Leicestershire Partnership NHS Trust

Public Meeting of the Trust Board
31st August 2021
Microsoft Teams
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**
9.30	1.	Apologies for absence and welcome to meeting: The Trust Board Members – Paper A	Chair
9.35	2.	Patient Voice film – FYPC Special Educational Needs and Disability - Verbal	Helen Thompson
9.45	3.	Staff voice - FYPC Special Educational Needs and Disability - Verbal	
10.05	4.	People's Council & Health Watch Report – Paper B	Mark Farmer
10.15	5.	Declarations of interest in respect of items on the agenda - Verbal	Chair
	6.	Minutes of the previous public meeting: 29th June 2021 – Paper C	Chair
	7.	Action Log & Matters arising – Paper D	Chair
	8.	Chair's Report – Paper E	Chair
	9.	Chief Executive's Report – Paper F	Angela Hillery
Governance and Risk			
10.25	10.	Organisational Risk Register – Paper G	Chris Oakes
10.40	11.	CQC Update Including Registration– Paper H	Anne Scott
10.50	12.	Fit and Proper Person Requirement for Directors Annual Declaration – Paper I	Chair
10.55	13.	Break	
Strategy and System Working			
11.05	14.	Service Presentation –FYPC Special Educational Needs and Disability - Verbal	Helen Thompson
11.20	15.	Step Up To Great Progress/Milestones/KPIs – Paper J	David Williams
11.30	16.	Provider Collaborative – Paper K	David Williams
Quality Improvement and Compliance			
11.35	17.	Quality Assurance Committee Highlight Report 27th July 2021- Paper L	Moira Ingham
11.40	18.	Patient and Carer Experience, Involvement and Complaints Quarter 1 Report – Paper M	Anne Scott

11.45	19.	Patient Safety Incident and Serious Incident Learning Assurance Report - Paper N	Anne Scott
11.50	20.	Safe Staffing Monthly Reports – June 2021- Paper Oi & July 2021 – Paper Oii	Anne Scott
11.55	21.	Staffing Capacity and Capability 6m Report (NQB) – Paper P	Anne Scott
12.00	22.	Learning from Deaths Q1 Report – Paper Q	Avinash Hiremath
12.05	23.	Annual Equality Reports – WRES Annual Report – Paper Ri & WDES Annual Report – Paper Rii	Sarah Willis
Performance and Assurance			
12.15	24.	Finance and Performance Committee Highlight Report – 27th July 2021 – Paper S	Faisal Hussain
12.20	25.	Finance Monthly Report – Month 4 – Paper T	Sharon Murphy
12.30	26.	Performance Report – Month 4 – Paper U	Sharon Murphy
12.40	27.	Charitable Funds Committee Highlight Report – 20th July 2021 – Paper V	Cathy Ellis
12.45	28.	Review of risk – any further risks as a result of board discussion?	Chair
	29.	Any other urgent business	Chair
	30.	Papers/updates not received in line with the work plan: • Safeguarding Annual Report (moved to October) • Patient and Carer Experience, Involvement and Complaints Annual Report (moved to October) • Level 1 Committees Annual Reports (moved to October)	Chair
12.50	31.	Public questions on agenda items	Chair
1.00	32.	**Date of next public meeting: 26th October 2021**	Chair

A

Our Trust Board

As of September 2021

Leicestershire Partnership NHS Trust

*Indicates joint role with Northamptonshire Healthcare NHS Foundation Trust (NHFT) as part of group model arrangement

Cathy Ellis
Chair

Angela Hillery
Chief Executive

Mark Powell
Deputy Chief Executive

Faisal Hussain
Non-Executive Director and Deputy Chair

Moira Ingham
Non-Executive Director

Vipal Karavadra
Non-Executive Director

Prof. Kevin Harris
Non-Executive Director

Ruth Marchington
Non-Executive Director

Darren Hickman
Non-Executive Director and Senior Independent Director

Richard Wheeler
Chief Finance Officer*

Sharon Murphy
Interim Director of Finance

Samantha Leak
Director of community health services

Gordon King
Director of adult mental health

Helen Thompson
Director of families, young people and children's services and learning disabilities

Sarah Willis
Director of human resources and organisational development

Chris Oakes
Director of corporate governance and risk*

David Williams
Director of strategy and business development*

Dr. Avinash Hiremath
Medical Director

Dr. Anne Scott
Director of nursing, allied health professionals and quality

B

Providing an independent voice to make LPT services great for all

Report from Mark Farmer

Chair of The People's Council and Healthwatch Leicester and Leicestershire Board member

The People's Council

We are nearly at the one-year mark of the establishment of the Council- this is therefore an opportune moment to spend some time over the next two months looking at how things are going and to look at what we may need to do differently to achieve our original aims. We have asked an external organisation to assist with this review. We would also like to work with members of Trust Board to better understand what role we could have in the Step Up To Great refresh and how we could help co produce it.

We are in the process of recruiting new members to the Council and are looking for up to eight new members. I would be grateful for anything that Trust Board members could do to promote these roles, including asking staff teams if they are aware of any patients and carers who may be suited to becoming a patient or carer leader. The closing date for applications is September 16th 2021 and the website address for circulation is www.leicspart.nhs.uk/involving-you/the-peoples-council/

The People's Council has been working to finalise and send a comprehensive response to the Step Up To Great for Mental Health consultation. Our report outline what we welcome about the proposals and areas that need more reflection on so that services better meet patient and carer needs. We are planning to have an ongoing role in the implementation stage and will be conducting a further review to see what lessons could be learnt about how to do a service review such as in the future.

We now look to our next priorities which are equality, diversity and inclusion and the personalisation of care. We also continue to have senior members of staff at LPT meet the Council, with us recently meeting the Director of Mental Health.

At our last meeting, the Head of Learning and Development attended the meeting and presented LPT's leadership strategy. A number of points were raised including the importance of patient and carers leaders in the design and delivery of leadership programmes, patient and carer leaders having access to leader training modules in U Learn and the possibility of Voluntary and Community Sector organisations having access to planned Integrated Care System leadership training events as a way of helping to make sure they can be fully effective within the new system. The Head of Service undertook to get back to us on all of these points.

I would also like to report that the Council's Leadership Team have been meeting with the Head of Patient Experience and Involvement to inform the development of lived experience roles at the Trust and we inputted into a paper to operational Executive.

It was my pleasure to represent Healthwatch and The People's Council at the recent judging panel for the Covid Hero Awards. Separately, the People's Council were asked to select the winner for the involvement award.

I would like to put on the record my personal thanks to Liz Rowbotham, (a former Non-Executive Director) who has been supporting me with the development of my skills as a Chair. Her supportive and considered advice has been of a real help to me. I will miss being able to tap into her vast experience.

Healthwatch

Our staff team has been touring the city and county to engage with people to understand their experiences of health and care services locally. We will use the intelligence gathered to inform our work and the team will share intelligence with our partners.

We have supported the Step Up To Great Mental Health consultation by promoting it to as many people across the County and City as possible. We have also been making sure that if we were receiving any information on any difficulties that people were having with filling in the form or any organisation or groups that wanted to be engaged with are contacted and supported by the CCG. We have been impressed by the innovative approaches and considerable effort put in by LPT and CCG members of staff into reaching out to the widest number of people as possible. Healthwatch has also produced a report on access to Mental Health services which will form part of the public consultation feedback.

We hope to see the results of the consultation and understand them before final a decision is taken by the CCG on the future of those services.

We have a created a Healthwatch Leicester and Leicestershire Board working party to look at how we want to see the Integrated Care System (ICS) for Leicester, Leicestershire and Rutland develop, and the role we would look to have within it and how the patient and carer voice will need to be put at its very heart. We continue to have membership of the ICS Partnership Board and all the Health and Wellbeing Boards.

I am a member of the system Design Groups for All-Age Mental Health and Primary and Community care integration as a patient and carer representative on behalf of Healthwatch and Co-Chair the group with the Director of Mental Health at LPTs. The All-Age Mental Health Design Group recently had an away day for the whole of the Mental Health system. We looked at how we can better deliver our programme of work, including how we do more co production, manage transformation and prepare for becoming a full ICS. One product of our away day will be to develop a systems outcome strategy for Mental Health. The Design Group has also been coordinating the considerable work required to manage the investment of over £18 million into mental health services.

I have recently been appointed as an Expert Advisor on Adult Mental Health to NHS England and have been invited to sit on the working group looking at access targets and there is currently a national NHS consultation about the new targets which are ambitious, but from a patient and carer perspective most welcome as they will help to give mental health parity of esteem with physical health.

Appendix 1 – Healthwatch Report Easy Read

B - appendix 1

healthwatch Leicester

healthwatch Leicestershire

Accessing Mental Health Services during Crisis

Easy Read

April 2021

Introduction

Healthwatch Leicester and Healthwatch Leicestershire is the independent voice of the public in health and social care services. We collect feedback from the public about their experiences of using health and social care services and use that feedback to work with service providers and commissioners to find ways to improve services. One of the ways that we collect feedback is by carrying out focused projects as part of our annual workplan.
We decided to make reviewing urgent access to mental health services a priority in 2020, because we were receiving a lot of concerns about the support people were receiving from urgent access mental health service providers. This includes the Crisis Team, telephone support and support at the Emergency Department (ED) at Leicester Royal Infirmary.

Since then, Leicestershire NHS Partnership Trust (LPT) with its partners has made several changes to the way in which some urgent mental health services are delivered. This has included the establish of an Urgent Access Hub at the Bradgate Unit, to help people who need urgent support with their mental health much quicker and to avoid people going to ED which can be a daunting prospect for many. There is also now a 24-hour helpline that anyone with concerns about their mental health call and can use to self-refer themselves into services.
Mark Farmer, Healthwatch Leicester and Leicestershire Board Member and lead for Mental Health said: “We would have liked to have heard from more people about their experiences of these services, but because of the current restrictions on face-to-face meetings this has not been possible. The information gathered through this project and our recommendations will be fed into the forthcoming consultation on moving mental health services to a neighbourhood model which the Clinical Commissioning Groups (CCGs) for Leicester, Leicestershire and Rutland will be launching in May 2021.

Mental Health will continue to be a priority for Healthwatch Leicester and Healthwatch Leicestershire and we will continue to champion better mental health services locally.
Many thanks to our partners that helped us to promote the survey and a big thanks to those that took part in the survey and online discussion session”.

Aims & Objectives

The aim of the project was to collect patient and public knowledge of how to access Urgent Mental Health support care and their experience of accessing, using and discharge from Mental Health support.

We wanted to:

- Understand how well patients/ public understand how to access urgent support.
- Capture the patient/ public experience of:
- Accessing support services
- Using urgent support services (i.e. LPT Referral service)
- Discharge from support services
- Highlight good practice and positive patient experience.
- Highlight common patient experience themes
- Highlight evidenced recommendations.

Methodology

We designed a survey to gather the patients experience of urgent mental health care services. The questions were designed to gain both quantitative and qualitative data. The survey was made available online and promoted through our social media channels. It was also cascaded to all our contacts and promoted across Leicester and Leicestershire.

We held an event, 'Healthwatch hour: bridging the gap in Mental Health services' to enable people to discuss their views on their local services.

Who we spoke to:
Local people to find their views on local services and in addition we received 19 individual survey responses and a group response from 8 participants.

Main Findings

Participants were asked where they live to assess whether there were any inequalities or differences in service provision throughout Leicester and Leicestershire. Feedback was consistent from participants from various parts of the county, so no inequalities or differences in service provision was found, however the sample size was small and not fully representative of all communities.

41% of participants live in the City of Leicester, 4% live in Blaby, 22% live in Charnwood, 11% live in Harborough, 7% live in Hinckley and Bosworth, 4% live in North-West Leicestershire, and 11% live in Oadby and Wigston.

When participants were asked if they would seek help from the NHS if they were struggling with their mental health 77% of participants stated that they would and 23% of participants stated that they would not.

Of those that reported that they would seek help from the NHS, 16 people indicated that they would go to their GP, 6 people reported that they would access community mental health services, 2 people indicated that they would seek help from their Community Psychiatric Nurse (CPN) or psychiatrist, and 4 people stated that they would access crisis mental health services.

The participants who indicated that they would not seek help from the NHS were asked the reasons behind their response, one participant reported it was due to 'an endless wait for phone cognitive behavioural therapy', another stated that they had 'previously had negative experiences with NHS mental health support', while a third felt that they 'would only be offered medication'.

Subsequently, those who stated that they would not seek help from the NHS were also asked where they would seek help instead, 3 people stated that they would go to their 'GP', 1 person stated they would go to Richmond Fellowship, and 1 person reported that they would seek help from social prescribers.

When participants were asked if they would approach the Crisis team or Central Access Point (CAP) if it was an emergency 41% indicated that they would, and 59% indicated that they would not.

Participants were asked what different ways they know to get support for their mental health, both inside and outside of the NHS, as this was an open text question, participants were able to list as many options as they wished.

GP appointment was the most frequent option reported by respondents which was mentioned by 16 people, 12 people stated that they would utilize charitable organisations, 8 people indicated that they would access privately funded counselling, 7 people stated that they would access Voluntary sector organisations, 7 people stated they would use 111 or 999 services, 5 people reported that they would use A&E, 4 people stated they would use the Central Access Point, 3 people would use self-help, 3 people stated they would rely on friends or family for support, and 2 people stated they would access community mental health services.

Participants were asked if they had ever had NHS support for their mental health and 89.5% reported that they have, whilst 10.5% reported that they have not.

Of those that indicated that they had received NHS support for their mental health, 41% reported that this was urgent help, and 59% reported that it was not urgent help.

These same participants were subsequently asked who provided the help, 38% stated that it was through their GP, 6% reported that it was through A&E, 6% stated that they had accessed the urgent care team, 13% had been involved with the community mental health team, 19% had accessed Let's Talk Wellbeing, and 19% reported they had used other services.

Participants who had reported that they had not had NHS support for their mental health, and those that reported they had used other NHS services were asked to specify where they had received support. 1 person reported that they had accessed privately funded treatment, 1 person has used liaison psychiatry, 2 people had had an inpatient admission, 2 people had accessed the crisis team and 1 person had accessed all services.

All participants were asked if they would access local authority mental health support services such as Social Services and 74% stated they would not while 26% stated that they would.

When asked if they have accessed urgent mental health support through A&E, 21% of participants indicated that they had and 79% of participants reported that had had not.

Participants were also asked if they had accessed urgent mental health support through any other services and 37% reported that they had, and 63% reported that had not.

Participants were asked to rate how strongly they agreed or disagreed with a set of 15 statements about mental health services.

28% of people strongly disagreed that contacting the service was straightforward, 17% disagreed, 6% neither agreed nor disagreed, 22% agreed and 28% stated that this was not applicable.

44% of respondents strongly disagreed that they were seen by the service quickly, 17% disagreed, 17% agreed and 22% stated that this was not applicable.

44% of participants strongly disagreed that they only had to explain their situation once, 22% disagreed, 6% neither agreed nor disagreed, 6% agreed and 22% stated that this was now applicable.

28% strongly disagreed that it was clearly explained how they would be supported, 33% disagreed, 6% neither agreed nor disagreed, 11% agreed, and 22% stated that this was not applicable.

33% of people strongly disagreed that they received enough information to make informed decisions about their support and treatment, 22% disagreed, 17% agreed, 6% strongly agreed, and 22% stated that this was not applicable.

39% of people strongly disagreed that they saw the same clinician throughout their support and treatment, 28% disagreed, 11% agreed, and 22% stated that this was not applicable.

39% strongly disagreed that there was no breaks in their treatment, 11% disagreed, 6% neither agreed nor disagreed, 22% agreed, and 22% stated that this was not applicable.

44% strongly disagreed that they had a care plan that met their specific needs, 11% disagreed, 6% neither agreed nor disagreed, 11% agreed, and 22% stated that this was not applicable.

28% strongly disagreed that they were treated with dignity, 6% disagreed, 17% neither agreed nor disagreed, 17% agreed, 11% strongly agreed, and 22% stated that this was not applicable.

39% strongly disagreed that it was clearly explained how their treatment would come to an end and when, 22% disagreed, 6% agreed, 6% strongly agreed, and 28% stated that this was not applicable.

28% strongly disagreed that they understood why their treatment came to an end, 17% disagreed, 17% neither agreed nor disagreed, 11% agreed, and 28% stated that this was not applicable.

28% strongly disagreed that they received support that was helpful, 11% disagreed, 11% neither agreed nor disagreed, 17% agreed, 11% strongly agreed, and 22% stated that this was not applicable.

17% strongly disagreed that they received information on groups they could speak to about their situation, 6% disagreed, 17% neither agreed nor disagreed, 28% agreed, 6% strongly agreed, and 28% stated that this was not applicable.

22% strongly disagreed that there was an emphasis on recovery, 11% disagreed, 17% neither agreed nor disagreed, 17% agreed, 6% strongly agreed, and 28% stated that this was not applicable.

17% strongly disagreed that they fully understand how to access support if they become mentally unwell again, 17% disagreed, 22% neither agreed nor disagreed, 11% agreed, 11% strongly agreed, and 22% stated that this was not applicable.

Participants were asked to rate the consistency of their experience of using mental health services more than once, and 40% found their experiences to be very inconsistent, 20% found their experiences to be fairly consistent, 13% found their experiences to be neither consistent nor inconsistent, 13% stated their experiences was quite consistent, and 13% stated their experiences were very consistent.

Finally, participants were asked what one thing would have made a big difference to their experience of urgent mental health services. 20 people responded to this this question, and almost all of them made more than one comment resulting in a total of 49 comments.

Five themes emerged from the feedback received to this question, the themes were gatekeepers, crisis response, service information and clarity, support/treatment, and mental health service/staff.

Gatekeepers were discussed **7** times by participants who felt that there should be *'trained staff answering the phones, not just admin staff'*, that *'the first person you speak to when you contact CAP is never a mental health professional'* and that they *'don't feel the GP receptionist is the right person to decide on appointment length, they aren't mental health trained'*. Participants also stated that '*mental health stigma means I don't want to have to explain to the person on the phone (Receptionist)'*.

Crisis response was discussed **8** times by participants, in terms of accessing support participants stated that *'when you call CAP you spend at the VERY least, 30 minutes waiting, with the phone ringing before the first person answers'* and that the time to have calls answered can be *'often much longer'*, other participants stated that it would be helpful if services could *'answer phones in a reasonable time, 30 minutes is too long'*. Participants also discussed lack of clarity with crisis response, stating that *'when you call CAP in crisis it is not clear who will make contact with me and when'* and inconsistency in *'the response to a crisis call to CAP can vary greatly from having crisis team out every day, to waiting 6 weeks for CAP to call back'*.

Service information and clarity was discussed **7** times by respondents who reported that '*sometimes CAP tell you that they are how you get referred to adult mental health services, sometimes they say they are not' and felt that 'when making the initial call to CAP, it is confusing what service you are actually ringing, sometimes they call themselves CAP sometimes they are turning point'*. Respondents also stated that they *'think CAP could be a great service - but inconsistencies, and apparent staff confusion about what they offer, and confusion on the users part of who they actually are CAP or Turning point - all these things make it quite a difficult service to use'* and that they '*think CAP need to make it clearer who they are and what they do'*. Other participants felt that there is '*not enough information available about services'* and that they *'didn't know about the crisis team or central access point, more information should be available'*.

Support/treatment was discussed **14** times by participants, some comments related to appointments with one participant reporting that they were '*referred urgently to adult mental health services and had to wait one year for an initial appointment, then another **23** months for psychodynamic therapy*' and another stating that '*the treatment received should be regular and reliable, without regular cancellations'*. Respondents also mentioned interruptions or delays to treatment, one person stated that it would help if they could *'get the help I need all at once rather than having to take a break before being referred again to then have a longer wait'* and another advised to *'have more Psychiatrists in Leicestershire'* as '*being able to see the same Psychiatrist and more frequently rather than once every 6 months'* would be beneficial to them. Other participants discussed treatment plans, stating they would like a *'more in-depth plan of my treatment'* and *'the treatment to be agreed in advance in terms of what's helpful, and flexible if that needs to change without needing to be re-referred'*. Other respondents spoke about access to support or treatment stating that there is not enough *'accessibility for dual diagnosis eg Autism Spectrum Disorder'* and it would be helpful if patients could *'access services when you need it' as 'sometimes you can't access the services when you want to'*. Other participants stated it would be helpful if they didn't *'have to repeat the problems over and over again'* and were able *'to talk at any level to a mental health specialist'*, one also reported the value of social support, stating that having *'visits from friends and family helped me get better'*.

Mental health service/staff was discussed **13** times by participants who felt that mental health services need *'more funding to make sure they aren't burned out and stressed and not able to take calls'* and that it would help patients if *'staff read my notes and followed advice from my consultant psychiatrist'* and that *'actually being supported and listened to without having to repeat to several types of professional in several departments'* and *'dealing with people who care and actually want to help you'* is important to patients. Other respondents stated they felt that *'a service that operates outside of office hours'* is necessary, that *'continuity of staff is paramount'* and that *'mental health referrals to crisis service for under 16s should be more consistent'*.

Healthwatch Hour online event

On Thursday 4 March 2021 we held a Healthwatch hour session called “bridging the gap in Mental Health services”.

People told us that:

They are experiencing long wait times in accessing mental health services, specifically when moving between services and often finding that consistency of care is left lacking and many people were unaware of the urgent care team and the access to the urgent care centres for mental health support.

Support is not being accessed through GPs due, in part, to waiting times for appointments and lack of training / understanding of administration staff.

Where people had been able to access an appointment, it is felt that GPs placed too much emphasis on the use of medications, where the patient felt that alternative options such as talk therapy, would be better suited to their needs. However, this often means another long waiting period before receiving support, and as such this has left individuals feeling that services are reactive rather than preventative.

"At what point is it bad enough to be taken seriously? Basically, you have to be at the point of no return.”
Female Aged 25 - 49 years

The deaf community are finding it difficult to access urgent mental health services due to communication challenges, often not having internet access is leaving people isolated and in increasing need of support.

RECOMMENDATIONS

1. There needs to be additional training on mental health and triage for GP surgery administrative staff.

2. Leicestershire Partnership NHS Trust (LPT) needs to explore ways to improve its triage service and not leave patient on hold on the phone for a long period of time.

3. LPT needs to address the inconsistencies in the Central Access Point (CAP) Service response for patients.

4. LPT needs to explore interim support for patients who are waiting for mental health services to respond.

5. There needs to be improved advertising of local urgent mental health services to all communities and age groups, including the support Social Services can provide to support those with mental ill health.

6. Urgent access to Mental Health Services needs to be made more accessible, especially for those that are deaf or hard of hearing.

7. Ensure that the patient mental health record is shared with relevant providers at the point of crisis so that patients do not have to keep repeating their story to different service providers.

8. Feed this information gathered from this review into the forthcoming combined Clinical Commissioning Group review into getting help in neighborhoods

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CONCLUSION

Many of the issues raised by the public in this review are the ones that led to Healthwatch Leicester and Healthwatch Leicestershire conducting this review, including the need to improve the response times for those who access urgent telephone-based services and making sure that people have access to support whilst waiting for support and treatment. There is also a need for organisations and staff to share and read information about a patient and their history, as patients continue to find it frustrating that they must keep repeating their story repeatedly.

This report highlights that people in urgent need of mental health support often go to their GP first and that when accessing these services, the first person that they talk to often does not have a sufficient level of understanding of mental health. It would also seem that not many people are aware that Social Services can provide support to people with mental ill health.

It is important that services are made more accessible for all the different communities of shared interest across Leicester and Leicestershire, especially for those that are deaf or hard of hearing who feel very excluded from being able to access services.

DEMOGRAPHICS

Age

The 25 – 49 years age group was the most frequently reported with 44% of respondents indicating that they are in this category, 7% were aged 18 – 24 years, 33% were aged 50 – 64 years, 11% were aged 65 – 79 years and 4% were aged 80+.

Gender

Only 4% of respondents chose not to disclose their gender, 77% reported that they identified as a woman and 19% reported that they identified as a man.

Ethnicity

Only 4% of respondents chose not to disclose their ethnicity, 4% reported that they were Asian/British: Bangladeshi, 19% reported that they were Asian/British: Indian, 4% reported that they were of other Asian/British background, 4% reported that they were of other Mixed/Multiple ethnic groups background, 58% reported that they were White British, and 8% reported that they were of other White background.

Religion or belief

28% of respondents reported that they were Christian, 6% reported that they were Hindu, 50% reported that they had no religion or belief, 11% reported that they were Sikh, and 6% reported they were of an other religion.

Sexuality

17% of participants reported that they were bisexual, 56% reported that they were heterosexual, 6% reported that they were a lesbian/gay woman, 6% were pansexual, and 17% preferred not to disclose their sexuality.

Health

Other demographic questions asked if participants considered themselves to have a long-term condition or illness, and if they consider themselves to have a disability. The findings of these questions have been represented in the chart below, 53% of respondents reported that they have a disability and 53% of respondents reported that they have a long-term condition or illness.

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healthwatch Leicestershire

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Leicestershire Partnership NHS Trust

Minutes of the Public Meeting of the Trust Board
29th June 2021 - Microsoft Teams Live Stream

Present:
Ms Cathy Ellis Chair
Mr Faisal Hussain Non-Executive Director/Deputy Chair
Mr Darren Hickman Non-Executive Director
Ms Ruth Marchington Non-Executive Director
Mrs Elizabeth Rowbotham Non-Executive Director
Ms Moira Ingham Non-Executive Director
Professor Kevin Harris Non-Executive Director
Ms Angela Hillery Chief Executive
Mr Mark Powell Deputy Chief Executive
Ms Sharon Murphy Interim Director of Finance
Dr Avinash Hiremath Medical Director
Dr Anne Scott Director of Nursing AHPs and Quality

In Attendance:
Mr Richard Wheeler Chief Finance Officer
Ms Fiona Myers Interim Director of Community Health Services
Mr Gordon King 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 Governance and Risk
Mr David Williams Director of Strategy and Business Development
Mr Mark Farmer Healthwatch
Mrs Kay Rippin Corporate Affairs Manager (Minutes)

TB/21/059	Apologies for absence – None Received. The Trust Board Members names, photographs and roles are shown in Paper A Welcome: CQC Inspection Team Kamy Basra Associate Director of Communications Staff Voice: Aoife Quigley SLT; Sharon Pritchard Community Nurse; Rebecca Mitchell Clinical Lead Specialist Autism Team; Rachel Parker Head of Communities and Youth Services. Service Presentation: Mark Roberts Assistant Director FYPC & LD; Sophie Pratt Clinical Project Manager LD QIP. Observing the Public Board: Lauren Bland – Student on Placement; Catherine Holland – Clinical Lead for the Vaccination Programme. The Chair advised that during the covid pandemic our agendas have focused on the 6 priority areas at the top of the agenda and would remain the focus of today's meeting due to the rise in cases of the delta variant; there were more papers than usual as seven of them were annual reports at today's meeting; all papers would be taken as read and presenters should highlight any changes since the paper has

	been written or that change the risk profile. The theme for today's meeting is Learning Disabilities.
TB/21/060	Patient voice film – Learning Disabilities (LD) A film was shared showing the experience of a service user with learning disabilities having her covid vaccination at the specialist LD clinic held at the Peepul Centre. The film showed the experience of the service user, her mother and the nurses and staff at the Peepul Centre. All gave positive feedback on their experience. Helen Thompson explained that the specialist clinics draw on the skills and expertise of the LD staff, more time is allocated to each appointment and the atmosphere is relaxed. The clinics have been a great success and 357 service users have accessed their vaccinations at the LD clinic. Angela Hillery commented that she was very proud of the staff and vaccination service. Leicester, Leicestershire and Rutland (LLR) have a clear focus on reducing health inequalities for people with learning disabilities and this is a way to support this work. Other Trusts have seen this work and followed our lead. Liz Rowbotham asked if this would be a model LPT would continue moving forward and Helen Thompson confirmed that the clinics were shared as a national exemplar and have provided useful learning for LPT moving forward. Ruth Marchington commented that this was a great example of different delivery and asked to see the statistics around take up from this group of service users and Helen Thompson confirmed that the LLR Vaccination Groups would have this data which she will share with the Board. **Action: Helen Thompson to share the LD covid vaccination take up data with the Board members**
TB/21/061	Staff voice - Learning Disabilities The team talked about their roles in the LD services and the transforming care agenda. They are a multi-disciplinary team offering post diagnostic support to people aged 14 years plus. Support is offered both in hospital and in the community to provide continuity of care and support a timely and successful discharge back into the community. Between April and October 2021 the focus was on those at imminent risk of admission and those admitted. From October onwards early intervention support will also become a focus for the team. The team have a wealth of experience and support a wide variety of needs both mental and physical health. The team members talked about their individual roles and how they all work together supporting the LD services users to get best outcomes. The team added that they were proud to work in LPT and felt that everyone was a leader. They felt connect to the trust values and leadership behaviours. The LD team had focused on the health and wellbeing of staff and had also applied to charitable funds to enhance their environments for patient and staff wellbeing. Sarah Willis commented that the team really demonstrated the leadership behaviours and asked if there was anything further that could be done to support the health and well-being of the team. Sharon Pritchard commented that the Wellbeing Wednesday initiative has been fantastic and it would be a real positive if this could continue. The Chair commented that health and well-being is important and will continue to be a priority. Avinash Hiremath praised the team and commented that it is not just the service users who get the benefits but also trainees who are developing their careers – the service is a national exemplar and LPT has developed the Frith prescribing guidelines that is currently in its 3rd Edition and is the only prescribing

	guideline for adults with learning disabilities in the world. Kevin Harris asked if they worked effectively with other agencies to enable the services users to stay out of acute settings and the team confirmed that they do – they have good links with social services and primary and secondary organisations to ensure care continuity. The team is multi-disciplinary – psychologists, speech and language therapists and occupational therapists and they have excellent working relationships with the primary care liaison nurse and the hospital liaison nurses too. They use a proactive holistic approach to identify physical as well as mental health needs. Angela Hillery and the Chair thanked the team, commenting that their passion and dedication is evident.
TB/21/062	Patient Voice – People's Council and Healthwatch Report –Paper B Mark Farmer presented the report confirming that Healthwatch received good feedback around LPT's speciality LD services. The highlights from this report were detailed as follows. Healthwatch have produced a report on the urgent access to mental health services and this will be discussed at a future board meeting. Healthwatch are holding two events in July in relation to the Step Up To Great Mental Health public consultation – dates will be circulated shortly. The People's Council remain focused on delivering against their priorities and their engagement is increasing online with consideration being made to future face to face engagement. The report asks the Trust Board to sign up to the protocol detailed in appendix 1. **Resolved: The Trust Board received the report and agreed to the protocol.**
TB/21/063	Declarations of interest in respect of items on the agenda No declarations were received.
TB/21/064	Minutes of the previous public meeting: 27th April 2021 – Paper C **Resolved: The minutes were agreed as an accurate record of the meeting and approved.**
TB/21/065	Public Trust Board Action Log & Matters Arising – Paper D **Resolved: The action log was agreed as all items listed complete.**
TB/21/066	Chair's Report – Paper E The Chair presented paper E commenting on the excellent Step Up To Great Mental Health (SUTG MH) consultation events so far and the successful launch of the Buddy to Buddy Veteran's Café. The Leicester City Homeless Charter Impact Report has been recently published and is a great example of multi-agency work. The Quality Improvement (QI) work continues, with joint work with NHFT on 8 strategic projects. The Chair attended the Learning Lessons Exchange Group and saw positive QI work ongoing. Our patients and staff have been busy transforming the gardens at the Bradgate Unit, the results of our annual "Let's Get Gardening competition will be announced on 14th July. The staff networks are a great showcase for our equalities work. There is a Health and Well-Being Festival planned for October following on from the success of the Spring festival in April where 400 people connected with the sessions. We are working to improve access so that more staff can join us as part of their working day. The Chair highlighted the #Red4Research day and congratulated UHL and LPT on achieving the highest recruitment of patients to covid studies in the country. The Chair congratulated Faisal Hussain on the successful appointment to the role of Deputy Chair to the Trust and he will be shadowing her at events as part of his development in this role. **Resolved: The Trust Board received the report for information.**

TB/21/067	Chief Executive's Report - Paper F Angela Hillery presented the report and thanked all staff who are still managing a significant challenge with covid which is still having a massive impact on services. We are operating on a safety first basis. Henrietta Hughes has stepped down from the National Guardian's Office. The Freedom To Speak Up (FTSU) index position for LPT remains above the national average, the cultural work undertaken is making a difference and this position demonstrates the Trust's openness. The SUTG mental health consultation is going well. The NHSI System Oversight Framework is now published and we will be progressing this with our partners. The document scanning team have achieved an accreditation which is fabulous news, well done team. Ruth Marching ton commented that she attended the SUTG mental health consultation event last week and was so impressed; it was very well led and facilitated. There was such quality of contribution from the voluntary sector and lived experienced participants. Will there be space in the programme to take into account their feedback and contributions? Angela Hillery confirmed that the CCGs are leading the public consultation, but the system is a team and all feedback is being gathered and we are confident that this will shape the plans going forward. Gordon King added that this opportunity has been built in from the outset and gave assurance that there is space and resource around collecting this insight. Darren Hickman asked if any of the additional £500m funding is coming into LLR/LPT and Angela Hillery confirmed that it was great to see money for mental health coming through the Mental Health Investment Standard (MHIS), there should be some coming into LLR and there are clear tools developed by finance colleagues to track the money so we will be able to see the impact that this is making and have a transparency around system monies. Mark Farmer asked how the patient & carer voice can be at the heart of the ICS and Angela Hillery confirmed that co-production is key and we will work to get system partners to understand this by sharing our learning and all learning behind co-production with challenge and support. The Chair added that each of the design groups have members with lived experience participating.. Angela Hillery confirmed that there is an important correlation between the Trust board, the Committees and the ICS. Anne Scott and Avinash Hiremath also support the Clinical Leaders Group offering triangulation in this regard. Moira Ingham added that the system quality group would be in line with National Quality Board standards. **Resolved: The Trust Board received the report and noted its contents.**
TB/21/068	Organisational Risk Register (ORR) – Paper G Chris Oakes presented the paper confirming that there are now 23 risks on the ORR demonstrating the dynamic nature of the register. The ORR undergoes monthly reviews supported by the Deputy Director of Governance and Risk. There is an emergent risk around water supply this currently remains with appropriate oversight and management at directorate level. Liz Rowbotham commented that the Quality Assurance Committee (QAC) and the Finance and Performance Committee (FPC) requested additional information at their last meetings regarding the assurance ratings on evidence and this has been reflected in the paper.. Ruth Marchington asked in relation to risk 1 – is there a plan to re-start the ward accreditation work? Anne Scott confirmed that this is currently being planned and will be brought to QAC once ready.

	Ruth Marchington asked with regards to risk 33 – is there an update on SystmOne training and David Williams confirmed that the training and support offer continues throughout the 12 months post roll out. Additional sessions are available for staff and super users are embedded in services. Darren Hickman commented that there are 2 risks above our risk appetite (4 – safe staffing & 54 – delivery of the 21/22 financial and operational plan). When do we anticipate that these will be back within our appetite range? Anne Scott confirmed that risk 4 is updated regularly and the papers presented to the Board today demonstrate mitigation of this risk. Chris Oakes confirmed that all risks have actions and it is not just these actions that change but the environment of the risks moves and changes so it is not always within our control. Sharon Murphy added that risk 54 reflects the higher level of uncertainty that we have around this year's financial landscape – we still await national guidance for the second half year (H2) planning. Angela Hillery added that this is common across the whole of the NHS and is not particular to LPT – it is a continual high risk area – workforce is a challenge due to increasing needs and specialist skills required of staff – we remain focused on this and the scrutiny of this continues at executive team meetings and level one committee meetings. **Resolved: The Trust Board received the report for assurance.**
TB/21/069	Documents Signed under Seal – Q1 – Paper H Chris Oakes presented the report for information. **Resolved: The Trust Board received the report for assurance and noted the contents.**
TB/21/070	NHS Provider Licence Self Certification – Paper I Chris Oakes presented the report for information confirming that the report details a non-compliance with G6 and FT4. This report does not reflect exactly where we are now due to the improvements that have been taken place since the last CQC inspection in 2018, but we hope that it will in the future if the Single Oversight Framework (SOF) rating improves. **Resolved: The Trust Board received the report for assurance and noted the non-compliance with G6 and FT4.**
TB/21/071	Standing Orders and Standing Financial Instructions and Scheme of Reservation and Delegation – Paper J Sharon Murphy presented paper J confirming the amendments as part of the annual up date to be due to both audit recommendations and the work from home changes that have been necessary during the pandemic period. This has been presented and approved by the executive team and the Audit and Assurance Committee (AAC). Sarah Willis suggested that a session is delivered at the senior leadership forum on the key highlights and changes and this was agreed as an action. **Action: Sarah Willis to ensure that a senior leadership forum session on the key highlights and changes in the SO & SFIs is delivered.** **Resolved: The Trust Board received the report and approved the amendments contained within.**
TB/21/072	Care Quality Commission Update – Paper K Anne Scott presented the paper confirming that the core services inspection has recently taken place, initial feedback received and actions plans drawn up with actions taken in line with our three phase QI methodology. **Resolved: The Trust Board received the paper and noted its content.**
TB/21/073	Service Presentation – Learning Disabilities

	Mark Roberts and Sophie Pratt presented the PowerPoint presentation which was circulated to all attendees prior to the meeting for information. Faisal Hussain commented that these are really encouraging steps forward in the work of LD and autism and asked how confident the team are that this work will improve the poorer health outcomes of this particular cohort considering the additional impact of covid. Mark Roberts confirmed that an LD Covid Sub cell, which is a multi-agency group, has run from the start of the pandemic focussing on early identification and rapid response to the needs of the LD community. There is a 3 year plan in place to support the health inequalities challenge. Trusts across the country are prioritising LD in the acute environments and LPT are prioritising services users on their caseload, but there are still more not on the caseload who are vulnerable. Annual physical health checks remain an LD team focus and there has been an increase in take up this year. Ruth Marchington commented that there has been regular reports to QAC on QI work in the Agnes Unit and it is great to see the outcomes and hear from the staff on the unit today. How is the work around violence and aggression moving forward? Sophie Pratt confirmed that there has been a huge improvement evidenced supported by regular debriefs; CCTV; strong team ethic; learning lessons forum and health and well-being support for staff. Avinash Hiremath commented that the LPT LD inpatient services are one of the first to be developed with quality accreditation infrastructures which is now being piloted across the country. Mark Farmer added that the work LD services is a great example of the LLR Integrated Care System working together. The Chair thanked the team for their presentation and commented that she was pleased to hear that service users, including the LD Talk and Listen Group had been actively involved in shaping services.
TB/21/074	Leicester, Leicestershire and Rutland Annual Reports for Learning Disabilities: Transforming Care Partnership - Paper Li Mortality review (LeDeR) - Paper Lii Mortality review easy read version (LeDeR) - Paper Liii David Williams and Avinash Hiremath presented the papers. David Williams commented that this group of papers demonstrated the work around tackling inequalities for people with learning disabilities. LPT have been leading in the development of the LLR system wide shared care record. We now have less LD and autism services users in hospital; the annual health check target of 70% has been achieved; there has been a change in culture and more support in connecting the LD community with mainstream services – helping to tackle the inequalities. The easy read version of the report reflects LPT's commitment to co-production. Avinash Hiremath commented that the data speaks for itself demonstrating a significant improvement in performance. There has been increased co-production and meaningful engagement with service users and their families. We are the only system to have produced an easy read version of the LeDer report. Darren Hickman asked if there was any benchmarking to national data available for the 70% target and David Williams confirmed that 15 months ago LPT were 44th of the 48 STPs – we are now 27th of 48 – this demonstrates a massive improvement over the year. Helen Thompson commented that the easy read version of the Mortality Review contains 11 recommendations around GPs – how confident are we around the embedding of this learning? Avinash Hiremath confirmed that there is a working

	group set up and they are working together across the system. In addition to this GPs are members of the design group and we are working closely with primary care. The STOMP medication guidelines are co-owned. Faisal Hussain commented that we are still aware that there are some diverse communities still not accessing LD services – what are we doing to close this gap? David Williams confirmed that there is a need to tackle the differences in outcomes across the system and data analysis has begun and conversations with voluntary groups in the city are taking place. Accuracy of data and reporting is also key and this will be a focus across the system over the coming months, particularly the Somali population. Avinash Hiremath commented that there is a positon paper for the Royal College of Psychiatrists referencing minority groups in LD communities asking if we are culturally intelligent enough and if we have a good connection with the third sector and the findings were positive. Angela Hillery thanked the team on behalf of the system – this is a great positon of LLR and a blue print for the system work. **Resolved: The Trust Board received the reports for information and assurance.**
TB/21/075	Step Up To Great Refresh informed by Reflect, Reset and Rebuild and Staff Survey Presentation – Paper M - Presentation Mark Powell, Sarah Willis and David Williams presented paper M talking through the slides. Work on recovery continues with a clear safety 1st approach. Engagement is key and over 800 colleagues have taken part in the Big Conversations. The recovery programme is simple, clear and time limited and will connect with our Step Up To Great strategy. Sarah Willis added that the TripleR and Staff Survey complement each other and this staff engagement approach is holistic and feeds in to and supports other programmes. David Williams confirmed that the SUTG strategy will be re-launched in the summer as part of the continuation of LPT's improvement journey. Darren Hickman commented on the quality of the Big Conversation event he attended. Mark Farmer asked how the People's Council's feedback can be fed in to this process and David Williams confirmed that there are plans to speak to the group and this information will then inform what is taken forward and what the recovery of services will look like. Faisal Hussain commented that staff will need to be supported during the return to business as usual whilst tackling waiting lists. Mark Powell confirmed that supporting staff to decompress is a large part of the programme – the process will need to be individualised for all. Waiting lists are part of the conversations to ensure we understand the scale of the challenge. There will be the opportunity with the new investment to develop and enhance the workforce. Managing expectations and looking after staff will be key. Angela Hillery thanked the communications team who supported the Big Conversation work and confirmed that system partners are considering using this methodology in LLR. In the staff survey 96.7% of staff said that they know how to speak up and raise issues of unsafe practice if they needed to – giving assurance to the Trust Board moving into the recovery period. Kevin Harris commented that there is a great focus of staff well-being – it's also to retain the beneficial changes too. Have we learnt about how it was possible to do what we did during the pandemic – some changes we made we have wanted to make for a long time. Also a commitment to evaluating what has been changed

	would be useful. Mark Powell confirmed that there is an ambition to evaluate and understand the impact for both staff and patients – there is part of the programme that will look at this. We will need to take learning from this and be confident in knowing that we can make safe decisions quickly. The Chair confirmed that a covid lessons learned exercise had been completed done as a system and at regional level . There is a session planned for the 20th July Trust Board development meeting and then this will feed in to the next Public Trust Board In August
TB/21/076	Group Model – Verbal David Williams stated that joint working with Northamptonshire Healthcare Foundation Trust (NHFT) and LPT offers greater benefits over and above what we can achieve as individual organisations. We can work together to challenge ourselves to be socially responsible and be the best in the country. We now have a committee in common; a formal governance programme and monthly meetings. Outcomes will be shared moving forward. Initial focuses are around 8 strategic areas : talent management, leadership and OD; joint governance, QI, Together Against Racism, strategic financial leadership and strategic estate leadership, innovation and research. The Chair added that these themes had been generated from the joint Board to Board meeting with NHFT. **Resolved: The Trust Board noted the progress and priorities of the LPT/NHFT Group**
TB/21/077	East Midlands Alliance Provider Collaborative – Paper N The collaborative includes NHS mental health providers across the East Midlands and St Andrew's from the independent sector. As previously detailed this is a joint programme, working together looking at all opportunities to develop together. This adds value to LPT. Whilst the Alliance is not a formal structure, it will be beneficial to have robust governance and the recruitment of an independent chair . Angela Hillery added that LPT are being recognised as leaders of the mental health community and this work can be used as a stronger voice for mental health both regionally and nationally. **Resolved: The Trust Board received the paper, supported the paper and approved the recommendations to implement a formal governance structure, recruit an Independent Chair and develop a partnership agreement.**
TB/21/078	Quality Assurance Committee Highlight Report – 25th May 2021 – Paper O Liz Rowbotham presented paper O confirming that QAC had received update papers on the Agnes Unit and Beacon Unit. QAC will be doing a deep dive on pressure ulcers at its next meeting following the increase in stage 2 pressure ulcers. Moira Ingham thanked Liz Rowbotham for the comprehensive handover of the role of chair of QAC and she was in a good position to take the work of QAC forward. **Resolved: The Trust Board received the report for information and assurance.**
TB/21/079	Patient and Carer Experience, Involvement and Complaints Quarter 4 Report – Paper P Anne Scott presented the paper highlighting that the report contains a balanced view of activity; noting the actions taken as detailed in the report and noting that the report contains a wide range of information around patient and carer experiences, involvement and complaints. Complaints were down on the previous quarter and it was noted that the complaint timescales had been temporarily revised due the covid second wave. The Friends and Family Test (FFT) feedback had seen a

	significant increase die to the implementation of the new texting method. Patients and carers were now engaged in over 30 live Quality Improvement projects across the trust. Faisal Hussain thanked the team for the grip and pace seen over the last 2 years and for their holistic and coordinated approach to the work especially in reflecting feedback into the design of the services. The Chair commented that she had recently presented at a patient involvement induction session and it is great to see the range of opportunities available for service users' involvement which is supported by appropriate training and induction. **Resolved: The Trust Board received the report for information and assurance.**
TB/21/080	Infection Prevention and Control (IPC) 6 Month Report – Paper Q (Embedded documents are available on request to show supporting evidence) Anne Scott resented the IPC Board Assurance Framework update which has 32 more key lines of enquiry (KLOEs) which have been shared with NHSEI and CQC colleagues. In January 2020 LPT were rated a strong amber following an IPC visit by NHSIE. The revisit was postponed and will now take place in August 2021. On 13 April LPT reported an outbreak of Carbapenemase Resistant Organism at the Evington Centre, a multi-agency Outbreak Committee was immediately formed and al patients were managed within national guidance. The outbreak was contained and closed by 12 May. There has been a system wide review of covid nosocomial infections with UHL and high level learnings are given in appendix 2 of the report. Clinical visits and audits continue within LPT and national guidance continues to be adhered to. There has been some precautionary water treatment following routine testing on the closed Bosworth Ward where legionella was discovered and immediate action taken. Hand hygiene audits are up and our deep cleaning rolling programme has recommenced. Ruth Marchington thanked the team for the report and asked if the learning from the covid vaccination success will be applied to the flu vaccination programme this year. Anne Scott confirmed that the approach will be co-delivery and learning is being used from covid and from outstanding Trusts and papers in relation to this will come through the quality governance routes. Richard Wheeler added that the water safety programme is running as part of the dormitory programme and the UHL facilities management team are being very responsive in this matter. Initial samples show no systemic contamination evident. **Resolved: The Trust Board received the report for information and assurance.**
TB/21/081	Patient Safety Incident and Serious Incident Learning Assurance Report – Paper R Anne Scott presented the bi-monthly report covering April and May 2021. Statutory Process Control (SPC) charts are detailed in appendix 1. There was increased reporting of pressure ulcers in February and March related to the increase in covid – this has now levelled off. Grade 4 pressure ulcers have reduced and the detail around grade 3 pressure ulcers has been included in the report. The learning lessons exchange forum and Foundations for Great Patient Care meetings with a continued focus on high standards and quality improvement. The Duty of Candour improvement work is noted and there has been steady progress on SI investigation reports. The Chair noted in the SPC charts that violence and aggression assaults are showing as an upward trend and asked that this theme is discussed further at at

	QAC. Ruth Marchington noted that the SI completion rate remains low and asked for a trajectory for improvement. Anne confirmed that this is currently being completed and will come up through the quality governance route shortly. **Action: Anne Scott to ensure that themes from a Violence and Aggression deep dive are discussed at the Quality Assurance Committee.** **Resolved: The Trust Board received the report for information and assurance.**
TB/21/082	Safe and Effective Staffing Monthly Reports April 2021 - Paper Si & May 2021 – Paper Sii Anne Scott presented the papers giving a summary of the information contained within each report. Weekly meetings continue to be held to look at risks and plan actions. Confirmation was given of assurance that LPT is sufficiently resilient and safely staffed across the Trust. The Chair noted that within the mental health services for older people wards there were more red areas for nursing in both months and asked if this is likely to be a trend moving forward. Anne Scott confirmed that acuity across these wards is significant and that they are currently looking at the skills mix. A recent visit to the wards confirmed the acuity and June's data will be considered. The Chair raised the issue of an increase in falls at Mill Lodge, our Huntingdon's Disease Unit, and Anne Scott confirmed that this will be monitored and if there is a theme a deep dive will be conducted. **Resolved: The Trust Board received the report for information and assurance.**
TB/21/083	Privacy and Dignity Annual Declaration & Single Sex Accommodation Annual declaration – Paper T Anne Scott presented paper T confirming that between April 2020 and March 2021 there were no reported breaches in line with national guidance. The Trust policy on Transgender service users is currently being updated. The Chair highlighted that she had attended the Spectrum staff network meeting last week which focused on transgender issues with Katie Neeve who described her "long walk to womanhood". It was agreed that transgender service users would be involved in creating the policy. **Resolved: The Trust Board receive the report and assured whilst noting the further work on the policy around transgender. The annual declaration was approved.**
TB/21/084	Ligature Risks Annual Report – Paper U Anne Scott presented the paper confirming benchmarking and gap analysis was conducted last year and the findings were reported through the quality governance route. There are 6 improvement plans in place. Between January 2019 and March 2021 of the 2,286 reported incidents 2,209 were non-fixed ligatures – these are priority for our Trust. There were 33 fixed point ligature incidents and themes have been taken from these to establish priority actions in the capital estates programme. **Resolved: The Trust Board received the report for information and assurance.**
TB/21/085	Guardian of Safe Working Hours Annual Report – Paper V Avinash Hiremath presented paper V the 2020-21 annual report confirming that there had been 24 exceptions raised as a result of breaches in rest provisions (8 hours in 24 hours with 5 between 12am and 7am) 4 of these were linked to the higher trainee scheme and 6 to core trainees on the Evington Centre due to the

	increase in volume of work when it became a covid red ward. Interventions to mitigate were quick and no further breaches were reported. Mitigations are in place for these e.g. hotel accommodation and time off in the next day. There is no evidence that the breaches affect next day productivity. **Resolved: The Trust Board received the report for information and assurance.**
TB/21/086	Learning From Deaths Quarter 4 Report – Paper W Avinash Hiremath presented the report thanking colleagues for their work on it. There is a well-established system in place to identify deaths in scope and extract learning. Demographic data and key learning is now included in this report. Collaboration with both UHL and the coroner's office is ongoing. Mark Farmer asked in light of the lessons learned are there any demographic themes, what will be done differently in the future and Avinash Hiremath confirmed that there were no demographic themes identified in this report and it is key to have sight of the data to be mindful of health inequalities. The chair asked how we were working to improve the quality and robustness of our process and Avinash Hiremath confirmed that directorates have established processes led by clinicians using structured judgement and a review tool to ensure that learning is harvested and shared immediately. **Resolved: The Trust Board received the report for information and assurance.**
TB/21/087	Freedom To Speak Up (FTSU) Guardian Annual Report – Paper X The half yearly report was presented by Sarah Willis on behalf of Pauline Lewitt the FTSU Guardian who was on annual leave. The report details an increase in cases which demonstrates LPT's positive culture of speaking up. LPT are above average in the FTSU index score. The Chair, CEO and NED champion meet regularly with the FTSU Guardian. Ruth Marchington asked if there was a good representation of clinical staff as FTSU champions and Sarah Willis confirmed that there were no identified gaps across professional groups. Avinash Hiremath hosts a regular forum for consultants. Angela Hillery added that the FTSU champions represented the diverse profile of our staff and work is ongoing between LPT and NHFT on this agenda. **Resolved: The Trust Board received the report for information and assurance.**
TB/21/088	Finance and Performance Committee Highlight Report – 25th May 2021 – Paper Y Faisal Hussain presented the report confirming that with regards to the performance report there was high assurance around the performance management framework and medium assurance around the data quality. The was medium assurance given to waiting times due to the extensive work services are carrying out to manage the waiting lists and conduct harm reviews. The impact of the Health Informatics Service (HIS) budget would be reported at a subsequent FPC meeting. **Resolved: The Trust Board received the report for information and assurance.**
TB/21/089	Finance Monthly Report – Month 2 – Paper Z Sharon Murphy presented the month 2 position which was positive with the summary target table showing all indicators as green. Income and expenditure broke even in month 2 with most services having a small underspend apart from LD which has a small overspend. For the second half year work continues on efficiency plans and a task and finish group has been set up. The cash, Better

	Payments Practice Code and capital positions currently look positive. The agency ceiling will be managed as a system this year. The mental health investment standard was resubmitted to respond to additional queries which were mainly around the category of the CCG spend. The Chair added that the LLR system finance is on track in month 2 and there is an LLR ICS system finance meeting taking place on 30th June. Ruth Marchington asked if the underspend in services was linked with recruitment (12.4% vacancy rate) and Sarah Willis conformed that recruitment is a big challenge and this is a key focus of the Strategic Workforce Committee with a deep dive on this planned for July looking at vacancies, hotspots and turnover. This is a constant focus at executive team meetings too. Mark Farmer asked if plans were in place to deal with any slippage around the mental health investment standard monies and Sharon Murphy confirmed that all directors have been asked for a plan B in case of slippage and work is ongoing with other partners to deliver in different ways rather than purely recruiting staff ourselves. **Resolved: The Trust Board received the report for information and assurance.**
TB/21/090	Performance Report – Month 2 – Paper AAA Sharon Murphy presented paper AAA confirming that the new metrics for 2021/22 have been agreed and will be added to the report as and when they are ready. There is a small trend towards improvement across services in line with trajectories but we are starting from a low base following the pandemic impact. This will continue to be monitored. Funding is available to support additional investment into some areas including CAMHS and Mental Health. The Statistical Process Control (SPC) methodology is being reviewed and will be clearer in future reports. The Qlik Sense automated reporting work is ongoing. The Chair commented that FPC has had high levels of scrutiny on waiting times and operational directors have a clear focus on this. She invited them to comment. Avinash Hiremath commented that each directorate has prioritised service lines with measures in place including demand capacity analysis and patient tracking lists. Monitoring and reducing the risk of harm is ongoing using methods such as correspondence, self-help information and sharing of urgent contact information. The next steps are audits of waiting lists to ensure that standard operating procedures (SOPs) are being adhered to. Fiona Myers confirmed that the continence service staff were moved back in April 2021 following their redeployment during covid and have a clear plan to work through the backlog including additional administration support and different methods of triage. Gordon King added that he too felt confident and that detailed action plans and trajectories were in place in the mental health directorate. They were working with the East Midlands Alliance demand and capacity tool. This was also supported by the SUTG Mental Health public consultation proposals to redesign services. Helen Thompson confirmed that services had access to their own dashboards and this was driving up data quality in FYPC. There had been an increased demand for the CAMHS Eating Disorders (ED) service and a plan was in place to strengthen this service and they were optimistic about recruitment moving forward – work is ongoing with the system and NHFT. Angela Hillery added that the CAMHS ED was a significant area of demand nationally and young people continue to be affected through covid. **Resolved: The Trust Board received the report for information and**

	assurance.
TB/21/091	Audit and Assurance Committee (AAC) Highlight Report – 4th June 2021 – Paper BBB Darren Hickman presented paper BBB confirming that AAC were fully assured on all reports submitted to the Trust Board EGM on 9th June 2021. The Cyber Security Report was comprehensive but AAC commented that it would have been enhanced by the inclusion of metrics as evidence so this report was returned for this to be included. The Chair added that at the EGM on 9th June 2021 LPT received a clean external audit report with no adjustments and the Internal Audit report gave significant assurance. Angela Hillery added that this was an important foundation block for the continuing great work in LPT's governance and thanked the teams involved. **Resolved: The Trust Board received the report for information and assurance.**
TB/21/092	Review of risk – any further risks identified as a result of Board discussion? The Chair identified the staffing risk which had been raised during the meeting and Sarah Willis confirmed that this was raised at the last Strategic Workforce Committee and that Risk 26 requires an update. The CAMHS Eating Disorder service risk will need monitoring and it was agreed that this will be considered in the next ORR review **Action: Sarah Willis & Anne Scott to update risk 26 to reflect more clearly the current staffing risk as the issue is recruitment rather than safe staffing.** **Action: Chris Oakes to consider the CAMHS ED risk in the next ORR review.**
TB/21/093	Any other urgent business The Chair confirmed that NHS Charities Together have awarded £492,000 to the LLR system for community partnership grants. A media release has been issued this week. On 23rd March 2021 the Board in its confidential session approved a bid to NHS Charities Together for £492,000 for community partnership grants. This grant will be shared amongst 7 local community/voluntary organisations of just over £70k each to reduce health inequalities impacted by Covid. • Disabilities – Enrych • Older vulnerable people – Reaching People • Younger Peoples mental health – Centre for Fun & Families • BAME families – Home start horizons • Adult mental health – Leicester City FC in the community • Adult mental health – Rural Community Council • Health Inequalities Research to Leicestershire Academic Health Partners (LPT,UHL and UOL)
TB/21/094	Papers/updates not received in line with the Board Architecture work plan: None – all papers received.
TB/21/095	Public questions on agenda items: **1 - Question received from Andy Dalton:** A recently published survey's findings shone a light on some shocking statistics surrounding NHS staff retention, including: 45% of staff are considering leaving the NHS and 52% have experienced anxiety and worry about the future, Top reasons for employees considering leaving are work/life balance, high workloads, and their own mental wellbeing,

	Yet 77% claimed more options for remote working would change their mind. The survey results found that this NHS-exodus could be stimmed by more remote working options with over 75% of those thinking about leaving their NHS organisation stated a robust digital system, allowing more flexibility, would change their minds. With this in mind what are the Trust's long term plans for addressing these issues. **Sarah Willis responded:** The move to a model of blended working is very much at the forefront of the Trust's work as we move to recovery of our services. We recently undertook a series of listening events with our staff and triangulated the outputs of these with annual staff survey feedback. Our staff have told us – very much in line with what you have stated – that, for many, there have been benefits to being able to work remotely in terms of improved balance between work and life outside of work. Staff have told us that they want to keep some of the technological and digital solutions we've introduced during the pandemic. Balanced with this is an identified need to have some physical and face to face contact with colleagues. We have a TripleR programme looking at reflect-reset-rebuild for our staff and services. Sitting across the 3 projects within this programme is an objective to maximise the use of technological and digital solutions in order to enable different ways of working. The Trust is committed to taking forward a strategic approach to support blended working – keeping and building on the best of what we have learned during Covid. It's probably worth noting that we have, for many years, had a policy that allows for flexible working requests to be considered, and feedback through the national staff survey is generally positive about the Trust's approach to flexible working, so we are building on this sound footing. In addition to this, the Trust has a comprehensive programme to support staff's mental and physical health and wellbeing. Continuing to develop this programme and ensure accessibility for all is another key objective in our recovery programme. **2 - Question received from Khzayad:** What is the strategic plan for infection control in medical laboratory? **Avinash Hiremath responded:** We access laboratory facilities from UHL. From LPT perspective, all samples collected are done with aseptic techniques under infection control guidance as per policy. The samples are usually blood tests and these are then sent to UHL labs in appropriate packaging.
	Date of next public meeting: **31st August 2021 - Microsoft Teams**

D

Leicestershire Partnership NHS Trust

TRUST BOARD 31st August 2021

MATTERS ARISING FROM THE PUBLICTRUST BOARD MEETINGS

All actions raised at the Trust Board will be included on this Matters Arising action log. This will be kept and updated 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 date and minute ref	Action/issue	Lead	Due date	Outcome/evidence actions are not considered complete without evidence)
936	29th June 2021 TB/21/060	Share the LD covid vaccination take up data with the Board members.	Helen Thompson	23.8.21	Complete – shared via email 18.8.21
937	29th June 2021 TB/21/071	Ensure that a senior leadership forum session on the key highlights and changes in the SO & SFIs is delivered.	Sarah Willis	23.8.21	Complete - on the SLF August Agenda
938	29th June 2021 TB/21/081	Themes from a Violence and Aggression deep dive to be discussed at QAC.	Anne Scott	27.7.21	Complete – On QAC agenda 27.7.21
939	29th June 2021 TB/21/092	Update risk 26 to reflect more clearly the current staffing risk as the issue is	Sarah Willis & Anne Scott	23.8.21	Complete - risk updated following SWC on the 27th July 2021

Action No	Meeting date and minute ref	Action/issue	Lead	Due date	Outcome/evidence actions are not considered complete without evidence)
		recruitment rather than safe staffing.			
940	29th June 2021 TB/21/092	Consider the CAMHS ED risk in the next ORR review.	Chris Oakes	23.8.21	Complete – as per the ORR Report
941					

E

Leicestershire Partnership NHS Trust

Public Trust Board – 31st August 2021

Chair's Report

Purpose of the report

Chairs report for information and accountability, summarising activities and key events From 29th June 2021 to 31st August 2021

Raising Health
LeicesterShire and Rutland's Community and Mental Health Charity

Thank you to all LPT staff who continue to step up to great in 2021

Hearing the patient and staff voice	To comply with Covid-19 guidelines and visitor restrictions, Chair and Non-Execs Boardwalks were postponed from mid-March 2020. We are connecting with staff and patients through virtual events until we are able to resume frontline visits safely. • Presented at Patient Involvement induction session to service users who are working with us to improve LPT services • Meeting with Peoples Council Chair • Quarterly meeting with our Freedom to Speak Up Guardian
Connecting for Quality improvement	• Chaired the Joint Working Group of LPT/NHFT committee in common, focusing on joint strategic projects in 2021/22 • CQC engagement meeting • Connected with the Infant Feeding Team and reviewed LPT & UHL's Joint Infant Feeding policy as part of my role as the UNICEF Baby Friendly Guardian
Promoting Equality Leadership & Culture	• Contributed to the shortlisting of LPT staff for the LPT Covid Heroes awards – celebration ceremony is on 1st October 2021 • Joined the two LPT staff sessions to celebrate South Asian Heritage Month • Attended the MAPLE (Mental and Physical Life Experience) staff network to hear the staff feedback on the Triple R (Reflect, Reset, Rebuild) • LLR Reverse Mentoring scheme – 2 meetings with my mentor to discuss living and working with a disability. We have reviewed the LPT Workforce Disability Equality Standard (WDES) action plan together.

	• I continue to promote Wellbeing Wednesdays with my weekly Health & Wellbeing Guardian blog and Wednesday lunchtime activities for staff: yoga, pilates, tai chi, zumba. We have launched the programme for the Autumn staff Health & Wellbeing Festival
Building strong Stakeholder relationships	• Focus on Covid19, vaccination delivery and waiting times recovery through NHSEI Regional Director calls with Midlands Chairs • Attended LLR ICS Partnership Board and LLR ICS NHS meetings to focus on development of the ICS and priorities for operational and strategic transformation • Chaired 3 meetings of the LLR ICS Finance Committee focusing on future trajectories and key risks. • Attended the Leicester City Health & Wellbeing Board which highlighted good practice and innovation in the LLR system, discussed the purpose principles and priorities of the ICS and outlined an approach to the City as a "Place" • 1:1 stakeholder meetings with John MacDonald Chair of UHL, David Sissling Chair of LLR ICS, Mark Farmer Healthwatch, Councillor Vi Dempster Chair of the City Health & Wellbeing Board
Good Governance	• Board development session held in July which focused on: the CQC core and well-led inspections, Step Up To Great strategy refresh, financial planning for the second half of 2021/22 and Together Against Racism. • Attended the joint board development session of the East Midlands Alliance organisations which highlighted the achievements to date of the mental health provider collaborative. • Recruited Vipal Karavadra as Non-Executive Director (NED) who joined LPT on 30th August and is supported by a full development plan. • Participated in the stakeholder panel to recruit the NED Audit Chair for NHFT. • Mentoring sessions with my mentee for the NHSEI Aspirant Chair programme • Observed the LPT Finance & Performance Committee with verbal feedback given to the Chair
Raising Health (LPT charity)	• Chaired the Charitable Funds committee – please refer to the highlight report in the Board papers. We continue to support patient experience and staff wellbeing initiatives that provide "extras" above the core NHS offer.

Abbreviations used:

LLR = Leicester, Leicestershire & Rutland; **NHSEI** = NHS England & Improvement **CQC** = Care Quality Commission **UHL** = University Hospitals of Leicester **CCGs** = Clinical Commissioning Groups **NHFT** = Northamptonshire Healthcare Foundation Trust **ICS =** Integrated Care System

Governance table

For Board and Board Committees:	Public Trust Board 31st August 2021	
Paper sponsored by:	Cathy Ellis	
Paper authored by:	Cathy Ellis	
Date submitted:	24 August 2021	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	N/A	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	N/A	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Reported every public board meeting	
STEP up to GREAT strategic alignment*:	High **S**tandards	X
	Transformation	X
	Environments	
	Patient Involvement	X
	Well **G**overned	X
	Single Patient **R**ecord	
	Equality, Leadership, Culture	X
	Access to Services	
	Trust Wide Quality Improvement	X
Organisational Risk Register considerations:	List risk number and title of risk	N/A
Is the decision required consistent with LPT's risk appetite:	N/A	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:	Yes reflects the role of our staff networks and personal commitment to inclusion	

F

Leicestershire Partnership NHS Trust

Trust Board of Directors – 31 August 2021
Chief Executive's Report

Purpose of the Report

This report provides an update on current local issues and national policy developments since the last meeting. The details below are drawn from a variety of sources, including local meetings and information published by NHS England/Improvement, Health Education England, NHS Providers, and the Care Quality Commission (CQC).

Analysis of the Issue

National Developments

Coronavirus COVID-19

We have reached another key milestone with the Government introducing 'step four' on its roadmap. In taking this step, the Government has ended the majority of COVID-19 restrictions, replacing them with guidance emphasising personal judgement and responsibility. Acknowledging that the number of people that become infected with COVID-19 in our communities will continue to rise, the Government noted that the vaccination programme has substantially weakened the link between infection and hospitalisation or death.

Despite these changes in wider society, NHS England/Improvement (NHSE/I) has confirmed that everyone accessing or visiting healthcare settings must continue to wear a face covering and follow social distancing rules. Public Health England's (PHE's) infection prevention control guidelines and hospital visiting guidance are set to remain in place for all staff and visitors to NHS services (including hospitals, GP practices, dental practices, optometrists and pharmacies) to ensure patients and staff are protected. Staff, patients and visitors will also be expected to continue to follow social distancing rules when visiting any care setting as well as using face coverings, masks and other personal protective equipment.

COVID-19 Vaccination Programme

Starting on 15 July, the NHS COVID-19 national vaccination programme team sent out text messages encouraging people to get their second dose of the COVID-19 vaccine eight weeks after their first. Messages were sent in line with updated guidance from the Joint Committee on Vaccination and Immunisation (JCVI), which aimed to ensure everyone has the strongest possible protection from the Delta variant of the virus ahead of the move to 'step 4' of the Government's COVID-19 roadmap as mentioned earlier.

The national team ran a 'grab a jab' campaign over the weekend on 17/18 July offering opportunities to adults to receive a COVID-19 vaccination in pop-up clinics running in various locations across the country, ranging from shops, to parks and at events. So far, the national NHS Vaccination Programme, has administered vaccinations to over 38 million people across the country – more than 85% of all adults.

Health and Care Bill

Last month the Health and Care Bill was introduced to Parliament. This is another significant step towards the Government's ambition to make it simpler for health and care organisations to work together to deliver more joined-up care. Building on the vision set out in the NHS Long Term Plan, the proposed reforms in the Bill are strongly supported by health and care stakeholders.

The Bill is a large document that covers a broad range of issues, so I have drawn out just a few points below to signal some of the changes we could expect to see in the future. A full copy of the Bill is available on the Parliament website: https://publications.parliament.uk/pa/bills/cbill/58-02/0140/210140.pdf

The Bill:

- Proposes to put Integrated Care Systems (ICS') and the Healthcare Safety Investigation Branch (HSIB) on a statutory footing and to formally merge NHS England and NHS Improvement.
- Contains new powers for the Secretary of State for Health and Social Care to intervene earlier in decisions about changes to local services and to direct NHS England outside the NHS Mandate.
- Establishes a two-part model for ICS':
    - The first part is an Integrated Care Board (ICB), which brings together local organisations responsible for planning and delivering NHS services. (Clinical Commissioning Groups will cease to exist.)
    - The second is an Integrated Care Partnership (ICP), which is the mechanism through which a broader group of organisations come together to improve health and care.
- Gives NHS England the power to set capital spending limits for NHS Foundation Trusts and proposes several changes to financial arrangements such as setting requirements to meet financial objectives and balance.
- Creates a new legal mechanism permitting ICBs and NHS providers to form joint committees, or two or more providers, to make joint arrangements and pool funds. Guidance will also be issued on joint appointments.

The integrated care systems have now been confirmed across the country, including one in Leicester, Leicestershire and Rutland (LLR). David Sissling will be the chair of our ICS. We shall continue to monitor the passage of the Bill through Parliament, building on our own local plans in developing the LLR ICS.

Data saves lives: reshaping health and social care with data

On 22 June 2021, the Department of Health and Social care published a draft strategy, which sets out ambitious plans to harness the potential of data in health and care, while maintaining the highest standards of privacy and ethics.

The strategy describes how data will be used to improve the health and care of the population in a safe, trusted and transparent way. It provides an overarching narrative and action plan to address the current cultural, behavioural and structural barriers in the system with the ultimate goal of having a health and care system that is underpinned by high quality, readily available data. It marks the next steps of the discussion about how we can best utilise data for the benefit of patients, service users, and the health and care system.

The strategy is being published in draft format to enable full and open engagement on the commitments made within it, before publishing a final version of the strategy later in 2021.

For more information, please visit the Government website: https://www.gov.uk/government/publications/data-saves-lives-reshaping-health-and-social-care-with-data-draft/data-saves-lives-reshaping-health-and-social-care-with-data-draft

Secretary of State for Health and Social Care

On 4 July 2021, the Government announced that the Rt Hon Sajid Javid MP had been appointed as Secretary of State for Health and Social Care, taking over from the Rt Hon Matt Hancock MP. On starting the role Mr Javid identified what he saw as two immediate challenges. "The first is how we restore our freedoms and learn to live with coronavirus (COVID-19). The second is to tackle the NHS backlog – something that we know is going to get far worse before it gets better."

National Inquiry into Government's handling of Covid19

LPT is making preparations following the Government announcement that a National Inquiry into the Government's handling of the Covid-19 pandemic will commence in the spring of 2022. It is anticipated that all organisations, including LPT, will be asked to identify all relevant information, perform retrospective analysis of the response to the pandemic, and ensure that evidence is disclosed and provided as required. Resources will be also made available for staff and patients to give feedback.

New Chief Executive for the NHS

The new Chief Executive of the NHS has thanks staff for their work in the pandemic and asked them to work with her to enable many more people to live longer and more fulfilling lives.

Amanda Pritchard took over the top job in NHS England from Simon Stevens in July 2021.

She said "I know the last 18 months have been hard on all of us. The pandemic has required many of you to make a considerable personal sacrifice – working beyond your normal hours for long stretches, taking on new and difficult roles at real speed and having to cope with deeply distressing circumstances, including losing valued colleagues. Supporting the health and wellbeing of all our NHS Staff, with compassionate and inclusive leadership will continue to be central to our future strategic and recovery".

She also said the pandemic had shown the potential digital measures such as virtual wards could make to improving healthcare.

To read her letter to NHS staff in full, follow this link; https://healthcareleadersupdate.cmail19.com/t/ViewEmail/d/8F78BA530C957F682540EF23F30FEDED/F8196213AF1F88C740EE66FE10287772

NHS Birthday

On 5 July 2021 events were held across the country to mark the 73rd birthday of the NHS and to remember NHS workers who have lost their lives to the virus. Dozens of sites across the country were lit up blue to mark the anniversary of the founding of the NHS and the huge contribution of health service staff during the pandemic.

Our Raising Health charity jointed the NHS Big Tea event organised by National Charities Together, enabling tea party celebration kits to be created for all our staff to enjoy as part of time out to reflect and celebrate. All of the 250 kits were ordered, enabling more than 6,500 staff and volunteers to hold local events to mark the birthday, as a thank you for all their hard work during the pandemic. Our IPC team provided guidelines to ensure these were held safely within Covid guidelines.

Her Majesty The Queen also awarded the George Cross to the National Health Services of the UK, recognising NHS staff in all four nations. In a personal, handwritten message, the Queen said NHS staff have carried out their work "with courage, compassion and dedication" for more than 70 years.

Chief Medical Officer's Report

On 21 July 2021, Professor Chris Witty published his annual report as Chief Medical Officer for the Department of Health and Social Care. This year's report concentrates on what Professor Witty sees as one of the most important challenges – health in coastal communities.

In his report, he describes the higher burden of physical and mental health conditions in coastal communities than in their inland counterparts. He also highlights that these areas experience difficulties in attracting health and social care staff. Professor Witty makes three key recommendations – to establish a cross-government strategy to improve the health and wellbeing of coastal communities; to address the mismatch between health and social care worker deployment and disease in coastal areas; and to deliver substantial improvement on the granularity of data and actionable research in coastal communities.

To access a copy of the report, please see the Government website: https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2021-health-in-coastal-communities

Fifth annual learning disability review and action report

Last month, the University of Bristol published the fifth annual report of the Learning Disabilities Mortality Review (LeDeR) Programme. The report focuses on findings from completed reviews of the deaths of people with learning disabilities that occurred in the calendar years 2018-20, identifying any trends that have occurred over time. (Report authors caution against year on year comparisons owing to the impact of the COVID-19 pandemic in 2020, which affected the lives and deaths of the entire population.)

In summary, the report confirms that 93% of the deaths notified to the LeDeR programme between January 2018 and June 2020 had been reviewed. The numbers of deaths fluctuated month on month with more deaths reported in winter (in common with the general population). There was a significant increase in the number of deaths at the peak of the COVID-19 pandemic (March to May 2020). The report provides a wealth of information and analysis on the findings of reviews undertaken, considering factors such as demography, long term conditions, place of residence and medication.

In parallel with the publication of the report, NHSE/I published figures indicating that three quarters of people with a learning disability aged 14 and over across the country have received an annual health check two years ahead of the target set in the NHS Long Term Plan. 97% of eligible reviews were completed within six months, a rise of a third compared to the previous year.

Please follow this link to access a copy of the report: https://www.england.nhs.uk/wp-content/uploads/2021/06/LeDeR-bristol-annual-report-2020.pdf

Recovery of planned care

Information released by NHSE/I in June demonstrates that the number of people waiting over 52 weeks to begin treatment dropped by more than 50k in April 2021. By the following month, operations and other planned NHS activity had already returned to 90% of pre-pandemic levels, ahead of the 75% threshold set out in official guidance.

Data on mental health services shows that Improving Access to Psychological Therapies (IAPT) referrals significantly increased to 159,140 in March 2021, an increase of 47% on the previous year. Waiting times standards have continued to exceed targets and recovery rates have achieved an annual high, remaining above the 50% standard.

New independent chair of the Learning Disability and Autism Children and Young People's Steering Group

Last month, NHSE/I confirmed the appointment of former Children's Commissioner Anne Longfield OBE to help transform the care of children and young people with a learning disability and autism. As the new independent chair of the Learning Disability and Autism Children and Young People's Steering Group, Anne will champion the rights of

children and young people to ensure they get the support they need at the right time and work closely with the Ministerial led 'Building the Right Support Board'.

Children and Young People's Mental Health

In May, a survey of NHS Mental Health Trust leaders undertaken by NHS Providers showed that services across the country are under growing pressure and are increasingly stretched. The COVID-19 pandemic was thought to be a significant contributory factor to the increase in pressure along with access to suitable social care provision.

In June, NHSE/I announced an extra £40m of funding to address the impact of COVID-19 on children and young people's mental health and to enhance services across the country. This funding will be used in a variety of ways, such as putting the right type of beds in the right places and ensuring alternatives to admission are available.

East Midlands Academic Health Science Network Impact Report 2020-21

The East Midlands Academic Health Science Network (EMAHSN) recently published its annual report for the 2020/21 financial year. EMAHSN is one of 15 networks across the country focussed on 'transforming lives through innovation'. It works to transform patient care, empower staff, strengthen the health and care system and stimulate economic growth.

The report describes how, over the last year, EMAHSN pivoted from its normal work to help local health systems respond to the COVID-19 pandemic. Opportunities for innovation emerged from this work, especially in digital technology and remote monitoring in hospitals, care homes and support for people in their own homes.

Please visit the EMAHSN website to access a copy of the report: https://emahsn.org.uk/impactreport2021/

Community Mental Health Framework

The Community Mental Health Framework has now replaced the Care Programme Approach (CPA). This represents a move towards a standard of high-quality care for everyone in need of community mental health services.

The CPA was originally introduced to provide greater shape and coherence to local services' approaches to supporting people with severe mental illnesses in the community, based on care coordination, care planning and case management. It has had central role in the planning and delivery of secondary care mental health services for almost 30 years. The move to replace it with the new framework comes as a result of evolutions in practice, new legislation and the more recent policy signals from the Government concerning statutory care planning.

One of its purposes of the new framework is to enable services to shift away from an inequitable, rigid and arbitrary CPA classification and bring up the standard of care towards a minimum universal standard of high-quality care for everyone in need of community mental healthcare. It is based on five broad principles:

1. A shift from generic care co-ordination to meaningful intervention-based care
2. A named key worker for all service users with a clearer multidisciplinary team (MDT)
3. High-quality co-produced, holistic, personalised care and support planning for people with severe mental health problems living in the community
4. Better support for and involvement of carers
5. A much more accessible, responsive and flexible system

2021/22 is a transitional year where providers like LPT will work closely with its peers and NHSE/I to adopt the new approach outlined in the framework. This is linked to our work on Step Up To Great Mental Health (see below).

NHSE/I will collaborate with the Department of Health and Social Care and other Arm's Length Bodies to produce further guidance and clarify metrics.

For more information on these changes please see the NHSE/I website: https://www.england.nhs.uk/wp-content/uploads/2021/07/Care-Programme-Approach-Position-Statement_FINAL_2021.pdf

Local Developments

Executive Team updates

Director of community health services: I am pleased to announce that after a rigorous external recruitment process, we have appointed Sam Leak to the role of Director of Community Health Services (CHS). Sam takes over from Fiona Myers, who is currently acting as interim director of CHS, from 2 August this year. We look forward to welcoming Sam to our LPT family, and I am sure she will be an excellent addition to our executive team.

Director of mental health directorate: Gordon King, director of mental health services, will be retiring at the end of September 2021. Gordon has made a huge impact on the delivery of our mental health services and led some outstanding achievements since joining the Trust in January 2019. He will be dearly missed, but I know he is keen to spend more time with his family and I would like to wish him a well-deserved retirement.

We will be going out to recruit to the post as soon as possible. In the meantime Fiona Myers, our current interim director of CHS, will re-join the Trust in September on an interim capacity as Director of Mental Health to ensure stability until the recruitment process is completed. Fiona has extensive experience as a former CEO of a mental health trust and also as a chief operating officer.

CQC core service and well led inspections

In my last report I referred to a CQC unannounced core service inspection which started in LPT on the 25 May 2021. The CQC visited a number of sites across our mental health services and undertook a Well Led inspection between the 29th June and the 5th and 6th July 2021. We are currently awaiting the formal draft report from the CQC.

It is great to see how teams have embraced this opportunity to shine about all their work to Step up to Great. We are responding to any issues identified from early feedback and findings. Thank you to all our staff for their hard work and commitment in supporting the inspection.

LPT and Northamptonshire Healthcare Foundation Trust Group Model

We have evolved our buddy partnership with NHFT to a more formal Group model arrangement. The changes do not mean that our trusts are merging, or that we will become one organisation. This evolution enables us to make the most of a unique and valuable opportunity, continue our strong relationship through an agreed formal way of working and focus upon quality improvements together.

The structure for the Group Model involves a Joint Working Group. This met in June to commit to eight joint strategic priorities and was attended by the Chairs from LPT and NHFT, the CEO, representative NEDs and the Deputy Chief Executives. Work has started to scope the workstreams for each of these joint priorities, and our communications teams and NHSE/I are working together to confirm how we can represent the group structure in our communication material. A formal written report will be available for both organisation's boards after the working group's August meeting.

Step up to Great mental health

The CCG have launched a public consultation on 24 May till 15 August seeking public views on LPT's plans to invest in and improve the way adult mental health care is delivered across Leicester, Leicestershire and Rutland. The move

follows a series of conversations, meetings and workshops (called the All Age Mental Health Transformation) with service users, public, staff, and voluntary organisations about their experiences of services over the last two years. The proposals to improve care provided when it is urgent and to deliver care closer to where people live include an extensive public consultation through online events, partnerships with voluntary and community sector networks, and a multi-media campaign signposting to the survey on a dedicated website: www.greatmentalhealthllr.nhs.uk

Refurb improvements at St Lukes hospital

Ward 1 at St Luke's Hospital has welcomed patients after a short closure for roof repairs, redecoration and minor alterations. The specialist stroke unit shut for three weeks at the beginning of July to allow the work to be completed without disturbing patients. You can see the refurbished Ward 1 in this short video: https://youtu.be/Q_aHVcBrYew

Awards

1. **Two LPT patient involvement initiatives have achieved national recognition as finalists in the annual Patient Experience Network (PEN) Awards 2021**. Our Recovery and Collaborative Care Planning Cafes have been shortlisted in the 'Strengthening the Foundation' award category and the Mental Health and Wellbeing Workbook has made the 'Support for Caregivers' award category.

   The Recovery Cafes are a shared space for patients, carers, health professionals and partners to come together to have collaborative conversations around care planning and recovery. They were developed alongside patients who share their lived experience of recovery and why it matters to them. LPT also uses the supportive groups to recruit participants to engage in other projects, such as the co-production of collaborative care planning guidance and the development of a five-week Recovery College course open to both staff and patients. Some service users are also involved in a quality improvement project within the Trust's mental health services.

   The Mental Health and Wellbeing Workbook was co-produced in response to the challenges of the Covid-19 pandemic, and the impact of lockdown on the mental health and wellbeing of LPT's service users. The workbook provides clear support, advice and activities for carers, friends, family members, LPT service users and the public. It can be downloaded in four different languages from LPT's website: https://www.leicspart.nhs.uk/involving-you/involving-you/

2. **LPT's specialist learning disability Covid-19 vaccination clinics have been shortlisted for a Nursing Times Award in the Learning Disability Nursing category.**

   The clinics, held at the Peepul Centre in Leicester, ran from the end of February to May and helped protect over 350 people with learning disabilities and autism from Covid-19, who couldn't be vaccinated in the normal way, by providing patients with a comfortable, specially adapted and safe environment to get their vaccine.

   One of the first Covid-19 vaccine clinics of its type to be set up in England, the innovative vaccine sessions were part of the wider vaccination effort in Leicester, Leicestershire and Rutland. They were set up quickly and proactively to provide a supportive and relaxed setting for patients, making several adjustments and using longer time slots and specialist distraction techniques. Patients' carers were also able to get their vaccine at the sessions.

   The clinics are staffed with a variety of learning disability nurses, support workers, doctors, volunteers and administration support staff, all of whom went out of their way to make it as easy as possible for people to be vaccinated. Well done and a big thank you to you all.

LPT Annual General Meeting (AGM) – 14 September 2021

Our AGM is open to our staff, our members and the wider public, and is an opportunity to hear about our Trust's highlights and achievements from over the last year. We will present our annual report and outline our progress against our vision – creating high quality, compassionate care and wellbeing for all – and our journey to Step up to Great.

You will have the chance to ask questions to our Chief Executive, Chair, and other members of the Trust Board. We will also share more about how our charity Raising Health has helped us to continue going above and beyond throughout the Covid-19 pandemic

Tuesday 14 September 2021, 4pm until 5.30pm

For more information and to register to attend please click https://www.leicspart.nhs.uk/about/corporate-responsibilities/annual-general-meeting-agm-2021/

Chief Executive and Deputy Chief Executive external meetings

July	August
Joint NEDs/Lay Member ICS Briefing	Healthwatch
C&YP Transformation Board	NHS Midlands Leaders Update
NHS Briefing for MPs	System Executive
NHS Midlands Leaders Update	ICS Provider Collaboratives
System Executive	LLR ICS NHS Board
Health Economy Strategic Coordinating Group	CYP Transformation
Council Leaders with LLR Health CEOs and LA CEOs	3 CEO's Directors of strategy(ICS Operating model)
3 Executive team meeting	21/22 Q1 Midlands Regional & National MH Deep Dive meeting
NHS Chief Executive	Health and Care Partnership Board
	CEO-CCG-LA - Leaders Discussion
	Mental Health Trusts CEO
	NHS Chief Executive
	East Midlands Alliance CEO

Proposal

It is proposed that the Board considers this report and seeks any clarification or further information pertaining to it as required.

Decision Required

The Board is asked to consider this report and to decide whether it requires any clarification or further information on the content.

Governance Table

For Board and Board Committees:	Trust Board 31 August 2021	
Paper sponsored by:	Angela Hillery, Chief Executive	
Paper authored by:	Angela Hillery, Chief Executive Kate Dyer, Deputy Director of Governance and Risk	
Date submitted:	24 August 2021	
Name and date of other committee/forum at which this report/ issue was considered:	N/A	
Level of assurance gained if considered elsewhere:	Assured	
	Partially assured	
	Not assured	
Date of next report:	July 2021	
DIGBQ strategic alignment:	**D**evelop	✓
	Innovate	✓
	Grow	✓
	Build	✓
	Quality	✓
Organisational Risk Register considerations:	Risk number/title	N/A
Is the decision required consistent with LPT's risk appetite?	Yes	
False Or Misleading Information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed.	
Equality considerations:	None	

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Leicestershire Partnership NHS Trust

Public Trust Board – 31 August 2021

Organisational Risk Register

The Organisational Risk Register (ORR) contains strategic risks that may prevent us from achieving our objectives. It is presented as part of a continuing risk review process.

Purpose of the report

This report provides assurance that risk is being managed effectively.

Analysis of the issue

Overall there are 22 risks on the ORR, of which, one is presented for closure;

Risk 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'.

The actions to mitigate this risk have been completed and the consultation period for Step up to Great Mental Health is drawing to a close. The delivery of this strategy will be subject to on-going review and any new risk identified will be considered for escalation onto the ORR.

On-going risk review

- Risk discussions in September 2021 will take account of the delivery of work programmes within the Mental Health Investment Standard, this has been tabled for the September 2021 Transformation Committee.
- The current risk score for **Risk 8** 'the transformation plan does not deliver improved outcomes for people with LD and/or autism' remains at 12, which is in line with risk appetite. A full risk review will be undertaken to determine the appropriateness of closure or de-escalation following completion of the mobilisation of additional leadership resource for ASD admission avoidance and discharge work.
- The lack of clarity over the arrangements for managing risk regarding Facilities Management until the transfer has been completed is captured in ORR **Risk 10** 'the Trust does not implement planned and reactive maintenance of the estate leading to an unacceptable environment for patients to be treated in'. This will be subject to further review in September 2021 with a view to potential inclusion as a separate risk on the ORR.
- A review of risk relating to the significant increase in demand for Children and Young Peoples Eating Disorder Services has taken place with the Director of FYPC and LD Services. Operationally, risk will continue to be overseen by the Directorate (risk 4677) and particular reference to the demand on this service has been made within the controls and assurances on the existing ORR **Risk 28** 'delayed access to assessment and treatment impacts on patient safety and outcomes'.
- **Risk 40** 'the ability of the Trust to deliver high quality care may be affected during a Coronavirus COVID-19 pandemic' is being maintained at a current risk score of 10. Whilst this is in line with the residual and target score, the risk remains on the ORR due to fluctuations in severity of the covid-19 pandemic. Over recent weeks we have seen a small but significant local response to an increase in community transmission rates of covid-19 which are tracking above the national average. We

continue to monitor the impact of these changes and update risk 40 accordingly with any new actions required to keep the mitigation of this risk in line with our appetite.

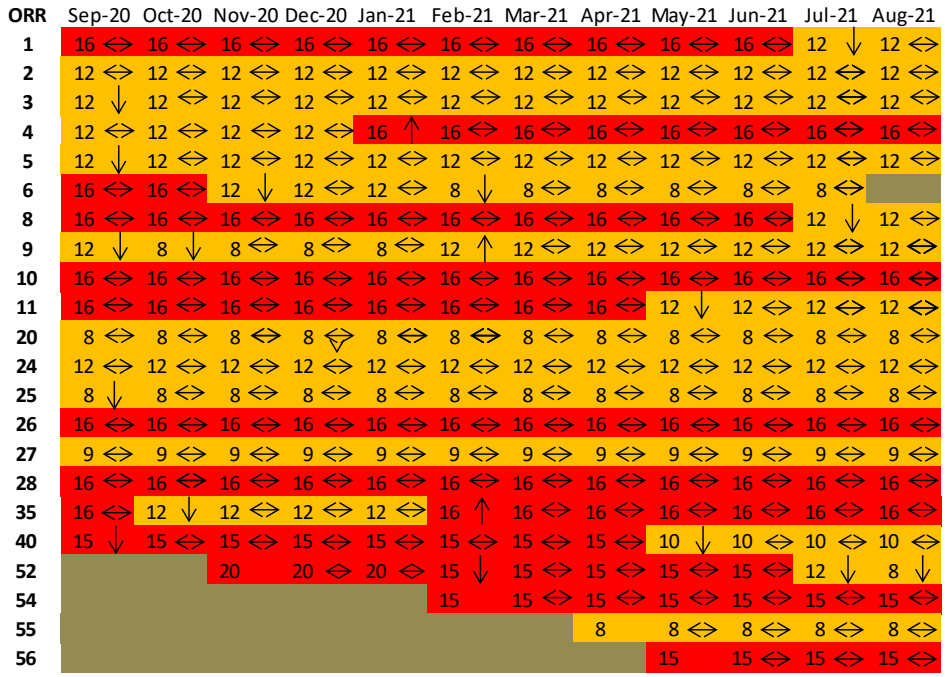
- The current score for **Risk 52** 'without sufficient student placement capacity, the health and social care system will have a shortfall in the availability of a qualified workforce' has reduced this month from 12 to 8 to reflect the progress made with mitigating action. There are blended placement offers now available including pathway placement supervisors, and the development programme is re-starting.

Summary list of risks and scores August 2021

There are seven risks with a high current score, this is a reduction from the 10 reported in June 2021.

No.	Title	SU2G	Initial risk	Current risk	Residual Risk	Target (Appetite)
1	The Trust's clinical systems and processes may not consistently deliver harm free care.	High Standards	16	12	8	8
2	The Trust's safeguarding systems do not fully safeguard patients and support frontline staff and services.	High Standards	12	12	8	8
3	The Trust does not learn from incidents and events and does not effectively share that learning across the whole organisation.	High Standards	15	12	8	8
4	Services are unable to meet safe staffing requirements	High Standards	12	16	12	8
5	Capacity and capability to deliver regulator standards	High Standards	12	12	8	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.*	*Transformation*	*16*	*8*	*8*	*8*
8	The transformation plan does not deliver improved outcomes for people with LD and/or autism.	Transformation	16	12	8	12
9	Inability to maintain the level of cleanliness required within the Hygiene Standards	Environment	12	12	8	8
10	Failure to implement planned and reactive maintenance of the estate leading to an unacceptable environment for patients to be treated in	Environment	16	16	12	12
11	The current estate configuration does not allow for the delivery of high quality healthcare	Environment	20	12	8	8
20	Performance management framework is not fit for purpose	Well Governed	20	8	4	4
24	Failure to deliver workforce equality, diversity and inclusion	Equality, Leadership, Culture	12	12	9	9
25	Staff do not fully engage and embrace the Trusts culture and collective leadership	Equality, Leadership and Culture	16	8	8	4
26	Insufficient staffing levels to meet capacity and demand and provide quality services	Equality, Leadership and Culture	16	16	12	12
27	The health and well-being of our staff is not maintained and improved	Equality, Leadership and Culture	9	9	6	6
28	Delayed access to assessment and treatment impacts on patient safety and outcomes	Access to Services	16	16	8	8
35	The quality and availability of data reporting is not sufficiently mature to inform quality decision making	Well Governed	16	16	12	12
40	The ability of the Trust to deliver high quality care may be affected during a Coronavirus COVID-19 pandemic	High Standards	20	10	10	10
52	Without sufficient student placement capacity, the health and social care system will have a shortfall in the availability of a qualified workforce	High Standards, Equality, Leadership and Culture	20	8	8	8
54	We are unable to deliver the LPT 2021/22 financial plan, LPT operational plans or LLR system plans.	Well Governed	15	15	10	6
55	The Leicester/Leicestershire / Rutland system does not deliver the transformation needed to deliver a successful ICS	Well Governed	8	8	6	6
56	Delivery of service recovery and workforce restoration will not safeguard the health and wellbeing of our staff and service users	High Standards	15	15	10	10

Summary trend of risk scores for all live risks (rolling year) as at 14 August 2021



Proposal

- On-going business rhythm of monthly ORR review and maintenance
- To continue to horizon scan

Decision required

- To approve the closure of Risk 6.
- To confirm a level of assurance over the management of strategic risk on the ORR.

Governance table

For Board and Board Committees:	Trust Board 31 August 2021	
Paper sponsored by:	Chris Oakes, Director of Governance and Risk	
Paper authored by:	Kate Dyer, Deputy Director of Governance and Risk	
Date submitted:	14 August 2021	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Regular ORR reports to level 1 Committees and the Trust Board. This June 2021 version has not been to any other forum.	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Each meeting	
STEP up to GREAT strategic alignment*:	High **S**tandards	Yes
	Transformation	Yes
	Environments	Yes
	Patient Involvement	Yes
	Well **G**overned	Yes
	Single Patient **R**ecord	Yes
	Equality, Leadership, Culture	Yes
	Access to Services	Yes
	Trust wide Quality Improvement	Yes
Organisational Risk Register considerations:	List risk number and title of risk	Yes
Is the decision required consistent with LPT's risk appetite:	Yes	

False and misleading information (FOMI) considerations:	None
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed
Equality considerations:	None

					Consequence	Likelihood	Combined
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.			Current Risk	4	3	12
Director risk owner:	Director of Nursing, AHPs and Quality and Medical Director	Date Last Reviewed:	13/08/21	Residual Risk	4	2	8
Governance / review:	PSIG, Quality Forum, QAC / Board - monthly review			Risk Appetite / Target Risk			8

Controls

Description:

- Staff Safety Huddles and Debrief
- Thematic reviews of patient safety incidents and QI approach adopted by the Trust
- Infection Prevention & Control policies & the monitoring of- BAF report to Trust Board
- Step up to Great Strategy / High Standards work streams - Pressure ulcers, Falls (moved to BAU) Deteriorating Patient (added Sepsis work stream), Positive and Safe, non fixed ligatures and Accreditation
- Patient Safety Plan - aligned to the National Patient Safety Strategy / Patient Safety Improvement Group (PSIG)
- Nutrition Group – now reporting to QF
- Learning Lessons Exchange Group including learning from thematic reviews
- Falls Group – monitoring of incidents, themes, and national aligning to best practice
- Suicide Reduction Plan in keeping with National Confidential Enquires Report
- Close linkage with Freedom to Speak Up Guardian and partners
- High Standards work stream –'Deteriorating Patient including sepsis' / 'Accreditation' including Accreditation Matron in post and accreditation process being implemented
- Deteriorating Patient Group / Harm assessment process / Learning from Death and Suicide Prevention Clinician recruited 01/06/20
- Additional recruitment into patient safety and complaints teams including new Investigation Leads
- Weekly meeting between patient safety and safeguarding teams
- Joint Director of HR/OD and Head of Patient Safety workshop to promote Just and Learning Culture
- Coordinated approach to SI and complaint investigations

Gaps:

- Revised model for clinical and quality governance which includes Trust wide learning lessons

Assurances

Internal:

- QAC Chair attendance at Quality Forum
- Quality Forum / Quality Assurance Committee / Strategic Workforce Committee
- Quality Accreditation
- Mental Health Act Reviews / monthly MHA compliance census reported to LEG
- Mortality reviews & Learning from Deaths Process
- Trust wide Adult & Child Safeguarding
- Mandatory training reports ; Clinical supervision reports
- Performance Report: Serious Incidents (number of)
- Deep dives at QAC
- Directorate risk registers
- Triangulation with Claims, Safeguarding and Complaints
- reporting flow in place and oversight infrastructure including the embedding of SI assurance reporting to QAC / Board – on track

Evidence:

- QAC observations of Quality Forum
- QAC and Quality Forum annual committee reviews
- Learning from deaths report to Trust Board
- Performance dashboard to FPC and Trust Board
- QAC / Board assurance reporting
- Update on progress of local Quality Accreditation
- Harm review paper
- SI reports
- Concerns / complaints
- Quality metrics

Assurance Rating Green

External:

- NHFT Chief Nurse and CCG observation of Quality Forum
- Regular reporting of patient safety related information to the CQC under the TRA
- CQC attendance at events and CQC focus groups
- Patient/family and staff FFT / PALS feedback
- Professional Bodies e.g. NMC, GMC, HCPC
- Quality Contract and Monitoring with CCG & Specialised Commissioning
- Health watch Leicester / Coroner feedback / External reviews of quality governance
- LLR Transferring Care Safely Group/LPT engaged (acute/secondary provider feedback)

Evidence:

- NHFT Chief Nurse observations of Quality Forum
- Patient experience report to QAC
- CQC feedback – assurance report to QAC

Assurance Rating Green

Gaps:

- Accreditation work paused (Nov 20 to date)

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Sept 21 Dec 21	Delivery of revised clinical and quality governance infrastructure Delivery of revised clinical and quality governance framework to include how we strengthen learning Trust Wide learning lessons	Deanne Rennie Nursing Heads of Nursing and governance leads	MoC consultation to start September 2021 Framework under development	Amber

Risk No: 2	High Standards	Date included:	01.10.19		Consequence	Likelihood	Combined
Risk Title:	The Trust's safeguarding systems do not fully safeguard patients and support frontline staff and services.			Current Risk	4	3	12
Director risk owner:	Director of Nursing, AHPs and Quality	Date Last Reviewed:	13/08/21	Residual Risk	4	2	8
Governance / Review:	Safeguarding Committee / QAC / Board - Monthly Review			Risk Appetite / Target Risk			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 which has separated out the safeguarding work from the LEG. • 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. • All vacant posts recruited to • New level 2 Safeguarding Committee • SystmOne Safeguarding Unit now live improving oversight and access to records.
	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 safeguarding training offer is not fully compliant with national standards and guidelines.

Assurances	Internal:	Source: • Legislative Committee and Safeguarding Committee • QAC provides oversight and challenge to the Safeguarding and Legislative 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 upon request and there are regular updates from the DoN to QAC/TB • Key Performance Indicators for the Legislative Committee and SG Committee • Progress and update reports regarding the external review action plan. • New collaborative Safeguarding new assurance templates for CCG, and the 4 safeguarding boards has been instigated to make the assurance meaningful and delivered in a timely , responsive manner.	Assurance Rating Amber
	External:	Source: • CQC inspections (contribution to CCG Safeguarding Inspections /direct LPT CQC Inspection) • Commissioner meetings, including quarterly safeguarding assurance template (SAT) Membership of four Local Safeguarding Boards, including the Boards' respective sub-committees , i.e. Performance Group, Policy Group and Review Group • External review completed and report accepted by the Trust.	Evidence: • External review of safeguarding structures report • CQC report • Local Safeguarding Board reports and minutes	Assurance Rating Green
	Gaps:	• Training figures		

Actions	Date:	Actions:	Action Owner:	Progress:	Status:
	Sept21	• Implement and embed the 32 recommendations from the external review.	Neil King / Safeguarding Dept	• Action plan mainly delivered [NK outstanding items]. Redesigned Team. Invested in increasing capacity, new posts in place. • Training is ongoing as part of consistent and constant team development.	Amber
	Sept 21	• Training capacity and offer to be reviewed	Neil King / Safeguarding Dept		

Risk No: 3	High Standards	Date included:	01.10.19		Consequence	Likelihood	Combined
Risk Title:	The Trust does not learn from incidents and events and does not effectively share that learning across the whole organisation.			Current Risk	4	3	12
Director risk owner:	Director of Nursing, AHPs and Quality	Date Last Reviewed:	11.08.21	Residual Risk	4	2	8
Governance / Review:	PSIG, Quality Forum, QAC / Board - Monthly Review			Risk Appetite / Target Risk			8

Controls	Description:	• Centralised process for identifying, processing, investigating, scrutiny and identifying Learning through the Serious Incident Process • Complaints process and PALs team • Patient and Staff Safety Incident review via triage and directorate responsibility • Outcomes from Clinical Audit & service evaluation • Learning from Deaths Group using a human factors approach • Learning lessons Exchange Group operating as a community of practice to embed a learning culture using a human factors approach • Patient Safety Improvement Group aligning with national patient safety strategy using a human factors approach • Appropriate groups for sharing learning in place and to follow up on progress against actions • Centralised SI reporting and oversight process • Recruited additional SI investigators		
	Gaps:	• Ensuring cross governance working to identify risk and share learning		
Assurances	Internal:	Source: • Learning from deaths report • Patient safety bi monthly 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 meet weekly to review potential SI's and all COVID19 incidents and escalate to ICC • SUTG: High Standards Work streams • Performance Report: STEIS SI action plans completed within timescales. • Triangulation with Claims, Safeguarding, Complaints and F2SU Guardian	Evidence: • Monthly SI performance report for Quality Forum and QAC • Bi monthly patient safety report to Board • Highlight information and escalation processes • Reduction in harm and incidents • Reduction in concerns and complaints • Improved staff feedback • Performance Report • Internal reviews of learning	Assurance Rating Amber
	External:	Source: • 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 • Internal Audit report – Duty of Candour	Evidence: • Patient experience report to QAC • CQC report / verbal feedback	Assurance Rating Green
	Gaps:			

Actions	Date: Dec 21	Actions: Implementation of re-designed clinical and quality governance structure and framework – see risk 1.	Action Owner: Anne Scott	Progress: See risk 1	Status: Amber

Risk No: 4	High Standards	Date included:	01.10.19		Consequence	Likelihood	Combined
Risk Title:	Services are unable to meet 'safe staffing' requirements			Current Risk	4	4	16
Director risk owner:	Director of HR / Director of Nursing, AHP's and Quality	Date Last Reviewed:	05.08.21	Residual Risk	4	3	12
Governance / Review:	Learning and OD Group, Quality Forum, QAC / Board - Monthly Review			Risk Appetite / Target Risk			8

Controls

Description:

Descriptor – this refers to the operational staffing of services to keep patients safe. See risk 26 for the central resourcing, supply, recruitment and retention of staff

- 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 and review of acuity data.
- 6 monthly establishment reviews include workforce planning, with an Annual reset 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 measurement
- National safe staffing return recommenced
- Face to face training programme for Mappa and ILS and all other local skills training i.e. insulin administration currently being reviewed by the ICC education cell.
- Bame risk assessments
- Fast track programme of support for redeployed staff linked to additional covid beds or surge wards - Additional surge beds opened on 12.1.21, redeployed staff training and supervision provided
- Process in place for non registered LPT staff who hold a nursing registration oversees to complete application for programme to achieve NMC registration
- Training and support and clinical readiness preparation for redeployed / mutual for Charnwood
- Recruited 'new to healthcare' staff in non registered roles with a bespoke induction package
- Recruited to a new workforce and safe staffing matron
- Recruited to the international l recruitment matron post
- Directorate safe staffing SOPs in place for escalation and management including deployment of bank and agency staffing

Gaps:

- Pause on annual establishment review – to re-start
- National difficulties in recruitment – particularly to mental health and community nursing.

Assurances

Internal:

Source:
- Weekly staffing meeting to review staffing risks, escalate areas to note, and actions to address any staffing shortfalls.
- 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.
- SUTG: High Standards Work streams
- Performance Report: Safe Staffing
- Weekly inpatient safe staffing meetings chaired by Ass Nursing Director

Evidence:
- Trust Workforce Plan
- Performance Report with updated KPIs
- 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 Nurse Sensitive Indicators has not identified correlation between staffing and impact to quality, safety and patient outcomes

Assurance Rating Amber

External:

Source:
- NHSE Safe staffing trends – monthly submission
- The Department of Health and Social Care's group annual governance statement – NHSI

Evidence:
- Unify and Health roster data
- SOF / AGS

Assurance Rating Green

Gaps:

- Evidence based acuity and dependency data for all in-patient areas
- National tools to measure therapy staffing for patient acuity and dependency

Actions

Date:	Actions:	Action Owner:	Progress: Ongoing	Status:
Oct 21	Winter planning and Trust preparedness for redeployed staff	Emma Wallis		Amber
Aug 21	Looking to Joint community and I/P therapy recruitment – to consider if feasible	Deanne Rennie		
Dec 21	Recruit 30 international nurses - timeline by end December 2021	Asha Day		
Dec 21	Completion of annual establishment reviews (the workforce and safe staff matron)	Elaine Curtin		

Risk No: 5	High Standards	Date included:	01.10.19		Consequence	Likelihood	Combined
Risk Title:	Capacity and capability to deliver regulator standards			Current Risk	4	3	12
Director risk owner:	Director of Nursing, AHPs and Quality	Date Last Reviewed:	09/08/21	Residual Risk	4	2	8
Governance / Review:	Foundation for GPC, Quality Forum, QAC / Board - Monthly Review			Risk Appetite / Target Risk			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
- Revised Governance structure – plus COVID-19 governance arrangements
- Book of brilliance
- Step up to great strategy
- Senior Leadership and Extended Senior Leadership Team Meetings / Board development sessions – on hold
- Completed CQC action plan and ongoing improvement programmes
- IPC inspection and action plan
- Risk management strategy and ORR - plus additional RM arrangements for COVD-19
- Action cards
- Approval of new AMAT database CQC module
- Reading room available on MS Teams
- Time to shine sessions – with targeted and 1:1 training in some areas
- CQC inspection preparation checklist available in Time to Shine Booklet
- Feedback on Director interviews provided at CEB 3 July 2020
- Sight of the new key lines of enquiry emerging from the 2020 focus groups
- Ongoing fortnightly position statement against warning notice actions
- Inspection project plan
- Well Led information pack
- Self assessment of current performance against warning notice areas
- Robust governance framework for grip and control QST with confidence

Gaps:

Assurances

Internal:	• Audit and Quality Accreditation programmes • Self assessment checklist • Quality surveillance tracker • Quality forum • AMAT tool – tracker including areas identified for further support showing closures • Foundation for Great Patient Care • SUTG: High Standards Work streams • Self assessment against all areas previously rated as inadequate	Evidence: • Monthly assurance report to QAC / Board • Monthly report to Strategic Exec Team • Foundation for Great Patient Care highlight report to Quality Forum • Deep dives at the Foundation for Great Patient Care • Information provided to the CQC under the TMA	Assurance Rating Green
External:	• Proactive design of information flow to CQC to inform the TMA with ongoing feedback • Ongoing focus groups, drop in sessions and invites for CQC to attend events • CQC inspection and engagement meetings / focus group outcomes • Third line assurance over compliance (outside of the CQC) • Quality and Performance system meetings – discussions with Commissioners • Regulator inspections including HSE, NHSEI/IPC • KPMG value for money conclusion	Evidence: • TMA feedback from the CQC • Internal re-rating including buddy trust peer review • Feedback from focus groups • Minutes of CQC engagement meeting • 3rd party assurance reports (HSE, IPC, NHFT buddy visits)	Assurance Rating Green
Gaps:	Current CQC rating - latest inspection date May-June (core service) July (well led) 2021 awaiting findings		

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Sept 21	Delivery of CQC actions around medical devices.	Deanne Rennie	Ongoing	Amber
Sept 21	Review and refresh of CQC action improvement and assurance oversight	Deanne Rennie	Ongoing	

Risk No: 6	Transformation	Date Included on ORR	01.10.19		Consequence	Likelihood	Combined
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.			Current Risk	4	2	8
Director risk owner:	Director MH	Date Last Reviewed:	07.06.21	Residual Risk	4	2	8
Governance / Review:	Transformation Committee, FPC / Board - Monthly Review			Risk Appetite / Target Risk score			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 and a service reconfiguration steering group
- on-going engagement with staff, service users and carers
- Mental health urgent care hub
- Central access point
- East Midlands Clinical Senate – approved model
- Completion of a pre-consultation business case (incl. QIA risk assessment and workforce model)
- JHOSC agreed
- Clinical senate agreed
- NHSE panel approval
- Consultation process is concluding

Gaps:

Assurances

Internal:	Source: • Large scale co-production events • Project Initiation Document • LPT Trust Board quarterly updates • Directorate Management Team (DMT) • Implementation plan • SUTG: Step up to Great Mental Health	Evidence: • Transformation Committee update papers • SUTG project delivery dashboard • Out of area improvement	Assurance Rating Green
External:	Source: • NHSE Strategic Direction • 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 • Clinical senate review of clinical model - approved	Evidence: • External presentations • CQC engagement minutes	Assurance Rating Green
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress	Status:
				Green

Risk No: 8	Transformation	Date Included on ORR	01.10.19		Consequence	Likelihood	Combined
Risk Title:	The transformation plan does not deliver improved outcomes for people with LD and/or autism.			Current Risk	4	3	12
Director risk owner:	Director, FYPC and LD Services	Date Last Reviewed:	14.08.21	Residual Risk	4	2	8
Governance / Review:	Transformation Committee, FPC / Board - Monthly Review			Risk Appetite / Target Risk			12

Controls

Description:

- TCP Collaborative formed led by LPT delivering improved performance and de-escalation of LLR by NHSEI June 21 – LeDeR, Annual Health Checks and admission trajectory on track.
- Executive as jt SRO and AD leadership of system response.
- 3 year road map for investment and improvement agreed with NHSEI and system partners – robust programme management arrangements in place
- New developments established to reduce admission – ie. Specialist Autism Team, strengthened outreach mode and LD Forensics offers.
- TCP Hub developed to co-ordinate LLR social care discharge work
- Adult and CYP discharge planning scrutinised weekly by AD led multiagency group.
- LPT LD service Quality Improvement Programme for inpatient and community services delivering large scale change informed by service users/carers
- Risk of Admission Register (ROAR) and associated e-learning, multiagency Dynamic Support Register in place.
- AMH TCP Group established to improve and coordinate response
- Increased LD Matron capacity to support transformation and TCP work programme
- Provider forum in place to develop community capacity
- Short breaks offer in place
- Mobilisation of Forensics, Outreach expansion and Post Diagnosis 14+ ASD services - pending Early Intervention cohorts for SAT team
- Agnes Unit financial model and financial recovery plan agreed with commissioning team

Gaps:

- Further controls/services under development as part of 3 year plan include Dynamic Support Pathway to increase early intervention
- DMH autism pathway in development
- Appropriate community placements in LLR including facility for 'unplanned care' response.
- Poor access to low and medium secure beds resulting in complex ASD case management in DMH and Agnes Unit.

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Board reporting • Transformation Committee report for LD QI and TCP. • DMH TCP Improvement plan • LD QI Programme governance to directorate SUTG DMT	• TCP Annual report. LeDeR report. • Reports into transformation committee • Improvement plan to DMH DMT • LD QI programme plan and progress reports	Amber
External:	• Multi-agency LD and Autism Executive Board - *reports into STP SLT, and is a Workstream of the STP.* • System wide LeDeR review and timely delivery of quality assurance • Adult & Children Case Managers (CCGs / Specialised Commissioning) • External input into Root Cause Analysis on all admissions • CCG and LAs engagement in LD QI Programme Board • System LD and Autism Executive	• Learning from RCAs to reduce future admissions • Minutes of the TCP Executive Board • System Performance against TCP inpatient trajectory, LeDeR and Health checks. NHSEI de-escalation letter.	Amber

Gaps:

- Reporting to the Transformation Committee not possible due to suspension of forum
- RCA process for admissions to be established in CAMHS

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Sept 21	• Mobilisation of additional AMH leadership resource for ASD admission avoidance and discharge work	MR	Plan drafted. DMT and CCH engagement pending.	Amber

					Consequence	Likelihood	Combined
Risk No: 9	Environment / High Standards	Date Included on ORR	01.10.19				
Risk Title:	Inability to maintain the level of cleanliness required within the Hygiene Standards			Current Risk	4	3	12
Director risk owner:	Director of Nursing, AHP's and Quality and Chief Finance Officer	Date Last Reviewed:	05.08.21	Residual Risk	4	2	8
Governance / Review:	IPCC, QAC and FPC / Board - Monthly Review			Risk Appetite / Target Risk			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
- 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
- SOPs in place to describe key responsibilities
- Audit programme includes Cleaners rooms and trolleys / Clear and agreed reporting mechanism against the Hygiene code
- 20/21 FM SLA and performance KPIs
- Revised cleaning spec/scope (zoned wards) and allocation of cleaning responsibilities (FM staff/Ward staff)
- On outbreak wards staff aligned to task for whole shift. System in operation and working.
- Appointment of x6 additional rapid response staff due 1/4/2021
- KPIs from UHL now available
- LPT participation in NHSEI cleaning with confidence (CwC) campaign – training programme added to Ulearn
- Rapid response team funded to support outbreak management and increase clearing where there are increased incidents of infection
- Service spec updated to introduce a third daily clean to IP areas

Gaps:

- Outstanding maintenance work following the environmental audits

Assurances

Internal:

Source:

- Cleaning report to the Estates Committee
- UHL and NHSPS contractual cleaning audits and confirmation that cleaning specifications meet covid IPC requirements. Daily SitRep received from UHL
- PLACE audit action plan
- 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
- IPC Bi-Annual report to Trust Board

DMTs

- Monthly reports to FPC (Estates) and QAC - (IPC)
- Environmental audit
- PLACE scores and report for 2019
- Contractual cleaning audit findings – showing majority green reporting
- Regular performance reports against hygiene standards and regular review at IPC

Assurance Rating Amber

External:

Source:

- NHSI IPC audit
- CQC inspections
- PLACE audits

Evidence:

- PLNational Guidance on cleaning for COVID-19
- Premises Assurance Model
- CQC IPC summary inspection report
- Daily SitRep reports received from UHL
- Additional spot check by UHL Facilities and LPT IPC team following the CRO outbreak and results of the environmental audit.

Assurance Rating Green

Gaps:

Actions

Date:	Actions:	Action Owner:	Progress	Status:
Sept 21	Plan to complete outstanding Estates maintenance jobs as a result of environmental audits – action log oversight at Trust facilities forum.	R Brown	Ongoing planning	Green
Sept 21	Review and implementation of phase one of the national cleaning standards	H Walton & A Hemsley		
Aug 21	NHSE/I visit for IPC			

					Consequence	Likelihood	Combined
Risk No: 10	Environment	Date Included on ORR	01.10.19				
Risk Title:	The Trust does not implement planned and reactive maintenance of the estate leading to an unacceptable environment for patients to be treated in			**Current Risk**	4	4	16
Director risk owner:	Chief Finance Officer	Date Last Reviewed:	11.08.21	**Residual Risk**	4	3	12
Governance / Review:	Estates Committee, FPC / Board - Monthly Review			**Risk Appetite / Target Risk**			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
- P22 partner 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 (see corresponding gap)
- FM Transformation Board (Jan 2020 onwards)
- PPM schedules (12 month forward view) received from UHL Dec 2019 and assessed as adequate
- Resources appointed to support FBC. FBC complete.
- Specialist estate resources procured from Turner & Townsend (T&T) to support PAM.
- ERIC return submitted
- FM transformation Business Case complete.

Gaps:

- Lack of systematic process for identify high risk areas requiring maintenance
- UHL not complying with the KPIs / maintenance and repairs are not always undertaken in a timely manner – UHL aware
- Clarity over the arrangements for managing risk with FM until transfer completed
- Unable to obtain detailed report and assurance over planned preventative maintenance leaving the Trust unable to apply suitable mitigations
- Now that the FM business case has been approved, any implementation risk will be identified and managed through the next ORR cycle

Assurances

Internal:

Source:
- Estates committee / FPC
- 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 tracker, deep dives and escalation process
- FM Oversight Group currently on hold (COVID) – reinstated starting October 2020

Evidence:
- FM Transformation plan updates shared in LPT committees.
- Report to the Estates Committee, and then to FPC which details performance
- PPM performance report
- Reports demonstrating implementation of the Estate Strategy to the Estates Committee
- Emergency reactive maintenance performance is good
- Cleaning audits – good performance and in line with KPIs

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
- Assurance information not being received from NHSPS. Some data starting to emerge.
- Poor performance against set KPI resulting in overall lack of assurance.

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Sep 21	• To utilise the additional resources via T&T to support the ongoing data collection and actions relating to PAM until submission date	Richard Brown	Ongoing	Green

					Consequence	Likelihood	Combined
Risk No: 11	Environment	Date Included on ORR	01.10.19				
Risk Title:	The current estate configuration does not allow for the delivery of high quality healthcare			Current Risk	4	3	12
Director risk owner:	Chief Finance Officer	Date Last Reviewed:	11.08.21	Residual Risk	4	2	8
Governance / Review:	Estates Committee, FPC / Board - Monthly Review			Risk Appetite / Target Risk			8

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
- Clinical model for Beacon Project approved by SEB in June 2020
- Recruited a new Head of Capital Projects & Property
- Priority of fire safety works have been completed - implementation plans being finalised.
- Priority of ligature works has been agreed - initial phase ensuite doors is being undertaken.
- ERIC return completed and submitted on time May 2021

Gaps:

- Premises Assurance Model to be updated
- Challenges around availability of capital funding – nine million of national funding secured in three MoUs (now all signed)
- Finalisation of the remedial fire works
- Action to upgrade ensuite and unobserved doors with modern safety products

Assurances

	Source:	Evidence:	
Internal:	• New Strategic Property Group established and operational • 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 (complete) • 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	Assurance Rating Amber
External:	Source: • PLACE audits complete and actions in hand by Property Officers • NHSI / CQC / HSE • Fire service • KPMG audit of financial and quality accounts • In-patient reconfiguration to eliminate dormitories. Phase 1 OBC approved by Exec	Evidence: • CQC report • 360 audit • Exec approval to OBC fee request.	Assurance Rating Green

Gaps:

- LPT to revisit Estates Return Information Collection (ERIC) data set

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Ongoing	• Implementation of Dormitory Eradication programme.	Richard Brown	• Currently on plan. Strong engagement. Willows and Bosworth complete.	Green

Risk No: 20	Well Governed	Date Included on ORR	01.10.19		Consequence	Likelihood	Combined
Risk Title:	Performance management framework is not fit for purpose			Current Risk	4	2	8
Director risk owner:	Director of Finance & Performance	Date Last Reviewed:	13.08.21	Residual Risk	4	1	4
Governance / Review:	FPC / Board - Monthly Review			Risk Appetite / Target Risk			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 • SUTG plan • SOP in place • Simplified board reporting and an agreed set of 2021/22 KPIs for the Board • Committee dashboards with KPIs owned by QAC/FPC • Performance review meetings • Highlight reporting for escalated items
	Gaps:	• Avoidable harm measures • Capacity of the information team due to demands from national sitrep reporting, changes to information team members • Level 2 committee dashboards – implementation delayed due to COVID

Assurances	Internal:	Source: • FPC / QAC • Bi monthly Performance review meeting routine established • DMT meetings • Trust Board • Revised business rhythm for level 1 committees	Evidence: • Routine performance reporting to FPC / QAC /Board • Agreement by QAC/FPC on the set of 2021/22 KPIs for the Board Report • Performance framework review meetings scheduled until end of the year • Performance reports are reviewed by Directorate Business Managers prior to release. • Evaluation of performance review meetings & performance report & level 2 dashboard implementation – Focussed review meeting planned for October 2021.	Assurance Rating Amber
	External:	Source: • Contract monitoring of quality indicators by Commissioners • Finance, Technical and Performance monitoring of contracted performance indicators • NHSI / CQC inspections • External and internal audit	Evidence:	Assurance Rating Amber
	Gaps:	• Fully embedded system (demonstrated once level 2 dashboards are fully implemented) • External Quality Account audit – no data testing due to COVID in 19/20 or 20/21, will be optional in future – The Trust's Auditor panel has agreed the quality accounts audit will be included in the Service Specification in the current external audit tender exercise. • Trust wide approach to reporting planned post covid performance & capacity		

	Date:	Actions:	Action Owner:	Progress:	Status:
Actions	Sept 21	• Consideration of avoidable harm measures including impact of partial or full COVID related closures	AS/ A Scott		Amber
	Sept 21	• Revised Board performance report implementation	SM	Qliksense project is underway, with established project team.	
	Sept 21	• Consider ORR links to performance report	SM/KD	Met to agree next steps for linking report & ORR; new staff will progress	
	Dec 21	• Review of Information Team capacity	SM		
	April 22	• External audit of quality accounts to be reinstated	SM		

					Consequence	Likelihood	Combined
Risk No: 24	Equality, Leadership, Culture	Date Included on ORR	01.10.19				
Risk Title:	Failure to deliver workforce equality, diversity and inclusion			Current Risk	3	4	12
Director risk owner:	Director of HR & OD	Date Last Reviewed:	09.08.21	Residual Risk	3	3	9
Governance / Review:	SWC, QAC / Board - Monthly Review			Risk Appetite / Target Risk			9

Controls

Description:

- Independent focus groups run and led by national WRES team- January 2019
- Delivery of key actions from focus groups
- Electronic system controls to support identification of staff who want to progress in their careers
- Staff survey results analysed and gaps identified annually
- WRES /WDES data and action plans updated and produced annually / Annual Report on WRES and WDES
- CEO sent letter to all BAME staff in response to BLM June 2020
- Risk assessments conducted for all staff
- Staff support networks meet on a regular basis (monthly) and have Executive sponsorship
- Continued listening events with staff
- Reverse mentoring cohorts, second system wide reverse mentoring programme underway (41 matched pairs with LPT having 14 reverse mentoring pairs)
- Cultural ambassadors
- Strong EDI governance in place
- Our Future Our Way / Leadership behaviours (which includes an EDI specific behaviour)
- 6 high impact action submission has been signed off by EDI Workforce Group
- Anti – Racism strategy co production with NHFT part of group model
- EDI Taskforce - 10 action areas agreed. Project Group established and being led by Chris Oakes

Gaps:

- WRES cultural pilot programme. On hold due to national WRES team changes
- Delivery against outcome measures / WRES and diversity metrics
- Embeddedness of WRES/ WDES/ Together Against Racism action plan/ NHSEI high impact actions

Assurances

Internal:

- Response to National Workforce Equalities letter from NHSEI reviewed by EDI Group
- WRES action plan
- Diversity workforce dashboard
- Trust board equalities report
- Annual Equalities Action Plan
- Staff support groups
- Equality Programme plan

- Highlight reports on WRES, WDES and Together Against Racism action plans, presented regularly to relevant governance committees
- Staff survey report Trust Board
- EDI Bi annual report to EDI committee / EDI group
- Annual meeting schedule across the year
- WRES/WDES DATA published action plan to QAC/SWC
- SEB approved recruitment of band 7 EDI Specialist role- June 2021

Assurance Rating Green

External:

Source:

- System wide EDI Taskforce established and identified seven priority areas for implementation
- People Plan Drivers embedded within LPT strategies
- Six race equality high impact actions mandated nationally and embedded within key strategies
- EDI strategy being developed

Evidence:

- Presentation of system wide priorities to SRO's scheduled for the 11th August 2021
- System wide funding to support seven key priorities- ongoing
- Coordination of activities through the EDI Taskforce- ongoing with high visibility of key projects, e.g reverse mentoring, key decision making framework, Cultural Intelligence programme and Your Voice tool

Assurance Rating Green

Gaps:

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Oct 21	• Delivery of WeNuture OD sessions	Haseeb Ahmed	• The WeNurture targeted BAME training is underway with one cohort who have completed the programme. cohort 2 commencement during summer 2021. On target.	Green
Aug 21	• WDES action plan development in collaboration with the MAPLE staff support network	Haseeb Ahmad	• Head of EDI is working with chair of MAPLE researching best practice and agreeing priorities for 2021/22 WDES action plan. Complete.	
Mar 22	• Embed Together Against Racism actions	Haseeb Ahmad	• Together Against Racism is one of the group strategic priorities for LPT and NHFT's Buddy programme. An action plan has been agreed and will be implemented over the next 12 months. This is in addition to the WRES action plan.	
Mar 22	• EDI Taskforce seven priorities plan	Haseeb Ahmad	• Plan being signed off by SRO's 11th August 2021	

Risk No: 25	Equality, Leadership, Culture	Date Included on ORR	01.10.19		Consequence	Likelihood	Combined
Risk Title:	Staff do not fully engage and embrace the Trusts culture and collective leadership			Current Risk	4	2	8
Director risk owner:	Director of HR & OD	Date Last Reviewed:	09.08.21	Residual Risk	4	2	8
Governance / Review:	SWC, QAC / Board - Monthly Review			Risk Appetite / Target Risk			4

Controls

Description:

- Our Future Our Way is LPT's Culture, Inclusion and Leadership programme.
- Change champions in place, facilitating sessions where possible
- Training provided to all change champions
- 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 Workshops
- Virtual Leadership Forum
- OD delivery plan
- E-learning training programme commenced
- Appraisal system aligned with leadership behaviours framework – new appraisal programme launched
- Senior leadership monthly meetings
- Leadership plan developed and signed off 'Leadership for all' engagement plan developed
- Leadership development programme linked to leadership behaviours
- People plan in place

Gaps:

Assurances

Internal:	Source: • 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 • Attendance at virtual SLT • Board development • People plan • Leadership for All Plan	Evidence: Leadership + Leadership engagement plans to be signed off May 2021 Staff survey report to Board 3rd March Board update on leadership behaviours progress Jan 20 Virtual SLT monthly Reports to SWC quarterly meetings continuing – papers include leadership behaviours update, appraisal framework, OD plan for bitesize sessions LPT people plan mapped to national and OFOW Board Development session 6th Oct People plan taken to SLF SWC QAC Trust board Plan gained approval and actions now being taken	Assurance Rating Green
External:	Source: • 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	Evidence: Staff survey results TMA feedback from the CQC CQC engagement meeting feedback	Assurance Rating Green

Gaps:

Actions

Date:	Actions:	Action Owner:	Progress	Status:
Sept 21	• Commissioning of Compassionate and Inclusive Leadership programme taking place	FMc	On track	Green
Sept 21	• Commissioning of Coaching for Managers programme taking place	FMc		
Nov 21	• Leadership for All conference taking place to embed collective leadership and LPT behaviours	FMc		

Risk No: 26	Equality, Leadership, Culture	Date Included on ORR	01.10.19		Consequence	Likelihood	Combined
Risk Title:	Insufficient staffing levels to meet capacity and demand and provide quality services			Current Risk	4	4	16
Director risk owner:	Director of HR & OD	Date Last Reviewed:	09.08.21	Residual Risk	4	3	12
Governance / Review:	SWC, QAC / Board - Monthly Review			Risk Appetite / Target Risk score			12

Controls

Description:

Descriptor – the central resourcing, supply, recruitment and retention of staff. See risk 4 for the operational staffing of services to keep patients safe.

- Recruitment action plan in place
- Service level workforce groups with action plans in place
- E rostering in place across inpatient services and community
- 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
- Proposal for super enhancing recruitment and attraction campaign and Bespoke plan for
- Significant Covid related recruitment activity taken place to support Surge capacity - Bring back staff/Retirees
- Home first - Aging well started / Community Service Redesign Aging well recruitment – integrated system website for nursing and therapy hubs
- Recruitment team moving to business as usual recruitment / Camhs Recruitment Plan

Gaps:

- Workforce Planning capacity
- Home first / Aging well
- National workforce nursing supply challenges
- Medical consultant capacity concerns in AMH/CAMHS
- All Age metal health investment standards has significant work recruitment expectation

Assurances

Internal:

Source:
- Three cohorts per year - nurse associate roles
- Degree nurse apprenticeship route
- HCA vacancy ambition
- Further development of other roles
- Reengineering of clinical roles
- SWC , Directorate Workforce groups , retention working group
- Workforce and Wellbeing Board
- Transformation committee
- Staff staffing report
- SUTG: Workforce Transformation Programme Plan
- Performance Report: Targets x 2 for sufficient staffing (Turnover and Vacancy)

Evidence:
- Progress reports to SWC
- Performance dashboard monthly
- Workforce reports monthly
- International Recruitment Plan
- HCSW recruitment plan
- SWC paper on internally recruitment progress

Assurance Rating Amber

External:

Source:
- National NHS people plan
- NHS retention support and benchmarking data
- Benchmarking reports
- LLR People Board

Evidence:
- Engagement with development of NHS people plan

Assurance Rating Green

Gaps:

Actions

Date:	Actions:	Action Owner:		Status:
Sept 21	Ageing well programme	CHS / HR	Progress ongoing, deadlines moved to September 2021	Amber
Sept 21	HCSW Recruitment Programme	Sarah Willis	Workforce group meeting to take forward	
Sept 21	International Recruitment	HR / Nursing	On going work progressing plans to supports workforce	
Sept 21	All age mental health investment standard workforce meetings	Asha day	Plans underway	
		HR / MH	Meeting to pull together plans and activity	

					Consequence	Likelihood	Combined
Risk No: 27	Equality, Leadership, Culture	Date Included on ORR	01.10.19				
Risk Title:	The health and well being of our staff is not maintained and improved			**Current Risk**	3	3	9
Director risk owner:	Director of HR & OD	Date Last Reviewed:	09.08.21	**Residual Risk**	3	2	6
Governance / Review:	SWC, QAC / Board - Monthly Review			**Risk Appetite / Target Risk**			6

Controls

Description:

- Occupational health service wellbeing strategy and implementation plan
- Workforce and wellbeing group
- Wellbeing calendar – including a range of wellbeing events - Wellbeing Wednesday launched
- Counselling service
- 1:1s, Supervision, Appraisals linked to Leadership Behaviours Framework (see action on risk 26)
- 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 Approach and bulletin launched
- Health and wellbeing champions / Virtual exercise classes / Wobble Rooms
- Staff Physiotherapy scheme
- MH first aid training
- Mindfulness programmes / Psychological support offer for staff
- Leadership Behaviours Framework
- Weekly OD bite size virtual sessions now underway
- NHS People Plan national support
- Daily Sickness absence monitoring
- All staff risk assessments in place supporting health and wellbeing - part of supervision and appraisal conversations
- System mental health HWB hub
- System level support for post incident psychological support for staff via HUB
- System wide virtual health and wellbeing week
- Mental health and Wellbeing Hub
- Triple R health and wellbeing plan on a page

Gaps: Embedding of National / Local People Plan and 6 step to recovery

Assurances

Internal:	• Monitoring sickness reports workforce reports • Sickness reviews within divisions • Wellbeing element of appraisal / Wellbeing conferences • Occupational health department / Staff reps / Amica • Risk assessments / stress indicator	Evidence: • Performance management report monthly • Staff side and management meetings monthly • SWC reports / Occupational Health annual report • Referrals to Amica • Review of hwb offer at strategic gold	Assurance Rating Green
External	Source: • NHSI reporting	Evidence: • NHSI benchmarking reports • Attendance at external NHSI wellbeing workshops	Assurance Rating Green

Gaps:

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Sept 21	• Review of progress against the health and wellbeing approach and action plan	Kathryn Burt	Progressing, deadline moved to September 2021	Amber
Sept 21	• Individual health and wellbeing process refreshed and launched	Kathryn Burt	Progressing guidance	

					Consequence	Likelihood	Combined
Risk No: 28	Access to Services	Date Included on ORR	01.10.19				
Risk Title:	Delayed access to assessment and treatment impacts on patient safety and outcomes			Current Risk	4	4	16
Director risk owner:	Divisional Directors / Medical Director	Date Last Reviewed:	13.08.21	Residual Risk	4	2	8
Governance / Review:	Waiting List and Harm Prevention Committee, FPC and QAC / Board - Monthly Review			Risk Appetite / Target Risk			8

Controls

Description:

- Access Policy
- Step up to Great MH transformation programme
- Strategic waiting times and harm review committee
- Covid Executive Team
- OPEL framework/daily escalation tool/calls in place
- System planning (design groups) established to manage patient flow and investment
- Business cases to address high risk areas / Outsourcing arrangements where appropriate (e.g. HEALIOS and St Andrew's)
- Revised performance report with narrative / Directorate level performance and accountability reviews in place
- Revised NHSI demand and capacity management training complete
- 21/22 priorities agreed and H1 and H2 plan in place
- EM demand and capacity modelling for MH
- Triple R programme in place / service recovery plans
- Covid sensitive trajectories for waiting time improvement of priority services – includes CYP ED as a prioritised service within FYPC

Gaps:

- Demand and capacity modelling in response to additional challenges resulting from Covid-19 / long Covid
- Outputs from joint LLR/Northants demand and capacity work including physical health
- Contract roll-over resulting in shortfall of funds to match growth of population / prevalence / demand
- Access Policy not fully implemented
- EM demand and capacity modelling limited to MH
- Triple R programme impact yet to be understood
- Still a level in variation between directorates in the approach safety of patients whilst waiting

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Directorate performance reports • Waiting time performance reported to Finance and Performance Committee monthly • Plan on a Page, recovery action cards and QIAs for each service • Spot checks of safety of patients waiting • Directorate risk management – including risk 4677 for CYP ED	• Performance management dashboard / dashboards to DMTs • Reports into waiting times and harm review group / QAC / FPC • Notes of the East Midlands Alliance are shared with the Exec Board meeting • Audit of twenty ND cases	Amber
External:	Source: • CQC inspection process • System performance monitoring • NHSI Regional Escalation oversight • National benchmarking data • Quality / Contract Monitoring with CCG & Specialised Commissioning with escalation route • LLR Transferring Care Safely Group/LPT engaged (acute/secondary provider feedback) • System-wide Clinical Forums for mental health, community services and children and young people.	Evidence: • Contract monitoring reports • Oversight reports to NHSEI • CQC Reports /focus groups	Amber

Gaps:

- Triangulation of evidence of harm with Trust wide data connecting incidents, SI's and complaints with people waiting
- CQC inspection
- Assurance on harm reduction and harm monitoring is limited

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Sept 21	Development of report to triangulate evidence of harm with Trust wide data from Patient Safety and Patient Experience	MH Partnership TW/ AK	East Midlands MH alliance working with NHSEI to develop MH capacity planning model – ongoing, deadline moved to Sept 21	Amber
Oct 21	Implementation of Access Policy	ASenior	ongoing	
Dec 21	Understanding the outputs of the demand and capacity modelling and feeding into the transformation programme	Director of MH	Agreed joint working approach between LLR and Northants system to undertake demand and capacity modelling	

					Consequence	Likelihood	Combined
Risk No: 35	Well Governed	Date Included on ORR	01.10.19	Current Risk	4	4	16
Risk Title:	The quality and availability of data reporting is not sufficiently mature to inform quality decision making			Residual Risk	4	3	12
Director risk owner:	Director of Finance & Performance	Date Last Reviewed:	06.08.21	Risk Appetite / Target Risk			12
Governance / Review:	FPC / Board - Monthly Review						

Controls	Description:	• Executive senior information risk officer (SIRO) sponsorship • Performance management framework (which includes the 6 dimensions of data quality) • Performance review meetings include Directorate level metrics • Data quality policy and procedure • Annual benchmark reporting against peers • Experienced subject matter experts in the corporate information team • National guidance • Electronic patient records (EPR) • Dedicated resource which supports Directorate reporting requirements • Ongoing work programme to improve ensure appropriate configuration of systems managed through the IM&T Committee
	Gaps:	• Incomplete data quality reports for local and national data sets; data quality framework being developed through Data Quality Committee • Insufficient monitoring of data quality incidents does not allow for learning opportunities • Configuration of systems to support requirements of information standards and NHS data models • Robust technical infrastructure to support timely and accessible use of data • Ownership of data quality across the Trust – being picked up with support of Change Champion attendance at Data Quality Committee

Assurances	Internal:	Source: • FPC / Trust Board • Clinical audit • Annual record keeping audit • Data security and protection toolkit self assessment • Regular oversight reports from the IM&T Committee • Data quality group included in updated Data Privacy TOR & alternate meetings focus on data quality.	Evidence: • DSPT 'standards met' annual submission made in June 2021 • Data quality actions will be reported to FPC via Data Privacy Committee highlight reports • Trust wide data quality group has agreed the data quality 21/22 work plan	Assurance Rating Amber
	External:	Source: • Internal audit programme for data quality and reporting • Internal audit review of our data security and protection toolkit (DSPT) • External Account (quality account indicators) Not undertaken for 19/20 or 20/21 • Commissioner scrutiny	Evidence: • Data quality framework 19/20 – Significant assurance rating over compliance with policy • DSPT 20/21 360 assurance audit – Significant assurance	Assurance Rating Green
	Gaps:	• Data quality group revised approach started in February 2021, not yet embedded actions in to services		

Actions	Date:	Actions:	Action Owner:	Progress:
	Feb 22	• Delivery of 21/22 data quality work plan, including trust wide ownership of data quality	SM	Ongoing
	Feb 22	• New data quality kite mark approach is being developed	SM	Ongoing
	Feb 22	• Review of system 1 data quality live issues in Data Quality Committee	SM	Discussion at 11/08/21 meeting

Status:
Assurance rating Amber

					Consequence	Likelihood	Combined
Risk No: 40	High Standards	Date Included on ORR	27.05.20				
Risk Title:	The ability of the Trust to deliver high quality care may be affected during a Coronavirus COVID-19 pandemic			Current Risk	5	2	10
Risk Owner:	Deputy Chief Executive Officer	Date Last Reviewed:	03/08/2021	Residual Risk	5	2	10
Governance / Review:	ICC / Strategic Exec Board / Board - Monthly			Risk Appetite / Target Risk			10

Controls

Description:

- NHS level 3 major incident led by COBR with national, regional and local resilience structures and policies
- COVID-19 Incident Mgt Team and Control Centre open 8 – 6 Monday to Friday, Weekends and Bank Holidays 9-5
- LPT Gold, Silver and Bronze chain of command with role specific cells to support the ICC
- ICC arrangements updated in readiness for third surge to ensure sustainability
- Policy controls and action cards for IPC, major incident, Flu pandemic, Brexit, mgt isolation and reporting / Agile home working policy / Occupational Health dedicated phone lines etc
- Participation in national and LLR health resilience forums
- Ongoing Webinars / Communications for COVID-19 both internally and externally
- Procurement hub with PPE planning and distribution, and systems and processes in place to respond to PPE shortages including mutual aid arrangements
- Established Covid surge and winter capacity in line with system requirements
- LLR and LPT established alert system to identify and respond to any local and Trust surges
- Exercise Rapid Response 3 - scenario planning exercise complete to set work programme for ICC
- Final step down proposals for redeployment with System Partners agreed
- UHL/LPT Hospital HUB in place / Workforce Bureau now operational
- COVID positive RED beds in place following surge actions complete
- Mass Vaccination Centre at Peepul Centre and two hospital hubs at Loughborough and Feilding Palmer hospitals are now operational

Gaps:

- Response to latest escalation level, hospitalisations and infection rates
- LPT Vaccination resource (Vaccination sites & FYPC Phase 3 delivery) impacting on the ability to staff non vaccination services (CHS) and each other

Assurances

Internal:	• Flash report by exception to Board • Covid vaccination programme board established • Communications structures to staff • Maintenance of the action, risk and decision log (ICC) • Daily National PPE SitReps • Daily national NHSE/I patient related SitRep also provided to the LLR system • Health Economy Tactical Coordinating Group (HETCG) SitRep (2 times a week) • Daily staffing SitRep • CEO sitrep • Revised COVID19 governance arrangements from 4 December 2020 • Finalise clinical and operational governance structure to provide oversight	Evidence: • Regular COVID staff briefing • Monthly risk report to level one committees • Situation Reports (SitReps) (CEO, Directorate, PPE etc) • Regular staff and stakeholder briefings • ICC decision log • Ongoing consideration of interim governance arrangements at Exec Team • Formalise duel COVID & Flu vaccination resource • ICC Clinical Leads to provide operational oversight of vaccination resource across LPT	Assurance Rating Green
External:	• Department of health / Public Health England / NHSEI / COBR / 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	Evidence: • Records of strategic gold coordinating group meetings • Records of health economy SCG and TCG • National intervention at the LLR Incident Management Team	Assurance Rating Green
Gaps:			

Date:	Actions:	Action Owner:	Progress: ongoing – deadlines moved to Sept to reflect ongoing work undertaken to mitigate	Status:
Sept 21	• Workforce Bureau interviewing & continuation of on-boarding staff c 500 for LLR Vaccination Bank	SW		Amber
Sept 21	• Review escalation levels in light of recent increases of system infection rates and system pressures	MP	Escalation levels continue to be reviewed weekly in line with government guidance	
Sept 21	• OPEL Level expansion and review to all operational directorates	MP	Revised OPEL Level definitions to be rolled out internally from mid-August	

Risk 52	High Standards / Equality, Leadership and Culture	Date Included on ORR	11.11.20		Consequence	Likelihood	Combined
Risk Title	Without sufficient student placement capacity, the health and social care system will have a shortfall in the availability of a qualified workforce			Current Risk	4	2	8
Director risk owner:	Director of Nursing, AHPs and Quality / Medical Director / Director of HR and OD	Date Last Reviewed:	11.08.21	Residual Risk	4	2	8
Governance / Review	SWC and QAC / Board - monthly review			Risk Appetite / Target			8

Controls	Description:	• Group placements, pathways and use of technology • Supervisors and assessors development training • Participation in clinical expansion programme for AHPs led by Health Education England • Regular LLR system wide groups including HEI partners • AHP clinical placement capacity project • Piloted new placement models and enhanced use of virtual placements. • Triple R programme – project 2 for enabling remote and digital placements • Provision of blended placement offers including pathway placement supervisors • Development programme re-starting		
	Gaps:			
Assurances	Internal:	Source: Clinical Reference Group Learning and OD Group Medical Education Group Multi Professional Education Team Annual QAC Chair attendance at SWC	Evidence: • Education and training weekly update to the CRG including figures • Multi professional education lead quarterly reports to Learning and OD Group • Weekly monitoring of Nursing and AHP placements at the Clinical Reference Group • Annual report to Trust Board • CRG and MEG reports to SWC • SWC highlight report to QAC / Board	Assurance Rating Green
	External:	Source: Health Education England Workforce Planning Groups LLR People Board LLR Placement Strategy Group Health Education England NMC / HCPC / GMC University of Leicester	Evidence: Nursing and AHP reporting Three times a year report to Health Education England Medical reporting to UoL and Health Education England LLR Placement Strategy Group reporting into LLR People Board Health Education England fortnightly placement call	Assurance Rating Amber
	Gaps:	• LLR wide robust system for capturing, monitoring and tracking of placements across multiple providers. • National directive around full time equivalent availability for students (currently opt in/out system for taking on students)		

Actions	Date: Sept 21	Actions Widening the range of remote mentoring for Private Voluntary and Independent sector	Action Owner: Elaine Curtin	Progress: Action ongoing – moved to Sept 21	Status: Green

Risk No: 54	Well Governed	Date Included on ORR	17.02.21		Consequence	Likelihood	Combined
Risk Title:	We are unable to deliver the LPT 2021/22 financial plan , LPT operational plans or LLR system plans.			Current Risk	5	3	15
Risk Owner:	Director of Finance & Performance	Date Last Reviewed:	06.08.21	Residual Risk	5	2	10
Governance / Review:	FPC / Board monthly			Risk Appetite / Target			6

Controls

Description:

- 2021/22 Quarter 1 & 2 financial arrangements rolled over from 2020/2021 quarter 4 arrangements
- 2021/22 Q3-4 financial planning will follow LPT & LLR system agreed process and governance
- LPT financial plan is part of the agreed LLR system 4 year financial strategy to deliver recurrent system breakeven by year 4
- System groups will lead the development of pathway plans , transformation proposals and flow of funds.
- System oversight will track organisational & system delivery of plans
- LPT Financial governance & control framework in place through SFIs with reporting to Audit Committee
- Transformation committee oversight of CIP & investment /transformation plans
- Operational oversight & management of cost forecasts through Directorate Management Teams
- Underlying cost run rate analysis feeds financial plans for LPT and LLR system
- Capital Management Committee's oversight of capital planning and agreed governance processes; Capital Financing strategy
- Treasury management policy , cash flow forecasting
- LPT operational plan will define priorities and inform financial, activity, workforce & performance plans
- H1 financial plan delivers breakeven position for LPT & LLR system
- H2 plan for LPT & LLR system relies on clarifying & addressing underlying deficit position of all organisations

Gaps:

- 2021/22 H2 planning guidance hasn't been published
- Uncertainty over ability to deliver workforce and spend assumptions for investment/transformation, particularly MHIS
- No long covid or post covid MH changes to demand are included in current plans
- System transformation work and design group outputs aren't feeding into organisational plans yet
- System wide approach to financial planning & in year management is new & untested
- Culture change required across system partners, particularly for UHL to move away from PBR funding model
- LLR capital strategy not yet clear
- 2021/22 Contracting arrangements beyond H1 not clear

Assurances

	Source:	Evidence:	Assurance Rating
Internal:	• Finance and Performance Committee report includes I & E, cash & capital reporting • Audit Committee • Capital management committee review & agreement of capital bids & development of capital plan & in year management • Transformation Committee oversight of CIPs, transformation & investments	• Formal I & E, cash & capital monitoring • Standing Financial instructions • Highlight report • Monthly Director of Finance report • Highlight report	Green
External:	• KPMG audit of 20/21 annual accounts and value for money conclusion • Internal Audit Plan 2020/21: Integrity of the General Ledger and Financial Reporting Q3/4; Financial Systems Q3/4 • ICS Finance committee with Executive & Non Executive leads from each NHS LLR organisation	• 2020/21 annual accounts unqualified opinion • Significant assurance IA opinions issued for financial systems 2020/21	Green
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Aug 21	Non recurrent activity backlog reserve bids submitted against system reserve	SM		Green
Sept 21	LPT Transformation committee oversight of H2 CIP, transformation & investment plans	SM	Regular reporting of H1 financial position and H2 plans to exec team, FPC , Trust Board & LLR forums	
Sept 21	Development of LPT long term plan to address underlying position	SM	In progress	
Oct 21	Finalise H2 operational & finance plans following planning guidance publication	SM		
Nov 21	Submit LLR & LPT H2 finance, activity, workforce & performance plans to NHSI	SM		

Risk No: 55	Well Governed	Date Included on ORR	07.04.21
Risk Title:	The Leicester/Leicestershire / Rutland system does not deliver the transformation needed to deliver a successful ICS		
Director risk owner:	Director of Strategy and Business Development	Date Last Reviewed:	11.08.21
Governance / Review:	Transformation Committee , FPC & Board		

	Consequence	Likelihood	Combined
Current Risk	4	2	8
Residual Risk	3	2	6
Risk Appetite / Target Risk			6

Controls

Description:

- A consistent agreed objective and system narrative that is used and tested in all system meetings, with all partners.
- System wide vision implemented and delivered
- Regular attendance at system meetings from senior LPT staff.
- Regular discussion and engagement with our Senior Leadership Team.
- Chief officers meeting fortnightly
- New collaborative ways of working demonstrated in transformed care pathways based on need and place

Gaps:

- Ensuring individual organisations maintain commitment to the agreed priorities for the ICS
- An agreed system risk share/approach
- Long term funding for the LLR Shared Care Record

Assurances

Internal:	Source: • Formal updates from system meetings to Executive meetings, Board sub-committees and Trust Board. • Regular discussion at executive meetings and with senior leaders. • Collaboratives for learning disabilities and mental health supported • Updated review of Director responsibilities and mapped to key stakeholders in the ICS	Evidence: • Minutes from Executive meetings, Board sub-committees, Trust Board and SLT meetings	Assurance Rating Green
External:	Source: • System assessment against the ICS maturity matrix • NHS E & I assessment of system maturity • System meetings and system performance dashboards • LLR Strategic Executive system meetings	Evidence: • Joint shared document of our system assessment • Agreed key priorities based on life courses • Summary of NHS E/I assessment of the system • Papers and minutes from system meetings • Joint meetings with Local Authorities to plan for the ICS in place in addition to system meetings	Assurance Rating Green

Gaps:

- No national blue-print
- The development of a successful ICS must involve wider stakeholders including local authorities and the voluntary and community sector

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
By Mar 22	• Agree draft MOU and system ways of working • Implement new ways of working to deliver an ICS from April 21 onwards, reviewing learning to inform future new ways of working • Deliver greater partnership working between organisations which enable the provider alliance concept to be tested.	CEO, DCEO, DoF, DoS, DoN & MD DCEO, Dir of MH & DoS	LPT is participating in system meetings and created a process for the internal development and review of the plan. Community & primary care, Mental Health and Learning Disability services provide opportunities for new ways of working	Green

Risk No: 56	High Standards	Date Included on ORR	05.05.21
Risk Title:	Delivery of service recovery and workforce restoration will not safeguard the health and wellbeing of our staff and service users		
Risk Owner:	Deputy Chief Executive Officer	Date Last Reviewed:	11.08.21
Governance / Review:	ICC / Strategic Exec Board / Board - Monthly		

	Consequence	Likelihood	Combined
Current Risk	5	3	15
Residual Risk	5	2	10
Risk Appetite / Target Risk			10

Controls

Description:

- LPT Operational Plan
- Service recovery model – 3R programme (reflect, reset and rebuild) approved plan
- Recovery programme Communications and Engagement plan
- Approval of time limited project manager support to deliver recovery projects
- 'Big Conversations' plan being delivered for staff consultation regarding recovery
- Recovery programme governance framework in place including the Covid Executive Group
- Staff Health and Wellbeing offer
- Big Conversations held, themes agreed.
- Triple R comms plan in four tiers
- Project 1 recovery programme - blended working principles and healthy working day guidance agreed

Gaps:

- Plans to address the impact of a surge in activity on wait times and staff resilience.
- Post covid surge on demand and the impact on staff capacity – this is modelled within the Directorates and the system is modelling based on national requirement.

Assurances

Internal:

Source:
- TripleR programme board and governance arrangements in place
- TripleR project groups set up and taking forward key deliverables
- Communications plan and structures
- Extra project management support sourced
- Staff health and well-being offer

Evidence:
- Minutes from TripleR meetings
- Plans on a Page for TripleR programme
- Plan on a page and project deliverables
- BIG conversation thematic review
- Health and well being communications

Assurance Rating Green

External:

Source:
- LLR system planning meetings
- Service user and carer forums

Evidence:
- BIG conversation with service users and carers
- System Operational Group minutes

Assurance Rating Green

Gaps:

- TripleR Programme Director gap from the end of June – recruitment commenced

Date:	Actions:	Owner:	Progress:	Status:
Sept 21	• Recruit PMO Programme Director	KB	Ongoing. Gemma Clayton Acting up to Head of PMO to support this gap.	Amber
Sept 21	• Each Directorate to develop activity plans to address backlogs that have increased during the pandemic. LLR funding available.	CO	Ongoing	

H

Leicestershire Partnership NHS Trust

Public Trust Board – 31st August 2021

Care Quality Commission Update Including Registration

The Trust continues to prioritise quality improvement, patient care and compliance with the Care Quality Commission (CQC) fundamental standards in all care delivery.

Purpose of the report

This report provides an update on CQC Well Led inspection, the quality surveillance tracker, details of foundations for great patient care meetings, quality accreditation and CQC focus groups.

Analysis of the issue

CQC Core and Well Led Inspection

On the 28th June, 5th and 6th July 2021 the CQC carried out a Well Led inspection of the trust. The inspection was well received and the trust was provided with positive feedback on being patient safety focused, values driven with good governance and leadership and having fostered partnership working.

The trust is expecting to receive the formal report containing full details of the results of the inspections in approximately 3 weeks around the 1st September 2021.

Quality Surveillance Tracker (QST)

The QST continues to capture emergent trust quality issues and intelligence to ensure there is oversight, grip and pace on improvement. Progress is monitored by the compliance team, a weekly report is provided to the trust board with highlighted concerns and successes.

Foundations for Great Patient Care

The Foundations for Great Patient Care meeting continues to meet on a weekly basis and throughout June and July 2021 have covered topics in relation to:

- Closed cultures
- Preparation for the well Led inspection
- Proposed new CQC strategy. Changes to inspection and what it may look like in practice.
- Duty of Candour
- Overview of the Well Led inspection, what went well and reflection
- The future of the Foundations for Great patient Care meeting and QST review
- Preparation for the forthcoming NHSE/I visit

I

Leicestershire Partnership NHS Trust

Public Trust Board 31 August 2021

Fit and Proper Person Self Declaration 2020/21

Purpose of the Report

The Care Quality Commission (CQC) introduced requirements regarding the 'Fit and Proper Person Tests' for Directors in November 2014, which became law from 1 April 2015. The Fit and Proper Person Test is a regulation to ensure that providers meet their obligations to only employ individuals who are fit for their role and to ensure that appropriate steps have been taken to ensure they are of good character, are physically and mentally fit, have the necessary qualifications, skills and experience for this role and can supply certain information (including a Disclosure and Barring Service (DBS) check and full employment history, if required.

At the time of establishing the LPT Fit and Proper Persons Register, the Board defined that there would be an annual self-declaration against compliance.

This self-declaration confirms our compliance with the Fit and Proper Persons Test for 2020/21.

Analysis of the issue

The Human Resource Department maintains the Trust's register to support compliance of the 'Fit and Proper Person Test'.

When recruited to posts that are subject to Fit and Proper Person checks, directors have had the Fit and Proper Person checks discharged in line with the LPT Recruitment and Selection and DBS policies. Those posts subject to the Fit and Proper Person checks include[1]

- All Executive and Operational Directors
- All non-executive Directors

As part of the recruitment process (and compliance for the Fit and Proper Person Test) for the defined staff group of directors appointed by LPT, a number of checks are undertaken.

These include

Checks on all individuals:

- Qualifications
- Competence, skills required, relevant experience and ability
- Good character
- Entitlement to work
- Identity
- Career History
- Consideration to the physical and mental health in line with the role and good occupational health practice

[1] https://www.cqc.org.uk/guidance-providers/regulations-enforcement/fit-proper-persons-directors

- Ensure, as far as possible the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether lawful of not) in the course of carrying on a regulated service; this includes any allegations of such
- DBS check.
  Only individuals who will be acting in a role that falls within the definition of a 'regulated activity' as defined by the Safeguarding Vulnerable Groups Act 2006 will be eligible for a check by the Disclosure and Barring Service (DBS)
- Review of Disqualified Directors Register (Companies House)
- Review Individual Insolvency Register (Gov.uk)
- Review of Insolvency Service Bankruptcy register
- Google search

In the period 1 April 2020 to 31st March 2021 two staff started where fit and proper person checks applied. Both have successfully passed relevant recruitment checks for fit and proper person requirements at the required level.

Four further staff started between 1st April 2021 and the date of this report, all have successfully passed relevant recruitment checks for fit and proper person requirements at the required level

Through appraisals each year (or through the Trust Policy on Supporting Performance), individuals are continually monitored to ensure that they meet the requirements to hold office of their appointment. Where they do not, action will be taken by the Chief Executive and / or Trust Chair or respective Director (and where appropriate consultation with the Remuneration Committee). For non-executive director appraisals, each contains a fit and proper person self-declaration for NHSEI.

The Chair has confirmed that of the 19 staff who fit and proper person checks apply to 17 have had an appraisal this year. The exceptions are two very recent new starters whose appraisals will take place for 2021/22.

Additionally, there are a number of ongoing checks relating to Fit and Proper Person that are repeated each year.

These are:

- Annual self-declaration process
- Review of Disqualified Directors Register (Companies House)
- Review Individual Insolvency Register (Gov.uk)
- Review of Insolvency Service Bankruptcy register
- Google search

These were refreshed as a cohort most recently on 19th October 2020. At this point in time refreshed checks relating to 13 staff who fit and proper person checks applied to. There were no issues with any of the staff checked.

(The other 6 staff have had these checks conducted after October 2020 as part of their recruitment as detailed above)

Where appropriate to their role, Directors have a Disclosure and Barring Service (DBS) check in place. The Trust is implementing a process whereby these checks will be refreshed as they approach 3 years of age, with Directors being required to enrol their new check in the DBS update service to maintain the check's currency.

As at the date of this report, 16 of the staff to who fit and proper person checks applied have a DBS check that is dated less than 3 years old, or are already in the update service. The DBS position of these staff is appropriate to their role.

3 members of staff whilst holding DBS at appropriate level, are currently in the process of having their DBS check updated.

As part of an annual cycle, Directors prior to the 31 August 2021 Trust Board meeting have been asked to update their compliance to the Fit and Proper Person Test by a further self-declaration prior to the Board meeting, thus a formal record will be held in the Board minutes and the register will be updated. Any Director with any information known to them which would not support their compliance should make this known to the Trust Chair prior to the meeting.

Decision required

To approve the position for 2020/21 that the Trust has discharged its requirements to meet Fit and Proper Person requirements for its Directors.

Governance table

For Board and Board Committees:	Trust Board 31 August 2021	
Paper sponsored by:	Cathy Ellis Trust Chair	
Paper authored by:	Dan Norbury, Head of Employment Services Kate Dyer, Deputy Director of Governance and Risk	
Date submitted:	23 August 2021	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	None	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	--	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Annual report.	
STEP up to GREAT strategic alignment*:	High **S**tandards	
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	Y
	Single Patient **R**ecord	
	Equality, Leadership, Culture	
	Access to Services	
	Trust Wide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	--
Is the decision required consistent with LPT's risk appetite:	Y	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed	
Equality considerations:	None	

J

Leicestershire Partnership NHS Trust

Public Trust Board Meeting

Step Up To Great Strategy a review of 2021/2 (Q1)

- This report provides a summary of the delivery of our Step Up To Great (SUTG) corporate strategy during the first quarter of the year 2021/22.

Purpose of the report

- This document provides a formal record of our achievements with our strategy within the first quarter of 2021/22. It is important to note that in early 2020 at the start of the COVID-19 pandemic the LPT Trust Board suspended our trust strategy and moved to "preserving life" as our key focus. Through this approach, combined with our incident management systems and ways of working we continued with elements of our SUTG strategy focusing on those where the implementation of them supported our preserving life focus.

Analysis of the issue

- LPT's strategy SUTG focus on 9 essential bricks that form the foundation for our values and our vision of "providing high quality, compassionate care and well-being for all."
- The attached slides note the progress of the delivery within each brick demonstrating that despite the continuation of the pandemic into 2021/22, considerable process has been made with the delivery of the trust strategy and transformation programmes.
- As we have remained in our major incident, this did result in us postponing some of the conversations we would have had with our stakeholders, service users and staff to revise our strategy for the new financial year. In July 2021, a new Trust Head of Strategy was appointed to commence the work required to engage with key stakeholders in order to refresh the Trust's strategy and the key timeline for this work is included within the full presentation.

Decision required

- That the board note the significant progress that has been made with the delivery of the strategy despite the COVID-19 pandemic.

Governance table

For Board and Board Committees:	Public Trust Board
Paper sponsored by:	David Williams (Director of Strategy and Business Development)
Paper authored by:	Samantha Wood, and SROs of each brick
Date submitted:	August 2021
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	None

If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning		
STEP up to GREAT strategic alignment*:	High **S**tandards	X
	Transformation	X
	Environments	X
	Patient Involvement	X
	Well **G**overned	X
	Single Patient **R**ecord	X
	Equality, Leadership, Culture	X
	Access to Services	X
	Trustwide Quality Improvement	X
Organisational Risk Register considerations:	List risk number and title of risk	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. Although link to many other risks, including our transformational change plans identified elsewhere.
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	Nothing has been identified	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed, this paper supports pathway & outcome improvement.	
Equality considerations:	This paper supports pathway & outcome improvement.	

Leicestershire Partnership NHS Trust

Step Up To Great Update

Trust Board
20 August 2021

WeAreLPT
compassion respect
integrity trust

www.leicspart.nhs.uk

Our Vision

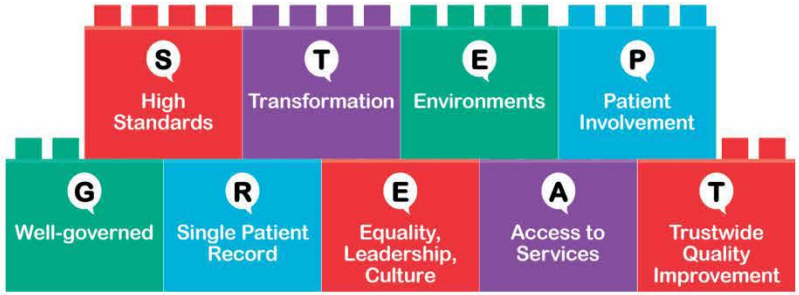
"Creating high quality, compassionate care and wellbeing for all"

Our Values

WeAreLPT
compassion respect
integrity trust

Our Strategy

STEP up to GREAT



Introduction

This report provides an update on progress with the Trust's Step up to Great (SUTG) strategy.

Due to the work to develop a refreshed Trust strategy and the significant impact of COVID-19 on the Trust's work, we focused this report on capturing;

- **how we have responded to the key delivery elements of "preserving life" during the COVID-19 major incident**
- **how the strategy refresh will pull through the priorities which require further time to deliver and embed.**

High Standards

Improve standards of safety and quality

Progress & Update

1. Priority continues to be on ensuring infection prevention control measures in response to COVID-19.
2. Weekly Clinical Reference Group being delivered to support clinical oversight of recovery and clinical decisions for the Incident Control Centre (ICC) and clinical leadership in ICC.
3. Hand hygiene audit improvement programme continue to be delivered- data reported via Quality Forum.
4. Workstreams for pressure ulcers, deteriorating patient adapted in light of COVID -19.
5. Falls programme working well and ongoing improvement to be embedded in business as usual governance frameworks.
6. Accreditation has recommenced with Ashby Ward, Aston Ward and Stewart House (mental health wards).
7. Audit Management and Tracking (AMaT) tool is in use for seclusion and is being reviewed to strengthen quality oversight of seclusion processes.
8. Weekly cross directorate virtual meetings continue to be delivered for 'Foundation for Great Patient Care' to enable focused discussion and development on ensuring the organisations meets the CQC standards. This meeting is currently being refreshed.
9. New workstreams have been set for 2021/22 in line with priority quality improvement areas in nutrition, self harm & ligatures and continence.

Transformation – Community Health Services (CHS)

Transform our community services

Transformation

Progress & Update

1. **Ageing Well** : Recruitment commenced to support 2 hour/2 day response with September start dates for posts. Baseline data to be established by September. Action plan revisited once baseline data established. Also by September we will have completed the mapping of clinical criteria for nursing and therapy and move to consistency of approach with partners.

2. **Community Services Redesign Phase 2** : Community Hospitals – CHS have agreed single bed base offer through system working group and Key Performance Indicators are being agreed.

3. **Integrated MSK Therapy Services :** On hold through COVID – this is part of our system recovery and reset and form a focus within the LLR design groups that drive the work of our system transformation work.

4. **Cardio Respiratory redesign :** Tele-health virtual ward offer plans being stepped up for Autumn for acute cardio respiratory patients to support step up and step down. Funding agreed and recruitment under way.

5. **Discharge :** Engagement with voluntary sector to support increase in people being discharged from hospital on what is known as “Pathway 0”. These are patients who are able to return to their usual place of residence (including care home). Patients on this discharge pathway are fully independent (require no additional support) or are able to restart their existing service. 2 care home beds have also been set up to support rehabilitation and return home for other patients. Community Home First triage of inpatient discharges, supporting UHL Discharge Collaboration to ensure an integrated triage offer. Dedicated ambulance to support pre 12.00 and 5.00 discharges from UHL to LPT community beds.

Transformation – Mental Health (MH)

Transform our mental health services

Transformation

Progress & Update

1. Created a new Mental Health Urgent Care Hub for all ages at the Bradgate site to stream individuals away from the Emergency Department and create a space for assessment and support in a physical environment

2. Created a new Central Access Point (CAP) for mental health and learning disabilities to provide 24/7 direct access for members of the public, service users and professionals. This allows people to refer for urgent triage, signposting and, if required, leads to further assessment and treatment. The CAP also includes a new centralised triage of non-urgent adult mental health referrals (predominantly coming from GPs) to better support people into the right support first time.

3. Step up to Great Mental Health - Transformation programme public consultation launched and ran for 3 months closing August 15th. Over 60 public events including wide range of groups BAME/faith groups/approx. 4000 individual inputs to consultation. The Commissioning Support Unit will deliver the LLR independent summary of the consultation in October. Work streams underway and delivering on core aspects re all 4 components of SUTG MH i.e;

    - Community/Planned Care
    - Urgent Care pathway
    - Therapeutic Improvement of Inpatient areas
    - Neighbourhood

Transformation – FYPC & LD

Transform our learning disability and autism services

Transformation

Progress & Update

1. Delivered provider collaborative model for regional Adult Eating Disorder Service - NHS England approval received for LPT to become the lead provider for the East Midlands Adult Eating Disorder Provider Collaborative that commenced on 1 April 2021 - collaborative is underway and governance arrangements currently being refined in partnership with Northamptonshire Healthcare Foundation Trust colleagues.

2. Transforming Care programme, 100% compliance of the Learning Disability Mortality Review (LeDeR) indicator, achievement of the annual health check indicator 29% reduction in inpatient numbers completed this year, benchmarked to 2014 data. A collaborative approach in place across Leicester Leicestershire and Rutland (LLR) from 1 April 21 – LLR Transforming Care Programme (TCP) delivery no longer in escalation with NHSEI. LeDeR, Annual Health Check, Inpatient trajectory and investment plans all now being manged by newly established LPT led multiagency TCP Collaborative.

3. Delivered the new Child and Adolescent Mental Health Service (CAMHS) inpatient unit - inpatient unit operationalised, continuous improvement programme in place overseen by Directorate, Enabling Services and Provider Collaborative's commissioning hub.

4. A 'LLR Learning Disability and Autism response service' has been mobilised. This service provides a multiagency process for agreeing any necessary interim care and support for individuals identified as high risk, in order to stabilise and reduce the risk - This was a particular focus of the LLR Learning Disability & Autism Covid SubCell and was established by the multiagency team. Now principle of Dynamic Support Register/Pathway has been adopted and if being implemented as part of admission avoidance work of the TCP Collaborative.

Environments

Environments will be welcoming, clean and safe

Progress & Update

1. **Estates Strategy –** We have focused Q1 on starting initial thinking on the revision of the long term strategic estates plan for LPT and work will continue on this to progress through Q2 and Q3. Plan will focus on supporting Clinical Strategies, SUTG, and supporting other key areas of focus such as finance, quality, workforce, finance and IT.

2. **Dormitory eradication –** Progressing with the conversion of dormitory rooms into single rooms across our Adult and older people mental health inpatient areas in order to improve the experience, privacy and dignity of our service users. This is moving forward well with one ward fully completed and a second to be completed in October. 8 wards feature within this scheme of work and early feedback from patients has been really positive.

3. **All Age Mental Health Inpatient Estate -** LPT funding has been approved for us to move forward with the development of the Outline Business Case (OBC) and we are working with clinical and operational teams to create an application for the 'New Hospital Programme' capital bid. The programme is estimated to require approximately £470m over 10 years. The priority for this scheme will be to replace old existing Bradgate wards as the age of the building and the internal technology and other infrastructure is becoming increasingly difficult to maintain.

Patient Involvement

Involve our patients, carers and families

Progress & Update

1. **Implementation of new Friends and Family Test (FFT) system and relaunch of FFT** : Q1 FFT priorities have been achieved with over 80% of all community-based services now collecting their FFT data via SMS and 100% of all inpatient services collecting their data via iPads. The Trust response rate is currently at 9% (500 responses) with an overall satisfaction rate of 83%. This is much higher than the improvement trajectory of 4% from a baseline position of 2% last year.

2. **Peoples Council :** Priorities have now been set for the People's Council and these are Step up to Great Mental Health; Equality Diversity and Inclusion and Personalisation of care. Monthly meetings with directors has commenced with Anne Scott attending the May meeting and Gordon King attending in July. The Trust board requirements have been agreed and signed off. 20 members at the time of writing report. but now doing a review of membership in light of agreed priorities.

3. **Patient Involvement :** Walk and Talk sessions have commenced and launch of '*QI in a box*' has taken place. Patient and Carer Leadership Programme has been moved to the Autumn to allow for face to face delivery following feedback from participants about preferences of modes of delivery. The aim of this is to develop a framework that will support people to move through the continuum of involvement right through to gaining paid employment where identified as an aim for the individual.

Well-governed

Be well-governed and sustainable

Progress & Update

Governance and Risk:

1. Annual Governance Statement compiled
2. Improved Head of Internal Audit Opinion
3. Established Group Governance Structure and agreed objectives for the joint governance programme
4. Embedded governance for Adult Eating Disorder Provider Collaborative
5. Completed effectiveness reviews for Board sub-committees
6. Continued to embed our new ways of working

Finance:

1. Continue to plan the long term financial strategy to ensure LPT contributes to the delivery of the LLR 4 year financial strategy.
2. The Trust's financial governance continues to operate according to our Standing Financial Instructions (SFIs).

Single Patient Record

Implement single patient record

Progress & Update

1. Data quality improvement groups established to develop and build new ways of working that increase the benefits from the connected IT system.

2. SystmOne Newsletter and comms are in place with: Monthly newsletter (previously launched) with key features, case studies, top tips and operational updates.

3. Monthly webchats – the first to be an open Question and Answer session with support from members of the workstream and Leicestershire Health Informatics Service.

4. A dedicated intranet section for directorate info around SystmOne

5. There is continued training available for users of SystmOne. These events are running throughout June and July.

6. Throughout the organisation we do also have a network of superusers and clinical champions who can provide informal support to their colleagues.

7. LPT is appointing a Medical Lead for the support of SystmOne based within the Mental Health Directorate, to support the improvement of the configuration and workflow within the system as part of the optimisation plan.

8. New Clinical Safety Officer in post.

9. Governance structure led by members of the DMH management and clinical leadership team and LPT data quality committee supporting the review of the benefit of SystmOne and the improvement in data quality.

Equality, leadership and culture

Improve culture, equality and inclusion

Equality, Leadership, Culture

Progress & Update

1. Review of Trans Employee, Reasonable Adjustment and Equal Opportunity Policies (due for adoption in October 2021)
2. Development of the Equality Diversity & Inclusion (EDI) Strategy 2021/25 (due for adoption September 2021)
3. EDI Workforce Group met on 26 May and highlight report produced. Some key actions centre on the need to review the recruitment and selection policy and practice through the lens of inclusion, including the approach to implementing diverse interview panels.
4. System wide reverse mentoring programme (lead by LPT's Head of EDI) has recruited 82 participants and is midway through a very well received initiative (due to conclude by December 2021)
5. System wide Cultural Intelligence Training being designed in partnership with the Midlands Academy
6. Race Equality and Cultural Intelligence Training continuing to be delivered through MS Teams.
7. Highly interactive Enact Drama based workshops run on Microagressions and Allyship (May 2021)
8. Compassionate Conversations: Understanding BAME communities run monthly.
9. Pride month celebrated with sessions run including external speaker on Trans equality (June 2021)
10. Interview skills training for BAME staff run (May 2021)
11. 2nd cohort We Nurture targeted programme for BAME staff started (June 2021)
12. Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) action plans in development and data reports compiled.
13. Provision of evidence at Leicester City Council's Scrutiny Committee on Black Lives Matter (June 2021)
14. Submission of NHSEI 6 high impact action plan response to the regional NHSEI team (June 2021).
15. Staff Network Meetings held across 7 networks including launch of new Womens Network.
16. Directorate level EDI Groups across CHS and AMH held during May and June 2021
17. FYPC anti-racism group meeting on a regular basis and developed action plan
18. Antiracism reading group established and meeting.

Access to services

Make it easy for people to access our services

Access to Services

Progress & Update

1. **Adults and Older People** – In Q1 the MH Central Access Point (Crisis Line) has, as a result of increasing its call handlers, reduced the time taken to answer calls which as a result has seen a dramatic improvement despite an overall increase in the number of calls being received. People receiving inpatient mental health care are also being supported to leave hospital much quicker with the service reaching the national average for length of stay. This has ensured availability of beds for patients most in need and improved overall access. The Trust has also maintained its position of not sending any adult mental health patient out of area due to bed capacity demonstrating a continuation of improved access within LLR.

2. **Children and Young People** – We have utilised MH Investment money in Q1 to focus on prevention in mental health of young people and have introduced schemes to take services out into the community. It is key that services are in more accessible locations such as schools and some examples of this are; the intensive community support team which is offering therapies to prevent crisis and reduce risk of admission as well as help reduce pressure on A&E. There have also been new initiatives in CAMHS Eating Disorders with the introduction of the home intervention treatment service. This looks to keep children safe whilst they are awaiting an inpatient admission. In Q2 onwards we are boosting MH Support Teams utilising external funding to increase to a wider geographical spread. The focus is on staff working in a greater number of schools to support children and young people with early onset mental health and to build emotional resilience to prevent more acute mental health problems.

3. **Remote Access to Care** - Continuation of review of digital patient appointment platforms underway through Triple R (Reflect, Reset and Rebuild) programme utilising feedback from front line and clinical staff as well as patients. Survey and telephone interviews underway to capture the feedback. Currently exploring four different platforms. Looking at the best platform that will support both 1-1 interactions as well as group therapies. Aiming for having an agreed platform in place by Autumn 2021.

Trust-wide quality improvement

Implement a trust-wide approach to quality improvement

Trustwide Quality Improvement

Progress & Update

1. Full Quality Improvement (QI) Change Programme established for Trust wide Quality Improvement and all 16 of the 360 Assurance Actions met. Signed off at Quality Assurance Committee.

2. Delivered pilot of QI training and rolled out across the trust with 12 month plan to January 2022. QI in a box series is now being rolled out 50 weeks a year and underpinned by NHSI QI Fundamentals. Full Quality Service Improvement and Redesign (SQIR) training on pause at NHFT although delivering QSIR lite.

3. 'LifeQI' system reporting 126 QI projects and ability to report on SUTG and Care Quality Commission (CQC) domains for LPT and Directorates. (Portfolio report enclosed evidencing SUTG and CQC Key Lines Of Enquiries and by directorate)

4. Clinical Audit and the National Institute for Health and Care Excellence (NICE) Quality Standards programmes strengthened by implementing into the Audit Management and Tracking System (AMaT) April 1st 2020 - March 31st 2022 - Underway

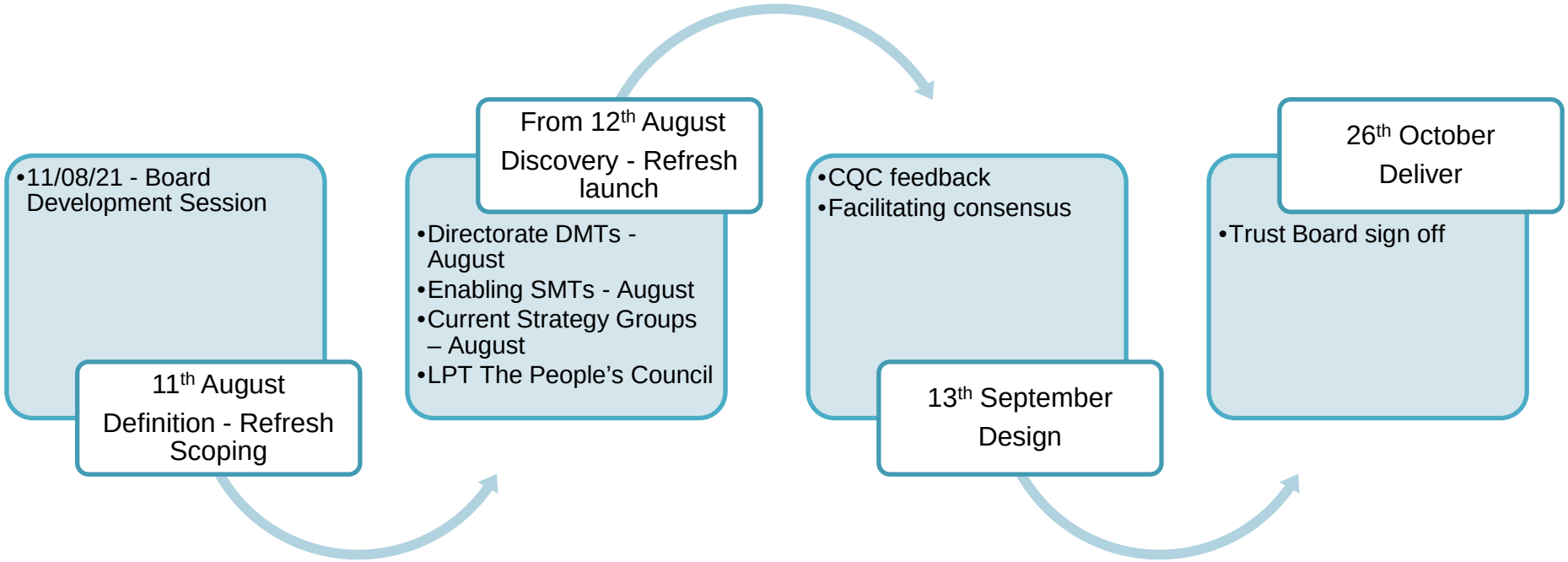
Priorities to carry forward will include…

Priority	
High Standards	• Co-creating personalised care plans • Reducing avoidable harm • Driving continuous improvements in patient outcomes.
Trustwide Quality Improvement	• Training and supporting staff in utilising QI knowledge • Continue to embed PDSA
Access to Services	• Capacity and demand modelling based on new blended ways of delivering patient contacts • Review access targets in partnership with commissioners • Data quality improvements • Service level performance dashboard implementation
High Standards	• Improvement in patient and carer satisfaction • Increase in patients actively involved in the care that they receive • Reduction in complaints from patients and carers in relation to standards of care • Reduced mortality rates • Compliance with IPC
Patient Involvement	• Delivery of patient experience and involvement strategy inc; • Increase in methods and spread across services of capturing patient and carer feedback • Accessibility of forms of communications
Equality, Leadership & Culture	• Delivery of the Trust's People Plan • Improvement in WRES standards • Phase 3 of Leadership and Culture Programme – Deliver Phase

Priorities to carry forward

Priority	
Transformation	• Mental Health – Delivery of Step Up To Great Mental Health • CHS – Delivery of Ageing Well, Alignment to ICS buckets • FYPC – Delivery against TCS, All age ED
Well Governed	• Financial sustainability plan • Stakeholder engagement • Delivery against ICS plan
Environment	• Development of a strategic estates plan • Continue delivery of elimination of dormitories programme • Business case for the reprovision of adult and mental health inpatient estate
Single EPR	• Continuous improvement of the single EPR including improved communication between primary and secondary care

Timeline for Strategy Refresh



WeAreLPT
compassion respect
integrity trust

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Leicestershire Partnership NHS Trust

East Midlands Alliance for Mental Health and Learning Disabilities

Trust Board Update 31st August 2021

- This report is a regular update on the activities of the East Midlands Alliance for Mental Health and Learning Disabilities and highlights areas for discussion to the executive team.
- The Alliance is the group of six NHS Mental Health and Learning Disability providers including independent provider St Andrews Healthcare, who provide services to our population in the East Midlands.
- The following key areas were progressed within the Alliance during June:
    - Demand and capacity modelling for mental health.
    - New Care Models.
    - Alliance governance arrangements.
    - Veterans High Intensity Service.
    - Research and innovation opportunities with the Police Academic Group.

Analysis of the issue

Demand and capacity modelling for mental health –*LPT Lead: Gordon King.*

- The East Midlands Mental Health and Learning Disabilities Alliance demand and capacity model supports the Alliance and individual providers with strategic service planning.
- NHFT will host this model on behalf of the Alliance from July 2021.

- **CAMHS & AED East Midlands Provider Collaborative Summary:** The CAMHS & AED East Midlands Provider Collaborative went live on 1 April 2021 as planned. Key progress since the previous Alliance Board**:** Medium term funding has been secured for CAMHS and NHFT is working closely with NHSE, providers from the collaborative and local commissioners to implement Community Intensive Support Teams across the collaborative footprint. This funding will help support transformation for children and young people across the East Midlands. The successful bid put forward by the lead provider has been welcomed by the provider collaborative and a programme of work established to deliver this new service. The Single Point of Referral established is working well and providing invaluable commissioning data, contract meetings have taken place with all providers with the commissioning hub. An Operations forum has been set up where all service leads from across the collaborative meet, share learning, ideas and seek solutions from their peers. This group will also help shape the specification for the Community Intensive Support Teams.

- **Adult Eating Disorders (AED):** The AED procurement of an additional 15 beds within the East Midlands has started, LPT lead this area of work and are working with NHS England on it.

- **Veterans High Intensity Service (HIS):** It was reported that the HIS continues to grow, develop and deliver as a partnership collaborative across the Midlands region, including the development of the operational model, sharing best practice and the caseload.
- Four case-studies were shared with the Alliance Board to show how the work undertaken across the partnership has evolved. The cases illustrate the value the HIS is adding to existing services.

They also show the positive difference the service makes to the lives, safety and rehabilitation prospects of its clients. This can include support for carers also.

- Some common themes in terms of success and challenges were that multiagency and partnership working with existing services and partner organisations is key to success. Examples of where this works well, limitations and gaps (such as access to information or differ opening hours) were also highlighted. The cases studies also give an indication of the workload involved in providing the service.

East Midlands Alliance, widening understanding

- **Development sessions:** The focus of the Alliance development sessions will be on sharing collaborative information across the East Midlands so that non-executive directors of the members are aware of the work of the alliance and help shape its development

Research & Innovation: East Midlands Police Academic group – *LPT Lead: Gordon King.*

- A workshop explored the different service models between local police forces and health providers in place across the East Midlands and looked at: Planned investments, improvements, successes, challenges and any further joint work opportunities.
- Service models in Leicestershire, Lincolnshire, Nottinghamshire, Northamptonshire and Derbyshire were shared.
- Areas of common interest were identified as: earlier support in the community, intensive support for vulnerable groups, access hubs and closer working with emergency pathways.
- Some areas of common provision found were: mental health triage / street cars, crisis cafes and crisis houses and the successful role played by them in reducing avoidable admissions.
- Common challenges faced included: fully resourcing these highly skilled roles, responding to surges in demand due to the pandemic and understanding the wider impact on the system regarding how we measure what these joint service developments prevent. Other challenges identified regarded response times and inconsistency in approach across points of contact. Difficulties in accessing mental health support, clarity on where people can get support, the significant level of preventable admissions, response time service levels and the high pressure on both Criminal Justice and Emergency Department pathways were also highlighted.

Proposal

- This report is offered by way of an update on the work of the East Midlands Alliance for Mental Health and Learning Disabilities.

Decision required

- That Board accept the update as an accurate reflection of the Alliance work.

Governance table

For Board and Board Committees:	Public Trust Board	
Paper sponsored by:	David Williams	
Paper authored by:	Amanda Johnston	
Date submitted:	17th August 2021	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	SEB 2nd July 2021	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Assured	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Regular	
STEP up to GREAT strategic alignment*:	High **S**tandards	x
	Transformation	x
	Environments	x
	Patient Involvement	
	Well **G**overned	x
	Single Patient **R**ecord	
	Equality, Leadership, Culture	
	Access to Services	x
	Trust wide Quality Improvement	x
Organisational Risk Register considerations:	List risk number and title of risk	all
Is the decision required consistent with LPT's risk appetite:	Y	
False and misleading information (FOMI) considerations:	NA	
Positive confirmation that the content does not risk the safety of patients or the public	Y	
Equality considerations:	NA	

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Leicestershire Partnership NHS Trust

QUALITY ASSURANCE COMMITTEE – 27th July 2021

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 Nursing, AHPs & Quality Report - Paper C	H	M	NHSEI next visit is 18th August. No new covid outbreaks since April. Nosocomial data continues to be monitored. The flu high level action plan is being developed and there will be a co-delivery with flu and covid boosters. The Beaumont Ward final summit held at the end of June continued to find no unsafe areas. There is a challenge emerging around the completion of SI investigations – due to the increase in SIs. This is being monitored through the Incident Oversight Group. Mill Lodge Quality Summit took place on 26th July - nothing to suggest that the unit is not safe. The committee received split high/medium assurance from the report due to good progress made but the need to wait and see how things progress remains.	1, 2, 3, 4, 5, 40, 52
Medical Director Update – Verbal	NA		There are significant national pressures in the medical workforce – particularly in CAMHS. Mitigation includes long term locums and exploring other mitigations details of which will be covered in more detail in future meetings. Research and development continues especially around covid, with LPT working closely with NHFT on this. Medical Examiner System – work continues to establish and develop this system.	1, 2, 3, 4, 5, 40, 52
Director of HR Update - Paper D	High		Deep dive was recently conducted into ILS & BLS training at executive team. More training capacity has been created but staff being able to attend training continues to be a problem. E learning cannot be used for this training. Work continues on improving this compliance. No	24, 25, 26, 27

Report	Assurance level*	Committee escalation	ORR Risk Reference
		current bottle necks identified. The People Board has recently looked at priorities and they have concluded that business intelligence and work force planning needs to be more robust - this is on the forward work plan.	
Performance Report - Quality and Workforce Measures - Paper E	Medium	Action plans around deteriorating data are in place for all deteriorating data areas - plans on a page also in use and improvements are being monitored closely. The vacancy rate is 12.2% and SWC look at dashboards to analyse hot spots at each meeting. Agency costs have grown considerably over the last few months and conversations are ongoing with the Finance Team to focus on this matter as we move out of the pandemic.	All
Provider Collaborative Report - Paper F	Medium	Report provides assurance up to the Board and escalate any risks the committee need to be sighted on. Single point of referral has been established meaning that there is now a single waiting list. The risk register is established and there are weekly meetings held to review this. Quality oversight has now been agreed and an independent patient safety quality group has been established. There are two further groups that have been established – the Clinical Escalation Group looking at areas of escalation and the Risk and Clinical Activity Panel looking at waiting lists. The committee agreed medium assurance from the report due to its infancy.	55
Safeguarding bi-monthly Report - Paper G	Medium	Section 42 agenda (inpatient) – work has been undertaken to strengthen the response and LPT have piloted a project to help identify positive learning Trust wide – this has been shared across the system. Community section 42 process is now aligned to the patient safety team and is a well-established process. High numbers around safeguarding matters continue and the pressures on the team remain – the risk on the register has been updated due to the capacity issues in the team and the continued increase in demand and review of the accessibility to the safeguarding helpline is currently underway. The committee agreed medium assurance from the report due to the ongoing pressures within the teams.	1, 2
Pressure Ulcer Report – Paper H	High	Deep dive due to the increase in numbers of pressure ulcers particularly category 4's. There has been a slight increase in inpatient but the cause for concern is within the community setting. This is likely due to the pandemic – a	1, 3

Report	Assurance level*	Committee escalation	ORR Risk Reference
		period where only essential visits and interventions took place, Patients were less mobile, and therefore at greater risk of developing pressure damage. The pandemic has affected our numbers but they remain below our trajectory. A QI programme is in place including a number of different work streams. 3 key areas to support this are holistic care planning, collaborative conversations and patient information – these will have key focus as are known to reduce pressure ulcers. The committee asked that a pressure Ulcer Update Report to be brought to each QAC meeting due to concerns around this matter.	
Deteriorating Patient Audit Update – Verbal	NA	Audit conducted by 360 Assurance – 5 key areas highlighted without robust plans in place - Policy & guidance, training, compliance, monitoring and governance. Audit also considered sepsis. Work has been carried out in community services around identifying deteriorating patients and clear sepsis pathways are in place for community staff. Further work around the policies and guidance needed to bring it all together in one place. Trust wide work on early warning scoring systems is ongoing. The sepsis package will be relaunched, sepsis awareness month is September. Deteriorating Patient Update Report to be brought to each QAC meeting until QAC are assured in this area.	
Nurses & AHPs Revalidation Annual Update - Paper I	High	100% of staff completed their annual registration April 2020-March 2021. 11 nurses lapsed their registration and did not re-validate. 99% of AHPs revalidated.	4
Medical Revalidation Annual Update - Paper J	High	Re-validation based on appraisal system. At the beginning of the pandemic appraisals and revalidations postponed – now back in operation. Delays in appraisals are being monitored and are under control.	4
Discussion Paper and Proposal for Deep Dive on Violence and Aggression – Paper K	NA	Proposal paper is here to ensure that the paper meets QAC's requirements in a further deep dive. It will be a Trust-wide paper, a multi-team approach and will be a comprehensive deep dive in order to capture the essence. QAC approved the proposal in the paper.	1, 3
Safe and Effective Staffing 6 Monthly Review	H / M	The last 2 reports were paused due to the pandemic. In December 2020 NHSIE published key work force needs and supply and how to embed risk assessment for ongoing planning.	1, 4

Report	Assurance level*	Committee escalation	ORR Risk Reference
- Paper L		LPT has responded well to these key work force needs despite the pandemic. Still plan to recruit 30 international nurses this year. The planned staffing levels have been achieved across the Trust. Temporary staffing utilisation has increased but LPT have a regular unified bank to support quality and continuity. Split high medium assurance is received from the report due to the ongoing recruitment challenges.	
Guardian for Safer Working Hours Quarterly Report Q1 - Paper M	High	There has been 1 exception in this quarter – mitigation detailed in the report.	1, 4
Organisational Risk Register - Paper N	High	12 risks with QAC oversight – all updated this month. No new risks or closure of risks proposed this month. Proposal to reduce the risk score for two of the risks this month.	All
Strategic Workforce Committee Highlight Report 1st June 2021 - Paper O	High	International recruitment was paused at the point of this meeting – but the pause has now been lifted and the original timescales remain. In response to NHSI's recommendations around compassionate approaches to disciplinary process the disciplinary policy has been reviewed.	1, 4
Health and Safety Highlight Report 8th July 2021 - Paper P	High	No red areas for escalation. 6 ambers areas – 2 key areas – security and lone working – and mandatory training for health and safety related topics – committee to note these items.	1, 3, 7
Legislative Committee Highlight Report 9th June 2021 - Paper Q	Medium	Refocusing on the mental health act and mental capacity act. Some ambers throughout the report – the pandemic and SystmOne contributed to this. Improvements are expected within the August report. QAC requested that the further detail around the census data be included in the next highlight report to QAC.	1
Safeguarding Committee Highlight Report 9th June 2021 - Paper R	High	Concerns around training compliance – improvements seen and improvement is ongoing with level 1 and 2 training. Significant improvement work ongoing with the Beacon unit. All policies are in date – Allegations Policy to be reviewed shortly. CHS oversight of safeguarding issues – good grip and oversight of issues.	1, 2
Quality Forum Highlight Report – 10th June 2021 – Paper Si 8th July 2021 - Paper Sii	High	Busy committee, good attendance and engagement. Escalations – SIs – progress being made – closing down of notifications on Ulysese remains an issue. Transporting patients in handcuffs – being discussed further as this is not something that LPT have historically done. Seclusion practice and language used on forms –	1, 3

Report	Assurance level*	Committee escalation	ORR Risk Reference
		reflects some of the feedback received from the CQC – development work flagged up in the committee.	
Annual Review of Committee including ToR - Paper T	NA	Committee has fulfilled its TOR during the covid period, membership has quorate and coped with in year changes well and strategic oversight has been successful. TOR changes were agreed.	NA

Chair	Moira Ingham

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Leicestershire Partnership NHS Trust

Public Trust Board 31 August 2021

Patient and Carer Experience and Involvement (PCEI) Quarterly Report (including Complaints) Quarter 1, 2021/22

Purpose of the report

- To provide an overview and update of the various aspects of the Patient Experience and Involvement teams work.
- To provide an overview and update on the complaints activity for quarter 4.
- To provide assurance to the Quality forum.

Analysis of the issue

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

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

- Frequent Feedback – comments, enquiries and concerns
- NHS Choices Feedback
- Friends and Family Test (FFT)
- Complaints
- Compliments
- Patient Surveys
- Patient Engagement and Involvement

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

Complaints and Patient Advice and Liaison Service [PALS]

Overview

In quarter 1, the Trust formally registered 54 complaints in total, which is an increase compared to 33 registered in the same period last year and 51 in the previous quarter. 12 complainants got back in touch to raise outstanding concerns compared to 7 in the same period last year.

During quarter 4 of last year, the Trust made a carefully considered decision in light of the ongoing pressures on the services as a result of the Covid-19 pandemic, to extend its investigation timeframes from 25 working days to 45 working days or a date agreed with the complainant. This extension has continued into quarter 1 of 2021/2022 and the Complaints Team have continued to work with anyone wishing to raise concerns to try and seek informal resolution in the first instance and, where this was not possible, their concerns were formally registered.

Due to the extension of investigation timeframes for complaints, we have noted that there are a majority of complaints logged in the first quarter, which are still under investigation and are therefore being carried into the next quarter's figures. Quarter 1 has also seen an increase in multi-agency complaints, however, we are aware that all agencies do not have the same timeframes as LPT and therefore the management of these complaints requires good communication amongst all parties involved, to ensure we get our responses to complainants, without unnecessary delays.

There has also been a significant increase in re-opened complaints during quarter 1, which has been reviewed by the Senior Complaints Officer and is being monitored for any trends, however, we are in regular weekly contact with each directorate to ensure they can bring any pressing issues to our attention and we can provide responses to any concerns they may have.

Complaints Activity Data – April 2021 – June 2021

Key Performance Indicator	Q1 21/22	Q4 20/21
% of complaints acknowledged within three working days	94%	94%
% of complaints responded to within the date agreed with the complainant	100%	58%
Number of complaints upheld or partly upheld in quarter	7	7
Number of reopened complaints	12	7
Number of complaints formally investigated by the PHSO	0	0
Number of complaints upheld or partly upheld by the PHSO	0	0

The Complaints Team are continuing their pilot of front end Ulysses with the Directorate of Mental Health and those with current front end access, can view their directorates' complaints, view their directorate data in graph form and add notes/communications to each complaint. Our aim is to have all directorates providing updates throughout the investigation process via front end by the end of quarter 3, when a new Complaints and PALS Manager is in post. A view of front end Ulysses has been provided to all three directorates and the general consensus is that the system will make not only the complaints process run more efficiently but also provide the data needed for risk and clinical governance reporting in a more user friendly way.

The Complaints Review Group, under the new leadership of Dr Anne Scott, Director of Nursing, Quality and AHP's met during the quarter. The group has reviewed and updated their terms of reference to ensure that there is clinical oversight of complaints within directorates through the Heads/Deputy Heads of Nursing. There is now also attendance by pharmacy to ensure oversight from a prescribing perspective.

Recruitment to the new Complaints and PALS Manger role commenced in the quarter. The new role is a clinical role and aims to provide a higher clinical oversight in the triaging and management of concerns and complaints. The role has been advertised as a 12 month secondment in the first instance to test the approach.
In the quarter 51 complaints were dealt with as informal concerns, this equates to 50% of all contacts that came through the to the complaints team.

The number of PALS contacts received in Q1 were 200, this is an 8% increase on the numbers received in Q4 (166), however the number of concerns, comments and enquiries received is line with the number received in Q3 (153).

The key themes for concerns and complaints received in the quarter were in relation to Communications (59); Access to services and appointments (46); Discharge from services (26) and Failure to provide adequate care (26).

The highest number of concerns and complaints received was within Adult Mental Health Directorate at 103. The main service area where concerns were received within this directorate related to Community Mental Health Services, this is consistent with Q4 for 2020/21 and focused on, ADHD Service (8) and Community Mental Health Teams (46). The number of concerns and complaints in relation to inpatient wards remained the same as Q4 with 19 but there was a small reduction in the numbers received in relation to the Central Access down to 9 from 13.

Community Health Services Directorate received 56 concerns and complaints which is a rise of 57% compared to Q4 but is similar to those seen in Q3 (57). Main service areas where concerns and complaints were raised within the directorate related to Community District Nursing Services (18) which is similar to Q4 and 16 concerns and complaints in relation to inpatient wards.

For Families, Children, Young People and Learning Disabilities the total number of concerns received was 71 which like CHS is an increase of 49% compared to Q4. 20 concerns related to CAMHS Services, both community services (18) and inpatient and crisis services (4), medical paediatrics also saw a large increase in both concerns and complaints with 14 received in the quarter.

12 concerns were received were in relation to Quality and Professional Practice with a breakdown of 9 concerns received in relation to the PALS Team and 2 in relation to Covid 19 and 1 relating to patient safety.

5 MP enquiries were received in the quarter.

The increase in the number of concerns and complaints could be attributed to the continued removal of Covid 19 restrictions. This will be monitored over the next two quarters.

During the quarter the PALS Team also managed 104 signposting requests. These included signposting to other local NHS services and support within primary and the acute care providers. 171 compliments were logged by services onto the Customer Service Platform; this is a similar number to those logged in Q4. Of those reported 101 related to Community Health Services, 24 from Families, Children and Young People's and Learning Disability Services and 44 from Mental Health Services and 2 for corporate services.

Activity data – 1 April 2021 – 30 June 2021

	PALS concerns	Complaints	Compliments
Number	188	54	171
Top 3 Themes	• Communications • Access to Services/Apps • Discharge	• Patient Care • Communications • Access to Service/Apps	• Staff Attitude • Customer Service • End of Life Care

Good news story

During the quarter 51 complaints were managed through the informal concerns process. This is 50% of all initial complaints that were received into the Trust. When a complaint or concern is received into the Team the first action taken is to speak with the complainant and to provide them with a range of options as to how their concerns can be managed. This approach continues to have a positive impact on the number of formal complaints that are managed informally which provide a quicker and less formal approach to responding to concerns and provides a better experience for the individual. All complainants are offered the option to progress their concerns through the complaints route is they are not satisfied with their informal concern response.

Keys areas of concern

Risks	Mitigations
Complaints Manager post currently vacant following the post holder leavening in June 2021. This reduced capacity in the team has meant that the Quality Improvement activities set out for Q1 have not been fully met.	• Review of the job role and requirements resulting in a new PALs and Complaints Manager Post • Offer of a 12 month secondment for the post advertised

Assurance

- The Complaints and PALS work reports into Quality Forum, Quality Assurance Committee and Trust board for assurance.

Friends and Family Test

Overview

The focus over Q1 has been on the collection FFT data using the new mandatory questions and response ratings. Services have agreed their preferred options on how they want to collect data e.g. SMS Text or using our iPads. In quarter 1 we have achieved the targets set out in the Quality Account:

- 40% of all community-based services implementing the new FFT system (80% achieved)
- 100% of all inpatient services implementing the new FFT system

The Trust achieved a response rate of 9% with a recommendation score of 83%.

As a result of the Trust receiving more responses using the SMS system this as resulted in a better balance of feedback where patients are reporting both positive and negative experiences. There is a good mix of both positive and negative feedback too, which again is different to the predominately positive feedback received using the previous approach of handing out cards. This has removed the bias and was agreed by the group provides services with much richer feedback which then can use as part of the 'you said, we did' when making improvements and acting on feedback.

The first FFT Newsletter has also been launched in the quarter. The newsletter provides information on tips and tools for services to use whilst reviewing their patient experience feedback which includes training and support.

.

FAQ's and drop in sessions have been established and are available to teams who may be interested in attending, these will cover an overview of the new system, how to extract and review data and will cover any questions that services may have.

Promotional posters have been distributed to all services both within the community and inpatient areas and include easy read posters.

Following feedback a review of the text message used within learning disabilities has been undertaken and changes have been made to ensure that this is now accessible for those service users with a learning disability.

Key Areas of concern

There are no key areas of concern for Friends and Family Test

Assurance

- The FFT Work reports into the Patient and Carer Experience Group, Quality Forum, Quality Assurance Committee and Trust board for assurance.

Patient and Carer Involvement

Overview

Patient and Carer Leaders have now been recruited to the membership of the Patient and Carer Experience Group and the EDI Patient Experience and Involvement Group.

The first Walk and Talk involvement sessions took place in the quarter. This is an opportunity for a small numbers of the involvement network to come together for a walk and to talk about involvement opportunities as well as being an opportunity to have a face to face connection with each other. All walks comply with the current Covid 19 regulations and future walks are planned as lockdown restrictions are released.

Involvement in Quality Improvement

Work is progressing in relation to involving service users and carers in quality improvement projects. Using the Engagement Planning Toolkit and in partnership with a patient leader, projects are reviewed and matched with either insight or involvement opportunities/ resources. To date **50 projects** have some element of involvement or insight identified and matched. In addition to this, and to support staff in relation to involvement, a new QI for Involvement in a Box has been launched. The one hour session has been co-designed and is co-delivered with a service user and is available to staff either through bespoke delivery or booking through ULearn

Quality Improvement case study

Are stroke survivors adequately prepared for discharge? – a co-designed quality improvement project to inform service delivery

Introduction: Current research informs us that comprehensive discharge planning is important for successful transitions from hospital to home after stroke. However, many hospitals do not collect qualitative data informing them of patients/relative's experiences of the discharge process. A recent evaluation of the Stroke Association Connect service also noted that almost 1 in 5 people had a safety concern identified post discharge. These concerns mostly related to follow up plans, medication and managing at home.

The aim of this project was to work collaboratively with stroke survivors, families and the wider multi-disciplinary team to co-design a questionnaire identifying the right questions to ask stroke

survivors/families about their recent discharge experience. The data gathered will be used to facilitate a robust clinically focused review of services to enable improvements through service development**.**

Methodology: Quality Improvement methodology was used with the model for improvement running 2 main PDSA cycles. The first cycle centered on the co-design of a questionnaire with stroke survivors, families, and staff to identify the right questions to be asked. The second cycle centered on the implementation of the questionnaire, gathering important feedback about when to administer the questionnaire and how the questionnaire was to be delivered.

Results: These will be collected on a system call Envoy which is a database able to produce live reports. These reports will be formally shared on a quarterly basis to provide system-wide feedback across the whole stroke pathway.

Conclusion: It is anticipated that implementation of a co-designed questionnaire will increase both the quantity and quality of feedback received on patients/relative's discharge experiences which will provide qualitative data from which to inform service delivery.

Involvement in Adult Mental Health

Work during the quarter has been focused on supporting to Step up to Great Mental Health consultation. The consultation which runs from 24 May to 15 August 2021 is being led by the CCG with support from the Trust. The Trust is also using this consultation to sign up participants for future involvement work with this Trust.

A small group of service users have been recruited and trained to support the Transformation Team on Mental Health Practitioner roles to help with recruitment. This has involved creating interview questions as well as taking part in recruitment panels.

Introduction to Involvement sessions will be delivered through the Recovery College and will offer the opportunity for service users to sign up for involvement and take part in Recovery Cafes as part of their own recovery

Involvement in Community Health Services

The Single Point of Access Team (SPA) has made improvements to the telephone options following feedback from patients and carers. This has resulted in a reduction in the number options provided, making selection much easier for the caller**.**

The directorate held their first Equality Diversity and Inclusion group. The aim of the group is to increase Patient Experience and Involvement champions.

The NHSX (digital arm of NHSE) case study has been completed around Digital Pathways with a focus on staff voice and patient voice. This involves two empowering stories about care/reassurance during Covid. The completed case study has been published at national level. NHSX podcast to be published soon

Involvement in Families, Children and Young People and Learning Disabilities

CAMHS

Conversations with Leicester's LGBT centre continue, based on service user feedback a proposal for training provided by the centre is being developed.

Beacon
Patient Focus group session was held as part of a rolling 7 week cycle of sessions.

Asperger Diagnostic Service
Patient feedback survey created to support potential name change for current service. Survey created to understand the views of services users diagnosed with autism currently. Survey will be sent via SMS to inform of service re-name and preferred options choices. Feedback and engagement from wider community groups will also contribute to this decision.

Mental Health in Schools Team (MHST)
Engagement plan and YAB involvement with levels of MHST underway, meetings have taken place to support moving forward on the proposed levels of involvement and engagement of CYP across the programme. Youth Advisory Board to be part of wave 5 recruitment interviews.

0-19 Healthy Together
Leicestershire County Council has developed the public engagement on Health Together services via an online survey for service users, families and professionals. Surveys currently being developed for views from families on 2 years reviews and Attend Anywhere appointments are underway within the Healthy Together Team.

SEND Transitions
Leicester Carers centre support group feedback around transitions within LLR, transitions lead attended group session to discuss journey and pathways with parents/carers. Involvement opportunities shared with Leicester and Leicestershire SEND Parent/carer forums hubs.

Learning Disabilities Agnes Unit
Inpatients continue to work alongside community teams in establishing FFT format, to aid with patients understand of this questionnaire.

Agnes Unit will be participating in the Trust wide independent review of nutrition. This is currently being set up by Helen Walton following feedback on patient meals across LPT In-patient and UHL services.

Learning Disabilities QIP Update
Through the carer survey, we have recruited 5 new engagement partners who are on the Trust involvement register.

The LD Speech and language therapists have all been trained in the Easy read Training package which includes Widgit; the training will be cascaded to teams in June along with access to Widgit online. Licences have been sent to team admin staff.

Friends and Family Test: The LD hierarchy has been agreed, and 6 iPad Pilot sites have been identified. The iPad format of FFT has been designed based on what people with learning disability told us and questions prioritised by the senior leadership team. When the iPads are ready to use, there will be training for the pilot site staff. SMS has been paused temporarily whilst the S1 data integrity paused. We will be co-designing a FFT freepost returnable card with people with a learning disability.

Adult Eating Disorders
Envoy is now being used for inpatient and outpatient experience questionnaires.

Patients and carers have provided input to the Quality Network for Eating Disorders (QED) as part of our outpatient service accreditation process. We have sought involvement from past inpatients, day

patients and their families/carers to be part of a working party looking at models of care as part of the East Midlands Provider Collaborative and have had a great response

We have initiated a Carers newsletter for patients on Langley Ward and are seeking their involvement in suggesting topics for future issues

The annual report of patient experience on Langley Ward 2020/21 has been produced.

Patient involvement/experience projects proposed for June;
-ADOS service user questionnaire survey feedback
-Healthy Together surveys
-FYPC OT DCD Pathway digital workshop parent/carer involvement
-Rutland Disabled Youth Forum (return visit)

Good news story

Three projects were entered into this year's Patient Experience Network National Awards.

- LPT Mental Health and Wellbeing Workbook – Category - Support for Care Givers, family and friends
- Recovery and Collaborative Care Planning Cafés – Category – Strengthening the Foundation
- Youth Advisory Board – Category - Partnership working to improve the experience

Both the LPT Mental Health and Wellbeing Workbook and the Recovery and Collaborative Care Planning Cafes have been shortlisted in their categories for the awards which will take place in September 2021.

Key areas of concern

There are currently no key areas of concern in relation to Patient and Carer Involvement

Assurance

- The Patient and Carer Involvement work reports into the Patient and Carer Experience Group, Quality Forum, Quality Assurance Committee and Trust board for assurance.

The People's Council

Overview

The work of the Council continues at pace and includes:

- Agreement of the priorities for the Council for the year, these are Step up to Great Mental Health; Equality, Diversity and Inclusion and Personalisation of Care, the Council will also look at other things but these will be the key focus for the year.

- Agreement has been made with the Trust Board on a set of principles on how the Council will work with the Trust Board.

- Both vice-chairs have now been aligned to a Patient/Carer leader member of the Council to provide support and advice as needed.

- The first People's Council to the Trust Board has been produced. The item was as the beginning of the meeting alongside the patient story and discussion which has meant that

Trust Board meetings have a really strong focus on the patient/carer at the beginning of each meeting which is really powerful. Future reports will also include any risks to involvement which have been identified following a request from the Board members.

- Marking and branding collateral is being developed for the Council and includes a Twitter account - @lptcouncil and a Facebook account which is being developed.

- A training needs assessment is being undertaken with Council members to help create individual training and development plans.

LPT Youth Advisory Board (YAB)

YAB continue to meet virtually, each week on MS TEAMS.

Members of YAB offered opportunity to write content for LPT health websites and also to signpost local social media influencers to support promotion of site.

CAMHS OT leads attended a YAB session to seek views on a QI 'Play' project. This return to YAB follows on from involving the group last year in the initial stages of the project. Opportunity for YP to be further involved in the project outside of YAB and to be part of interviews for OT roles, dates offered to the group for June interviews to be involved.

Clare Stuart Modern Matron UHL joined YAB to discuss how UHL are working on making the children hospital wards more environmentally friendly. YP engaged with Clare around ideas that could be implemented to reduce the carbon footprint and gave suggestions for Clare to take forward within UHL. Clare will return to YAB in 2 months- time to report the changes and progression of this work.

2 YAB members continue to be part of the LPT Peoples council, feeding back into the YAB.

Good news story

YAB re-met with Digital content creator Alex Mantle. This follow up meeting with Alex showed the changes that have been made to social media Health for Teens posts after YAB shared ideas/suggestions.

A YAB member has written a short paragraph/article for the Health for Teens site and Public Health colleagues to promote vaccine confidence in YP, having had both Covid-19 vaccines.

Key Areas of concern

Risks	Mitigations
A number of members of the Council have stepped down due to other commitments. This will impact of the diversity of the Council members	• A review of current membership and recruitment campaign is planned by the Council leadership team and it is hoped that new members will be recruited through this process

Assurance

- The People's Council Work reports into the Patient and Carer Experience Group, Quality Forum, Quality Assurance Committee and Trust board for assurance.

Proposal

- The Trust Board is asked to be assured of the work of the Patient Experience and Involvement Team.
- All risks and mitigations have been set out within **key concerns.**

Decision required

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

Governance table

For Board and Board Committees:	Public Trust Board 31.8.21	
Paper sponsored by:	Anne Scott, Director of Nursing, AHPs and Quality	
Paper authored by:	Alison Kirk, Head of Patient Experience and Involvement	
Date submitted:	12 August 2021	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Quality Forum, 12th August 2021	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Assured	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	regular	
STEP up to GREAT strategic alignment*:	High **S**tandards	X
	Transformation	X
	Environments	
	Patient Involvement	X
	Well **G**overned	X
	Single Patient **R**ecord	
	Equality, Leadership, Culture	X
	Access to Services	
	Trust Wide Quality Improvement	X
Organisational Risk Register considerations:	List risk number and title of risk	N/A
Is the decision required consistent with LPT's risk appetite:	na	
False and misleading information (FOMI) considerations:	na	
Positive confirmation that the content does not risk the safety of patients or the public	yes	
Equality considerations:	considered	

Appendix 1 – Quarter 1 Complaints Breakdown

Complaints Activity for Q1 – 1 April – 30 June 2021

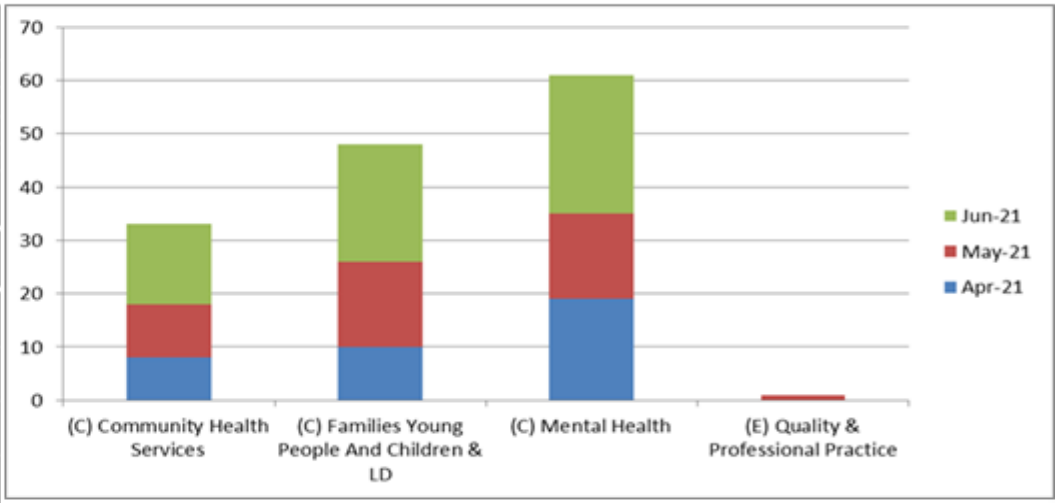
	Apr 2021	May 2021	Jun 2021	Total Q1	Total 21/22
Mental Health Service	5	3	14	22	22
Community Health Services	5	7	8	20	20
Families, Young People and Children & LD	2	5	5	12	12
Total Received	**12**	**15**	**27**	**54**	**54**
Complaints vs Patient Activity (Complaints Rate as a %)*	0.02	0.02	0.05	0.05	0.05
% of complaints acknowledged within three working days	83	100	100	94	94
Number of complaints responded to within the date agreed with the complainant****	6	6	1	13	13
Number of complaints responded to in 45 working days	6	6	1	13	13
Number of complaints responded to in a date agreed with the complainant	3	0	0	3	3
Number under investigation at the end of the Quarter	3	9	26	38	38
% of complaints responded to within the date agreed with the complainant ****	100	100	100	100	100
Number of complaints upheld or partly upheld in quarter	2	5	0	7	7
Number of complaints ongoing after 3 months**	3	3	3	3	3
Number of complaints ongoing after 6 months***	0	0	0	0	0
Number of reopened complaints	3	9	3	12	12
Number of complaints formally investigated by the PHSO	0	0	0	0	0
Number of complaints upheld or partly upheld by the PHSO	0	0	0	0	0

*Patients attended and seen

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

***Complaints ongoing after 6 months at the end of Q1. These do not include those complaints

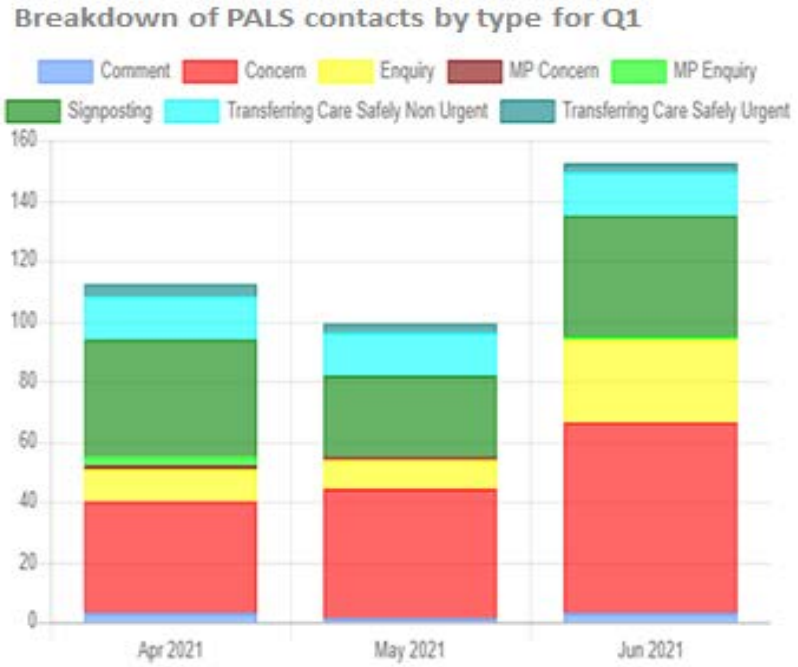
Complaints by Directorate for Quarter 1



Complaints Received by Top 10 Primary Categories (Quarter)

Complaints and PALS received by Service area:

		Complaints	Concerns
Directorate of Adult Mental Health	ADHD Service	0	8
	CMHT's City	1	18
	CMHT's County	7	20
	Crisis Resolution Team	2	3
	Central Access Point	1	8
	Mental Health Triage	2	0
	Assertive Outreach	1	1
	DMH Management Team	0	0
	Place of Safety	0	0
	Perinatal Mental Health	0	0
	Inpatient Wards	5	15
	Bradgate Outpatients	0	0
	Dynamic Psychology	0	0
	Forensic CMHT	0	0
	Francis Dixon Lodge	0	1
	CBT	1	0
	Memory Service East	1	1
	Mental Health Liaison	0	1
	Mental Health Urgent Care	0	3
	Mill Lodge	0	1
	Pier	0	1
	MHSOP CMHT County	1	0
Community Health Services	District Nursing – City	3	8
	District Nursing – County	1	4
	District Nursing – Wards	2	0
	Community Therapies	2	2
	Community Integrated Neurology	0	2
	SPA	2	1
	SALT – Adult	1	0
	Heart Failure Team	1	0
	Phlebotomy	1	0
	MSK Physiotherapy (LH)	0	1
	Podiatry	0	5
	Falls Service	0	1
	Continence	0	3
	Inpatient Wards	7	9
Families, Children and Young People and Learning Disabilities	CAMHS – City	0	1
	CAMHS Beacon	0	2
	CAMHS – County	4	13
	CAMHS Crisis	0	2
	Children's Therapies	0	2
	FYPC Area 1	1	0
	Healthy Together Administration	0	3
	Nutrition and Dietetics	0	2
	FYPC Blaby	0	3
	FYPC Oadby and Wigston	0	2
	FYPC Harborough	0	1
	FYPC Hinckley and Bosworth	0	2
	FYPC North West Leicestershire	1	2
	FYPC Melton, Rutland & Harborough	0	1
	FYPC South Charnwood	0	1
	Health Visiting for additional needs	1	0
	LD Psychiatry	1	0
	Pod 2	0	1
	Primary mental health team	0	1
	School immunisations	0	1
	Paediatrics Medical Servicing	2	12
	Paediatrics Admin	0	1
	Paediatrics Phlebotomy	0	1
	SALT – Children's	2	3
	Langley Ward	0	1
	Audiology	0	1
Corporate and Enabling	Quality and professional practice	0	12
	Covid 19	0	2
	PALS	0	9
	Patient Safety	0	1



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FFT Responses – April – June 2021

Response and Ratings by Directorate

	Response Rate	Positive	Negative
Directorate of Mental Health	7%	58%	28%
Community Health Services	9%	89%	5%
Families, Children, Young People & Learning Disabilities	5%	83%	11%

8%
Response Rate

Positive: 82.81%
Negative: 9.70%
Ratings

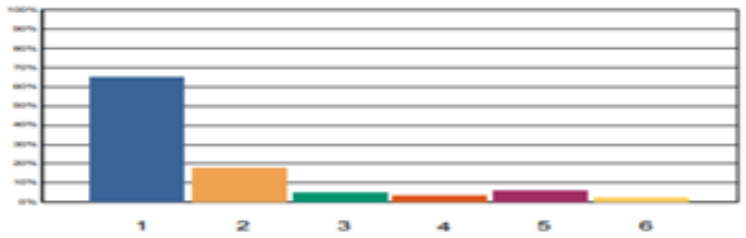
Top 10 Themes

+ Positive		− Negative	
1. Staff attitude	1748	1. Staff attitude	336
2. Implementation of care	1251	2. Implementation of care	272
3. Environment	755	3. Communication	260
4. Communication	606	4. Environment	258
5. Patient Mood/Feeling	519	5. Patient Mood/Feeling	180
6. Clinical Treatment	414	6. Clinical Treatment	179
7. Waiting time	235	7. Waiting time	144
8. Admission	193	8. Admission	78
9. Staffing levels	70	9. Staffing levels	35
10. Catering	61	10. Catering	14

Top 10 Words

+ Positive		− Negative	
1. Good	777	1. Help	122
2. Service	463	2. Call	82
3. Staff	406	3. Time	79
4. Helpful	316	4. Waiting	74
5. Care	290	5. Service	71
6. Excellent	252	6. Phone	71
7. Received	246	7. Feel	63
8. Friendly	232	8. Appointment	62
9. Time	214	9. Care	60
10. Professional	165	10. Face	57

Overall Scores



Response Option	Responses	Percentage
1 - Very good	3,688	64.80%
2 - Good	1,025	18.01%
3 - Neither good nor poor	302	5.31%
4 - Poor	199	3.50%
5 - Very poor	353	6.20%
6 - Don't know	124	2.18%

Breakdown

No Gender Breakdown Available

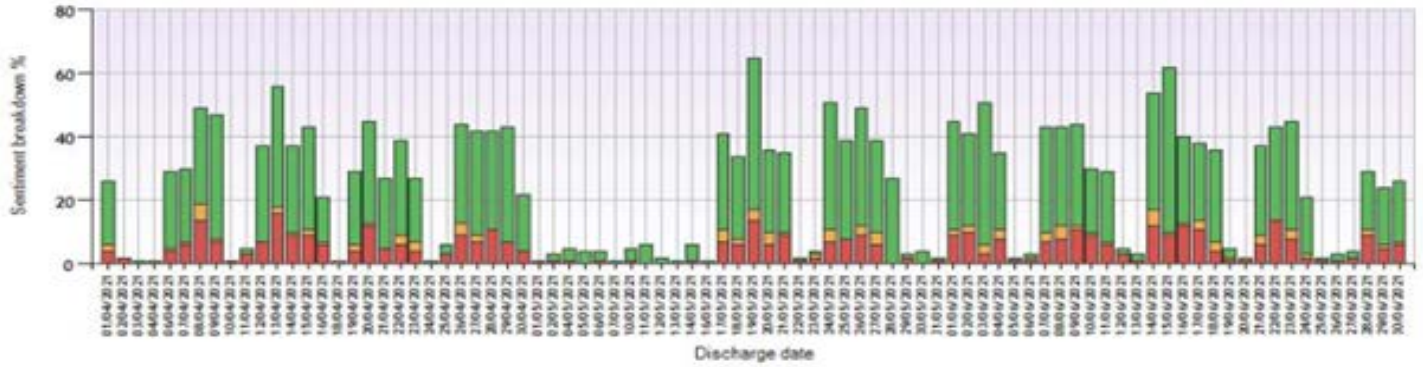
Total Responses
5691

FFT Sentiment Analysis – all Services April – June 2021

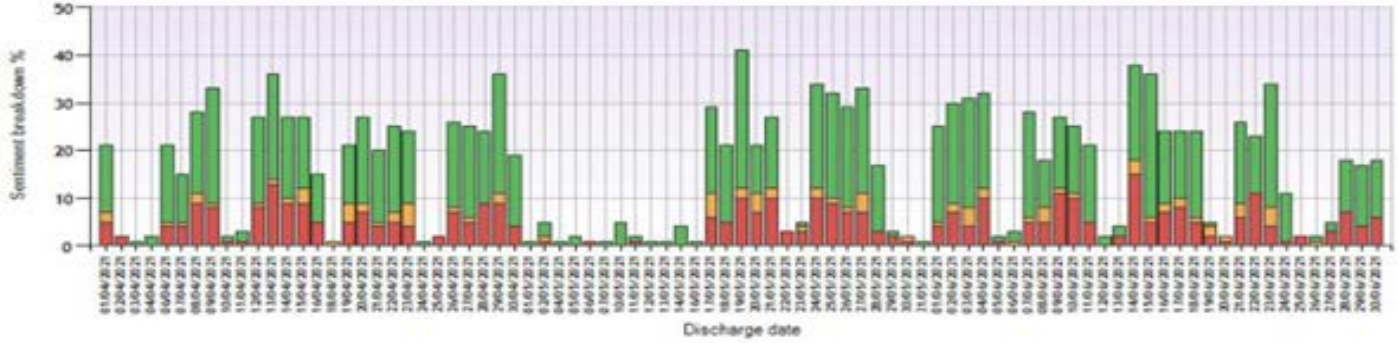
Legend

- Positive
- Neutral
- Negative

Staff Attitude



Implementation of Care



Compliments Received May – July 2021

Compliments by Directorate	
Directorate of Mental Health	44
Community Health Services	101
Families, Young People, Children's & Learning Disabilities	24
Corporate	2

Compliment by theme	
Staff Attitude	43
Care and Treatment	63
Customer Service	20
End of Life Care	30
Communications	8
Other	7

Compliments received during the quarter

"Thankyou for all the help and support you have given me over the last few years. Your understanding and compassion is so lovely to receive and I wish that there was more people like you within the mental health service!"

"Thank you for being a brilliant therapist and restoring my faith in therapy. Best wishes."

"We would like to express our thanks for the care you have given at the end of his life. Your kindness and compassion helped us through our darkest days and we thank you so much."

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Leicestershire Partnership NHS Trust

Public Trust Board – 31st August 2021

Report title

Patient Safety Incident and Serious Incident Learning Assurance Report for June – July 2021

Purpose of the report

This document is presented to the Trust Board bi-monthly to provide assurance of the efficacy of the overall incident management and Duty of Candour compliance processes. Incident reporting supporting this paper has been reviewed to assure that systems of control continue to be robust, effective and reliable underlining our commitment to the continuous improvement of keeping patients and staff safe by incident and harm reduction.

The report also provides assurance around 'Being Open', numbers of serious incident (SI) investigations, the themes emerging from recently completed investigation action plans, a review of recent Ulysses incidents and associated lessons learned.

Analysis of the issue

The Corporate Patient Safety Team (CPST) continues to work to support the governance of patient safety improvement and early recognition of trending incidents across the trust to offer early insight for leaders and working closely with the Directorates.

The data presented in relation to incidents is considered in the specialist groups with the learning and actions required to improve patient care and staff engagement in the investigation process; the expectation is that they are owned and monitored through the directorate governance route.

As we continue recovery from Covid19, our management and compliance with NHS framework timescales of Serious Incident (SI) investigations continue to be challenging with variable compliance with the 60 working day deadline for submission to the CCG. Mainly due to investigations that are required to be resubmitted to satisfy closure, following feedback (both internal and CCG feedback) We are slowly progressing with planned changes to patient safety incident investigations with an improved focus on the quality of the reports and learning, working collaboratively with families/patients and our staff involved; less focussed on timescales. Timescale compliance of internal investigations of 40 days currently remains extended to 50 working days to assist teams in local learning and pandemic recovery and the increasing challenges of clinical workload and investigating.

CPST continue to work with directorates to recover and strengthen processes to improve the position. The timely closure and enactment of SI and internal action plans to close the investigation process continues to be challenging, particularly in the Directorate of Mental Health. However, the Directorates have embraced ownership and are working hard to improve. The backlog position continues to be monitored and scrutinised both internally and externally with robust oversight of the specific risk detailed on the ORR and local monitoring processes regularly reporting into local and Trust wide groups.

Analysis of Patient Safety Incidents reported

Appendix 1 contains all of the Statistical Process Control (SPC) charts utilising the NHSI Toolkit that are shared to support the narrative and analysis below and local speciality incident information. We

have now included the overall position of all investigations and action plans previously unreported through the bi-monthly board report.

All incidents reported across LPT in June and July 2021

In the Patient Safety arena, incident reporting is not seen as a good single indicator of safety in the clinical environments, however, these can provide an early indication of incident change in specialities or trust-wide. Our incident reporting remains consistent with timely upload to the national reporting and learning system (NRLS), which, over the next 18 months, is in a period of transition to a more robust and advanced database system allowing for improved and quicker identification of national/regional trends in themes, earlier national escalation and eventually learning.

Review of Patient Safety Related Incidents

Pressure Ulcers - Patients affected by pressure ulcers developed whilst in LPT care

There continues to be an inconsistent trend in the trajectory and the impact on patients with category 4 Pressure Ulcers; this is also mirrored in category 2 pressure ulcers which showed a sharp decline in June 2021 from May 2021; however, there has been an upward trajectory in July 2021.

We continue to share the reporting of category 3 pressure ulcers that have developed in LPT care as this is the focus for preventative care planning to understand why pressure ulcers then further deteriorate to category 4 for our patients in our care.

Within the category 4 pressure ulcer domain, we saw a downward trajectory in June 2021, however, July 2021 has seen similar numbers for this time in July 2020.

All inpatient acquired category 4 pressure ulcers are reported as SI's and both the Executive Director of Nursing and the CQC are notified; there were none reported for June/July 2021.

Falls

Across the Trust, we noted an increase in the number of falls reported in June 2021,returning to a lower trend in July 2021, as seen in summer 2020. The falls group continue to meet and monitor all falls and the CPST support this work, offering additional scrutiny with increased focus on work promoting the importance of accuracy with falls risk assessment to inform and proactively manage the required nursing and therapy intervention in the clinical area.

We are now noting continued success with early recognition of gaps in care and learning form the bespoke reporting of falls with harm. These are some of the most serious incidents affecting our patients in both physical injury and requirements of additional unplanned NHS care as a result; many never returning to their pre-fall wellbeing. We continue to share the bespoke 72hr falls with harm report that has proved to be successful and promoting transparency with the CCG, CQC and reporting to the Trust Executive team through a new bulletin approach.

LPT Falls Steering group have been working across the directorates to improve the safe management of patients who are at risk of falling.

Initiatives include:

- Promoting learning culture by supporting directorates to improve the scrutiny of incidents at ward level
- Implementation of patient centred interventions and utilisation of learning to improve practice
- Utilising available data to undertake deep dive on inpatient sites, e.g. mapping times and location of falls to inform service improvement
- Rolling out use of 'Flat lifting' equipment to enable staff to safely raise people, who have fallen, off the floor and thus reducing the risk of exacerbating any injury

- Development of a clinical reasoning tool to support safe management of people who are at risk falling out of bed. The 'Safe Bed Management tool' supports sound decision making around use of bed rails, low beds or increased supervision.
- Electronic Patient Record processes related to falls risk assessment and management of falls are being reviewed to ensure they are user friendly to support staff compliance with policy
- Planning event to develop role of Falls Champions across all inpatient and community adult teams

All Self- Harm including Patient Suicide

We have seen a significant increase in all self-harm incidents resulting in moderate harm and above in July 2021 along with an overall increase in patient death, considered to be due to suicide. Community mental health access services continue to report increasing numbers of patients in crisis who have allegedly self-harmed many who, are then are escalated into acute care.

Self-harm reporting continues to demonstrate that it can fluctuate depending on individual patients and their individual risk profile. These incidents range from very low harm to multiple attempts by inpatients during individual shifts posing significant challenge to staff to keep them safe and supported. CPST continues supporting individual specialities, CAMHS & LD inpatients and recently added Belvoir and Low Secure services to understand triggers by sharing incident details including information such as time of day, area, method of self-harm.

Violence, Assault and Aggression (VAA)

There continues to be high numbers of VAA across the Trust. These incidents have increased sharply during June 2021 for incidents of moderate harm and above; some have these have been escalated to an SI and staff injury. This category of incident features in all mental health, CAMHS inpatient and all learning disabilities top 5 incidents. There has been a 'deep dive' to understand the nature, place, time of incidents and tools available to our staff to support them in managing these incidents. Our position is not unique as VAA have featured nationally across all aspects of the NHS in particular access services; LPT's challenge is to understand the patient's impact of mental health wellbeing and risk mitigations in place.

In addition the Health & Safety Committee will now also discuss the ongoing concerns in relation to VAA across LPT to facilitate partnership working. 360 Audit are planning an audit and the Terms of Reference are being considered. There are new National Standards and Health and Safety are carrying out a self assessment.

Medication incidents

Medication incidents are reviewed/managed locally, with the use of the BESS medication error tool (stored in Ulysses) to facilitate learning. A 'just' approach to supporting and managing staff following medication errors is well established; there is room for improvement in utilising the BESS Tool as part of the incident review & supporting staff. The CPST Lead Nurse has been involved with pharmacy colleagues in the review of the Trusts Medication Error Policy and also supporting easier incident reporting. Next steps in autumn 2021 is to explore supporting Band 6 and above clinical staff in improved reporting and management and learning from medication errors.

CPST are working with clinical and pharmacy colleagues to consider the system in relation to medication errors rather than the individual.

Directorate Incident Information

Appendix 1 details the top 5 reported Incidents for each Directorate speciality illustrating the level of diversity. Violence and Aggression has been reported in the top 5 reported incidents across Mental Health, CAMHS and Learning Disability specialities, which demonstrates some of the challenges that the clinical teams continue to face across the Trust as they interact and deliver care to our patients.

Infection control has featured for CHS in relation to spike in Covid19 infections amongst the staff in line with national reporting.

Queries Raised by Commissioners / Coroner / CQC on SI Reports Submitted

The CQC has continued to request update to information relating to some 72hr reports for newly notified SI's, completed SI reports and action plans along with evidence.

New provider collaboratives plan to share processes over the next quarter.

Learning Lessons and Action Plan Themes

The learning lessons exchange group is working together as a community of practice to achieve true sharing of learning, the membership has also been extended to roles where patient safety improvement work takes place. Learning will often mean the need for a system change rather than individual change and these groups is learning together to spread and implement this thinking along with sharing what already exists at foundation of great care. System thinking and Human factors are naturally 'Just'. The group recently looked at the transferrable learning from both the Ockenden Review and the Cumberledge.

These were particularly

- Teams learning and training together
- Investing resource in analysing data
- Culture-psychological safety of speaking up

This is also supported with a common goal for excellence at the Foundations of Great Care group,

The key learning themes from SI's:-

This continues to highlight the following recurrent themes which remain unchanged:

- Lack of risk assessment reviews and putting actions into place to reduce the identified risk remain an area across are a recurrent theme through multiple incident categories eg falls, self harm.
- Communication between and across teams of patients identified risks (hand over)
- Communication and understanding of common processes linked to this in speciality teams

Focussed themes and learning on Pressure Ulcers

Continued reporting of all community acquired category 4 pressure ulcers to StEIS was altered in November 2020 to being managed locally. This process is working well with significant improvement in duty of candour communication with patients/families, compliance and final information sharing. There has been an alteration to the verification and investigation template in collaboration with the CPST Lead Nurse and the teams involved to improve earlier learning/information. We are now undertaking a rigorous case review and short report for 4 out of 5 patients affected by category 4 pressure acquired in LPT care and a full investigation for every5th patient.

Learning and continued themes identified

Themes remain unchanged from previous board reports and the QI work has been re focussed to take a more pragmatic approach to the implementation of improvements.

Focused themes and learning themes from Pressure Ulcer category 4

- No individualised care plan
- Recognition and timely escalation for additional supporting pressure ulcer relieving equipment
- Lack of timely holistic patient assessments and updating
- Mental capacity assessments on initial admission to caseloads and when patient's conditions change featuring where 'patient compliance' has been described as a factor in ulcer development/decline.

Focused themes and learning from falls with harm

The key early learning from recent falls has been,

- Selection of appropriate interventions in relation to low beds/bed rails and crash mats **Action** total bed management protocol in final stages
- 1:1 supervision of patients at risk of falls- staff are sometimes called away **Action** guidance to be developed to allow permission for the staff to not leave the patients side

The group continue to work on

1. **Reassessment of Patients who Fall** - Consider reassessing a patient who has fallen, even if they did not incur harm, 24 hours after their initial fall to check for delayed pain or change of condition.
2. **Nursing observation intervention** – not being adhered to or not assessed correctly/timely when there are patient changes
3. **Huddles - Post Fall Huddles** should be carried out as soon as able following a patient fall and as part of the wider team discussion. There continues to be one pilot area in acute mental health. MHSOP is demonstrating continued sustained improvement along with a focus on improvement from matrons/ward managers in these areas and early escalation into CPST for falls with concern for harm. However inconsistent adherence/embedding to falls huddles remains a challenging across all areas.

Culture of Candour

We consider this as a as a key driver for cultural change with all incidents under the principles of 'Being Open and Duty of Candour' (Culture of Candour) to raise the profile of saying 'sorry' to patients and families when care or services have fallen below expected standards with or without harm. This is not only a national requirement, but the right thing to do for our patients and families.

During June and July 2021 we noted continued improvement across all directorates in the timeliness and quality of letters/communication with our patients and families. There has been an acceptance and embracing of a positive change in practice with less reliance on investigators in cases of SI's/internal investigations. The continued Trust Board support for final duty of candour communication to be undertaken by directors of services has also seen a sustained and positive change for our patients, their families and our staff. This is significant and continues to allow our investigators to focus on describing investigation and inclusion in the process, rather than having to undertake duty of candour. We are seeing a positive change with letters that are well written, demonstrating kindness, compassion, apology (saying sorry) and need for learning from incidents for both final and initial culture of candour letters.

Incident Review & Investigation Process

The CPST continue to facilitate the weekly incident review meeting process that is shared with all three directorate governance teams and other key stakeholders which was extended to LLR CCG in June 2021. We continue to promote the inclusion of medical colleagues in this process.

In mid May 2021 the CPST Lead Nurse introduced a short training session for all band 6 and above clinical staff to promote the importance of initial incident reviews and the need for quality to better inform decision making for next steps investigation. This training support has been well received and continues at least monthly along with bespoke sessions for individual teams.

We are seeing more team leaders presenting their incidents, sharing post incident learning and participating in the decision making for next steps for investigation.

Incident Oversight and action plans post investigation

The incident oversight group continues to monitor the completion of serious incident reports and action plans; there continues to be challenges faced by all directorates in relation to compliance and timely completion. Whilst progress is slow all teams are committed to improving ; the information is shared in the appendices.

There continues to be regular sustained commitment from the CPST in supporting the teams to address and embed this change in ensuring robust oversight of action plans and completion with a member of the team designated to undertake this.

Learning from Deaths (LfD) - Progress update

There continues to be progress within the directorates in relation to managing the learning from deaths process.

- Q 1 there were a 121 deaths.
- During this period there were a total of 16 deaths which are linked to Serious Incident Investigation.
- There were 12 adult deaths of individuals with Learning Disabilities which are undergoing LeDer review, and are to be reviewed using the mSJR case record review within FYPC.

We have successfully recruited to Governance and Quality Assurance Coordinator role for Learning from Deaths team; who should commence towards the end of October. Work is underway to standardise family feedback through bereavement letters or personalised phone calls, to do this we have set up a bereavement support inbox to learn and improve from feedback given by families. DMH/MHSOP has identified a number of themes which contribute to the deaths of patients which include: (1) Social Circumstance, (2) Chronic physical and mental health problems, and (3) Self-harm. These are now included in our updated theming as well as being embedded in the LfD Quality and Safety review forms.

Suicide Prevention – Progress updates include:

- **Supporting staff after patient suicide:** continues to be rolled out across the disciplines in developing a simple model for supporting staff after death by suicide of patients they have cared for.
- System-wide Suicide Prevention training for staff across the disciplines continues to be actively explored and developed
- Development work has completed in FYPC/LD for the introduction of clinical pathways to provide consistent guidance on managing non-fixed ligatures and patients at risk from this self-harm. Assurance around training and embedding of these principles will be reviewed over the next couple of months.
- The launch of armed forces veterans 'buddy support' happened in June 2021 which is ever important following the sharing of the national report in relation to UK Armed Forces from The King's Centre for Military Health Research (KCMHR) that has found that more than two thirds (68%) of UK military personnel continue to misuse alcohol at levels that are hazardous to their health and wellbeing.
- STORM Training/Suicide Awareness, Prevention and Postvention has been well received in June 2021 as positive step forward for staff training and is planned for the future across the mental health specialities.

CPST update: new NHS Patient Safety Strategy

Outline of the short and medium term implications:

1. Just culture

2. National Patient Safety Alerts
3. Improving quality of incident reporting
4. Support transition from NRLS and StEIS to PSIMS
5. Involvement in implementing the new Patient Safety Incident Response Framework (PSIRF)
6. Implementation of the Framework for Involving Patients in Patient Safety
7. Patient safety education and training
8. National patient safety improvement programmes
9. COVID-19 recovery planning.

Serious Incident Investigators

The designated Patient Safety Incident Investigators have been recruited and are due to start at the beginning of September. This is a new and exciting step forward for investigating our most serious incidents and supporting patients, families and staff in developing our future approach to investigations.

Decision required

- Review and confirm that the content and presentation of the report provides assurance around all levels and categories of incidents and proportionality of response.
- Be assured systems and processes are in place to ensure effective investigations are undertaken that identify appropriate learning.
- To enable sighting of the senior Trust team of emerging themes through incident reporting and patient safety improvements

Governance table

For Board and Board Committees:	Public Trust Board 31.8.21	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Sue Arnold, Jo Nicholls, Tracy Ward (Corporate Patient Safety Team)	
Date submitted:	19/08/2021	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	PSIG-Learning from deaths-Incident oversight	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Assurance of the individual work streams are monitored through the governance structure	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Bi Monthly	
STEP up to GREAT strategic alignment*:	High **S**tandards	X
	Transformation	
	Environments	

	Patient Involvement	
	Well **G**overned	X
	Single Patient **R**ecord	
	Equality, Leadership, Culture	
	Access to Services	
	Trust Wide Quality Improvement	x
Organisational Risk Register considerations:	List risk number and title of risk	1 – There is a risk that the Trust's systems and processes and management of patients may not be sufficiently effective and robust to provide harm free care on every occasion that the Trust provides care to a patient. 3-- There is a risk that the Trust does not demonstrate learning from incidents and events and does not effectively share that learning across the whole organisation.
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:		
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:		

Appendix 1

The following slides show Statistical Process Charts of incidents that have been reported by our staff during June and July 2021

Any detail that requires further clarity please contact the Corporate Patient Safety Team

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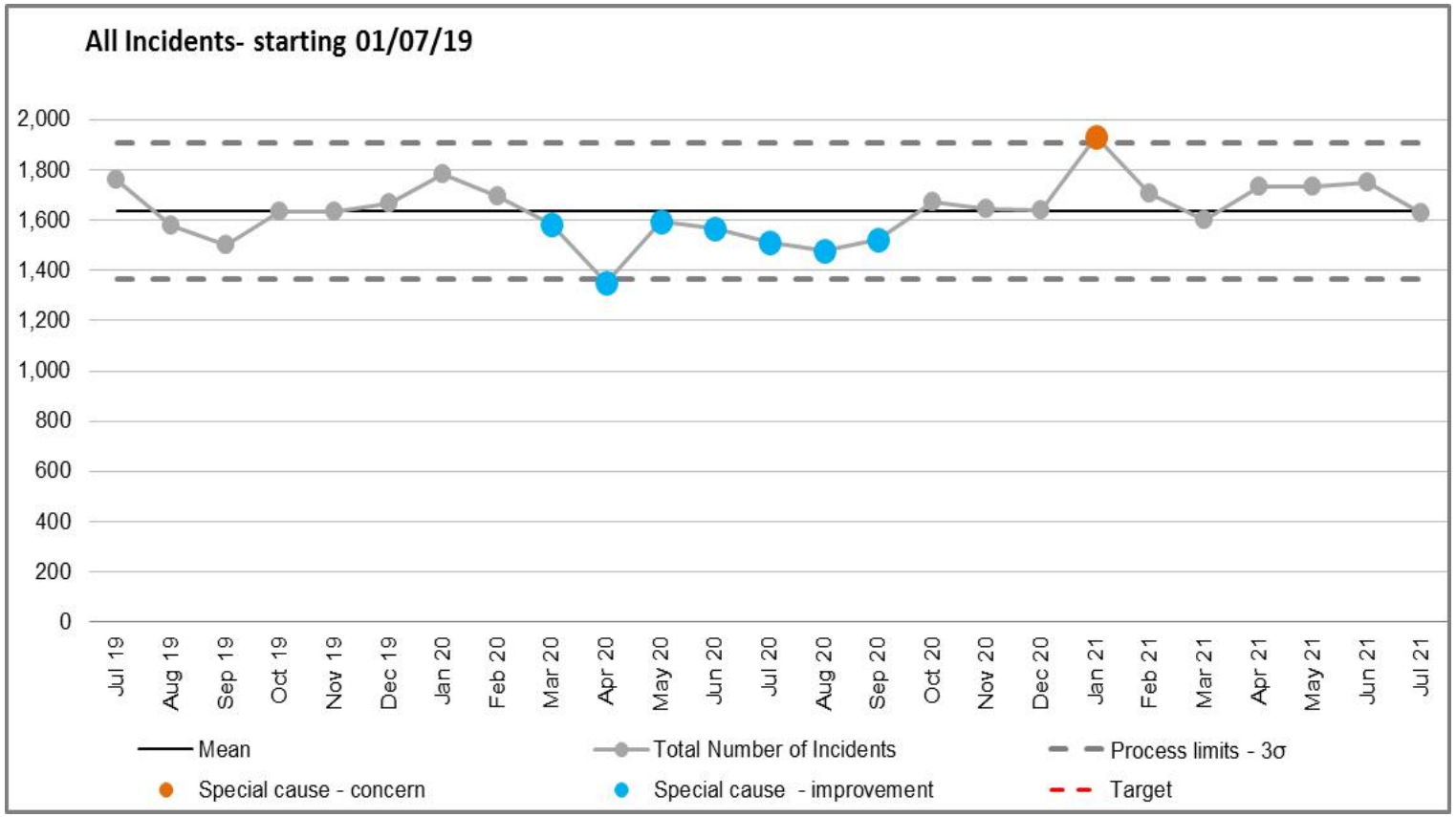
1. All incidents



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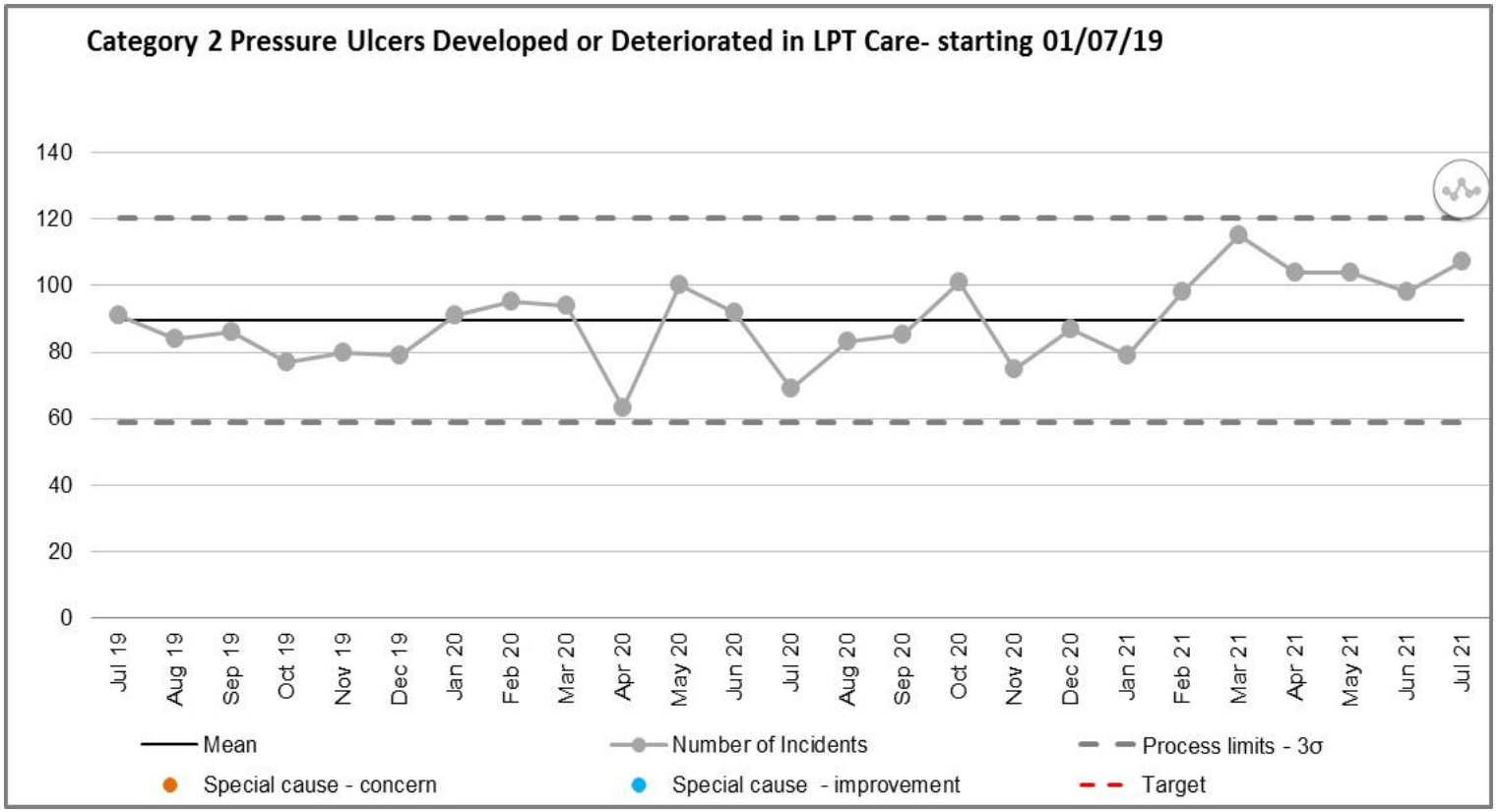
2. Category 2 Pressure Ulcers developed or deteriorated in LPT Care



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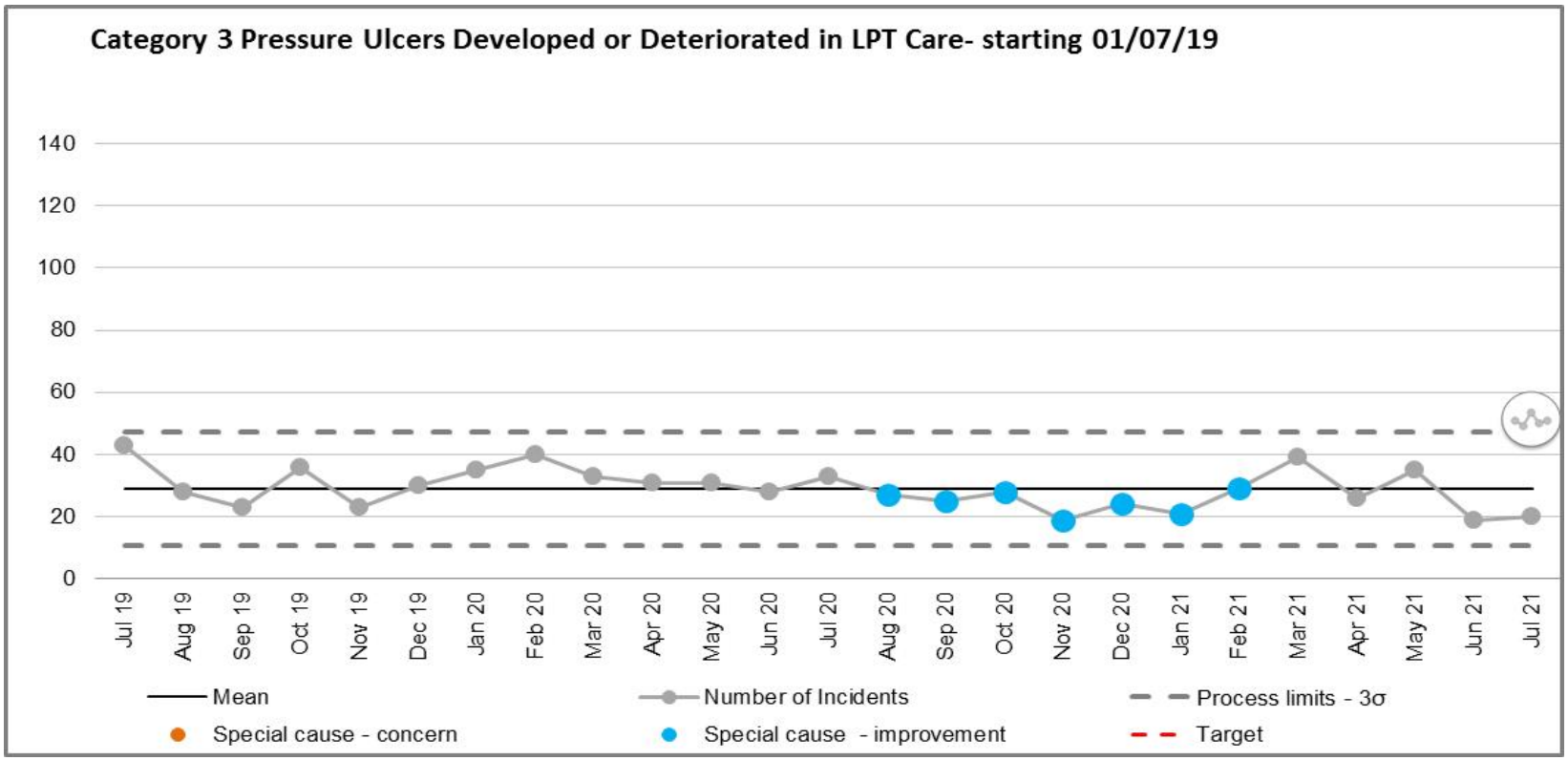
3. Category 3 Pressure Ulcers developed or deteriorated in LPT Care



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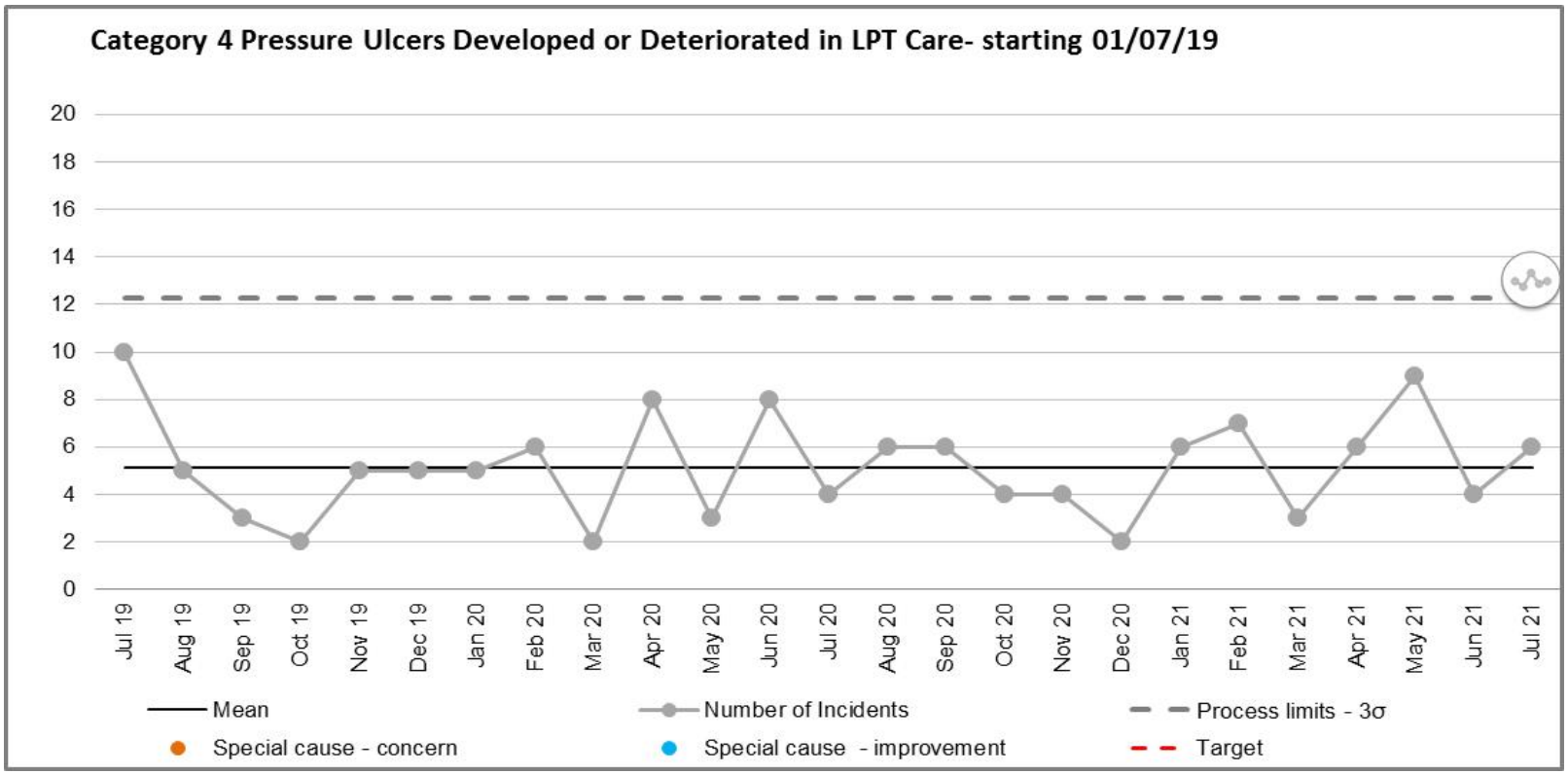
4. Category 4 Pressure Ulcers Developed or deteriorated in LPT Care



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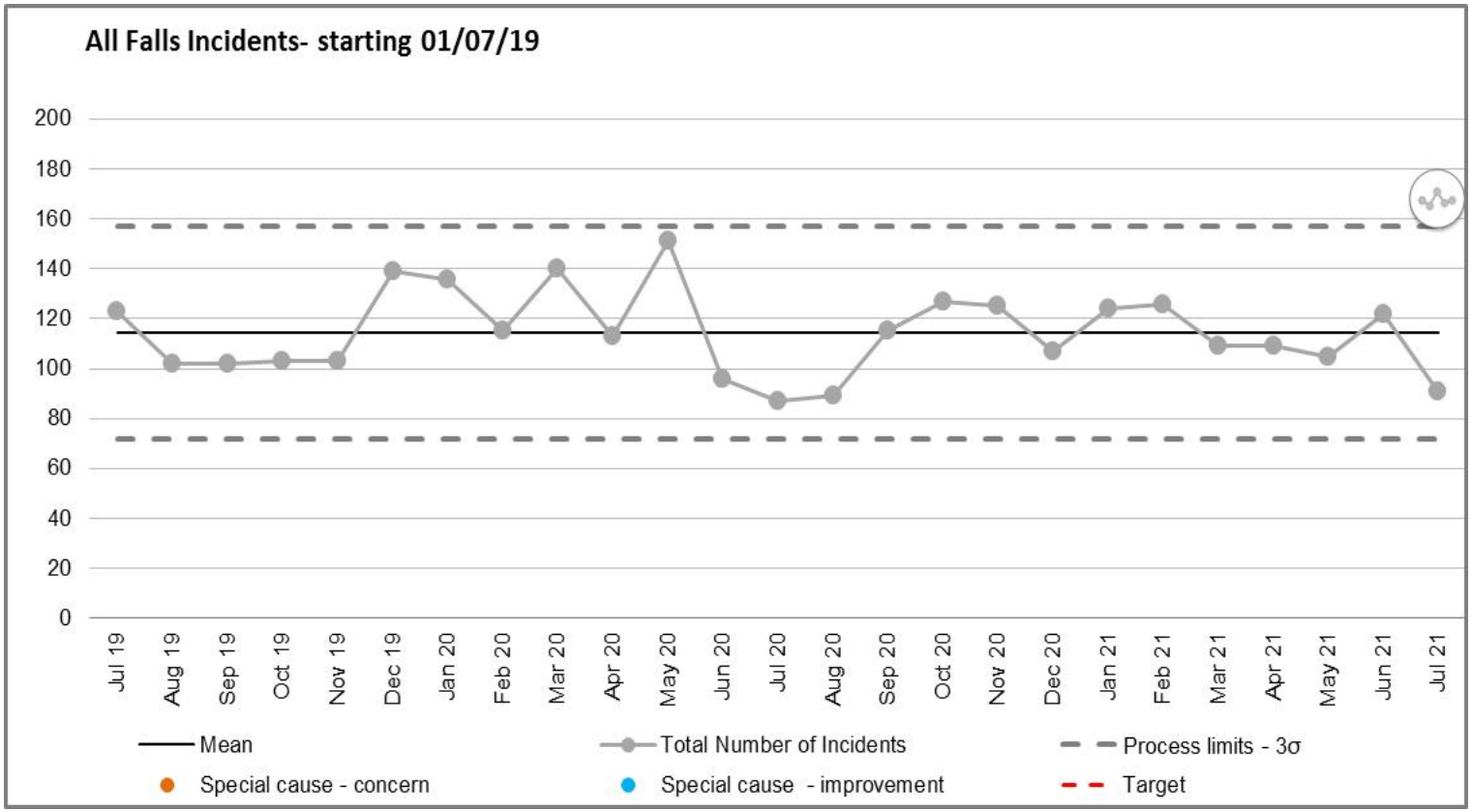
5. All falls incidents reported



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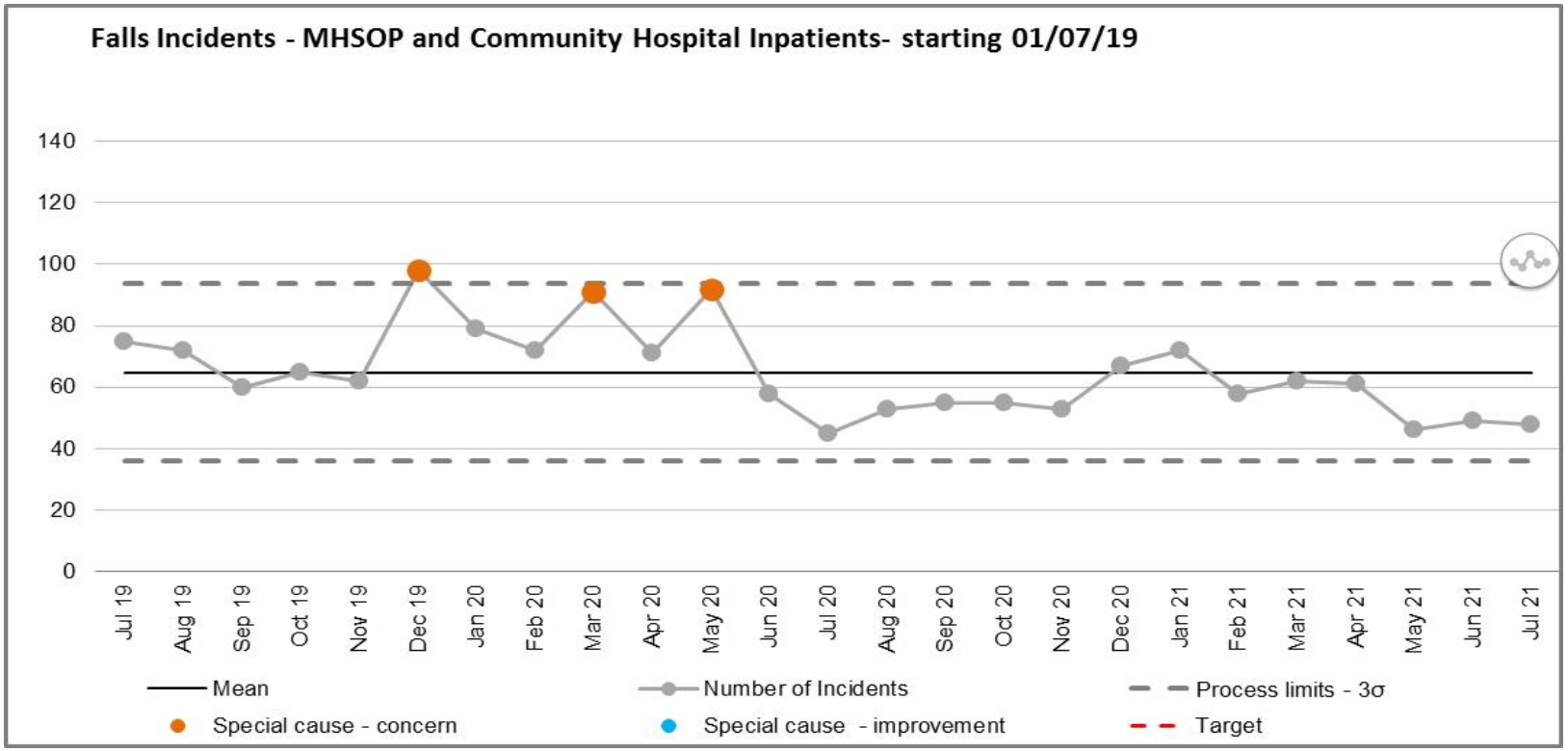
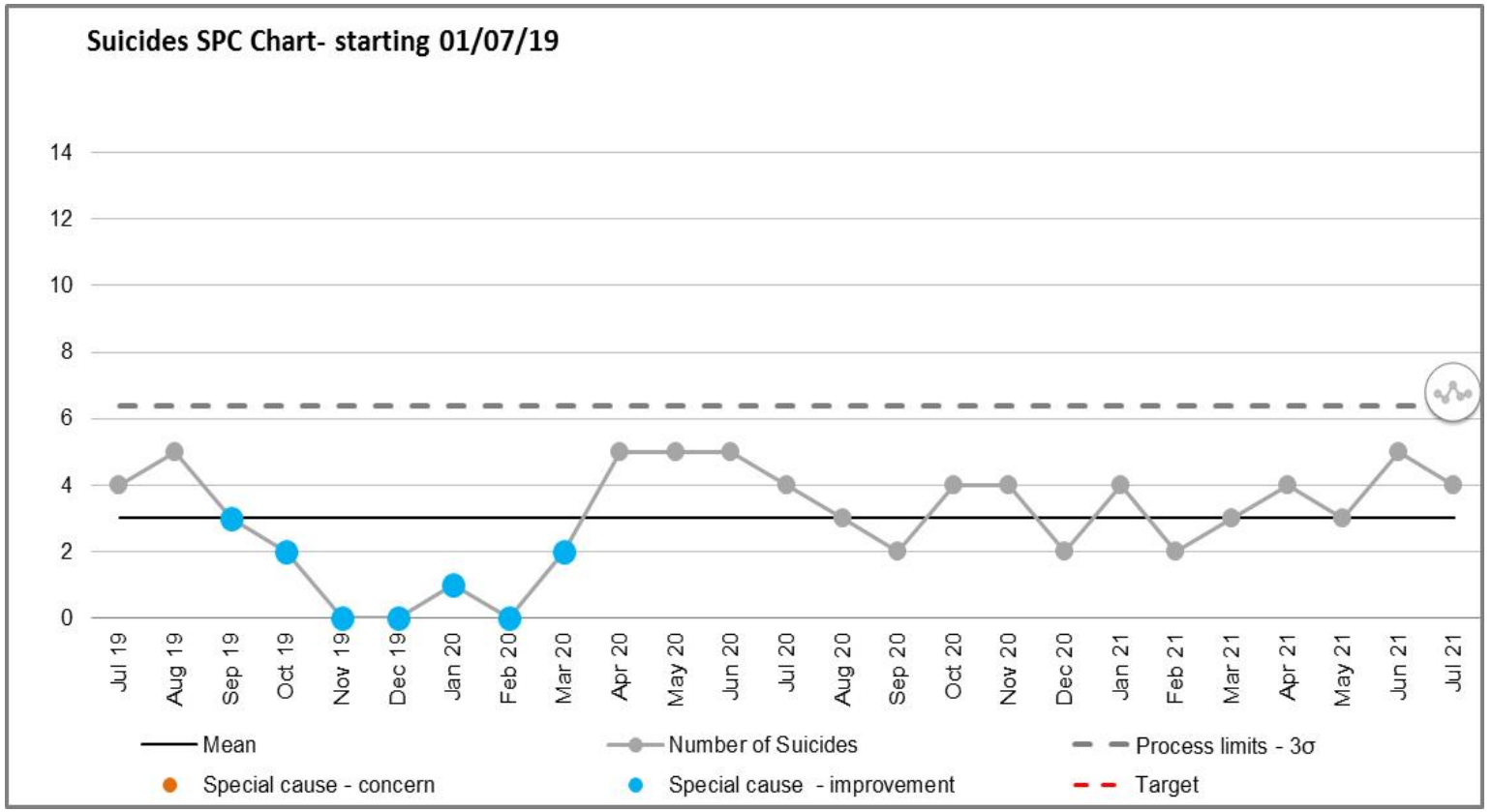
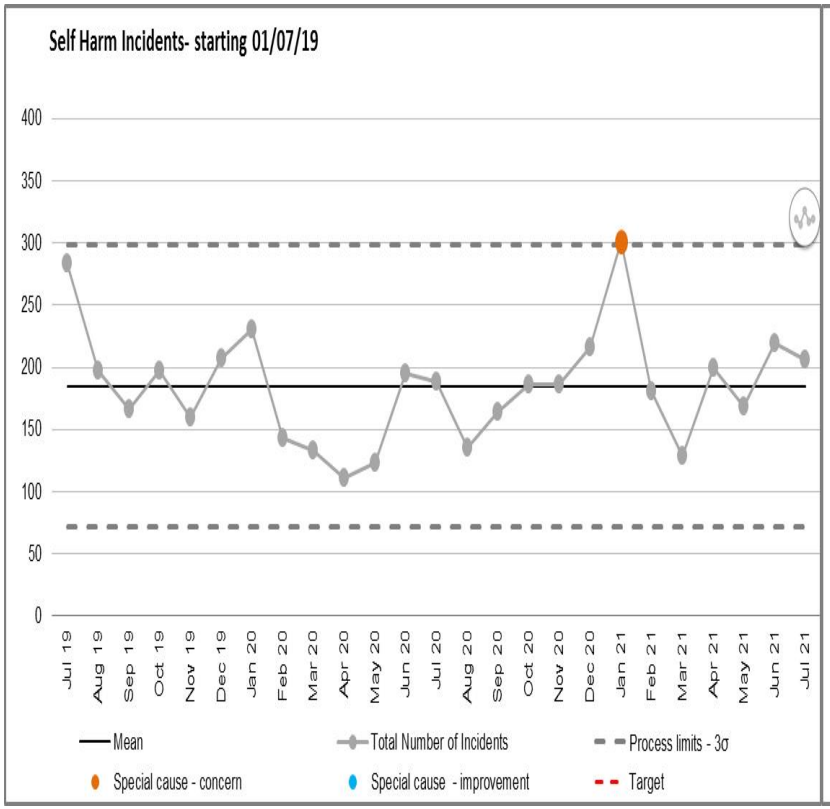
6. Falls incidents reported – MHSOP and Community Inpatients

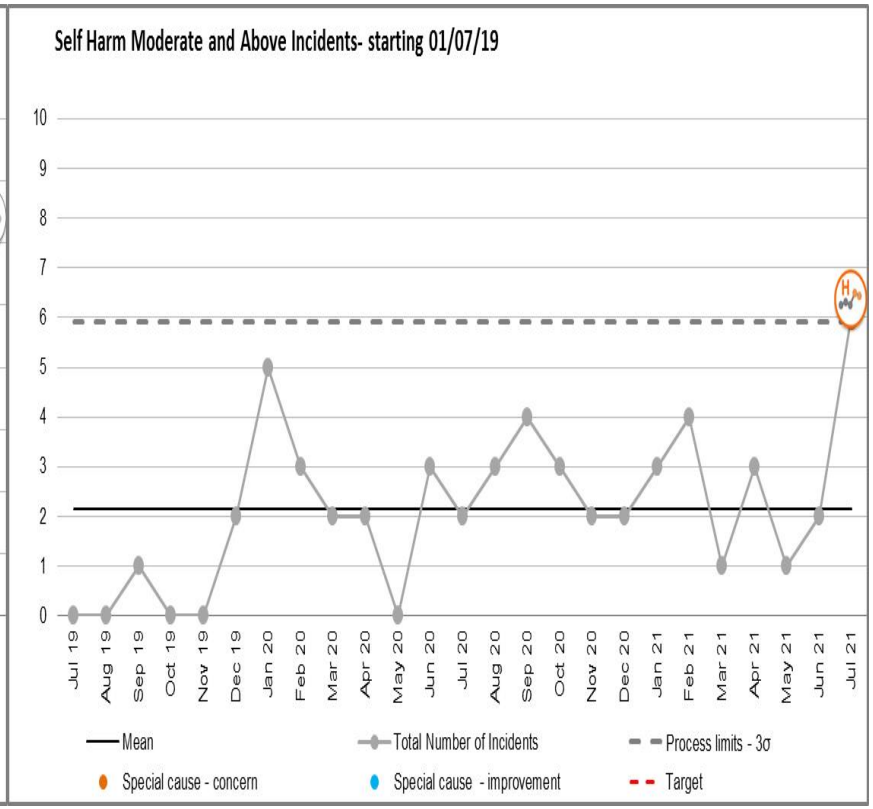


7. All reported Suicides



8. Self Harm reported Incidents





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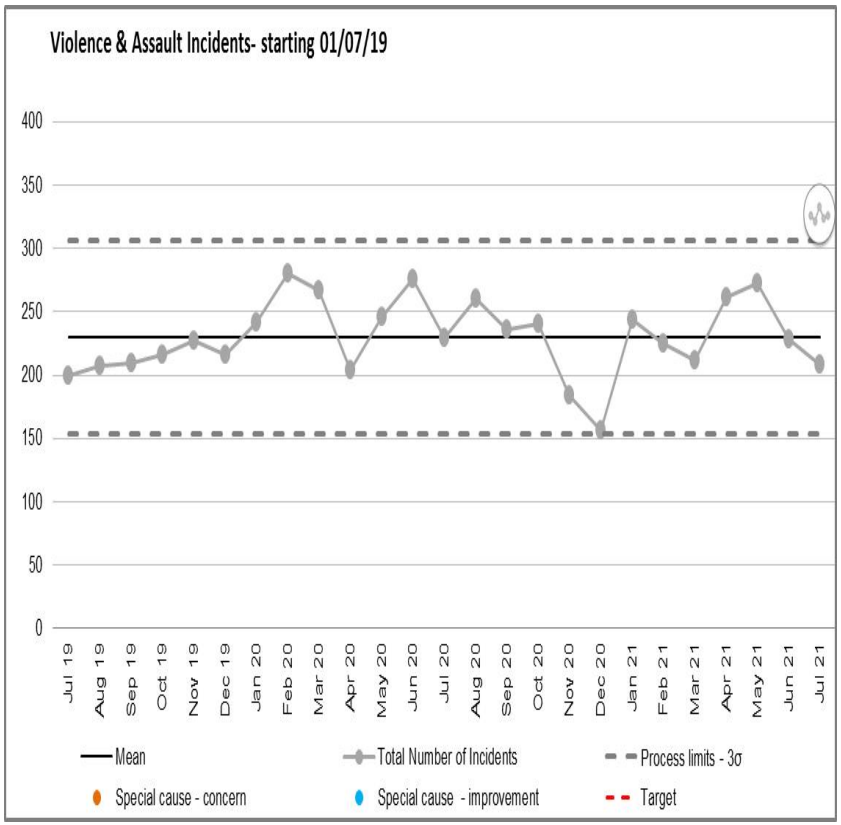
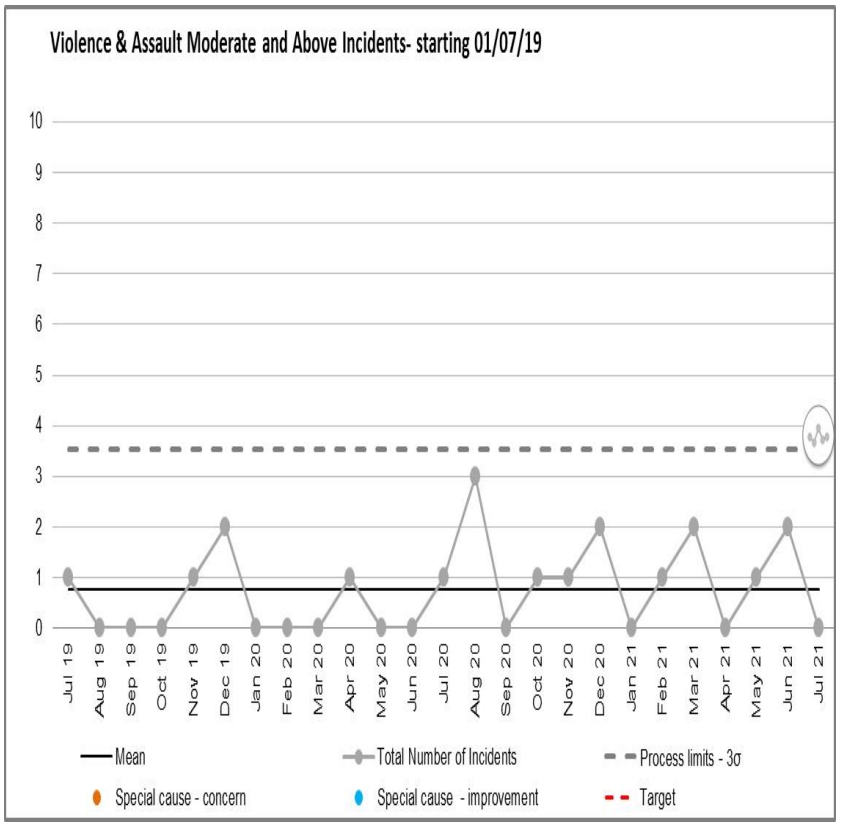
9. All Violence & Assaults reported Incidents





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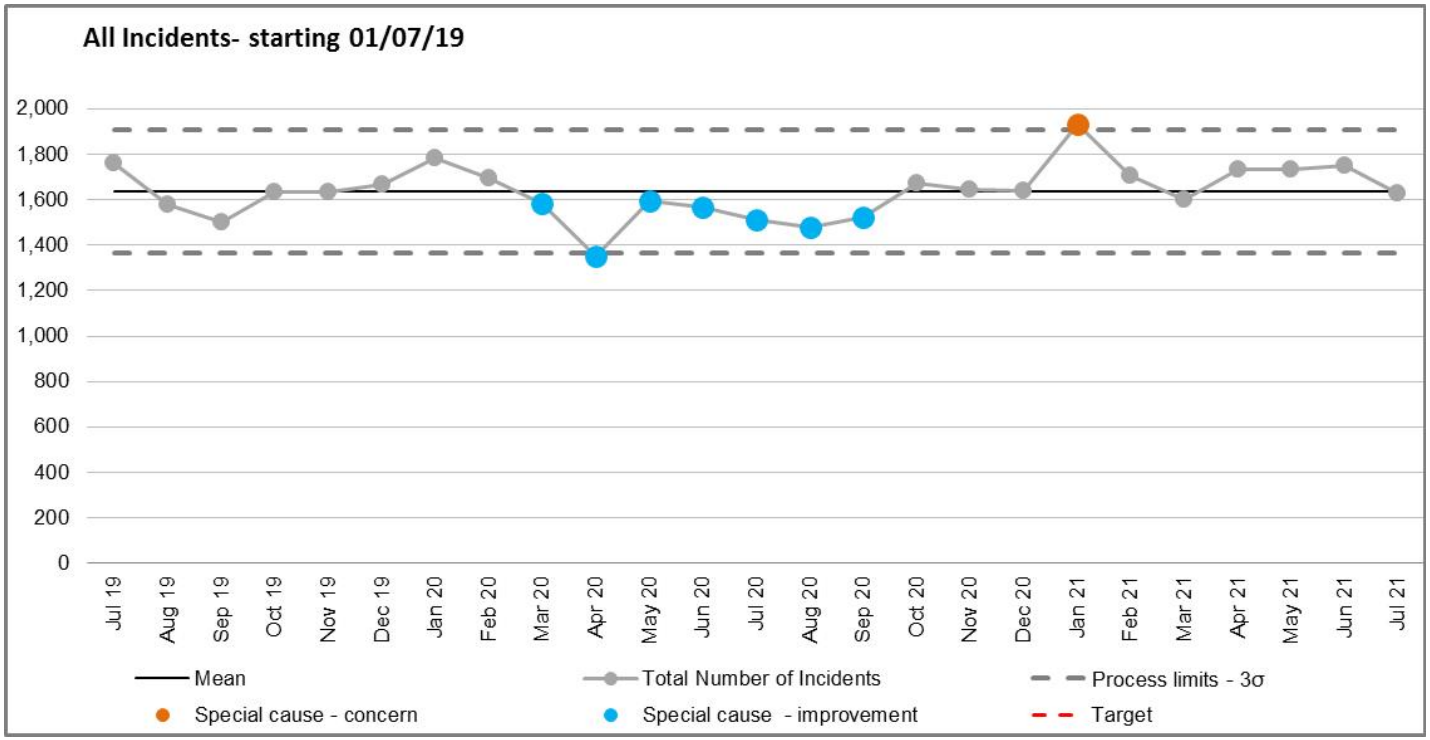
10. All Medication Incidents reported



11. Directorate Specialities describing Top 5 Incidents

Table 1: Mental Health: Inpatients

Mental Health Non MHSOP Inpatient - June	
Cause Group	**Total**
Violence/Assault	120
Self Harm	61
Patient Falls, Slips, And Trips	54
Clinical Condition	39
Security	26

Mental Health Non MHSOP Inpatient - July	
Cause Group	**Total**
Violence/Assault	118
Self Harm	41
Patient Falls, Slips, And Trips	29
Clinical Condition	25
Security	21

Table 2: Mental Health Community

Mental Health Non MHSOP Community - June	
Cause Group	**Total**
Self Harm	55
Violence/Assault	31
Safeguarding (Adults)	16
Patient Death	14
Clinical Condition	11

Mental Health Non MHSOP Community - July	
Cause Group	**Total**
Self Harm	58
Violence/Assault	29
Infection Control	19
Security	13
Clinical Condition	12
Safeguarding (Adults)	12

Directorate Specialities describing Top 5 Incidents

Table 3: MHSOP – Inpatients

MHSOP Inpatient - June	
Cause Group	**Total**
Patient Falls, Slips, And Trips	32
Violence/Assault	20
Clinical Condition	15
Medication	9
Missing Patient	4

MHSOP Inpatient - July	
Cause Group	**Total**
Patient Falls, Slips, And Trips	27
Clinical Condition	20
Violence/Assault	18
Medication	5
Mental Health Act	4

Table 4: MHSOP – Community

MHSOP Community - June	
Cause Group	**Total**
Self Harm	10
Patient Death	9
Case Notes & Records	3
Safeguarding (Adults)	3
Communication	2

MHSOP Community - July	
Cause Group	**Total**
Patient Death	9
Self Harm	4
Infection Control	3
Allegations Against Staff	1
Clinical Assess. (Diag, Scans, Tests)	1

Directorate Specialities describing Top 5 Incidents

Table 5: Learning Disability – In-Patient

LD Agnes Unit - June	
Cause Group	**Total**
Violence/Assault	44
Clinical Condition	4
Communication	3
Self Harm	3
Accident	2
Allegations Against Staff	2

LD Agnes Unit - July	
Cause Group	**Total**
Violence/Assault	35
Clinical Condition	6
Self Harm	5
Communication	4
Patient Falls, Slips, And Trips	3

Table 6: Learning Disability - Community

LD Community - June	
Cause Group	**Total**
Self Harm	11
Safeguarding (Adults)	7
Violence/Assault	5
Missing Patient	4
Safeguarding (Children)	3

LD Community - July	
Cause Group	**Total**
Violence/Assault	6
Safeguarding (Adults)	5
Case Notes & Records	3
Infection Control	3
Self Harm	3

Directorate Specialities describing Top 5 Incidents

Table 7: FYPC Inpatient CAMHS

FYPC CAMHS Inpatient - June	
Cause Group	**Total**
Self Harm	85
Violence/Assault	15
Medication	6
Allegations Against Staff	2
Clinical Condition	2

FYPC CAMHS Inpatient - July	
Cause Group	**Total**
Self Harm	94
Allegations Against Staff	2
Case Notes & Records	2
Medical Equipment	2
Mental Health Act	2
Missing Patient	2

Table 8: FYPC non LD Non CAMHS

FYPC Non LD Non CAMHS - June	
Cause Group	**Total**
Violence/Assault	3
Safeguarding (Children)	2
Confidentiality	1
Fire	1
Missing Patient	1

FYPC Non LD Non CAMHS - July	
Cause Group	**Total**
Self Harm	16
Violence/Assault	4
Case Notes & Records	2
Confidentiality	2
Infection Control	2

Directorate Specialities describing Top 5 Incidents

Table 10: CHS In-Patient

CHS Inpatient - June	
Cause Group	**Total**
Tissue Viability	40
Patient Falls, Slips, And Trips	17
Patient Death	8
Medication	6
Clinical Assess. (Diag, Scans, Tests)	5
Clinical Condition	5

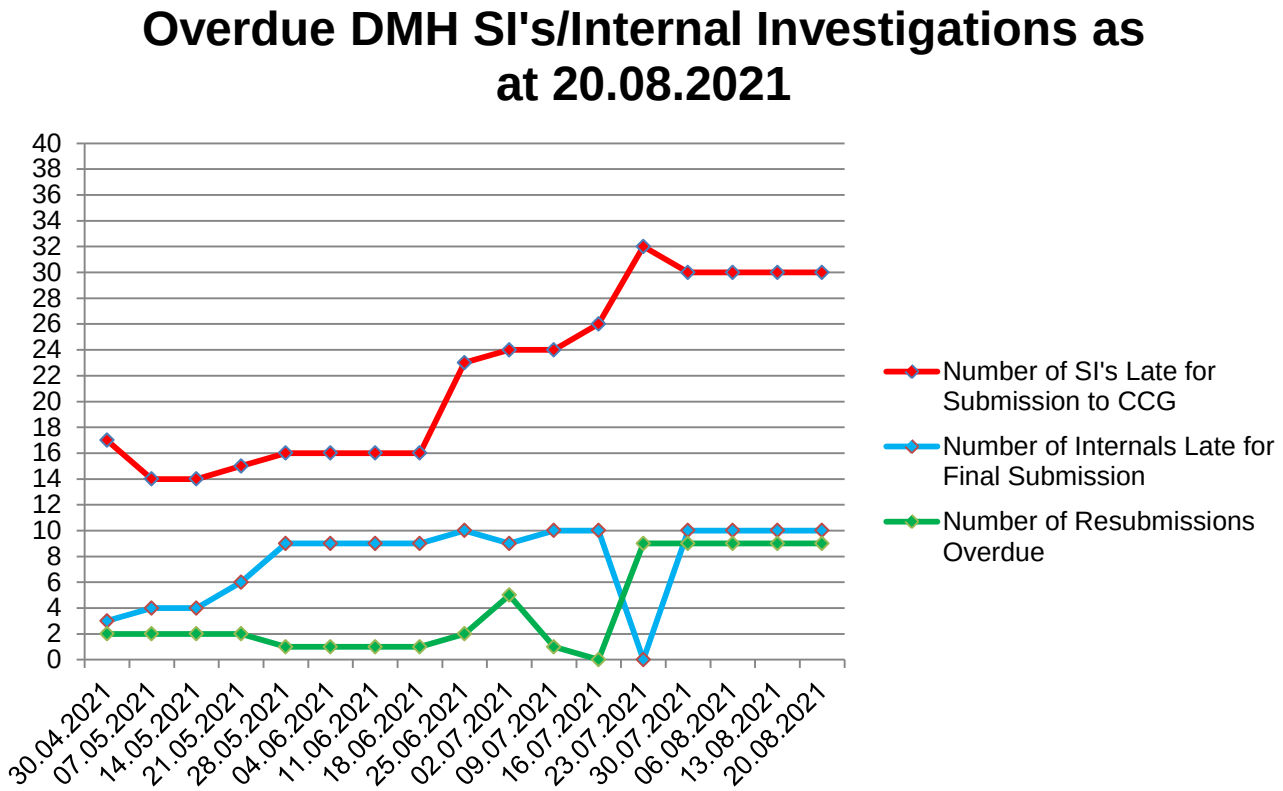
CHS Inpatient - July	
Cause Group	**Total**
Tissue Viability	33
Patient Falls, Slips, And Trips	21
IT Equipment / Systems	8
Patient Death	8
Medication	7

Table 11: CHS Community

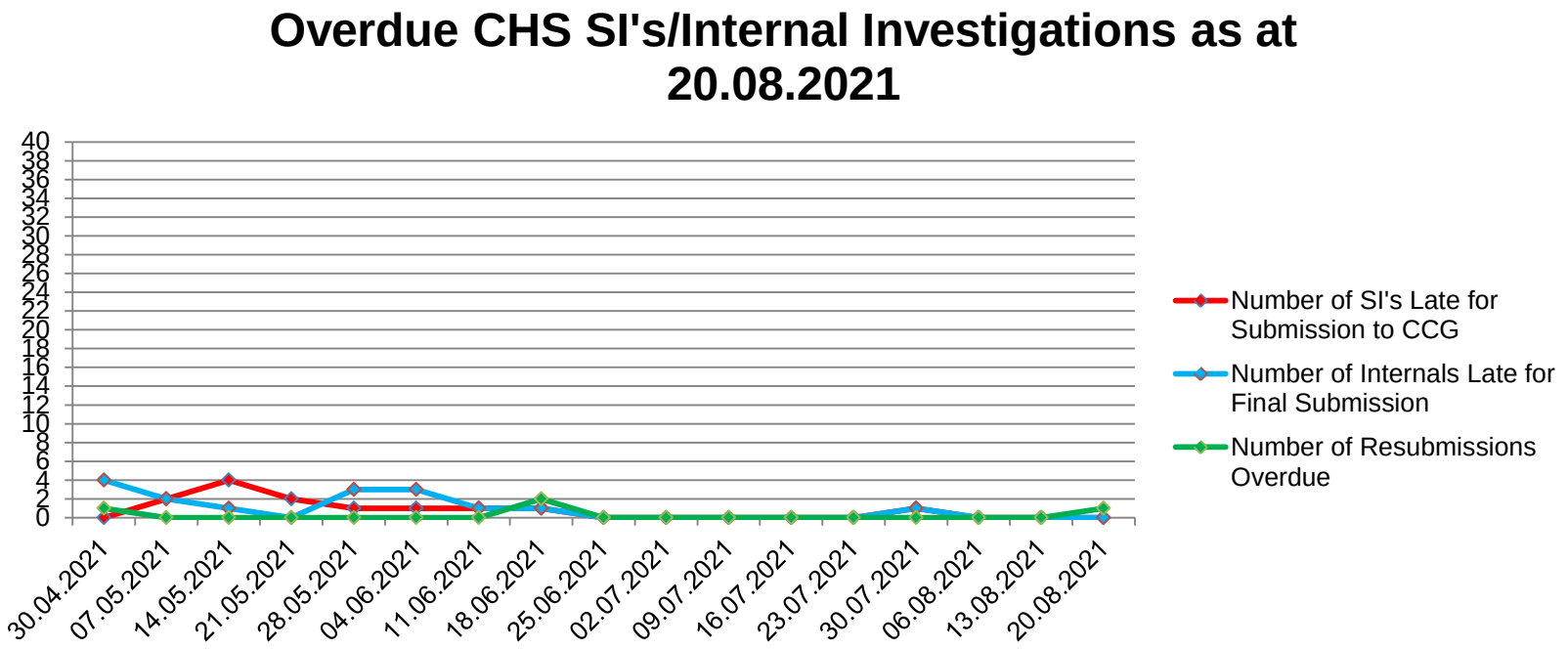
CHS Community - June	
Cause Group	**Total**
Tissue Viability	430
Medication	20
Patient Falls, Slips, And Trips	10
Safeguarding (Adults)	8
Infection Control	6

CHS Community - July	
Cause Group	**Total**
Tissue Viability	440
Infection Control	17
Medication	14
Safeguarding (Adults)	10
Violence/Assault	8

12a. Overdue Serious Incidents/Internal Investigation & CCG resubmissions (includes totals) - DMH



12a. Overdue Serious Incidents/Internal Investigation & CCG resubmissions(includes totals) - CHS



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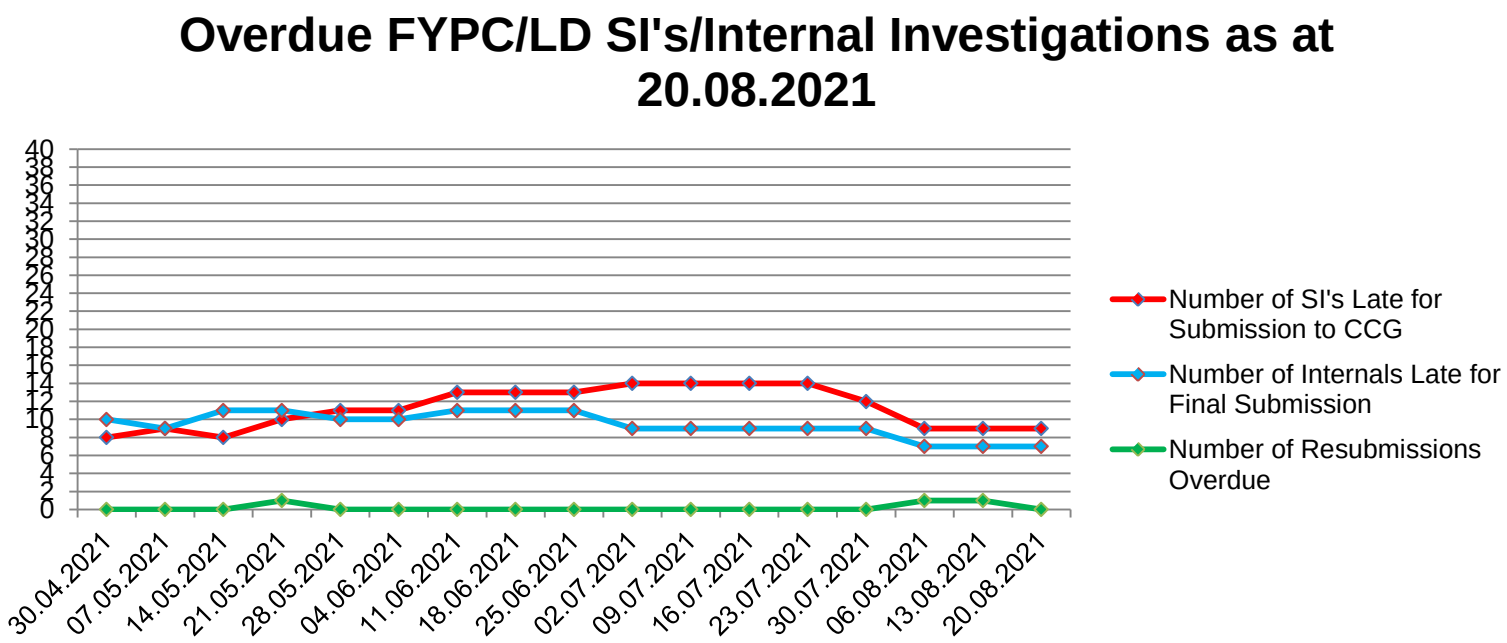
12a. Overdue Serious Incidents/Internal Investigations & CCG resubmissions (includes totals) - FYPCLD



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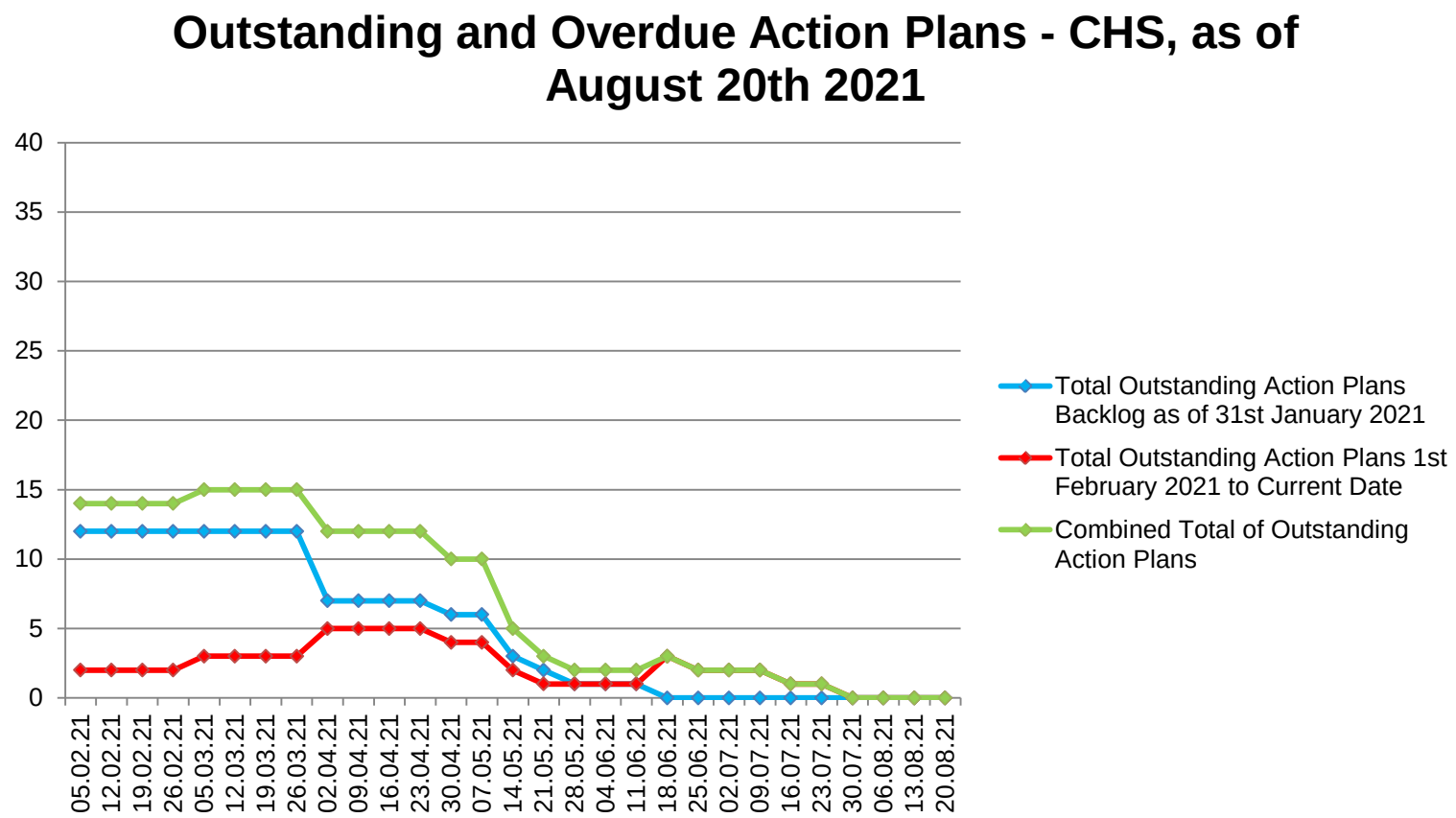
12b. Directorate SI Action Plan Compliance Status 2020/21 to date - CHS



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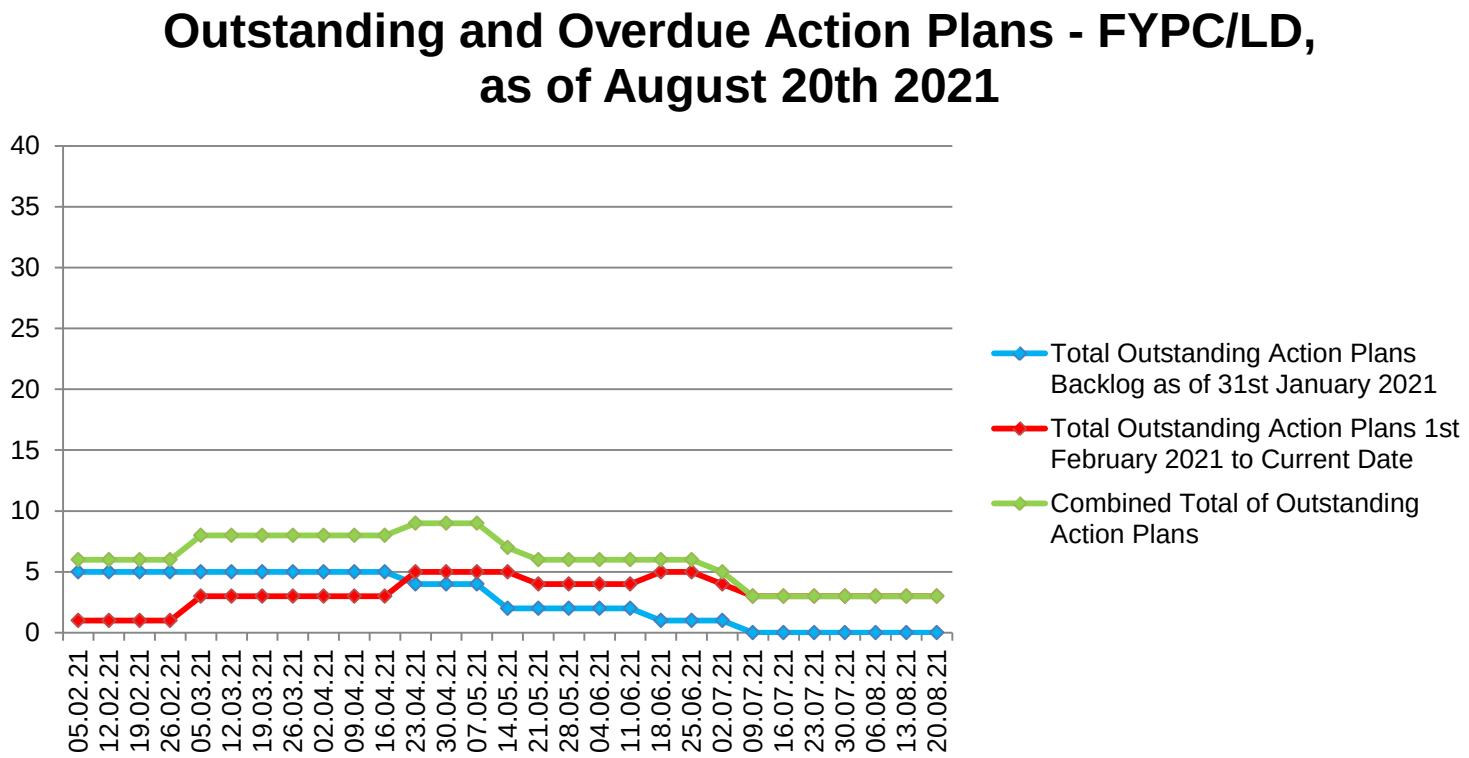
12.b Directorate SI Action Plan Compliance Status 2020/21 to date - FYPCLD



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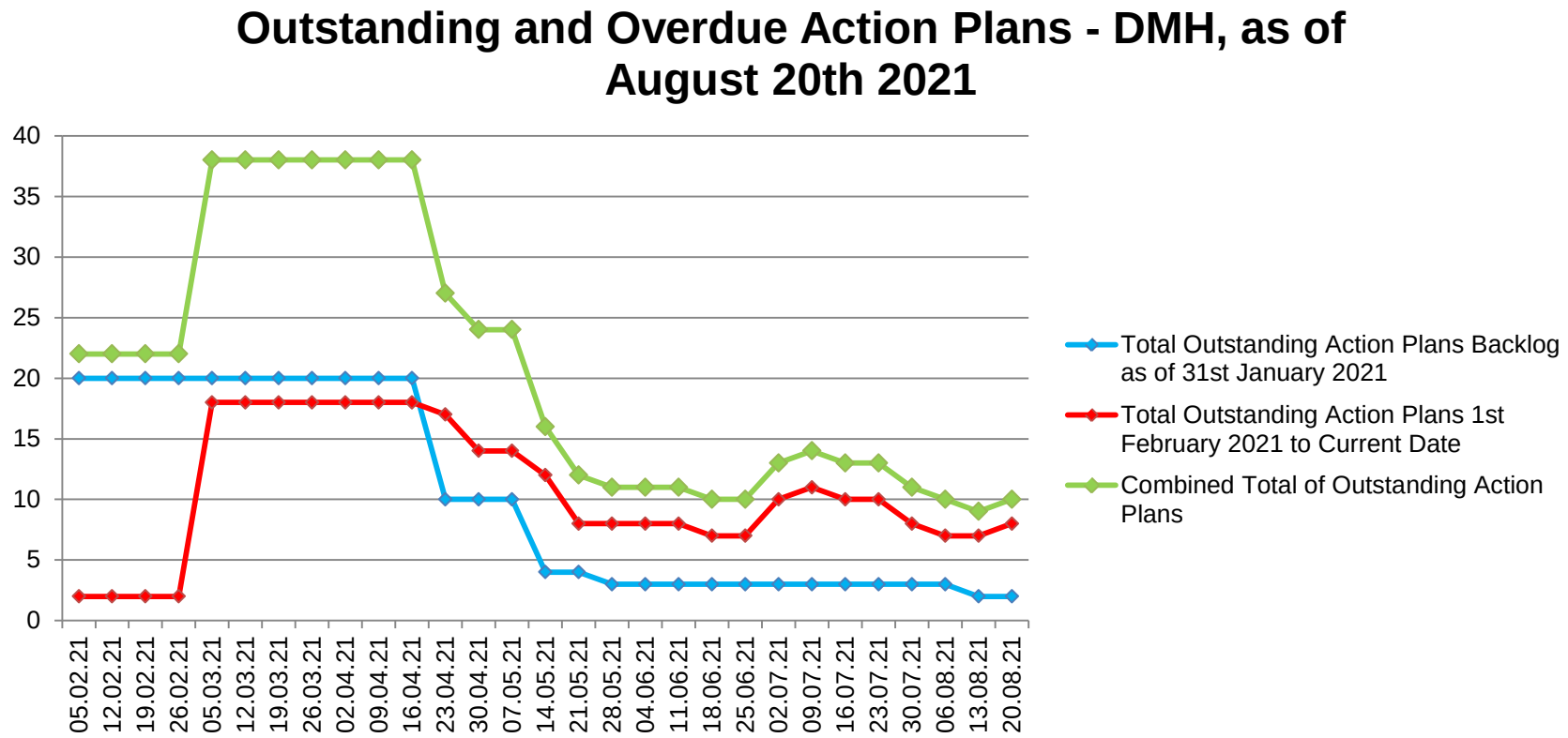
12.b Directorate SI Action Plan Compliance Status 2020/21 to date - DMH



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12. Learning

Serious Incidents roundup of Learning – The patient safety team gathered learning to share with the CQC at the recent inspection and thought it helpful to share with Trust Board.

Cardiac arrests

Risk of arrests in LPT clinics – access to defibrillator not as convenient as we would have liked. Trust wide assessment of access to defibrillators and additional defibrillators purchased

Diabetes management

DN's not using consistent approach – assessed across the whole of community- Human Factors approach –designed a simpler and clearer authorisation and recording. – policy strengthened.

DMH-physical health team identified knowledge gap in relation to diabetes management and have shared information with teams and are currently developing a pathway for the management of hypoglycaemia – ensuring that the recoding of this also supports staff with actions to take.

Learning Continued

Post ligature incidents

Identified through incidents that there was variation in how children were managed post ligature –pathway developed for use on Beacon and shared with Agnes and DMH to adapt for adults. Pathway includes post head banging and prolonged seizure

Venous Thrombo Embolism (VTE)

Learned from hospital acquired VTE and changed risk assessment as if the patient had the ability to be mobile they were assessed as not at risk, however Mental Health patients may have the ability to mobilise but do not as they are depressed – Risk assessment changed to reflect this

SEPSIS

Identified through deteriorating patient incidents that NEWS 2 not being used consistently and therefore SEPSIS screening not always undertaken– training re rolled out and oversight increased.

Oi

Leicestershire Partnership NHS Trust

Public Trust Board - 31 August 2021

Safe Staffing- June 2021 review

Purpose of the report

This report provides an overview of nursing safe staffing during the month of June 2021, including a summary of staffing areas to note, updates in response to Covid-19, potential risks, and actions to mitigate the risks to ensure that safety and care quality are maintained.

The report triangulates workforce metrics, fill rates, Care Hours Per Patient Day (CHPPD), quality and outcomes linked to Nurse Sensitive Indicators (NSIs) and patient experience feedback. A summary is available in Annex 1; scorecard, with a detailed overview and exception report narrative by in-patient area and service in annexe 2.

Analysis of the issue

Right Staff

- Temporary worker utilisation rate slightly increased this month; 0.92% reported at 36.41% overall and Trust wide agency usage slightly increased this month by 1.74% to 13.57% overall. This is largely attributed to increased patient acuity and dependency and additional staff to support safe levels of observation and care.
- In June 2021; 21 inpatient wards/units utilised above 6% agency staff, one change from last month; Rutland Ward. Areas to note are identified either by the Head/Deputy Head of Nursing due to; high percentage of temporary worker/agency utilisation, or concerns relating to; increased acuity, high risk patients, staff sickness, ability to fill additional shifts and the impact to safe and effective care.
- There are 23 inpatient 'areas to note' with five changes to the previous month; Coalville Ward 1, Kirby, Welford and Ashby Wards due to increased agency utilisation above 6% and St Lukes Ward 1 due to increased patient acuity and dependency, vacancies, maternity leave and sickness.
- There are eight community team 'areas to note', changes to the previous month; Assertive Outreach is an emerging area to note due to the impact of planned service changes, vacancies and retirement.
- There is increasing operational pressure across the whole community nursing service with a large number of staff absent from work with long and short term illness. A significant number of the absence sits in the city community hubs that remain key areas to note specifically City West and East hubs. A number of actions are in place to try to mitigate the staffing risks, detailed page 5.

- Weekly safe staffing forecast meetings with Workforce and Safe staffing matron, Head/Deputy Heads of Nursing and Head of Workforce support continue to review staffing levels, actions to meet planned staffing, review of the risks and actions to mitigate the risks.

Right Skills

Changes to Mandatory and Role Essential Training during Covid-19:

- The compliance renewal date for each topic has been extended by 6 months.
- All face to face training is slowly being reintroduced with staff being invited to attend mandatory training on a clinical risk basis, contacted directly by Learning & Development to attend.
- Correct to 30 June 2021 Trust wide substantive staff;
    - Appraisal at 89.9 % compliance GREEN
    - Clinical supervision at 86.4% compliance GREEN
    - All core mandatory training compliance GREEN with the exception of Information Governance AMBER at 90.6%
    - Clinical mandatory training compliance improved position for both BLS and ILS.
        - BLS improved 5.9% to 81.1% compliance AMBER
        - ILS improved 4.2% from RED to AMBER at 75% compliance.

Right Place

- The Covid-19 risk managed wards are North, Beacon, Langley, Agnes Unit and Gwendolen Ward. Risk managed is to mean that the ward is caring for patients on the emergency admission Covid-19 high and medium risk pathways, as per the national safe staffing descriptors and IPC care pathways, maintaining separation between possible and confirmed COVID-19 patients and supporting staff cohorting.
- Fill rates below 100% for actual HCSWs predominantly on days reflect adjusted staffing levels and skill mix to meet patient care needs.
- The total Trust CHPPD average (including ward based AHPs) is reported at 15.11 CHPPD in June 2021, with a range between 6.3 (Ashby Ward) and 73.8 (Agnes Unit) CHPPD.
- General variation reflects the diversity of services, complex and specialist care provided across the Trust. Analysis has not identified significant variation at service level; indicating that staff are being deployed productively across services.

Staff absence data

The table below shows absence captured by the LPT Staff Absence Sitrep on 30 June 2021;

Self-Isolation - Household WFH wte	3.92
Self-Isolation – Symptomatic wte	8.8
Self-Isolation - Vulnerable Group wte	0

Test and Trace Notification wte	1.0
Covid-19 related absence wte	13.8
General Absence wte	217.2
Covid-19 related absence %	0.3%
General Absence %	4.6%
Total Absence	**4.9%**

Table 1 – Trust COVID-19 and general absence – 30 June 2021

In comparison to the previous month overall absence has increased 0.4% due to self and household isolation due to Covid-19.

In-patient Staffing

Summary of inpatient staffing areas to note;

Wards	April 2021	May 2021	June 2021
Hinckley and Bosworth East Ward	X	X	X
Hinckley and Bosworth North Ward	X	X	X
St Lukes Ward 1	X		X
St Lukes Ward 3	X	X	
Beechwood	X	X	X
Clarendon	X	X	X
Coalville Ward 1			X
Coalville Ward 2			
Rutland		X	X
Dalgleish	X	X	X
Coleman	X	X	X
Gwendolen	X	X	X
Kirby			X
Welford			X
Wakerley	X	X	X
Aston	X	X	X
Ashby			X
Beaumont	X	X	X
Belvoir	X	X	X
Griffin	X	X	
Phoenix	X	X	X
Heather			
Watermead			
Mill Lodge	X	X	X
Agnes Unit	X	X	X
Langley	X	X	X
Beacon (CAMHS)	X	X	X

Table 2 – In-patient staffing areas to note

Areas to note are identified either by the Head/Deputy Head of Nursing due to; high percentage of temporary worker/agency utilisation, or concerns relating to; increased

acuity, high risk patients, staff sickness, ability to fill additional shifts and the impact to safe and effective care.

Covid-19 risk managed wards are also identified as areas to note; North Ward Hinckley, Langley, Agnes Unit and Gwendolen Ward. Risk managed is to mean that the ward is caring for patients on the emergency admission COVID pathway as per the national safe staffing descriptors and IPC care pathways medium and high.

The Agnes Unit and CAMHS Beacon Unit are 'areas to note' due to a combination of factors; high percentage of temporary worker/agency utilisation, concerns relating to; increased acuity, high risk and vulnerable patients, safeguarding and safety incidents and impact to safe and effective care. Both areas are being supported with quality improvement plans, with oversight to the Trust Quality Assurance Committee.

Mill Lodge is an area to note due to the number of vacancies and due to concerns in regard to the high number of patient falls. The Director of Nursing, AHPs and Quality to visit the Ward on 1 July 2021 with a quality summit planned within month and deep dive review of patient falls.

Number of occupied beds, temporary workforce percentage together with the NSIs that capture outcomes most affected by nurse staffing levels is presented in the tables per in-patient area by service and directorate in Annex 2.

Community Teams

Summary of community 'areas to note';

Community team	April 2021	May 2021	June 2021
City East Hub- Community Nursing	X	X	X
City West Hub- Community Nursing	X	X	X
Healthy Together – City (School Nursing only)	X	X	X
Healthy Together County	X	X	X
Looked After Children	X	X	X
Central Access Point team (MH)	X	X	
CRISIS DMH	X	X	
South Leicestershire CMHT		X	X
Assertive outreach			X
LD Community Physiotherapy		X	X

Table 3 – Community areas to note

Community areas to note are identified either by the Head/Deputy Head of Nursing due to; high percentage of temporary worker/agency utilisation, or concerns relating to; increased case load, high risk patients, staff sickness, ability to fill additional shifts and the impact to safe and effective care.

FYPC/LD Community

Healthy Together County, Healthy Together City and Looked After Children (LAC) teams continue to be rated to be at Amber escalation level due to a reduction in the established team; vacancies and retirement. Healthy Together teams are rated amber due to Specialist Community Public Health Nurse (SCPHN) vacancies and a number of staff retiring. LAC team recruited three Band 5 staff members. Risks continue to be monitored within the Directorate on a weekly basis.

Learning disabilities community physiotherapy is rated amber, the team continue to assess and treat all red and amber RAG rated referrals. Recruitment process is ongoing as there are challenges in recruiting to the Band 6 post.

CHS Community

There is increasing operational pressure across the whole community nursing service with a large number of staff absent from work with long and short term illness. A significant number of the absence sits in the city community hubs that remain key areas to note specifically City West and East hubs. A number of actions are in place to try to mitigate the staffing risks including;

- Deferred non-essential meetings
- Working with Centralised Staffing Solutions to support fill of shifts
- Redeploying community nurses from other hubs where possible and safe to do so
- Deployed staff from other clinical teams such as tissue viability and podiatry to support
- Integrated Community Specialist Palliative Care Team supporting community nursing activity as appropriate
- Continue to monitor and manage staff sickness and absence
- Targeted band 5 registered nurse, assistant practitioner and nursing associate recruitment

MH Community

The Central Access Point (CAP) continues to experience high levels of routine referrals; however the team has a new staffing model and plan in place to mitigate and this has now been removed from the risk register. The number of vacancies across community services generally remains challenging and gaps continue to be filled with bank and agency wherever possible; community mental health teams find it difficult to recruit agency workers for the block booking commitment required. South Leicestershire CMHT remains an area to note and Assertive Outreach is an emerging area to note due to the impact of planned service changes, vacancies and retirement.

Proposal

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

Decision required

The board is asked to confirm a level of 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 is maintained.

June 2021

Ward Group	Ward	Average no. of Beds on Ward	Average no. of Occupied Beds	Fill Rate Analysis (National Return) – Actual Hours Worked divided by Planned Hours – Nurse Day: Average % fill rate registered >=80%	Nurse Day: Average % fill rate non-reg >=80%	Nurse Night: Average % fill rate registered >=80%	Nurse Night: Average % fill rate non-reg >=80%	AHP Day: Average % fill rate registered	AHP Day: Average % fill rate non-reg	% Temporary Workers (NURSING ONLY): Total <20%	Bank	Agency	Overall CHPPD (Nursing And AHP)	Med Errors	Falls	Complaints
AMH Bradgate	Ashby	21	20	104.5%	192.4%	103.1%	76.7%			34.8%	28.3%	6.5%	6.3	0	0	0
	Aston	19	18	104.5%	116.8%	100.4%	84.4%			32.0%	24.5%	7.5%	6.9	3	1	0
	Beaumont	22	19	101.7%	180.9%	98.3%	143.1%			58.0%	48.3%	9.7%	13.6	3	1	2
	Belvoir Unit	10	8	125.9%	176.2%	195.4%	137.6%			43.7%	32.5%	11.2%	22.6	2	4	1
	Heather	18	18	88.1%	148.4%	97.7%	134.1%			32.8%	27.7%	5.0%	7.3	1	3	0
	Thornton	20	17	112.3%	114.8%	101.3%	94.8%			38.2%	35.3%	2.9%	7.4	1	0	0
	Watermead	20	19	105.6%	116.9%	92.9%	88.9%		100.0%	18.5%	16.5%	2.1%	6.7	0	9	0
	Griffin - Herschel Prins	6	6	117.1%	170.0%	103.1%	424.5%		100.0%	44.4%	41.1%	3.4%	26.8	0	1	0
AMH Other	Phoenix - Herschel Prins	12	10	117.2%	137.0%	105.3%	130.9%			44.9%	32.7%	12.2%	12.6	0	0	1
	Skye Wing - Stewart House	30	20	149.8%	98.2%	137.8%	137.8%			31.6%	28.9%	2.7%	7.7	1	3	1
	Willows	9	6	179.3%	91.2%	104.5%	102.2%			16.7%	16.2%	0.5%	17.2	0	0	0
	Mill Lodge	14	12	83.5%	86.8%	128.9%	102.0%			48.8%	38.8%	9.9%	12.7	2	32	0
CHS City	Kirby	24	23	66.7%	120.8%	126.7%	155.3%	100.0%	100.0%	36.9%	30.7%	6.3%	7.4	3	11	0
	Welford	24	20	71.7%	111.3%	126.6%	182.0%		100.0%	19.9%	14.4%	5.5%	6.7	3	7	0
	Beechwood Ward - BC03	24	21	149.2%	65.8%	122.8%	248.7%	100.0%	100.0%	33.2%	14.4%	18.9%	8.6	1	3	2
	Clarendon Ward - CW01	22	18	156.0%	60.7%	153.3%	230.0%			24.1%	8.3%	15.8%	8.4	1	3	0
	Coleman	21	17	75.7%	301.8%	139.2%	797.7%	100.0%	100.0%	65.0%	33.8%	31.2%	23.2	3	6	0
	Gwendolen	18	5	15.3%	18.7%	26.7%	42.2%			34.8%	14.6%	20.2%	31.6	0	0	0
	Wakerley (MHSOP)	21	13	77.2%	192.4%	157.8%	453.6%			54.4%	35.9%	18.5%	18.6	0	0	0
CHS East	Dalgleish Ward - MMDW	17	14	92.8%	71.0%	155.9%	156.1%	100.0%	100.0%	20.6%	10.5%	10.1%	9.0	1	1	0
	Rutland Ward - RURW	16	12	166.8%	73.5%	158.4%	155.9%			24.7%	15.0%	9.6%	11.5	0	1	1
	Ward 1 - SL1	15	12	75.7%	79.2%	181.4%	175.1%	100.0%	100.0%	20.6%	15.4%	5.1%	13.5	0	0	0
	Ward 3 - SL3	13	11	236.4%	72.0%	153.3%	189.1%	100.0%	100.0%	12.8%	9.3%	3.6%	12.3	1	1	0
CHS West	Ellistown Ward - CVEL	12	15	190.5%	61.4%	151.1%	160.3%	100.0%	100.0%	12.9%	7.7%	5.1%	11.3	0	0	0
	Snibston Ward - CVSN	18	15	106.9%	79.3%	173.1%	267.0%	100.0%	100.0%	17.0%	7.8%	9.2%	12.3	0	4	1
	East Ward - HSEW	22	16	66.3%	86.7%	162.8%	296.6%	100.0%	100.0%	28.5%	9.9%	18.6%	11.9	2	1	0
	North Ward - HSNW	18	14	91.0%	88.9%	143.1%	217.9%	100.0%	100.0%	24.0%	7.0%	17.0%	10.9	0	2	0
	Swithland Ward - LBSW	18	15	181.3%	73.8%	147.2%	150.8%	100.0%	100.0%	7.2%	3.3%	3.9%	10.4	0	1	0
FYPC	Langley	15	11	113.1%	118.1%	133.3%	162.2%	100.0%		46.9%	32.5%	14.4%	14.9	1	3	0
	CAMHS Beacon Ward - Inpatient Adolescent	0	8	129.6%	254.9%	142.0%	515.9%	100.0%	100.0%	66.8%	34.3%	32.5%	24.5	0	0	0
LD	Agnes Unit	4	3	161.8%	196.4%	165.4%	226.6%			52.2%	21.9%	30.3%	73.8	0	0	0

Annexe 2: Inpatient Ward triangulation staffing and NSIs.

Trust thresholds are indicated below;

- Temporary worker utilisation (bank and agency);
  - green indicates threshold achieved less than 20%
  - amber is above 20% utilisation
  - red above 50% utilisation
  - red agency use above 6%
- Fill rate >=80%

Mental Health (MH)

Acute Inpatient Wards

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints
Ashby	20	104.5%	192.4%	103.1%	76.7%	34.8%	28.3%	6.5%	6.3	0→	0→	0→
Aston	18	104.5%	116.8%	100.4%	84.4%	32.0%	24.5%	7.5%	6.9	3→	1↑	0→
Beaumont	20	101.7%	180.9%	98.3%	143.1%	58.0%	48.3%	9.7%	13.6	3↓	1↑	2↑
Belvoir Unit	9	125.9%	176.2%	195.4%	137.6%	43.7%	32.5%	11.2%	22.6	2↑	4↑	1↑
Heather	17	88.1%	148.4%	97.7%	134.1%	32.8%	27.7%	5.0%	7.3	1↓	3↑	0→
Thornton	19	112.3%	114.8%	101.3%	94.8%	38.2%	35.3%	2.9%	7.4	1↑	0→	0→
Watermead	19	105.6%	116.9%	92.9%	88.9%	18.5%	16.5%	2.1%	6.7	0↓	9↑	0→
Griffin	6	117.1%	170.0%	103.1%	424.5%	44.4%	41.1%	3.4%	26.8	0↓	1↑	0→
TOTALS										**10↓**	**19↑**	**3↑**

Table 4 - Acute inpatient ward safe staffing

All medication errors have been reviewed in line with Trust policy; there were ten errors that occurred on five wards, a decrease compared to May 2021. Of the ten incidents, analysis has shown there were three key themes; wrong dose administration, medication being found in patient property (medicines bought in to the ward) and wrong patient administration. To note as a consequence of the errors there was no or low levels of harm to the patient as an outcome.

Of the two wrong patient administration incidents it has been identified that staffing was a contributory factor; one error occurred and the staff member was an agency staff member and the other incident occurred when the ward was short staffed and a member of staff moved to support and was not familiar with the patients, analysis has linked the errors to not following medicines administration processes and patient identification robustly. All errors have been assessed and managed in line with the Trust medication error policy and supportive actions and reflection taken.

Analysis of the falls has shown two key themes; physical health linked to low blood pressure and dizziness and behavioural/mental health presentation, placement on floor.

As a result there is increased physiotherapy and occupational therapy activity supporting physical health needs. The physical health team review all patient fall incidents and highlight learning and feedback Ward leaders and members of the Multi-Disciplinary Team (MDT), PHT, this is generating increased communication and falls awareness by offering interventions and assessment opportunities. As a result staff are reviewing falls prevention and management interventions differently including levels of observations to support patient's needs.

Low Secure Services – Herschel Prins

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints
HP Phoenix	10	117.2%	137.0%	105.3%	130.9%	44.9%	32.7%	12.2%	12.6	0→	0→	1↑
TOTALS										**0→**	**0→**	1↑

Table 5- Low secure safe staffing

There were no medication errors or falls reported in June 2021 at Phoenix, Hershel Prins.

Phoenix continues to use a higher proportion of agency staff this month, this is due to staff leaving and waiting for newly recruited staff to start, temporary staffing bank registered nurse fill rate and the ongoing COVID-19 impact of staff isolation.

Rehabilitation Services

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers %	Bank %	Agency %	CHPPD	Medication	Falls	Complaints
Skye Wing	20	149.8%	98.2%	137.8%	137.8%	31.6%	28.9%	2.7%	7.4	1→	3↑	1↑
Willows	6	179.3%	91.2%	104.5%	102.2%	16.7%	16.2%	0.5%	17.5	0↓	0→	0→
Mill Lodge	12	83.5%	86.8%	128.9%	102.0%	48.8%	38.8%	9.9%	14.1	2↑	32↓	0→
TOTALS										3↑	**35↓**	1↑

Table 6 - Rehabilitation service safe staffing

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

There were three medication errors reported in June 2021, analysis has shown that one incident was in regard to medication being administered despite the prescription indicating for the medicine to cease, a second incident was in relation to medication being found with the patient and the third regarding medication not being prescribed on admission, on this occasion the patient self-administered the medication. All of the medication errors have been reviewed in line with the Trust policy, whilst no staffing factors were identified, learning was identified in regard to admission processes being robust and followed and as a result the patient pathway has been revisited with staff.

There were three patient falls at Stewart House, analysis has shown that one fall was unwitnessed, one was a fall during a self-transfer and one patient lost their balance. A review of the incidents has not identified any staffing impact as a contributory factor.

There were 32 patient falls on Mill Lodge, 16 of the falls were experienced by one patient, and analysis has shown that a high number of the falls occurred in the communal area as a result. The patient's risk assessment and care plan was reviewed in line with outcomes from the falls huddles and staffing increased to facilitate observation in the communal area.

Two other patients had repeated falls linked to mobilising in the bedroom between bed and the toilet. This is a known and ongoing managed risk for patients who are still mobile and wishing to maintain their independence without calling for assistance. Staff encourage patients to request assistance to support their preference and needs.

Causes of the falls were attributed to patient factors associated with Huntingdon's Disease; loss of balance and spatial awareness and also challenges in regard to consistent use of mobility aids.

Mental Health Services for Older People (MHSOP)

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints
BC Kirby	23	66.7%	120.8%	126.7%	155.3%	36.9%	30.7%	6.3%	7.4	3→	11↑	0→
BC Welford	20	71.7%	111.3%	126.6%	182.0%	19.9%	14.4%	5.5%	6.7	3↑	7↑	0→
Coleman	17	75.7%	301.8%	139.2%	797.7%	65.0%	33.8%	31.2%	23.2	3↑	6↑	0→
Gwendolen	5	15.3%	18.7%	26.7%	42.2%	34.8%	14.6%	20.2%	31.6	0↓	5↓	0→
Wakerley	13	77.2%	192.4%	157.8%	453.6%	54.4%	35.9%	18.5%	18.6	0→	0→	0→
TOTALS										9↑	**29↑**	**0→**

Table 7 - Mental Health Services for Older People (MHSOP) safe staffing

The MHSOP wards did not meet planned fill rates on days for Registered Nurses (RNs).The staffing establishment on wards consist of a Medication Administration Technician (MAT) and on Kirby Ward a mental health Practitioner (MHP). The ward skill mix also includes a registered nursing associate.

The service continue to have rolling adverts for band 5 recruitment, however applications and uptake in terms of attendance to interviews remains low. The service continues to use temporary staff to support unfilled shifts due to vacancies and to support increased patient acuity and levels of observation. Staffing is risk assessed and managed across all MHSOP wards and staff moved to support safe staffing levels and skill mix and patient care needs/acuity and dependency.

Due to the lower patient occupancy on Coleman and Wakerley Wards the staffing numbers and skill mix have been adjusted to reflect both the numbers of patients and their acuity and dependency levels. It is worth noting that both Coleman and Wakerley wards have higher levels of intensive patient observations and due to the functional bed demand at the Bennion centre at times the service has used the Evington centre (dementia) beds to facilitate admissions.

Matrons review all incidents, review of the medication errors and falls has shown that the majority of incidents reported resulted in no harm or minor, non-permanent harm with the exception of one patient fall on Kirby Ward that is subject to a serious incident investigation.

There were nine medication incidents reported in total across the four wards, of these three involved a medication administration error directly impacting a patient, all incidents were no harm incidents in terms of outcome to patient and all errors were reviewed in line with the Trust policy for medication errors. The remaining six medication incidents were in regard to the e-CD register and prescribing issues related to shared care agreements and access to medication through GP's for patients discharged.

Community Health Services (CHS)

Community Hospitals

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints
MM Dalgliesh	14	92.8%	71.0%	155.9%	156.1%	20.6%	10.5%	10.1%	9.0	1↑	1→	0→
Rutland	12	166.8%	73.5%	158.4%	155.9%	24.7%	15.0%	9.6%	11.5	0→	1↓	1↑
SL Ward 1	12	75.7%	79.2%	181.4%	175.1%	20.6%	15.4%	5.1%	13.5	0→	1↑	0↓
SL Ward 3	11	236.4%	72.0%	153.3%	189.1%	12.8%	9.3%	3.6%	12.3	1↑	1↓	0→
CV Ellistown 2	15	190.5%	61.4%	151.1%	160.3%	12.9%	7.7%	5.1%	11.3	0→	3↑	0→
CV Snibston 1	15	106.9%	79.3%	173.1%	267.0%	17.0%	7.8%	9.2%	12.3	0↓	2↑	1↑
HB East Ward	16	66.3%	86.7%	162.8%	296.6%	28.5%	9.9%	18.6%	11.9	2↑	1↓	0→
HB North Ward	14	91.0%	88.9%	143.1%	217.9%	24.0%	7.0%	17.0%	10.9	0→	2→	0→
Swithland	15	181.3%	73.8%	147.2%	150.8%	7.2%	3.3%	3.9%	10.4	0→	1↓	0→
CB Beechwood	21	149.2%	65.8%	122.8%	248.7%	33.2%	14.4%	18.9%	8.6	1→	3↑	2↑
CB Clarendon	18	156.0%	60.7%	153.3%	230.0%	24.1%	8.3%	15.8%	8.4	1↑	3↑	0→
TOTALS										6↑	19↓	4↑

Table 8 - Community hospital safe staffing

Feilding Palmer Hospital (FPH) continues to be temporarily closed to inpatient admissions in response to national COVID-19: infection, prevention and control guidance and to ensure patient and/or staff safety is not compromised and safety is prioritised. A review of the risk assessment against national guidance continues on a monthly basis at the Directorate Management Team meeting. Feilding Palmer Hospital continues to be used as part of the COVID 19 Vaccination Hub programme.

The high risk/red pathway site for Covid-19 positive patients continues to be North Ward Hinckley and Bosworth Hospital.

There is a low fill rate for the day shifts for Health Care Support Workers (HCSWs) across nine of the wards, an increased position from May 2021 (six wards). This continues to be due to a combination of factors linked to HCSW sickness and vacancies and adjusted skill mix during the month with some of the unfilled HCSW shifts filled with registered nurses (RNs), which also accounts for the increase in the fill rate of RNs.

Temporary workforce usage has increased further compared to May 2021 across the following wards; Dalgliesh, Rutland, St Lukes Ward 1, East, North, Beechwood and Clarendon Wards due to increased patient acuity and dependency, vacancies, maternity leave and sickness.

A review of the Nurse Sensitive Indicators (NSIs) for the community hospital wards has identified that there has been a further decrease in the number of falls incidents from 28 in May 2021 to 19 in June 2021. Ward 'areas to note' for increased falls include; Snibston and Ward 2 Coalville Hospital, Beechwood and Clarendon Wards. The wards have noted an increase in patient acuity including delirium presentation of the patients. Review of the

increased incidences has not identified any direct correlation between staffing and the impact to quality and safety of patient care/outcomes.

The number of medication incidents for the in-patient wards has increased from one in May to six in June 2021. A review of this incident has identified that there had been a failure of staff to follow medication procedure/policy/ guidelines, the incident has not identified any themes or direct correlation with staffing.

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

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints
Langley	11	113.1%	118.1%	133.3%	162.2%	46.9%	32.5%	14.4%	14.9	1↓	3↑	0→
CAMHS	8	129.6%	254.9%	142.0%	515.9%	66.8%	34.3%	32.5%	24.5	0→	0→	0→
TOTALS										**1↓**	**3↑**	**0→**

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

The increased temporary worker utilisation for both Langley and CAMHS is reflective of deployment of temporary staff to meet vacancies and patient care needs associated with increased and high levels of patient acuity. Recruiting to vacant posts continues to be a priority.

There was one medication error on Langley this month. An in-depth review has not identified any staffing impact on the quality and safety of patient care/outcomes and no harm caused. There has been an increase in falls during this quarter however this has not identified any staffing concerns.

Learning Disabilities (LD) Services

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints
Agnes Unit	3	161.8%	196.4%	165.4%	226.6%	52.2%	21.9%	30.3%	73.8	**0→**	0↓	**0→**
TOTALS										**0→**	0↓	**0→**

Table 10 - Learning disabilities safe staffing

Patient acuity remains high and staffing is increased to meet patient care needs, this is reflected in both the over utilisation of staff deployed against planned levels and high CHPPD. There were no medication errors, falls or complaints in June 2021.

Governance table

For Board and Board Committees:	Public Trust Board 31.8.21	
Paper sponsored by:	Anne Scott, Interim Executive Director of Nursing, AHPs and Quality	
Paper authored by:	Emma Wallis, Interim Deputy Director of Nursing and Quality	
Date submitted:	23.8.21	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Quality Forum	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Assured	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Monthly report	
STEP up to GREAT strategic alignment*:	High **S**tandards	√
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	√
	Single Patient **R**ecord	
	Equality, Leadership, Culture	
	Access to Services	
	Trust wide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	1: Deliver Harm Free Care 4: Services unable to meet safe staffing requirements
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:	considered	

Oii

Leicestershire Partnership NHS Trust

Public Trust Board - 31 August 2021

Safe Staffing- July 2021 review

Purpose of the report

This report provides an overview of nursing safe staffing during the month of July 2021, including a summary of staffing areas to note, updates in response to Covid-19, potential risks, and actions to mitigate the risks to ensure that safety and care quality are maintained.

The report triangulates workforce metrics, fill rates, Care Hours Per Patient Day (CHPPD), quality and outcomes linked to Nurse Sensitive Indicators (NSIs) and patient experience feedback. A summary is available in Annex 1; scorecard, with a detailed overview and exception report narrative by in-patient area and service in annexe 2.

Analysis of the issue

Right Staff

- Temporary worker utilisation rate slightly increased this month; 2.42% reported at 38.83% overall and Trust wide agency usage slightly increased this month by 1.04% to 14.61% overall. This is largely attributed to increased patient acuity and dependency and additional staff to support safe levels of observation and care. The increase use of agency is linked to two factors; increased demand and reduced bank fill rate associated with seasonal holiday.
- In July 2021; 26 inpatient wards/units utilised above 6% agency staff, this equates to 84% of our inpatient Wards and Units, changes from last month; Swithland, Griffin, Heather, Watermead and St Lukes Ward 3. Areas to note are identified either by the Head/Deputy Head of Nursing due to; high percentage of temporary worker/agency utilisation, or concerns relating to; increased acuity, high risk patients, staff sickness, ability to fill additional shifts and the impact to safe and effective care.
- There are 27 inpatient 'areas to note'; 26 of the 27 areas to note are due to agency utilisation over 6%.
- There are nine community team 'areas to note', changes to the previous month; Attention Deficit Hyperactivity Disorder (ADHD) Service is an emerging area to note due to the impact of planned service changes, vacancies and retirement.
- There is continued operational pressure across the whole community nursing service with a large number of staff absent from work with long and short term illness. A significant number of the absence sits in the city community hubs that remain key areas to note specifically City West and East hubs.

- Weekly safe staffing forecast meetings with Workforce and Safe staffing matron, Head/Deputy Heads of Nursing and Head of Workforce support continue to review staffing levels, actions to meet planned staffing, review of the risks and actions to mitigate the risks.

Right Skills

Changes to Mandatory and Role Essential Training during Covid-19:

- The compliance renewal date for each topic has been extended by 6 months.
- Correct to 1 August 2021 Trust wide substantive staff;
- Appraisal at 85.4 % compliance GREEN
- Clinical supervision at 75.9% compliance AMBER
- All core mandatory training compliance GREEN with the exception of Information Governance AMBER at 88.2%
- Clinical mandatory training compliance for substantive staff;
    - BLS slight reduction in compliance by 1.4% to 79.7% compliance AMBER
    - ILS improved 2.1% to 75% compliance AMBER
- Clinical mandatory training compliance for bank only workforce remains low;
    - BLS 50.8 % at RED compliance
    - ILS 37.5% at RED compliance

Right Place

- The Covid-19 risk managed wards are North, Beacon, Langley, Agnes Unit and Gwendolen Ward. Risk managed is to mean that the ward is caring for patients on the emergency admission Covid-19 high and medium risk pathways, as per the national safe staffing descriptors and IPC care pathways, maintaining separation between possible and confirmed COVID-19 patients and supporting staff cohorting. To note Gwendolen Ward is currently closed as there are no Covid-19 positive patients.
- Fill rates below 100% for actual HCSWs predominantly on days reflect adjusted staffing levels and skill mix to meet patient care needs.
- The total Trust CHPPD average (including ward based AHPs) is reported at 17.67 CHPPD in July 2021, with a range between 6.9 (Stewart House) and 75.0 (Gillivers, Short Breaks) CHPPD.
- General variation reflects the diversity of services, complex and specialist care provided across the Trust. Analysis has not identified significant variation at service level; indicating that staff are being deployed productively across services.

Staff absence data

The table below shows absence captured by the LPT Staff Absence Sitrep on 1 August 2021;

Self-Isolation - Household WFH wte	9.5
Self-Isolation – Symptomatic wte	9.5
Self-Isolation - Vulnerable Group wte	0
Test and Trace Notification wte	8.0
Covid-19 related absence wte	36.3
General Absence wte	217.2
Covid-19 related absence %	0.7%
General Absence %	4.6%
Total Absence	**5.3%**

Table 1 – Trust COVID-19 and general absence – 1 August 2021

In comparison to the previous month overall absence has increased 0.4% due to self and household isolation due to Covid-19 and a small number of staff following test and trace notification.

In-patient Staffing

Summary of inpatient staffing areas to note;

Wards	May 2021	June 2021	July 2021
Hinckley and Bosworth East Ward	X	X	X
Hinckley and Bosworth North Ward	X	X	X
St Lukes Ward 1		X	X
St Lukes Ward 3	X		X
Beechwood	X	X	X
Clarendon	X	X	X
Coalville Ward 1		X	X
Coalville Ward 2			
Rutland	X	X	X
Dalgleish	X	X	X
Swithland			X
Coleman	X	X	X
Gwendolen	X	X	X
Kirby		X	X
Welford		X	X
Wakerley	X	X	X
Aston	X	X	X
Ashby		X	X
Beaumont	X	X	X
Belvoir	X	X	X
Griffin	X		X
Phoenix	X	X	X
Heather			X
Watermead			X
Mill Lodge	X	X	X

Agnes Unit	X	X	X
Langley	X	X	X
Beacon (CAMHS)	X	X	X

Table 2 – In-patient staffing areas to note

Areas to note are identified either by the Head/Deputy Head of Nursing due to; high percentage of temporary worker/agency utilisation, or concerns relating to; increased acuity, high risk patients, staff sickness, ability to fill additional shifts and the impact to safe and effective care.

Covid-19 risk managed wards are also identified as areas to note; North Ward Hinckley, Langley, Agnes Unit and Gwendolen Ward. Risk managed is to mean that the ward is caring for patients on the emergency admission COVID pathway as per the national safe staffing descriptors and IPC care pathways medium and high. To note Gwendolen Ward is currently closed as there are no Covid-19 positive patients.

The Agnes Unit and CAMHS Beacon Unit are 'areas to note' due to a combination of factors; high percentage of temporary worker/agency utilisation, concerns relating to; increased acuity, high risk and vulnerable patients, safeguarding and safety incidents and impact to safe and effective care. Both areas are being supported with quality improvement plans, with oversight to the Trust Quality Assurance Committee.

Mill Lodge is an area to note due to the number of vacancies and due to concerns in regard to the high number of patient falls. The Director of Nursing, AHPs and Quality visited the Ward on 1 July 2021 and a quality summit was held including a deep dive review of patient falls. A number of actions are in place terms of recruitment to support continuity of staffing across the Ward with consideration to new/alternative roles. The Ward is supporting recruitment of two International Nurses and a Medicines Administration Technician. This will be further supported by the completion of the annual safe staffing establishment review in the next few months.

Number of occupied beds, temporary workforce percentage together with the NSIs that capture outcomes most affected by nurse staffing levels is presented in the tables per in-patient area by service and directorate in Annex 2.

Community Teams

Summary of community 'areas to note';

Community team	May 2021	June 2021	July 2021
City East Hub- Community Nursing	X	X	X
City West Hub- Community Nursing	X	X	X
Healthy Together – City (School Nursing only)	X	X	X
Healthy Together County	X	X	X
Looked After Children	X	X	X
Central Access Point team (MH)	X		

CRISIS DMH	X		
South Leicestershire CMHT	X	X	X
Assertive outreach		X	X
ADHD service			X
LD Community Physiotherapy	X	X	X

Table 3 – Community areas to note

Community areas to note are identified either by the Head/Deputy Head of Nursing due to; high percentage of temporary worker/agency utilisation, or concerns relating to; increased case load, high risk patients, staff sickness, ability to fill additional shifts and the impact to safe and effective care.

FYPC/LD Community

Healthy Together County, Healthy Together City and Looked After Children (LAC) teams continue to be rated to be at Amber escalation level due to a reduction in the established team; vacancies and retirement. Healthy Together teams are rated amber due to Specialist Community Public Health Nurse (SCPHN) vacancies and a number of staff retiring. LAC team recruited three Band 5 staff members. Risks continue to be monitored within the Directorate on a weekly basis.

Learning disabilities community physiotherapy is rated amber, the team continue to assess and treat all red and amber RAG rated referrals. Recruitment process is ongoing as there are challenges in recruiting to the Band 6 post.

CHS Community

There is increasing operational pressure across the whole community nursing service with a large number of staff absent from work with long and short term illness. A significant number of the absence sits in the city community hubs that remain key areas to note specifically City West and East hubs. As a result the service has had to defer a number of wound and holistic assessments and some treatment plans such as Doppler's.

A number of actions are in place to try to mitigate the staffing risks including;

- Deferred non-essential meetings
- Working with Centralised Staffing Solutions to support fill of shifts
- Redeploying community nurses from other hubs where possible and safe to do so
- Deployed staff from other clinical teams such as tissue viability and podiatry to support
- Integrated Community Specialist Palliative Care Team supporting community nursing activity as appropriate
- Continue to monitor and manage staff sickness and absence
- Targeted band 5 registered nurse, assistant practitioner and nursing associate recruitment

MH Community

The Central Access Point (CAP) continues to experience high levels of routine referrals; however the team has a new staffing model and plan in place to mitigate and this has now been removed from the risk register. The Crisis team had to cancel some home visits during July 2021 due to pressures on the service, no impact to patient safety; all patients were triaged and visited if deemed appropriate.

The number of vacancies across community services generally remains challenging and gaps are filled with bank and agency wherever possible; community mental health teams find it difficult to recruit agency workers for the block booking commitment required. Areas to note are South Leicestershire CMHT, Assertive Outreach and the Attention Deficit Hyperactivity Disorder (ADHD) Service is an emerging area to note due to the impact of planned service changes, vacancies and retirement.

Proposal

In light of the triangulated review of workforce metrics, nurse sensitive indicators and patient feedback, the Executive Director of Nursing, AHPs and Quality is assured that there is sufficient resilience across the Trust not withstanding areas to note, to ensure that every ward and community team is safely staffed.

Decision required

The board is asked to confirm a level of 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 is maintained.

July 2021

Ward Group	Ward	Average no. of Beds on Ward	Average no. of Occupied Beds	Fill Rate Analysis (National Return) Actual Hours Worked divided by Planned Hours – Nurse Day: Average % fill rate registered >=80%	Nurse Day: Average % fill rate non-reg >=80%	Nurse Night: Average % fill rate registered >=80%	Nurse Night: Average % fill rate non-reg >=80%	AHP Day: Average % fill rate registered	AHP Day: Average % fill rate non-reg	% Temporary Workers (NURSING ONLY): Total <20%	Bank	Agency	Overall CHPPD (Nursing And AHP)	Med Errors	Falls	Complaints
AMH Bradgate	Ashby	21	18	100.0%	131.3%	103.3%	81.3%			47.5%	38.2%	9.3%	7.1	0	1	1
	Aston	19	17	104.3%	220.6%	88.5%	146.2%			38.1%	30.3%	7.8%	8.0	0	1	0
	Beaumont	22	15	94.5%	155.5%	95.3%	118.9%			52.6%	47.3%	5.3%	14.8	2	3	0
	Belvoir Unit	10	8	116.4%	165.5%	184.6%	123.6%			44.4%	28.5%	15.8%	21.9	1	0	0
	Heather	18	16	89.8%	164.2%	91.2%	175.7%			48.8%	31.8%	17.0%	8.7	3	5	0
	Thornton	18	17	105.4%	159.8%	96.8%	110.6%			34.7%	32.8%	1.8%	29.4	0	0	0
	Watermead	20	16	94.7%	224.2%	91.7%	129.7%		100.0%	32.0%	25.9%	6.1%	7.9	1	4	1
	Griffin - Herschel Prins	6	5	130.9%	127.3%	96.3%	285.5%		100.0%	36.4%	30.6%	5.8%	26.6	1	0	0
AMH Other	Phoenix - Herschel Prins	12	10	105.9%	107.6%	109.4%	107.7%			42.5%	31.4%	11.1%	10.4	0	1	0
	Skye Wing - StewartHouse	30	21	122.3%	99.3%	150.1%	127.1%			35.7%	33.5%	2.2%	6.9	0	0	0
	Willows	9	6	145.3%	97.7%	105.7%	106.2%			29.0%	27.2%	1.8%	19.7	2	0	0
	Mill Lodge	14	13	94.6%	106.6%	129.0%	127.9%			61.3%	43.4%	17.9%	14.1	0	14	0
CHS City CHS East	Kirby	24	22	65.3%	117.1%	124.9%	182.6%	100.0%	100.0%	42.5%	35.0%	7.6%	7.7	1	4	0
	Welford	24	21	73.4%	152.5%	122.6%	282.0%		100.0%	33.8%	23.3%	10.5%	8.1	1	11	0
	Beechwood Ward - BC03	23	21	145.5%	71.5%	123.7%	255.7%	100.0%	100.0%	37.4%	19.1%	18.4%	8.9	0	1	0
	Clarendon Ward - CW01	21	18	168.0%	71.2%	154.8%	219.9%			29.7%	9.0%	20.7%	8.9	3	2	0
	Coleman	21	15	88.4%	246.1%	170.1%	540.6%	100.0%	100.0%	63.4%	36.3%	27.2%	21.4	2	5	0
	Wakerley (MHSOP)	21	16	74.3%	168.5%	137.6%	380.5%			48.7%	31.9%	16.7%	13.1	0	0	0
	Dalgleish Ward - MMDW	17	14	85.7%	80.8%	163.2%	177.2%	100.0%	100.0%	28.8%	14.7%	14.1%	9.1	0	2	0
CHS East CHS West	Rutland Ward - RURW	16	14	159.1%	77.4%	152.8%	150.3%			26.4%	13.7%	12.8%	9.2	1	6	0
	Ward 1 - SL1	17	8	15.8%	13.2%	29.7%	44.1%	100.0%	100.0%	11.9%	5.9%	5.9%	34.7	0	1	0
	Ward 3 - SL3	13	11	252.1%	70.3%	153.2%	291.2%	100.0%	100.0%	19.1%	12.5%	6.6%	13.0	0	1	0
	Ellistown Ward - CVEL	12	15	176.7%	66.2%	150.8%	158.3%	100.0%	100.0%	14.5%	9.5%	5.0%	11.6	0	0	0
CHS West FYPC	Snibston Ward - CVSN	18	17	118.2%	83.3%	202.2%	262.0%	100.0%	100.0%	22.0%	6.4%	15.6%	11.3	0	1	0
	East Ward - HSEW	23	20	69.8%	94.3%	152.0%	328.4%	100.0%	100.0%	29.9%	9.0%	20.9%	10.2	3	1	0
	North Ward - HSNW	18	12	88.6%	105.2%	155.8%	290.5%	100.0%	100.0%	34.1%	5.1%	29.0%	15.3	0	4	0
	Swithland Ward - LBSW	20	16	178.1%	70.3%	153.5%	153.3%	100.0%	100.0%	13.4%	5.6%	7.8%	9.7	0	2	0
	Langley	15	11	120.2%	123.8%	129.0%	138.7%	100.0%		48.1%	38.3%	9.7%	13.5	2	1	0
FYPC	CAMHS Beacon Ward - Inpatient Adolescent	16	9	111.6%	243.0%	133.9%	418.6%	100.0%	100.0%	68.3%	39.4%	28.9%	25.3	0	0	0
LD	Agnes Unit	4	2	151.5%	164.5%	182.2%	202.3%			46.5%	21.1%	25.4%	66.5	0	3	0
	Gillivers	1	1	84.5%	92.7%	90.3%	111.8%			0.5%	0.5%	0.0%	75.0	0	0	0

Annexe 2: Inpatient Ward triangulation staffing and NSIs.

Trust thresholds are indicated below;

- Temporary worker utilisation (bank and agency);
  - green indicates threshold achieved less than 20%
  - amber is above 20% utilisation
  - red above 50% utilisation
  - red agency use above 6%
- Fill rate >=80%

Mental Health (MH)

Acute Inpatient Wards

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints
Ashby	18	100.0%	131.3%	103.3%	81.3%	47.5%	38.2%	9.3%	7.1	0→	1↑	1↑
Aston	17	104.3%	220.6%	88.5%	146.2%	38.1%	30.3%	7.8%	8.0	0↓	1→	0→
Beaumont	15	94.5%	155.5%	95.3%	118.9%	52.6%	47.3%	5.3%	14.8	2↓	3↑	0↓
Belvoir Unit	8	116.4%	165.5%	184.6%	123.6%	44.4%	28.5%	15.8%	21.9	1↓	0↓	0↓
Heather	16	89.8%	164.2%	91.2%	175.7%	48.8%	31.8%	17.0%	8.7	3↑	5↑	0→
Thornton	17	105.4%	159.8%	96.8%	110.6%	34.7%	32.8%	1.8%	29.4	0↓	0→	0→
Watermead	16	94.7%	224.2%	91.7%	129.7%	32.0%	25.9%	6.1%	7.9	1↑	4↓	1↑
Griffin	5	130.9%	127.3%	96.3%	285.5%	36.4%	30.6%	5.8%	26.6	1↑	0→	0→
TOTALS										**8↓**	**14↓**	**2↓**

Table 4 - Acute inpatient ward safe staffing

Beaumont has utilised a higher percentage of temporary workforce in July 2021 this is mainly due to high patient acuity as the Ward is the admission ward for acute mental health, in addition there are higher levels of sickness and vacancies within the Ward team.

All medication errors have been reviewed in line with Trust policy; there were eight errors analysis has shown that out of the 8 medication related incidents reported 3 for Heather ward were incorrectly reported as medication errors as follows:

- 1 incident was reported twice
- 1 was a safeguarding incident reported as medication related
- 1 was rapid tranquilliser given which was not an error and given with consent

This leaves five actual medication incidents for the month, four of which were not administration errors. These four reported incidents were medicines management errors related to charting on Wellsky, storage, disposal of controlled drugs and misplaced medication.

The administration error was due to medication being administered outside of the recommended frequency. Relevant Trust policies were followed, no harm occurred to the patient and there was no link to staffing.

There were 14 reported falls in July 2021, analysis has shown that the falls that occurred were a mixture of patients who had a 'first' fall and repeated falls. One patient's 5th fall since admission was reported; the falls are attributed to behaviour and possibly due to elements of chronic pain. The patient has been supported with all members of the Multi-Disciplinary Team during this admission.

The majority of falls occurred on Beaumont the admission ward, and then Heather ward (where they have usually transferred to) followed by Watermead Ward, linking to patient acuity.

During July the patient fall themes have been;

- Deterioration of mental health affecting behaviour resulting in repeated placements on the floor and falls due to risky behaviour
- Trips
- Hypotension
- Pseudo seizures

Low Secure Services – Herschel Prins

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints
HP Phoenix	10	105.9%	107.6%	109.4%	107.7%	42.5%	31.4%	11.1%	10.4	0→	1↑	0↓
TOTALS										**0→**	1↑	0↓

Table 5- Low secure safe staffing

Phoenix continues to use a higher proportion of agency staff this month due to staff leaving and waiting for newly recruited staff to start, temporary staffing bank registered nurse fill rate.

There were no medication errors and one fall reported in July 2021 at Phoenix. Analysis has shown this fall was linked to physical health, paramedics attended and all physical observations within normal parameters, patient remained on Phoenix and under regular medical review. This incident could be classified as deterioration in clinical condition and not a fall as the patient was found on the floor.

Rehabilitation Services

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers %	Bank %	Agency %	CHPPD	Medication	Falls	Complaints
Skye Wing	21	122.3%	99.3%	150.1%	127.1%	35.7%	33.5%	2.2%	6.9	0↓	0↓	0↓
Willows	6	145.3%	97.7%	105.7%	106.2%	29.0%	27.2%	1.8%	19.7	2↑	0→	0→
Mill Lodge	13	94.6%	106.6%	129.0%	127.9%	61.3%	43.4%	17.9%	14.1	0↓	**14↓**	0→
TOTALS										2↓	**14↓**	0↓

Table 6 - Rehabilitation service safe staffing

Mill Lodge is an area to note due to the number of vacancies and due to concerns in regard to the high number of patient falls. The Director of Nursing, AHPs and Quality visited the Ward on 1 July 2021 and a quality summit was held including a deep dive review of patient falls. A number of actions are in place terms of recruitment to support continuity of staffing across the Ward with consideration to new/alternative roles. The Ward is supporting recruitment of two International Nurses and a Medicines Administration Technician. This will be further supported by the completion of the annual safe staffing establishment review in the next few months.

Mill Lodge continues to utilise a high percentage of temporary workforce due to the amount of vacancies, there are also two staff on long term sick and incidents of staff isolation due to Covid-19.

There were two medication errors reported in July 2021, both at Willows and both regarding patients receiving an extra dose. One was due to a 24hour period of as required medication (PRN) not being taken into account and one patient took an extra tablet that had been put to the side to administer a fresh one. Learning has been communicated in terms of discarding medication immediately and PRN alerts, no patient harm occurred and there were no staffing contributory factors identified in the reflections.

There were 14 patient falls on Mill Lodge a significant reduction compared to May and June 2021. This reduction is due to a female patient being discharged who experienced a high number of repeated falls in previous months.

Analysis has shown that the 14 falls were experienced by five patients. Themes of the falls were linked to mobilising in the bedroom between beds and the en-suite toilet facility, two 'rolls' from a bed and some trips associated with special awareness and footing linked to patient factors associated with Huntingdon's disease.

Mental Health Services for Older People (MHSOP)

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints
BC Kirby	22	65.3%	117.1%	124.9%	182.6%	42.5%	35.0%	7.6%	7.7	1↓	4↓	0→
BC Welford	21	73.4%	152.5%	122.6%	282.0%	33.8%	23.3%	10.5%	8.1	1↓	11↑	0→
Coleman	15	88.4%	246.1%	170.1%	540.6%	63.4%	36.3%	27.2%	21.4	2↓	5↓	0→
Wakerley	16	74.3%	168.5%	137.6%	380.5%	48.7%	31.9%	16.7%	13.1	0→	0→	0→
TOTALS										4↓	20↓	**0→**

Table 7 - Mental Health Services for Older People (MHSOP) safe staffing

The MHSOP wards did not meet planned fill rates on days for Registered Nurses (RNs) on all wards with the exception of Coleman Ward.

The staffing establishment on wards consist of a Medication Administration Technician (MAT) and on Kirby Ward a Mental Health Practitioner (MHP). The ward skill mix also includes a registered nursing associate.

Coleman Ward used 63.4% temporary staffing to maintain planned safe staffing levels, the increase in reliance on temporary staff this month is due to increased acuity, long term sickness and vacancies. In addition, Coleman staff have been securing additional workforce to cover anticipation of opening Gwendolen Red Zone for high risk/Covid-19 positive patients.

The service continues to use temporary staff to support unfilled shifts due to vacancies and to support increased patient acuity and levels of observation. Staffing is risk assessed and managed across all MHSOP wards and staff moved to support safe staffing levels and skill mix and patient care needs/acuity and dependency. In addition to increased acuity, the nature of the patients on the organic wards in particular necessitate a higher level of observation, therefore staffing levels need to reflect this increase level of need.

The service continues to have rolling adverts for band 5 recruitment, however applications and uptake in terms of attendance to interviews remains low. The service is planning to accommodate 8 international recruitment registered general nurses (2 per ward), expected to arrive in December 2021.

Analysis of the medication errors has shown that in all incidents there has been no harm to patients, one incident involved a patient being given the wrong medication whilst medications were administered by an agency worker who was unfamiliar with the patient and asked a student to confirm the patient's identity, staffing was a contributory factor for this incident.

Analysis of the falls has shown that there has been an increase in falls on Welford ward, associated with the physical frailty of patients admitted to the ward. There is a correlation between the change of Welford Ward to a mixed sex ward, and an increase in patient falls. In addition, Welford ward has had a patient who has sustained repeated falls, and observation levels have increased to support the patient.

Community Health Services (CHS)

Community Hospitals

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints
MM Dalgliesh	14	85.7%	80.8%	163.2%	177.2%	28.8%	14.7%	14.1%	13.1	0↓	1→	0→
Rutland	14	159.1%	77.4%	152.8%	150.3%	26.4%	13.7%	12.8%	9.1	1↑	6↑	0↓
SL Ward 1	8	15.8%	13.2%	29.7%	44.1%	11.9%	5.9%	5.9%	9.2	0→	1→	0↓
SL Ward 3	11	252.1%	70.3%	153.2%	291.2%	19.1%	12.5%	6.6%	34.7	0↓	1→	0→
CV Ellistown 2	15	176.7%	66.2%	150.8%	158.3%	14.5%	9.5%	5.0%	13.0	0→	3↑	0→
CV Snibston 1	17	118.2%	83.3%	202.2%	262.0%	22.0%	6.4%	15.6%	11.6	0→	1↓	0↓
HB East Ward	20	69.8%	94.3%	152.0%	328.4%	29.9%	9.0%	20.9%	11.3	3↑	1→	0→

HB North Ward	12	88.6%	105.2%	155.8%	290.5%	34.1%	5.1%	29.0%	10.2	0→	4↑	0→
Swithland	16	178.1%	70.3%	153.5%	153.3%	13.4%	5.6%	7.8%	15.3	0→	2↑	0→
CB Beechwood	21	145.5%	71.5%	123.7%	255.7%	37.4%	19.1%	18.4%	8.9	0↓	1↓	0↓
CB Clarendon	18	168.0%	71.2%	154.8%	219.9%	29.7%	9.0%	20.7%	8.9	3↑	2↓	0→
TOTALS										**7↑**	**23↑**	0↓

Table 8 - Community hospital safe staffing

Feilding Palmer Hospital (FPH) continues to be temporarily closed to inpatient admissions in response to national COVID-19: infection, prevention and control guidance and to ensure patient and/or staff safety is not compromised and safety is prioritised. A review of the risk assessment against national guidance continues on a monthly basis at the Directorate Management Team meeting. Feilding Palmer Hospital continues to be used as part of the COVID 19 Vaccination Hub programme.

The high risk/red pathway site for Covid-19 positive patients continues to be North Ward Hinckley and Bosworth Hospital.

Ward 1 St Lukes Hospital is a stroke Ward, the ward was temporarily closed for essential roof repairs and refurbishment from 2 July to 26 July 2021. Stroke pathway beds were relocated to Snibston Ward, Coalville changing medical beds into 18 stroke beds. As a result the fill rate for Snibston increased and shows as higher than planned for RNs on days, this was due to an increase in the number of stroke patients as detailed above and the need to increase to three RNs on all shifts to manage the patient change and increase in levels of acuity and dependency during the month.

There is a low fill rate for the day shifts for Health Care Support Workers (HCSWs) across seven of the wards, decreased position from June 2021 (nine wards). This continues to be due to a combination of factors linked to HCSW sickness and vacancies and adjusted skill mix during the month with some of the unfilled HCSW shifts filled with registered nurses (RNs), which also accounts for the increase in the fill rate of RNs.

Temporary workforce usage has increased further compared to June 2021 across all wards with the exception of St Lukes Ward 1 and Ward 3 and Ward 2 Coalville this is due to increased patient acuity and dependency, patients requiring enhanced observations due to one to one care, annual leave, vacancies, maternity leave, sickness and the impact of track and trace.

A review of the Nurse Sensitive Indicators (NSIs) for the community hospital wards has identified an increase in the number of falls incidents from 20 in June 2021 to 23 in July 2021. Ward 'areas to note' for increased falls include; Ward 2 Coalville Hospital, North Ward Hinckley and Rutland Wards. The wards have noted an increase in patient acuity including delirium presentation of the patients. Review of the increased incidences has not identified any direct correlation between staffing and the impact to quality and safety of patient care/outcomes.

The number of medication incidents for the in-patient wards has increased from 6 in June to 7 in July 2021. A review of these incidents has identified these relate to the new electronic

CD drug register rollout across the wards and has not identified any themes or direct correlation with staffing.

There were no formal complaints received during July 2021.

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

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints
Langley	11	120.2%	123.8%	129.0%	138.7%	48.1%	38.3%	9.7%	13.5	2↑	1↓	0→
CAMHS	9	111.6%	243.0%	133.9%	418.6%	68.3%	39.4%	28.9%	25.3	0→	0→	0→
TOTALS										2↑	1↓	0→

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

The increased temporary worker utilisation for both Langley and CAMHS is reflective of deployment of temporary staff to meet vacancies and patient care needs associated with increased and high levels of patient acuity. Recruiting to vacant posts continues to be a priority in both areas. The Beacon has recruited a number of band 5 registered nurses and continues to make efforts to fill vacancies.

There were two medication errors and one patient fall on Langley Ward in July 21, analysis has shown that the first medication error was due to a patient engaging staff in a discussion about medication and checking these off whilst they were being dispensed leading to the error. The fall occurred when a patient was on a group walk outside; the patient missed her footing whilst trying to avoid a puddle and fell over and sustained minor injuries, no harm.

Learning Disabilities (LD) Services

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints
Agnes Unit	2	151.5%	164.5%	182.2%	202.3%	46.5%	21.1%	25.4%	66.5	0→	3↑	0→
Gillivers	1	84.5%	92.7%	90.3%	111.8%	0.5%	0.5%	0.0%	75.0	0→	0→	0→
TOTALS										0→	3↑	0→

Table 10 - Learning disabilities safe staffing

Patient acuity remains high and staffing is increased to meet patient care needs, this is reflected in both the over utilisation of staff deployed against planned levels and high CHPPD. There were three patient falls on the Agnes Unit in July 2021. On review all of these falls where the same individual who was presenting with mania and fast pacing; impacting on the individuals mobility/stability. The patient has been stabilised with medication the individual's presentation and mobility has improved.

Governance table

For Board and Board Committees:	Public Trust Board	
Paper sponsored by:	Anne Scott, Interim Executive Director of Nursing, AHPs and Quality	
Paper authored by:	Emma Wallis, Interim Director of Nursing and Quality	
Date submitted:	20.8.21	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Quality Forum	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Assured	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Monthly report	
STEP up to GREAT strategic alignment*:	High **S**tandards	√
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	√
	Single Patient **R**ecord	
	Equality, Leadership, Culture	
	Access to Services	
	Trust wide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	1: Deliver Harm Free Care 4: Services unable to meet safe staffing requirements
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:	considered	

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Leicestershire Partnership NHS Trust

Public Trust Board – 31 August 21

Six month Safe and Effective Staffing review – January 2021 – June 2021

Purpose of the report

The purpose of the report is to provide a six month overview of nursing safe staffing including; right staff, right skills, right place; establishment reviews, workforce planning, new and developing roles and recruitment and retention in line with NHS Improvement (NHSI) *Developing Workforce Safeguards policy* [1].

Background

All NHS Trusts are required to deploy sufficient, suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively, National Quality Board (NQB)' *Safe sustainable and productive staffing* [2].

The monthly Trust safe staffing reports provide a triangulated overview of nursing safe staffing for our in-patient areas and community teams. The report includes; actual staffing against planned staffing (fill rates), Care Hours Per Patient Day (CHPPD) and quality and safety outcomes for patients sensitive to nurse staffing.

The last six month safe and effective report was presented to Trust Board on 3 March 2020. Subsequent six monthly reviews due in July 2020 and January 2021 were paused from the Quality Assurance Committee (QAC) work plan due to the pandemic; in addition there have been no formal annual establishment reviews during this time period.

In responding to Covid-19 staffing surge and escalation plans, decisions regarding skill mix and nurse ratios were taken in conjunction with a review of patient acuity and dependency, professional judgement and the environment of care. Proposals for redeployment and surge/escalation plans were connected to the wider system, with proposal papers and quality impact assessments submitted to the Trust Clinical Reference Group, then Incident Control Centre for robust governance and assurance.

Trust self- assessments against NHS Key actions; Management and Assurance of Nurse Staffing during current wave of Covid-19 pressures and Mental Health and Learning Disabilities Safe Staffing Board Assurance framework was presented to QAC as part of the Director of Nursing (DoN) report in March 2021. To note; no gaps were identified following self-assessment and review.

Analysis of the issue

National Overview

In December 2020 NHS England & Improvement (NHSE & I) in conjunction with Health Education England (HEE) outlined key priorities for organisations to meet the workforce requirement for the phase 3 Covid-19 response;

- Assess the clinical workforce required for services needed over winter
- Deliver additional workforce supply from the sources identified (including Bringing Back Staff regional hubs and NHS Professionals).
- Embed ongoing risk assessments as part of workforce planning and ongoing discussions with staff.
- Maintain the health and wellbeing of the whole workforce

In addition, Ruth May, Chief Nursing Officer for England asked for a continued focus to increasing the nursing and midwifery workforce, aligned to the Government's commitment to an additional 50,000 nurses using a multi-factorial approach at national, regional and organisational level. The following national actions were outlined to support local implementation;

Temporary registrants

The government introduced emergency legislation that allowed the Nursing and Midwifery Council (NMC) to create a Covid-19 temporary register. Over 13,000 nurses and midwives signed up to the temporary register. Actions to support returners in the short term and how we can retain them in the longer term were outlined with national guidance on routes to enable individuals to re-join the permanent register, supported by national funding from HEE.

The Trust actively engaged with the National NHS "Bring Back Staff" campaign (BBS). This saw 59 people approach the Trust to come back in the first wave, broken down as 19 AHPs, 11 medics, 27 nurses and 2 pharmacists. In general terms, BBS applicants had been out of clinical practice for some time and assessed by clinicians as not safe to deploy back in to practice without robust levels of training, supervision and enhanced support. Additionally some of the applicants only wanted non-patient facing roles due to shielding related reasons and others could only offer very part time hours e.g. 7 hours a month.

Currently there are nine nurses working within the Trust as temporary registrants.

International nurse recruitment

The pandemic has impacted on international recruitment (IR) of nurses in multiple ways however as some international markets reopen there is a real opportunity to accelerate the recruitment and arrival of international nurses. As such the CNO team developed a national offer for organisations to support the pastoral cost elements of IR, including

flights, airport transfers, welcome packages, OSCE training, quarantine periods and accommodation.

On this basis LPT submitted two funding bids to Health Education England to support the IR programme, educational and pastoral support .A Trust plan to internationally recruit thirty registered general nurses by December 2021 and a pathway to 'grow our own' non-registered staff with a non-UK nursing qualification to achieve NMC registration was presented to the Strategic Executive Board on 16 October 2020 and 15 January 2021.

The plan included recruitment to new Trust posts to lead, support and co-ordinate the recruitment, educational and pastoral support programme for international recruitment. The International Recruitment (IR) Matron post was recruited to on 12 April 2021, Education and Practice development Nurse recruited to and commences on 16 August 2021 and HR IR support worker commenced on 5 July 2021. Recruitment was impacted due to the pause nationally in May 2021 and withdrawal of Global Learners recruitment agency. The team are currently working in conjunction with system partners University Hospitals of Leicester to recruit through a UHL procured agency and access the UHL OSCE education and training programme.

A non-registered staff member from Mental Health Services for Older People (MHSOP) service is the first person to attend 'grow our own' non-registered IR pathway and has successfully worked through this and passed their OSCE and is now registered with the NMC. We have six further non-registered staff on the pathway.

Healthcare support workers

Healthcare support workers (HCSWs) play a vital role supporting our clinical teams to deliver the best outcomes for our patients. During the pandemic there was increased interest in healthcare roles and local efforts to recruit to vacancies from other affected sectors. Funding to accelerate recruitment, on-boarding and ongoing support for new HCSWs without prior health or social care experience, in order to significantly reduce established vacancies as close to zero as operationally possible by March 2021 was made available for Trusts.

In response to this ambition, an intense 5 day core Health Care Assistant (HCA) clinical skills training programme has been developed and delivered with sufficient assurance built into the training and on boarding process, that the current essential requirement for all HCA to have previous health/care experience to apply for band 2 posts has been removed for substantive posts.

The aim is also to use the project as a springboard to develop a sustainable and viable initial core training programme which would be offered to all HCAs coming to work within LPT.

Without a team of designated clinical educators to deliver the programme, a Band 7 CHS Clinical Education Lead has acted as the course lead. Teaching is delivered on a sessional basis provided by Clinical Educators from within CHS, Directorate of Mental Health (MH) and from the LPT Integrated Care Home Team.

- Six courses delivered to date with a total of 60 places available.
- 28 delegates have attended: 8 delegates new to health care, 14 joining with some prior care experience, 4 existing LPT HCAs and 2 Bank staff.
- Of those numbers; 24 HCAs have been appointed to community hospital wards, one to FYPC&LD Services and one to Mental Health Services.
- To further support learning in practice, Allied Health Professionals (AHPs) have been delivering a therapy training day for the HCAs within the ward areas.
- Individual session and course evaluations have been extremely positive and rated excellent.
- The programme has been submitted as a Quality Improvement project. The outcome measures will include capturing how training has impacted from participants, colleagues and managers perspective.
- Feedback from ward managers has been that the course has given the HCAs the initial skills they need to start in practice. HCAs have said they feel valued and supported.

Midlands Out of Hospital Nursing Workforce Group

This is a sub-group of the Midlands Nursing & Midwifery Workforce Board. The introduction of the Out of Hospital Nursing (OOHN) Workforce Group aims to support the delivery of workforce related ambitions across primary, community and social care. It will enable focused discussion in support of the development and delivery of a regional OOHN workforce programme. Although it will focus on the nursing agenda, it will also align to other groups to promote multi-disciplinary team working and alignment with other directorate colleagues and across professional boundaries. The Trust interim Deputy Director of Nursing and Quality has been selected to join this regional group.

Trust overview - 'Right staff, Right Skills, Right Place'

Right Staff

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

	DAY		NIGHT		
Trust wide	% of actual vs total planned shifts RN	% of actual vs total planned shifts care HCSW	% of actual vs total planned shifts RN	% of actual vs total planned shifts care HCSW	Temp Workers%
Jan 21	117.7%	104.3%	127.1%	117.7%	35.52%
Feb 21	118.7%	108.2%	128.1%	118.7%	37.27%
March 21	113.5%	108.1%	124.8%	113.5%	38.28%
April 21	120.1%	113.3%	126.1%	120.1%	32.60%
May 21	108.8%	117.0%	132.0%	108.8%	35.49%
June 21	106.4%	114.5%	127.5%	106.4%	36.41%
Average	**114.0%**	**110.9%**	**127.6%**	**114.0%**	**35.92%**

Overall the planned staffing levels were achieved across the Trust on a monthly basis. Exception reporting is provided monthly within the Trust safe staffing report per service.

Over the last six months the Mental Health Older People (MHSOP) wards did not consistently meet the planned registered nurse (RN) fill rate on days and Community Hospital wards did not consistently meet the planned Health Care Support Worker (HCSW) fill rate on days.

MHSOP Wards

The staffing establishment on wards consist of a Medication Administration Technician (MAT) and on Kirby Ward a mental health Practitioner (MHP). The ward skill mix also includes a registered nursing associate.

Staffing is risk assessed and managed across all MHSOP wards and staff moved to support safe staffing levels and skill mix and patient care needs/acuity and dependency. Analysis has shown that changes/staff movement is not always consistently updated and reflected on eRoster this impacts the actual fill rate data for RNs on days.

Community Hospitals

The low Health Care Support Workers (HCSWs) fill rate on day shifts across eight of the wards is due to a combination of factors impacted by HCSW sickness, vacancies and occupancy resulting in adjusted skill mix to meet actual staffing needs. The unfilled HCSW shifts have on occasions been substituted with registered nurses this accounts for the increase in the fill rate of registered nurses.

Increased utilisation and fill rates of HCSWs

Increased utilisation of additional HCSWs remains high in Mental Health Services for Older People (MHSOP) wards, Mental Health (MH) wards, CAMHS, Families Young People and Children's (FYPC) and Learning Disabilities (LD) services. Additional HCSWs are deployed to support increased patient acuity and high levels of patients requiring increased levels of observation within these areas to support safe care.

Temporary staffing utilisation

The Trust (six month average) percentage use of temporary workers is 35.92% this is a slight increase (3.82%) from the previous reported six month average. Utilisation of temporary workers is to support vacancies, sickness and increased patient acuity and dependency. In this time period it was also to support additional surge wards across the Trust as part of the system pandemic response. To note the majority of temporary workers utilised are Trust bank only staff, who work regularly across our services, wards and community teams.

The Trust (six month average) percentage of temporary workers who are agency staff is 11.55%; this is a significant increase across services in the last 12 months. Contributory factors linked to increased demand due to high patient acuity and dependency, surge wards, increased staff Covid-19 absence, increased incidences and Covid-19 outbreaks, and staff movement due to individual risk and care pathways.

Right Skills

Changes to Mandatory and Role Essential Training during Covid-19:

- The compliance renewal date for each topic has been extended by 6 months.
- All face to face training is slowly being reintroduced with staff being invited to attend mandatory training on a clinical risk basis, contacted directly by Learning & Development to attend.
- Correct to 1 June 2021 Trust wide substantive staff;
    - Appraisal at 89.5 % compliance GREEN
    - Clinical supervision at 88.1% compliance GREEN
    - PPE donning and Doffing at 89.6% GREEN

Changes to Mandatory and Role Essential Training during Covid-19:

- The compliance renewal date for each topic has been extended by 6 months.
- All face to face training is slowly being reintroduced with staff being invited to attend mandatory training on a clinical risk basis, contacted directly by Learning & Development to attend.
- Correct to 1 June 2021 Trust wide substantive staff;
    - Appraisal at 89.5 % compliance GREEN

- Clinical supervision at 88.1% compliance GREEN
- PPE donning and Doffing at 89.6% GREEN

Area to note;

Resuscitation training is a mandatory training requirement for all clinical (registered and non-registered) staff. The determination of which resuscitation training each staff requires is identified in the national core skills training framework. All training in the Trust is accredited with the UK Resus Council. There are two forms of resus delivered: Basic Life Support; and Immediate Life Support.

Basic Life Support (BLS):
3431 substantive staff and 705 bank staff, require this on an annual basis (Covid-19 refresher 18 monthly)

Compliance substantive staff as 1 June 2021 – 75.2% (AMBER, trending up)
Compliance for bank staff as at 1 June 2021 – 48.9% (RED, trending down)

Immediate Life Support (ILS):
587 substantive staff and 140 bank staff, require this on an annual basis (Covid-19 refresher 18 monthly)

Compliance substantive staff as at 1 June 2021 – 70.8% (RED, trending up)
Compliance for bank staff as at 1 June 2021 – 31.9% (RED, trending down)

The Covid-19 impact:

- Face to face training stopped for 3 month April 2020 to 6th July 2020 (3 months) for substantive and bank staff.
- 6 month refresher extension given to mandatory training topics for all staff
- **I**LS and MAPA compliance rule for bank staff to book shifts removed to enable more support for clinical services
- Training course capacity reduced by 50% to 75% due to 2m rule
- Trainer capacity - Trainer's training full-time; 1 w.t.e reduced due to long term sickness from March 2021 onwards.
- Incidences of delegates attending and their Covid-19 status requiring courses to be stopped or leaving the course.
- Non-attendance on booked places (DNAs) without cancelling increased from a pre-Covid-19 accepted 15% DNA rate to upwards of 25% regularly
- Trainers and delegates in PPE including face masks and visors

A number of actions and steps taken to support improved attendance and compliance, summary below;

- Issue of non-attendance at training (DNA) raised at both Training, Education and Development Group (TED) and Deteriorating Patient and Resus Group (DPARG). Actions were taken from these groups by service lead members to respond within their clinical services and through to Directorate Management Teams.
- BLS is delivered at sites across the county and city to improve attendance of local staff
- Available places at BLS are shared on closed Facebook, through TED and the Education and Training ICC cell.
- Managers are sent emails from the current LMS when staff have not attended or cancelled training
- ILS recertification has been reduced from a full day's training to ½ day training. This has enabled more courses to be delivered.
- Resus trainers are now also supporting the delivery of BLS, in particular BLS Hospital which has released clinical trainer capacity and additional courses to be run (approx. additional 200 places in June 2021)
- Approved recruitment over establishment for an additional two w.t.e clinical trainers. Successful interviews with anticipated start date of September/October 2021.

Managing the risk of potential untrained/out of date staff in practice

- Managers receive reports of staff who are out of date with resus training and also emails from the LMS when they do not attend
- Managers have a local risk assessment to support them in covering practice with appropriately qualified staff are on shift e.g. moving an ILS trained staff member to cover
- Resus training team reintroduced clinical drills on site in April 2021 as a support to those services/staff who have been unable to attend ILS/BLS training.

Bank staff training compliance

The Trust has a large bank only workforce with individuals working across a wide range of professions, roles and services. Compliance with mandatory training for bank staff has historically been lower than that of substantive staff. This raises challenges particularly in areas where bank use is high and assurance is required that bank workers who are actively working in our services have the right skills.

From June 2021, the Trust introduced pay progression for bank staff to recognise their contribution in creating high quality, compassionate care and wellbeing for all. One of the eligibility criteria for pay progression is that all mandatory training is in date (core and clinical mandatory) and clinical supervision is in date (at least one every three months). It is anticipated that this may work as an incentive and as a result will improve attendance and compliance.

Right Place

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

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

CHPPD includes total staff time spent on direct patient care but also on activities such as updating patient records and sharing care information with other staff and departments. It covers both temporary and permanent care staff but excludes student nurses and staff working across more than one ward. CHPPD relates only to hospital wards where patients stay overnight.

NHS England and Improvement national nursing CHPPD data is reported from the organisational monthly staffing returns from 195 Trusts including LPT.

The national nursing average is reported at 10.21 CHPPD in April 2021. The Trust nursing average is reported at 12.4 CHPPD in April 2021.Comparative Trust averages; Lincolnshire 10.25 CHPPD, Derbyshire 16.23 CHPPD and Midlands Partnership 11.32 CHPPD.

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

Establishment reviews – In-patient Wards

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

Due to the pandemic response, the annual establishment reviews and bi-annual acuity and dependency evidence based data collection was paused.

In responding to Covid-19 staffing surge and escalation plans, decisions regarding skill mix and nurse ratios were taken in conjunction with a review of patient acuity and dependency, professional judgement and the environment of care. Proposals for redeployment and surge/escalation plans were connected to the wider system, with

proposal papers and quality impact assessments submitted to the Trust Clinical Reference Group, then Incident Control Centre for robust governance and assurance.

To support and facilitate a triangulated and evidence based review of all in-patient nursing establishments a new post Workforce and Safe Staffing matron commenced on 7 June 2021. The plan is to commence a staged approach to acuity and dependency data collection form August 2021 using the Shelford Mental Health Optimal Staffing tool, Learning Disabilities Optimal Staffing Tool in DMH and FYPC and Activities of Daily Living tool (Hurst) in CHS.

Community Nursing Service Workload, Staffing and Quality Project

CHS Community Nursing have been selected to join the NHS England and Improvement Community Nursing Service workload, staffing and quality project as part of phase 3 development of the tool.

Workforce Planning

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

We are the NHS: People Plan 2020/21

We are the NHS: People Plan 2020/21 – action for us all, along with Our People Promise, sets out what our NHS people can expect from their leaders and from each other. It builds on the creativity and drive shown by our NHS people in their response, to date, to the COVID-19 pandemic and the interim NHS People Plan.

It focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as take action to grow our workforce, train our people, and work together differently to deliver patient care

It includes specific commitments around:

- **Looking after our people**
- **Belonging in the NHS**
- **New ways of working and delivering care**
- **Growing for the future**

A summary of the Trust response to the key commitments;

Looking after our people

- Ensuring diversity across recruitment panels

- Continue to support and provide staff with information and resources to support their health and well-being
- Flexible working
- Together against racism

Belonging in the NHS

- Growing the network of staff support groups
- Increase BAME staff representation at bands 8 a and above
- Embedding our leadership behaviours across the organisation
- Continuing the Our Future Our Way culture leadership inclusion programme

New ways of working and delivering care

- Developing new roles to ensure multidisciplinary teams can provide the right capacity at the right time in the right place
- Using digital systems and new ways of working to make best use of skills, experience and capacity

Growing for the future

- Grow our own clinical apprentice to registrant
- Career development and progression with the aim of retaining our workforce
- Enhancing the student placement experience

Recruitment

Across the Trust, we currently have 328 nursing vacancies, according to our vacancy data reports. This is at Band 5 and Band 6 level.

This is broken down as below, to note there are certain caveats with the data:

- The numbers above may not be a true reflective picture as some services may be over-recruited on some wards and under-recruited on others against their financial establishment.
- There may be vacancies that are covered by other staff and this is not reflected in the establishment fully

Directorate	Number of Vacancies	Number of Live Nurse Adverts	Number of Live Band 5 Adverts	Number of Live Band 6 Adverts	Number of candidates with interviews booked	Number of candidates at recruitment check stage
DMH	155	7	4	3	28	20
FYPC/LD	64	8	5	3	19	12
CHS	109	7	6	1	19	17
TOTALS	**328**	**22***	**15**	**7**	**66**	**49**

Breakdown of Recruitment campaigns by Directorate

This is a summary of major campaigns that have been employed in addition to the 'business as usual' approach taken to promote recruitment opportunities.

CHS

CHS Community Recruitment

- 12 month recruitment campaign signed off to fill 30 vacancies in 2 specific locations in Leicester City. Campaign will launch in July 2021.
- A major focus of the campaign is offering flexible working hours to help attract Nurses.

HomeFirst

CHS Community benefited from an LLR system-wide recruitment campaign utilising the HomeFirst brand that was launched in Oct 2020. This targeted all roles including Nursing and AHPs for LPT and system partners. Attraction approaches used included:

- Multiple smaller, local radio stations in particular making sure that stations aligned to different communities were utilised to widen message and support an inclusive recruitment approach
- Social Media campaign including paid Google and Facebook promotion
- Bespoke landing page on the Your Future website deployed to support campaign and act as a cross system destination to promote opportunities
- Setting up a text response service to capture interest of candidates
- The campaign is still running with adverts utilising the #HomeFirst on adverts.

CHS Inpatient Nursing

- Launching a landing page for recruitment on Your Future, in July 2021.
- 30-day RCNi Job advert signed off to go live in July 2021.
- Trying a centralised approach of recruitment with a push on flexibility in terms of working hours to attract further candidates.

FYPC/LD

LD Recruitment Campaign

Launched a recruitment campaign at the end of 2020 due to additional funding to recruit a range of roles including nurses and AHPs for LPT and the wider system.

- Set up a landing page on Your Future and posted content through social media.
- Recruitment team offered a hands-on approach in terms of supporting the recruitment process and prioritising recruitment checks for successful candidates.

DMH

Crisis/CAP MHP Recruitment

- Currently recruiting for 42.5 WTE Mental Health Practitioners (MHPs) and Senior MHPs.
- Recruitment has been happening consistently for the past months for this service. This will be enhanced with different recruitment marketing – currently in the process of agreeing funding and an execution plan.

International Recruitment

As highlighted earlier in the report; a cross directorate initiative with a Trust commitment to recruit 30 nurses across the Trust by December 2021. Plans have been impacted by Covid-19 both in UK and India, but we are now progressing this with staff recruited to support the programme.

Grow Our Own

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

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

Roles that impact the establishment	**Roles that need specific education**
Nursing Associates	Health Visitor
Medicine Administration Technicians	School Nurse
Physicians Associate	District Nurse
Advanced Clinical/Nurse Practitioner	Physiotherapy
Medical Assistants	Occupational Therapy
Peer Support Worker	Nursing
Assistant Practitioner	Nursing Associate
	Clinical Apprentice
	Non-Medical Prescriber
	Clinical/Medical Psychology
	Advanced Clinical Practitioner

The table below outlines the current position;

Role	**Currently on programmes**	**Breakdown per directorate / profession**	**Comments**
Trainee Nursing Associates	36	MH- 16 FYPC – 7 CHS – 13	2 Cohorts due to complete March & June 2022 2 Cohorts due to complete March & June 2023
Registered nursing	0		Recruitment recently undertaken

Role	Currently on programmes	Breakdown per directorate / profession	Comments
Degree programme (Top Up)			11 due to commence programme October 2021
Clinical Apprentices	12	Physio x 8 OT x 4	4-year part-time programme with Coventry University 4-year part-time programme with Coventry University
Degree Apprenticeship nurses	4	LD – 2 CHS – 1 MH – 1	Feb 2021 Cohort – 4 year part time programme with OU

Currently there are 22 registered nursing associates working in all three clinical directorates.

eRoster

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

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

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

These actions will help services to better plan their workforce and manage staffing levels on a shift by shift basis. Detailed reports on rostering effectiveness are provided to services each month to measure the impact of different initiatives and to help identify areas for improvement.

Safe care

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

Safe Care also has a positive impact on improving accuracy of rosters through contemporaneous updating of changes which further informs decision making and visibility. The net result of the above is an improved utilisation of substantive staff and reduction in temporary staff requirement.

Data collection/fact finding meetings will commence in July 2021 with a view to commencing as a pilot in four services where Allocate will take us through the pilot implementation using a train the trainer approach. Workforce systems will then continue the implementation across the Trust as per plans (to be developed).

Decision required

The Trust Board is asked to confirm a level of assurance in light of the report.

References

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

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

Governance table

For Board and Board Committees:	Public Trust Board 31.8.21	
Paper sponsored by:	Anne Scott, Executive Director of Nursing, AHPs and Quality	
Paper authored by:	Emma Wallis, Associate Director of Nursing and Professional Practice. Contributions from; Amrik Singh, Dan Norbury, Alison O'Donnell, Julie Cliffe, Elaine Liquorish, Asha Day	
Date submitted:	23.8.21	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Quality Assurance Committee 27.7.21	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Amber rated	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Six monthly	
STEP up to GREAT strategic alignment*:	High **S**tandards	√
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	√
	Single Patient **R**ecord	
	Equality, Leadership, Culture	√
	Access to Services	√
	Trustwide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None identified	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:	BAME risk assessment Clinically Extremely Vulnerable staff Workforce prioritisation	

Q

Leicestershire Partnership NHS Trust

Public Trust Board 31.8.21

Safety and Quality in Learning from Deaths Assurance (Quarter 1)

1. Purpose of the report

This report is presented to the Trust Board as assurance of the efficacy of the Learning from Deaths (LfD), Child Death Overview Panel (CDOP), Learning Disabilities Mortality Review (LeDeR), and Serious Incident (SI) processes in adherence to the National Quality Board (NQB) guidance on Learning from Deaths (2017). This Report presents data from April to June 2021 inclusive (Quarter 1: Q1), as well as data reviewed and learning from Quarter 4 (Q4: January-March 2021) at Leicestershire Partnership Trust (LPT).

2. Analysis of the issue

- The information presented in this report is collated by the patient safety team and allocated to each Directorate; LfD meetings are carried out within each Directorate, with the presence of the Trust Learning from Deaths Lead.
- As a means of improving from Q4, it is clear that demographic information is not being completed at a service level. We are now emphasising the importance of this data as a means of better understanding and overcoming potential health inequalities.
- We have welcomed 2 LeDer Practitioner nurses who attend the FYPC/LD LfD meetings as a means of timely insight into Learning Disabilities deaths.
- The Band 5 Governance and Quality Assurance co-ordinator (LfD) deaths is now advertised as a means of assisting with LfD process at LPT.
- Work is underway to standardise family feedback through bereavement letters or personalised phone calls.
- DMH/MHSOP has identified a number of themes which contribute to the deaths of patients which include: (1) Social Circumstance, (2) Chronic physical and mental health problems, and (3) Self-harm. These have been recommended to be added as categorised themes.

3. Proposal

The Board is asked to consider the content of this paper in alignment with Learning from Deaths guidance. The board is also asked to recognise the action and progress being in the LfD process at LPT.

4. Demographics

Demographic information is provided in Tables 1-5 (p.2). After working with our Information Team it is clear that demographic information is not being captured at a service level. In order to overcome gaps in demographic information, an in-depth discussion took place during the Trust wide LfD meeting, where it was agreed that we needed Directorate and Board Level Support to mandate the completion of demographic information at the service leevl, potentially as soon as a referral to LPT was initiated.

Table 1: Q1 Gender & Age

Gender	Age Bands									
	1-28 (D)	Up to 12 (M)	1-10 (Y)	11-18	19-24	25-44	45-64	65-79	80+	Total
Female	0	1	0	0	1	6	11	16	21	56
Male	0	2	1	0	0	10	11	24	17	65
Total	**0**	**3**	**1**	**0**	**1**	**16**	**22**	**40**	**38**	**121**

Table 2: Q1 Ethnicity

Ethnicity	
English/Welsh/Scottish/Northern Irish /British/Irish	65%
White & Black Carribean	2%
Indian	12%
Bangladeshi	1%
Pakistani	4%
Any other Asian Background	1%
African	2%
Not Recorded	14%
Total	100%

Table 3: Q1 Religion

Religion	
Christian	15%
Hindu	7%
Muslim	4%
Sikh	1%
Not recorded	74%
Total	**100%**

Table 4: Q1 Disability

Disability	
Disability	33%
No Disability	6%
Not recorded	61%
Total	**100%**

Table 5: Q1 Sexual Orientation

Sexual Orientation	
Heterosexual	21%
Not Applicable	3%
Not Disclosed	2%
Not Recorded	74%
Total	**100%**

5. Number of Deaths reported and reviewed in Q4

In adherence with NHS/I (2017) recommendations, the number and percentages of deaths reviewed through mSJR case record review and the Serious Incident (SI) process across LPT in Q4 are shown in Table 6:

Table 6: Time lag in reviewing of deaths by Directorate

Q4	Total number of deaths	Review		% of deaths subject to mSJR* Case record review	% of deaths subject to an SI investigation
		mSJR	SI		
	127	113	14		
Breakdown by Directorate				Number and % of deaths subject to mSJR* case record review completed	Number and % of deaths subject to an SI investigation completed
CHS		mSJR	SI		
		33		31	2
		31	2	100%	100%
DMH/MHSOP		83		61	7
		72	11	85%	64%
FYPC/LD		11		9	1
		10	1	90%	100%

KEY

CHS: Community Health Services; **DMH/MHSOP:** Directorate of Mental Health/Mental Health Services for Older people; **FYPC/LD:** Families Young Persons and Children/Learning Disabilities

6. Learning themes and good practice

6.1 Learning themes identified

Learning and discussions associated with deaths in Q4 within the CHS directorate identified the importance of timely reviews as learning can be less effective if too much time has elapsed (themed as: C616: Clinical Care, Investigations). A resulting learning action was to take the learning from the reviews back into Directorate more frequently. Within DMH/MHSOP, Learning from Death discussions focused on the need for increased support for patients to access services outside of DMH/MHSOP, which include the GP, whom if the patients are unwell contact (C718: Clinical Care, multi-disciplinary, and inter-speciality liaison) – which will be fed back into services, as a means of increasing support. In FYPC/LD it was emphasised that there was a need for timely and robust information sharing across multiple agencies (C718: Clinical Care, multi-disciplinary team working continuity of care). A quality review has been organised with AHP/Nursing/safeguarding and Patient safety to develop actions based on the learning. Additional learning from all directorates is provided in Appendix 1 (p.6).

6.2 Examples of good practice

Examples of good practice in the current Quarter (Q1) consisted of:

- **CHS:** Derbyshire Health United (DHU) had thoroughly reviewed and communicated the care provided to CHS EOL patients, as a means of enhancing the use of ReSPECT documentation and to have better informed decision making.
- **DMH/MHSOP:** Actions from CPN in which discussions regarding the end of life and advance care planning were initiated with GP, encouraging connected working to benefit our patients.
- **FYPC/LD:** Diana Team and Physiotherapists went over and beyond to support mother following a patient's death.

7. Number of deaths reported during Q1

Table 7 shows the number of deaths reported by each Directorate for Q1. Formal investigations consist of Serious Incident (SI) investigations and modified Structured Judgement Reviews (mSJR) case record reviews:

- There were 121 deaths in Q1.
- There were a total of 16 deaths which are for Serious Incident Investigation.
- There were 12 adult deaths of individuals with Learning Disabilities which are undergoing LeDer review, and are to be reviewed using the mSJR case record review within FYPC.

Table 7: Number of deaths (Q1)

Q1 Mortality Data 2021										
Q1	**Apr**			**May**			**Jun**			**Total**
	C	**D**	**F**	**C**	**D**	**F**	**C**	**D**	**F**	**121**
Number of Deaths	18	23	7	9	19	2	9	26	8	
Consideration for formal investigation										
	C	**D**	**F†**	**C**	**D**	**F†**	**C**	**D**	**F†**	
Serious Incident	1	4	0	1	2	0	1	6	1	**16**
mSJR* Case record review	17	19	7	8	17	2	8	20	*7*	***105***
Number completed	*1*	*2*	*6*	*0*	*0*	*0*	*0*	*0*	*0*	*9*
Learning Disabilities deaths	-	-	5	-	-	2	-		5	*12*
Number of deaths reviewed/investigated and as a result considered more likely than not to be due to problems in care	0	0	0	NK	NK	NK	NK	NK	NK	-

KEY

C: Community Health Services; **D:** Directorate of Mental Health/MHSOP; **F:** Families Young Persons and Children/LD

8. Decision required

The Trust Board is required to confirm assurance on the implementation of the National Quality Boards Learning from Deaths guidance within the Trust.

9. Governance table

For Board and Board Committees:	Trust Board	
Paper presented by:	Dr Avinash Hiremath	
Paper sponsored by:	Professor Al-Uzri	
Paper authored by:	Saydia Razak & Tracy Ward	
Date submitted:	24.8.21	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Learning from Deaths Meeting (27th July 2021)	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Report provided to the Trust Board quarterly	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Report provided to the Trust Board quarterly	
STEP up to GREAT strategic alignment*:	High **S**tandards	✓
	Transformation	
	Environments	
	Patient Involvement	✓
	Well **G**overned	
	Single Patient **R**ecord	
	Equality, Leadership, Culture	
	Access to Services	
	Trust wide Quality Improvement	✓
Organisational Risk Register considerations:	List risk number and title of risk	1, 3
Is the decision required consistent with LPT's risk appetite:	na	
False and misleading information (FOMI) considerations:	na	
Positive confirmation that the content does not risk the safety of patients or the public	yes	
Equality considerations:	considered	

Appendix 1. Examples of Learning

Learning Code/Theme	Learning Impact	Learning Action
CHS Q4		
C514: Clinical Care, Clinical documentation within the clinical record	Lack of documentation impacted on case review does not promote good practice. This is an ongoing theme.	Discussed with individual staff member to promote learning.
C24: Clinical Care, Communication, Management	Medical plans are not always followed particularly during the OOH period. Discussion regarding advocacy of nursing staff for patients.	Nurse consultant to monitor via monthly readmission report and learning from death reviews.
DMH/MHSOP: Q4		
C718: Clinical Care, multi-disciplinary, and inter-speciality liaison	Learning from Death discussions focused on the need for increased support for patients to access services outside of DMH/MHSOP, which include the GP, whom if the patients are unwell contact.	Learning to be fedback into services.
DMH/MHSOP: Q1 Learning was possible as discussed in most recent LfD meetings		
C927: Clinical Care, Monitoring, Recognition & Escalation/Ceiling of Care, escalation / Ceiling of Care	Discussed the succinct follow up of patients who do not engage with CAP, and the importance of knowing when to escalate or follow up those patients who exhibit a lack of engagement.	Actions by individual teams escalated to them by representatives of mortality surveillance group.
FYPC/LD: Q4		
C718: Clinical Care, multi-disciplinary team working continuity of care	The need for information sharing across multiple agencies.	A quality review has been organised with AHP/Nursing/safeguarding and Patient safety to develop actions based on the learning.
FYPC/LD: Q1: Learning was possible as discussed in most recent LfD meetings		
C1030: Clinical Care, Known to safeguarding	Discussions surrounded a patient's last contact with LPT and how the patient was on a child protection plan.	Themes and Findings are now shared at Clinical Leadership Forum and DMT Quality and Safety meeting.

Abbreviations

AHP: Allied Health Professional; **CAP:** Central Access Point, **OOH:** Out Of Hospital

Ri

Leicestershire Partnership NHS Trust

Public Trust Board – 31st August 2021

Workforce Race Equality Standard Metrics Report 2020/21

Purpose of the Report

- The Workforce Race Equality Standard (WRES) was mandated through the NHS standard contract from 2015/16 to address the finding that the NHS treats black and minority ethnic (BME) staff less favourably in their recruitment, promotion, discipline and career progression.

- The present report aims to fulfil the Trust's statutory duties in relation to the WRES metrics, which include actions for the Trust's Board:
  - Approve the 2020/21 WRES metrics for submission to NHS England via a reporting portal and publication on the Trust's website, by 31st August 2021 and 31st October 2021, respectively;
  - Approve the 2020/21 WRES metrics for presentation to the lead commissioner.
  - Approve the 2021/22 WRES action Plan (attached as appendix 1 to the report)

- Assurance is provided that the Trust's statutory duties in relation to the WRES metrics will be met if the above actions are undertaken.

Analysis of the issue

- Analysis of the WRES metrics indicates that BME staff are at a disadvantage or have poorer outcomes when compared to White staff in terms of
  - Career progression
  - Recruitment
  - Non-mandatory training
  - Bully, harassment and abuse from other staff
  - Belief that the Trust provides equal opportunities in career progression
  - Discrimination from other staff
  - Representation on the Trust's board

- These findings reflect long-term trends that are being addressed through the Trust's WRES Action Plan. The WRES action plan was, and continues to be developed in collaboration with the BME Staff Support Group and senior leaders, including board members. It is a further statutory requirement that the WRES action plan is seen by the Trust's board for approval, and published on the Trust's website by 31st October 2021. The WRES technical guidance states that boards should "own this work and how progress is to be made and monitored."

- Please see the report that accompanies this summary for the full analysis of the WRES metrics.

Proposal

- It is asked that the Trust's Board approves the 2020/21 WRES metrics for two purposes:
    - Submission to NHS England via a reporting portal by 31st August 2021,
    - Publication of the accompanying WRES metrics report and action plan on the Trust's public-facing website by 31st October 2021.

- These are statutory requirements.

- The requirements above reflect an annual governance cycle.

- The 2020/21 WRES Metrics Report, which is intended for publication on the Trust's public-facing website, is provided below for information.

Decision required

- Please approve the WRES metrics for submission to NHS England.

- Please approve the accompanying WRES metrics report and action plan for publication on the Trust's public-facing website.

- Failure to comply to with the WRES Regulations can result in
    - Enforcement action undertaken by the Equality and Human Rights Commission
        - Formal investigations and assessments
        - Action to ensure that the metrics are produced and published

- Ultimately, a failure to act upon the equality issues indicated by the WRES metrics could result in a failure to deliver workforce equality, diversity and inclusion (item 24 on the Trust's risk register).

Governance table

For Board and Board Committees:	Public Trust Board 31.8.21
Paper sponsored by:	Sarah Willis (Director of Human Resources and Organisational Development)
Paper authored by:	Haseeb Ahmad (Head of Equality, Diversity and Inclusion); Iain Darker (Data Analyst: Equality, Diversity

	and Inclusion)	
Date submitted:	2nd August 2021	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Equality, Diversity and Inclusion Workforce, 28th July 2021	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Assured	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	This report is part of an annual governance cycle	
STEP up to GREAT strategic alignment*:	High **S**tandards	
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	X
	Single Patient **R**ecord	
	Equality, Leadership, Culture	X
	Access to Services	
	Trust Wide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	24. Failure to deliver workforce equality, diversity and inclusion
Is the decision required consistent with LPT's risk appetite:	na	
False and misleading information (FOMI) considerations:	na	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmation provided	
Equality considerations:	Y	

Workforce Race Equality Standard

Leicestershire Partnership NHS Trust

March 2021

Introduction to the Workforce Race Equality Standard

Research over the past two decades and longer indicates that the NHS treats black and minority ethnic (BME) staff less favourably in their recruitment, promotion, discipline and career progression. In 2014, the NHS Equality and Diversity Council agreed action to ensure employees from BME backgrounds have equal access to career opportunities and receive fair treatment in the workplace. The Workforce Race Equality Standard (WRES) was mandated through the NHS standard contract from 2015/16.

The WRES comprises nine specific metrics to compare the profile and experiences of BME and White staff within an NHS organisation. The purpose of the metrics is to inform a local action plan that will target specific areas within a given organisation where the treatment or experience of BME staff is poor. The WRES metrics will also enable the organisation to demonstrate progress in areas where the treatment of BME staff needs to improve; and facilitate challenge where progress is not being made.

NHS Trusts are required to submit WRES data centrally, to NHS England, by the end of August. An action plan and the metrics must be ratified by the Trust's Board and must be published on the Trust's website by the end of September.

The WRES metrics

Metric 1. Pay Bands

Description of metric 1:

- The percentage of BME staff in each of the Agenda for Change Pay Bands 1 to 9 and VSM (including executive Board members) compared with the percentage of BME staff in the overall workforce, calculated separately for non-clinical and for clinical staff.

Narrative for metric 1:

- At March 2021, BME staff made up 24.4% of Leicestershire Partnership NHS Trust's (LPT) substantive workforce of known ethnicity (1287/5278).

- This represents a significant increase over the past three years, from 22.6% BME staff observed at March 2019 (1171/5178), through 23.5% BME staff at March 2020 (1221/5203); part of a long-term trend for year-on-year increases in the percentage of BME staff in the substantive workforce from 16.6% (924/5564) at March 2012.

- Ethnicity was known (declared on the Electronic Staff Record) for 97.2% of the substantive workforce at March 2021 (5278/5429). Thus, there were 151 staff for whom ethnicity was not known.

- Non-clinical:
    - BME people were overrepresented at Band 2 (37.3%, 98/263) and Band 3 (33.2%, 93/280). This largely reflected an overrepresentation of Asian British people in lower-level Administrative roles.
    - BME people were proportionately represented from Band 4 (29.3%, 55/188) to Band 8a (26.6%, 17/64).
    - There was a significant drop in BME representation at Band 8b (11.4%, 4/35), with low levels of representation from Band 8b to Very Senior Manager level in general (8.6%, 6/70).

- Clinical:
    - Bands 2 to 4 (essentially Additional Clinical Services):
        - BME people were overrepresented at the lowest pay band, Band 2 (37.0%, 194/524), and were underrepresented at higher bands, Bands 3 and 4 (16.6%, 127/767). This was especially the case for Black British staff.
    - Bands 5 and above (primarily Registered Nurses):
        - BME people were proportionately represented at Band 5 (24.2%, 171/707), and were underrepresented at higher bands, Bands 6 and above (15.7%, 289/1845). This was especially the case for Black British staff.
    - Medical:
        - BME staff were overrepresented in Medical roles (63.9%, 129/202), particularly Asian British staff. This reflected occupational segregation, with Asian British staff underrepresented in Registered Nursing roles.

- The distribution of BME staff by pay band across the workforce has changed little over the period March 2019 to March 2021, or indeed over the longer term.

- The WRES does not consider staff who work solely on the Bank for LPT (i.e., staff who work for LPT on a zero-hours contract and who do not have a substantive role with the Trust):
    - Bank staff are more likely to come from a BME background (45.5% BME, 456/1004) than substantive staff (24.4% BME, 1287/5278).
    - Bank staff typically work at lower pay bands than substantive staff (69.4% of Bank staff are at Band 4 and below, 761/1096, whilst 38.2% of Substantive staff are at Band 4 and below, 2073/5429 – figures include staff of unknown ethnicity).
    - Consequently, the WRES underestimates the percentage of BME staff in LPT's overall workforce, especially at lower pay bands.

- The ethnicity profile of substantive staff at Leicestershire Partnership NHS Trust, by individual pay band, at March 2019, March 2020, and March 2021 is detailed in Table 1, to the standard WRES specification. A summarised version of this information is given in Table 2, with pay bands grouped to convey the principle trends observed.

Table 1: Metric 1: The ethnicity profile of substantive staff at Leicestershire Partnership NHS Trust, by pay band, at March 2019, March 2020, and March 2021

Table in 7 columns by 31 rows (including header row)

Pay Band	Percentage BME staff March 2019	Percentage BME staff March 2020	Percentage BME staff March 2021	Number of BME staff March 2019	Number of BME staff March 2020	Number of BME staff March 2021
Substantive Staff Overall	22.6%	23.5%	**24.4%**	1171 out of 5178	1221 out of 5203	**1287 out of 5278**
Non-clinical Band 1	53.3%	40.0%	**0.0%**	8 out of 15	4 out of 10	**0 out of 2**
Non-clinical Band 2	34.0%	33.1%	**37.3%**	90 out of 265	86 out of 260	**98 out of 263**
Non-clinical Band 3	32.2%	32.7%	**33.2%**	96 out of 298	88 out of 269	**93 out of 280**
Non-clinical Band 4	25.3%	28.3%	**29.3%**	49 out of 194	54 out of 191	**55 out of 188**
Non-clinical Band 5	31.7%	30.3%	**30.3%**	46 out of 145	43 out of 142	**46 out of 152**
Non-clinical Band 6	28.8%	30.1%	**28.4%**	30 out of 104	34 out of 113	**31 out of 109**
Non-clinical Band 7	29.1%	27.3%	**28.7%**	30 out of 103	27 out of 99	**29 out of 101**
Non-clinical Band 8a	25.5%	27.6%	**26.6%**	14 out of 55	16 out of 58	**17 out of 64**
Non-clinical Band 8b	5.3%	11.9%	**11.4%**	2 out of 38	5 out of 42	**4 out of 35**
Non-clinical Band 8c	9.5%	11.1%	**11.8%**	2 out of 21	2 out of 18	**2 out of 17**
Non-clinical Band 8d	0.0%	0.0%	**0.0%**	0 out of 9	0 out of 9	**0 out of 11**
Non-clinical Band 9	0.0%	0.0%	**0.0%**	0 out of 1	0 out of 1	**0 out of 2**
Non-clinical VSM	0.0%	0.0%	**0.0%**	0 out of 6	0 out of 4	**0 out of 5**
Clinical Band 1	26.1%	20.0%	**33.3%**	6 out of 23	4 out of 20	**1 out of 3**
Clinical Band 2	31.3%	36.8%	**37.0%**	155 out of 496	193 out of 525	**194 out of 524**
Clinical Band 3	16.2%	16.5%	**19.1%**	76 out of 468	80 out of 485	**93 out of 487**
Clinical Band 4	12.7%	12.4%	**12.1%**	29 out of 229	31 out of 249	**34 out of 280**
Clinical Band 5	22.9%	22.0%	**24.2%**	179 out of 782	162 out of 735	**171 out of 707**
Clinical Band 6	15.1%	16.1%	**16.5%**	167 out of 1107	181 out of 1125	**190 out of 1149**
Clinical Band 7	11.8%	13.9%	**16.0%**	48 out of 406	57 out of 411	**71 out of 443**
Clinical Band 8a	10.4%	10.2%	**9.4%**	15 out of 144	16 out of 157	**16 out of 170**
Clinical Band 8b	19.0%	13.3%	**13.8%**	11 out of 58	8 out of 60	**8 out of 58**
Clinical Band 8c	7.1%	7.1%	**16.7%**	1 out of 14	1 out of 14	**3 out of 18**
Clinical Band 8d	20.0%	20.0%	**16.7%**	1 out of 5	1 out of 5	**1 out of 6**
Clinical VSM	no staff	0.0%	**0.0%**	no staff	0 out of 1	**0 out of 1**
Medical Trainee Grade	58.2%	66.2%	**66.1%**	32 out of 55	43 out of 65	**41 out of 62**
Medical Non-consultant	48.0%	47.6%	**57.1%**	12 out of 25	10 out of 21	**16 out of 28**
Medical Consultant	64.2%	66.1%	**62.9%**	70 out of 109	72 out of 109	**66 out of 105**
Medical Senior Manager	66.7%	60.0%	**100.0%**	2 out of 3	3 out of 5	**7 out of 7**

Key to colour coding in table: ● BME staff overrepresented, O BME staff proportionately represented, ● BME staff underrepresented

Table 2: Metric 1: The ethnicity profile of substantive staff at Leicestershire Partnership NHS Trust, by grouped pay bands, at March 2019, March 2020, and March 2021

Table in 7 columns by 8 rows (including header row)

Pay Band Group	Percentage BME staff March 2019	Percentage BME staff March 2020	Percentage BME staff March 2021	Number of BME staff March 2019	Number of BME staff March 2020	Number of BME staff March 2021
Substantive Staff Overall	22.6%	23.5%	**24.4%**	1171 out of 5178	1221 out of 5203	**1287 out of 5278**
Non-clinical Bands 2 to 8a	30.5%	30.7%	**31.8%**	355 out of 1164	348 out of 1132	**369 out of 1159**
Non-clinical Bands 8b to VSM	5.3%	9.5%	**8.6%**	4 out of 75	7 out of 74	**6 out of 70**
Clinical Band 2	31.3%	36.8%	**37.0%**	155 out of 496	193 out of 525	**194 out of 524**
Clinical Bands 3 to 4	15.1%	15.1%	**16.6%**	105 out of 697	111 out of 734	**127 out of 767**
Clinical Band 5	22.9%	22.0%	**24.2%**	179 out of 782	162 out of 735	**171 out of 707**
Clinical Bands 6 to VSM	14.0%	14.9%	**15.7%**	243 out of 1734	264 out of 1773	**289 out of 1845**

Key to colour coding in table: ● BME staff overrepresented, O BME staff proportionately represented, ● BME staff underrepresented

Metric 2. Recruitment

Description of metric 2:

- Relative likelihood of White people compared to BME people being appointed from shortlisting across all posts. The percentage of White people appointed from shortlisting divided by the percentage of BME people appointed from shortlisting.

Narrative for metric 2:

- In 2020/21 White people were more likely than BME people to be appointed from amongst those shortlisted (White people were 1.46 times more likely than BME people to be appointed from shortlisting).

- This represents a deterioration of the position observed in 2019/20 when White people were 1.14 times as likely as BME people to be appointed from shortlisting (statistically equivalent). The position in 2020/21 is more similar to the positions observed in 2016/17, 2017/18, and 2018/19 when White people were 1.45, 1.33, and 1.97 times more likely than BME people to be appointed from shortlisting, respectively by year. Indeed, the value for 2020/21, 1.46, appears to reflect regression to the mean following an unusually high value of 1.97 in 2018/19 and an unusually low value of 1.14 in 2019/20. Please refer to Table 3.

Table 3: Metric 2: The relative likelihood of White people and BME people being appointed from amongst those shortlisted at Leicestershire Partnership NHS Trust during 2018/19, 2019/20, and 2020/21

Table in 4 columns by 6 rows (including header row)

Recruitment	2018/19	2019/20	2020/21
Relative likelihood of appointment from shortlisting (White/BME)	1.97	1.14	**1.46**
Percentage of White people appointed from shortlisting	9.7%	11.3%	**12.0%**
Percentage of BME people appointed from shortlisting	4.9%	10.0%	**8.2%**
Number of White people appointed from shortlisting	371 out of 3844	341 out of 3005	**400 out of 3327**
Number of BME people appointed from shortlisting	124 out of 2525	186 out of 1861	**171 out of 2082**

Key to colour coding in table: ● BME people disadvantaged

Metric 3. Formal disciplinary process

Description of metric 3:

- Relative likelihood of BME staff compared to White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation, based on data from the most recent two-year rolling average (however, potentially, there will be a switch to one-year windows in the current reporting year, to be confirmed when new guidance is released, consequently, figures based on a one-year window for 2019/20 and 2020/2021 are also provided below). The percentage of BME staff entering the formal disciplinary process divided by the percentage of White staff entering the formal disciplinary process.

Narrative for metric 3:

- In the two-year window 2019/20 to 2020/21, BME staff and White staff were similarly likely to enter formal disciplinary proceedings (BME staff were 0.74 times as likely as White staff to enter formal disciplinary proceedings).

- This is similar to the positions observed for the two previous two-year windows 2017/18 to 2018/19 and 2018/19 to 2019/20, when BME staff were 1.35 and 0.59 times as likely as White staff to enter formal disciplinary proceedings, respectively (both statistically equivalent).

- This indicator is liable to vary to a large degree year-on-year due to the relatively small number formal disciplinary proceedings (even when aggregated across a two-year window). Please refer to Table 4. For reference, in the two-year windows to March 2016 and March 2017, the relative likelihoods were close to 1 (1.19 and 1.17 respectively), but in the two-year window to March 2018 relative likelihood was higher at 1.92.

- The official WRES statistics do not consider Bank staff. A supplementary analysis of formal disciplinary proceedings amongst Bank staff for the two-year period 2019/20 to 2020/21 indicated that, overall, bank staff were 4.4 times more likely than substantive staff to enter formal disciplinary proceedings. Of particular relevance to the WRES, amongst bank staff, BME bank staff were 3.81 times more likely than White bank staff to enter formal disciplinary proceedings.

Table 4: Metric 3 (two-year windows): The relative likelihood of BME staff and White staff entering the formal disciplinary process at Leicestershire Partnership NHS Trust during the two-year windows 2017/18 to 2018/19, 2018/19 to 2019/20, and 2019/20 to 2020/21

Table in 4 columns by 6 rows (including header row)

Formal disciplinary process	**2017/18 to 2018/19**	**2018/19 to 2019/20**	**2019/20 to 2020/21**
Relative likelihood of entering the formal disciplinary process (BME/White)	1.35	0.59	**0.74**
Percentage of BME staff entering the formal disciplinary process	1.5%	0.8%	**0.9%**
Percentage of White staff entering the formal disciplinary process	1.1%	1.4%	**1.2%**
Number of BME staff entering the formal disciplinary process	17 out of 1171	10 out of 1221	**11 out of 1287**
Number of White staff entering the formal disciplinary process	43 out of 4007	55 out of 3982	**46 out of 3991**

Key to colour coding in table: ● BME staff disadvantaged

- Potentially, new guidance, not yet officially released, will require this indicator to be calculated based on a one-year window from the present reporting year. Consequently, figures based on a one-year window are provided below for the substantive workforce.

- In the one-year window 2020/21, BME staff and White staff were similarly likely to enter formal disciplinary proceedings (BME staff were 1.24 times as likely as White staff to enter formal disciplinary proceedings). This is similar (statistically equivalent) to the position observed for the one-year window 2019/20 when BME staff were 0.53 times as likely as White staff to enter formal disciplinary proceedings. When calculated using a one-year window, this indicator is liable to vary to an even larger degree year-on-year than when calculated using a two-year window due to the small number formal disciplinary proceedings. Please refer to Table 5.

Table 5: Metric 3 (one-year windows): The relative likelihood of BME staff and White staff entering the formal disciplinary process at Leicestershire Partnership NHS Trust during the one-year windows 2019/20 and 2020/21

Table in 3 columns by 6 rows (including header row)

Formal disciplinary process	**2019/20**	**2020/21**
Relative likelihood of entering the formal disciplinary process (BME/White)	0.53	**1.24**
Percentage of BME staff entering the formal disciplinary process	0.4%	**0.5%**
Percentage of White staff entering the formal disciplinary process	0.8%	**0.4%**
Number of BME staff entering the formal disciplinary process	5 out of 1221	**6 out of 1287**
Number of White staff entering the formal disciplinary process	31 out of 3982	**15 out of 3991**

Key to colour coding in table: ● BME staff disadvantaged

Metric 4. Non-mandatory training

Description of metric 4:

- Relative likelihood of White staff compared to BME staff accessing non-mandatory training and CPD. The percentage of White staff accessing non-mandatory training divided by the percentage of BME staff accessing non-mandatory training.

Narrative for metric 4:

- In 2020/21 White staff were more likely than BME staff to access non-mandatory training (White staff were 1.06 times more likely than BME staff to access non-mandatory training).

- This is similar to the positions observed in 2018/19 and 2019/20 when White staff were 1.09 and 1.10 times as likely as BME staff to access non-mandatory training, respectively by year. Please refer to Table 6.

- In particular, White staff were more likely than Asian British staff (1.07 times more likely) to access non-mandatory training, reflecting occupational segregation in the workforce. White staff were overrepresented in Registered Nursing roles, where non-mandatory training was more common, whilst Asian British staff were overrepresented in Administrative and Clerical roles where non-mandatory training was less common. Nonetheless, the overall levels of those accessing non-mandatory training increased in 2020/21 for both White and BME staff.

Table 6: Metric 4: The relative likelihood of White staff and BME staff accessing non-mandatory training and CPD during 2018/19, 2019/20, and 2020/21

Table in 4 columns by 6 rows (including header row)

Non-mandatory training	2018/19	2019/20	2020/21
Relative likelihood of accessing non-mandatory training (White/BME)	1.09	1.10	**1.06**
Percentage of White staff accessing non-mandatory training	61.7%	80.4%	**88.3%**
Percentage of BME staff accessing non-mandatory training	56.8%	73.2%	**83.5%**
Number of White staff accessing non-mandatory training	2473 out of 4007	3203 out of 3982	**3526 out of 3991**
Number of BME staff accessing non-mandatory training	665 out of 1171	894 out of 1221	**1075 out of 1287**

Key to colour coding in table: ● BME staff disadvantaged

- Please note: when an outcome (such as undertaking non-mandatory training) is common for both groups considered in a likelihood ratio, the difference between the two groups can be statistically significant even though the likelihood ratio is close to 1. Under these circumstances, the odds ratio gives a clearer indication of the degree of difference – in both 2019/20 and 2020/21, the odds of White staff undertaking non-mandatory training was 1.50 times greater than the odds of BME staff undertaking non-mandatory training.

Metric 5. Harassment, bullying or abuse from patients, relatives or the public

Description of metric 5:

- The percentages of White staff and BME staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months, derived from the NHS Staff Survey.

Narrative for metric 5:

- The 2020 NHS Staff Survey indicated that White staff and BME staff were similarly likely to suffer harassment, bullying or abuse from patients / service users, their relatives or other members of the public (22.3%, 487/2183 White staff and 24.4%, 126/516 BME staff).

- However, Black British staff in particular were more likely than White staff to suffer this type of harassment, bullying or abuse (39.6%, 36/91). Pease refer to Table 7. This may reflect that Black British staff are overrepresented in frontline clinical roles, including Additional Clinical Services and Registered Nursing. There is a long-term trend, back to at least 2015, for Black British staff to be at a greater risk of harassment, bullying or abuse from patients / service users, their relatives or other members of the public.

- The NHS Staff Survey goes only to substantive staff. LPT conducts its own survey of bank staff. For reference, in 2020, levels of harassment, bullying or abuse from patients / service users, their relatives or other members of the public were similar amongst BME bank staff in general, (37.7%, 26/69) and White bank staff (29.2%, 38/130), but were higher for Black British bank staff in particular (51.2%, 19/37), mirroring the position observed for substantive staff.

Table 7: Metric 5: The percentages of White staff and BME staff who experienced harassment, bullying or abuse from patients / service users, their relatives or other members of the public, Staff Survey 2018, Staff Survey 2019, Staff Survey 2020

Table in 4 columns by 7 rows (including header row)

Harassment, bullying or abuse from patients, relatives or the public	**2018**	**2019**	**2020**
Percentage White staff	23.1%	22.9%	**22.3%**
Percentage BME staff	24.0%	23.4%	**24.4%**
Percentage Black British staff	33.3%	39.5%	**39.6%**
Number White staff	460 out of 1991	429 out of 1876	**487 out of 2183**
Number BME staff	117 out of 488	102 out of 435	**126 out of 516**
Number Black British staff	27 out of 81	34 out of 86	**36 out of 91**

Key to colour coding in table: ● BME staff disadvantaged

Metric 6. Harassment, bullying or abuse from other staff

Description of metric 6:

- The percentages of White staff and BME staff experiencing harassment, bullying or abuse from other staff in last 12 months, derived from the NHS Staff Survey.

Narrative for metric 6:

- The 2020 NHS Staff Survey indicated that BME staff were more likely than White staff to suffer harassment, bullying or abuse from other staff (24.8%, 128/516 BME staff and 19.8%, 432/2187 White staff). This is similar to the position for BME staff observed in 2019 when levels of harassment, bullying or abuse from other staff were at 24.4%, but represents a deterioration relative to 2018 when levels of harassment, bullying or abuse from other staff were at 20.1% for BME staff. Pease refer to Table 8.

- The levels of harassment, bullying or abuse from other staff suffered by Black British staff have been elevated over the long-term (32.8%, 20/61 Black British staff in 2017 and 32.9%, 27/82 Black British staff in 2018), but recently levels of this type of abuse have been more similar to the levels suffered by BME staff in general (27.7%, 23/83 Black British staff in 2019 and 25.6%, 23/90 Black British staff in 2020)*.

- The NHS Staff Survey goes only to substantive staff. LPT conducts its own survey of bank staff. For reference, in 2020, levels of harassment, bullying or abuse from other staff were similar amongst BME bank staff in general (18.8%, 13/69), and amongst Black British bank staff in particular (24.3%, 9/37), when compared to White bank staff (15.9%, 21/132). This represents an improvement on the position observed in 2019 for BME bank staff when levels of harassment, bullying or abuse from other staff were higher amongst BME bank staff in general (52.3%, 67/128), and amongst Black British bank staff in particular (65.1%, 54/83), than amongst White bank staff (24.8%, 30/121). However, it is noted that the overall number of respondents to the Bank Staff Survey dropped considerably between 2019 and 2020, from 475 to 210 respondents. Amongst those of known ethnicity, there was a particular drop in the number of responses from Black British Additional Clinical Services staff (from 70 in 2019 to 30 in 2020); Black British Additional Clinical Services staff are most likely to experience bullying and harassment from other staff.

Table 8: Metric 6: The percentages of White staff and BME staff who experienced harassment, bullying or abuse from other staff, Staff Survey 2018, Staff Survey 2019, Staff Survey 2020

Table in 4 columns by 7 rows (including header row)

Harassment, bullying or abuse from other staff	**2018**	**2019**	**2020**
Percentage White staff	18.8%	**19.9%**	**19.8%**
Percentage BME staff	20.1%	**24.4%**	**24.8%**
Percentage Black British staff*	32.9%	**27.7%**	**25.6%**
Number White staff	374 out of 1994	**373 out of 1879**	**432 out of 2187**
Number BME staff	98 out of 487	**107 out of 438**	**128 out of 516**
Number Black British staff*	27 out of 82	**23 out of 83**	**23 out of 90**

Key to colour coding in table: ● BME staff disadvantaged

* Levels of harassment, bullying or abuse from other staff are underestimated for Black British staff relative to White staff and relative to the pooled BME group. This is because the figures for White and BME staff come from the official WRES statistics which are calculated for NHS England's WRES Team to reflect harassment, bullying or abuse from *all* staff. This is done by combining responses to two questions from the NHS Staff Survey at the individual respondent level. One question relates to harassment, bullying or abuse from managers, and the other to harassment, bullying or abuse from other colleagues. Meanwhile figures for Black British staff are derived locally from summary data. It is not possible to gain a combined figure for harassment, bullying or abuse from *all* staff from these summary data. Consequently, the levels of harassment, bullying or abuse reported for Black British staff relate to that from other colleagues only (not managers).

Metric 7. Equal opportunities for career progression or promotion

Description of metric 7:

- The percentages of White staff and BME staff believing that the Trust provides equal opportunities for career progression or promotion, derived from the NHS Staff Survey.

Narrative for metric 7:

- The 2020 NHS Staff Survey indicated that BME staff, and especially Black British staff, were less likely than White staff to believe that the Trust provides equal opportunities for career progression or promotion (71.6%, 250/349 BME staff, 61.5%, 32/52 Black British staff, and 89.8%, 1428/1590 White staff).

- The position for BME staff has remained low across 2018 and 2019 (75.3% and 68.4% respectively), as has the position for Black British staff in particular (55.8% and 55.4% respectively). Please refer to Table 9.

- The NHS Staff Survey goes only to substantive staff. LPT conducts its own survey of bank staff. For reference, in 2020, belief that the Trust provides equal opportunities for career progression or promotion was lower amongst BME bank staff in general (62.5%, 15/24), and Black British bank staff in particular (46.2%, 6/13), than amongst White bank staff (88.6%, 78/88). This is similar to the position observed in 2019 when belief that the Trust provides equal opportunities for career progression or promotion was also lower amongst BME bank staff in general (49.4%, 43/87), and Black British bank staff in particular (47.3%, 26/55), than amongst White bank staff (75.0%, 54/72).

Table 9: Metric 7. The percentages of White staff and BME staff who felt that the organisation provides equal opportunities for career progression or promotion, Staff Survey 2018, Staff Survey 2019, Staff Survey 2020

Table in 4 columns by 7 rows (including header row)

Equal opportunities for career progression or promotion	2018	2019	2020
Percentage White staff	90.7%	**88.0%**	**89.8%**
Percentage BME staff	75.3%	**68.4%**	**71.6%**
Percentage Black British staff	55.8%	**55.4%**	**61.5%**
Number White staff	1310 out of 1444	**1145 out of 1301**	**1428 out of 1590**
Number BME staff	244 out of 324	**193 out of 282**	**250 out of 349**
Number Black British staff	29 out of 52	**31 out of 56**	**32 out of 52**

Key to colour coding in table: ● BME staff disadvantaged

Metric 8. Discrimination at work from a manager, team leader or other colleagues

Description of metric 8:

- The percentages of White staff and BME staff experiencing discrimination at work from their manager / team leader or other colleagues in last 12 months, derived from the NHS Staff Survey.

Narrative for metric 8:

- The 2020 NHS Staff Survey indicated that BME staff, and especially Black British staff, were more likely than White staff to have experienced discrimination at work from their manager / team leader or other colleagues (14.5%, 74/511 BME staff, 26.1%, 23/88 Black British staff, and 5.9%, 129/2175 White staff).

- The position for BME staff has remained elevated across 2018 and 2019 (10.8% and 13.1% respectively), as has the position for Black British staff in particular (16.9% and 17.6% respectively). Pease refer to Table 10.

- Notably, the present levels of discrimination for BME staff overall, and Black British staff in particular, are at their highest levels since at least 2015 (when discrimination from other staff was at 12.9% for BME staff overall and 20.7% for Black British staff in particular).

- The NHS Staff Survey goes only to substantive staff. LPT conducts its own survey of bank staff. For reference, in 2020, levels of discrimination at work from a manager / team leader or other colleagues were similar amongst BME bank staff in general (37.7%, 26/69) and White bank staff (29.2%, 38/130), but were higher amongst Black British bank staff in particular (51.4%, 19/37). Compared to 2019, this represents an improvement for BME bank staff overall, but there was no change for Black British bank staff. In 2019, levels of discrimination at work from a manager / team leader or other colleagues were higher amongst BME bank staff in general (41.4%, 53/128), and Black British bank staff in particular (49.4%, 41/83), than amongst White bank staff (16.5%, 20/121).

Table 10: Metric 8: The percentages of White staff and BME staff who experienced discrimination at work from their manager / team leader or other colleagues in last 12 months, Staff Survey 2018, Staff Survey 2019, Staff Survey 2020

Table in 4 columns by 7 rows (including header row)

Discrimination at work from a manager / team leader or other colleagues	2018	2019	2020
Percentage White staff	4.3%	5.8%	**5.9%**
Percentage BME staff	10.8%	13.1%	**14.5%**
Percentage Black British staff	16.9%	17.6%	**26.1%**
Number White staff	85 out of 1987	108 out of 1863	**129 out of 2175**
Number BME staff	52 out of 481	57 out of 434	**74 out of 511**
Number Black British staff	13 out of 77	15 out of 85	**23 out of 88**

Key to colour coding in table: ● BME staff disadvantaged

Metric 9. Board representation

Description of metric 9:

- Percentage difference between BME representation in the organisation's Board membership and the organisation's overall workforce, disaggregated by the Board's voting membership and executive membership.

Narrative for metric 9:

- At March 2021, compared to the level of representation in the workforce overall, BME people were underrepresented
    - amongst board members overall (-12.6% difference in representation),
    - and amongst executive board members (-14.4% difference in representation);
- however, BME people were proportionately represented
    - amongst voting board members (-6.2% difference in representation).
- This represents an improvement on the position observed at March 2020.
- Please refer to Table 11.

Table 11: Metric 9. Differences in the levels of representation of BME people amongst board members (overall, voting members, and executives), relative to the level of representation of BME people in the workforce overall, at March 2019, at March 2020, and at March 2021

Table in 4 columns by 5 rows (including header row)

Board representation	March 2019	March 2020	March 2021
Percentage BME in the substantive workforce overall	22.6%	**23.5%**	**24.4%**
Difference between percentage BME amongst all board members and the substantive workforce overall	-15.5%	**-17.6%**	**-12.6%**
Difference between percentage BME amongst voting board members and the substantive workforce overall	-13.5%	**-14.4%**	**-6.2%**
Difference between percentage BME amongst executive board members and the substantive workforce overall	-22.6%	**-23.5%**	**-14.4%**

Key to colour coding in table: ● BME people underrepresented

Appendix 1

Leicestershire Partnership Trust

Draft WRES Action Plan 2021/22

Objective 1. Ensure Recruitment and Selection processes are inclusive and free from bias where candidates from Black, Asian and Minority Ethnic backgrounds have an equitable outcome compared to their white colleagues from application to appointment across all employment roles with an aim of eliminating any race equality disparities by 2025.

No.	Action	Lead	By When	Milestone	Progress	RAG
1	Undertake a robust review (rehaul) of the Recruitment and Selection Policy and develop a "Recruiting for Inclusion Policy and process" in line with the 6 National Race Equality High Impact Actions (REHIA) listed at the end of this action plan	Head of Employee Relations and Head of EDI	March 2022	• Commencement of review September 2021 • Engagement with stakeholders October 2021 • Production of revised policy and process March 2022	Diverse panel process in place and being monitored in line with 6 high impact Race Equality and Inclusion Strategy (REHIA) actions. REHIA (actions 2 and 5) to overhaul R&S processes will be addressed through this review.	B

Objective 2. Ensure that BAME staff are benefiting from Talent Management, Succession Planning and Career Progression leading to achievement of LPT model employer target of 24% by 2025

No.	Action	Lead	By When	Milestone	Progress	RAG
2	Establish Talent Management and succession planning Processes enabling BAME staff to progress in to senior management positions in line with model employer targets (24% BAME staff into band 8a	Head of OD and Head of EDI	March 2022	• Develop On-Merit plan aligning to LPT, Group, regional and national Talent Management strategies September 2022 • Launch programme October 2022	Action 3 of the National 6 high impact actions require focus on establishing criteria for talent pools. System wide EDI Taskforce have set Talent Management, Succession Planning and Career Progression as a key priority for 2021/22. Talent	A

	and above roles by 2025)				Management and Succession Planning Strategy in place and includes focus on model employer target. TM pilot programme has started with Executive Directors and will be cascaded down management tiers.	
3	Continue to provide targeted Interview Skills training for BAME colleagues.	Recruitment Manager	March 2022	• Dates set and advertised for 2021/22 (September 2021)	These sessions are being regularly run. Numbers are small but positively received. Continuation of these sessions are planned for 2021/22 with an aim of increasing participation.	A
4	Provide targeted career development opportunities for BAME colleagues	Head of OD	March 2022	• Run 4 cohorts of We Nurture training to BAME colleagues • Work in collaboration with the Midlands Academy to run local Stepping Up Programme	2nd cohort We Nurture Programme is underway. Working with Midlands Leadership Academy to run local Stepping Up Programme. All leadership programmes were put on hold during the pandemic.	A

Objective 3. Create a culturally inclusive organisation for Black, Asian and Minority Ethnic Colleagues in order that there are demonstrable improvements in WRES staff survey indicators 7 and 8

No.	Action	Lead	By When	Milestone	Progress	RAG
5	Deliver a series of Listening events for staff who are BAME, Disabled and LGBT.	Head of EDI in collaboration with chairs of staff networks	March 2022	• Agree timetable of LIA events (August 2022) • Ensure outputs from events feature in staff network highlight reports to EDI Workforce Group (December 2021)	A number of Trustwide and directorate level Listening events have taken place during 2020/21. Plans are to continue these as they have worked well as a mechanism for raising concerns and feedback.	G
6	Continue to deliver impactful	EDI Lead	March 2022	• Communicate requirement for	Over 200 managers have attended	G

	Race and Cultural Intelligence Learning Sets which include lived experience of BAME staff to all line-managers			all line-managers to attend the learning sets August 2021 • Report numbers attending to EDI Workforce Group (September 2021)	the training to date.	
7	Complete 2nd Cohort Reverse Mentoring Programme	Head of EDI	December 2021	• Arrange midway Reflective training session for mentees (July 2021) • All reverse mentoring meetings concluded (October 2021) • Celebratory Event (December 2021)	2nd programme is underway and midway through programme delivery. 3 Peer support sessions have taken place. Newsletter developed and shared with participants. Feedback is positive.	G
8	Delivery of Cultural Intelligence train the trainer Masterclasses for EDI specialists in line with Midlands academy process	Head of EDI	November 2021	• Commencement of procurement process (July 2021) • Appointment of provider September 2021 • Commencement of project November 2021	Midlands Leadership Academy are leading on the development of a procurement process to secure a suitable provider of Cultural Intelligence/competency training. Service specification has been drawn up and project group established.	A
9	Develop EDI outcome based Objectives within all leadership appraisals.	Head of EDI and Head of OD	January 2022	• Develop guidance October 2021 • Consult on guidance November 2021 • Roll out of guidance for implementation January 2022	TBC	B
10	Integrate the Inclusive Decision Making Framework (IDMF) within LPT's Due Regard process	Head of EDI	December 2021	• LLR IDMF workshops delivered (September 2021) • Process for integrating approach commenced (October 2021) • LPT IDMF integrated documentation complete December 2021	IDMF workshops being run during July through to September. This will enable a better understanding of the application of the IDMF and how LPT Due Regard (EIA) processes can be integrated with the IDMF.	B
11	Ensure that key/important	Chair of BAME Staff	March 2022	• Calendar of events and festivals	Plans are in place for South Asian	A

	events and festivals are celebrated and used as learning opportunities for staff from all backgrounds	Support Network		developed (July 2021) • Delivery of important events (SAHM and BHM) November 2021 • Celebration of other key events (Diwali, Vaisakhi etc (March 2022)	Heritage Month and Black History Month. Vaisakhi has been marked for 2021 – plans will be developed for key festivals for 2021/2022. Best practice from 2020 will be used to develop future activities. BAME SSN Chair has been working with the SSN to co-design and Co-deliver. Working with NHFT to deliver a programme across both Trusts.	
12	Ensure the Together Against Racism Strategy and WRES Action plan are clearly aligned to ensure clarity and synergy of work streams.	Head of EDI and Director of Corporate Governance	July 2021	• WRES Action Plan and Together Against Racism Strategy launched (August 2021) • Communication regarding how both complement each other issued (July 2021) • Ongoing communication to key stakeholders to ensure clarity of vision and scope for each will be ongoing throughout 2021/22	Plans in place to communicate this through Team Brief and staff bulletin.	A

6 National High Impact Race Equality actions

1. Ensure ESMs own the agenda, as part of culture changes in organisations, with improvements in BAME representation (and other under-represented groups) as part of objectives and appraisal by setting specific KPIs and targets linked to recruitment which are time limited, specific and linked to incentives or sanctions

2. Introduce a system of 'comply or explain' to ensure fairness during interviews. This system includes requirements for diverse interview panels, and the presence of an equality representative who has authority to stop the selection process, if it was deemed unfair.

3. Organise talent panels, creating a 'database' of individuals by system who are eligible for promotion and development opportunities and ensure these are advertised to all staff, agree positive action approaches to filling roles for under-represented groups and set transparent minimum criteria for candidate selection into talent pools

4. Enhance EDI support available to train organisations and HR policy teams on how to complete robust / effective Equality Impact Assessments of recruitment and promotion policies and to ensure that for Bands 8a roles and above, hiring mangers include requirement for candidates to demonstrate EDI work / legacy during interviews.

5. Overhaul interview processes to incorporate training on good practice with instructions to hiring managers to ensure fair and inclusive practices are used, ensure adoption of values-based shortlisting and interview approach and consider skills-based assessment such as using scenarios.

6. Adopt resources, guides and tools to help leaders and individuals have productive conversations about race.

Rii

Leicestershire Partnership NHS Trust

Public Trust Board – 31st August 2021

Workforce Disability Equality Standard Metrics Report 2020/21

Purpose of the Report

- The Workforce Disability Equality Standard (WDES) was mandated through the NHS standard contract from 2018/19 to address the finding that Disabled staff have a less favourable experience of working for the NHS than their non-disabled colleagues.

- The present report aims to fulfil the Trust's statutory duties in relation to the WDES metrics, which include actions for the Trust's Board:
  - approve the 2020/21 WDES metrics and action plan for submission to NHS England via a reporting portal and publication on the Trust's website, by 31st August 2021 and 31st October 2021, respectively;
  - approve the 2020/21 WDES metrics and action plan for presentation to the lead commissioner.

- Assurance is provided that the Trust's statutory duties in relation to the WDES metrics will be met if the above actions are undertaken.

Analysis of the issue

- Analysis of the WDES metrics indicates that Disabled staff are at a disadvantage or have poorer outcomes when compared to non-disabled staff in terms of
  - entry into formal capability proceedings
  - bully, harassment and abuse from
    - service users,
    - managers,
    - and other colleagues
  - belief that the Trust provides equal opportunities in career progression
  - pressure from a manager to come to work, despite not feeling well enough to perform their duties
  - satisfaction with the extent to which the organisation values their work
  - staff engagement scores
  - representation amongst board-level executives

- Additionally, disability status was not known for 18.9% of the substantive workforce, primarily due to staff selecting the "prefer not to say" option. This makes it difficult to use workforce data

to inform strategies to improve the experiences of Disabled staff in the workplace. Benchmarking against the staff survey indicates that in-house workforce data may underestimate the percentage of Disabled staff in the workforce by a factor of four.

- These findings reflect long-term trends that are being addressed through the Trust's WDES Action Plan. The WDES action plan was, and continues to be developed in collaboration with the MAPLE Staff Support Group and senior leaders, including board members. It is a further statutory requirement that the WDES action plan is seen by the Trust's board for approval, and published on the Trust's website by 31st October 2021.

- Please see the report that accompanies this summary for the full analysis of the WDES metrics.

Proposal

- It is asked that the Trust's Board approves the 2020/21 WDES metrics and action plan for two purposes:
    - submission to NHS England via a reporting portal by 31st August 2021,
    - publication of the accompanying WDES metrics report and action plan on the Trust's public-facing website by 31st October 2021.

- These are statutory requirements.

- The requirements above reflect an annual governance cycle.

- The 2020/21 WDES Metrics Report, which is intended for publication on the Trust's public-facing website, is provided below for information.

Decision required

- Please approve the WDES metrics for submission to NHS England.

- Please approve the accompanying WDES metrics report for publication on the Trust's public-facing website.

- Failure to comply to with the WDES Regulations can result in
    - enforcement action undertaken by the Equality and Human Rights Commission
        - formal investigations and assessments

- action to ensure that the metrics are produced and published

- Ultimately, a failure to act upon the equality issues indicated by the WDES metrics could result in a failure to deliver workforce equality, diversity and inclusion (item 24 on the Trust's risk register).

Governance table

For Board and Board Committees:	Public Trust Board 31.8.21	
Paper sponsored by:	Sarah Willis (Director of Human Resources and Organisational Development)	
Paper authored by:	Haseeb Ahmad (Head of Equality, Diversity and Inclusion); Iain Darker (Data Analyst: Equality, Diversity and Inclusion)	
Date submitted:	2nd August 2021	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Equality, Diversity and Inclusion Workforce Group, 28th July 2021	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Assured	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	This report is part of an annual governance cycle	
STEP up to GREAT strategic alignment*:	High **S**tandards	
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	X
	Single Patient **R**ecord	
	Equality, Leadership, Culture	X
	Access to Services	
	Trust Wide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	24. Failure to deliver workforce equality, diversity and inclusion
Is the decision required consistent with LPT's risk appetite:	na	
False and misleading information (FOMI) considerations:	na	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmation provided	
Equality considerations:	Y	

Workforce Disability Equality Standard

Leicestershire Partnership NHS Trust

March 2021

Introduction to the Workforce Disability Equality Standard

In response to findings that indicate Disabled staff have a less favourable experience of working for the NHS than their non-disabled colleagues, NHS England has initiated a Workforce Disability Equality Standard (WDES). The WDES was mandated through the NHS standard contract from 2018/19.

The WDES comprises ten metrics to compare the profile and experiences of Disabled and non-disabled staff within an NHS organisation. The purpose of the metrics is to inform a local action plan that will target specific areas within a given organisation where the treatment or experience of Disabled staff is poor. The WDES metrics will also enable the organisation to demonstrate progress in areas where the treatment of Disabled staff needs to improve; and facilitate challenge where progress is not being made.

NHS Trusts are required to submit WDES data centrally, to NHS England, by the end of August. An action plan and the metrics must be ratified by the Trust's Board and must be published on the Trust's website by the end of October.

The WDES metrics

Metric 1. Pay Bands

Description of metric 1:

- Percentage of Disabled staff in Agenda for Change pay bands, calculated separately for non-clinical and for clinical staff, medical and dental subgroups and Very Senior Managers (including Executive Board members) compared with the percentage of staff in the overall workforce.

Narrative for metric 1:

- At March 2021, Disabled staff made up 5.9% of Leicestershire Partnership NHS Trust's (LPT) substantive workforce of known disability status (258/4402); however, disability status was not known for 18.9% of the substantive workforce (1027/5429).

- By comparison, in LPT's 2020 Staff Survey 25.0% of staff who gave their disability status identified as disabled (689/2753), with just 0.9% of respondents withholding the information (24/2777). Thus, data held in the Electronic Staff Record may underestimate the percentage of disabled staff in the organisation, potentially by a factor of 4. Notably, the NHS Staff Survey collects equality monitoring information anonymously. By contrast, whilst equality monitoring information held in the Electronic Staff Record is held confidentially, this information is linked to the individual's record in an identifiable manner.

- Amongst staff of known disability status, Disabled staff had the highest levels of representation at non-clinical pay bands 5 to 7 (7.8%, 24/306), whilst Disabled staff had the lowest levels of representation at non-clinical pay bands 8c to VSM (0.0%, 0/28) and amongst Career Grade Medics (0.0%, 0/24). Please refer to Table 1.

- There were no statistically significant variations in the percentages of Disabled staff by pay band. However, disability status was not known for 18.9% of substantive staff overall, and up to 48.0% at clinical pay bands 8c to VSM. Thus, findings related to the distribution of disabled staff across pay bands should be considered unreliable.

- Almost all substantive staff for whom there was no information on disability status selected the "prefer not to say" option in the Electronic Staff Record (98.1%, 1007/1027), rather than the record being blank. Before reliable inferences can be drawn about the disability profile of staff based on information held in the Electronic Staff Record, there is a need to address the incompleteness of this equality monitoring information.

- The incompleteness of equality monitoring information on disability has decreased year-on-year from 45.0% at March 2012 to 21.8% at March 2019, 20.3% at March 2020, and 18.9% at March 2021, but remains too high nonetheless.

Table 1: Metric 1: The disability profile of substantive staff at Leicestershire Partnership NHS Trust, by pay band cluster, at March 2019, March 2020, and March 2021 (staff of known disability status)

Table in 7 columns by 13 rows (including header row)

Pay Band Cluster	Percent Disabled March 2019	Percent Disabled March 2020	Percent Disabled March 2021	Number Disabled March 2019	Number Disabled March 2020	Number Disabled March 2021
Substantive Staff Overall	5.4%	5.8%	**5.9%**	226 out of 4151	247 out of 4245	**258 out of 4402**
Non clinical Cluster 1, Bands 1 - 4	6.3%	6.5%	**7.2%**	41 out of 650	40 out of 620	**45 out of 626**
Non clinical Cluster 2, Band 5 - 7	7.8%	7.5%	**7.8%**	23 out of 293	22 out of 293	**24 out of 306**
Non clinical Cluster 3, Bands 8a - 8b	1.5%	2.9%	**1.4%**	1 out of 67	2 out of 70	**1 out of 70**
Non clinical Cluster 4, Bands 8c - 9 and VSM	3.4%	4.0%	**0.0%**	1 out of 29	1 out of 25	**0 out of 28**
Clinical Cluster 1, Bands 1 - 4	4.2%	5.2%	**5.4%**	41 out of 971	55 out of 1059	**59 out of 1090**
Clinical Cluster 2, Band 5 - 7	5.7%	6.1%	**5.8%**	106 out of 1875	114 out of 1877	**113 out of 1950**
Clinical Cluster 3, Bands 8a - 8b	3.6%	3.8%	**4.7%**	5 out of 137	6 out of 157	**8 out of 172**
Clinical Cluster 4, Bands 8c - 9 and VSM	0.0%	0.0%	**7.7%**	0 out of 5	0 out of 8	**1 out of 13**
Clinical Cluster 5, Medical Consultants	4.0%	6.9%	**6.7%**	2 out of 50	4 out of 58	**4 out of 60**
Clinical Cluster 6, Medical Non-Consultants	11.1%	0.0%	**0.0%**	2 out of 18	0 out of 15	**0 out of 24**
Clinical Cluster 7, Medical Trainee Grades	7.1%	4.8%	**4.8%**	4 out of 56	3 out of 63	**3 out of 63**

Key to colour coding in table:

● Disabled staff overrepresented, O Disabled staff proportionately represented, ● Disabled staff underrepresented

Metric 2. Recruitment

Description of metric 2:

- Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts. The percentage of non-disabled staff appointed from shortlisting divided by the percentage of Disabled staff appointed from shortlisting.

Narrative for metric 2:

- In 2020/21 non-disabled people and Disabled people were similarly likely to be appointed from amongst those shortlisted (non-disabled people were 1.13 times as likely as Disabled people to be appointed from shortlisting).

- This is similar to the positions observed in 2018/19 and 2019/20 (non-disabled people were 1.40 and 1.39 times as likely as Disabled people to be appointed from shortlisting, respectively by year). Please refer to Table 2.

Table 2: Metric 2: The relative likelihood of non-disabled people and Disabled people being appointed from amongst those shortlisted at Leicestershire Partnership NHS Trust during 2018/19, 2019/20, and 2020/21

Table in 4 columns by 6 rows (including header row)

Recruitment	**2018/19**	**2019/20**	**2020/21**
Relative likelihood of appointment from shortlisting (non-disabled/Disabled)	1.40	**1.39**	**1.13**
Percentage of non-disabled people appointed from shortlisting	8.0%	**11.2%**	**10.8%**
Percentage of Disabled people appointed from shortlisting	5.7%	**8.1%**	**9.6%**
Number of non-disabled people appointed from shortlisting	477 out of 5952	**504 out of 4493**	**550 out of 5079**
Number of Disabled people appointed from shortlisting	24 out of 419	**30 out of 371**	**35 out of 364**

Key to colour coding in table: ● Disabled staff disadvantaged

Metric 3. Formal capability process

Description of metric 3:

- Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. The percentage of Disabled staff entering the formal capability process divided by the percentage of non-disabled staff entering the capability process.

Narrative for metric 3:

- In the two-year window 2019/20 to 2020/21, Disabled staff were 10.22 times more likely than non-disabled staff to enter formal capability proceedings.

- This is similar to the position observed for the two-year window 2018/19 to 2019/20, when Disabled staff were 6.22 times more likely than non-disabled staff to enter formal capability proceedings; and represents a deterioration of the position observed in the two-year window 2017/18 to 2018/19, when Disabled staff were 2.48 times as likely as non-disabled staff to enter formal capability proceedings. Please refer to Table 3.

Table 3: Metric 3: The relative likelihood of Disabled staff and non-disabled staff entering the formal capability process at Leicestershire Partnership NHS Trust during the two-year windows 2017/18 to 2018/19, 2018/19 to 2019/20, and 2019/20 to 2020/21

Table in 4 columns by 6 rows (including header row)

Formal capability process	**2017/18 to 2018/19**	**2018/19 to 2019/20**	**2019/20 to 2020/21**
Relative likelihood of entering the formal capability process (Disabled/non-disabled)	2.48	**6.22**	**10.22**
Percentage of Disabled staff entering the formal capability process	1.3%	**2.0%**	**2.7%**
Percentage of non-disabled staff entering the formal capability process	0.5%	**0.3%**	**0.3%**
Number of Disabled staff entering the formal capability process	3 out of 226	**5 out of 247**	**7 out of 258**
Number of non-disabled staff entering the formal capability process	21 out of 3925	**13 out of 3998**	**11 out of 4144**

Key to colour coding in table: ● Disabled staff disadvantaged

Metric 4. Harassment, bullying or abuse

Description of metric 4:

- 4 a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from:
    - i) Patients/Service users, their relatives or other members of the public,
    - ii) Managers,
    - iii) Other colleagues
- 4 b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

Narrative for metric 4a, parts i, ii, and iii:

- In 2020, Disabled staff were more likely than non-disabled staff to suffer harassment, bullying or abuse from patients / service users, their relatives or other members of the public (30.7%, 210/684 Disabled staff and 20.2%, 415/2050 non-disabled staff); a similar position to that seen in 2018 and 2019. Please refer to Table 4.

- In 2020, Disabled staff were more likely than non-disabled staff to suffer harassment, bullying or abuse from managers (17.7%, 121/682 Disabled staff and 8.9%, 183/2047 non-disabled staff); a similar position to that seen in 2018 and 2019. Please refer to Table 5.

- In 2020, Disabled staff were more likely than non-disabled staff to suffer harassment, bullying or abuse from other colleagues (22.3%, 150/673 Disabled staff and 13.0%, 262/2020 non-disabled staff); a similar position to that seen in 2018 and 2019. Please refer to Table 6.

Table 4: Metric 4a i: The percentages of Disabled staff and non-disabled staff who experienced harassment, bullying or abuse from patients / service users, their relatives or other members of the public, Staff Survey 2018, 2019, and 2020

Table in 4 columns by 5 rows (including header row)

Harassment, bullying or abuse from patients / service users, their relatives or the public	**2018**	**2019**	**2020**
Percentage Disabled staff	32.5%	30.1%	**30.7%**
Percentage non-disabled staff	21.0%	20.9%	**20.2%**
Number Disabled staff	181 out of 557	165 out of 548	**210 out of 684**
Number non-disabled staff	411 out of 1957	376 out of 1803	**415 out of 2050**

Key to colour coding in table: ● Disabled staff disadvantaged

Table 5: Metric 4a ii: The percentages of Disabled staff and non-disabled staff who experienced harassment, bullying or abuse from managers, Staff Survey 2018, 2019, and 2020

Table in 4 columns by 5 rows (including header row)

Harassment, bullying or abuse from managers	2018	2019	2020
Percentage Disabled staff	15.9%	20.5%	**17.7%**
Percentage non-disabled staff	7.6%	8.1%	**8.9%**
Number Disabled staff	88 out of 554	111 out of 542	**121 out of 682**
Number non-disabled staff	149 out of 1952	145 out of 1801	**183 out of 2047**

Key to colour coding in table: ● Disabled staff disadvantaged

Table 6: Metric 4a iii: The percentages of Disabled staff and non-disabled staff who experienced harassment, bullying or abuse from other colleagues, Staff Survey 2018, 2019, and 2020

Table in 4 columns by 5 rows (including header row)

Harassment, bullying or abuse from other colleagues	2018	2019	2020
Percentage Disabled staff	21.0%	23.6%	**22.3%**
Percentage non-disabled staff	12.5%	13.5%	**13.0%**
Number Disabled staff	115 out of 548	126 out of 534	**150 out of 673**
Number non-disabled staff	242 out of 1934	238 out of 1766	**262 out of 2020**

Key to colour coding in table: ● Disabled staff disadvantaged

Narrative for metric 4b:

- In 2020, Disabled staff and non-disabled staff were similarly likely to say they, or a colleague, reported their last incident of harassment, bullying or abuse (56.3%, 166/295 Disabled staff and 57.6%, 314/545 non-disabled staff); a similar position to that seen in 2018 and 2019. Please refer to Table 7.

Table 7: Metric 4b. The percentages of Disabled staff and non-disabled staff who say they, or a colleague, reported their last incident of harassment, bullying or abuse, Staff Survey 2018, 2019, and 2020

Table in 4 columns by 5 rows (including header row)

Reporting harassment, bullying or abuse	2018	2019	2020
Percentage Disabled staff	54.4%	**50.2%**	**56.3%**
Percentage non-disabled staff	57.7%	**56.5%**	**57.6%**
Number Disabled staff	118 out of 217	**118 out of 235**	**166 out of 295**
Number non-disabled staff	258 out of 447	**280 out of 496**	**314 out of 545**

Key to colour coding in table: ● Disabled staff disadvantaged

Metric 5. Equal opportunities for career progression or promotion

Description of metric 5:

- Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

Narrative for metric 5:

- In 2020, Disabled staff were less likely than non-disabled staff to feel that the organisation provides equal opportunities for career progression or promotion (79.8%, 375/470 Disabled staff and 88.4%, 1320/1493 non-disabled staff); a similar position to that seen in 2018 and 2019. Please refer to Table 8.

Table 8: Metric 5. The percentages of Disabled staff and non-disabled staff who felt that the organisation provides equal opportunities for career progression or promotion, Staff Survey 2018, 2019, and 2020

Table in 4 columns by 5 rows (including header row)

Equal opportunities for career progression or promotion	2018	2019	2020
Percentage Disabled staff	81.8%	77.0%	**79.8%**
Percentage non-disabled staff	89.3%	86.3%	**88.4%**
Number Disabled staff	320 out of 391	291 out of 378	**375 out of 470**
Number non-disabled staff	1248 out of 1397	1056 out of 1223	**1320 out of 1493**

Key to colour coding in table: ● Disabled staff disadvantaged

Metric 6. Pressure from a manager to come to work, despite not feeling well enough

Description of metric 6:

- Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Narrative for metric 6:

- In 2020, Disabled staff were more likely than non-disabled staff to have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties (26.6%, 119/447 Disabled staff and 18.9%, 154/814 non-disabled staff); a similar position to that seen in 2018 and 2019. Please refer to Table 9.

Table 9: Metric 6. The percentages of Disabled staff and non-disabled staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties, Staff Survey 2018, 2019, and 2020

Table in 4 columns by 5 rows (including header row)

Pressure from a manager to come to work, despite not feeling well enough	**2018**	**2019**	**2020**
Percentage Disabled staff	27.8%	26.2%	**26.6%**
Percentage non-disabled staff	16.7%	17.9%	**18.9%**
Number Disabled staff	110 out of 395	101 out of 386	**119 out of 447**
Number non-disabled staff	159 out of 952	161 out of 900	**154 out of 814**

Key to colour coding in table: ● Disabled staff disadvantaged

Metric 7. Satisfaction with the extent to which the organisation values work

Description of metric 7:

- Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

Narrative for metric 7:

- In 2020, Disabled staff were less likely than non-disabled staff to be satisfied with the extent to which the organisation valued their work (38.7%, 265/685 Disabled staff and 53.1%, 1086/2045 non-disabled staff); an improvement on the position seen in 2019 for non-disabled staff, but similar to the position seen in 2018 and 2019 for Disabled staff. Please refer to Table 10.

Table 10: Metric 7. The percentages of Disabled staff and non-disabled staff who were satisfied with the extent to which the organisation valued their work, Staff Survey 2018, 2019, and 2020

Table in 4 columns by 5 rows (including header row)

Satisfaction with the extent to which the organisation values work	**2018**	**2019**	**2020**
Percentage Disabled staff	41.8%	37.8%	**38.7%**
Percentage non-disabled staff	52.5%	47.4%	**53.1%**
Number Disabled staff	233 out of 558	207 out of 547	**265 out of 685**
Number non-disabled staff	1027 out of 1957	853 out of 1801	**1086 out of 2045**

Key to colour coding in table: ● Disabled staff disadvantaged

Metric 8. Adequate adjustments

Description of metric 8:

- Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

Narrative for metric 8:

- In 2020, Amongst Disabled staff at LPT, 79.4% (359/452) reported that their employer had made adequate adjustments to enable them to carry out their work – similar to the national average of 76.6% (52444/68509); a similar position to that seen in 2018 and 2019 for LPT, but reflecting an increase in the national average. Please refer to Table 11.

Table 11: Metric 8. The percentages of Disabled staff reporting that their employer has made adequate adjustment(s) to enable them to carry out their work, Staff Survey 2018, 2019, and 2020

Table in 4 columns by 5 rows (including header row)

Adequate adjustments	2018	2019	2020
Percentage Disabled staff at LPT	78.6%	80.3%	**79.4%**
Percentage Disabled staff nationally	73.0%	73.8%	**76.6%**
Number Disabled staff at LPT	257 out of 327	281 out of 350	**359 out of 452**
Number Disabled staff nationally	34684 out of 47531	44809 out of 60699	**52444 out of 68509**

Key to colour coding in table: ● Disabled staff at LPT at an advantage compared to Disabled staff nationally

Metric 9. Staff engagement and facilitating the voices of Disabled staff

Description of metric 9:

- 9 a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation

  A note on interpreting the staff survey engagement score: The engagement score is a composite score, which is drawn from 9 individual questions in the NHS Staff Survey, each of which contributes to the overall engagement score and to one of three sub-scales as outlined below. The overall engagement score and that on each subscale is standardised to give a value out of 10.

  - Motivation subscale:
    - Q2a - "I look forward to going to work."
    - Q2b - "I am enthusiastic about my job."
    - Q2c - "Time passes quickly when I am working."
  - Ability to contribute to improvements subscale:
    - Q4a - "There are frequent opportunities for me to show initiative in my role."
    - Q4b - "I am able to make suggestions to improve the work of my team / department."
    - Q4d - "I am able to make improvements happen in my area of work."
  - Recommendation of the organisation as a place to work / receive treatment subscale:
    - Q21a - "Care of patients / service users is my organisation's top priority."
    - Q21c - "I would recommend my organisation as a place to work."
    - Q21d - "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation."

- 9 b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (yes) or (no)

Narrative for metric 9a:

- In 2020, Disabled staff scored lower than non-disabled staff on the engagement score (6.67 for Disabled staff and 7.14 for non-disabled staff); a similar position to that seen in 2018 and 2019 for Disabled staff, but an improvement on the position at 2019 for non-disabled staff. Please refer to Table 12.

Table 12: The engagement score for Leicestershire Partnership NHS Trust overall, and for Disabled and non-disabled staff separately, Staff Survey 2018, 2019, and 2020

Table in 4 columns by 4 rows (including header row)

Staff engagement	2018	2019	2020
Disabled staff	6.67	6.56	**6.67**
Non-disabled staff	7.08	6.96	**7.14**
LPT overall	6.98	6.87	**7.02**

Key to colour coding in table: ● Disabled staff disadvantaged

Metric 9b. Action taken by the Trust to facilitate the voices of Disabled staff in the organisation to be heard:

- Channels for voices to be heard:
    - Disabled Staff Support Group: MAPLE (Mental and Physical Life Experience) which feeds into the
        - Equality, Diversity and Inclusion Strategic Workforce Group
        - Equality, Diversity and Inclusion Patient Involvement and Experience Group

- Themes identified through the MAPLE group
    - Reasonable adjustments
    - Recruitment process
    - Health passports
    - Ability Allies

- Outputs
    - Ongoing co-production of training packages and tools to include
        - Unconscious bias training
        - Managing ill health (for line managers, including access to work, reasonable adjustment, and stress management)
        - Stress management toolkit and links to the discussion of health and well-being at appraisal
    - Policy Reviews
    - Listening into Action Event
    - Joint Staff Networks Day with Northamptonshire Healthcare Foundation Trust (our buddy Trust)
    - Linking of well-being to the appraisal process through the Leadership Behaviour Framework

Metric 10. Board representation

Description of metric 10:

- Percentage difference between Disabled staff representation in the organisation's Board membership and the organisation's overall workforce, disaggregated by the Board's voting membership and executive membership.

Narrative for metric 10:

- At March 2021, compared to the level of representation in the workforce overall, Disabled people were proportionally represented amongst board members overall (+4.1% difference in representation), and amongst voting board members (+6.6% difference in representation); however there were no Disabled people amongst executive board members (-5.9% difference in representation). The position is similar to that observed in March 2020.

- Disability status was not known for 41% of board members and 19% of the substantive workforce overall. Before reliable inferences can be drawn about the disability profile of the board and staff based on information held in the Electronic Staff Record, there is a need to address the incompleteness of equality monitoring information on disability status.

Table 13: Metric 10. Differences in the levels of representation of Disabled staff amongst board members (overall, voting members, and executives), relative to the level of representation in the workforce overall, at March 2019, March 2020, and March 2021

Table in 4 columns by 5 rows (including header row)

Board representation	March 2019	March 2020	March 2021
Percentage Disabled staff in the substantive workforce overall	5.4%	5.8%	**5.9%**
Difference between percentage Disabled people amongst all board members and the substantive workforce overall	+2.9%	+2.5%	**+4.1%**
Difference between percentage Disabled people amongst voting board members and the substantive workforce overall	+5.7%	+5.3%	**+6.6%**
Difference between percentage Disabled people amongst executive board members and the substantive workforce overall	-5.4%	-5.8%	**-5.9%**

Key to colour coding in table: ● Disabled people underrepresented

Appendix 1

WDES Action Plan 2021 – 23

Objective1: To guarantee Dignity at work for all disabled staff (and those with long-term ill health) by creating a culture free from bullying, harassment and discrimination

Action Number	Action	Lead	Date	WDES data 2019/ 2020	Progress	RAG
1.	To ensure that there is full engagement with the disability agenda, in line with Leadership Behaviours leading to demonstrable culture change in respect of attitudes and approaches	Head of EDI Chair of MAPLE Group	March 2022	NHS Staff Survey (metrics 4, 5, 6, 7, 8 and 9a)	A series of disability sessions were delivered during 2020 Disability History Month and part of International Day of Disabled People (IDODP). Further sessions are planned for 2021 that will integrate leadership values as part of any education and awareness. Consideration should be given to building in to EDI objectives within appraisals including take up of reverse mentoring opportunities.	Amber
2.	Ensure disability diversity balance on decision making Forums i.e. Review all Boards/ committees/decision making forums. Do staff from protected groups sit on these boards/groups	Deputy Director of Governance and Risk	March 2022	WDES Indicator 9	To be commenced.	Blue
3.	To ensure that policies and Practices accommodate the needs	EDI Coordinator and HR Business Partner FYPC and Hosted	November 2021	NHS Staff Survey (metrics 4, 5, 6, 7, 8 and	The reasonable adjustments policy is currently under review and will provide an opportunity to	Amber

	of staff with disabilities	Services		9a)	create a revised approach which will improve the experience of employees with disabilities.	

Objective 2: Examine and prioritise issues facing disabled staff and have strategies in place to support individuals.

Action Number	Action	Lead	Date	WDES data 2019/ 2020	Progress	RAG
1.	Give voice to staff with disability using existing MAPLE network	Chair of MAPLE Group, Freedom to Speak Up Guardian, Director of HR and OD	Ongoing	WDES indicator 9	The MAPLE Group has grown and there have been changes in the chair and vice-chair positions. Activity of the group has increased during 2020. A Listening Event was held in December 2020 and plans are in place to continue this positive work in order to ensure that disabled staff continue to have safe spaces where they feel they can speak up.	Green
2.	To promote and communicate a wide range of disability related topics through Team Brief and team meetings. Also use this as a way of getting feedback/ intelligence	Chair of MAPLE, Associate Director of Communications, Head of EDI	March 2022	NHS Staff Survey (metrics 4, 5, 6, 7, 8 and 9a)	The Chair of MAPLE has run a session with finance. It is planned to communicate more information and guidance through channels such as Team Briefs, staff bulletin and where appropriate the FB closed page and awareness sessions Trust Wide and within	Blue

					teams.	
3.	To develop a People Library (volunteers from the MAPLE Group who can share their lived experience and expertise through short sessions (which can be recorded and shared via video clips) where colleagues can ask them questions)	The MAPLE Group	December 2021	As above	To be commenced.	Blue
4.	Identify, share, and engage with "hotspot" areas linked to 'health and wellbeing' questions in the additional questions part of the NHS staff survey. (any disabled staff Health and Wellbeing stories to be featured as part of the Wellbeing Wednesday news.)	Chair of MAPLE Group Health & Wellbeing Lead	March 2022	As above	To be commenced.	Blue
5.	Commission access audits LPT Estates and Facilities	Director of Finance Head of EDI Director of Estates	March 2022	Indicator 8	To be commenced.	Blue

Objective 3: All disabled staff have the confidence to declare their disability on ESR

Action Number	Action	Lead	Date	WDES data 2019/ 2020	Progress	RAG
1.	Develop a communication campaign so that staff feel confident declaring disability on ESR	Communication Lead for MAPLE Network	March 2022	NA	To be commenced	Blue
2.	Increased promotion of Trust as a 'Disability Confident' employer both internally and via recruitment social media sites	Resourcing Manager/ Communication Lead for MAPLE Network	March 2022	Indicator 1	Recruitment literature includes Disability Confident logo and criteria such as guaranteeing an interview to candidates who meet the minimum criteria. Further work required.	Amber
3.	Share Lived Experiences from disabled staff regarding their experiences in the workplace	MAPLE Network, EDI-Coordinator & Communication Lead	March 2022	Indicators 3, 4, 5, 6, 7, and 9.	MAPLE members shared lived experience during 2020 DHM and IDODP. Plans underway to step this up for 2021 activity.	Amber

Objective 4: Embed Inclusive recruitment practice towards the employment and retention of candidates with disabilities to guarantee fairness throughout the process.

Action Number	Action	Lead	Date	WDES data 2019/ 2020	Progress	RAG
1.	Work with Trust communications to ensure that we present an inclusive picture to potential job applicants, for example, recruitment adverts to feature a photo of existing disabled staff & brief statement about being a disability confident employer	MAPLE Communication Lead Resourcing Manager	March 2022	Indicator 1	Review of recruitment and selection policy and procedure planned.	Blue
2.	Enhance recruitment training so focus is on reducing unconscious bias at all stages of selection	Head of EDI Resourcing Manager	March 2022	As above	As above.	Blue
3.	Expand and mandate diversity of all selection panels	Director HR Resourcing Manager	March 2022	Indicator 1	As above.	Blue
4.	Recruit inclusion Allies	MAPLE Chair	March 2022	Indicator 1	To be commenced.	Blue

Objective 5: Ensure Career Progression for staff with disabilities through the Talent management and succession planning approach.

Action Number	Action	Lead	Date	WDES data 2019/ 2020	Progress	RAG
1.	Develop a Disability Confident Training Package for managers	Resourcing Manager and Head EDI	March 2023	Indicator 1	To be commenced.	Blue
2.	Develop disability awareness training for all	Head of EDI MAPLE Chair	March 2023	All	Build on the sessions run in 2020.	Amber
3.	Encourage managers (via training, ongoing education and coaching conversations) to have health and well-being discussions with staff about what reasonable Adjustments can be made	Head of OD	March 2023	Indicator 8 and 9.	Health and well Being is included in staff appraisals. Consider further guidance and support to managers to have this discussion.	Blue

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Leicestershire Partnership NHS Trust

FINANCE AND PERFORMANCE COMMITTEE – 27th July 2021

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 Update	**NA**	The H1 approach is likely to be rolled over into H2 but with a potential efficiency requirement along with questions around the covid funding allocation and the 3% pay award and whether this will be funded in its entirety – LPT therefore need to keep focus on the underlying cost base. Work is needed across LLR - 87 transformation schemes across LLR and the management of these as a system is currently being considered. A deep dive into financial planning is planned for the 11th August Trust Board Development Meeting. 2019/20 reference costs feedback - the East Midlands Costing Group have pushed back on the results –it has not been nationally published and should present no risk to LPT further feedback to FPC once received.	54, 55
CFO – Strategic Estates Update	**NA**	FM Transformation – the intentions to bring back in-house have now been shared with UHL; draft letters, notice and exit agreements are prepared and will be formally issued next week. Water Quality Issues – results are now back and are all clear. Testing has been extended across other LPT sites now. Safety Groups – the Water safety Group has been revived and the Ventilation Safety Group has been set up. Fire and Ligature Group – fire alarm systems and door replacement programme underway and going well. Capital – the dormitory work is complete in the Willows and Bosworth and work is no taking place on Thornton. The Welford and Langley Ward exchange was given approval by execs on 16th July 2021 – 23 beds will be lost but this meets the requirements.	10,11,
Director of	**NA**	The ICS work continues and triple exec meetings are	55

Report	Assurance level*	Committee escalation	ORR/Risk Reference
Strategy and Business Development Update		being held every 6-8 weeks. There was good feedback from the EMA Board meeting.	
Finance Report Month 3 - Paper C	**H** **M**	The month 3 income and expenditure shows a small overspend but overall delivery of the plan as expected. Covid & agency spend has increased and a deep dive is planned into agency spend at OEB in August. The headroom created across the system in H1 – has been released and LPT bids are being pulled together to support waiting times and activity backlog. Agency spend - the DMH locum costs will be reducing next month due to an overestimate this month. The bulk of the costs are around the investment standard monies which will be addressed moving forward. Block booking leads to quality of staff and these two issues need to be balanced. The committee agreed that split high medium assurance was received from the report – with the medium assurance representing the uncertainty of H2.	54
Mobile Telephony Tender Report – Paper D	**high**	Report details the proposal to move to a new provider – Cantium Business Solutions – who offer a better package and cost savings which will be used to fund two Band 5 engineers to support the roll out. The contract will be managed within the Procurement Team and a roll out plan is prepared ready for the contract start. The committee recommended Trust Board to approve the contract.	54
AED Contract Governance – Paper E	**high**	The committee noted the process and approved the creation of the subcontracts and agreed the matter to go to Trust Board for approval.	54
Disposable Continence Product Contract Extension and Pricing Discount – Paper F	**high**	The committee recommended approval of the contract at Trust Board.	54
Business Pipeline – Paper G	**high**	Bids detailed within the report were discussed and agreed as important for relationship building especially with non-medical organisations.	55
Performance Report Month 3 - Finance and Performance Metrics - Paper H	**medium**	There are a large number of new SOF metrics particularly around HR – work around this is ongoing to ensure that the performance report does not become too large. The new 21/22 metrics will be populated as they become available. Performance concerns continue to be discussed in performance review meetings.	20,35
Waiting Times Report	**low**	Starting to see a reduction in the 52 ww in FYPC and 1st appointments – this could possibly be attributed to the	28

Report	Assurance level*	Committee escalation	ORR/Risk Reference
Month 3 - Paper I		improved capture of data. The treatment lists remain steady with as many new people joining the list as are being seen. The national standards wait time target was achieved for PIER but not CAMHS ED or Children's Audiology – a robust plan is in place to address this. It was agreed that the executive team look at wait times and activity backlog in more detail at the next SEB.	
Provider Collaborative Performance - Paper J	**high**	This paper is to provide assurance up to the Trust Board and to escalate any risks that FPC identify. The mobilisation has been successful with positive relationships being established. A risk register is now in place and two groups have been established – the clinical Escalation Group and the Clinical Activity Panel. The Committee received high assurance from the report and It was noted that QAC received medium assurance due to queries around quality governance.	54, 55
Caldicott Guardian Report - Paper K	**NA**	The actions referred to in the paper were not included – so the committee agreed to put the item on the September agenda for resubmission.	
PLACE Audit - Paper L	**medium**	This has been suspended again this year and the approach is the same as NHFT have taken. It is proposed that this is picked up again as part of the FM Transformation. The option of conducting a PLACE light audit remains open. The committee supported the proposal not to conduct the PLACE audit in 2020/21 approving the postponement subject to confirmation on the impact on CQC assessment. Medium assurance was received from the report.	10,11
ORR - Paper M	**high**	The new Risk and Assurance Lead was in post from today and would be looking at the ORR, actions and gaps in more detail. The committee agreed the closure of risk 48.	All FPC Risks
Estates and Medical Equipment Committee Highlight Report 16th June 2021– Paper N	**high**	The committee received high assurance from the report.	10,11
IM&T Committee Highlight Report 18th June 2021	**high**	The committee approved the TOR update and received high assurance from the report.	
Data Privacy Committee Highlight Report 8th June 2021– Paper P	**high**	A meeting has since taken place with HIS confirming that SNOMED had been implemented and the next steps were to make it useful. The committee received high assurance from the report taking in to account the SNOMED update.	20,35

Report	Assurance level*	Committee escalation	ORR/Risk Reference
Strategic Waiting Time and Harm Review Committee Highlight Report 25th June 2021 – Paper Q	**low**	The committee agreed that low assurance was received from the report due to the data within it.	28
Annual Review of Committee including ToR - Paper R	**NA**	The committee received and agreed the paper.	

Chair	**Faisal Hussain, Non-Executive Director**

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Leicestershire Partnership NHS
NHS Trust

Finance Report for the period ended
31 July 2021

For presentation at the
Trust Board
31st August 2021

Contents

Executive Summary and overall performance against targets

Introduction

1. This report presents the financial position for the period ended 31 July 2021 (month 4). A net income and expenditure surplus of £94k is reported for the period, which is in line with the 'H1' (first half year) monthly financial plan. The total H1 plan is an I&E break-even at the end of month 6, and current forecasts show the position to be on target to deliver this.

2. Within the Trust's overall M4 position, net operational budgets report a £144k overspend. Directorate overspends include Estates (£118k), FYPC (£107k), LD (£70k) and Enabling services (£24k). CHS, Hosted and DMH are underspending by £110k, £38k and £26k respectively.

3. Central reserves report a corresponding underspend of £144k to offset the operational overspends.

4. Closing cash for July stood at £35.2m. This equates to 44.4 days' operating costs.

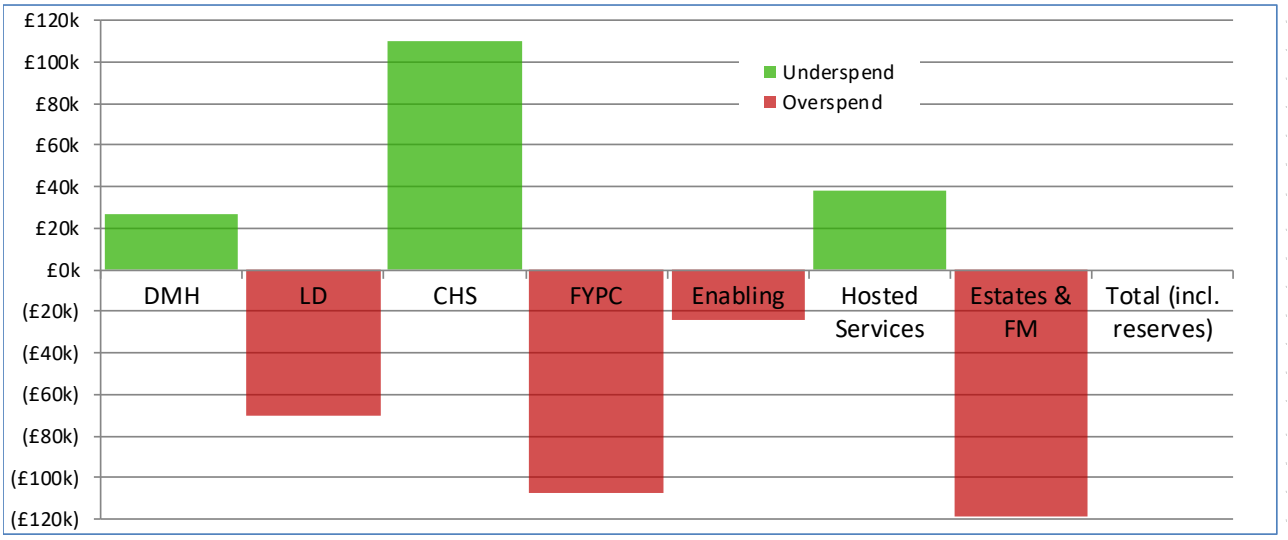
Performance against key targets and KPIs

NHS Trust Statutory Duties	Year to date	Year end f'cast	Comments
1. Income and Expenditure break-even.	G	G	The Trust is reporting a £94k surplus position at the end of July 2021. Achievement of the plan break-even by the end of the current planning period (H1) is expected **[see 'Service I&E position' and *Appendix A*]**.
2. Remain within Capital Resource Limit (CRL).	G	G	The capital spend for July is £1,482k, which is within limits.
3. Achieve the Capital Cost Absorption Duty (Return on Capital).	G	G	The dividend payable is based on the actual average relevant net assets; therefore, the capital cost absorption rate will automatically be 3.5%.
4. Remain within External Financing Limit (EFL).	n/a	G	The closing month 4 cash balance is £35.2m. The year-end forecast is £18m.

Secondary targets	Year to date	Year end f'cast	Comments
5. Comply with Better Payment Practice Code (BPPC).	G	G	The target is to pay 95% of invoices within 30 days. Cumulatively, the Trust achieved all 4 BPPC targets in July.
6. Achieve Efficiency Savings targets.	n/a	G	There is no formal Efficiency Savings Programme during the current planning period (H1).
7. Deliver financial plan surplus	n/a	n/a	During H1 there is no requirement to deliver a financial surplus (target = I&E break-even).
Internal targets	**Year to date**	**Year end f'cast**	**Comments**
8. Achieve a Financial & Use of Resources metric score of 2 (or better)	G	G	There is currently no formal requirement to be monitored against the Financial & Use of Resources metrics. An internal summary calculation is still conducted to measure progress internally, and this suggests that the Trust is currently scoring a '2'
9. Achieve retained cash balances in line with plan	G	G	A cash balance of £35.2m was achieved at the end of July 2021. **[See 'cash and working capital']**
10. Deliver capital investment in line with plan (within +/- 15% YTD planned spend levels)	G	G	Capital expenditure totals £1,482k at the end of month 4 **[See 'Capital Programme 2021/22']**

Income and Expenditure position

The month 4 position shows a net operational overspend against year-to-date budgets, offset by an underspend within reserves.



Estates services are reporting the largest adverse variance in month 4. This is mainly due to the revenue impact of water improvement works within the Bradgate site.

FYPC are reporting an overspend due primarily to the use of bank and agency at the Beacon and Langley wards. Within FYPC last financial year, Healthy Together community underspends helped to offset inpatient overspends. However, this year many of the previous Healthy Together vacancies have now been filled, reducing the beneficial impact of any underspend.

LD services continue to report overspends relating to the Agnes Unit due to the requirement to have all 5 pods in operation.

Enabling Services are reporting a £24k overspend which includes temporary agency usage to support the Triple R recovery programme.

The Mental Health directorate is underspending by £26k at the end of month 4 mainly due to slippage on investments linked to the spending review monies. Whilst there is slippage against other investments (e.g MHIS) due to recruitment challenges, there is an expectation that any underspend will be re-used within the system through the implementation of alternative schemes. As such, no financial benefit relating to any MHIS underspend is reflected in the LPT position.

Community Health Services are underspent by £110k due to reductions in travel costs and other non-pay underspends.

Covid costs

Covid costs have reduced considerably in July (£337k versus £724k in June). This is mainly due to the changes within MHSOP (DMH). In previous months, 5 wards (as opposed to the usual 4) were in operation to provide additional capacity to enable the segregation of Covid patients. The significant additional costs of running the fifth ward were considered to be a Covid cost. Now that the service is running 4 wards again, there is no additional Covid cost. June's costs also included the high cost of additional Covid/IPC compliant furniture that was incurred during that month, with only minimal costs being incurred in July.

Ongoing costs now largely relate to bank staff, and the Covid pay incentives that they are receiving.

For a breakdown of Covid costs please refer to ***Appendix E***.

Efficiency savings

Plans for the remainder of the year are likely to include a level of efficiency savings requirement, both to offset any further internal pressures and also to meet any requirement within national H2 planning guidelines. Savings assumptions are currently focussed on Trust-level opportunities and the continuation of existing underspends (e.g travel). However, as overall plans to 31st March 2022 continue to be refined, the introduction of some form of directorate savings or underspend target may be required.

Savings on travel costs and other expenditure lines (particularly in respect of staff working remotely) have been declared in H1, and amount to £537k as at month 4. These are not currently managed through any formal CIP process.

Forecast position

The forecast for H1 (half-year 1) continues to align with the planned H1 income and expenditure break-even assumption.

The national timescales for confirming the planning approach and finalising H2 plans have now been extended to November. However, work continues within the Trust and the wider system to confirm local plans in advance of these dates.

H2 income from LLR CCGs has not yet been confirmed and where this may be influenced by national planning guidance, this uncertainty may continue for some months. H1 income is based on receipts in Q3 last financial year - a period in which the Trust benefitted from considerable amounts of non-recurrent income. If an alternative approach to income allocations is adopted for H2, it is likely that income levels will be significantly lower, increasing the likelihood of an H2 financial deficit, and therefore a deficit for the year as a whole.

Additional agency expenditure analysis

Due to concerns over the high levels of agency expenditure being experienced in the current year, further analysis has been undertaken this month.

For the period April to July, total expenditure on agency staff was £6.3m. The forecast for the year is £19.5m. Forecast expenditure is slightly less than the estimate made last month due to adjustments to the accruals for Covid vaccination agency staff.

Total agency expenditure in financial year 2019/20 (being the last full year before Covid began to have an impact) was £10.2m. To compare the current year forecast with 2019/20, it is necessary to exclude the direct costs of Covid which are forecast to be £1.6m for the year. This results in comparative figures of £10.2m (19/20) and £17.9m (21/22 forecast).

Even after excluding Covid costs, the 2021/22 agency costs are still further distorted by the exceptionally high level of external investment this year, which is requiring additional agency staff in the short term to fill the large number of new posts. These investment related costs are expected to total £2.7m for the year.

The table below shows the 2019/20 position by directorate, and then compares this against the Covid-excluded 2021/22 position, with a further adjustment to remove the forecast investment related cost. This shows an adjusted cost of £15.2m for 2021/22 and so a £4.6m movement across the 2 years.

AGENCY COST ANALYSIS (EXCLUDING ANY COSTS RELATING TO COVID)

Directorate	2019/20	2021/22 including new investm.	2021/22 excluding new investm.	**Movement 19/20 to 21/22**		Estimated underlying agency positon 1st April 2022
	£000	£000	£000	**£000**	Comment on movement	£000
DMH	3,400	7,714	5,804	**2,404**	The service now has 6 additional Medic vacancies. Total locum spend in 19-20 was £1.5m, estimate for 21-22 is £3.4m. Nursing vaccancies have also risen (ignoring investment posts) which has resulted in an increase in nursing agency	5,804
CHS	4,341	4,463	4,463	**122**	[no material agency cost relating to investments - 21/22 costs and underlying position broadly on a par with 19/20]	4,463
FYPC	2,059	3,406	2,626	**567**	Increased level of vacancy within CAMHs consultant services; addressing CAMHs wait times; Hub & CAP staff; high usage of agency on the Beacon ward due to acuity of patients, use of level 1 obs, support for Children at UHL, sickness; use of agency on Langley due to acuity of patients	2,266
LD	301	1,453	1,453	**1,152**	Locum consultant cover for Forensic Service prior to appointment of permanent Consultant; Agnes unit operating over 5 pods in first quarter 21/22 combined with vacancies and sickness within funded establishment (anticipated to reduce pod usage from August although new admissions may require patients to require single pod use which will necessiate agency support).	1,021
Enabling / Hosted	541	905	858	**317**	Staffing to support recovery & TripleR; ICC staffing	655
TOTAL:	**10,642**	**17,941**	**15,204**	**4,562**		**14,209**

From the analysis above it can be seen that the majority of the underlying increase from 2019/20 to 2021/22 is within DMH (£2.4m), in particular, the additional medical locum cover. An increase in nursing vacancies is also driving up the agency usage.

LD agency costs have increased by £1.2m across the 2 years. This includes locum cover and also the high cost of staffing the Agnes Unit.

With FYPC, the increase is £0.6m, with the key drivers being CAMHS vacancies and the need to address wait times, along with Hub & CAP staffing, and pressures within Beacon and Langley wards.

Within Enabling the majority of the increase relates to the ICC and TripleR programme.

Additional detail of the current year agency expenditure is provided in ***Appendix C***.

Position for 2022/23

As part of this further analysis, directorate finance leads have begun to estimate the likely underlying agency staff position for 2022/23. This initial estimate assumes no further Covid costs, and for the purposes of comparative analysis also excludes the impact of further investment.

The estimate also adjusts for other costs deemed to be non-recurrent in 2021/22, and so results in an overall estimated cost of £14.2m for 2022/23 (before investment costs). In this estimate, the residual underlying increases when compared to 2019/20 are predominantly within DMH and LD, suggesting that these are the areas that may need the most focus.

Initial overall expenditure forecasts for 2022/23 factor in the recurrent position as outlined above. Agency costs to support additional investment would be offset by the new income and so the introduction of these, as 2022/23 plans are refined, should be cost neutral overall.

If agency costs can be reduced even down to 2019/20 levels, the premium cost savings would be significant. The Trust was previously set an even lower agency cost ceiling target of £8.1m. Whilst current costs are well in excess of this target, aligning our longer term aims to this recognised level would seem a logical ambition. The emerging efficiency programme for 22/23 highlights a number of opportunities to reduce agency staff.

Statement of Financial Position (SoFP)

PERIOD: July 2021	2020/21 31/03/21 Audited £'000's	2021/22 31/07/21 July £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	178,757	177,084
Intangible assets	2,438	2,302
Trade and other receivables	1,129	1,129
Total Non Current Assets	**182,324**	**180,515**
CURRENT ASSETS		
Inventories	574	552
Trade and other receivables	8,304	10,197
Cash and Cash Equivalents	24,139	35,237
Total Current Assets	**33,017**	**45,986**
Non current assets held for sale	**280**	**0**
TOTAL ASSETS	**215,621**	**226,501**
CURRENT LIABILITIES		
Trade and other payables	(21,587)	(32,546)
Borrowings	(296)	(297)
Capital Investment Loan - Current	(189)	(189)
Provisions	(2,851)	(2,757)
Total Current Liabilities	**(24,923)**	**(35,789)**
NET CURRENT ASSETS (LIABILITIES)	**8,374**	**10,197**
NON CURRENT LIABILITIES		
Borrowings	(7,464)	(7,464)
Capital Investment Loan - Non Current	(3,183)	(3,102)
Provisions	(1,397)	(1,397)
Total Non Current Liabilities	**(12,044)**	**(11,963)**
TOTAL ASSETS EMPLOYED	**178,654**	**178,749**
TAXPAYERS' EQUITY		
Public Dividend Capital	95,441	95,441
Retained Earnings	37,055	37,149
Revaluation reserve	46,158	46,159
TOTAL TAXPAYERS EQUITY	**178,654**	**178,749**

Non-current assets

- Property, plant and equipment (PPE) amounts to £177.1m. Capital additions amount to £1,482k, offset by July's depreciation charges.

Current assets

- Current assets of £46m include cash of £35.2m and receivables of £10.2m.

Non-current assets held for sale

- Following the recent disposal of Rubicon Close, the Trust does not have any non-current assets held for sale.

Current Liabilities

- Current liabilities amount to £35.8.m and mainly relate to payables of £32.5m.
- Net current assets / (liabilities) show net assets of £10.2m.

Working capital

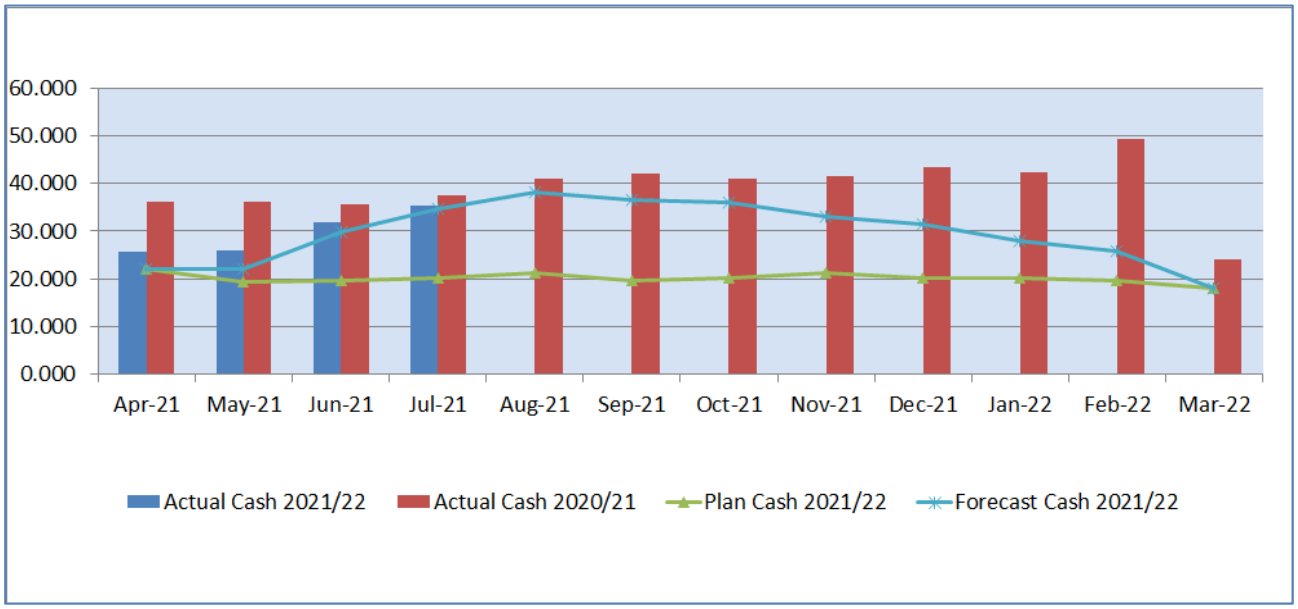
- Cash and changes in working capital are reviewed on the following pages.

Taxpayers' Equity

- July's surplus of £94k is reflected within retained earnings.

Cash and Working Capital

12 Months Cash Analysis Apr 21 to Mar 22



Cash – Key Points

The closing cash balance at the end of July was £35.2m, an increase of £3.4m during the month.

In line with the nationally mandated approach for calculating organisational funding envelopes, H1 monthly block income contract values have been set at last year's Q3 levels. We know these are in excess of what we would normally receive as Q3 included a number of one-off payments e.g., Covid funding, Mental Health Investment Standard allocations, SDF and Spending Review monies. This has resulted in forecast cash for the first six months of the year being significantly more than for the second six months (H2).

A cash-flow forecast is included at ***Appendix D.*** A year-end closing cash balance of £18m is currently forecast. This assumes:

- All 2020/21 year-end liabilities, including creditors and provisions, will be paid in the year
- The Trust will breakeven at the end of the year (no I&E surplus is currently assumed)
- The approved capital programme of £17.6m will be delivered by the end of the financial year
- H2 block contract income allocations will revert to pre-Covid arrangements i.e., not based on 2020/21 Q3 levels

The forecast year end cash position will be revised following guidance from NHSI on H2 funding levels and updates on Mental Health Investment expenditure profiling.

Receivables

Current receivables (debtors) total £10.2m; an increase of £2.2m during the month. The increase relates to the quarterly educational training invoice raised in July.

Receivables	Current Month (July 2021)					
	NHS £'000	Non NHS £'000	Emp's £'000	Total £'000	% Total	% Sales Ledger
Sales Ledger						
30 days or less	2,714	250	7	**2,971**	**26.2%**	**69.3%**
31 - 60 days	440	168	5	**613**	**5.4%**	**14.3%**
61 - 90 days	21	29	3	**53**	**0.5%**	**1.2%**
Over 90 days	205	247	198	**650**	**5.7%**	**15.2%**
	3,380	694	213	**4,287**	**37.9%**	**100.0%**
Non sales ledger	2,368	3,542	0	**5,910**	**52.2%**	
Total receivables current	**5,748**	**4,236**	**213**	**10,197**	**90.0%**	
Total receivables non current		1,129		1,129	**10.0%**	
Total	**5,748**	**5,365**	**213**	**11,326**	**100.0%**	**0.0%**

Debt greater than 90 days decreased by £970k since June and now stands at £650k. Receivables over 90 days should not account for more than 5% of the overall total receivables balance. The proportion at Month 4 is 5.7% (last month: 17.8%).

The aged debt performance has significantly improved this month due to the payment of £444k from DHU HealthCare and £684k from Leicestershire County Council. These have been long standing debts; the combined £1.1m payment of these two debts relates to 35 individual invoices.

The non-current receivables balance of £1.3m remains unchanged since the previous month; it comprises of a £396k long term debtor with NHSI to support the clinical pensions' tax provision and a £733k prepayment to cover PFI capital lifecycle costs.

The provision for bad debts stands at £341k; this has not changed since the start of the year.

Payables

The current payables position in Month 4 is £32.5m, an increase of £5m since June. This increase relates to the inclusion of additional non purchase ledger accruals and deferred income adjustments. Expenditure accruals are required to cover costs where invoices have not yet been received but goods and services have been delivered and deferred income adjustments relate to income received for future periods' activity.

Better Payment Practice Code (BPPC)

The specific target is to pay 95% of invoices within 30 days. Cumulatively the Trust achieved all 4 BPPC targets in July. Further details are shown in ***Appendix B***.

Capital Programme 2021/22

Capital expenditure totals £1.5m at Month 4 and continues to relate to estates service improvements, backlog maintenance schemes, IT and medical devices equipment.

	Annual Plan	July Actual Exp	Year End Forecast	Revision to Plan
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**
Depreciation & technical adjustments	9,500	1,202	9,500	0
Dormitory elimination - Bradgate (PDC)	2,612	0	2,612	0
Dormitory elimination - Evington (PDC)	1,500	0	1,500	0
Agnes unit PFI lifecycle costs	100	0	100	0
Property disposal - Rubicon Close	280	280	280	0
Cash utilisation from previous years' surplus	1,000	0	1,000	0
PDC IM&T System-wide capital	2,560	0	2,560	0
Total Capital funds	**17,552**	**1,482**	**17,552**	**0**
Application of Funds	**£'000**	**£'000**	**£'000**	**£'000**
Estates & Innovation				
Estates service improvements	(5,019)	(310)	(4,990)	29
Estates backlog	(2,395)	(251)	(2,394)	1
Estates other rolling programmes	(1,950)	(33)	(2,064)	(114)
Estates staffing	(360)	(137)	(385)	(25)
Estates & FM transformation	(699)	0	(699)	0
Medical devices	(120)	(124)	(236)	(116)
	(10,543)	**(855)**	**(10,768)**	**(225)**
IT Programme				
Rolling programmes	(1,865)	(395)	(1,865)	0
Other projects	(595)	(42)	(595)	0
	(2,460)	**(437)**	**(2,460)**	**0**
Directorate capital investment projects	**(1,689)**	**(13)**	**(1,633)**	**56**
IM&T system-wide capital (tbc)	**(2,560)**	**0**	**(2,560)**	**0**
Revenue to capital transfers	**0**	**(177)**	**(178)**	**(178)**
Contingency	**(300)**	**0**	**47**	**347**
Total Capital Expenditure	**(17,552)**	**(1,482)**	**(17,552)**	**0**
(Over)/underspend	**0**	**0**	**0**	**0**

£2.6m is included in the plan to support system-wide IM&T investment. Originally £900k of this was for shared care records (IT) and the remaining £1.7m split between LPT and UHL for contingencies. UHL has recently confirmed that they do not require any of the contingency allocation this year, therefore the total £2.6m will support LPT capital investment this year.

The need for additional LPT capital has been recognised - to accelerate the IT lap-top rolling replacement programme; address the requirements of the Mental Health investment

initiatives, and meet the outcomes of the Triple R Programme. The system capital allocation will cover these new capital pressures, however any spending plans will need to be on-hold until NHSE&I approval to drawdown the £2.6m is granted.

The sales proceeds from the recent disposal of Rubicon Close has generated £280k of capital funds to support this year's programme.

All new capital bids and any changes made to existing schemes are shown in the table below. Dependent on value, these have been approved by either the Capital Management Committee and/or the Acting Director of Finance & Performance, as stipulated in our Standing Financial Instructions.

Changes to capital schemes: M1- M4

Month	Ref	Scheme type	Scheme	Dept	Plan	Forecast	Change (Inc) / Dec	Reason
					£000	£000	£000	
M02	6C84	Emergency	Beacon swing doors (FYPC)	Est	0	(69)	(69)	Emergency bid approved to support modifications
M02	6C85	Emergency	Beacon classroom doors (FYPC)	Est	0	(41)	(41)	Emergency bid approved to support modifications
M02	6C91	Emergency	CDM Principal Designer	Est	0	(25)	(25)	Emergency bid approved to support minor works schemes
M04	6C84	Emergency	Beacon modifications (FYPC) - approved in M02	Est	0	(46)	(46)	Emergency bid approved to support modifications
					0	**(181)**	**(181)**	
M02	6C87	Existing	Site wide - Electrical remedial work following 5 yr fixed t	Est	(150)	(225)	(75)	Expand work to complete full 100% requirements in 21-22
M02	6C63	Existing	Stewart House - Purchase external fire escape doors	Est	(25)	(73)	(48)	Increase required to match GMP (2 sets of doors plus)
M02	6C50	Existing	Springfield Road - remainder of roof to recover	Est	(50)	(80)	(30)	Increase required to match GMP
M02	6C10	Existing	Clinical hub sites installation of pre-purchased LED light	Est	(50)	(78)	(28)	Increase required to match GMP
M02	6C35	Existing	Coalville roof phase 1 (from 20/21)	Est	(56)	(74)	(18)	Increase required to match GMP
M02	6C89	Existing	OSL House toilets	Est	(108)	(119)	(11)	Increase required to match GMP
M02	6C69	Existing	Staff room upgrades - Stewart House	Est	(20)	(25)	(5)	Increase required to match GMP
M02	6C70	Existing	Beacon - Install additional EM lights to perimeter (ICL?)	Est	(5)	(8)	(3)	Increase required to match GMP
M02	6C28	Existing	OSL boilers	Est	(57)	(47)	10	Reduction required to match GMP
M02	6C72	Existing	Staff room upgrades - OSL House	Est	(20)	0	20	Not required; boiler works already completed in 20-21
M02	6C48	Existing	Swithland House - Conifer reduction	Est	(20)	0	20	Not capital, charge to revenue
M02	6C14	Existing	Stewart House - Windows and internal doors (same sex	Est	(100)	(69)	31	Reduction required to match GMP (4 sets of doors only)
M02	6C61	Existing	Stewart House fire doors	Est	(37)	0	37	Duplicated scheme; confirmed at walk round on 09.06.21
M02	6C99	Existing	Bradgate Watermead emergency lighting replacement	Est	(192)	(150)	42	Reduction required to match GMP
M02	6C53	Existing	Stewart House internal doors - absconsion	Est	(55)	0	55	Duplicated scheme; confirmed at walk round on 09.06.21
M02	6C59	Existing	Stewart House - same sex	Est	(100)	0	100	Duplicated scheme; confirmed at walk round on 09.06.21
M02	6C38	Existing	Loughborough Hospital - Phase 2 – DSU Theatre AHU	Est	(150)	0	150	Not capital; work to be undertaken on existing, not new system
M04	6C11	Existing	Site wide - Anti-barracade	Est	(50)	(350)	(300)	H&S survey completed; standardised rolling rep't needed
M04	6C08	Existing	Site wide - H&S - Fire	Est	(100)	(300)	(200)	H&S survey completed; more sites requiring work
M04	6C88	Existing	Coalville Hospital - Replacement roof phase 2. Ward 1,	Est	(150)	(300)	(150)	Budget increased to £300k to include for access road
M04	6C24	Existing	Coalville Hospital - Ward 1 radiator covers and redecora	Est	(15)	(120)	(105)	More work required than envisaged at plan stage
M04	6C22	Existing	Coalville Hospital - Ward 2 radiator covers and redecora	Est	(25)	(120)	(95)	More work required than envisaged at plan stage
M04	6C06	Existing	Mawson House - Boiler replacements	Est	(50)	(38)	12	Reduction required to match GMP
M04	6C73	Existing	CAP clinical triage room - deferred from 20/21	Est	(20)	0	20	Not required due to change of plan
M04	6C47	Existing	Westcotes House - High Level Roof repairs	Est	(50)	(20)	30	Site visit found repairs not as extensive as first thought
M04	6C94	Existing	Site wide - Redecoration programme	Est	(119)	(89)	30	£30k already included in Coalville wards redec. programme
M04	6C54	Existing	Evington Centre - Structural cracks & hand rail replacem	Est	(80)	(40)	40	Revised cost after receipt of GMP
M04	6C71	Existing	Evington Centre - Ward entrance doors	Est	(75)	(26)	49	Revised cost after receipt of GMP
M04	6C19	Existing	Bradagte Unit - Glenvale reconfiguration	Est	(250)	0	250	Priority areas already addressed in 20-21 so scheme removed
M04	6C52	Existing	Site wide - H&S - Ligature	Est	(1,000)	(700)	300	£300k deferral into 22-23
					(3,179)	**(3,051)**	**128**	
M02	6C07	Existing - defe	Medical Devices	Med	(120)	(236)	(116)	Planned for 20-21 but delivered after 31.03.21
					(120)	**(236)**	**(116)**	
M02	2514	Revenue	Revenue to Capital transfers - IT hardware	Rev	0	(3)	(3)	IT equipment purchased via revenue
M03	2514	Revenue	Revenue to Capital transfers - IT hardware	Rev	0	(67)	(67)	IT equipment purchased via revenue
M03	2514	Revenue	Revenue to Capital transfers - Furniture	Rev	0	(16)	(16)	IT equipment purchased via revenue
M04	2514	Revenue	Revenue to Capital transfers - IT hardware	Rev	0	(92)	(92)	IT equipment purchased via revenue (inc 20-21 TMS scheme)
					0	**(178)**	**(178)**	
Total Changes - M4					**(3,299)**	**(3,646)**	**(347)**	

Capital contingency

The capital contingency of £300k set at the start of the year has now been fully utilised; the plan is now over-committed by £47k. This is manageable within the overall programme due to anticipated expenditure slippage on estates schemes in the latter part of the year.

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 31 July 2021	YTD Actual M4 £000	YTD Budget M4 £000	YTD Var. M4 £000
Revenue			
Total income	111,960	110,255	1,705
Operating expenses	(109,661)	(107,896)	(1,765)
Operating surplus (deficit)	**2,298**	**2,358**	**(60)**
Investment revenue	0	0	0
Other gains and (losses)	60	0	60
Finance costs	(340)	(340)	0
Surplus/(deficit) for the period	**2,018**	**2,018**	**(0)**
Public dividend capital dividends payable	(1,924)	(1,924)	0
I&E surplus/(deficit) for the period (before tech. adjs)	**94**	**94**	**(0)**
IFRIC 12 adjustments	0	0	0
Donated/government grant asset reserve adj	0	0	0
Technical adjustment for impairments	0	0	0
NHSE/I I&E control total surplus	**94**	**94**	**(0)**
Other comprehensive income (Exc. Technical Adjs)			
Impairments and reversals	0	0	0
Gains on revaluations	0	0	0
Total comprehensive income for the period:	**94**	**94**	**(0)**
Trust EBITDA £000	**5,654**	**5,714**	**(60)**
Trust EBITDA margin %	**5.1%**	**5.2%**	**-0.1%**

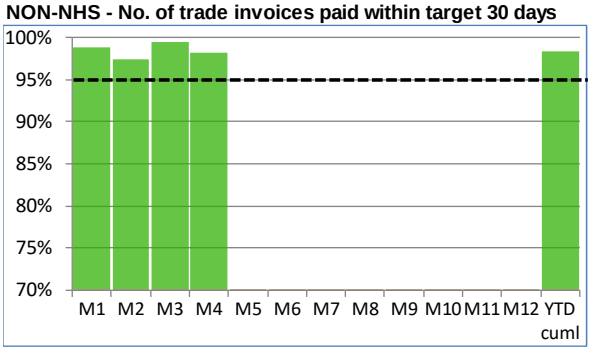
APPENDIX B – BPPC performance

Trust performance – current month (cumulative) v previous

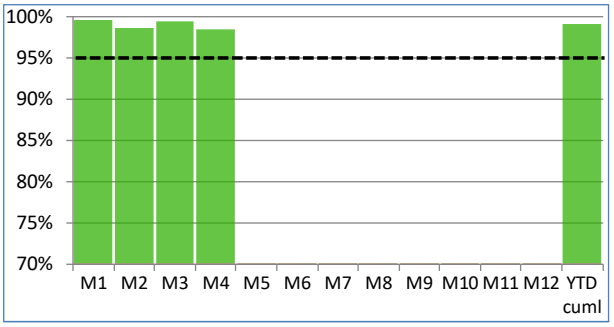
Better Payment Practice Code	July (Cumulative)		June (Cumulative)	
	Number	£000's	Number	£000's
Total Non-NHS trade invoices paid in the year	9,192	35,944	6,972	26,459
Total Non-NHS trade invoices paid within target	9,037	35,619	6,858	26,279
% of Non-NHS trade invoices paid within target	**98.31%**	**99.10%**	**98.4%**	**99.3%**
Total NHS trade invoices paid in the year	267	19,361	180	13,908
Total NHS trade invoices paid within target	255	18,891	178	13,740
% of NHS trade invoices paid within target	**95.51%**	**97.57%**	**98.9%**	**98.8%**
Grand total trade invoices paid in the year	9,459	55,305	7,152	40,367
Grand total trade invoices paid within target	9,292	54,510	7,036	40,019
% of total trade invoices paid within target	**98.23%**	**98.56%**	**98.4%**	**99.1%**

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

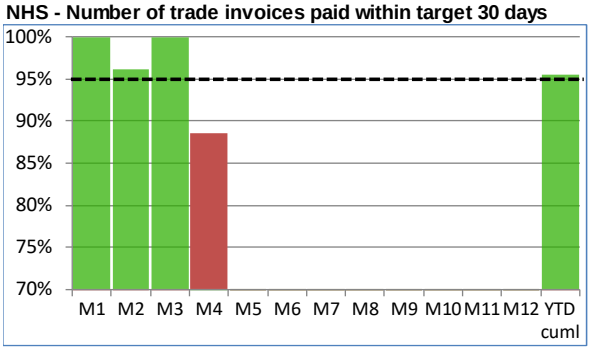
NON-NHS - No. of trade invoices paid within target 30 days



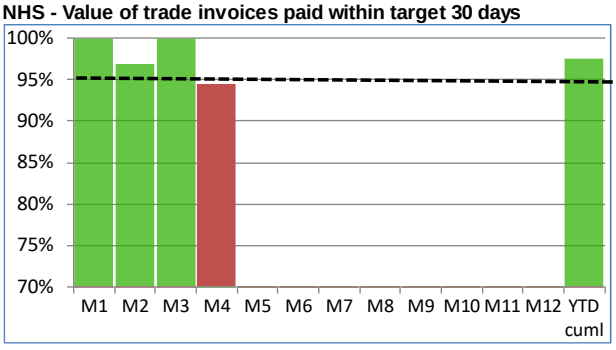
NON-NHS - Value of trade invoices paid within target 30 days



NHS - Number of trade invoices paid within target 30 days



NHS - Value of trade invoices paid within target 30 days



APPENDIX C – Agency staff expenditure

2021/22 Agency Expenditure	2020/21 Outturn	2020/21 Avg mth	2021/22 M1	2021/22 M2	2021/22 M3	2021/22 M4	2021/22 M5	2021/22 M6	2021/22 M7	2021/22 M8	2021/22 M9	2021/22 M10	2021/22 M11	2021/22 M12	21/22 YTD		21/22 Year End
	£000s Actual	£000s Actual	£000s Actual	£000s Actual	£000s Actual	£000s Actual	£000s F'Cast	£000s F'Cast	£000s F'Cast	£000s F'Cast	£000s F'Cast	£000s F'Cast	£000s F'Cast	£000s F'Cast	£000s Actual		£000s F'Cast
DMH																	
Agency Consultant Costs	-2,561	-213	-290	193	-520	-265	-265	-265	-380	-360	-340	-320	-300	-280	-881		-3,391
Agency Nursing	-2,642	-220	-344	-265	-301	-422	-320	-350	-375	-390	-390	-390	-390	-390	-1,332		-4,327
Agency Scient, Therap. & Tech	-152	-13	-19	-14	-14	-25	-20	-20	-20	-20	-20	-20	-20	-20	-71		-231
Agency Other clinical staff costs				-11	-16	-11	-20	-20	-20	-20	-20	-20	-20	-20	-39		-199
Agency Non clinical staff costs	-187	-16	-21	-32	-54	-21	-45	-40	-40	-40	-40	-40	-40	-40	-128		-453
Sub-total for Directorate - DMH	**-5,541**	**-462**	**-673**	**-129**	**-905**	**-743**	**-670**	**-695**	**-835**	**-830**	**-810**	**-790**	**-770**	**-750**	**-2,451**	**0**	**-8,600**
Agency Spend relating to Investments			**-57**	**-88**	**-115**	**-130**	**-145**	**-160**	**-175**	**-200**	**-210**	**-210**	**-210**	**-210**	-390		**-1,910**
Agency spend relating to COVID			-59	-97	-150	-40	-100	-80	-90	-70	-60	-60	-60	-60	-346		**-926**
LEARNING DISABILITIES																	
Agency Consultant Costs	-48	-4	-12	-8	-10	-13	-10	-10	-10	0	0	0	0	0	-43		-73
Agency Nursing	-761	-63	-129	-135	-156	-165	-150	-120	-100	-100	-80	-80	-80	-50	-585		-1,345
Agency Scient, Therap. & Tech	-85	-7	-13	-8	4	-1	-3	-2	-2	-2	-2	-2	-2	-2	-18		-35
Agency Other clinical staff costs															0		0
Agency Non clinical staff costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0
Sub-total for Directorate - LD	**-894**	**-74**	**-154**	**-151**	**-162**	**-178**	**-163**	**-132**	**-112**	**-102**	**-82**	**-82**	**-82**	**-52**	**-647**	**0**	**-1,454**
Agency Spend relating to Investments			**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0		**0**
Agency spend relating to COVID			-1	0	0	0	0	0	0	0	0	0	0	0	-1		**-1**
CHS																	
Agency Consultant Costs	-9	-1	0	0	0	0	0	0	0	0	0	0	0	0	0		0
Agency Nursing	-3,959	-330	-239	-354	-338	-411	-380	-360	-340	-340	-370	-350	-330	-330	-1,342		-4,142
Agency Scient, Therap. & Tech	-375	-31	-36	-36	-50	-42	-40	-35	-35	-35	-35	-35	-35	-35	-164		-449
Agency Other clinical staff costs															0		0
Agency Non clinical staff costs	-28	-2	-5	-10	-11	0	-10	-10	-8	-6	-3	-3	-3	-3	-25		-71
Sub-total for Directorate - CHS	**-4,371**	**-364**	**-279**	**-401**	**-399**	**-453**	**-430**	**-405**	**-383**	**-381**	**-408**	**-388**	**-368**	**-368**	**-1,532**	**0**	**-4,663**
Agency Spend relating to Investments			**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	0		**0**
Agency spend relating to COVID			-56	-18	-10	-21	-20	-15	-15	-15	-15	-15			-140		**-200**
FYPC			0														
Agency Consultant Costs	-816	-68	-70	-17	-48	-63	-50	-50	-50	-50	-50	-50	-50	-50	-198		-598
Agency Nursing	-2,546	-212	-241	-259	-232	-245	-230	-230	-230	-210	-210	-210	-210	-210	-977		-2,717
Agency Scient, Therap. & Tech	0	0	0	0	0	-3	0	0	0	0	0	0	0	0	-3		-3
Agency Other clinical staff costs															0		0
Agency Non clinical staff costs	-10	-1	-5	-14	-6	-11	-9	-9	-9	-5	-5	-5	-5	-5	-37		-89
Sub-total for Directorate - FYPC	**-3,371**	**-281**	**-315**	**-290**	**-287**	**-322**	**-289**	**-289**	**-289**	**-265**	**-265**	**-265**	**-265**	**-265**	**-1,215**	**0**	**-3,407**
Agency Spend relating to Investments			**0**	**0**	**0**	**0**	**0**	**-100**	**-100**	**-100**	**-120**	**-120**	**-120**	**-120**	0		**-780**
Agency spend relating to COVID			-1	0	0	0	0	0	0	0	0	0	0	0	-1		**-1**
Enabling, Hosted & reserves																	
Agency Consultant Costs	0	0	0	0	0										0		0
Agency Nursing	-8	-1	0	0	0										0		0
Agency Scient, Therap. & Tech	-83	-7	-5	-10	-8	-28	-8	-8	-8	-8	-8	-8	-8	-8	-52		-116
Agency Other clinical staff costs			0	0	0										0		0
Agency Non clinical staff costs	-977	-81	-105	-131	-158	-49	-115	-115	-90	-90	-90	-90	-90	-90	-444		-1,214
Sub-total for Directorate - ENAB, HOST&RESV	**-1,069**	**-89**	**-110**	**-141**	**-166**	**-78**	**-123**	**-123**	**-98**	**-98**	**-98**	**-98**	**-98**	**-98**	**-496**	**0**	**-1,330**
Agency Spend relating to Investments			**0**	**0**	**-5**	**0**	**-5**	**-5**	**-5**	**-5**	**-5**	**-5**	**-5**	**-5**	-5		**-47**
Agency spend relating to COVID			0	0	-3	-38	-48	-48	-48	-48	-48	-48	-48	-48	-41		**-425**
TOTAL TRUST																	
Agency Consultant Costs	-3,433	-286	-371	168	-578	-341	-325	-325	-440	-410	-390	-370	-350	-330	-1,123		-4,062
Agency Nursing	-9,915	-826	-953	-1,013	-1,028	-1,243	-1,080	-1,060	-1,045	-1,040	-1,050	-1,030	-1,010	-980	-4,236		-12,531
Agency Scient, Therap. & Tech	-696	-58	-73	-68	-69	-99	-71	-65	-65	-65	-65	-65	-65	-65	-309		-835
Agency Other clinical staff costs				-11	-16	-11	-20	-20	-20	-20	-20	-20	-20	-20	-39		-199
Agency Non clinical staff costs	-1,202	-100	-135	-188	-230	-81	-179	-174	-147	-141	-138	-138	-138	-138	-634		-1,827
Total	**-15,246**	**-1,270**	**-1,532**	**-1,113**	**-1,920**	**-1,775**	**-1,675**	**-1,644**	**-1,717**	**-1,676**	**-1,663**	**-1,623**	**-1,583**	**-1,533**	**-6,340**	**0**	**-19,453**
Total Trust Agency Spend relating to Investments	-	-	**-57**	**-88**	**-120**	**-130**	**-150**	**-265**	**-280**	**-305**	**-335**	**-335**	**-335**	**-335**	-395		**-2,737**
Total Trust Agency Spend relating to Covid-19	2,578	215	**-117**	**-115**	**-163**	**-99**	**-168**	**-143**	**-153**	**-123**	**-123**	**-123**	**-108**	**-108**	-494		**-1,553**
Total excluding Covid-19 and Investment costs	**-12,668**	**-1,055**	**-1,358**	**-910**	**-1,637**	**-1,546**	**-1,357**	**-1,236**	**-1,284**	**-1,238**	**-1,205**	**-1,165**	**-1,140**	**-1,090**	**-5,451**		**-15,164**

Agency costs for July were £1.8m. Excluding Covid and investment funded posts, costs were £1.6m.

Last month the forecast cost for the year had increased to over £20m. This has been revised down slightly this month (to £19.5m), mainly due to a revised estimate for the level of agency staff supporting the Covid vaccination programme.

Additional detail on agency staff expenditure has been provided in the main body of the report.

Leicestershire Partnership NHS
NHS Trust

APPENDIX D – Cash flow forecast

2021/22 CASH-FLOW FORECAST	JULY	JULY	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	YTD	21/22
	FORECAST	ACTUAL	VARIANCE	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	ACTUAL	FORECAST
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
OPENING BALANCE	**31,823**	**31,823**	**0**	**35,237**	**38,191**	**36,527**	**36,106**	**33,070**	**31,405**	**28,001**	**25,872**	**24,139**	**24,139**
INCOME													
Leicester & Leicesteshire CCG block contracts	22,936	23,025	**89**	22,936	22,936	20,249	20,249	20,249	20,249	20,249	20,252	91,833	259,202
Other CCG block contracts	293	293	**0**	293	293	293	293	293	293	293	293	1,175	3,519
East Midlands Provider Collaborative - CAMHS	142	142	**0**	142	142	142	142	142	142	142	142	568	1,704
Local Authorities block contracts	1,474	1,400	**(74)**	1,516	1,442	1,442	1,442	1,442	1,442	1,442	1,442	5,694	17,304
NHS England	756	774	**18**	783	783	783	783	783	783	783	783	3,123	9,387
UHL contract	500	0	**(500)**	750	250	250	250	250	250	250	250	446	2,946
MADEL	2,600	0	**(2,600)**	2,199	0	2,800	0	0	0	2,000	0	2,838	9,837
Out of County recharges	0	0	**0**	0	0	0	0	0	0	0	0	0	0
HIS income	200	188	**(12)**	200	200	200	200	300	300	449	574	864	3,287
360 Assurance income	100	364	**264**	100	100	300	100	100	300	100	136	461	1,697
UHL rental income	512	0	**(512)**	640	128	128	128	128	128	128	132	0	1,540
Previous year's income	0	1,812	**1,812**	0	0	0	0	0	0	0	0	4,887	4,887
VAT	250	310	**60**	555	250	250	250	250	250	250	250	1,564	3,869
Property sales	341	341	**0**	0	0	0	0	0	0	0	0	341	341
PDC for capital investment	0	0	**0**	0	1,306	0	0	1,306	0	0	1,500	0	4,112
Other income	488	831	**343**	488	488	488	488	388	388	388	530	1,836	5,482
Total Receipts	**30,592**	**29,480**	**(1,112)**	**30,602**	**28,318**	**27,325**	**24,325**	**25,631**	**24,525**	**26,474**	**26,284**	**115,630**	**329,114**
PAYMENTS													
Payroll	18,600	18,670	**70**	19,600	19,600	19,600	19,600	19,600	19,600	19,600	20,154	74,316	231,670
Capital	1,343	300	**(1,043)**	343	843	1,343	1,343	1,343	1,343	2,000	1,952	982	11,492
Non pay general expenditure	4,000	4,381	**381**	4,000	4,000	4,500	4,000	4,000	4,500	4,500	6,611	21,497	57,608
UHL - Estates & FM Services	1,880	940	**(940)**	1,880	940	940	940	940	940	940	940	2,820	11,280
UHL - Other contracts	604	290	**(314)**	435	145	145	145	145	145	145	145	290	1,740
NHS Property Services rents	122	0	**(122)**	472	600	300	300	300	305	300	300	928	3,805
Community Health Partnerships rents	448	472	**24**	118	118	118	118	118	118	118	118	472	1,416
HCL Agency Nursing Costs	650	1,013	**363**	800	800	800	800	800	978	1,000	1,000	3,112	10,090
Out of Area (OOA) costs for patients placed in private hospitals	50	0	**(50)**	0	50	0	0	50	0	0	50	0	150
Public dividend capital payment (PDC)	0	0	**0**	0	2,886	0	0	0	0	0	2,886	0	5,772
Other finance costs (inc loan interest and principal repayments)	0	0	**0**	0	0	0	115	0	0	0	0	115	230
Total Payments	**27,697**	**26,066**	**(1,631)**	**27,648**	**29,982**	**27,746**	**27,361**	**27,296**	**27,929**	**28,603**	**34,156**	**104,532**	**335,253**
CLOSING CASH BOOK BALANCE	**34,718**	**35,237**	**519**	**38,191**	**36,527**	**36,106**	**33,070**	**31,405**	**28,001**	**25,872**	**18,000**	**35,237**	**18,000**

APPENDIX E – Covid-19 expenditure, July 2021

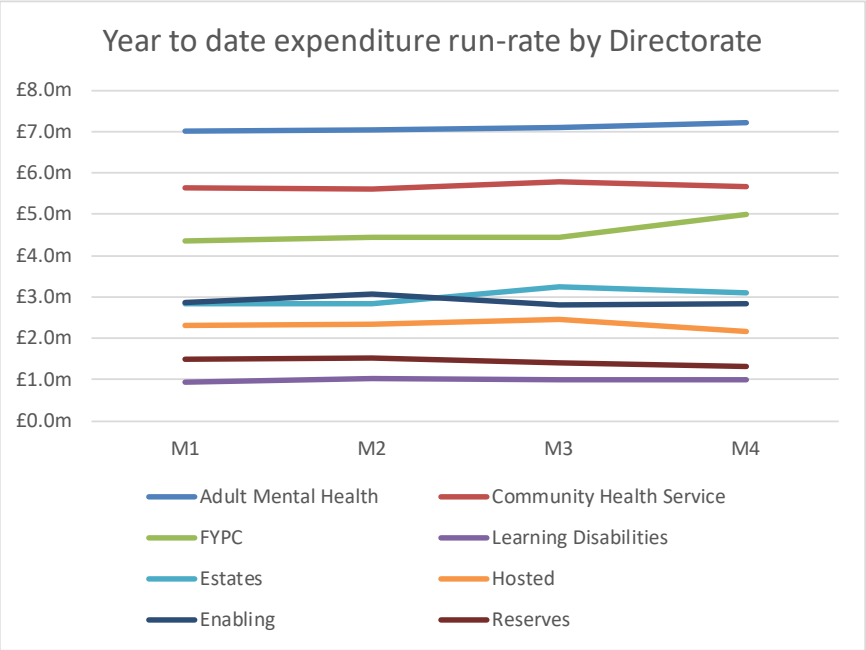
Cost of Covid response

CATEGORY	DMH	CHS	FYPC	LD	ESTS	ENAB	HOST	RSRVS	TOTAL
PAY	£000	£000	£000	£000	£000	£000	£000	£000	£000
Expand NHS Workforce - Medical / Nursing / AHPs / Hcare Scientists / Other									
Substantive	2	1	0	0	0	0	0	0	**3**
Bank	100	37	0	0	0	0	0	0	**137**
Agency	40	21	0	0	0	38	0	0	**99**
Existing workforce additional shifts									
Substantive	0	0	0	0	0	17	0	0	**17**
Bank	0	0	15	7	0	35	0	0	**57**
Agency	0	0	0	0	0	0	0	0	**0**
Backfill for higher sickness absence									
Substantive	0	0	0	0	0	0	0	0	**0**
Bank	0	0	0	0	0	0	0	0	**0**
Agency	0	0	0	0	0	0	0	0	**0**
Sick pay at full pay (all staff types)	0	0	0	0	0	0	0	0	**0**
NON-PAY	£000	£000	£000	£000	£000	£000	£000	£000	£000
NHS Staff Accommodation - if bought outside of national process	0	0	0	0	0	0	0	0	**0**
PPE - locally procured	0	0	0	0	0	0	0	0	**0**
PPE - other associated costs	0	0	0	0	0	0	0	0	**0**
Increase ITU capacity (incl hospital assisted respiratory / mech. ventilation)	0	0	0	0	0	0	0	0	**0**
Remote management of patients	0	0	0	0	0	0	0	0	**0**
Support for patient stay at home models	0	0	0	0	0	0	0	0	**0**
Segregation of patient pathways	0	0	0	0	0	0	0	0	**0**
Plans to release bed capacity	0	0	0	0	0	0	0	0	**0**
Decontamination	6	0	0	0	0	0	0	0	**6**
Additional Ambulance Capacity	0	0	0	0	0	0	0	0	**0**
Enhanced Patient Transport Service	0	0	0	0	0	0	0	0	**0**
NHS 111 additional capacity	0	0	0	0	0	0	0	0	**0**
After care and support costs (community, mental health, primary care)	0	0	0	0	13	0	0	0	**13**
Infection prevention and control training	0	0	0	0	0	0	0	0	**0**
Remote working for non patient activites:									
IT/Communication services and equipment	0	0	0	0	0	5	0	0	**5**
Furniture, fittings, office equip for staff home working	0	0	0	0	0	0	0	0	**0**
Internal and external communication costs	0	0	0	0	0	0	0	0	**0**
Covid Testing	0	0	0	0	0	0	0	0	**0**
Business Case (SDF) - Ageing Well - Urgent Response Accelerator	0	0	0	0	0	0	0	0	**0**
Direct Provision of Isolation Pod	0	0	0	0	0	0	0	0	**0**
PPN / support to suppliers (continuity of payments if service is disrupted)	0	0	0	0	0	0	0	0	**0**
TOTAL M4 COVID COSTS:	**148**	**59**	**15**	**7**	**13**	**95**	**0**	**0**	**337**
TOTAL M1 to M3 COVID COSTS:	1,160	281	38	32	37	255	0	0	1,803
TOTAL YTD COVID COSTS:	**1,309**	**340**	**53**	**39**	**50**	**350**	**0**	**0**	**2,141**

Covid Vaccination costs

Total Covid vaccination costs incurred to date (April to July) are £2.1m. Virtually all the costs relate to staffing. The Vaccination Programme forecast has now been extended to November and the plan assumes total vaccination costs of £6.3m for the period April to November. Vaccination costs are currently direct funded based on actual costs incurred, so the programme as a whole is forecast to have no impact on the Trust bottom line financial position.

APPENDIX F – Expenditure run-rate, April to July



TRUST RUN-RATE	M1	M2	M3	M4
Trust total expenditure:	£27.5m	£27.9m	£28.2m	£28.3m

The directorate run-rate chart above shows that expenditure levels appear reasonably static during the first 4 months of the year. Increases in FYPC expenditure in M4 indicate that a higher level of investment costs are now being incurred.

Looking at the total Trust expenditure position as per the table above, a slow but steady increase in overall costs becomes more apparent – with total costs increasing from £27.5m in month 1 to £28.3m in month 4. This largely reflects the impact of the new investments.

Leicestershire Partnership NHS Trust

Trust Board – 31/08/21

Month 4 Trust finance report

Purpose of the Report

- To update the Trust Board with the current Trust financial position

Proposal

- The Trust Board is recommended to review the summary financial position and receive assurance that financial performance is in line with the H1 financial plan.

Decision required: N/A

Governance table

For Board and Board Committees:	Trust Board	
Paper sponsored by:	Sharon Murphy, Acting Director of Finance	
Paper authored by:	Chris Poyser, Acting Deputy Director of Finance Jackie Moore, Financial Controller	
Date submitted:	24/08/2021	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Operational Executive Board 20/08/21	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Monthly update report	
STEP up to GREAT strategic alignment*:	High **S**tandards	
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	x
	Single Patient **R**ecord	
	Equality, Leadership, Culture	
	Access to Services	
	Trustwide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	all
Is the decision required consistent with LPT's risk appetite:	NA	
False and misleading information (FOMI) considerations:	NA	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:	NA	

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Leicestershire Partnership NHS Trust

Public Trust Board – 31.08.21

Board Performance Report July 2021 (Month 04)

Purpose of the report

To provide the Trust Board with the Trust's performance against KPI's for July 2021 Month 4.

Analysis of the issue

The report is presented to Operational Executive Team each month, prior to it being released to level 1 committees.

The following should be noted by the Trust Board with their review of the report and looking ahead to the next reporting period:

New KPIs 21/22 Update

Following review of the development of the new KPI's for 21/22, where these still require additional reporting configuration in the clinical system or development of the numerators and denominators for the metric, these have been removed from the report.

These metrics will be added to the relevant Directorate Performance Report in order that their development can be monitored. Once work has been completed to capture the data to be presented in reports, they will initially be included in the Directorate Performance Report for discussion at the Performance Review Meetings and escalated to the Board Performance Report where the Directorate advises the necessity.

New Metrics included in this months report include wait times for Aspergers and LD Community.

With the publication of the Community Mental Health Framework, CPA has now been superseded nationally. As such, measures relating to CPA have been removed from all MHSDS outputs from April 2021 data onwards. These metrics will therefore be removed from all future Board Performance Reports.

Key issues escalated from Directorate Performance Reviews

Appendix 1 to this paper provides a position statement and assurance around the work being undertaken to address key issues escalated from the Directorate Performance Reviews.

Proposals

The Trust Board is asked to note the above caveats to the performance report

Decision required

The Trust Board is asked to

- Approve the performance report

Governance table

For Board and Board Committees:	Public Trust Board 31.8.21	
Paper sponsored by:	Sharon Murphy, Interim Director of Finance and Performance	
Paper authored by:	Sam Kirkland, Head of Data Privacy	
Date submitted:	23.08.21	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Operational Executive Board 20.08.21	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	None	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Standard month end report	
STEP up to GREAT strategic alignment*:	High **S**tandards	
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	x
	Single Patient **R**ecord	
	Equality, Leadership, Culture	
	Access to Services	
	Trustwide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	20 - Performance management framework is not fit for purpose
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:	None identified	

Appendix 1

Key issues escalated from Directorate Performance Reviews

Key escalation areas from month 3 Performance meetings	Assurance re actions being taken
Community Health Services Directorate	
CINSS compliance with target	The service has received additional funding to increase capacity and has a revised trajectory to achieve 95% compliance by February 2022.
Continence waiting times	The service has an improvement plan in place working on a number of actions to support with waiting times management e.g. increasing capacity by: recruiting to additional posts – both clinical and administrative posts, reviewing the triage process, and scoping the use of alternative providers to assess patients on the waiting list.
Number of pressure ulcers	A Community Services pressure ulcer quality improvement plan is in place and has five key workstreams: • **Think Patient** • **Patient and carer information** • **Patient centred holistic assessment** • **Mental Capacity Assessments** • **Collaborative conversation** A new Community Hospital pressure ulcer quality improvement project is now underway, with the first tasks being to undertake a baseline audit using quarter 4 category 2 pressure ulcer data. The Lead Nurse is also undertaking a review of all categories of pressure ulcers on admission for Community Hospitals.

Families Young People & Children Directorate	

Backlog and waiting times	• Close monitoring of performance through DMT and Silver Deep Dives • Focused use of additional finance through MHIS and COVID backlog funding • Review of harm whilst waiting through clinical processes • Demand & Capacity reviews of service processes to support flow and discharge
Recruitment	• Innovative use of new roles e.g. nursing associate • Use of apprentices to nurture grow your own staff including professional qualifications e.g. occupational therapists • Having 'open' sessions for candidates to encourage applicants
Staff wellbeing	• H&WB leads in SMT and services • Use of charitable bids to promote 'team togetherness' e.g., 'the Big Tea' • Standard agenda item on all silver meetings • Promoting manageable caseloads and working day • Supporting staff to work in a blended way
Finance on the wards	• Increasing recruitment of substantive staff to prevent use of agency staff to cover vacancies • Director/HOS sign off for all DRA's • Monitoring the roster • Employing a peripatetic team to provide cover across all 3 directorate wards
Learning Disabilities	
Finance pressures on the Agnes Unit	• Working with CCG to implement a new financial model for high acuity patients • Increasing recruitment of substantive staff to prevent use of agency staff to cover vacancies • Director/HOS sign off for all DRA's • Closer monitoring and utilisation of the roster • Employing a peripatetic team to provide cover across all 3 directorate wards
Waiting lists for therapy services	• Demand &Capacity review to look for pathway efficiencies and to identify gaps in funding • Ensuring processes in place to risk manage the waiting list and prevent

	harm

Directorate of Mental Health	
Waiting times	Each service has a waiting times improvement plan in place and has developed a trajectory that sits alongside this. The SUTG-MH transformation programme will support long term sustainable reductions in waits, but interim plans include maximising capacity using bank and overtime, offering group treatment where appropriate and streamlining clinical pathways. All services are broadly on track against the planned trajectories. Two services currently have increasing waiting lists (although this is factored into the planned trajectories). One of these is the ADHD service, which is launching a tender process on 1st September to outsource part of the waiting list backlog. The second is the TSPPD treatment waiting list. The service is working rapidly through a large backlog of patients awaiting assessment – these are a priority as their potential risk is not yet known. A number of targeted assessment weeks are ongoing. This plan is on target to eliminate existing waits for assessment and has already reduced this by significant numbers. As patients are assessed, a proportion are added to the treatment waiting list, hence these numbers are quickly and expectedly rising. As part of SUTG MH the service is delivering from Sept/Oct a new group treatment offer, which will clear all existing waits for treatment and provide a sustainable model for future demand management.
workforce (recruitment)	The directorate is working closely with the recruitment team to ensure opportunities for successful recruitment are maximised. This includes reviewing how/ where opportunities are advertised and ensuring career development pathways are clear and promoted to attract candidates to posts. A dedicated Resourcing Manager for DMH has been sourced to support the volume of recruitment activities required across the Directorate and to expedite recruitment processes. Where recruitment to specific posts is a challenge, skill mix and alternative roles are being considered/ developed. This includes roles such as Assistant psychologists, Peer Support Workers, Patient facing pharmacy roles. The directorate is also working closely with PCNs and the neighbourhood projects so that funding can also be used in voluntary sector organisations to support our work.
Underspends on investment funding	Spend on investment funding is closely tracked. Where there is likely to be slippage, alternative non-recurrent schemes have been developed. Also some schemes have been brought forward from 22/23 to start in 21/22. Current projections predict an underspend of £15k on investment funds in 21/22.

Leicestershire Partnership NHS
NHS Trust

Trust Board
31 August 2021

Board Performance Report
July 2021 (Month 4)

Highlighted Performance Movements - July 2021

Improved performance:

Metric	Performance - %	
Gatekeeping Target is >=95%	100.0%	100% performance for past 2 months
Delayed Transfers of Care Target is <=3.5% across LLR	1.9%	

Deteriorating Performance:

Metric	Performance	
Personality Disorder - 52 weeks	325	
Care Programme Approach – 7-day follow up Target is 95% (reported a month in arrears)	91.7%	

Other areas to highlight:

Metric	Performance (No)	
No. of episodes of seclusions >2hrs *Target decreasing trend*	16	Decreased from 28 reported last month
No. of episodes of supine restraint *Target decreasing trend*	6	Decreased from 9 reported last month
No. of episodes of prone (unsupported) restraint *Target decreasing trend*	0	Decreased from 1 reported last month

1. Hospital Acquired COVID Infection Reporting

A nosocomial infection is an infection that is acquired in a hospital or other health care facility. How likely each patient Covid-19 case is to be a nosocomial case is based on the duration of time between admission to a healthcare facility and positive specimen date;.

- **Hospital-Onset Probable Healthcare-Associated** – positive specimen date 8 -14 days after hospital admission.
- **Hospital-Onset Definite Healthcare-Associated** – positive specimen date 15 or more days after hospital admission.

Indicator: Total Admissions

Month	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Sparkline
Total Admissions	404	353	389	330	374	366	368	381	377	347	396	377	406	398	437	418	404	

Indicator: Covid Positive Prior to Admission

Month	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Sparkline
Total Covid +ve Admissions	18	49	31	11	5	4	2	28	41	44	66	31	11	1	0	3	6	
Covid +ve Admission Rate	4.5%	13.9%	8.0%	3.3%	1.3%	1.1%	0.5%	7.3%	10.9%	12.7%	16.7%	8.2%	2.7%	0.3%	0.0%	0.7%	1.5%	

Indicator: Covid Positive Following Swab During Admission

No of Days	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Sparkline
0-2	1	4	2	2	0	0	0	2	5	4	5	4	0	0	0	0	0	
3-7	2	9	9	1	1	0	1	0	7	12	20	8	1	0	1	0	0	
8-14	1	8	9	2	0	0	0	0	1	15	9	5	2	0	0	0	0	
15 and over	11	14	5	2	0	0	0	7	5	29	18	35	9	1	0	0	0	
Hospital Acquired Rate *	3.0%	6.2%	3.6%	1.2%	0.0%	0.0%	0.0%	1.8%	1.6%	12.7%	6.8%	10.6%	2.7%	0.3%	0.0%	0.0%	0.0%	

• Community-Onset (CO) positive specimen date - <=2 days after hospital admission or hospital attendance.
• Hospital-Onset Indeterminate Healthcare Associated (HO.IHA) – positive specimen date 3-7 days after hospital admission.
• Hospital-Onset Probable Healthcare-Associated (HO.pHA) – positive specimen date 8 -14 days after hospital admission.
• Hospital-Onset Definite Healthcare-Associated (HO.dHA) – positive specimen date 15 or more days after hospital admission.
** - Includes the Hospital-Onset Probable Healthcare-Associated and Hospital-Onset Definite Healthcare-Associated categories.*

Indicator: Overall Covid Positive Admissions Rate

Month	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Sparkline
Total Covid +ve Admissions	33	84	56	18	6	4	3	37	59	104	118	83	23	2	1	3	6	
Average Covid +ve Admissions	8.2%	23.8%	14.4%	5.5%	1.6%	1.1%	0.8%	9.7%	15.6%	30.0%	29.8%	22.0%	5.7%	0.5%	0.2%	0.7%	1.5%	

Current LPT data sources for nosocomial Covid-19

Daily Directorate Covid-19 Sit-rep reports

The template includes; number of confirmed Covid-19 patients diagnosed with Covid-19 between midnight to 23.59:59 on the day before against the date of the positive specimen in line with the above definitions. This information is submitted directly to the ICC and copied to the Trust Infection Prevention and Control team.

IPC team local access database

The IPC team have a local access database for clinical patient reviews that captures all patients with long term infections and more recently Covid-19.The data source is taken from the daily Directorate sit-reps, or though IPC referrals. Data is validated using SystmOne records and ilab to confirm results. The system is backed up daily.
The objective is to move to a utilising System1 functionality when it is available, with reporting through Qliksense. The Information and IPC teams are currently working up this system and process.

Internal reporting

There was no cases reported for the month of July.

We continue to test, screen and triage all patients and use a risk assessment process. The pathways for patient admission have been updated to reflect the changes to a number of recent recommendations i.e. PPE useage. There are no red wards currently in use in the Trust, however a number of beds/areas have been identified in the directorates that meet the covid isolation requirements if patients test positive. An aggregated nosocomial/outbreak review of our cases from March 2020 until March 2021 for covid has been submitted in the Trust Board IPC 6 monthly report.

The campaign Hands, Face, Clean your space launched on the 15th July, to support the Trusts recovery plans and continue to promote the Infection prevention and control messages, these include:
- Dump the Junk
- How tidy is your cupboard
- Swap shop, can it be repurposed in another service if not needed (in line with mandatory requirements)
- Stock rotation, improving stock flow, expiry dates and stock levels.

Actions to minimise nosocomial Covid-19 infection

The weekly Trust wide outbreak meeting has been reinstated due to a staff outbreak involving 3 staff members, with a potential of an increase involved. The service is Mental Health Liasion Service, based at the Leicester Royal Infirmary. All staff are currently undergoing a PCR test.

2. Quality Account

The following standards form the measures for the 2020/21 Quality Account that being reported against in 2021/22 until the new metrics have been agreed.

<table>
<tr><th rowspan="2">Standard</th><th rowspan="2">Trust Performance</th><th rowspan="2">RAG/ Comments on recovery plan position</th><th colspan="2">SPC Flag</th></tr>
<tr><th>Assurance of Meeting Target</th><th>Trend</th></tr>
<tr><td rowspan="3">The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period</td><td><table><tr><td>Feb-21</td><td>Mar-21</td><td>Apr-21</td><td>May-21</td><td>Jun-21</td><td>Jul-21</td></tr><tr><td>81.0%</td><td>79.4%</td><td>93.2%</td><td>98.8%</td><td>100.0%</td><td>100.0%</td></tr></table></td><td rowspan="2"></td><td>?</td><td>NO CHANGE</td></tr>
<tr><td colspan="2">Over the series of data points being measured, key standards are being delivered inconsistently</td></tr>
<tr><td rowspan="3">The percentage of patients on CPA (care programme approach) who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period

(reported a month in arrears)</td><td><table><tr><td>Jan-21</td><td>Feb-21</td><td>Mar-21</td><td>Apr-21</td><td>May-21</td><td>Jun-21</td></tr><tr><td>83.5%</td><td>93.1%</td><td>85.2%</td><td>94.3%</td><td>96.2%</td><td>91.7%</td></tr></table></td><td rowspan="2">There were a number of service users who could not be contacted for their 7 day follow up contact during June. Appropriate attempts were made by staff.</td><td>?</td><td>NO CHANGE</td></tr>
<tr><td colspan="2">Over the series of data points being measured, key standards are being delivered inconsistently</td></tr>
<tr><td rowspan="2">The Trusts “Patient experience of community mental health services” indicator score with regard to a patient’s experience of contact with a health or social care worker during the reporting period</td><td><table><tr><td>2017/18</td><td>2018/19</td><td>2019/20</td><td>2020/21</td></tr><tr><td>7.4</td><td>6.4</td><td>7.1</td><td>6.9</td></tr></table></td><td>The majority of scores within Leicestershire Partnership NHS Trust’s results sit in the intermediate 60% of the Trusts surveyed by Quality Health, although there are also a number (over a third) that fall into the bottom 20% range, particularly with the Support and Wellbeing section.
However, there is a trend of positive change in many of the scores.
Many scores continue to show improvement and there are more scores in the intermediate range than bottom now. The score for overall rating of care has moved from the bottom to intermediate range.
Older adults continue to report more positively.</td><td>n/a</td><td>n/a</td></tr>
<tr><td colspan="2">Not applicable for SPC as reported infrequently</td></tr>
<tr><td rowspan="2">The percentage of patients aged:
(i) 0 to 15 and
(ii) 16 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period</td><td><table><tr><td colspan="6">Age 0-15</td></tr><tr><td>Feb-21</td><td>Mar-21</td><td>Apr-21</td><td>May-21</td><td>Jun-21</td><td>Jul-21</td></tr><tr><td>66.7%</td><td>0.0%</td><td>0.0%</td><td>66.7%</td><td>0.0%</td><td>0.0%</td></tr><tr><td colspan="6">Age 16 or over</td></tr><tr><td>32.5%</td><td>28.8%</td><td>31.7%</td><td>35.3%</td><td>32.8%</td><td>4.8%</td></tr></table></td><td></td><td>n/a</td><td>n/a</td></tr>
<tr><td colspan="2"></td></tr>
</table>

2. Quality Account

The following standards form the measures for the 2020/21 Quality Account that being reported against in 2021/22 until the new metrics have been agreed.

<table>
<tr><th rowspan="2">Standard</th><th rowspan="2">Trust Performance</th><th rowspan="2">RAG/ Comments on recovery plan position</th><th colspan="2">SPC Flag</th></tr>
<tr><th>Assurance of Meeting Target</th><th>Trend</th></tr>
<tr><td>The number and, where available rate of patient safety incidents reported within the Trust during the reporting period</td><td><table><tr><td>Feb-21</td><td>Mar-21</td><td>Apr-21</td><td>May-21</td><td>Jun-21</td><td>Jul-21</td></tr><tr><td>973</td><td>937</td><td>1093</td><td>1081</td><td>1155</td><td>1052</td></tr><tr><td>57.1%</td><td>58.5%</td><td>63.0%</td><td>62.3%</td><td>65.3%</td><td>62.4%</td></tr></table></td><td></td><td>n/a</td><td>n/a</td></tr>
<tr><td>The number and percentage of such patient safety incidents that resulted in severe harm or death</td><td><table><tr><td>Feb-21</td><td>Mar-21</td><td>Apr-21</td><td>May-21</td><td>Jun-21</td><td>Jul-21</td></tr><tr><td>6</td><td>3</td><td>3</td><td>1</td><td>9</td><td>5</td></tr><tr><td>0.6%</td><td>0.3%</td><td>0.3%</td><td>0.1%</td><td>0.8%</td><td>0.5%</td></tr></table></td><td></td><td>n/a</td><td>n/a</td></tr>
<tr><td>Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral
(reported a month in arrears)</td><td><table><tr><td>Jan-21</td><td>Feb-21</td><td>Mar-21</td><td>Apr-21</td><td>May-21</td><td>Jun-21</td></tr><tr><td>93.3%</td><td>63.6%</td><td>84.0%</td><td>89.5%</td><td>79.2%</td><td>87.5%</td></tr></table></td><td></td><td>?</td><td>UP</td></tr>
<tr><td></td><td></td><td></td><td colspan="2">Over the series of data points being measured, key standards are being delivered inconsistently</td></tr>
<tr><td>Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) Inpatient Wards b) EIP Services c) Community Mental Health Services (people on care programme approach)</td><td>Reported Bi-annually
Inpatient Wards<table><tr><td>Mar-20</td><td>Sep-20</td><td>Mar-21</td></tr><tr><td>60.0%</td><td>58.0%</td><td>96.0%</td></tr></table>EIP Services<table><tr><td>Mar-20</td><td>Sep-20</td><td>Mar-21</td></tr><tr><td>93.0%</td><td>-</td><td>97.0%</td></tr></table>Community Mental Health Services on CPA (arrears)<table><tr><td>Mar-20</td><td>Sep-20</td><td>Mar-21</td></tr><tr><td>-</td><td>34.0%</td><td>-</td></tr></table></td><td>Comments on March 2021 results

To continue the work as has been achieved thus far. Staff should be commended on their excellent work in this area particularly in light of the impacts and implications of COVID.</td><td>n/a</td><td>n/a</td></tr>
<tr><td></td><td></td><td></td><td colspan="2">Not applicable for SPC as reported infrequently</td></tr>
<tr><td>Admissions to adult facilities of patients under 16 years old</td><td><table><tr><td>Feb-21</td><td>Mar-21</td><td>Apr-21</td><td>May-21</td><td>Jun-21</td><td>Jul-21</td></tr><tr><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr></table></td><td></td><td>n/a</td><td>n/a</td></tr>
</table>

3. NHS Oversight

The following targets form part of the 2020/21 NHS Oversight Framework.

Target	Trust Performance						RAG/ Comments on recovery plan position	SPC Flag	
								Assurance of Meeting Target	Trend
Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral Target is >=60% *(reported a month in arrears)*	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21		?	UP
	93.3%	63.6%	84.0%	89.5%	79.2%	87.5%		Over the series of data points being measured, key standards are being delivered inconsistently	
Mental Health data submission to NHS Digital: % clients in employment No Target Set	2019/20 Q3	2019/20 Q4	2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4		NO	UP
	4%	4%	3%	3%	4%	4%		Key standards are not being delivered but are improving	
Mental Health data submission to NHS Digital: % clients in settled accommodation No Target Set	2019/20 Q3	2019/20 Q4	2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4		NO	UP
	39%	39%	34%	32%	43%	45%		Key standards are not being delivered but are improving	
6-week wait for diagnostic procedures (Incomplete) Target is >=99% *(reported a month in arrears)*	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	In line with national COVID-19 guidance, this service was suspended. It was re-established in October and due to COVID restrictions can only work at 60% previous activity. To support this, additional audiologist capacity has been secured and a successful capital bid for an additional clinical room this financial year. The service is on track to deliver the recovery trajectory for the backlog of CYP.	YES	DOWN
	31.1%	42.4%	70.7%	72.0%	75.2%	68.6%		Key standards are being delivered but are deteriorating	

4(a). Access - Waiting Time Standards - DMH

The following performance measures (reported a month in arrears) are key waiting time standards for the Trust:

Target	Performance							RAG/ Comments on recovery plan position	SPC Flag	
									Assurance of Meeting Target	Trend
Adult CMHT Access Six weeks routine Target is 95%		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Service has an improvement plan in place and additional capacity (weekend clinics and overtime) is supporting a reduction in waiting times. Significant improvement has been made over the last few months.	N/A	N/A
	Complete	53.5%	40.0%	58.6%	59.8%	69.6%	60.3%			
	Incomplete	n/a	46.6%	59.2%	66.0%	63.8%	58.1%		NO	NO CHANGE
									Key standards are not being delivered and are deteriorating/ not improving	
Memory Clinic (18 week Local RTT) Target is 95%		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Service has a robust improvement plan and trajectory in place, based on a PDSA approach streamlining the patient pathway and maximising clinical capacity. The incomplete waiting times compliance is improving consistently and the number of people waiting is falling in line with this. The service has had 2 WTEs on long term sick leave from May, which is impacting on progress.	N/A	N/A
	Complete	22.1%	13.5%	19.0%	25.9%	43.8%	25.5%			
	Incomplete	62.2%	62.1%	63.0%	64.8%	68.1%	68.5%		N/A	N/A
ADHD (18 week local RTT) Target is: Complete - 95% Incomplete - 92%		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Service has an improvement plan - some elements are dependent on increasing capacity to match the increase in demand. Recruitment to the specialist posts has been inconsistent. The service continues to work on a tender process, which will launch on 1st Sep.	N/A	N/A
	Complete	23.5%	22.7%	18.2%	25.0%	5.6%	18.2%			
	Incomplete	39.5%	38.0%	40.3%	37.3%	37.6%	39.9%		N/A	N/A

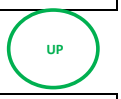
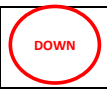
4(b). Access - Waiting Time Standards - CHS

The following performance measures (reported a month in arrears) are key waiting time standards for the Trust:

Target	Performance						RAG/ Comments on recovery plan position	SPC Flag	
								Assurance of Meeting Target	Trend
CINSS - 20 Working Days (Complete Pathway) Target is 95%	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Urgent compliance is consistently 100%. Trajectory and action plan in place to meet 95% by March 2022.	N/A	N/A
	59.3%	31.3%	32.2%	27.6%	36.6%	30.8%			
Continence (Complete Pathway) Target is 95%	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	March 2020: Service suspended to support COVID system pressures & staff redeployed to community nursing hubs. Improvement plan in place with trajectory to reduce the number of patients waiting.	N/A	N/A
	37.8%	32.6%	23.3%	13.6%	40.6%	33.7%			

4(c). Access - Waiting Time Standards - FYPC

The following performance measures (reported a month in arrears) are key waiting time standards for the Trust:

Target	Performance							RAG/ Comments on recovery plan position	SPC Flag	
									Assurance of Meeting Target	Trend
CAMHS Eating Disorder – one week (complete pathway) Target is 95%		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Urgent - The Service has seen a sustained increase in urgent referrals, which is consistent with the National profile. Referrals are prioritised and additional capacity has been agreed through the MHIS. An improvement plan and trajectory are in place, which has Executive oversight. In addition, a number of young people are being supported in the community whilst waiting.		
		100.0%	100.0%	66.7%	33.3%	0.0%	30.0%			
CAMHS Eating Disorder – four weeks (complete pathway) Target is 95%		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Routine - routine referrals are being delayed due to the prioritisation of urgent cases. Additional capacity has been agreed through the MHIS and an improvement plan is in place, with Executive oversight.		
		0.0%	33.3%	50.0%	50.0%	33.3%	42.9%			
Children and Young People's Access – four weeks (incomplete pathway) Target is 92%		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Resources are being diverted to deal with the urgent referrals.		
		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		Over the series of data points being measured, key standards are being delivered inconsistently	
Children and Young People's Access – 13 weeks (incomplete pathway) Target is 92%		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	The current KPI is breaching due to increasing demand. Additional capacity has been agreed through the MHIS and an action plan to retrieve the KPI standard by end of Q2 is in place. The service is currently ahead of trajectory		
		100.0%	90.3%	78.2%	69.3%	71.5%	74.8%			
Aspergers - 18 weeks (complete pathway)	Wait for Treatment	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	The service is receiving an increase in referrals and this may start to impact on the target. This is being monitored at DMT and Silver meetings.	N/A	N/A
		92.3%	96.6%	93.9%	93.1%	97.9%	100.0%			
	No. of Referrals	28	45	56	42	68	30			
LD Community - 8 weeks (complete pathway)	Wait for Assessment	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21		N/A	N/A
		95.2%	89.3%	93.6%	91.4%	87.5%	89.2%			
	No. of Referrals	76	117	135	97	112	126			

5. 52 week waits

No patient should wait for more than 52 weeks from referral to the start of their treatment.

The following services have 52 week waits within their service:

Target	Trust Performance						Longest wait (latest month)	RAG/ Comments on recovery plan position	SPC Flag	
									Assurance of Meeting Target	Trend
Cognitive Behavioural Therapy	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	9 weeks	The CBT improvement plan remains effective in supporting the number of 52 week waiters to fall. The service has 2 new recruits, but they have been delayed in taking on caseloads because of a wait for the Trust induction.	NO	NO CHANGE
	54	58	50	45	38	47			Key standards are not being delivered and are deteriorating/ not improving	
Dynamic Psychotherapy	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	103 weeks	The number of 52 week waiters continues to fall, and is now below the planned trajectory. Group offers continue to support the improvement plan, alongside a re-design of the future service offer under SUTG-MH.	NO	DOWN
	59	46	43	23	20	19			Key standards are not being delivered but are improving	
Personality Disorder	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	206 weeks	Plans to re-design the psychological treatment offer for patients with a personality disorders continue to be developed. Pilot psychological skills groups are taking place - planning is underway to scale up the delivery of these groups, within locality teams from the autumn. The number of patients waiting for treatment is likely to rise, as the service works through the assessment waiting list of over 52 week waits.	NO	UP
	204	205	210	214	241	325			Key standards are not being delivered and are deteriorating/ not improving	
CAMHS	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	113 weeks	This waiting list includes CYP waiting for treatment and those waiting for Neurodevelopmental assessment. The service is currently dealing with a spike in demand relating to the Access improvement plan 12- 18 months ago. Once this is clear there are significantly less children waiting per week and there will be a more rapid recovery.	NO	UP
	175	205	257	250	219	218			Key standards are not being delivered and are deteriorating/ not improving	

6. Patient Flow

The following measures are key indicators of patient flow:

Target	Trust Performance						RAG/ Comments on recovery plan position	SPC Flag	
								Assurance of Meeting Target	Trend
Occupancy Rate - Mental Health Beds (excluding leave) Target is <=85%	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Occupancy levels are closely monitored and actions taken in line with the covid surge plans to ensure adequate capacity is available on a day to day basis.	?	NO CHANGE
	80.5%	83.1%	83.8%	79.0%	82.0%	77.7%		Over the series of data points being measured, key standards are being delivered inconsistently	
Occupancy Rate - Community Beds (excluding leave) Target is >=93%	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	The Trust is below the local target rate of 93%, however there is engagement with commissioners to review the benefits of this target to support flow. Occupancy is one of a range of measures to support flow and 93% does not ordinarily work. The national level is 87% and this is still challenging due to the separation of red and green beds / IPC requirements.	?	DOWN
	75.3%	73.8%	76.0%	82.8%	81.1%	84.1%		Over the series of data points being measured, key standards are being delivered inconsistently	
Average Length of stay Community hospitals National benchmark is 25 days.	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Fluctuating LoS will be attributed to changes in discharge protocol as a result of the COVID-19 response	YES	NO CHANGE
	16.9	17.6	17.1	16.6	17.7	18.2		Key standards are being consistently delivered and are improving/ maintaining performance	
Delayed Transfers of Care Target is <=3.5% across LLR	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	NHS Digital has advised this national metric is being paused to release resources to support the COVID-19 response. We will continue to monitor locally.	?	NO CHANGE
	4.1%	3.1%	2.9%	2.7%	2.9%	1.9%		Over the series of data points being measured, key standards are being delivered inconsistently	
Gatekeeping Target is >=95%	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21		?	NO CHANGE
	81.0%	79.4%	93.2%	98.8%	100.0%	100.0%		Over the series of data points being measured, key standards are being delivered inconsistently	
Care Programme Approach – 7-day follow up Target is 95% *(reported a month in arrears)*	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	There were a number of service users who could not be contacted for their 7 day follow up contact during June. Appropriate attempts were made by staff.	?	NO CHANGE
	83.5%	93.1%	85.2%	94.3%	96.2%	91.7%		Over the series of data points being measured, key standards are being delivered inconsistently	
72 hour Follow Up after discharge Target is 80% *(reported a month in arrears)*	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21		N/A	N/A
	69.1%	78.8%	70.9%	80.4%	88.1%	87.6%			
Care Programme Approach 12-month standard Target is 95%	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	A CPA review improvement plan is now in place. Performance deteriorated as reports were not available for a 5 month period during the SystmOne migration.	NO	DOWN
	52.2%	54.2%	64.9%	68.7%	67.8%	70.4%		Key standards are not being delivered and are deteriorating/ not improving	
Perinatal - Number and Percentage of women accessing service Target is 8.6%	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Access for this indicator is defined as requiring a face to face or video consultation i.e. telephone contacts are excluded. Due to the pandemic, the service has been using telephone as a replacement for some face to face work. There are also some issues where the modality has not been recorded correctly. The service has an agreed trajectory for improvement in place.	N/A	N/A
	593	547	504	502	480	481		N/A	N/A
	4.7%	4.4%	4.0%	4.0%	3.8%	3.8%			

7. Quality and Safety

Target	Trust Performance							RAG/ Comments on recovery plan position	SPC Flag	
									Assurance of Meeting Target	Trend
Serious incidents		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21		N/A	NO CHANGE
		5	10	10	2	18	8		Over the series of data points being measured, key standards are being delivered inconsistently	
STEIS - SI action plans implemented within timescales (in arrears) Target = 100%		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Awaiting validated data to assess achievement of measure	?	DOWN
		33.3%	31.0%	20.0%	14.3%	50.0%	66.5%		Over the series of data points being measured, key standards are being delivered inconsistently	
Safe staffing No. of wards not meeting >80% fill rate for RNs Target 0		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	This measure has been temporarily suspended during COVID-19 as staffing capacity is changing rapidly and continually to respond to the pandemic	NO	UP
	Day	5	5	5	7	7	5		Key standards are not being delivered and are not improving *SPC based on day shift*	
	Night	0	0	0	0	1	1			
Care Hours per patient day		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21		N/A	N/A
				12.4	12.3	12.3	12.5		Key standard has no target; however performance is consistent	
No. of episodes of seclusions >2hrs Target decreasing trend		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21		N/A	NO CHANGE
		40	23	30	32	28	16		Key standard has no target; however performance is consistent	
No. of episodes of supine restraint Target decreasing trend		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21		N/A	NO CHANGE
		25	8	4	4	9	6		Key standard has no target; however performance is consistent	
No. of episodes of side-line restraint Target decreasing trend		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21		N/A	NO CHANGE
		2	14	27	29	29	16		Key standard has no target; however performance is consistent	
No. of episodes of prone (unsupported) restraint Target decreasing trend		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21		N/A	NO CHANGE
		2	0	2	0	1	0		Key standard has no target; however performance is consistent	
No. of episodes of prone (supported) restraint Target decreasing trend		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21		N/A	NO CHANGE
		2	2	5	5	5	3		Key standard has no target; however performance is consistent	

No. of Category 2 and 4 pressure ulcers developed or deteriorated in LPT care Target decreasing trend (RAG based on commissioner trajectory)		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Oversight of the pressure ulcer data occurs at the LPT Pressure Ulcer Quality Improvement Group. This group is responsible for the Pressure Ulcer Quality Improvement project and LifeQI is the tool being used to capture this work.	N/A	NO CHANGE
	Category 2	79	100	120	105	103	98		N/A	NO CHANGE
	Category 4	6	5	3	5	7	3		*Key standard has no target; however performance is consistent for category 2 and consistent for category 4*	
No. of repeat falls Target decreasing trend		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	General reduction in patient numbers over the Covid period will result in greater variance than has been seen historically. This is monitored via the Falls Steering Group including the impact on Harm.	N/A	NO CHANGE
		54	65	53	43	46	64		*Key standard has no target; however performance is consistent*	
LD Annual Health Checks completed - YTD Target is 75%		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Year To date from 1 April 2021, 496 competed up to 14/07/21 (most recent data).	N/A	N/A
				106	255	430	496			
LeDeR Reviews completed within timeframe		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	New LeDeR system is in place – further reporting to be developed.	N/A	N/A
		As at 26/07/21 - 16 awaiting alloation, 16 on hold and 19 in progress								

8. 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	Performance						RAG/ Comments on recovery plan position	SPC Flag	
								Assurance of Meeting Target	Trend
	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21		NO	UP
MH Data quality Maturity Index Target >=95%	90.6%	91.2%	91.2%	91.5%	91.3%	91.0%		Key standards are not being delivered but are improving	

9. Workforce/HR

Target	Trust Performance						RAG/ Comments on recovery plan position	SPC Flag	
								Assurance of Meeting Target	Trend
Normalised Workforce Turnover rate (Rolling previous 12 months) Target is <=10%	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	The Trust is below the ceiling set for turnover.	YES	DOWN
	8.7%	8.4%	8.5%	8.8%	9.1%	9.1%		Key standards are being consistently delivered and are improving performance	
Vacancy rate Target is <=7%	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21		NO	UP
	9.1%	9.5%	10.8%	12.4%	12.2%	11.6%		Key standards are not being delivered and are deteriorating/ not improving	
Health and Well-being Sickness Absence (1 month in arrears) Target is <=4.5%	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21		NO	DOWN
	5.1%	4.1%	3.5%	4.4%	4.6%	5.1%		Key standards are not being delivered but are improving	
Health and Well-being Sickness Absence Costs (1 month in arrears) Target is TBC	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21		n/a	n/a
	£675,994	£486,469	£477,073	£580,557	£639,392	£668,739			
Health and Well-being Sickness Absence YTD (1 month in arrears) Target is <=4.5%	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21		n/a	n/a
	4.9%	4.9%	4.7%	4.4%	4.5%	4.7%		Not applicable for SPC as measuring cumulative data	
Agency Costs Target is <=£641,666 (NHSI national target)	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21		?	UP
	£1,976,000	£2,635,595	£1,531,718	£1,556,256	£1,919,728	£1,775,099		Over the series of data points being measured, key standards are being delivered inconsistently	
Core Mandatory Training Compliance for substantive staff Target is >=85%	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	The Trust is meeting the target set for Core Mandatory Training.	YES	NO CHANGE
	93.3%	93.4%	94.0%	94.6%	94.2%	92.5%		Key standards are being consistently delivered and are improving/ maintaining performance	
Staff with a Completed Annual Appraisal Target is >=80%	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	The Trust is meeting the target set for Annual Appraisal	YES	DOWN
	86.4%	86.7%	88.2%	89.5%	89.9%	85.2%		Key standards are being delivered but are deteriorating	
% of staff from a BME background Target is >= 22.5%	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	The Trust is meeting the target set.	NO	UP
	23.6%	23.7%	23.8%	23.7%	23.7%	23.9%		Key standards are not being delivered but are improving	
Staff flu vaccination rate (frontline healthcare workers) Target is >= 80%	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21		n/a	n/a
% of staff who have undertaken clinical supervision within the last 3 months Target is >=85%	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21		NO	DOWN
	80.4%	82.1%	85.6%	88.1%	85.4%	75.9%		Key standards are not being delivered and are deteriorating	
Health and Wellbeing Activity - Number of LLR staff contacting the hub in the reporting period (1 month in arrears)	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21		N/A	N/A
				135	148	240			

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	Over the series of data points being measured, 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

Performance headlines – July 2021

The SPC measure includes data up to the current reporting month for the indicator

Key:			
	The SPC measure has improved from previous month	**NEW**	The first assessment of a metric using SPC
	The SPC has not changed from previous month	**R**	Metric will be removed from future reports
	The SPC measure has deteriorated from previous month	**C**	Change in performance can be attributed to COVID-19

Key standards being consistently delivered and improving or maintaining performance

C Length of stay - Community Services
Normalised Workforce Turnover rate
Core Mandatory Training Compliance for Substantive Staff

Key standards being delivered but deteriorating

C 6-week wait for diagnostic procedures
Staff with a Completed Annual Appraisal

Key standards being delivered inconsistently

CAMHS ED one week (complete)
Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral
CAMHS Eating Disorder – four weeks - (complete pathway)
Children and Young People's Access – four weeks (incomplete pathway)
Children and Young People's Access – 13 weeks (incomplete pathway)
C Occupancy rate – mental health beds (excluding leave)
C Average Length of stay (excluding leave) from Bradgate acute wards
Delayed transfer of care (DToC)
Gatekeeping
CPA 7 day
C Diff
STEIS action plans completed within timescales
Agency Cost
Admissions to adult facilities of patients under 16 years old
C Occupancy rate – community beds (excluding leave)

Key standards not being delivered but improving

Mental Health data submission - % clients in employment (target updated to: no target set)
Mental Health data submission - % clients in settled accommodation (target updated to: no target set)
MH Data Quality Maturity Index
% of staff from a BME background
Sickness Absence
Dynamic Psychotherapy over 52 weeks

Key standards not being delivered but deteriorating/ not improving

C Adult CMHT Access six week routine (incomplete)
CPA 12 month
Safe Staffing
Cognitive Behavioural Therapy over 52 weeks
Personality Disorder over 52 weeks
CAMHS over 52 weeks
Vacancy rate
% of staff who have undertaken clinical supervision within the last 3 months

Key standard we are unable to assess using SPC

Patient experience of mental health services
Readmissions with 28 days
Patient safety incidents
Patient safety incidents resulting in severe harm or death
Serious incidents (no target)
Quality indicators (no targets)
Cardio-metabolic assessment and treatment for people with psychosis

Governance table

For Board and Board Committees:	FPC/QAC/Trust Board	
Paper sponsored by:	Sharon Murphy - Interim Director of Finance and Performance	
Paper authored by:	Information Team	
Date submitted:	23/08/2021	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):		
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Monthly report	
STEP up to GREAT strategic alignment*:	High **S**tandards	
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	x
	Single Patient **R**ecord	
	Equality, Leadership, Culture	
	Access to Services	
	Trustwide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	35 - Provides assurance of the improving quality and availability of data reporting to inform quality decision making
Is the decision required consistent with LPT's risk appetite:		
False and misleading information (FOMI) considerations:		
Positive confirmation that the content does not risk the safety of patients or the public		
Equality considerations:		

V

Leicestershire Partnership NHS Trust

CHARITABLE FUNDS COMMITTEE– DATE 6th JULY 2021

HIGHLIGHT REPORT

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

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

Report	Assurance level*	Committee escalation	Risk Reference
Review of Risk Register	High	1 risk and 3 risk assessments were reviewed; minor amendments were requested by the committee.	4618
Raising Health Investment Strategy annual review	High	The charity's investment strategy was reviewed, no material updates had been made and the strategy was approved.	4618
Fundraising Manager's report	High	The fundraising manager provided an update on activities to 18th June. The NHS Charities Together (NHSCT) phase 2 bid (community grants) had been approved. LLR would receive £492k, and would give LPT great opportunities to work alongside the 7 community groups to address health inequalities. The committee noted that the Carlton Hayes bids for the first half of 2021/22 had closed and the funding was fully committed against schemes. The Carlton Hayes trustees are pleased with the way the funding is being managed by raising Health. Community fundraising and events were starting up again following the pandemic, and the charity would benefit from a return to these activities. The committee noted that funding received from	4618

Report	Assurance level*	Committee escalation	Risk Reference
		external donors for specific projects remained at risk if funds were not spent in a timely way. The risk assessment on delays to larger estates projects funded by the charity was discussed. It was agreed a trustee would meet with estates leads to discuss the team's capacity to deliver the charity's schemes & consider options for rapidly resolving any delays.	
Finance report – Q4	High	An update on the charity's financial position was provided. The investment value had increased by £2k in quarter 4, a decrease on the previous quarter's gain of £117k. Over the financial year, the investment value had increased by £336k. Total income was £190k in quarter 4, including some significant donations: - £121k from NHS Charities Together - £16k covenant fund for veterans Expenditure was £103k in the quarter, including patient expenses (£39k), staff welfare expenses (£23k) charity running costs (£25k) and lottery prizes (£13k). Future expenditure commitments total £664k. The cash balance was £694k at the end of March. Cash was expected to remain in a good position in the rolling 3 year cash flow forecast. The total funds available was £2.6m at the end of quarter 4, an increase of £87k on the previous quarter and a £912k increase for the financial year. The finance team agreed to investigate if we are able to open a Government Banking Service bank account for the charity to provide a higher value of protection for cash balances.	4618
Annual Review of the effectiveness of the committee	High	The charity's Annual committee review was reviewed and agreed. No changes to the Terms of Reference were required The report will be presented at the next Audit & Assurance Committee.	4618
Internal Audit letter of engagement	High	The Internal audit letter of engagement for the independent review of the charity's accounts was reviewed and agreed. It was noted that should the charity's annual realised income exceed £1m that a formal audit would need to be undertaken. This was not considered likely; the charity was close to the threshold this year due to the exceptional value	4618

Report	Assurance level*	Committee escalation	Risk Reference
		of NHSCT income received. The committee also approved internal audit undertaking the regularity review of financial systems.	
Review of SFIs and SORD		The 2021/22 Standing Financial Instructions update was reviewed and agreed, specifically noting the amendments in respect of the charity's expenditure authorisation processes.	4618
Update on previous bids	High	• **NHSCT Phase 1** – expenditure to date was reviewed against the receipt of 3 separate grants totalling £123.5k which the Board approved in August 2020. • **NHSCT Phase 3** – £121k. Funding has been allocated for Mental Health First Aid training for staff and the staff room wellbeing project. • **NHSCT covid second wave** – £50k. The committee agreed that the Trust exec trustees and Associate Director of Communications would meet to discuss potential areas of focus for bids as part of the Triple R recovery programme. • **Carlton Hayes Charity** – Outstanding commitments against approved bids was reviewed.	4618
New bids received	High	Bids were approved by the committee: • Masters in Research – 2 bids (total c£15k) Bids not approved by the committee: • Steel sheds for Beacon unit garden (£4k). Further information was requested around Health & Safety assessments and whether the sheds should be funded from core funds.	4618
Benefits realization – assessing VFM of long term projects		The annual review of the research funding allocations was received. Updates were provided on £74k of bids approved in previous bidding rounds, covering 4 research projects/courses. All were progressing well. Updates were also provided on 2 staff who received funding for PHD courses which had now been successfully completed. 1 masters award had closed after 1 year as the recipient had left the Trust. Fees were repaid in line with the Trust's study policy. As well as the two new bids submitted to the committee (approved above), ad hoc awards below £500 would continue to be supported. The research fund balance is currently £51k.	

Report	Assurance level*	Committee escalation	Risk Reference
New funds created	High	None.	4618
Work plan	High	The work plan was reviewed. No changes were required.	4618
Review of risk register	High	No additional risks had been identified.	4618
AOB	High	None.	4618

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