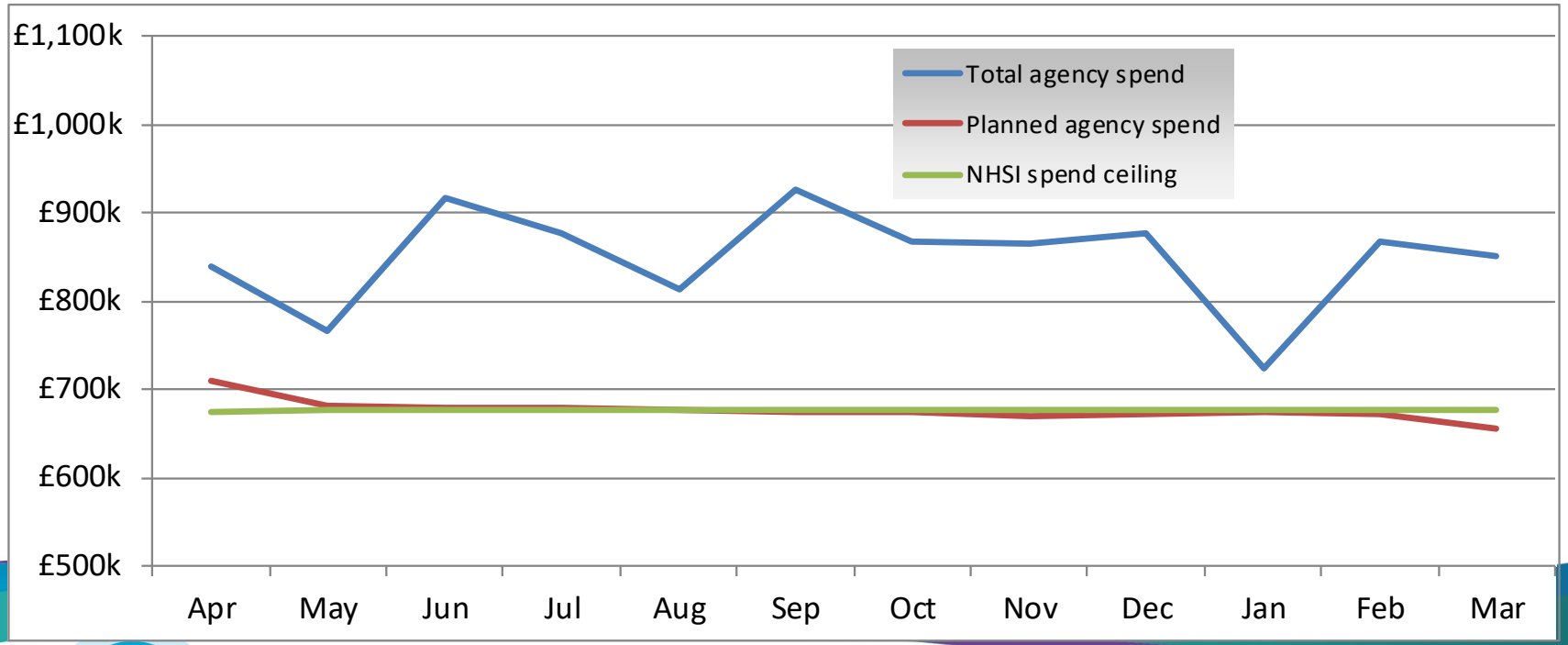
Cost Improvement Programme

Initial analysis of CIP delivery indicates that 57% of the total Directorate CIP target of £4m has been achieved. This incorporates the NHSI stretch target of £0.5m which was not achieved.

CIP delivery 2019/20 - Provisional Accounts	AMHS & LD £000	CHS £000	FYPC £000	Estates £000	Enabling £000	NHSI Stretch Target £000	Total directorate CIPs £000
Actual CIP delivery	53	870	586	257	519	0	**2,285**
Planned CIP delivery	674	870	586	862	555	500	**4,047**
Variance	-621	0	0	-605	-36	-500	**-1,762**
% achieved	7.9%	100.0%	100.0%	29.8%	93.5%	0.0%	**56.5%**

Agency ceiling

The Trust has spent £10.2m on agency staff in 2019/20. This is an overspend of £2.1m against the Trust plan and the NHSI agency spend ceiling.



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Covid-19 expenditure

In order to prepare for, and deal with the pressures created by the Covid-19 pandemic, considerable additional expenditure has been incurred. In March, NHSI/E provided NHS organisations with assurances that additional funding would be made available to support the majority of this expenditure.

A summary of the expenditure incurred in 2019/20 is shown below, along with the impact of anticipated NHSI/E funding.

Covid-19 related revenue costs to 31st March 2020	Supported £'000	Not Supported £'000
Additional staffing and overtime/overhours	333	
Purchase of 100 new beds	294	
Purchase of PPE	64	
Wards - minor works	30	
Other misc. expenditure	19	
Cost of cancelled / carried forward annual leave		31
Lost income due to other organisations re-focussing their business		82
GROSS COSTS	**740**	**113**
NHSI/E funding	740	0
NET COSTS REFLECTED IN 19/20 FINAL ACCOUNTS	**0**	**113**

Statement of Financial Position

Statement of financial position	31/03/2019 Year end Audited £'000	31/03/2020 Year end Draft £'000
Total non-current assets	202,824	183,342
Total current assets	22,479	27,970
Total current liabilities	(16,471)	(20,594)
Total assets less current liabilities	**208,832**	**190,718**
Total non-current liabilities	(12,664)	(12,517)
Total net assets employed	**196,168**	**178,201**
Financed by		
Public dividend capital	83,675	89,453
Revaluation reserve	64,205	49,512
Income and expenditure reserve	48,288	39,236
Total taxpayers' and others' equity	**196,168**	**178,201**

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Cash

- The closing cash balance on 31st March 2020 was £15.4m – cash continued to exceed plan in to month 12. The external financing limit (EFL) was achieved.

- The closing cash balance was £7m higher than in 2018/19.

Capital

- Capital expenditure at the end of the year was £14.6m and was within the Capital Resource Limit agreed with NHSI.

Better Payment Practice Code

The Trust achieved all 4 BPPC targets (being 95% invoices paid within 30 days) based on cumulative performance at the end of the year:

- Non NHS Value (97.36%)
- Non NHS Number (96.23%)
- NHS Value (99.34%)
- NHS Number (95.09%)

It is worth noting that the Trust achieved 2 of the 4 BPPC targets in 2018/19.

Leicestershire Partnership NHS
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Leicestershire Partnership NHS Trust

Performance Report (Month 12)

Trust Board
5th May 2020

Performance headlines – March 2020

Key:

The SPC measure has improved from previous month

The SPC has not changed from previous month

The SPC measure has deteriorated from previous month

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)

Length of stay - Community services

Gatekeeping

Key standards being delivered but deteriorating

6-week wait for diagnostic procedures

Key standards being delivered inconsistently

CAMHS Eating Disorder – four weeks - (complete pathway)

Children and Young People's Access – 13 weeks (incomplete 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

Key standards not being delivered but improving

Mental Health data submission - % clients in employment

Data quality maturity index

Key standards not being delivered but deteriorating/ not improving

Mental Health data submission - % clients in settled accommodation

18 week RTT

CAMHS ED on week (complete)

Adult CMHT Access five day urgent (incomplete)

Adult CMHT Access six week routine (incomplete)

STEIS action plans completed within timescales

Key standard we are unable to assess using 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)

Quality indicators (SPC due April 2020)

Sickness absence (current data not yet available)

Vacancy rate (current data not yet available)

% staff from BME background (current data not yet available)

Staff flu vaccination rate (frontline healthcare workers) (current data not yet available)

% staff undertaken clinical supervision within the last 3 months (current data not yet available)

Performance headlines – March 2020

COVID-19 Update
The Trust continues to prioritise its COVID-19 response in light of the worldwide pandemic. Whilst existing performance standards remain in place, a consequence of this response is the short-term postponement of the March 2020 directorate performance reviews and delays in the reporting of some information. The report is annotated to identify where data is not available due to delays and future reports will include information missing during month 12.

This means the commentary and RAG ratings in this report will pertain to the January 2020 directorate performance reviews. The data quality kite marks also pertain to the previous six month period.

Performance figures and SPC icons have been updated to reflect the latest available data.

Future iterations of this report will identify where performance has been affected by COVID-19.

Improvement Plans *(based on January 2020 directorate performance reviews)*
- Improvement plans are in place for CAMHS Eating Disorders (and on track)

- ADHD RTT recruited additional staff and moved to a multi-disciplinary team (MDT) model from 1st April 2020

- Improvement plans for the data standards are still to be developed

- Improvement plans for CMHT access are being developed.

- 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
- *see COVID-19 update (above)*

2020/21 Key Performance Indicators
- New quality KPIs were approved by Board sub committees in March 2020 and the full Board in early April 2020.

- New indicators have been included to gather performance information for quality measures including repeat falls, restraint, seclusion and pressure ulcers.

- The 2020/21 KPI setting process included KPIs linked to the Quality Account commitments which will 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
NO	The system is expected to consistently fail the target
YES	The system is expected to consistently pass the target
?	The system may achieve or fail the target subject to random variation

Icon	Trend Description
UP	Special cause variation – cause for concern (indicator where high is a concern)
DOWN	Special cause variation – cause for concern (indicator where low is a concern)
NO CHANGE	Common cause variation
UP	Special cause variation – improvement (indicator where high is good)
DOWN	Special cause variation – improvement (indicator where low is good)

Useful icon combinations to understand performance:

Performance	Trend	Description
YES	UP/ DOWN or NO CHANGE	Key standards are being consistently delivered and are improving/ maintaining performance
YES	UP/ DOWN	Key standards are being delivered but are deteriorating
?	Any trend icon	Key standards are being delivered inconsistently
NO	UP/ DOWN	Key standards are not being delivered but are improving
NO	UP/ DOWN or NO CHANGE	Key standards are not being delivered and are deteriorating/ not improving

Data Quality Kite Mark

The Trust has introduced a data quality kite mark to help to assess priority wait time and key performance indicators (KPIs) against the six domains of data quality.

Each domain is rated using a standard assessment as being green (assured processes are in place), amber (room for improvement), red (issues identified for action).

Code	**R**	**V**	**T**	**C**	**A**	**Rv**
Domain	Reliability	Validity	Timeliness	Completeness	Accuracy	Relevance

The domain descriptions are as below:

Reliability - there are clear standard operating processes (SOPs) aligned to patient pathways
Validity - clinical systems, local reports and KPIs are in place to meet the needs of the service
Timeliness - data is entered in a timely manner – in line with the record keeping policy
Completeness - data quality is regularly checked in the service (patient tracking lists etc.)
Accuracy - KPIs/ reports are quality checked and authorised for external release
Relevance - KPIs/ reports are regularly reviewed through the performance process

The data quality kite marks have been applied to priority wait times and priority indicators – as agreed by the Trust Executive Team. The data quality kite marks are re-assessed every six months or when significant change warrants a review.

1. NHS Oversight

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

Target	Trust Performance	RAG/ Comments on recovery plan position	SPC Flag: Assurance of Meeting Target	SPC Flag: Trend
Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral Target is 56%	Oct-19: 66.7%; Nov-19: 72.0%; Dec-19: 66.7%; Jan-20: 72.2%; Feb-20: 81.8%; Mar-20: 63.2%		YES	NO CHANGE Key standards are being consistently delivered and are maintaining performance
Inappropriate Out of Area bed days for Adult Mental Health services Target is 0 by end March 2021	Oct-19 / Nov-19 / Dec-19 / Jan-20 / Feb-20 / Mar-20 Total Inappropriate OAPs bed days: 604 / 508 / 464 / 483 / 380 / 213 Total Inappropriate OAPs bed days (excl progress beds): 269 / 154 / 92 / 114 / 141 / 18 R / V / T / C / A / Rv	The Trust continues to meet the reduction trajectory. From April 2020, the number of progress beds reported will be zero.	YES	NO CHANGE Key standards are being consistently delivered and are maintaining performance
Mental Health data submission to NHS Digital: % clients in employment Target is 85%	2018/19 Q2: 0%; 2018/19 Q3: 1%; 2018/19 Q4: 0%; 2019/20 Q1: 2%; 2019/20 Q2: 3%; 2019/20 Q3: 4%	Improvements are expected to follow the SystmOne go live - date TBC as a result of COVID-19 pandemic	NO	UP Key standards are not being delivered but are improving
Mental Health data submission to NHS Digital: % clients in settled accommodation Target is 85%	2018/19 Q2: 13%; 2018/19 Q3: 38%; 2018/19 Q4: 37%; 2019/20 Q1: 36%; 2019/20 Q2: 37%; 2019/20 Q3: 39%	Improvements are expected to follow the SystmOne go live - date TBC as a result of COVID-19 pandemic	NO	NO CHANGE Key standards are not being delivered and are deteriorating/ not improving
18-week Referral to Treatment (incomplete) Target is 92%	Oct-19: 86.2%; Nov-19: 79.9%; Dec-19: 78.9%; Jan-20: 73.3%; Feb-20: 69.3%; Mar-20: 64.3% R / V / T / C / A / Rv This data refers to the following services: • ADHD and ASD (Aug 2019 - Dec 2019) • ADHD (Jan 2020 -March 2020)	ADHD moved to a new MDT model from 1st April 2020. From April 2020, the Trust will have no 18-week RTT services	NO	DOWN Key standards are not being delivered and are deteriorating
6-week wait for diagnostic procedures (incomplete) Target is 99%	Oct-19: 99.7%; Nov-19: 100.0%; Dec-19: 100.0%; Jan-20: 99.5%; Feb-20: 97.8%; Mar-20: 93.0% This data refers to the Audiology Service only	In line with national COVID-19 guidance, this service has been suspended. Deteriorating waits throughout the COVID-19 lockdown period will be due to this suspension	YES	DOWN Key standards are being delivered but are deteriorating

2. Access - wait time standards

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

Target							RAG/ Comments on recovery plan position	SPC Flag	
								Assurance of Meeting Target	Trend
CAMHS Eating Disorder – one week (complete pathway) Target is 95%	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20		NO	NO CHANGE
	66.7%	100.0%	100.0%	50.0%	100.0%	75.0%		Key standards are not being delivered and are not improving	
	R	V	T	C	A	Rv			
CAMHS Eating Disorder – four weeks (complete pathway) Target is 95%	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	A funded interim improvement plan is on track to deliver the agreed trajectory.	?	UP
	62.5%	62.5%	100.0%	57.1%	100.0%	91.7%		Key standards are being delivered inconsistently but are improving	
	R	V	T	C	A	Rv			
Children and Young People's Access – four weeks (incomplete pathway) Target is 92%	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20		?	NO CHANGE
	94.4%	96.7%	96.7%	98.3%	88.1%	80.0%		Key standards are being delivered inconsistently and are not improving	
	R	V	T	C	A	Rv			
Children and Young People's Access – 13 weeks (incomplete pathway) Target is 92%	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20		?	DOWN
	100.0%	99.5%	100.0%	99.5%	96.8%	85.4%		Key standards are being delivered inconsistently	
	R	V	T	C	A	Rv			
Adult CMHT Access Five day urgent (incomplete pathway) Target is 95%	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20		NO	NO CHANGE
	66.7%	66.7%	n/a	66.7%	75.0%	50.0%		Key standards are not being delivered and are not improving	
	R	V	T	C	A	Rv			
	'n/a' denotes no patients waiting as at last day of the month. There were two referrals made to the service in December 2019								
Adult CMHT Access Six weeks routine (incomplete pathway) Target is 95%	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20		NO	NO CHANGE
	50.0%	50.0%	43.7%	46.8%	50.9%	43.1%		Key standards are not being delivered and are not improving	
	R	V	T	C	A	Rv			

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:

COVID-19 Update

The month 12 data in this section of the report is delayed due to the impact of COVID-19. M12 data will be provided in the next iteration of the report

Target							Longest wait (latest month)	RAG/ Comments on recovery plan position	SPC Flag	
									Assurance of Meeting Target	Trend
Adult General Psychiatry - Community Mental Health Teams and Outpatients – Treatment (6 weeks)	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	weeks	No reduction in the number of 52 week waits. Audit of each patient taking place.	*SPC icons due May 2020 when 12 months of data is available*	
	76	89	89	76	105	TBC				
Liaison Psychiatry (13 weeks)	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	weeks	Service will be subsumed into new Core 24 service. No new referrals from December 2019.	*SPC icons due May 2020 when 12 months of data is available*	
	6	15	11	9	14	TBC				
	R	**V**	**T**	**C**	**A**	**Rv**				
Cognitive Behavioural Therapy (13 weeks)	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	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*	
	31	30	28	33	35	TBC				
Dynamic Psychotherapy (13 weeks)	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	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*	
	56	51	47	46	40	TBC				
Personality Disorder (13 weeks)	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	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*	
	62	63	59	61	93	TBC				
Medical/ Neuropsychology (18 weeks)	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	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*	
	37	53	48	48	40	TBC				
CAMHS (13 weeks)	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	weeks	Significant improvement being delivered in line with improvement plan.	*SPC icons due May 2020 when 12 months of data is available*	
	51	19	16	6	6	TBC				

4. Patient Flow

The following measures are key indicators of patient flow:

Target							RAG/ Comments on recovery plan position	SPC Flag	
								Assurance of Meeting Target	Trend
Occupancy Rate - Mental Health Beds (excluding leave) Target is <=85%	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20		?	NO CHANGE
	86.2%	85.6%	85.9%	89.6%	87.8%	84.2%		Key standards are being delivered inconsistently	
Occupancy Rate - Community Beds (excluding leave) Target is >=93%	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Fluctuating vacancy rates will be attributed to ward changes as a result of the COVID-19 response	?	NO CHANGE
	89.7%	88.5%	89.2%	91.9%	87.5%	83.4%		Key standards are being delivered inconsistently	
Average Length of stay (excluding leave) from acute Bradgate wards Target is <=33 days (national benchmark)	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Fluctuating LoS will be attributed to changes in discharge protocol as a result of the COVID-19 response	n/a	n/a
	35.2	33.5	41.9	36.9	35.5	44.6		*SPC icons due April 2020 when 13 months of data is available*	
Average Length of stay Community services National benchmark is 25 days.	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Fluctuating LoS will be attributed to changes in discharge protocol as a result of the COVID-19 response	YES	NO CHANGE
	17.7	19.9	17.9	20.4	18.1	18.5		Key standards are being consistently delivered and are maintaining performance	
Delayed Transfers of Care Target is <=3.5% across LLR	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	The target is being met as a wider LLR system	?	NO CHANGE
	4.4%	4.6%	3.8%	3.8%	4.0%	3.9%			
	R	V	T	C	A	Rv		Key standards are being delivered inconsistently	
Gatekeeping Target is >=95%	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20		YES	NO CHANGE
	98.8%	98.7%	98.6%	95.6%	95.9%	96.4%			
	R	V	T	C	A	Rv		Key standards are being consistently delivered and are maintaining performance	
Care Programme Approach – 7-day follow up (reported 1 month in arrears) Target is 95%	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Data quality improvements have been made by way of regular reporting and reminder to staff responsible for follow-ups	?	NO CHANGE
	89.2%	97.8%	96.1%	98.1%	97.0%	96.3%			
	R	V	T	C	A	Rv		Key standards are being delivered inconsistently	
Care Programme Approach 12-month standard Target is 95%	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Data quality improvements have been made by way of regular reporting and reminder to staff responsible for reviews	?	NO CHANGE
	92.4%	94.8%	94.5%	93.5%	93.6%	91.1%			
								Key standards are being delivered inconsistently	

5. Quality and safety

Target	Trust Performance						RAG/ Comments on recovery plan position	SPC Flag	
								Assurance of Meeting Target	Trend
C difficile Full year ceiling is 12.	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Trust is below ceiling year to date with 6 cases year to date	?	NO CHANGE
	0	2	0	1	0	0		Key standards are being delivered inconsistently	
Serious incidents	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20		N/A	NO CHANGE
	3	18	9	16	13	5		Key standards are not improving	
STEIS - SI action plans implemented within timescales Target = 100%	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Awaiting validated data to assess achievement of measure	?	DOWN
	No Plans	0.0%	No Plans	0.0%	40.0%	0.0%		Key standards are being delivered inconsistently and are deteriorating	
Safe staffing No. of wards not meeting >80% fill rate for RNs Target 0		Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	This measure is not relevant during COVID-19 as staffing capacity is changing rapidly and continually to respond to the pandemic	NO	NO CHANGE
	Day	1	2	3	2	2	n/a		Key standards are not being delivered and are not improving *SPC based on day shift*	
	Night	2	1	1	1	1	n/a			
No. of episodes of seclusions >2hrs Target decreasing trend	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20		N/A	N/A
	25	14	22	32	34	35		*SPC icons due April 2020 when 12 months of data is available*	
No. of episodes of supine restraint Target decreasing trend	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20		N/A	N/A
	7	4	7	3	16	14		*SPC icons due April 2020 when 13 months of data is available*	
No. of episodes of side-line restraint Target decreasing trend	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20		N/A	N/A
	37	9	19	26	29	21		*SPC icons due April 2020 when 13 months of data is available*	
No. of episodes of prone (unsupported) restraint Target decreasing trend	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20		N/A	N/A
	0	0	0	0	0	0		*SPC icons due April 2020 when 13 months of data is available*	
No. of episodes of prone (supported) restraint Target decreasing trend	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20		N/A	N/A
	5	6	8	4	2	6		*SPC icons due March 2020 when 12 months of data is available*	
No. of Category 2 and 4 pressure ulcers developed or deteriorated in LPT care		Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20		N/A	N/A
	Category 2	86	77	80	79	92	96		*SPC icons due April 2020 when 13 months of data is available*	
	Category 4	3	2	3	4	6	6			
No. of repeat falls Target decreasing trend	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20		N/A	N/A
	36	39	37	49	49	45		*SPC icons due April 2020 when 13 months of data is available*	

Additional quality measures

• 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.
• The new Quality KPI improvements will be reviewed at the end of 2020/21 quarter two.

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.

Target							RAG/ Comments on recovery plan position	SPC Flag	
								Assurance of Meeting Target	Trend
MH Data quality Maturity Index	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	The Trust is failing to deliver the 95% target. Improvement plan required.	NO	UP
	88.0%	91.1%	92.5%	92.7%	92.4%	91.5%			
Target >=95%								Key standards are not being delivered but are improving	

7. Workforce/HR

The following measures are key indicators of patient flow:

COVID-19 Update
The month 12 data in this section of the report is delayed due to the impact of COVID-19. M12 data will be provided in the next iteration of the report. RAGS and SPC relate to M11

Target							RAG/ Comments on recovery plan position	SPC Flag	
								Assurance of Meeting Target	Trend
Normalised Workforce Turnover rate (Rolling previous 12 months) Target is <=10%	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	The Trust is below the ceiling set for turnover.	YES	DOWN
	8.8%	8.8%	9.3%	8.8%	8.6%	TBC		Key standards are being consistently delivered and are improving performance	
Vacancy rate Target is <=7%	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Performance improved in October and November. A vacancy control process is now in place linked to financial turnaround.	NO	DOWN
	8.8%	8.6%	8.5%	8.8%	8.7%	TBC		Key standards are not being delivered but are improving	
Health and Well-being Sickness Absence (1 month in arrears) Target is <=4.5%	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	The Trust is not delivering the ceiling set for sickness absence. Subject to a SWG review.	NO	NO CHANGE
	4.9%	5.2%	5.2%	5.3%	5.4%	TBC		*Key standards are not being delivered and are not improving*	
Agency Costs Target is <=£641,666 (NHSI national target)	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Increased controls over agency spend is part of the financial turnaround process.	?	UP
	£867,920	£864,714	£875,918	£724,425	£867,533	£852,000		Key standards are being delivered inconsistently	
Core Mandatory Training Compliance for substantive staff Target is >=85%	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20		YES	NO CHANGE
	95.4%	95.3%	95.3%	95.4%	95.2%	TBC		Key standards are being consistently delivered and are maintaining performance	
Staff with a Completed Annual Appraisal Target is >=80%	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20		YES	UP
	93.5%	93.5%	93.0%	93.8%	93.5%	TBC		Key standards are being consistently delivered and are improving performance	
% of staff from a BME background Target is >= 22.5%	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20		NO	UP
	22.5%	22.5%	22.7%	21.9%	22.9%	TBC		Key standards are not being delivered but are improving	
Staff flu vaccination rate (frontline healthcare workers) Target is >= 80%	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	The Trust has not yet achieved the 80% rate. Significant focus on this measure.	NO	UP
	22.0%	44.0%	55.0%	58.7%	60.6%	TBC		Key standards are not being delivered but are improving	
% of staff who have undertaken clinical supervision within the last 3 months Target is 85%	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20		NO	UP
	86.0%	86.2%	81.7%	83.0%	83.9%	TBC		Key standards are not being delivered but are improving	

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Leicestershire Partnership NHS Trust

TRUST BOARD – 5 May 2020

AUDIT AND ASSURANCE COMMITTEE held 6 March 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
Risk Assurance (Chairs of FPC and QAC)	MEDIUM	Organisational Risk Register now being actively used but still need sight of updated Register. An evolving process and step change in approach expected to be seen during March 2020 ie updated Register. The Register is one part of wider corporate governance changes that is underway for assurance triangulation. A risk around system-wide contracting arrangements to be considered.	All
Internal Audit Progress Report	HIGH	Update on reports issued and follow-ups status. The later was much improved but still just below significant at 73% (upon 60% reported at last meeting). Year-end completion of plan should be achieved. A re-look at KPI for sign-off timescale for approving Terms of Reference for internal audits (given new governance arrangements) for Executive team would be undertaken.	1 18
Draft Interim Head of Internal Audit Opinion	MEDIUM	Some audits were still to be completed with movement on assessment possible on the three opinion segments.	1 18
Internal Audit Plan 2020/21	HIGH	Total days allocated were up on 2019/20 plan and scope was agreed for flexibility. LPT was benchmarking low for number of audit days. Possible external reviews could be considered	1 18

Report	Assurance level*	Committee escalation	ORR Risk Reference
Counter Fraud Strategy and Plan 2020/21		for Internal Audit going forward. Patient census is a standby audit if nothing else emerges from forthcoming CQC Inspection. Plan agreed. Counter Fraud Strategy and Plan discussed and approach and days agreed.	
External Auditors Progress report	HIGH	Reported received and positive progress noted.	17
Counter Fraud Progress Report Counter Fraud Annual Survey Supplier Bank Account Arrangements – mandate fraud	HIGH	The draft Fraud, Bribery and Corruption Policy was considered for adequacy. Nothing material had changed. Noted. Matter discussed with the Finance team and changes suggested had been implemented.	17
Agreement of Annual Accounts Timetable, Progress and Plans	HIGH	Timetable of dates now confirmed along with IFRS16 impact. Awareness of IFRS 16 for committee members was to be undertaken at April meeting review of draft Accounts.	17
Quality Accounts Timetable Update	MEDIUM	Sighting of timetable needed to be seen at QAC and followed up by lead Executives.	1 17
Annual Governance Statement Process	HIGH	Guidance recently received from NHS I was to be circulated and the draft Annual Governance Statement going to the Strategic Executive Board in April to be shared with committee members.	1 17
Annual Refresh of Standing Financial Instructions (SFIs) including Scheme of Reservation and Delegation (SORD) and Standing Orders (SOs)	HIGH	The issue raised for further adequacy check by the committee had been addressed through amended approval expenditure levels The SFIs, SOs and SORD had been updated and approved.	17
Summary of Chief Executive Waivers and Awarded Tenders	HIGH	It was agreed that it would be helpful to review criteria for waiver application to ensure we are on the front foot for contract expiry.	17

Report	Assurance level*	Committee escalation	ORR Risk Reference
Internal Audit Follow-Ups	HIGH	Major step forward with closure of almost all of the outstanding follow-ups for 2019/20. In addition clarity of follow-ups upcoming also improved. Being clear on actions to take to close off risks was critical and part of education that was needed. The renewed focus of the Executive Operations meeting was providing good traction on follow-ups and assurance to the committee.	1 18
Deep Dive - Changes to Contracting Arrangements	HIGH	The topic was introduced and background explained by the Chair for Integrated Care Systems. Further comments were added by the Director of Finance and Director of Strategy. Committee role is “what does this mean for LPT?” There will be difficult population health needs debates over financial allocation for competing needs across the local and regional locales. Assurance for risk management for health economy by Internal Audit was a possibility. Agreed that building the committee’s understanding of the issue was needed with a possible re-visit of the topic. Also agreed that the Chair would contact Audit committees’ Chairs for UHL and CCGs for understanding of their views and expectations for common risks as part of the new contracting arrangements.	3

Chair	Darren Hickman