Leicestershire Partnership NHS Trust

Public Meeting of the Trust Board
21st December 2021
Microsoft Teams

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 Agenda			
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 – Adult Mental Health - Getting Into Employment	Fiona Myers
9.45	3.	Staff voice – Adult Mental Health - Employment Services	
10.05	4.	Patient Voice – People's Council and Health Watch Report – Paper B	Mark Farmer
10.10	5.	Declarations of interest in respect of items on the agenda - Verbal	Chair
	6.	Minutes of the previous public meeting: 26th October 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			
10.20	10.	Organisational Risk Register – Paper G • Including Annual Review of ORR & Risk Appetite Statement	Chris Oakes
Strategy and System Working			
10.35	11.	SUTG MH Business Plan –Paper H	Fiona Myers David Williams
10.50	12.	Break	
Quality Improvement and Compliance			
11.00	13.	Quality Assurance Committee Highlight Report 30th November 2021 – Paper I	Moira Ingham
11.05	14.	CQC inspection report and action plan – Paper J	Anne Scott
11.15	15.	IPC 6 Monthly Report – Paper K	Anne Scott
11.25	16.	Patient Safety Incident and Serious Incident Learning Assurance Report – Paper L	Anne Scott
11.35	17.	Learning from Deaths Q2 Report – Paper M	Avinash Hiremath
11.40	18.	Patient and Carer Experience, Involvement and	Anne Scott

		Complaints Quarter 2 Report – Paper N	
11.45	19.	Safe Staffing Monthly Report – Paper O	Anne Scott
11.55	20.	BAF Winter 2021 preparedness: Nursing and midwifery safer staffing - Paper P	Anne Scott
12.05	21.	Freedom To Speak Up Guardian 6 Month Report – Paper Q	Pauline Lewitt
Performance and Assurance			
12.20	22.	Finance and Performance Committee Highlight Report – 30th November 2021 – Paper R	Faisal Hussain
12.25	23.	Finance Monthly Report – Month 8 – Paper S	Sharon Murphy
12.35	24.	Performance Report – Month 8 – Paper T	Sharon Murphy
12.45	25.	Audit and Assurance Committee Highlight Report – 3rd December 2021 – Paper U	Darren Hickman
12.50	26.	Review of risk – any further risks as a result of board discussion?	Chair
	27.	Any other urgent business	Chair
	28.	Papers/updates not received in line with the work plan:	Chair
	29.	Public questions on agenda items	Chair
1.00	30.	**Next public meeting:** **25th January 2022 - Microsoft Teams**	Chair

A

Our Trust Board

As of October 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
Acting Director of Finance

Samantha Leak
Director of community health services

Fiona Myers
Interim 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

Report from Mark Farmer

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

Providing an independent voice to make LPT services great for all

The People's Council

The external review of the Council has now concluded, and the Council is considering next steps. The report notes what we are doing well, which included the Council's leadership team providing support to Council members and what we need to do to improve, to get the most from our members. One of the key findings was that members of the Council needed to see that they are making a difference to services provided by the Trust. Next year, it would be useful to discuss with Board in a joint development session on how we could address that finding and the recommendations.

There was a special meeting of the Council to discuss the outcomes to the Step Up To Great consultation, now it will be moving into the all-important implementation phase, the Council will need to consider what its ongoing role be.

Council members continue to work closely with the Head of Patient Experience and Involvement to develop a new approach to patient and carer leadership, this work includes what would the Trust need to do to create a patient and carer Director at the Trust, with lived experience, which is a recent NICE guideline and creating a lived experience framework.

Angela is coming to our next Council meeting in December. The Council will be talking to her about the CQC Inspection and what the plans are in response to it and we also want to discuss strengthening LPT's approach to patient and carer engagement and involvement. I and Al Richardson, Chair of the Council's communications sub-group were part of the interview panel for the role of Deputy Head of Experience and Involvement at the Trust.

Healthwatch

In January, the Board of Healthwatch is due to receive a report on male suicide in Leicester and Leicestershire. We will then this send report to partners, including the All-Age Mental Health Design Group, the Governance Team at LPT, Health Overview and Scrutiny Committees and the two Health and Wellbeing Boards. We have recently signed off reports of people's experience of accessing GP services.

Healthwatch has been part of developing an Integrated Care System approach to engagement, which has been led by the combined Clinical Commissioning Group Engagement and Involvement team, with the involvement of LPT and UHL. We need to consider how we better use all the intelligence that we have in each organisation to inform strategy and service planning and ICS decision making at all levels.

We continue to receive concerns from members of the public about the long wait times to access Personality Disorder services at the Trust and how people seemingly have regular changes to their consultant in a number of adult mental health services and how they have to keep repeating their story There also continues to be concerns raised about the Crisis Team and it not being treatment focused, supportive or responsive to those that need their services the most. I remained assured that the implementation of Step Up To Great for Mental Health will address these concerns, but we will keep this under review.

General Updates

I continue to Co-Chair All Age Mental Health Design Group the this with the Interim Director of Mental Health Services. We recently had a session on how we do we make sure that we have all the right relationships in place and what barriers we need to overcome as we move towards a collaborative model for mental health. There is real commitment from partners to come together in a collaborative way to move plans to transform mental health services right across all mental health services. It is evident that we need an agreed framework for what everyone's shared priorities on mental health will be.

I have taken part in national meetings with NHS England:

- I am part of a working party looking at outcome measures in Community Mental Health services

- I had a meeting with the Adult Mental Health team about changes to the way in which GP's are paid for carrying out health checks for those with Serious Mental Illnesses, following concerns raised locally about changes made to the payment arrangements that could result in the checks falling down a practices list of priorities.
- I have contributed to the development of new national inpatient guidelines
- I attended a meeting of the national forum for Expert Advisors on Adult Mental Health, where we reviewed the job support service for those with mental ill health that need that require that additional support to get into employment.

I am pleased to report that with the support of Cathy Ellis, I have recently secured a one-year placement on the Board of East Midlands Ambulance Service NHS Trust as a Non-Executive Board Director in training.

I would like to finish my report by thanking all of you for being supportive of the Council, the work of Healthwatch and for the support you have personally given me. I do really appreciate, and I am grateful. You are a great team to work with, I am pleased that our work together it is paying off, with the CQC, in its latest inspection report, praising the Trust for the work we are leading together on engagement and involvement. Well done all.

C

Leicestershire Partnership NHS Trust

Minutes of the Public Meeting of the Trust Board
26th October 2021 9.30am - Microsoft Teams Live Stream

Present:
Ms Cathy Ellis Chair
Mr Faisal Hussain Non-Executive Director/Deputy Chair
Mr Darren Hickman Non-Executive Director
Ms Moira Ingham Non-Executive Director
Professor Kevin Harris Non-Executive Director
Mr Vipal Karavadra Non-Executive Director
Ms Angela Hillery 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 Sam Leak Director of Community Health Services
Ms Fiona Myers Interim Director of Mental Health
Ms Helen Thompson Director Families, Young People & Children Services & Learning Disability Services
Mrs Sarah Willis Director of Human Resources & Organisational Development
Mr Chris Oakes Director of Governance and Risk
Mr Mark Farmer Healthwatch
Ms Kate Dyer Deputy Director of Governance and Risk
Mrs Kay Rippin Corporate Affairs Manager (Minutes)

TB/21/126	Apologies for absence: Mr Mark Powell Deputy Chief Executive Mr David Williams Director of Strategy and Business Development Ms Ruth Marchington Non-Executive Director
TB/21/127	The Trust Board Members – Paper A Introducing all Trust Board members.
TB/21/128	Patient voice film – Adult Mental Health The film was shared with Trust Board featuring Ryan who has been with the Community Enhanced Rehabilitation Team (CERT) for 12 months following a lengthy hospital stay. The team have given him increased confidence and techniques to manage his anxiety and Ryan feels that his life has direction now. The team offered regular and ongoing contact and support and have had a positive impact on Ryan's life and rehabilitation.
TB/21/129	Staff voice – Adult Mental Health Dr Kelly Fenton - Consultant Clinical Psychologist & Enhanced Rehabilitation and Recovery Pathway Lead; Adele Wheway – Occupational Therapist; Michelle Gray – Team Leader; Nick Johnstone – Health Care Support Worker. Dr Kelly Fenton described how proud she was of the team which had been formed during the pandemic. It is a multi-disciplinary team offering holistic person centered care which offers service users a genuine choice about their care within a community setting. Michelle Gray confirmed that staff and service user feedback on the team had been very positive and the team continued to see positive results for service users

	including engagement with meaningful activities and service users moving into housing and employment. Adele Wheway explained that in her role she supports service users to overcome both mental health and physical health barriers and is passionate about supporting service users to engage in meaningful activities to support recovery. This includes meeting the spiritual needs of service users from our diverse communities in LLR. Nick Johnstone offers one to one support in his role including supporting with activities such as cooking, obesity and getting outdoors into the community Faisal Hussain asked if the service was being overwhelmed and Kelly Fenton confirmed that the team are very responsive and currently have no waiting list. They begin working with service users before they are discharged from the inpatient setting and data confirms that this reduces both anxiety and readmissions. The team remain mindful of increasing pressures. Avinash Hiremath commented that it was great to see the service evaluations and that he would be happy to support with evaluations and sharing learning across the Trust. Darren Hickman agreed it was really positive to see service users being reintegrated back into their communities and asked what happens if service users have difficulty engaging? The team confirmed that once trust is built engagement is usually successful. Kevin Harris commented that the pandemic has driven the already present health inequalities wider and asked the team if they actively try to minimise these inequalities. Kelly Fenton confirmed that the client group have severe and enduring mental health difficulties and are some of the most deprived within society which in the past has resulted in multiple readmissions.There is focus on the service users' physical health and wellbeing and environmental factors to support addressing inequalities. Patients with severe and enduring mental health die on average 20 years earlier There are plans to build in more support work like this in response to feedback. Michelle Gray added that the CERT team help service users connect with their GP, optician, podiatrist and housing to give a holistic service centred on individual needs. Angela Hillery commended the team on their great work commenting that their compassion was evident and asked how they have stayed connected as a team during covid. The team confirmed that they work a blended working model and hold a huddle on MS Teams every morning. They have shared lunch and other social events over MS Teams and have held one to one supervision and team meetings outdoors to connect in person. Kelly Fenton added that the team have created a video about meetings outdoors to boost wellbeing for the CERT team. Mark Farmer asked how long the support was for and if there are key lessons from the work that could be shared across LPT? Kelly Fenton confirmed that there were 3 timescales with the work – Transition – 12 week period supporting the move from inpatient to community; Hub – up to 2 years within the community setting and Spoke – bespoke work that is carried out alongside other community mental health teams in LPT. Learning from this centres around the success of this 'social model' which is a more holistic approach and can this can be shared across the Trust. Faisal Hussain commented that this model requires collaboration and partnership working with other agencies and asked if this had presented any challenges. The team confirmed that they sit within the Enhanced Rehabilitation Community Pathway and they work with colleagues from all sectors and hold monthly meetings to consider collective care. The agencies all work well together and they are currently looking at developing further links with supported accommodation to support flow through the system. The Chair thanked the team for presenting to the Board today and thanked them for stepping up this new service during the pandemic.
TB/21/130	Patient Voice – Healthwatch Report – Paper B

	Mark Farmer presented the report confirming that the People's Council had now been established for one year and had recently received 5 new applications for membership including a member to represent Rutland which is really positive. There is work ongoing around developing patient director and lived experience roles to support within LPT. The People's Council have been joined at meetings by Mark Powell (Deputy CEO) and Moira Ingham (Non-Executive Director and Chair of QAC). Healthwatch have a current focus on GP access and services and also plan some Enter & View service inspections for next year. **Resolved:** The Trust Board received the report for information.
TB/21/131	Declarations of interest in respect of items on the agenda – Verbal No additional declarations were received.
TB/21/132	Minutes of the Previous Public Meeting: 31st August 2021 – Paper C **Resolved:** The Trust Board approved the minutes as an accurate record of the meeting held on 31st August 2021
TB/21/133	Action Log & Matters arising – Paper D **Resolved:** The Trust Board agreed the actions as complete and closed.
TB/21/134	Chair's Report – Paper E The Chair presented the report which detailed recent activity including a recent staff awards ceremony – Covid Heroes – reflecting the support and innovation shown by teams through the pandemic. Ongoing activity across the Trust includes a continued focus on inclusion and staff wellbeing. Over 350 staff attended the October Health and Wellbeing Festival held on MS Teams. The Annual General Meeting (AGM) was held virtually in September and over 100 people attended this meeting. Positive work with stakeholders continues to support the development of the ICS for the region. **Resolved:** The Trust Board received the report for information.
TB/21/135	Chief Executive's Report – Paper F Angela Hillery started by thanking all staff for their incredible work supporting LPT and the system in relation to covid, general pressures, vaccinations and now moving into winter pressures. Children and Young People's Mental Health services are under increasing pressure in particular in relation to eating disorders and there is a national challenge around demand and a regional summit planned. There has been a recent appointment to the National Director for Learning Disabilities and Autism (Tom Cahill) who will be a great advocate. Teams within LPT have been receiving national awards - further evidence of teams going above and beyond. Thanks were offered to the Communications Team for their ongoing work across the Trust for the Covid Heroes awards and AGM. Faisal Hussain asked if the new National Mental Health Standards were unrealistic considering the backlogs within services , a view echoed in national forums he attended, and Angela Hillery responded that any change in access standards can cause concerns but LPT have just completed the Step Up To Great (SUTG) Mental Health public consultation and so are on the right path to work through this standard. Access does need to be improved and so we welcome the focus on improving access. **Resolved:** The Trust Board received the report for information.
TB/21/136	CQC Update – Paper G Anne Scott presented the paper confirming that the CQC core and Well Led inspections took place in May, June and July this year and positive verbal feedback was received at the time, we await the publication of the final report and once this is received an action plan will be put into place to address issues raised. The Quality Surveillance Tracker continues to monitor actions and the Foundations For Great Patient Care Forum continues to meet. The CQC staff focus groups have recommenced. Peer reviews based on the 15 steps will report through its clinical governance route.

	Mark Farmer suggested that once received the CQC report could be presented to the People's Council for their views and Anne Scott confirmed that this was planned. Angela Hillery added that it was important to share that we anticipate the CQC to comment on the dormitory accommodation within LPT's estate. We have plans underway to eradicate this accommodation.. **Resolved:** The Trust Board received the report for information and assurance.
TB/21/137	Organisational Risk Register – Paper H Chris Oakes presented the paper confirming that there were no changes in the risks to highlight to Board. It is proposed that risks 8 and 52 are closed. Work continues through robust reviews with directors and there was a Board workshop held on 22nd October where an in-depth review took place. The Chair asked with regards to risk 10 – the maintenance of our estate – is there an opportunity to address any more backlog maintenance? Richard Wheeler confirmed that there was backlog across a number of Trusts and that an expression of interest had been submitted to the New Hospital Programme which could support ongoing work in progress. **Resolved:** The Trust Board received the report for information and assurance and approved the closure of Risks 8 & 52.
TB/21/138	Documents Signed under Seal Q2 Report – Paper I Chris Oakes presented the paper for information. **Resolved:** The Trust Board received the report for information.
TB/21/139	Level 1 Committees Annual Reports: Chris Oakes presented the reports • Quality Assurance Committee (QAC) - Paper Ji – the focus of the committee is on quality, safety and workforce. There have been effective arrangements throughout the year including peer review from NHFT. The committee is well run and key changes have included the move to bi-monthly meetings, revised report formats and support from the Corporate Governance Team. Focus for the future will be to build on the good work and focus on the health and wellbeing of staff. • Finance and Performance Committee (FPC) – Paper Jii – a similar picture to QAC with a focus on financial and operational performance. Successes are described within the report and the future focus will be building on this work and recovery and financial delivery in H2 and beyond. • Charitable Funds Committee – Paper Jiii – report contains great news around the NHS Charities Together monies to support staff wellbeing and patient experience brand awareness and an increasing focus on income generation and partnerships. • Audit and Assurance Committee – Paper Jiv – the committee have oversight of governance and the ORR review and continue to meet quarterly. The meetings are effective and all members are well involved with external assurance provided by 360 internal audit and KPMG external audit. Key successes are detailed within the report and include reviewing the embeddedness of the ORR. Overall best practice has been deployed working within our group and with the enhancement of governance to support the committees there is ongoing quality improvement evident. Moira Ingham commented that she has joined LPT recently and has evidenced good flow from levl 2 to level 1 committees and working together with FPC in shared areas of risk. Faisal Hussain commented that having a cross committee Non-Executive Director (NED) for QAC & FPC helped to support the joint work. **Resolved:** The Trust Board received the report for information and assurance.
TB/21/140	Trust Board Dates 2022 – Paper K Cathy Ellis presented the paper for information. **Resolved:** The Trust Board received the report for information.

TB/21/141	Service Presentation – Community Enhanced Rehabilitation Team – Paper L Dr Kelly Fenton - Consultant Clinical Psychologist & Enhanced Rehabilitation and Recovery Pathway Lead; Michelle Gray – Team Leader;. Fiona Myers introduced the presentation commenting that this was a great opportunity for the Board to learn about the holistic work of this, ambitious and compassionate team. The team talked through and shared the PowerPoint Presentation included in the Board pack (Paper L). This included the approach to recovery, the new pathways, the evaluated impact of the service for service users and the health and wellbeing of the CERT staff. Angela Hillery thanked the team for presenting and commented that she was pleased to see the group work with NHFT noting the excellent work within both Trusts. Mark Farmer asked if the time frames with work with services users, this could feel arbitrary for some people and asked if support can be extended if required. Kelly Fenton confirmed that the time frames are simply guidelines based on current evidence and could be extended as required – once needs are identified measures can be put in place to meet those needs. Mark Farmer also asked about the equality and diversity needs of service users. Kelly Fenton advised that the CERT team link with neighbourhood servicesand that care plans reflect the holistic needs of the service user, including interpreting and chaplaincy services.. Faisal Hussain asked how the work is aligned with the community mental health teams but does not duplicate this work. Michelle Gray confirmed that the teams work collaboratively together within the same pathway and the collaborative working prevents duplication. This team's work is enhancement – work that other teams are unable to carry out. The work therefore compliments rather than duplicates. Fiona Myers reflected that this team enables service users transition well to live in the community and continue to have good outcomes. The Chair thanked the team for their presentation and would like to feature the CERT team in the next Wellbeing Wednesday message.
TB/21/142	People Plan Progress Report – M Sarah Willis presented the report detailing an update on activity aligned with the national People Plan. The 9 Principles for the Health and Wellbeing Guardian role are detailed in the appendix to the report. Health and Wellbeing work continues to be a focus across the Trust with the TripleR Programme, blended working principles and health working day guidelines as examples of this work. Other work includes the recruitment of 30 international nurses, Together Against Racism work across the group including the recent masterclass. The Trust's Change Champions are currently supporting culture and leadership work. The Staff Survey is out now. Vipal Karavadra asked for some detail around the challenges of international recruitment and Sarah Willis confirmed that the lead for this work has been working in partnership with University Hospitals Leicester (UHL) and the learning from these challenges will be shared with the working group. Anne Scott added that this is a nationally supported programme, moving forward we will be looking at what happens when it becomes a local pressure to resolve – plans for the future are being considered. Vipal Karavadra asked what are LPT doing locally to promote recruitment for example to young people and Sarah Willis confirmed that there are recruitment fairs and that we have good relationships with local universities. Anne Scott added that LPT have honorary contracts with the universities both for nurses and Allied Health Professionals (AHPs) providing lecturing and shadowing opportunities. Moira Ingham asked if there was a plan for international mental health nurses moving forward and Anne Scott confirmed that there was a plan, and for international consultants too. Kevin Harris raised the ethical dimension of the recruitment of international nurses from countries which may need and value them more and Sarah Willis confirmed

	that conversations are had with the recruits around their future aspirations. Avinash Hiremath added that with doctors international recruitment, two years working away from their home country can give them additional skills to return with. A recent retention and recruitment paper is being considered and scoped by the Strategic Executive Board. **Resolved:** The Trust Board received the report for information and assurance.
TB/21/143	Quality Assurance Committee Highlight Report 28th September 2021 – Paper N Moira Ingham presented the report confirming that the Director of Nursing Report received medium assurance from the committee due to the temporary staffing use and staffing levels in general; the SI investigations and ongoing of recruitment of the investigators. The committee noted quality improvement work on the Agnes Unit, Beacon Unit and Beaumont Ward. The Performance Report offered split assurances with the committee being assured around the measures in place to support quality and workforce but low assurance around the vacancy rate although noting that this rate included new roles. There was assurance on compliance with the annual seclusion room audit. Anne Scott gave a verbal update on the NHSI Infection Prevention and Control visit which has taken place since the report was written. The NHSI previous visit was in January 2020 where the Trust was rated as a strong amber. The re visit took place on 14th October – 3 clinical areas were inspected (Evington Wards & Agnes Unit), 2 announced and 1 unannounced and significant improvements evidenced and the Trust is now rated as green. The letter and action plan will be presented to Trust Board in December 2021. **Action:** Present the findings and associated action plans from the IPC Visit to the Trust Board December meeting. **Resolved:** The Trust Board received the report for information and assurance.
TB/21/144	Patient Safety Incident and Serious Incident Learning Assurance Report – Paper O Anne Scott presented the report which covers August and September 2021. Timescales continue to be a challenge with variable compliance evident. However, work is ongoing to progress, improve and mitigate these risks. There are inconsistent trends shown for category 4 pressure ulcers. The success with the quality improvement work around falls is evident within the report. There is a decline in the numbers of self-harm incidents in August but this is not the case in the September report. There continues to be a higher level of violence and aggression incidents across the Trust and a deep dive into this showed a theme – which was an individual patient on a low secure unit waiting for a transfer to a medium secure unit which better suited their needs. The culture of candour is embedding across the Trust with no statutory breaches to report in this time period. Vipal Karavadra asked how are the incidents of violence and aggression incidents against staff mitigated against and Anne Scott confirmed that they are all subject to a serious investigation (SI) where all of the detail is contained. Wrap around support is offered to staff and the incidents are monitored by the Patient Safety Team and Health and Safety Team and other staff teams who lean in to support. Staff are trained to manage these incidents and all staff are up to date with their mandatory training. Fiona Myers commented that the acuity of the patients has changed and with the and workforce challenges a deep dive is planned which will support triangulating the information. Moira Ingham added that the Statistical Process Control (SPC) charts make the information very clear and are good to support preventing themes reoccurring. Future reports could also detail how practice has changed as a result of learning to support this. Faisal Hussain commented that the pressure ulcer data is still concerning and asked if visits into the community have improved along with increased early provision of information, guidance and support to service users and their carers on

	reducing them? Anne Scott confirmed that here has been a significant focus in this area and there is a level of concern which is detailed in the Safe Staffing paper and directorates are paying attention to this area and focusing on mitigating the risk. Sam Leak confirmed that rapid response actions are in place and team meetings are held regularly to support this. A quality summit is being held next week. Transformational change within the team is being considered and measures are in place to ensure that this is embedded. Anne Scott added that they are working coherently and supporting family members and carers and all best practice improvements are being followed. Angela Hillery asked how the human factors work is developing and Anne Scott confirmed that both the Head of Patient Safety and the Head of Clinical and Quality Governance are passionate about human factors and are developing this line of work and linking with NHFT.. Darren Hickman asked with regard to the overdue SIs – when can we expect to see this coming down and how are the families being kept informed? Anne Scott confirmed that that 4 of the 8 investigators have now started with LPT and we anticipate a dramatic impact from this. Part of the role of the investigator is to keep the families informed and involved. Kevin Harris asked if violence and aggression incidents are referred to the police. Anne Scott advised that a decision is made locally and the most serious incidents are referred to the police. The Chair highlighted that the medications incidents chart has plateaued and asked if there was anything more we could do with pharmacy colleagues to further reduce the medication errors.Anne Scott confirmed that the 'Medicines Management Group' is considering this. **Resolved:** The Trust Board received the report for information and assurance on the systems and processes and emerging themes.
TB/21/145	Safe Staffing Monthly Reports August 2021 – Paper Pi – this paper was taken as read and the focus was on the most recent paper. September 2021– Paper Pii Anne Scott presented the paper confirming that temporary worker utilisation rate was lower in September. Key inpatient areas of note include the Beacon Unit, Agnes Unit, Mill Lodge and Beaumont Ward. There are in addition to this 13 community areas of note – details are within the report. There was a quality summit held to look at these issues at the end of September This looked at patient safety risks and the NHSI tipping point factors. Weekly safe staffing meetings continue to be held and the Beacon Unit will operate 7 beds until the end of December due to staffing issues. There are quality improvement and recruitment plans in place with oversight by QAC. The community hospitals are operating at an amber risk with an increasing number of shifts having 1 registered nurse and over 50% agency staffing. Mill Lodge has nursing vacancies, with only 1 registered nurse on a night shift, but they are supported by neighbouring Stewart House. The Beaumont ward follow up quality summit showed no evidence to suggest that the ward was not safe. Community Health Services are operating at OPEL level 3 and business continuity plans are in place with reprioritisation of appointments. There have been 3 Sis with pressure ulcer harm. Anne Scott and the senior team have undertaken clinical visits and a quality summit is planned next week for the Community Hubs.. Any actions from this will go through the governance route and feed through to QAC and Trust Board as necessary. Anne Scott confirmed that further reports would be balanced and detailed and there is current consideration of new roles and different ways of working to release time to care. Clinical mandatory training has improved, but improvement is still required for bank staff. Angela Hillery noted that both Anne Scott and Avinash Hiremath are part of the ICS clinical leadership groups and all learning will be shared across the system. Anne

	Scott will continue to monitor the delivery of LPT services to ensure that they remain safe. Workforce is one of the greatest challenges that we have and we are confident about the ongoing quality summit work around safer staffing. Sarah Willis added that there was an energy around recruitment with lots of activity in this area. Kevin Harris added that this will not be a quick fix and the reports will need to show how we are managing the risk and what mitigations are in place. **Resolved:** The Trust Board received the report for information and assurance on the processes to ensure safe staffing.
TB/21/146	Annual Flu Plan – Paper Q Anne Scott presented the paper outlining the Trust plan for flu, covid 19 and boosters for staff and frontline workers. There is an increased risk of flu this year as it was low last year. We have a 100% offer of boosters to LPT staff and enough vaccine has been ordered.The co delivery plans for flu and covid are outlined in the paper. We have taken a quality improvement approach and we have used the Public Health England best practice checklist. Equitable uptake considerations are being looked at and there is a robust plan in place to support conversations around vaccine hesitancy. The data for Friday 22nd October was 15% flu; 92% covid – covid booster data is not yet available. Faisal Hussain asked how the trust planned to engage and utilise our diverse community infrastructure including existing faith and community groups to increase uptake and Anne Scott confirmed that the trust has linked in with other areas where there is good practice and this will be made explicit in updates which will be taken to the executive team regularly. **Action:** The percentage of vaccination uptake data to be captured in a report that feeds through QAC and will then feed up to Trust board through the QAC highlight report. **Resolved:** The Trust Board received the report and approved the plan detailed within the report.
TB/21/147	Safeguarding Annual Report – Paper R Anne Scott presented the annual report which is here to be approved for publication on the Trust website. The report demonstrates that we have transformed access to the safeguarding team for frontline LPT staff. The identified risks are noted in the report and are mainly around staff capacity – mitigations are detailed in the report and include external support. The Chair noted that the safeguarding NED is Moira Ingham and this role is carried out through QAC. Helen Thompson commented that it is good to see the theme of thoughtfulness running through the report and asked that within the objectives could the ”ThinkFamily approach be specifically referred to. SystmOne is the golden opportunity to join up and link with families. **Action:** To reference the Think Family theme within the Safeguarding Annual report. **Resolved:** The Trust Board approved the report for publication subject to the further enhancement on think family.
TB/21/148	Patient and Carer Experience and Involvement Annual Report - Paper S Anne Scott Presented the report which forms part of the 3 year delivery plan. The development of the People’s council is one of the key successes detailed in the report. Overall there is greater patient, service user and carer involvement and co-design in LPT services. **Resolved:** The Trust Board received the report for information.
TB/21/149	Complaints Annual Report – Paper T Anne Scott Presented the report confirming that 1441individual pieces of concerns, comments and compliments feedback had been received during the year – breakdowns can be found within the report. There have been challenges throughout the pandemic year and processes have been adapted to meet need. There have

	been a 25% reduction in complaints compared to the previous year. The Chair confirmed that both Paper S & T were helpful reports and that it was good to see an overview of activity and great to see the increased involvement of service users. **Resolved:** The Trust Board received the report for information
TB/21/150	Gender Pay Gap Annual Report – Paper U Sarah Willis presented the 2020/21 report which needs to be published by 31st March 2022. LPT are reporting a slight gender pay gap which can be attributed to the significant percentage of the female workforce in part time roles. There is an action within the people plan to offer flexible working from the employment start date. We continue to work on the blended approach to work as part of our Triple R (Reflect, Reset, Rebuild) programme. **Resolved:** The Trust Board received and noted the report, endorse the action plan and approve the publication on the Trust's website.
TB/21/151	Finance and Performance Committee Highlight Report – 28th September 2021 – Paper V Faisal Hussain presented the report confirming that the FM transformation programme is monitored through FPC and progress on this will be included in future highlight reports. The finance report was given a high level of assurance noting the agency spend is an area of concern. Further reports will be received at FPC regarding controls over agency spend. A recovery and financial sustainability plan for the Beacon Unit was requested by FPC to look at lessons learned and a further update will be brought back to FPC next year. The business pipeline received a high level of assurance due to greater cohesion and proactive working between teams including the procurement and contract teams. The Performance Report was given a split assurance due to some metrics yet to be populated. The Waiting times Report had a split rating due to the backlog of waiters but trajectories are in place and are beginning to have an impact. The work around keeping patients safe whilst waiting was good. The level 2 committee highlight reports show no escalations however FPC continue to monitor and have asked for further detail to be brought back to FPC around the Estates Returns Information Collection (ERIC) on backlog maintenance. The Transformation Committee has been reinstated for oversight of work streams.. The IMT committee continue to monitor the SytsmOne migration. The Data Privacy Committee raised concerns around the email migration to nhs.net and are monitoring this closely. **Resolved:** The Trust Board received the report for information and assurance.
TB/21/152	Finance Monthly Report Month 6 – Paper W Sharon Murphy presented the report confirming a break even position in month 6. The delivery plan for H1 is complete and is break even despite some operational overspends being offset. To note that income is higher than we would usually expect and there will be a focus during H2 to look at this. The agency spend in month 6 was £2m and £21.6m is the forecasted outturn, this includes covid costs and is mostly nursing staff due to increased acuity and staffing for surge wards. A task and finish group has been set up to look at this (Sharon Murphy and Sarah Willis) and a paper is going to be presented to the Operational Executive Board around short and long term actions planned. The Better Payments Practice Code for non-NHS performance is below 95% during September but this has been identified as a single, one off issue and we remain on target to achieve 95%. With regards to capital there have been some changes in schemes due to national supply chain issues and as such a new plan is being reviewed and agreed with the Chief Finance Officer (CFO) currently. The revised forecast is £16.m which includes £0.5m extra for laptop replacement and £0.8m contingency. Monthly reviews are currently being undertaken to review any slippage. The Chair asked if there was any scope for using capital contingency for the backlog maintenance issues and Richard Wheeler confirmed that this had been

	discussed and it was challenging due to the very large estates programme – there is no capacity for this financial year but it could be built into future plans. **Resolved:** The Trust Board approved the month 6 report.
TB/21/153	Performance Report Month 6 – Paper X Sharon Murphy presented the paper confirming that the picture is more positive with the Directorate for Mental Health seeing an increase in performance, for example 67% for Community Mental Health Team of patients accessing treatment within target. The memory clinic has also seen an increase in performance against target. Community Health Services Continence Service have seen 50% of patients within target and in Families and Young People's services Child and Adolescent Mental Health (CAMHS) Eating Disorder service saw 100% of urgent cases within target and there was an increase in target for routine cases too. 6 week diagnostics for Audiology has the lowest figures seen so far this year and this is due to recruitment issues and an increase in referrals. In relation to the 52 week waits the numbers waiting for personality disorder services assessments is lower but has increased for treatment as expected in the forecast trajectory. The key areas of escalation from the month 3 reviews and updates from the month 5 reviews are detailed within the report. Angela Hillery commented that it was encouraging to see the green shoots of recovery and that it is important to demonstrate the additional resources provided and the team having a clear approach around trajectories and to escalate these when we are not achieving them. The Chair asked why the readmissions rate went from 31% in April to 45% in September and Sam Leak confirmed that a deeper dive was needed around this but it was likely due to the flexed criteria for community beds having an impact on the readmission data. The Chair asked when the new KPIs would be brought in for this report for example the new community health standards of 2 hour response times –Sharon Murphy confirmed that there has been delay on the new community health service metrics due to a national issue with the system set up. There are technical solutions being developed behind the scenes. **Resolved:** The Trust Board received the report for information and assurance.
TB/21/154	Charitable Funds Committee Highlight Report 14th September 2021 – Paper Y Cathy Ellis presented the report confirming the high level of assurance throughout. The NHS Charities Together (NHSCT) community grants have been fantastic for the LLR system and most recently the NHSCT £50,000 covid fund has been allocated to reflective gardens and benches across the Trust. **Resolved:** The Trust Board received the report for information and assurance.
TB/21/155	Charitable Funds Annual Report – Paper Z Cathy Ellis presented the annual report and accounts which have been audited and which details the work of the charity during the year. Sharon Murphy noted that advice had been given nationally that NHSCT funds may need to have a different classification of funds in the accounts This will be discussed with the auditors and the Board will be advised of any change in classification. Faisal Hussain commented on how much the charity had achieved and looked forward to getting back out on Board walks to see the project staht had been delivered. The Chair highlighted that the charitable funds received by LPT are for projects that deliver extras over and above the core NHS funds. **Resolved:** The Trust Board received the report for assurance and approved the charity's accounts.
TB/21/156	Audit and Assurance Committee Highlight Report 3rd September 2021 – Paper AAA Darren Hickman presented the report where high assurance was received for all items except for one. The committee were not fully assured as the internal audits follow up rate had deteriorated slightly. The committee were, however, supportive of the new system to be used to support this area of work.

	Angela Hillery added that the team are working hard on this matter and actions are being taken to resolve this issue. **Resolved:** The Trust Board received the report for information and assurance
TB/21/157	Review of risk – any further risks as a result of board discussion? Further risks were identified as a result of the board discussions today for consideration: Staffing risk - to be reviewed in the ORR monthly review.
TB/21/158	Any other urgent business No other business was raised.
TB/21/159	Papers/updates not received in line with the work plan: Modern Slavery Act and Human Trafficking Statement (Annual) – this has been moved to the December 2021 Trust Board meeting.
TB/21/160	Public questions on agenda items – No questions received.
	Next public meeting 21st December 2021

D

Leicestershire Partnership NHS Trust

TRUST BOARD 21st December 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)
945	26th October 2021 TB/21/143	Present the findings and associated action plans from the IPC Visit to the Trust Board December meeting.	Anne Scott	21.12.21	Complete – on 21st December Trust Board Agenda
946	26th October 2021 TB/21/146	The percentage of vaccination uptake data to be captured in a report that feeds through QAC and will then feed up to Trust Board.	Anne Scott	17.11.21	Complete
947	26th October 2021 TB/21/147	To reference the Think Family theme within the Safeguarding Annual	Anne Scott	21.12.21	Complete

Action No	Meeting date and minute ref	Action/issue	Lead	Due date	Outcome/evidence actions are not considered complete without evidence)
		report prior to its publication on the website.			
948					

E

Leicestershire Partnership NHS Trust

Trust Board – 21st December 2021

Chair's Report

Purpose of the report

Chairs report for information and accountability, summarising activities and key events
From 26th October 2021 to 21st December 2021

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

Thank you to all LPT staff who have stepped up to great in 2021

Hearing the patient and staff voice	• The Chair and Non-Execs Boardwalks are restarting with visits to GREEN areas and appropriate infection and prevention controls in place. Visits this period include: o Loughborough Hospital o Adult speech and language therapy o Heart Failure Nursing team o Charnwood Community Mental Health Team • Joined the Homeless mental health service team meeting to hear how the service has adapted during the pandemic and consider how we shape it for the future. • Participated in the LPT Medical Trainee Awards, great to recognise their achievements and check in on their wellbeing.
Connecting for Quality improvement	• Attended the East Midlands Academic Health Science Network national showcase event which highlighted innovations developed in LPT (Chat Health secure text messaging service for young people to access help) and those piloted in LPT (ADHD diagnostic tool used in assessment) • Attended the Research Envoys celebration, several members of staff presented their work on research studies in LPT • CQC engagement meeting to follow up on progress since the recent inspection
Promoting Equality Leadership & Culture	• Joined the 3 LPT events for Disability Month, highlighting my learning from the Reverse Mentor scheme and experience as a Line Manager supporting Faisal Hussain (NED) who is a full-time wheelchair user • Attended the ICS and Midlands training events for Leadership in Health Inequalities • Participated in the Diwali staff virtual celebrations • Joined the men's health week suicide awareness session • As the Health & Wellbeing Guardian, I continue to promote Wellbeing

	Wednesdays with my weekly blog and have connected with the NHSI network and NHS Confederation to benchmark LPT. I attended the Workforce Wellbeing Group to talk to colleagues about our wellbeing offer and hear their views on what else we can do to support staff during the Winter.
Building strong Stakeholder relationships	• Focus on Covid19, vaccination delivery and waiting times recovery through NHSEI Regional Director calls with Midlands and LLR Chairs • Attended LLR Health & Care Partnership Board and LLR Integrated Care Board (NHS) meetings to focus on development of the ICS and priorities for operational and strategic transformation • Part of the interview panel for the ICS CEO appointment • Chaired the monthly LLR ICS Finance Committee meetings focusing on future trajectories, transformation and key risks. • Attended the Leicester City Health & Wellbeing Board which focused on Learning Disability services • Attended Leicester City Homeless Charter Board to connect our services with other partners • Attended University of Leicester Council and Finance committee meetings • Attended the Leicestershire Academic Health Partners Board • 1:1 stakeholder meetings with John MacDonald Chair of UHL, David Sissling Chair of LLR ICS, Councillor Vi Dempster Chair of the City Health & Wellbeing Board, Mark Farmer Chair of LPT's Peoples Council
Good Governance	• Board development workshop held on 23rd November which focused on: freedom to speak up self-assessment, the covid 19 public inquiry, developing plans for clinical, IM&T, Estates and a Greener NHS. There was also a deep dive on staffing pressures. • Attended the Joint Working Group meetings for the LPT/NHFT group • Conducted 1:1 appraisals with all 11 of our Mental Health Act Managers and chaired their team meeting • Chaired the interview panel for a Consultant Medical Psychotherapist
Raising Health (LPT charity)	• Chaired the Charitable Funds committee which continues to support patient experience and staff wellbeing initiatives that provide "extras" above the core NHS offer. • Approved bids for Carlton Hayes charity which supports activities for mental health in-patients and service users
Non-Executive Directors (NED)	• Professor Kevin Harris will be retiring from LPT at the end of December 2021 after 3 and a half years on the LPT Board. Kevin is the NED nominated by the University of Leicester and his successor will be Professor Kevin Paterson who is Professor of Psychology and current Head of Neuroscience, Psychology and Behaviour at the University of Leicester. • Supported Chair colleagues at University Hospitals of Leicester and Lincolnshire with NED interview panels

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 21st December 2021	
Paper sponsored by:	Cathy Ellis	
Paper authored by:	Cathy Ellis	
Date submitted:	13 December 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 – 21 December 2021

Chief Executive's report

Purpose of the report

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

Analysis of the issue

National Developments

Coronavirus COVID-19

On the 12 December 2021, the Prime Minister confirmed that the NHS vaccination programme will offer every adult the chance to book a COVID-19 booster vaccine by the end of the calendar year in a race to protect the nation against the Omicron variant.

This follows the Prime Minister's announcement on the 8 December 2021 that England will move to Plan B following the rapid spread of the Omicron variant in the UK. Early analysis suggests that cases of the Omicron variant could be doubling at a rate of as little as 2.5 to 3 days. Plan B involves the following;

- From Friday 10 December, face coverings will become compulsory in most public indoor venues, such as cinemas, theatres and places of worship. There will be exemptions in venues where it is not practical to wear one, such as when you are eating, drinking or exercising.
- From Monday 13 December, those who can will be advised to work from home.
- From Wednesday 15 December, and subject to parliamentary approval, the NHS Covid Pass on the NHS App will become mandatory for entry into nightclubs and settings where large crowds gather – including unseated indoor events with 500 or more attendees, unseated outdoor events with 4,000 or more attendees and any event with 10,000 or more attendees.

Parliament will be debating the measures, with a vote expected to take place on Tuesday 14 December.

So far the total number of vaccinations has reached 96 million, and the NHS has urged those in newly eligible groups to take up the vaccine following the increase of the new COVID variant Omicron across England. People can get their vaccine by booking online through the National Booking Service

The Government has announced that health and social care workers, including volunteers who have face-to-face contact with service users, will need to provide evidence they have been fully vaccinated against COVID-19 in order to be deployed. The new requirements come into force in the Spring 2022, subject to the passage of the regulations through Parliament.

NHS Talking Therapy programme

Many people have struggled with their mental health during the pandemic, and the NHS Talking Therapy Programme saw a 5% increase in the number of people completing a course of treatment during 2020/21 for conditions including depression and anxiety. Data from NHS England's programme published on 25 November 2021 showed that more than half of those completing treatment recovered from their condition.

The NHS encourages adults with mental health issues such as anxiety or depression to consider either being referred by their GP or via self-referral online. For more information, please visit the nhs.uk website.

Details of helplines for those with a condition escalating into crisis are also available on the nhs.uk website.

Autumn Budget and Spending Review 2021

27 October 2021 saw this year's Budget presented by the Chancellor, Rishi Sunak. The Spending Review that informed the Budget aimed to "begin the work of preparing for a new economy post Covid. The Prime Minister's economy of higher wages, higher skills… rising productivity [and] of strong public services".

Amongst the funding announcements was £5.9bn capital funding for the NHS over the next three years to support elective recovery and improve digital technology. In addition, there will be a £9.6bn investment into COVID-19 programmes from next year to 2024/25, which includes the COVID-19 vaccination programme and targeted testing. LPT has received £2.5m to expand our digital healthcare and virtual wards capability in supporting people with long term conditions, enhancing the current provision for those with respiratory and COPD conditions, to many other categories of patient, including those with depression, cancer, stroke and epilepsy.

The public sector pay freeze will be lifted and there will be a return to the independent pay setting process. This will mean pay rises for public sector workers over the next three years.

To access the Budget, please visit the Government's website: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1029974/Budget_AB2021_Web_Accessible.pdf

UK Threat Level

Following the incident outside Liverpool Women's Hospital on 14 November and taking account of the previous tragic incident involving an MP, the independent Joint Terrorism Analysis Centre has raised the UK's threat level from 'substantial' to 'severe'. This means that a terrorist attack is considered to be 'highly likely'.

Threat levels are a tool for security practitioners, including the police and NHS Emergency Preparedness Resilience and Response (EPRR) leads, to use in determining what protective security response may be required.

Evolving regulation and oversight within systems

In response to the acceleration of system working and the introduction of the Health and Care Bill, the national regulators – CQC and NHS England and NHS Improvement – are adapting their regulatory models to harmonise with new ways of working. Respectively, NHS England and NHS Improvement has introduced its system oversight framework (SOF) and CQC is implementing its revised regulatory approach as part of its new strategy.

For more information on the CQC's developments, please visit the CQC website: https://cqc.citizenlab.co/en-GB/projects/developing-our-oversight-of-systems. For more information on the SOF, please visit the NHS England website: https://www.england.nhs.uk/publication/system-oversight-framework-2021-22/.

CQC State of Care Report for 2020/21

On 22 October, the CQC published its annual assessment of the state of health and social care in England. This year's report reflects on how the 'system' has dealt with the COVID-19 pandemic by working collaboratively and the impact on people who use care services. It highlights key areas affecting the system as a whole across four common themes (i.e. People's experiences of care; Ongoing quality concerns; Flexibility to respond to the pandemic; and Challenges for systems). To access the report please visit the CQC's website: https://www.cqc.org.uk/publications/major-report/state-care

CQC community mental health survey

This survey looks at the experiences of people who use community mental health services across the NHS. People were eligible to take part in the survey if they had at least one contact with services between September and November 2020, with another contact either before, during or after this period. In addition, some questions ask

participants to reflect on their care over the last 12 months. Therefore, results of this survey reflect experiences of care throughout the COVID-19 pandemic.

The report shows that people are consistently reporting poor experiences of NHS community mental health services, with few positive results. Many people reported that their mental health had deteriorated as a result of changes made to their care and treatment due to the pandemic.

The Step Up To Great Mental Health transformation work includes improving community mental health services and has been part of a public consultation. The outputs and recommendations from the consultation are being taken through the Leicester, Leicestershire and Rutland CCG governing body on 14th December for review and decision. The plan for Mental Health Community Services includes the following key elements;

- Improving timely access to community mental health services including psychological therapies.
- Reducing waiting times – patient being seen in the right place, right time by the most appropriate clinician.
- The development of Planned Treatment and Recovery Teams.
- Development of new roles to meet the need of the local population.
- Patients and carers being a collaborative partner in their care and treatment and being supported to independently manage their mental health and well-being.

National Voices Annual Report 2020-21

During 2020/21, the National Voices organisation supported people living with ill health, impairment and disability during the pandemic. The three key interventions made by the organisation were:

- Publishing the Nothing About Us Without Us Five Principles that 100 members and partner organisations signed up to.
- Releasing insight reports into people's lived experience of the shift to digital appointments, and the digital exclusion which negatively impacted upon some people's ability to access good quality care The Dr Will Zoom You Now and Unlocking the Digital Front Door: the keys to inclusive healthcare.
- Launching Our COVID Voices, a digital platform that gave people living with ill health or disability a way to express how the pandemic was impacting their lives. This then led to What We Need Now, a qualitative review based on Our COVID Voices and a series of I Statements, eight expressions of expectations simply communicated as illustrations.

For more information please visit the National Voices website:
https://www.nationalvoices.org.uk/sites/default/files/public/news/download/nv_trustees_annual_report_and_financial_statements_for_publishing.pdf

The Big Ask – the Big Answers

The Children's Commissioner's Big Ask set out to hear the voices of as many children in England as possible, to amplify them, and to deliver improved life chances for this generation and beyond. Over half a million responded – a record for a survey of its kind. The feedback demonstrates that what children want is remarkably consistent: a good home life, a good education, a job, enough money, friends, to feel well, to be treated fairly and to look after the environment. To access the report, please visit the children's commissioners' website:
https://www.childrenscommissioner.gov.uk/wp-content/uploads/2021/09/the_big_ask_the_big_answer_09_2021.pdf

National Child Mortality Database Report

During October 2021, the Healthcare Quality Improvement Partnership (HQIP) published a report on data from the National Child Mortality Database (NCMD). This report, one of a number of thematic reports, sought to examine death by suicide in order to identify what can be learned to prevent future deaths by suicide from happening.

Examining data from 1 April 2019 to 31 March 2020, the report found that:

- Services should be aware that child suicide is not limited to certain groups.

- 62% of children or young people reviewed had suffered a significant personal loss in their life prior to their death, this includes bereavement and "living losses" such as loss of friendships and routine due to moving home or school or other close relationship breakdown.
- Over one third of the children and young people reviewed had never been in contact with mental health services.
- 16% of children or young people reviewed had a confirmed diagnosis of a neurodevelopmental condition at the time of their death.
- Almost a quarter of children and young people reviewed had experienced bullying either face to face or cyber bullying.

To access the report please visit the NCMD website: https://www.ncmd.info/wp-content/uploads/2021/11/NCMD-Suicide-in-Children-and-Young-People-Report.pdf

Mental Health Support in Schools and Colleges

In March 2021, the government announced £79 million to boost mental health support for children and young people in England. The new funding was part of the £500 million already announced for mental health support during the 2020 Spending Review. Over the course of 2021/22, funding will be used to expand the support available to children and young people, including increasing the number of Mental Health Support Teams (MHSTs) in schools and colleges and improving access and reducing waiting times for community mental health support. LPT's MHST has been introduced in local schools and will continue to expand to support children and young people in schools across LLR.

For more information on MHSTs, please see the NHSE/I website: https://www.england.nhs.uk/mental-health/cyp/trailblazers/

NHS Transactions Guidance Consultation

NHS England and Improvement (NHSE/I) has launched a consultation on proposed changes to its NHS transactions guidance for trusts undertaking transactions, including mergers and acquisitions. The proposed changes reflect the increasing role of systems and collaboration between providers in the period leading up to a transaction and put a greater emphasis on the opportunities to deliver patient and population benefits. NHSE/I intends the updated guidance to offer reduced regulatory burden and reduced costs to trusts, while ensuring proposed transactions meet the needs of patients and the public.

To access the consultation and the proposed changes, please see the NHS England website: https://www.engage.england.nhs.uk/pricing-and-costing/consultation-on-proposed-changes-to-the-nhs-transa/

United Nations (UN) Climate Change Conference of the Parties 2021 (COP26)

The UK hosted COP26, which took place in late October/early November in Glasgow. The conference aimed to bring parties together to secure global net zero by mid-century and keep 1.5 degrees within reach; adapt to protect communities and natural habitats; mobilise finance; and work together to deliver.

On 10 November, the Secretary of State for Health and Social Care wrote to all NHS Trust Chief Executives to 'underline the vital role that the NHS must play in achieving our shared ambitions on climate change and the environment'. In his letter, he notes that "the government made a world-leading legal commitment to achieve net zero emissions by 2050" and that it has since published its Net Zero Strategy, which sets out "measures to transition to a green and sustainable future, helping businesses and consumers to move to clean power, supporting hundreds of thousands of well-paid jobs".

NHS England and Improvement has clearly set out the requirement for all trusts and integrated care systems (ICSs) to produce a 3-year Green Plan, agreed by Trust boards. The Secretary of State invited "all trust CEOs to feed in their

ideas about how we can all work more sustainably, and better embed issues like net zero and biodiversity across key processes and systems, especially those relating to the allocation of capital."

For access to the guidance from NHSE/I on developing a Green Plan, please visit the NHSE/I website: https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2021/06/B0507-how-to-produce-a-green-plan-three-year-strategy-towards-net-zero-june-2021.pdf

Integrated Care Boards

On 22 October, NHSE/I published guidance on how the NHS financial framework will support collaboration between NHS organisations on their partners across integrated care systems (ICS). The guidance confirms that NHSE/I will make funding allocations to Integrated Care Boards (ICBs), which includes budgets for services currently commissioned by Clinical Commissioning Groups (CCGs) and, where agreed, budgets from NHSE/I (e.g. for primary care). The costs of establishing ICBs will need to be managed within existing budgets.

The guidance confirms that NHSE/I expects providers to be formal partners of ICBs and, where providers provide services across multiple ICBs, that each provider's revenue resources will be 'mapped' to one ICB only. Model terms of reference for audit and remuneration committees of ICBs have also been published. Governance arrangements for the Leicester, Leicestershire and Rutland ICB are currently under development. The LLR ICS Chief Executive and Chair have been appointed.

Primary Care and Local Health System

NHS chief executive Amanda Pritchard has asked Dr Claire Fuller, senior responsible officer of the Surrey Heartlands Integrated Care System, to set out how systems can accelerate implementation of the primary care, out of hospital care and prevention ambitions in the NHS Long Term Plan and drive more integrated primary, community and social care services at a local level. Dr Fuller, a practising GP, will look closely at how primary care networks can support integrated care systems by bringing partners together at a local or 'Place' level to address health inequalities and improve the health of the local population. Dr Fuller will describe the next steps by March 2022 ahead of Integrated Care Systems' becoming statutory organisations in April 2022, as the legislation proposes.

Lifechanging careers in the NHS

On 21 October, NHS England Chief Executive Amanda Pritchard launched the health service's annual recruitment drive, encouraging anyone looking for a career change to consider joining one of hundreds of rewarding roles on offer. The We are the NHS campaign will shine a light on careers within healthcare and showcase the range of job opportunities available, from nursing to radiography to podiatry. The COVID-19 pandemic has shown more than ever that the future of England's health and social care system relies on its people. For more information and to find out more about the range of nursing, allied health professionals, and healthcare support worker roles available within the NHS, search NHS careers.

Guidance on finance and contracting arrangements for H2 2021/22

NHS England and Improvement published updated planning guidance for the second half of the current financial year ('H2') on 30 September. System leaders are asked to ensure that plans for H2 appropriately consider the system's 'carry forward' position from H1 and that this balances across the full period. Regarding mental health services specifically, national guidance confirms that CCGs must continue to the meet the Mental Health Investment Standard (MHIS) as a minimum and to continue to deliver against previous plans set in H1. The total expenditure on mental health services should not reduce from the notified full-year plan, adjusted for the impact of the higher pay award. Specialised mental health, learning disability and autism provider collaboratives will continue and will expand in number.

For more information on the planning guidance, please visit the NHSE/I website: https://www.england.nhs.uk/wp-content/uploads/2021/09/C1406-guidance-on-finance-and-contracting-arrangements-h2-21-22.pdf /

https://www.england.nhs.uk/wp-content/uploads/2021/09/C1404-operational-planning-guidance-oct-21-march-22-submission-guidance-v3.pdf

Local Developments

£6.5 million to help reduce NHS waiting times in Leicester, Leicestershire and Rutland

NHS services across Leicester, Leicestershire and Rutland (LLR) have been awarded £6.5 million to help cut waiting lists. The funding will help reduce waiting times for patients locally by expanding the number of operating theatres and available beds. This will include two new day surgery units, so that more patients can be treated without needing to stay in hospital overnight and a new ward, due to open in January, for patients who do need to stay in hospital. There will also be investment in technology to improve patients' experiences of care and help those with long-term health conditions to be better able to manage their health themselves at home.

Leicestershire Partnership NHS Trust will receive just over £2.5 million. Most of this will go towards expanding an existing project which allows clinicians to monitor the condition of certain patient groups in their own home, using digital technology. They can be given appropriate advice or have a clinician visit should their condition deteriorate. At present this is used to care for patients with certain heart and lung conditions. We will be using the new money to expand this to many other categories of patient, including those with depression, cancer, stroke and epilepsy.

Another project involves equipment and support for those with severe asthma and the lung condition COPD, so they can also be monitored in their own homes

LLR crisis response service gets national recognition from NHSE Chief Executive

We were privileged to host a visit from Amanda Pritchard, Chief Executive Officer at NHS England on Tuesday 23 November to the Neville Centre, where she was able to meet colleagues working in the Leicester City two-hour crisis response service – an integrated health and social care model used across the city and county.

The crisis response service helps patients with a range of urgent needs including those who have suffered from falls in their home or those that require urgent pain relief, ultimately helping them to receive care at home, quickly and often avoiding hospital admission. Referrals to service can be made through NHS 111, 999, general practice staff and ambulance services.

LLR was chosen as one of seven accelerator sites to trial this model of care to develop crisis response standards, which will soon be used to help replicate the model across the country.
The LLR two-hour crisis response pathway is crucial to support and meet the needs of our diverse local population so that patients receive the right care, at the right time, and in the right place, with health and social care colleagues collectively making decisions regarding the best treatment plan for each patient. The crisis response pathway has supported approximately 11,689 patients on our two-hour pathway between February and September 2021.

Amanda expressed how impressed she was by the dedication and commitment of our teams in working collaboratively to support patient's receive exemplary care a sentiment which I wholeheartedly echo. You can view what Amanda had to say of her visit to the crisis response service here.

NHS national spotlight on two East Midlands health innovations

The NHS national Director of Innovation and Life Sciences, Matt Whitty visited Leicester on 29 November to learn how two initiatives that started at LPT, have been adopted across the NHS and are now benefiting millions of people throughout the country. The visit was organised by the East Midlands Academic Health Sciences Network as part of a wider regional showcase of the projects they have supported.

Matt Whitty (who is also Chief Executive of the Accelerated Access Collaborative) visited the ADHD service to see a demonstration of a new digital test that is significantly reducing the time parents have to wait for their child to be diagnosed with ADHD.

He also visited the award-winning ChatHealth - a safe and secure health messaging service developed by staff at Leicestershire Partnership NHS Trust, that allows users to have conversations with health professionals via their mobile devices about issues including mental health, sexual health and general health concerns. Originally available to 65,000 teens in Leicester, Leicestershire and Rutland, the service is now available to over 6 million people nationwide.

We were proud to showcase the innovative work of our teams at LPT and a big thank you to all involved in the visit. These are two exceptional examples of how our clinicians are pioneering solutions to improve access to healthcare that can be adopted for the benefit of many more people nationwide. Thanks to the East Midlands AHSN our Award winning ChatHealth innovation is now supporting more than six million people across the country, which has been particularly invaluable during the COVID-19 pandemic. We have recently launched a ChatAutism and ChatMentalHealth service and continue to innovate this product for other audiences."

The day also included a wider stakeholder discussion about the East Midlands mental health collaborative.

Awards

Three LPT nurses have been awarded the prestigious title of Queen's Nurse (QN).

Louise Mead, Julie Potts, and Sam Screaton were notified that they'd beat off thousands of other applicants to be awarded the accolade, which is only given to nurses, health visitors and midwives with at least five years' experience of working in the community and who have demonstrated a high level of commitment to patient care and nursing practice.

- Sam Screaton, who is a learning disability nurse at the Trust and has been practising for 20 years, has recently been leading the vaccination clinics for people with learning disabilities, which was a finalist in this year's Nursing Times Awards.
- Julie Potts, who is the Diana service children's palliative care nurse lead at the Trust, has been with the service since 1998. She has played a central role in supporting Diana service colleagues in the coordination and delivery of palliative and end of life care for children, young people and their families.
- Louise Meads is a district nurse on ward 10 at Hinckley Community Hospital, with a nursing career spanning 30 years. She has worked in a variety of roles, and started her role in community nursing in 2006.

A big well done and thank you to all of you.

Avril Archibald, registered children's nurse in the Diana service, has been awarded a prestigious national Cavell Star award in recognition of her outstanding contribution to nursing in the NHS.

Avril started nursing over 47 years ago and retired in November 2021. She originally trained as an enrolled nurse before converting to a registered children's nurse. During her career, Avril was involved in a project to set up a respite service for children with complex nursing needs to allow families a much-needed break from caring responsibilities. Over 25 years ago, the respite team joined other professionals providing care to children in the community, forming the Diana community children's service to support more children, young people and their families across Leicester, Leicestershire and Rutland. Before retiring, Avril was part of the management team for the service, which now offers acute and ongoing nursing care, Macmillan nursing, continuing care, respiratory physiotherapy, child and family support, training, special schools nursing and multicultural support.

Youth Advisory Board – finalists in the national CYP Now awards

Our youth advisory board were shortlisted in the national Children and Young Peoples Now Awards in the Partnership Working category. The young group have been involved in co-designing many improvement initiatives and are jointly supported by LPT and Leicester City Council. The YAB, which was set up two years ago, is made up of young people, aged 13-21, who have used our services - as well as representatives from the Leicester City Council's Youth Council.

Clinical Research Network Awards – Rising star award for Sam Tromans

Sam Tromans, LPT psychiatrist, was awarded the NIHR (National Institute for Health Research) Clinical Research Network East Midlands' Rising Star Award on 25 November for his research around autism.

HSJ Awards and Nursing Times Awards

A joint project between LPT and UHL was shortlisted by the HSJ Awards in the Digitising Patient Services Initiative. The shortlisting recognised our use of remote monitoring technologies to keep heart failure, COPD and Covid-19 patients safe and at home during the pandemic.

Our learning disabilities vaccination clinics were shortlisted by the Nursing Times Awards in the Learning Disabilities Nursing categories. A huge well done to all involved.

First anniversary of Covid vaccinations programme

LPT is featured in a new video to mark the first anniversary of Covid vaccinations in the Midlands.

The one-minute video has been produced by the regional NHSE communications team. It includes clips of "Spiderman" attending our LPT clinics for Learning Disability patients at the Peepul Centre, and Covid survivor Kully Sidki being applauded out by staff at Coalville Community Hospital.

You can watch the whole video here: https://www.youtube.com/watch?v=Z6VbuB5EX88 .

Leicestershire Partnership and Northamptonshire Healthcare Group

I have previously shared information on the eight strategic areas in which we are working together with our partners at Northamptonshire Healthcare NHS Foundation Trust (NHFT). I have drawn out a couple of these areas in my report this month and will share information on the other areas in future reports.

Talent management: people are our greatest strength and at the heart of everything we do. Our talent management priority plan focuses on broadening opportunities for colleagues to help them develop and progress across our group. Joint learning and networking opportunities will support our colleagues in building and sharing their skills. Empowering and motivating for the individual, they also help our trusts keep talented and experienced colleagues while we work towards being more inclusive employers. There will also be additional support for BAME staff looking to progress.

Leadership and organisational development: We want to develop, empower and inspire great leaders at all levels within our trusts. Leaders who can meet the needs of our joint workforces while creating a culture that supports our individual missions. Compassionate and inclusive leadership will help us Step Up To Great here in LPT, and support the DIGBQ strategy in NHFT – develop in partnership, innovate, grow our staff capability, build a sustainable organisation and quality and safety at the foundation of all we do. Plans include a focus on how to lead remote teams as well as leadership masterclasses. The emphasis will be on sharing learnings and leading together.

Black History Month

October was Black History Month, which the Trust marked together with its partners at Northamptonshire Healthcare NHS Foundation Trust (NHFT) with a series of events connected by this year's theme 'proud to be'. Events included the power of allyship, international history and heroes and local history and heroes – all of which will be celebrated with live lunchtime Microsoft Teams sessions. Guest speakers included Morcea Walker MBE and Shareen Pavaday, Equality and Inclusion, NHSE England and Improvement. This year's events form part of our joint programme of work with NHFT 'Together Against Racism'.

Armistice and Remembrance

Earlier this month, LPT joined organisations and people across the country in remembrance of the service and sacrifice of the British Armed Forces community, paying tribute to the special contribution of families and of the emergency services and acknowledging innocent civilians who have lost their lives in conflict and acts of terrorism.

Veterans, serving members of staff and their families are an incredible asset. Their dedication, discipline, and passion for the work they do is rivalled by their sense of patriotism. At LPT we work to support those who serve to give them the time and flexibility they need to create a space for the service that they undertake. We are incredibly grateful to them and for all they do for us and we want to ensure we do our part. From being part of the Armed Forces Covenant and achieving Gold standard to consistently trying to evolve our human resources policies to support our armed forces community in more ways, we strive to make a difference.

We will be holding a resigning of the Covenant on January 17 to reinforce our commitment as a Trust.

National Allied Health Professionals' Day

We celebrated national Allied Health Professionals' (AHPs') Day on 14 October, hosting a number of events across the week for colleagues, inspiring the future generations of AHPs and raise the profile of these roles in our communities. My thanks to all AHPs across the Trust for their continued commitment to outstanding compassionate care, especially during the COVID-19 pandemic.

International Mens Day

We joined forces with our Group partners NHFT for International Men's Day on 19 November celebrating the positive difference men make to the world. We marked the occasion with a programme of events focusing on men's health and wellbeing for all colleagues across our trusts. From fathers and brothers to sons, nephews and friends – caring for the men in our lives makes a difference. Our inspiring speakers and NHFT and LPT panellists covered topics from the male menopause to mental wellbeing and prostate cancer to practical tips on dealing with stress. You can watch all of the sessions on demand here.

Similar joint events are being planned by the Women's Network support groups for March 2022. The Two staff networks are also planning a joint event for LGBT+ history month in February 2022.

Relevant External Meetings attended, and Service Visits undertaken since last Trust Board meeting

Whilst formal service visits have been suspended throughout this time for Infection Prevention and Control reasons, we are ensuring that leadership is visible across the Trust through a range of digital solutions including Microsoft Teams, recorded videos, the staff briefing and Twitter.

Chief Executive and Deputy Chief Executive external meetings

November 2021	December 2021
LLR CEO's Meeting	LLR ICS NHS Board
Healthwatch	MP Briefing
Learning Disability Conference (Opening)	LLR CEO's Meeting
EMAHSN	CQC
LLR ICS NHS Board	East Midlands Alliance CEO
LLR HoSC (MP)	LA - CCG CEO's - Leaders Meeting
Supporting Leicester, Leicestershire, and Rutland (LLR) Staff through Mental Health and Well-Being Event	Eating Disorder Workshop - East Midlands Alliance
CQC	LLR QSRM - Q2 20212022
CEO NHSI Visit	LPT-NHFT CiC Joint Working Group
NHS Midlands Leaders Update: Provider CEOs/CCG AOs/STP Leads with Regional Director NHS Midlands	Mental Health Trusts CEO meeting
LA-CCG CEO- Leaders Meeting	LLR LMC General Practice Access Summit
Mental Health Trusts CEO meeting- Midlands & East	Leicestershire Academic Health Partners Board
NHS Providers board meeting	Lutterworth Plan Steering Group
System Executive Group meeting	Director of Public Health and Sports Services, Leicester City Council
MH and LD CEO Meetings	
East Midlands Alliance Board LLR CEO's Meeting	

Director of Public Health and Sports Services, Leicester City Council	
UHL CEO	
LRF Executive Board	
Leicestershire County Council Health Overview and Scrutiny Committee	
PWC/CCG meeting	
NHS England visit to LLR (LPT on 29th)	

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 21 December 2021	
Paper sponsored by:	Angela Hillery, Chief Executive	
Paper authored by:	Kate Dyer, Deputy Director of Governance and Risk	
Date submitted:	13 December 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:	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	Routine board report	
STEP up to GREAT strategic alignment*:	High **S**tandards	
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	Yes
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trust wide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	none
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	

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Leicestershire Partnership NHS Trust

Trust Board – 21 December 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

Approach to the ORR Refresh

The ORR has been reviewed and aligned to the Trust's refreshed strategic objectives. The two key brick changes include the following;

- **T – T**ransformation has broadened out to also include Digital **T**ransformation
- **R** (formally EP**R** electronic patient record) is now **R**eaching Out. Other bricks remain the same in terms of the overarching title however risks have been updated to reflect the revised aims within each area.

We have undertaken the following steps to refresh the ORR;

- Held a Trust Board Development Session on the 22 October 2021. Board members reviewed the risk appetite statement, and the ORR; for each brick, the Board determined whether we should Close, Keep or Create risks on the refreshed ORR.
- The Trust Board reviewed the output of the development session at the Trust Board Confidential Section on 26 October 2021 where support was given to the approach taken and next steps. The Board also approved the refreshed risk appetite matrix and the corresponding tolerance levels.
- An in-depth review was undertaken with executive directors during the first two weeks of November 2021 to shape the new ORR. Where risks were being kept or created, they were articulated to reflect the 'cause, risk, effect' model of writing risk statements.
- The revised risk titles were approved by the Quality Assurance Committee and the Finance and Performance Committee in November 2021.
- The review of risk has taken account of the operational risk profile within Directorate and local risk registers.
- The review ensured that any gaps in control and assurance, and any actions have mapped across to the refreshed ORR or where applicable or closed / de-escalated.
- The refresh has identified several format changes to the layout of the ORR to support ongoing maturity and detail. The slide pack provided to Trust Board is the first draft of the refreshed slides which will be subject to ongoing review and refinement.
    - The risk appetite will be provided alongside the approved tolerance level.
    - Controls and assurance will be streamlined, this is part of an iterative process to strengthen the ORR.
    - Each ORR slide will now name an operational lead in addition to the lead executive director. This will underpin a more detailed monthly review between the Risk and Assurance Lead and the operational leads. Updates will then continue to be discussed

monthly between the Deputy Director of Governance and Risk and the executive directors.

Refreshed ORR

- 14 risks were kept and reworded to ensure that they fully articulate the risk according to the cause, risk and effect methodology.
- Seven new risks have been created.
- These 21 risks have been provided in full in table 1
- The mapping of the 14 former risks to the refreshed ORR is provided in table 2
- Five risks have been closed or de-escalated, detailed below.

Closed or De-escalated

The following five risks have been removed from the ORR;

Closed

- ORR 25. Staff do not fully engage and embrace the Trusts culture and collective leadership. This is considered closed, all actions have now been completed and the risk has been mitigated to a score of 8 in line with appetite.
- ORR 55. The Leicester/Leicestershire / Rutland system does not deliver the transformation needed to deliver a successful ICS. Working partnerships are now business as usual and work is underway within the system to ensure that governance arrangements are in place to support the transformation.
- ORR 40. The ability of the Trust to deliver high quality care may be affected during a Coronavirus COVID-19 pandemic. This has been superseded by refreshed and new risks 63 (mandatory training), 74 (health and wellbeing) and 75 (waiting times) to allow for more specific reference to where covid is having an impact.
- ORR 56. Delivery of service recovery and workforce restoration will not safeguard the health and wellbeing of our staff and service users. This has been superseded by refreshed risk 74 (health and wellbeing).

De-escalated

- ORR 9. Inability to maintain the level of cleanliness required within the Hygiene Standards. New leadership and management of cleaning teams through the FM Transformation will mitigate this risk. This needs to be supported by local management through Ward Environmental Checklists to inspect cleanliness and IPC requirements aligned to the new National Standards for Cleanliness and will therefore be de-escalated to the Directorate risk registers until the ward audits indicate that the risks have been mitigated at a local level.

Risk Appetite Refresh

The benefit of a Risk Appetite framework is that risks can be identified and quantified in a structured way across the Trust's strategic objectives. This allows for informed choice over taking particular amounts of particular risks, in line with its overall strategy and in contrast to passive risk-taking. The Trust continues to base its risk appetite on the Good Governance Institute risk appetite matrix. This accommodates different types of key risk that can be faced within each of the SUTG bricks and any escalated corporate risk.

To support the ongoing maturity of the appetite framework, and to ensure that appetite is applied consistently, we are introducing a tolerance range (anticipated range of risk scores) for each level of risk on the appetite matrix.

Introduction of tolerance levels

Risk tolerance represents the practical application of risk appetite. The risk appetite statement (provided in full in Appendix 1) involves qualitative statements, risk tolerance operationalises the statements by using quantitative measures to better support the monitoring and review of risk.

Risk tolerance measures the levels of risk taking acceptable to manage the category of risk determined by the risk appetite statement. Essentially, the lower the appetite, the more mitigation required to ensure sufficient controls are in place to manage the risk. These are designed to keep the Trust within the risk appetite and to provide a safety margin to prevent a program from reaching or exceeding its risk capacity. These will be applied automatically based on the appetite level and will support consistency of application across the ORR.

RISK APPETITE LEVEL → RISK TYPES ↓	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2. CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3. OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4. SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk.)	5. SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward planning and responsive systems are robust.
APPETITE	NONE	LOW	MODERATE	HIGH	SIGNIFICANT	
Appetite tolerance	0 - 3	4 - 8	9 - 11	12 - 15	16 - 20	20+

The greater the risk appetite the more assurance we need against the existing controls. Confidence will be gained through appropriate controls being in place that positively affect outcomes and through assurance that the controls are operating effectively.

Risk Summary December 2021

There are 21 risks on the refreshed ORR. Of these, nine have a high current risk score. The table below shows these in order of severity;

ORR SUTG	Title	Current Score
76 **S**	As a result of the introduction of vaccination as a condition of deployment (VCOD), any staff who have not had two doses of covid vaccine by 1 April 2022 will no longer be able to work in roles involving patient contact. This may cause staffing challenges which could impact on patient safety and staff morale/wellbeing	20
60 **S**	A lack of staff with appropriate skills will not be able to safely meet patient care needs, which may lead to poor patient outcomes and experience.	16
61 **S,E**	A high vacancy rate for registered nurses, AHPs, HCSWs and medical staff, is leading to high agency staff usage, which may result in poor quality care and patient harm.	16
65 **E**	The present FM provision does not meet our quality standards or requirements, leading to the inability to provide the full hard and soft Facilities Management and maintenance service within LPT. This impacts compliance, timeliness of maintenance responses and quality of services for patients, staff and visitors.	16
68 **G**	A lack of accessibility and reliability of data reporting and analysis will impact on the Trust's ability to use information for decision making, which may impact on the quality of care provided	16
72 **R**	If we do not have the capacity and commitment to proactively reach out, we	16

	will not fully address health inequalities which will impact on outcomes within our community.	
75 **A**	Increasing numbers of patients on waiting lists and increasing lengths of delay in accessing services will mean that patients may not be able to access the right care at the right time and may lead to poor experience and harm.	16
70 **G**	Inadequate control, reporting and management of the Trust's financial position could mean we are unable to deliver our financial plan and adequately contribute to the LLR system plan, resulting in a breach of LPT's statutory duties and financial strategy (including LLR strategy).	15
71 G	If we do not have a sufficiently detailed financial plan for 2022/23, the Trust will not have clarity over the actions required to deliver the plan, resulting in a plan which is not fit for purpose for the Trust or LLR.	15

- The highest risk profile is within the strategic objective for High **S**tandards, and within the appetite for Quality. This carries a significant tolerance range for the residual risk score of between 16-20.
- All risks on the ORR are being mitigated within the tolerance range. This means that mitigation is on track to bring the residual risk scores in line (or lower than) our appetite.

Proposal

- On-going refinement and maintenance of the ORR

Decision required

- To confirm a level of assurance over the management of strategic risk on the ORR.

Table 1. Refreshed ORR Summary - December 2021

ORR	Risk Title	Tolerance Level	Current Score	Residual Score
57 High **S**tandards	The lack of an embedded clinical and quality governance infrastructure may result in insufficient or inconsistent application of systems and processes, resulting in poor quality care and patient harm.	Significant 16-20 Appetite Quality-Seek	12	8
58 High **S**tandards	Insufficient capacity and capability within the Safeguarding Team may result in restrictions and limitations on service provision, which may result in poor quality care and patient harm.	Significant 16-20 Appetite Quality-Seek	12	8
59 High **S**tandards	As a result of the shortage of SI investigators, SI reports may not be timely, may be poor quality and may lack sufficient learning, which could lead to poor quality care and patient harm.	Significant 16-20 Appetite Quality-Seek	12	8
60 High **S**tandards	A lack of staff with appropriate skills will not be able to safely meet patient care needs, which may lead to poor patient outcomes and experience.	Significant 16-20 Appetite People-Seek	16	12
61 High **S**tandards and **E**quality, Leadership, Culture	A high vacancy rate for registered nurses, AHPs, HCSWs and medical staff, is leading to high agency staff usage, which may result in poor quality care and patient harm.	Significant 16-20 Appetite Quality-Seek	16	12
62 High **S**tandards	Insufficient understanding and oversight of regulatory standards and key lines of enquiry may result in non-compliance and/or insufficient improvement in priority areas, leading to sub-standard care.	Moderate 9-11 Appetite Regulation-Cautious	12	8
63 High **S**tandards and **E**quality, Leadership, Culture	Demand of winter pressures and covid on staff availability to attend mandatory training will lead to poor training compliance, which may lead to poor quality care.	Significant 16-20 Appetite Quality-Seek	12	8
64	If we do not retain existing and/or develop new business	Moderate 9-11	12	9

Transformation	opportunities, we will have less financial sustainability and infrastructure resulting in a loss of income and influence within the LLR system.	Appetite Financial-Cautious		
65 **E**nvironments	The present FM provision does not meet our quality standards or requirements, leading to the inability to provide the full hard and soft Facilities Management and maintenance service within LPT. This impacts compliance, timeliness of maintenance responses and quality of services for patients, staff and visitors.	Significant 16-20 Appetite Quality-Seek	16	12
66 **E**nvironments	The lack of detail around accommodation requirements in strategic business planning, means that the Estates Strategy cannot adequately plan for potential building solutions, leading to an estate configuration which is not fit to deliver high quality healthcare.	Significant 16-20 Appetite Quality-Seek	12	8
67 **E**nvironments	The Trust does not have a Green Plan or identified resource for the green agenda, leading to non-compliance with national requirements which will impact on the environment and the Trust's reputation.	Moderate 9-11 Appetite Regulation-Cautious	12	9
68 Well **G**overned	A lack of accessibility and reliability of data reporting and analysis will impact on the Trust's ability to use information for decision making, which may impact on the quality of care provided.	Moderate 9-11 Appetite Regulation-Cautious	16	12
69 Well **G**overned	If we do not appropriately manage performance, it will impact on the Trust's ability to effectively deliver services, which could lead to poor quality care and poor patient experience.	Moderate 9-11 Appetite Regulatory-Cautious	8	4
70 Well **G**overned	Inadequate control, reporting and management of the Trust's financial position could mean we are unable to deliver our financial plan and adequately contribute to the LLR system plan, resulting in a breach of LPT's statutory duties and financial strategy (including LLR strategy).	Moderate 9-11 Appetite Financial-Cautious	15	10

71 Well **G**overned	If we do not have a sufficiently detailed financial plan for 2022/23, the Trust will not have clarity over the actions required to deliver the plan, resulting in a plan which is not fit for purpose for the Trust or LLR.	Moderate 9-11 Appetite Financial-Cautious	15	10
72 **R**eaching Out	If we do not have the capacity and commitment to proactively reach out, we will not fully address health inequalities which will impact on outcomes within our community.	Significant 16-20 Appetite Quality-Seek	16	12
73 **E**quality, Leadership and Culture	If we don't create an inclusive culture, it will affect staff and patient experience, which may lead to poorer quality and safety outcomes.	Significant 16-20 Appetite People-Seek	12	9
74 **E**quality, Leadership and Culture	As a result of covid 19, winter pressure, service recovery and workforce restoration there is a risk that our staff's health and wellbeing will be compromised, leading to increased sickness levels.	Significant 16-20 Appetite People-Seek	9	6
75 **A**ccess	Increasing numbers of patients on waiting lists and increasing lengths of delay in accessing services will mean that patients may not be able to access the right care at the right time and may lead to poor experience and harm.	Significant 16-20 Appetite Quality-Seek	16	8
76 High **S**tandards	As a result of the introduction of vaccination as a condition of deployment (VCOD), any staff who have not had two doses of covid vaccine by 1 April 2022 will no longer be able to work in roles involving patient contact. This may cause staffing challenges which could impact on patient safety and staff morale/wellbeing	Significant 16-20 Appetite Quality-Seek	20	15
77 Well **G**overned	Without the appropriate level of focus, resource and preparation, the Trust cannot adequately support the National Public Inquiry into the Covid Pandemic, leading to a lack of lessons learned, inability to respond effectively to future situations and major incidents, a failure to comply with the Public Inquiry statute and reputational damage.	Moderate 9-11 Appetite Reputational–Cautious	12	8

Table 2. Mapping former to refreshed ORR risks

SUTG	Former ORR	Risk Treatment	Refreshed ORR
High **S**tandards	ORR 1 The Trust's clinical systems and processes may not consistently deliver harm free care.	Keep and reword	ORR 57 The lack of an embedded clinical and quality governance infrastructure may result in insufficient or inconsistent application of systems and processes, resulting in poor quality care and patient harm.
High **S**tandards	ORR 2 The Trust's safeguarding systems do not fully safeguard patients and support frontline staff and services.	Keep and reword	ORR 58 Insufficient capacity and capability within the Safeguarding Team may result in restrictions and limitations on service provision, which may result in poor quality care and patient harm.
High **S**tandards	ORR 3 The Trust does not learn from incidents and events and does not effectively share that learning across the whole organisation.	Keep and reword	ORR 59 As a result of the shortage of SI investigators, SI reports may not be timely, may be poor quality and may lack sufficient learning, which could lead to poor quality care and patient harm.
High **S**tandards **P**atient Experience	ORR 4 Services are unable to meet 'safe staffing' requirements	Keep and reword	ORR 60 A lack of staff with appropriate skills will not be able to safely meet patient care needs, which may lead to poor patient outcomes and experience.
High **S**tandards	ORR 26 Insufficient staffing levels to meet capacity and demand and provide quality services	Keep and reword	ORR 61 A high vacancy rate for registered nurses, AHPs, HCSWs and medical staff, is leading to high agency staff usage, which may result in poor quality care and patient harm.
High **S**tandards Well **G**overned	ORR 5 Capacity and capability to deliver regulator standards	Keep and reword	ORR 62 Insufficient understanding and oversight of regulatory standards and key lines of enquiry may result in non-compliance and/or insufficient improvement in priority areas, leading to sub-

			standard care.
High **S**tandards and **E**quality, Leadership and Culture	N/A	Create new	ORR 63 Demand of winter pressures and covid on staff availability to attend mandatory training will lead to poor training compliance, which may lead to poor quality care.
Transformation	N/A	Create new	ORR 64 If we do not retain existing and/or develop new business opportunities, we will have less financial sustainability and infrastructure resulting in a loss of income and influence within the LLR system.
Environment	ORR 10 The Trust does not implement planned and reactive maintenance of the estate leading to an unacceptable environment for patients to be treated in	Keep and reword	ORR 65 The present FM provision does not meet our quality standards or requirements, leading to the inability to provide the full hard and soft Facilities Management and maintenance service within LPT. This impacts compliance, timeliness of maintenance responses and quality of services for patients, staff and visitors.
Environment	ORR 11 The current estate configuration does not allow for the delivery of high-quality healthcare	Keep and reword	ORR 66 The lack of detail around accommodation requirements in strategic business planning, means that the Estates Strategy cannot adequately plan for potential building solutions, leading to an estate configuration which is not fit to deliver high quality healthcare.
Environment	N/A	Create new	ORR 67 The Trust does not have a Green Plan or identified resource for the green agenda, leading to non-compliance with national requirements which will impact on the environment and the Trust's reputation.
Well **G**overned	ORR 35 The quality and availability of	Keep and reword	ORR 68 A lack of accessibility and reliability of data reporting and analysis

	data reporting is not sufficiently mature to inform quality decision making		will impact on the Trust's ability to use information for decision making, which may impact on the quality of care provided.
Well **G**overned	ORR 20 Performance management framework is not fit for purpose	Keep and reword	ORR 69 If we do not appropriately manage performance, it will impact on the Trust's ability to effectively deliver services, which could lead to poor quality care and poor patient experience.
Well **G**overned	ORR 54 We are unable to deliver the LPT 2021/22 financial plan, LPT operational plans or LLR system plans	Keep and reword	ORR 70 Inadequate control, reporting and management of the Trust's financial position could mean we are unable to deliver our financial plan and adequately contribute to the LLR system plan, resulting in a breach of LPT's statutory duties and financial strategy (including LLR strategy).
Well **G**overned	N/A	Create new	ORR 71 If we do not have a sufficiently detailed financial plan for 2022/23, the Trust will not have clarity over the actions required to deliver the plan, resulting in a plan which is not fit for purpose for the Trust or LLR.
Reaching Out	N/A	Create new	ORR 72 If we do not have the capacity and commitment to proactively reach out, we will not fully address health inequalities which will impact on outcomes within our community.
Equality, Leadership and Culture	ORR 24 Failure to deliver workforce equality, diversity and inclusion	Keep and reword	ORR 73 If we don't create an inclusive culture, it will affect staff and patient experience, which may lead to poorer quality and safety outcomes.
Equality, Leadership and Culture	ORR 27 The health and wellbeing of our staff is not maintained and	Keep and reword	ORR 74 As a result of covid 19, winter pressure, service recovery and workforce restoration there is a risk that our staff's health and

	improved		wellbeing will be compromised, leading to increased sickness levels.
Access	ORR 28 Delayed access to assessment and treatment impacts on patient safety and outcomes	Keep and reword	ORR 75 Increasing numbers of patients on waiting lists and increasing lengths of delay in accessing services will mean that patients may not be able to access the right care at the right time and may lead to poor experience and harm.
High **S**tandards	N/A	Create new	ORR 76 As a result of the introduction of vaccination as a condition of deployment (VCOD), any staff who have not had two doses of covid vaccine by 1 April 2022 will no longer be able to work in roles involving patient contact. This may cause staffing challenges which could impact on patient safety and staff morale/wellbeing
Well **G**overned	N/A	Create new	ORR 77 Without the appropriate level of focus, resource and preparation, the Trust cannot adequately support the National Public Inquiry into the Covid Pandemic, leading to a lack of lessons learned, inability to respond effectively to future situations and major incidents, a failure to comply with the Public Inquiry statute and reputational damage.

Leicestershire Partnership NHS Trust

Appendix One – Risk Appetite Matrix and Statement

RISK APPETITE LEVEL → RISK TYPES ↓	0 NONE Avoidance of risk is a key organisational objective.	1 MINIMAL Preference for very safe delivery options that have a low degree of inherent risk and only a limited reward potential.	2. CAUTIOUS Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential.	3. OPEN Willing to consider all potential delivery options and choose while also providing an acceptable level of reward.	4. SEEK Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk.)	5. SIGNIFICANT Confident in setting high levels of risk appetite because controls, forward planning and responsive systems are robust.
FINANCIAL → How will we use our resources?	We have no appetite for decisions or actions that may result in financial loss.	We are only willing to accept the possibility of very limited financial risk.	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	We are prepared to accept some financial risk as long as appropriate controls are in place. We have a holistic understanding of VFM with price not the overriding factor.	We will invest for the best possible return and accept the possibility of increased financial risk.	We will consistently invest for the best possible return for stakeholders, recognising that the potential for substantial gain outweighs inherent risks.
REGULATORY → How will we be perceived by our regulator?	We have no appetite for decisions that may compromise compliance with statutory, regulatory of Policy requirements.	We will avoid any decisions that may result in heightened regulatory challenge unless absolutely essential.	We are prepared to accept the possibility of limited regulatory challenge. We would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some regulatory challenge as long as we can be reasonably confident we would be able to challenge this successfully.	We are willing to take decisions that will likely result in regulatory intervention if we can justify these and where the potential benefits outweigh the risks.	We are comfortable challenging regulatory practice. We have a significant appetite for challenging the status quo in order to improve outcomes for stakeholders.
QUALITY → How will we deliver safe services?	We have no appetite for decisions that may have an uncertain impact on quality outcomes.	We will avoid anything that may impact on quality outcomes unless absolutely essential. We will avoid innovation unless established and proven to be effective in a variety of settings.	Our preference is for risk avoidance. However, if necessary, we will take decisions on quality where there is a low degree of inherent risk and the possibility of improved outcomes, and appropriate controls are in place.	We are prepared to accept the possibility of a short-term impact on quality outcomes with potential for longer term rewards. We support innovation.	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	We seek to lead the way and will prioritise new innovations, even in emerging fields. We consistently challenge current working practices in order to drive quality improvement.
REPUTATIONAL → How will we be perceived by the public and our partners?	We have no appetite for decisions that could lead to additional scrutiny or attention on the organisation.	Our appetite for risk taking is limited to those events where there is no chance of significant repercussions.	We are prepared to accept the possibility of limited reputational risk if appropriate controls are in place to limit any fallout.	We are prepared to accept the possibility of some reputational risk as long as there is the potential for improved outcomes for our stakeholders.	We are willing to take decisions that are likely to bring scrutiny of the organisation. We outwardly promote new ideas and innovations where potential benefits outweigh the risks.	We are comfortable to take decisions that may expose the organisation to significant scrutiny or criticism as long as there is commensurate opportunity for improved outcomes for our stakeholders.
PEOPLE → How will we be perceived by the public and our partners?	We have no appetite for decisions that could have a negative impact on our workforce development, recruitment and retention. Sustainability is our primary interest.	We will avoid all risks relating to our workforce unless absolutely essential. Innovative approaches to workforce recruitment and retention are not a priority and will only be adopted if established and proven to be effective elsewhere.	Wea are prepared to take limited risks with regards to our workforce. Where attempting to innovate, we would seek to understand where similar actions had been successful elsewhere before taking any decision.	We are prepared to accept the possibility of some workforce risk, as a direct result from innovation as long as there is the potential for improved recruitment and retention, and developmental opportunities for staff.	We will pursue workforce innovation. We are willing to take risks which may have implications for our workforce but could improve the skills and capabilities of our staff. We recognise that innovation is likely to be disruptive in the short term but with the possibility of long-term gains.	We seek to lead the way in terms of workforce innovation. We accept that innovation can be disruptive and are happy to use it as a catalyst to drive a positive chain.

Leicestershire Partnership NHS Trust

Governance Table

For Board and Board Committees:	Trust Board 21 December 2021	
Paper sponsored by:	Chris Oakes, Director of Governance and Risk	
Paper authored by:	Kate Dyer, Deputy Director of Governance and Risk	
Date submitted:	13 December 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):	QAC / FPC November 2021 (excluding full slide pack)	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Green	
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	
STEP up to GREAT strategic alignment*:	High **S**tandards	Yes
	Transformation	Yes
	Environments	Yes
	Patient Involvement	Yes
	Well **G**overned	Yes
	Reaching Out	Yes
	Equality, Leadership, Culture	Yes
	Access to Services	Yes
	Trust wide Quality Improvement	Yes
Organisational Risk Register considerations:	All	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	

Risk No: 57	Date included	29 November 2021	Date revised	8/12/2021
Objective: S	High Standards			
Risk Title:	The lack of an embedded clinical and quality governance infrastructure may result in insufficient or inconsistent application of systems and processes, resulting in poor quality care and patient harm.			
Risk owner:	Exec: Director of Nursing, AHPs and Quality and Medical Director	Local: Associate Director of AHPs and Quality		
Governance:	Quality Forum, QAC / Board - monthly review			

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

Tolerance level Significant 16-20 (Appetite Quality-Seek)

Controls	Description:	• Policies and procedures in place for delivery against all CQC Registration and Health and Social Care act requirements (i.e. core standards) • Clinical and quality governance model - systems and processes • Corporate Governance structures (3-tiered model) • Clinical quality teams in place to support delivery against core standards – corporate and directorate
	Gaps:	• Final implementation of clinical Quality Governance management of change • Integration and embeddedness of the model consistently across all clinical directorates

Assurances	Internal:	Source • Quality Forum and QAC • SEB/OEB • DMTs	Evidence: • Monthly and Bi-Monthly oversight/escalation reports from level 3 committees. • SEB/OEB regular quality and safety agenda • DMTs – Regular quality reports to DMT	Assurance Rating Green
	External:	Source • CQC Inspection (2021) • Internal Audit	Evidence: • CQC identified weaknesses with local governance processes. • Management of Fixed Ligature Points – Split assurance	Assurance Rating Amber
	Gaps:	• Outstanding Internal audit reports • Weaknesses in governance processes identified by CQC • Consistency of DMT reporting – substance and regularity.		

	Date:	Actions:	Action Owner:	Progress:	Status
Actions	Mar 22	Embed revised clinical and quality governance infrastructure.	Associate Director of AHPs and Quality (DR)	• Management of change complete – recruitment to be finalised	Amber
	Mar 22	Delivery of CQC Must Do actions		• CQC action plan in place	
	Jan 22	Develop year long programme for the review of current structures to ensure integration		• Initial review initiated	

Risk No: 58	Date included	29 November 2021	Date revised	7th December 2021		Consequence	Likelihood	Combined
Objective: S	High Standards / Sub objective: Safeguarding and Public Protection				Current Risk	4	3	12
Risk Title:	Insufficient capacity and capability within the Safeguarding Team may result in restrictions and limitations on service provision, which may result in poor quality care and patient harm.				Residual Risk	4	2	8
Risk owner:	Exec: Director of Nursing, AHPs and Quality		Local: Head of Safeguarding		Tolerance level Significant 16-20 (Appetite Quality-Seek)			
Governance:	Safeguarding Committee / QAC / Board - Monthly Review							

Controls	Description	• Identified Safeguarding Lead Nurses & Practitioners -Child Lead, Adult Lead) and named Doctor for safeguarding children. • Member of four local Safeguarding Boards, two Community Safety Partnerships and the Safeguarding Vulnerabilities group. • Adult and Children's Safeguarding Team in place. • Advice line and use of incident reporting system to raise high priority safeguarding issues for specialist oversight by safeguarding team.		
	Gaps:	• The safeguarding training offer is not fully compliant with national standards and guidelines.		
Assurances	Internal:	Source: • Legislative Committee and Safeguarding Committee / QAC • Annual Quality Account. • The identified Safeguarding Lead Nurses access safeguarding supervision 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 Green
	External:	Source: • External review by quarterly SAT return to the CCG • CQC Inspection 2021 • 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: • Findings of external review • CQC identified no major safeguarding concerns feedback from the CQC report published 10th November 2021. • Local Safeguarding Board reports and minutes	Assurance Rating Amber
	Gaps:	• Training figures		

Actions	Date:	Actions:	Action Owner:	Progress:	Status
	Ongoing Mar 22 Jan 22	• 2021 -2023 work programme to be implemented • Implement and embed recommendations from the external review. • Training capacity and offer to be reviewed	All - Safeguarding Dept	• Work programme approved safeguarding committee (08/12/2021) • Action from external review on track • The training offer reintroduces face to face training from January 2022. This is blended with e-learning.	Amber

Risk No: 59	Date included	29 November 2021	Date revised	10/12/2021		Consequence	Likelihood	Combined
Objective: S	High Standards				Current Risk	4	3	12
Risk Title:	As a result of the shortage of SI investigators, SI reports may not be timely, may be poor quality and may lack sufficient learning, which could lead to poor quality care and patient harm.				Residual Risk	4	2	8
Risk owner:	Exec: Director of Nursing, AHPs and Quality		Local: Head of Patient Safety		Tolerance level Significant 16-20 (Appetite Quality-Seek)			
Governance:	IOG, Quality Forum, QAC / Board - Monthly Review							

Controls	Description:	• Centralised SI reporting and oversight process • Incident reporting policy • Recruited additional SI investigators • Governance arrangements for escalation		
	Gaps:	• Timely and high-quality SI investigations • CQC feedback The trust must ensure that managers review incident in a timely way, in line with trust policy. (Reg17 (1))		
Assurances	Internal:	Source: • Incident Oversight Group -Quality Forum • Quality Assurance Committee	Evidence: • Incident oversight Group – November 2021 highlight report limited assurance • Quality Forum - patient safety monthly report Nov 2021 – highlight report limited assurance • QAC – Quality Forum November 2021 – highlight report limited assurance	Assurance Rating Amber
	External:	Source: • CQC Inspection 2021 • CCG sign off and feedback for SI reporting	Evidence: • CQC Inspection timeliness of notification of incidents • CCG – number of reports signed off / number returned for additional work	Assurance Rating Amber
	Gaps:	• Internal assurance / evidence to demonstrate the learning		

Actions	Date:	Actions:	Owner:	Progress:	Status
	Dec 21	Operationalise the newly recruited SI investigators	T.Ward	All investigators in post and going through induction	Amber
	Mar 22	Delivery of CQC actions –must do 16	F.Myers and Michelle Churchard		
	Ongoing	Incident investigation training monthly rolling programme	T.Ward		

Risk No: 60	Date included	29 November 2021	Date revised	7.12.21		Consequence	Likelihood	Combined
Objective: S	High Standards				Current Risk	4	4	16
Risk Title:	A high vacancy rate for registered nurses, AHPs, HCSWs and medical staff, is leading to high agency staff usage, which may result in poor quality care and patient harm.				Residual Risk	4	3	12
Risk owner:	Exec: Director of Nursing, AHPs and Quality		Local: Associate Director of Nursing and Professional Practice		Tolerance Level Significant 16-20 (Appetite People-Seek)			
Governance:	Quality Forum, SWC/QAC /Board - Monthly Review							

Controls	Description:	• NHS Developing Workforce Safeguards standards incorporated into monthly staffing reviews • Directorate safe staffing SOPs in place for business continuity, escalation and management including deployment of bank and agency staffing • Dedicated workforce and safe staffing matron and an international recruitment matron • Trust retention and attraction schemes • LLR System and LWAB working together on system initiatives • Flexible working guidance launched • Home first - Aging well started / Community Service Redesign Aging well recruitment • International recruitment – 30 nurses recruited by end December 2021 with a second bid to recruit a further 48 IR nurses by March 2023 • eRoster – early winter planning and roster sign off		
	Gaps:	• National workforce shortages – particularly in LD, mental health and community nursing. • Workforce Planning capacity • Medical Consultant capacity in AMH/CAMHS • Trust wide Safe Staffing policy		
Assurances	Internal:	Source: Winter Preparedness 2021 Nursing Safer Staffing BAF November 2021 National safe staffing return 6 monthly establishment reviews Monthly safe staffing reports to QAC/Trust Board Weekly staffing meeting	Evidence: • Self-assessment complete 4 key themes to enhance assurance, action plan developed • 16 of each month date of last national submission • July 2021 date of last 6 monthly establishment review, submitted to QAC in July 2021, then Trust Board in August 2021 • Staffing report Oct/Nov. Highlight report from QAC significant assurance • Weekly situational and forecast staffing meeting – updates and actions to assurance to Director of Nursing	Assurance Rating Green
	External:	Source: • The Department of Health and Social Care's group annual governance statement – NHSI • CQC Inspection 2021	Evidence: • Noted in the organisational risk and monthly reporting.	Assurance Rating Green
	Gaps:			

Actions	Date:	Actions:	Action Owner:	Progress:	Status
	Jan 22 Jan 22 Jan 22 Dec 21	• Proposal for super enhancing recruitment and attraction campaign • All age MH standard recruitment to working planning capacity • To develop a Trust wide safe staffing policy • To develop a Trust wide local induction checklist for bank and agency staff	John Edwards Elaine Curtin Louise Evans	Ongoing Policy drafted, currently under consultation Task and finish group set up	Amber

Risk No: 61	Date included	29 November 2021	Date revised	7/12/21
Objective: S	High Standards and Equality, Leadership, Culture			
Risk Title:	A lack of staff with appropriate skills will not be able to safely meet patient care needs, which may lead to poor patient outcomes and experience.			
Risk owner:	Exec: Director of Nursing, AHPs and Quality and Director of HR & OD	Local: Head of Education, Training and Development		
Governance:	SWC, QAC / Board - Monthly Review			

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

Tolerance level Significant 16-20 (Appetite Quality-Seek)

Controls	Description:	• Mandatory and Role Essential Training Policy, Study Leave Policy • National and local People Plan • Safer staffing policies and guidance • MHOST tool for review of patient acuity and dependency measurement • E rostering in place across inpatient services and community • Auto planner within CHS • On-going recruitment programme • E rostering in place across inpatient services and community • Auto planner within CHS		
	Gaps:	• National tools to measure therapy staffing for patient acuity and dependency		
Assurances	Internal:	Source: • SWC , Directorate Workforce groups , retention working group • Quarterly workforce triangulation going to ops exec to review hotspots and take action • Workforce and Wellbeing Board • Transformation committee • Hotspots identified on Directorate Risk Registers • Weekly safe staffing meeting	Evidence: • Mandatory Training and Role Essential Training Flash Report (December) • Noc trust board and SEB deep dive • Directorate risk registers received at DMTs • Quarterly triangulation document to Exec Team with action plan.	Assurance Rating Green
	External:	Source: • NHS retention support and benchmarking data	Evidence:	Assurance Rating Green
	Gaps:			

	Date:	Actions:	Action Owner:	Progress	Status
Actions	Jan 22 Jan 22 Jan 22 Dec 21 March 22	1. New process for amending compliance requirements to position numbers 2. Remove 6 month topic refresher extension from 1st January 3. Recovery of Mandatory Training compliance action log reported to Training Education and Development Group monthly 4. Manager compliance and DNA reports live on ulearn 5. Pilot safe care and review establishment	Head of Education Training/Dev Amrik Singh / Emma Wallis	Since previous month -improvement seen in resus courses by 2-3%, drop in compliance with MAPA course by 2-3 % Overall Trust position for all mandatory topics (including e-learning) remains good Received at ops exec and actions underway underway	Amber

Risk No: 62	Date included	29 November 2021	Date revised	6 December 2021		Consequence	Likelihood	Combined
Objective: S	High Standards				Current Risk	4	3	12
Risk Title:	Insufficient understanding and oversight of regulatory standards and key lines of enquiry may result in non-compliance and/or insufficient improvement in priority areas, leading to sub-standard care.				Residual Risk	4	2	8
Risk owner:	Exec: Director of Nursing, AHPs and Quality		Local: Lead for Quality, Compliance and Regulation		Tolerance Level Moderate 9-11 (Appetite Regulation-Cautious)			
Governance:	Foundation for GPC, Quality Forum, QAC / Board - Monthly Review							

Controls	Description:	• Quality Improvement work programme / Quality accreditation • Foundation for Great Patient Care with KLOEs driving the agenda • Quality Surveillance Tracker • Core standards training / 3 phased methodology • Trust self-assessment for KLOE/Well Led framework • CQC inspection preparation checklist • Procedure for responding to a CQC Inspection • Time to Shine Booklet and Training • Well Led information pack		
	Gaps:	• Embedded clinical and quality governance framework to support directorate well led and KLOE improvement		
Assurances	Internal:	• Quality surveillance tracker • CQC action plan • Weekly CQC action plan assurance meeting • Foundation for great patient care / Quality forum / QAC / Trust Board • 15 Steps • Feedback from Focus Groups • Patient feedback	Evidence: • QST • CQC action plan	Assurance Rating Green
	External:	Source: • CQC Inspection 2021 • External Audit value for money conclusion 2020/21	Evidence: CQC overall rating Requires Improvement	Assurance Rating Amber
	Gaps:			

Actions	Date: Multiple Jan 22	Actions: • Delivery of actions on the CQC action plan. Must and Should Do's • Redesign Foundation for Great Patient Care to ensure cross Trust learning of actions arising from the CQC action plan.	Action Owner: Deanne Rennie/Jane Howden	Progress: Ongoing	Status: Amber

Risk No: 63	Date included	29 November 2021	Date revised	7th Dec 2021			
Objective: S	High Standards and Equality, Leadership & Culture						
Risk Title:	Demand of winter pressures and covid on staff availability to attend mandatory training will lead to poor training compliance, which may lead to poor quality care.						
Risk owner:	Exec: Director of Nursing, AHPs and Quality and Director of HR & OD		Local: Head of Education, Training and Development				
Governance:	Foundation for GPC, Quality Forum, QAC / Board - Monthly Review						

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

Tolerance Level Significant 16-20 (Appetite Quality-Seek)

Controls	Description:	• Policy for Mandatory and Role specific training • ULearn live reporting on compliance • Monthly flash reports • Weekly compliance reports • Increased trainer capacity • Rostering and deployment of staff		
	Gaps:	• Covid secure training spaces • Winter pressures		
Assurances	Internal:	Source: Operational exec Training and education group ted QAC Safe staffing reports monthly Weekly staffing reviews DMT review in workforce meetings	Evidence: SWC spc charts November 2021 (amber assurance rating) Workforce Reports to DMTs monthly Flash reports weekly QAC performance report – November 2021 (amber assurance rating) workforce triangulation quarterly to Exec Team to consider hots spots with action plan	Assurance Rating Amber
	External:	Source:	Evidence:	Assurance Rating
	Gaps:			

Actions	Date: April 22	Actions: Implement Bank staff action to stop booking shifts until compliance is achieved	Owner Amrik Singh	Progress: Ongoing	Status Amber

Risk No: 64	Date included	29 November 2021	Date revised	7 December 2021		Consequence	Likelihood	Combined
Objective: T	Transformation				Current Risk	4	3	12
Risk Title:	If we do not retain existing and/or develop new business opportunities, we will have less financial sustainability and infrastructure resulting in a loss of income and influence within the LLR system.				Residual Risk	3	3	9
Risk owner:	Exec: Director of Strategy and Business Development		Local: Head of Strategy		Tolerance Level Moderate 9-11 (Appetite Financial-Cautious)			
Governance:	Transformation Committee / FPC / Board - Monthly Review							

Controls	Description:	• Engagement and support to LLR wide system strategy meetings, including ICB/ICP meetings, system executive meetings, local authority scrutiny and health and well-being board meetings. • A clear Step Up to Great Strategy (SUTG) developed and shared with stakeholders. The SUTG strategy sets out a 3 year vision and is supported by an annual operational delivery plan. This annual delivery plan enables a regular conversation with our stakeholders to understand our changing environments. • Engagement and support by LPT to the development of models of Integrated Care within LLR		
	Gaps:	• SUTG delivery plans		
Assurances	Internal:	Source: Transformation Committee Joint Working Group (JWG) of LPT & NHFT Executive, board meetings & board development sessions	Evidence: Transformation Committee will review progress of internal transformational priorities. JWG reviews progress on key joint priorities. Executive, Board meetings and development sessions include a focus on our strategic priorities and transformation. Evidence available in papers, agenda and minutes	Assurance Rating Green
	External:	Source: Internal Audit HOIAO Feedback from NHS E/I Feedback from stakeholders (CQC, CCG/ICB & local authorities) Attendance at local authority scrutiny meetings	Evidence: Formal feedback from audit opinion, formal meetings and our stakeholder feedback.	Assurance Rating Green
	Gaps:	Further building of our work with voluntary and community organisations		

Actions	Date:	Actions:	Owner:	Progress:	Status
	Jan 22	SUTG delivery plans	David Williams	In draft currently (December 2021)	Green
	Ongoing	Regular attendance at ICS Board meetings, transition and steering groups	Chair & CEO	Achieving (this action will be on-going)	

Risk No: 65	Date included	29 November 2021	Date revised	10/12/21
Objective: E	Environments			
Risk Title:	The present FM provision does not meet our quality standards or requirements, leading to the inability to provide effective hard and soft Facilities Management and maintenance services. This impacts compliance, timeliness of maintenance responses and quality of estates provision for patients, staff and visitors.			
Risk owner:	Exec: Chief Finance Officer		Local: Associate Director Estates & Facilities	
Governance:	Estates Committee, FPC / Board - Monthly Review			

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

Tolerance Level Significant 16-20 (Appetite Quality-Seek)

Controls	Description:	• FM Business Case approved by the Board • Legal Exit Agreement in progress • FM Transformation Programme compliance and business case capacity through external contract • Relentless focus on driving up standards, with governance through EMEC • Increased property manager capacity to work with Operational teams on estates management • Compliance manager in post to oversee the data provided by contractors and escalate high risk areas requiring maintenance
	Gaps:	• Exit legal agreement and staff engagement sessions via UHL as employer • Data on compliance has been very slow to be provided through our contract • Lack of supplier ownership and proactive management of estates risks • Poor KPIs performance with maintenance and repairs are not always undertaken in a timely manner

Assurances	Internal:	Source: FM Oversight Group FM Transformation Board Estates and Medical Equipment Committee FPC Estates risk register	Evidence: • Provider service review meetings • Ongoing review of audit actions • Monthly estates updates including health and safety reviews • FPC estates updates	Assurance Rating Green
	External:	Source: • CQC inspection 2021	Evidence: • CQC report	Assurance Rating Amber
	Gaps:	• Unable to obtain detailed report and assurance over planned preventative maintenance leaving the Trust unable to apply suitable mitigations • Joint staff communications and engagement to support TUPE		

Actions	Date: Jan 22	Actions: • Exit agreement to be agreed and staff engagement/ TUPE sessions jointly planned.	Action Owner: Richard Wheeler	Progress: In progress

Status: Green

Risk No: 66	Date included	29 November 2021	Date revised	10/12/21		Consequence	Likelihood	Combined
Objective: E	Environments				Current Risk	4	3	12
Risk Title:	The lack of detail around accommodation requirements in strategic business planning, means that the Estates Strategy cannot adequately plan for potential building solutions, leading to an estate configuration which is not fit to deliver high quality healthcare.				Residual Risk	4	2	8
Risk owner:	Exec: Chief Finance Officer		Local: Associate Director Estates & Facilities		**Tolerance** level Significant 16-20 (Appetite Quality-Seek)			
Governance:	Estates Committee, FPC / Board - Monthly Review							

Controls	Description:	• Approved Strategic plan for the elimination of dormitory accommodation • New Hospitals Programme (NHP) Expression of Interest submitted • Refresh of Mental Health inpatient Strategic Outline Case and bed modelling • Tripe R outputs • Estates Strategy refresh in progress • Capital resource prioritisation framework • Refreshed SUTG strategy 2021		
	Gaps:	• Clarity on clinical model changes and mental health expansion estates impact • Finalised estates strategy and delivery plan • Directorate and enabling business plans		
Assurances	Internal:	Source: • Strategic Property Group • Estates and Medical Equipment Committee • Finance and Performance Committee • Health and Safety Committee. Directorate Health and Safety Action Groups	Evidence: • Reports to EMEC • Consideration of estates strategy with directorates • Monthly report to FPC on progress against the Estate Strategy • Health and Safety Reports and confirmation of compliance	Assurance Rating Green
	External:	Source: • CQC Inspection 2021 • Consideration of NHP expression of interest	Evidence: • CQC report • NHSEI	Assurance Rating Amber
	Gaps:			

Actions	Date: Ongoing Jan 22	Actions: • Implementation of Dormitory Eradication programme. • Estates delivery plan	Action Owner: Richard Brown Richard Brown	Progress: • Complex project on plan • In draft	Status Green

Risk No: 67	Date included	29 November 2021	Date revised	10 December 2021	
Objective: E	Environments				
Risk Title:	The Trust does not have a Green Plan or identified resource for the green agenda, leading to non-compliance with the NHS commitment to NHS Carbon Zero.				
Risk owner:	Exec: Chief Finance Officer		Local: Chief Finance Officer		
Governance:	Estates Committee, FPC / Board - Monthly Review				

	Consequence	Likelihood	Combined
Current Risk	3	4	12
Residual Risk	3	3	9

Tolerance Level Moderate 9-11 (Appetite Regulation-Cautious)

Controls	Description:	• Chief Finance Officer asked to take the Executive lead in November 2021. • Self assessment undertaken on the Green Plan requirements. • Consideration of the requirements and self assessment through Board Development and Strategic Executive Board sessions • Chapter provisional leads identified • LLR Greener NHS Board authentic representation of the position and request for support made • Job Descriptions drafted for Head of Sustainability, and Sustainability Manager (potential secondment/development role)
	Gaps:	• Lack of data on carbon footprint • Lack of historic Sustainable Development Management Plan • Corporate Social Responsibility Strategy 2016 – 2021 not implemented • Chapter leads to be confirmed • Job Descriptions awaiting banding and funding approval • 100% renewable energy to be purchased from 1 April 2021, work is in progress to move over to this.

Assurances	Internal:	Source:	Evidence:	Assurance Rating
	External:	Source: Request to LLR Greener Board for support Work to share across the Group with NHFT knowledge and experience on sustainability	Evidence: Greener Board – November 2021 Committees in Common – November 2021	Assurance Rating
	Gaps:			

Actions	Date: Dec 21 Mar 22 Jan 22	Actions: Funding approval for sustainability posts Outline chapters drafted and shared with provisional chapter leads Consideration of PMO support	Action Owner:	Progress: Currently with banding panel CFO taking the lead on research to support draft chapters Support to establish a structure programme across estates	Status Amber

Risk No: 68	Date included	29 November 2021	Date revised	02/12/21
Objective: G	Well Governed			
Risk Title:	A lack of accessibility and reliability of data reporting and analysis will impact on the Trust's ability to use information for decision making, which may impact on the quality of care provided.			
Risk owner:	Exec: Director of Finance & Performance		Local: Head of Information	
Governance:	FPC / Board - Monthly Review			

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

Tolerance Level Moderate 9-11 (Appetite Regulatory-Cautious)

Controls	Description:	• Executive senior information risk officer (SIRO) sponsorship • Information asset owners in place • Clinical system training in place • Performance management framework (which includes the 6 dimensions of data quality) • Data quality policy and procedure
	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 • Capacity of the information team due to demands from national sitrep reporting, changes to information team members

Assurances	Internal:	Source: • Performance review meetings include Directorate level metrics • 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 committee • Local Risk register	Evidence: • DSPT 'standards met' annual submission made in June 2021 • Data quality action reported to FPC via Data Privacy Committee highlight report – assurance rating Green (November) - Local risks reviewed in Data Quality Committee	Assurance Rating Green
	External:	Source: • Annual benchmark reporting against peers • Internal audit programme for data quality and reporting • Internal audit review of our data security and protection toolkit (DSPT) • Commissioner scrutiny	Evidence: • Data quality framework 21/22 audit due Q4 • DSPT 21/22 audit due Q1 2022/23 (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 • External Account (quality account indicators) Not undertaken for 19/20 or 20/21		

	Date:	Actions:	Action Owner:	Progress:	Status
Actions	Feb 22	• Delivery of 21/22 data quality work plan, including trust wide ownership of data quality	SM	On track	Amber
	Feb 22	• New data quality kite mark implementation	SM	On track	
	Feb 22	• Review of system 1 data quality live issues in Data Quality Committee	SM	On track	
	Apr 22	• External audit of quality accounts	SM		

Risk No: 69	Date included	29 November 2021	Date revised	02/012/21		Consequence	Likelihood	Combined
Objective: G	Well Governed				Current Risk	4	2	8
Risk Title:	If we do not appropriately manage performance, it will impact on the Trust's ability to effectively deliver services, which could lead to poor quality care and poor patient experience.				Residual Risk	4	1	4
Risk owner:	Exec: Director of Finance & Performance		Local: Director of Finance & Performance		Tolerance Level Moderate 9-11 (Appetite Regulatory-Cautious)			
Governance:	FPC / Board - Monthly Review							

Controls	Description:	• Board approved Performance management framework • Board level performance dashboard • Revised governance framework • SUTG plan • SOP in place		
	Gaps:	• 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 / Trust Board reports • Bi monthly Performance review meetings • Simplified, directorate owned, board reporting and an agreed set of 2021/22 KPIs for the Board	Evidence: • Routine performance reporting with committee dashboards to FPC / QAC /Board – assurance rating amber (November) • Actions & risks from performance reviews reported to Board • Performance reports narrative updated by Directorate Business Managers prior to release.	Assurance Rating Amber
	External:	Source: • CQC inspection 2021 • External and internal audit	Evidence: • Internal audit review of performance framework being undertaken Q3 21/22.	Assurance Rating Green
	Gaps:	• Fully embedded system (demonstrated once level 2 dashboards are fully implemented) • Trust wide approach to reporting planned post covid performance & capacity		

	Date:	Actions:	Action Owner:	Progress:	Status
Actions	Jan 22	• Revised Board performance report implementation	SM	Report delayed due to technical issue with SPC chart reporting	Amber
	Feb 22	• Consider ORR links to performance report	SM/KD	Revised date of February 2022 for the ORR links to the performance report, to be led by the new Risk and	
	Dec 21	• Review of Information Team capacity & delivery model	SM	Assurance Lead now in post.	
	April 22	• Quality accounts reporting & management of actions	SM	Options paper going to OEB 17/12/21	

Risk No: 70	Date included	29 November 2021	Date revised	02/12/21
Objective: G	Well Governed			
Risk Title:	Inadequate control, reporting and management of the Trust's 2021/22 financial position could mean we are unable to deliver our financial plan and adequately contribute to the LLR system plan, resulting in a breach of LPT's statutory duties and financial strategy (including LLR strategy).			
Risk owner:	Exec: Director of Finance & Performance		Local: Deputy Director of Finance	
Governance:	FPC / Board monthly			

	Consequence	Likelihood	Combined
Current Risk	5	3	15
Residual Risk	5	2	10

Tolerance Level Moderate 9-11 (Appetite Financial-Cautious)

Controls	Description:	• National H2 planning guidance • LPT Financial & Operational Plan • Standing Financial Instructions • Treasury management policy , cash flow forecasting • Capital Financing strategy & plan • LPT & LLR Financial strategy
	Gaps:	• Culture change required across system partners, particularly for UHL to move away from PBR funding model

Assurances	Internal:	Source: • Audit Committee • Operational oversight & management of cost forecasts through Directorate Management Teams • Capital Management Committee's oversight of capital delivery and agreed governance processes; • Finance and Performance Committee report includes I & E, cash & capital reporting	Evidence: • Reports & updates from Internal & external auditors • Monthly Director of Finance report to FPC / Trust Board – highlight report assurance rating Green (November)	Assurance Rating Green
	External:	Source: • KPMG audit of 20/21 annual accounts and value for money conclusion • Internal Audit Report 2021/22: Key financial systems • Internal Audit Report 2021/22: Integrity of the general ledger and financial reporting • Internal Audit Report 2021/22: Capital expenditure processes	Evidence: • 2020/21 annual accounts unqualified opinion • Significant assurance • Report due Q4 • Report due Q4	Assurance Rating Green
	Gaps:			

	Date:	Actions:	Action Owner:	Progress:	Status
Actions	Mar 22	Ongoing oversight and management of all aspects of financial position against plans	SM	On track	Green
	Mar 22	Monthly reports to OEB/SEB/FPC/Board/ICS finance committee on all aspects of delivery against plan	SM	On track	

Risk No: 71	Date included	29 November 2021	Date revised	02/12/21
Objective: G	Well Governed			
Risk Title:	If we do not have a sufficiently detailed financial plan for 2022/23, the Trust will not have clarity over the actions required to deliver the plan, resulting in a plan which is not fit for purpose for the Trust or LLR.			
Risk owner:	Exec: Director of Finance & Performance		Local: Deputy Director of Finance	
Governance:	FPC / Board monthly			

	Consequence	Likelihood	Combined
Current Risk	5	3	15
Residual Risk	5	2	10

Tolerance Level Moderate 9-11 (Appetite Financial-Cautious)

Controls

Description:

- LPT & LLR system 4-year financial strategy defines plan deliverables
- LPT Financial & Operational Planning process supports plan development
- H1 & H2 financial plan forecasts a breakeven position for LPT & LLR system, ensuring solid foundations for 22/23 planning
- Agreed prioritisation criteria for internal investments
- LLR Triple lock process for system funded investments
- Transformation Committee oversight of efficiency plan development
- Capital Management Committee develops the capital plan with input from key estates & I, M & T leads & prioritises schemes against agreed criteria
- Standing Financial instructions underpin planning approach

Gaps :

- System wide approach to financial planning & in year management is new & untested
- 2022/23 Planning guidance not published yet
- Trust's transformation & value approach to identifying efficiencies is new
- LLR Design groups ability to identify & deliver sufficient savings
- No long covid or post covid MH changes to demand are included in current plans
- Culture change required across system partners, particularly for UHL to move away from PBR funding model
- LLR capital strategy not yet defined

Assurances

Internal:	Source: • Plan reports for committees includes I & E, cash, efficiency & capital plans to deliver against NHSI guidance , statutory requirements and the LPT & LLR financial strategy	Evidence: • Draft plans will be presented to OEB, SEB, FPC & Trust Board December – March • Efficiency plans continue to be presented to Transformation Committee • Final Trust board plan sign off target date 29/03/22	Assurance Rating Green
External:	Source: • ICS Finance committee with Executive & Non-Executive leads from each NHS LLR organisation • ICB sign off of ICS financial plan • NHSI acceptance of submitted plan	Evidence: Highlight report presented to ICB Minutes of meeting	Assurance Green
Gaps :			

Actions

Date:	Actions:	Action Owner:	Progress:	Status
Jan 22	Develop 22/23 operational & finance plans following planning guidance publication	SM	On track	Green
	Trust Board approval of 2022/23 plans	SM		
Mar22	Submit LPT finance, activity, workforce & performance plans to ICS/NHSI	CP	On track	
TBC				

Risk No: 72	Date included	29 November 2021	Date revised	7 December 2021
Objective: R	Reaching Out			
Risk Title:	If we do not have the capacity and commitment to proactively reach out, we will not fully address health inequalities which will impact on outcomes within our community.			
Risk owner:	Exec: Director of Strategy and Business Development		Local: Head of Strategy	
Governance:	Transformation Committee / FPC bi-monthly / Board Quarterly			

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

Tolerance Level Significant 16-20 (Appetite Quality-Seek)

Controls	Description:	• We are supporting our most vulnerable in society; raising health equity across LLR, through attendance at LLR Health inequalities meetings. • Our people plan and our system people plan supports a sustainable local community in LLR, through the development of our workforce and the support to staff and the development of new roles. • We are seeking to positively support environmental, economic & regeneration improvements, policies and practices in LLR
	Gaps:	• Publication of the LPT response to the NHS Green plan • The development of our own information and data to address inequalities • Internal capacity to deliver and transform our planned change

Assurances	Internal:	Source: Transformation Committee Joint Working Group (JWG) of LPT & NHFT Executive, board meetings & board development sessions	Evidence: Transformation Committee will review progress of internal transformational priorities. JWG reviews progress on key joint priorities. Executive, Board meetings and development sessions include a focus on our strategic priorities and transformation. Evidence available in papers, agenda and minutes	Assurance Rating: Green
	External:	Source: Internal Audit HOIAO Feedback from NHS E/I Feedback from stakeholders (CQC, CCG/ICB & local authorities) Attendance at local authority scrutiny meetings	Evidence: Formal feedback from audit opinion, formal meetings and our stakeholder feedback.	Assurance Rating: Green
	Gaps:	Calculating the impact/value of the reaching out programme to LPT and to our communities.		

	Date:	Actions:	Owner:	Progress:	Status
Actions	Jan 22	Reaching out delivery plan as part of the Step Up to Great (SUTG) strategy and plan	David Williams	In draft currently (December 2021)	Amber
	Ongoing	Regular attendance at system meetings	Chair & CEO	Achieving (this action will be on-going)	
	Mar 22	Further agreement on our approach and calculating impact and value	David Williams	To be developed once the SUTG delivery plan completed	

Risk No: 73	Date included	29 November 2021	Date revised	7 Dec 2021		Consequence	Likelihood	Combined
Objective: E	Equality, Leadership, Culture				Current Risk	3	4	12
Risk Title:	If we don't create an inclusive culture, it will affect staff and patient experience, which may lead to poorer quality and safety outcomes.				Residual Risk	3	3	9
Risk owner:	Exec: Director of HR & OD		Local: Head of Equality, Diversity and Inclusion		Tolerance Level Significant 16-20 (Appetite People - Seek)			
Governance:	SWC, QAC / Board - Monthly Review							

Controls	Description:	• 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. • We Nurture OD sessions for staff • Reverse mentoring. Second cohort complete. • National and LPT People Plan • WRES action plan • WDES action plan	
	Gaps:	• Improved delivery against outcome measures / WRES and diversity metrics • Embeddedness of WRES/ WDES/ Together Against Racism action plan/ NHSEI high impact actions	
Assurances	Internal:	• Diversity workforce dashboard • Trust board equalities report • Annual Equalities Action Plan • Staff survey results	• EDI Bi-annual report to EDI committee / EDI group • WRES/WDES DATA published action plan to QAC/SWC – highlight report assurance ratings? • Staff survey report Trust Board – results Assurance Rating Green
	External ..	Source: • System wide EDI Taskforce established and identified seven priority areas for implementation	Evidence: • EDI Taskforce – highlight report assurance rating • CQC feedback Assurance Rating Green
	Gaps:		

	Date:	Actions:	Owner:	Progress:	Status
Actions	Mar 22 Mar 22 Mar 22	• Development of EDI strategy • Embed Together Against Racism actions • Delivery of the WRES action plan and six high impact Race Equality Actions.	Haseeb Ahmed	• Ongoing • Ongoing • Ongoing	Amber

Risk No: 74	Date included	29 November 2021	Date revised	7 Dec 2021		Consequence	Likelihood	Combined
Objective: E	Equality, Leadership, Culture				Current Risk	3	3	9
Risk Title:	As a result of covid 19, winter pressure, service recovery and workforce restoration there is a risk that our staff's health and wellbeing will be compromised, leading to increased sickness levels.				Residual Risk	3	2	6
Risk owner:	Exec: Director of HR & OD		Local: Deputy Director of HR and OD		Tolerance Level Significant 16-20 (Appetite People - Seek)			
Governance:	SWC, QAC / Board - Monthly Review							

Controls	Description:	• Wellbeing, sickness management policy • Counselling service • Anti bullying harassment and advice service • Staff Physiotherapy scheme • Health and wellbeing champions • Leadership Behaviours Framework • NHS People Plan national support • Staff risk assessments / stress indicator • System mental health HWB hub • Mental health and Wellbeing Hub • Occupational health service wellbeing strategy and implementation plan • Occupational health department / Staff reps / Amica		
	Gaps:			
Assurances	Internal:	• Daily Sickness absence monitoring • Sickness and workforce reports (including performance) to SWC / QAC • Sickness reviews within divisions • Staff side – monthly meetings • Referrals to Amica • Workforce and wellbeing group	Evidence: • Sickness absence rate • SWC highlight report – assurance rating amber due to sickness levels • Staff side – feedback • Referral rate for Amica • Workforce and wellbeing group assurance rating	Assurance Rating Amber
	External	Source: • NHSI reporting	Evidence: • NHSI benchmarking reports • Attendance at external NHSI wellbeing workshops • MHWB hub data	Assurance Rating Green
	Gaps:			

Actions	Date: Ongoing	Actions: • Delivery of the Health and Wellbeing Action Plan	Action Owner: Kathryn Burt	Progress: Progressing	Status: Amber

Risk No: 75	Date included	29 November 2021	Date revised	10 December 2021		Consequence	Likelihood	Combined
Objective: A	Access to Services				Current Risk	4	4	16
Risk Title:	Increasing numbers of patients on waiting lists and increasing lengths of delay in accessing services will mean that patients may not be able to access the right care at the right time and may lead to poor experience and harm.				Residual Risk	4	2	8
Risk owner:	Exec: Medical Director		Local: Operational Executive Directors		**Tolerance Level** Significant 16-20 (Appetite Quality-Seek)			
Governance:	Waiting List and Harm Prevention Committee, FPC and QAC / Board - Monthly Review							

Controls	Description:	• Access Policy • Waiting list management approaches and Standardised Operational Processes applied to waiting lists in all services including waiting list validation, patient tracking lists, demand capacity modelling . Trajectories in place to plot performance of waiting times improvement in prioritised services. • Service pathway re-design including measures as part of the Step up to Great MH transformation programme • System planning (design groups) established to manage patient flow and investment • NHSI demand and capacity management training • 21/22 priorities agreed and H1 and H2 plan in place • Triple R programme in place / service recovery plans • Approaches in services to reduce risk of harm while waiting by supporting service users with appropriate information • Covid sensitive trajectories for waiting time improvement of priority services – includes CYP ED as a prioritised service within FYPC • Headroom additional funding received for 2021/22 to increase resource for challenged WL services
	Gaps:	• QIA Policy • 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 • EM demand and capacity modelling limited to MH

Assurances	Internal:	Source: • Strategic waiting times and harm review committee • Directorate level performance and accountability reviews • Waiting time performance reported to Finance and Performance Committee • Spot checks of safety of patients waiting • Directorate risks including risk 4677 for CYP ED	Evidence: • Performance dashboards and reporting to DMTs , OEB and Trusts Board • Trajectory for improvement and measurement against trajectory • Transformation plans	Assurance Rating Green
	External:	Source: • CQC inspection 2021 • System performance monitoring • NHSI Regional Escalation oversight • National benchmarking data • Quality / Contract Monitoring with CCG & Specialised Commissioning with escalation route	Evidence: • CQC inspection 2021 action plan	Assurance Rating Amber
	Gaps:	• Triangulation of evidence of harm with Trust wide data connecting incidents, SI's and complaints with people waiting		

	Date:	Actions:	Owner:	Progress:	Status
Actions	Dec 21	Development of report to triangulate evidence of harm with Trust wide data from Patient Safety and Patient Experience	TW/ AK	Ongoing; all SI's now have waiting list associated risk as part of their ToR's; report from Patient Experience now tabled in Improving Access Committee	Amber
	Dec 21	Understanding the outputs of the demand and capacity modelling and feeding into the transformation programme	Director of MH	East Midlands MH alliance working with NHSEI to develop MH capacity planning model	
	Dec 21	Consideration of avoidable harm measures including impact of partial or full COVID related closures	AS/AvH	Agreed joint working approach between LLR and Northants system to undertake demand and capacity modelling Actively considered and covered in regular reports	

Risk No: 76	Date included	December 2021	Date revised	10/12/21
Objective: S	High Standards			
Risk Title:	As a result of the introduction of vaccination as a condition of deployment (VCOD), any staff who have not had two doses of covid vaccine by 1 April 2022 will no longer be able to work in roles involving patient contact. This may cause staffing challenges which could impact on patient safety and staff morale/wellbeing.			
Risk owner:	Exec: Director of Nursing, AHPs and Quality and Director of HR and OD	Local: ICC and Staff Vaccination lead and Deputy Director of HR/OD		
Governance:	SWC / QAC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	5	4	20
Residual Risk	5	3	15

Tolerance Level Significant 16-20 (Appetite Quality - Seek)

Controls	Description:	• Trust and System Covid vaccination programme established with all staff supported to have vaccine. • Weekly vaccination Sitreps for reporting on performance and identifying improvement. • Designated staff clinical vaccination lead • NHSE guidance 'Vaccination as a condition of deployment for healthcare workers: phase one planning and preparation' 6/12/21 • LPT Strategic Flu and Covid Vaccination Strategic Board • Weekly LLR Workforce Cell meeting		
	Gaps:	• Confirmation form directorates of roles in scope • Validation of the data of unvaccinated staff • Regulations still subject to parliamentary approval (expected by 17 December 2021) • Phase 2 operational templates and guidance for HR process		
Assurances	Internal:	Source: Mandatory Covid Vaccination Task and Finish Group Strategic Flu and Covid Trust Group. Quality Forum	Evidence: Notes and actions from T&F Group Directorate reports for Strategic Gold (fortnightly) focused on business continuity and risk Weekly Sitrep report Wed 8/12/21 Moderate Assurance Highlight report from Strategic Flu and Covid Trust Group 9/12/21 Moderate Assurance Moderate Assurance	Assurance Rating Amber
	External:	Source: LLR System Vaccination Operation Centre NHS Midlands Data	Evidence: Midlands Flu and Covid weekly report summary Weekly Moderate Assurance	Assurance Rating Amber
	Gaps:			

	Date:	Actions:	Action Owner:	Progress: - all ongoing	Status
Actions	Dec 21	1. Directorates to be supported with resources and training to increase capability to undertake vaccine confidence conversations.	SC/KBa		Amber
	Dec 21	2. Drop in events to be held for staff / managers	Kbu/KBa		
	Dec 21	3. Directorates to determine which roles are in and out of scope	Ops leads		
	Dec 21	4. Letter to be sent to staff to support uptake and validation of data.	Kbu		
	Dec 21	5. FAQs to be finalised	KBu		

Risk No: 77	Date included	1 December 2021	Date revised	1 December 2021		Consequence	Likelihood	Combined
Objective: G	Well Governed				Current Risk	4	3	12
Risk Title:	Without the appropriate level of focus, resource and preparation, the Trust cannot adequately support the National Public Inquiry into the Covid Pandemic, leading to a lack of lessons learned, inability to respond effectively to future situations and major incidents, a failure to comply with the Public Inquiry statute and reputational damage.				Residual Risk	4	2	8
Risk owner:	Exec: Deputy Chief Executive		Local: Deputy Director of Governance and Risk		**Tolerance** level Moderate 9-11 (Appetite Reputational–Cautious)			
Governance:	Public Inquiry Programme Board / SEB / Trust Board - monthly review							

Controls	Description:	• LPT Public Inquiry Project Board and Joint Programme Board with NHFT feeding into the Trust Board • Joint Lead for the Public Inquiry with NHFT • Local Lead and interim project lead appointed		
	Gaps:	• National Public Inquiry appointment of a Chair / Terms of Reference • Local strategy for the National Public Inquiry • Finalised IM&T strategy		
Assurances	Internal:	Source • SEB • Joint Public Inquiry Programme Board • LPT Project Board	Evidence: Highlight reports from the LPT Project board to SEB (last dated 3 December 2021) Amber Assurance	Assurance Rating Amber
	External:	Source	Evidence:	Assurance Rating
	Gaps:			

Actions	Date:	Actions:	Action Owner:	Progress:	Status
	Jan 22	Development of a local strategy.	Sandra Mellors /Kate Dyer	Being drafted. To present to the SEB 7 Jan 22	Amber
	Jan 22	Implementation of the Public Inquiry IM&T strategy	SM/KD	In draft	

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Leicestershire Partnership NHS Trust

LPT Board – 21 December 2021

Step Up to Great Mental Health – Programme update

Purpose of the report

The report provides an update to the LPT Board on the progress with this programme of work, the review of the consultation feedback, the Report of Findings, Equality Impact Assessment and Decision-making Business Case. It explains the decisions that the CCG Governing body has made on the 14th December 2021.

Analysis of the issue

The LLR system has been developing plans to improve Urgent and Emergency Mental Health and Integrated Community Mental Health services for four years. As previously set out to the Board, the process to be followed to make significant service change involves:

- Finalise the proposed broad service models
- A review of the proposed service changes by the Clinical Senate
- Discussion with the joint Health Overview and Scrutiny Committee to agree the plans for engagement and consultation
- The development of a Pre-Consultation Business Case for review and sign off by the LPT and CCG Boards
- Completion of an Equality Impact Assessment on the proposed service changes
- The development of a consultation document and communications plan by the CCG
- Review of the approved PCBC, Senate report, HOSC minutes, EIA, consultation document and plan by NHS England
- 12-week consultation process
- Halfway report
- Initial consultation report
- Review and response to the consultation responses
- Decisions and impact on implementation plans by service area
- Review with the Equality Impact Assessment VCS group to inform a further Equality Impact Assessment
- Full consultation report including responses profiled by protected characteristics – Report of Findings
- Decision-Making Business Case
- Implementation plans
- Implementation

Progress

1. A post-consultation celebration event was held on Friday 8 October 2021, with the voluntary and community sector organisations who had worked with us to promote the consultation and ensure the voices of their communities were heard. The event also shared best practice and particularly captured the learning and how we all want to work together in partnership going forward.

2. A second event will take place on 16 December to further explore partnership working, setting a blueprint for future collaboration, that results in community empowerment and improved health and wellbeing.

3. The results of the consultation were set out in the CSU Report of Findings which has been shared widely including to the LPT Board.

4. On Wednesday 1 December 2021, the system Public and Patient Involvement Assurance Group (PPIAG) reviewed the Report of Findings. They integrated the information to assess whether the proposals to improve mental health services in Leicester, Leicestershire and Rutland been developed with appropriate and sufficient public and patient involvement and whether the NHS have sufficient insights and business intelligence from a diverse range of service users, staff, carers and public, to inform decision of the CCG Governing Body regarding mental health services

5. The PPIAG were able to assure in both areas, acknowledging the extend of work that had been undertaken. The group noted that there was strong support for the proposals. They also recommended that the qualitative insights and business intelligence provided by people is carefully considered and that co-production remains at the forefront of implementation.

6. An independent external Equality Impact Assessment reviewing the consultation process has been completed. This has also been shared with the LPT Board.

7. The findings from the consultation have been considered in setting out the final proposals in the Decision Making Business Case. This has been shared with the LPT Board.

8. The CCG Governing Bodies will have considered the DMBC, EIA and Report of Findings on 14 December in both private and then public sessions. The CCG Board paper is appended to this update. The meeting takes place after the deadline for this paper. A verbal update will be shared at the LPT Board meeting.

9. The recommendations to the CCG Board are divided up by service area, then some overarching recommendations followed by the EIA review recommendations. These are not restated in this update as they have previously been shared, form the final chapter of the DMBC and are detailed in the appendix to this paper.

10. The themed recommendations and EIA recommendations set the parameters and a commitment to co-producing implementation plans with communities, service users, carers, staff and partners. The key themed recommendations that will influence the approach to implementation are:

Working with local communities, voluntary and community sector	Agree to apply the principles set out in chapter 7 on the role of the VCS in implementation planning, co-production, making the service changes and in the on-going delivery of these services.
Working with carers	Agree to apply the principles set out in chapter 7 in our work with carers and with VCS groups acting as advocates of carers to ensure that the service improvements align with carer needs and are co-produced with their support.

11. The CCG governing body met on the 14th December 2021 and agreed to the recommendations set out in the Decision Making Business Case.

12. The expected next step is to communicate the outcome from the governing body widely to staff, communities and wider stakeholders and to develop a series of implementation plans. For some service changes, the recommendation is to make already temporary services permanent, for others, the implementation plans need refreshing and revisiting with partners, and for other services there is significant work to plan the implementation living up to the commitments of co-design and co-production.

13. The LPT Board should receive a summary of a plan for the implementation phase at the next Board meeting.

Decision required

The LPT Trust Board is asked to:

- note the further progress made since the last Board update and outcome from CCG governing body
- receive a further update at the next Board meeting including a plan for the implementation phase.

Governance table

For Board and Board Committees:	Trust Board meeting 21.12.21	
Paper sponsored by:	Fiona Myers	
Paper authored by:	Graeme Jones	
Date submitted:	10 December 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):	The LPT Board has received a number of previous updates on the elements of this service investment and improvement programme.	
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	Update at the next LPT Board.	
STEP up to GREAT strategic alignment*:	High **S**tandards	
	Transformation	X
	Environments	
	Patient Involvement	X
	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	
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:	EIA completed in December 2020. Further post consultation EIA completed in December 2021.	

Version 1.0

Appendix A: Covering paper to LLR CCG Governing body of 14th December

<table>
<tr><td>Name of meeting:</td><td>LLR CCGs' Governing Body meetings in common
Public ✓ | Confidential</td><td>Date:</td><td>14 December 2021</td><td>Paper:</td><td>A</td></tr>
<tr><td>Report title:</td><td colspan="5">Step Up to Great Mental Health – Decision-Making Business Case</td></tr>
<tr><td>Presented by:</td><td colspan="5">Rachna Vyas, Executive Director of Integration and Transformation, LLR CCGs, Richard Morris, Deputy Director of People and Innovation, Avinash Hiremath, Medical Director, Leicestershire Partnership NHS Trust (LPT) and John Edwards, Associate Director for Transformation for Mental Health, LPT</td></tr>
<tr><td>Report author:</td><td colspan="5">Graeme Jones, Director</td></tr>
<tr><td>Executive lead:</td><td colspan="5">Rachna Vyas, Executive Director of Integration and Transformation, LLR CCGs,</td></tr>
<tr><td>Action required:</td><td colspan="5"><table><tr><td>Receive for information only:</td><td></td><td>Progress update:</td><td></td></tr><tr><td>For assurance:</td><td></td><td>For approval / decision:</td><td>✓</td></tr></table></td></tr>
<tr><td>Executive summary:</td><td colspan="5">At the Leicester, Leicestershire and Rutland Clinical Commissioning Groups Governing Bodies meeting on 10th May 2021 the individual Governing Bodies approved the Pre-Consultation Business Case which set out a set of proposals for investment and reconfiguration of adult mental health services for Leicester, Leicestershire and Rutland. It also approved the commencement of formal consultation with the public on those proposals. This decision was based on a successful NHS England pre-consultation assurance review in March 2021.

Formal public consultation commenced on 24 May 2021 and ran until 15 August 2021. The results of the consultation are set out in the Report of Findings. The findings from the consultation have been considered in setting out the final proposals in the Decision Making Business Case.

An independent external Equality Impact Assessment has been completed reviewing the consultation process.

This paper asks the Leicester, Leicestershire and Rutland Clinical Commissioning Groups Governing Bodies to approve the proposals set out in the Decision Making Business Case which include EIA recommendations to build on the consultation in co-designing implementation plans.</td></tr>
<tr><td>Appendices:</td><td colspan="5">Appendices

1. CSU Report of Findings
2. Equality Impact Assessment report</td></tr>
<tr><td>Recommendations:</td><td colspan="5">The Governing Bodies of East Leicestershire and Rutland CCG, Leicester
City CCG and West Leicestershire CCG are individually asked to:

• RECEIVE the Report of Findings, Equality Impact Assessment report and Decision-Making Business Case.</td></tr>
</table>

- **AGREE** to the following recommendations set out in the Decision-Making Business Case.

<u>Decisions relating to the consultation</u>

Provide an additional comprehensive suite of self-help guidance and tools

a) Agree to provide a comprehensive suite of self-help guidance and tools in one place online, while making the material available in printable format.
b) Agree to address the feedback on the type and simplicity of the information, and access routes to the information with the support of a service user advisory group and wider engagement as we develop and implement our plans.
c) Agree to provide support to find and understand the information via the Mental Health Central Access Point for people unable to navigate or understand the information on the website.
d) Agree to share a QR code on posters and business cards in a wide range of settings including GP practices.
e) Agree to pilot the use of publicly accessible IT terminals to access the self-care guidance.

Introduction of a Central Access Point

a) Agree to make the Central Access Point permanent.
b) Agree to address the consultation feedback on promotion and awareness of the CAP, access routes for vulnerable groups, interpreter and BSL support, improving responsiveness and performance standards as part of the implementation and further development phase.
c) Agree to develop the service to provide support to families and carers. To support this, the CAP and the Urgent and Emergency Care Steering Group will be expanded to include family and carer representatives to develop and test material.
d) Agree to undertake a review of demand, capacity and workforce models alongside the potential use of technology to improve the support offer. The review of capacity will include modelling the workforce required to introduce a call-back service and a text access route.

Expand the number of Crisis Cafes

a) Agree to open a further 22 crisis cafes in community locations in Leicester, Leicestershire and Rutland.
b) Agree to work with local communities and voluntary and community groups to identify suitable locations, to co-design appropriate support offers considering diversity and ethnicity, co-location of other services and to link with wider community assets. Developing an appropriate local offer in each neighbourhood.
c) Agree to work with local communities and service user groups to inform the names of the Cafés to identify a different term or terms for the cafes.

	Improve and expand the Crisis Service a) Agree to improve and expand the Crisis Service in Leicester, Leicestershire and Rutland as set out in the Pre Consultation Business Case. b) Agree to promote the range of Urgent and Emergency Care (UEC) services and build awareness of the support available across the pathway. c) Agree to work with the UEC service user group to consider options to improve communication with service users and their families as part of our implementation and on-going review processes. **Introduce an Acute Mental Health Liaison Service** a) Agree to create an Acute Mental Health Liaison Service by joining together the existing teams and basing them at Leicester Royal Infirmary close to the emergency department. b) Agree to address the feedback on promoting the service to UHL staff and building awareness of all wards and departments through implementation. c) Agree to provide support and development training to acute hospital colleagues including to A&E staff in mental health awareness. **Establish a Mental Health Urgent Care Hub** a) Agree to make the Urgent Care Hub permanent and to undertake an options appraisal on whether to maintain the Hub at the Bradgate Unit in the longer term. b) Agree to include staff training in customer care to strengthen the nature of the welcome at the Urgent Care Hub. **Expand the hours that the Triage car is provided** a) Agree to expand the hours of the Triage car service and to expand the joint working with East Midlands Ambulance Service. b) Agree to develop further mental health awareness training alongside the police and ambulance services. **Intensive support to vulnerable groups** a) Agree to implement the investment and recruitment plans set out in the consultation, focusing our implementation plans on effective collaboration between the teams coming together. **Create eight Community Treatment and Recovery Teams focused on adults and eight Community Treatment and Recovery Teams focused on older people** a) Agree to move eight Community Treatment and Recovery Teams for adult mental health with eight dedicated teams for Older People's mental health operating on the same geographic footprints. b) Agree to undertake dedicated engagement in each locality to agree the working hours that best meet the need of the local population.

	c) Agree to focus implementation plans on existing service users and managing their care during the period of transition. These plans will be linked to specific quality and safety triggers to be applied during the implementation phase. **Dramatically cut waiting times to access Personality Disorder Services** a) Agree to the investment and expansion to the Personality Disorder service set out in the Pre-Consultation Business Case focusing on integration with other services. **Expand the service available for perinatal women from pre-conception to 24 months after birth** a) Agree to the investment and expansion of the perinatal service including doubling the period of support from 12 months to 24 months after birth. b) Agree to develop specific implementation plans to reflect the diverse community and work with relevant community groups to build awareness and access to the support on offer. **Improve the support for women who are experiencing trauma and loss in relation to maternity experience** a) Agree to the investment and expansion of the maternal outreach service including the development of support services for fathers and partners. b) Agree to address the suggestions of training on cultural diversity and incorporating multicultural practices through the implementation plans. **Improve psychosis intervention and early recovery service.** a) Agree to support the investment and service change plans to improve psychosis intervention and early recovery, set out in the Pre-Consultation Business Case. **Enhance the memory service introducing different ways of providing the service** a) Agree to the investment and improvement proposals relating to the Memory Service, set out in the Pre-Consultation Business Case. b) Agree that provision via digital means will be an option rather than the only route to Memory Services and that service users will be able to choose the vehicle that suits them best. **Establish an Enhanced Recovery Hub team** a) Agree to establish an Enhanced Recovery Hub team and to develop the services, as set out in the Pre-Consultation Business Case. **Telephone and video-based services**

a) Agree to continue to offer and develop telephone and video-based services as an option for service delivery.
b) Agree that the use of telephone and video as a vehicle to interact with service users will be offered a choice determined by the service user.
c) Agree to pilot the use of publicly accessible IT terminals to access the self-care guidance.

Decisions relating to overall consultation feedback themes

Working with local communities, voluntary and community sector

Agree to apply the principles set out in chapter 7 on the role of the VCS in implementation planning, co-production, making the service changes and in the on-going delivery of these services.

Working with carers

Agree to apply the principles set out in chapter 7 in our work with carers and with VCS groups acting as advocates of carers to ensure that the service improvements align with carer needs and are co-produced with their support.

Decisions relating to the Equality Impact Assessment

Agree to the following eight recommendations from the independent EIA review.

1. The intelligence and guidance achieved to date is a rich learning opportunity for the future; it is acknowledged that the results of the consultation are being shared widely and whilst doing so, recommends communities are formally thanked for their contribution.

2. Build upon the relationships and alliances that have already established through the consultation, by enhancing the current arrangements to create genuine and sustainable partnership arrangement with the voluntary and community sector. Where mutually agreeable, partnering during the co-design, implementation phase; post-project evaluation and beyond to find lasting solutions to issues on an ongoing mutual basis.

3. Empower communities and capitalising on front line NHS staff being members of such communities, maintaining an understanding and support of protected groups through long term collaboration.

4. Apply the same rigour of focus, devoted to the communities served, to staff and the organisations' ways of working.

5. Ensure the Trust's staff education and training programme is

	inclusive of understanding beliefs and values of different communities and of a broad cultural education. 6. Persevere, to engage under-represented groups in co-design and implementation phases. 7. Develop a plan for digital enablement and health literacy, to appropriately support the delivery of treatment and use of digital tools across communities. 8. Aspire to be an exemplar system for health inequality through collaboration with communities.
Report history and prior review:	The Pre-Consultation Business was approved by the LLR CCGs on 10 May 2021. This started a period of formal consultation and this Decision Making Business Case sets out the final proposals for approval following the formal consultation.

Aligned to Strategic Objectives		
Leicester City CCG	**West Leicestershire CCG**	**East Leicestershire and Rutland CCG**
✓	✓	✓

Implications	
a) Conflicts of interest:	None
b) Alignment to Board Assurance Framework	Not applicable
c) Resource and financial implications	Investment commitments are already made
d) Quality and patient safety implications	None identified
e) Patient and public involvement	The Decision Making Business Case sets out the decisions for approval by the LLR CCGs Boards following formal consultation with the public on the proposals set out in the Pre Consultation Business Case. The Report of Findings sets out in detail the feedback from the consultation.
f) Equality analysis and due regard	An updated post-consultation Equality Impact Assessment is set out as part of this report.

Appendix B: Link to Step up To Great Mental Health Report of Findings, Equality Impact assessment and Decision Making Business Case

http://3xmatc1p0cnc3crfv93ovogp-wpengine.netdna-ssl.com/wp-content/uploads/2021/12/SUTG-Mental-Health-DMBC-and-report-of-findings-reduced-Appendices-1-to-3.pdf

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Leicestershire Partnership NHS Trust

QUALITY ASSURANCE COMMITTEE – 30th November 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	IPC visit successful outcome; planning for mandatory covid vaccinations for healthcare workers from new year; improvements in Duty of Candor; SI process remains under scrutiny with a QI plan in place and a Quality Summit planned; pressure ulcers – recent quality and safety summit concluded no immediate concerns, further summit planned. Quality Summits in other services planned. The staffing situation remains fragile and this narrative is unlikely to change in the near future – Trust Board and the committees will continue to be fully sighted on this. Split High/Medium assurance rating – grip and confidence was evident and there is progress in some areas but others give lower assurance.	57, 58, 59, 62, 76
Medical Director Update - Paper D	Medium		In relation to data on suspected suicides, a Quality Summit involving CAP/Crisis teams is planned for January 2022 and learning reviews taking place weekly within mental health services. The 6 actions for the 360 Assurance MHA audit – 4 are complete subject to confirmation from auditors. Medical recruitment and consultant caseload to be detailed in the next Medical Director Update. Medium assurance was agreed, as there is good grip but ongoing issues remain.	57, 76
Director of HR Update - Paper E	Medium		The Health and Wellbeing Autumn Festival was well attended by over 370 staff and continues to be accessed via StaffNet. A drop in training compliance anticipated due to return to the pre covid arrangements in terms of compliance.	60, 61, 63, 73, 74, 76

Report	Assurance level*	Committee escalation	ORR Risk Reference
		Training compliance and DNAs continue to be discussed at DMTs with protected time for training planned on rotas from January. 30 international nurses have joined LPT and are settling in well. The National Staff Survey reached 52% completion rate which is the same as last year.	
Performance Report - Quality and Workforce Measures - Paper F	Medium	QI plan is in place for increase in Sis. Pressure ulcers category 2 have reduced but category 4 have increased and a QI plan is in place including a patient and carers pilot by the Hinckley District Nurses. Sickness rates remain stable although above target, supervision rates have slightly increased and there has been a dip in appraisal compliance.	57, 60, 61, 75, 76
Provider Collaborative Performance Report - Paper G	High	The patient safety and quality meeting continues and the service user representation is working well. There were no matters for escalation.	57
Safeguarding Quarter 2 Report - Paper H	Medium	Focus remains on implementing the improvement plan. An external consultant is leading on this. The next update (Q3 report) is due in February 2022 –the Liberty Protection Safeguards position will be detailed.	57, 58
Response to the GIRFT - Paper – I	High	While in their report, NHSI used historical data, there has been a real focus on GIRFT in the SU2GMH consultation. Recommendations from the deep-dive are being considered and there is a plan to re-run the exercise with current data next year and will be brought back to QAC once complete.	All
Violence and Aggression Deep Dive Update – Paper J	H / M	The violence and aggression standards were introduced earlier this year and a self-assessment had identified gaps. A governance arrangement has been put in place and a high level strategic project group, meeting twice a year, will provide assurance. QAC received high assurance from the report and the grip over the process and systems but note that the violence and aggression position offers medium assurance.	57, 59
Guardian for Safer Working Hours Quarterly Report - Paper K	High	There have been 14 exception reports in the last quarter – wellbeing support and supervision is continuing through the Junior Doctors Forum. Gaps in the Bradgate Unit rota have been addressed by a new on-call booking system.	57, 60, 61
Organisational Risk Register - Paper L	High	The revised risk appetite has informed the report. Directorate level risks will pick up any specific areas of risk. The level 2 committees receive the	All

Report	Assurance level*	Committee escalation	ORR Risk Reference
		ORR and the directorate level risk register. The ORR therefore remains strategic. QAC approved the report for presentation to the December Trust Board meeting.	
Deteriorating Patient (focus on sepsis) Audit Reports Paper M	High	Limited assurance audit report. There were 12 actions, 1 high, 10 medium and 1 low and all but 1 are completed and closed. The outstanding action has been placed onto the Quality Surveillance Tracker and has a robust plan in place for delivery.	57
CQC Action Plan Process – Paper N	High	A process is in place and there is a firm grip on all actions.	57, 62
QAC Mid-Year Review – Paper O	NA	QAC fulfilled its TORs and met the membership requirements. Improvement targets for the remainder of the year have been identified.	57
Strategic Workforce Committee Highlight Report 13th September 2021 - Paper P	High	Bank staff training compliance improvement to 71.8% was noted and further updates on training compliance from the November SWC will come to QAC in February.	60, 61, 63, 73, 74, 76
Health and Safety Highlight Report 4th November 2021 - Paper Q	High	Lessons learned from recent Covid outbreaks and risk assessments reviewed. Programme of business continuity desk-top exercises in the directorates. 360Audit of fixed and non-fixed ligatures in progress. Estates work continues in areas identified by CQC.	57, 59
Legislative Committee Highlight Report 29th September 2021 - Paper R	Medium	The committee expects a reduction in training compliance variation for MHA/MCA and there are improvements in reading of rights and a patient and carer liaison officer role is being developed to support this. Directorates are currently undertaking reviews of the quality of information presented to ensure they support these issues moving forward.	57
Safeguarding Committee Highlight Report 13th October 2021- Paper S	Medium	There is a programme of improvement work ongoing to improve the safeguarding offer both internally and at a system level and there is ongoing work around relationship building with local authorities and system partners led by the Executive DON/AHP's & Quality. QAC received medium assurance due to the capacity and demand pressures that are being dealt with at this time.	57, 58
Quality Forum Highlight Reports 14th October 2021 & 11th November	Medium	A number of low assurance areas were highlighted at both meetings. At the October meeting, the Forum undertook a deep-dive on staffing, where negative assurance was given on the increasing demand of our workforce and the	57, 59

Report	Assurance level*	Committee escalation	ORR Risk Reference
2021 - Paper T		deterioration of staffing levels was noted. However positive assurance was also noted in terms of robust recruitment and retention plans in place and mitigations in place to ensure safety and quality are maintained. CHS highlighted low staffing levels as a factor in the increase in pressure ulcer incidence and staff capacity for prevention. There also remains a risk to the timely completion of SI investigations and a specific Quality Summit is planned Trust-wide to investigate further The committee has good oversight of low assurance areas.In relation to waiting times and harm the 3 directorates use a risk matrix and have a SOP and this work is being triangulated with information from the patient safety and patient experience team. QAC received medium assurance overall as there is grip on the risks and issues but they remain a significant risk particularly the staffing concern.	

Chair	Moira Ingham

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Leicestershire Partnership NHS Trust

Public Trust Board 21st December 2021

Care Quality Commission (CQC) Report and Must Do Action Plan

Purpose of the report

The paper outlines the key findings of the CQC Well Led and Core inspection completed over May / June and July 2021 and activities undertaken to date. The report outlines the key highlights, the plans for oversight of assurance on improvements and includes the 'Must Do' action plan in Appendix 1 which have been submitted to the CQC.

Introduction

The Trust received the CQC inspection report on the 28th October 2021 following inspection of three core services and the Well Led domain. The service areas inspected were acute wards for adults of working age and psychiatric intensive care units, long stay or rehabilitation wards for working age adults and wards for people with a learning disability or autism.

The full report can be accessed online at: Trust - RT5 Leicestershire Partnership NHS Trust (10/11/2021) INS2-10775599601 (cqc.org.uk)

Key Findings

1. Retained the overall rating of Requires Improvement.
2. Retained the Good rating for Caring.
3. Improved the Well-led domain which has progressed from Inadequate to Requires Improvement.
4. The acute wards for adults of working age and psychiatric intensive care unit progressed from Inadequate to Requires Improvement
5. The long stay or rehabilitation mental health wards for working age adults progressed from Inadequate to Requires Improvement.
6. The wards for people with learning disability or autism remains at Requires Improvement.
7. No warning notices were received although there are 24 Must Do and 16 Should Do actions.

Improvements Recognised

The Trust demonstrated significant improvements in the following areas:

- Out of area placements for people requiring Mental Health beds in crisis have drastically decreased.
- Staff manage risks better and have reduced ligature risks to keep our inpatients safe.
- Elimination of mixed sex accommodation.
- Improved seclusion environments.

- Significantly improved medicines management**.**
- Improved patient involvement in planning care and service improvements.
- Mental health patients have good access to physical healthcare and support to live healthier lives.
- Practice good infection prevention control.
- Complaints are taken seriously, and lessons shared with staff to keep improving.

Areas to address

- Elimination of dormitories.
- Call buzzers, ensuring every patient has access to summon assistance when required.
- Timeliness and responsiveness to the need for repairs.
- Storage for our patients clothing and personal belongings.
- Safety in the management of contraband.
- Individualised plans of care.
- Privacy and dignity.
- Recovery, following Covid-19, of our mandatory training percentages.
- Recruitment to key posts: Occupational Therapy, Psychology, Nursing.

Action planning process and oversight

Following receipt of the report, directorates involved in the inspection have engaged with the action planning process to develop plans to resolve the issues identified to achieve regulatory compliance. The 'Must do' action plan templates were completed and returned to the CQC on the 25/11/2021 which was within the 28-day timescale required.

All 'Must do' and 'should do' actions have been incorporated onto one action plan for weekly oversight at a CQC action and improvement plan meeting attended by responsible action owners and executive leads. Each action will be scrutinised at this meeting and only signed off by the Executive Director of Nursing/AHP's and Quality with demonstrable evidence of closure. Executive leads are identified for each action for accountability of delivery and progress. These plans are formally reported to the Operational and Strategic Executive Boards respectively and Quality Assurance Committee.

The Compliance Team will maintain a master copy of the excel action and improvement plan. This is to ensure that essential and timely updates are captured, for reporting purposes. All other quality improvement issues identified from the report are integrated into the quality surveillance tracker for weekly monitoring and operation.

Oversight of the well led actions and development plan will be monitored by the Transformation Committee, led by the Deputy Director for Governance and Risk in close working with Head of Compliance.

The Foundations for Great Patient care meetings will continue, but with the expectation of a wider audience to include: medical representation, matrons, nurses and AHP's. The meeting will focus on

learning from the report, knowledge and understanding of the fundamental standards of care, sharing practice and the importance of sustaining quality improvements.

Potential Risks

The Trust is required to clearly articulate its commitment to addressing the concerns raised within the CQC inspection report and demonstrate progress against the actions. This requires effort, support, finance and tenacity to ensure that improvements made are sustainable, clearly impact on the quality of care for patients and are also represented in the future trust ratings. Escalation and mitigation will be required should any of the improvement activities be delayed or not achieved.

The Trust is required to deliver timely responses and updates to the CQC which demonstrate achievement and compliance in meeting the regulated activities. All wards, teams, directorates, trust leaders will be required to commit to this, at a time when there are seasonal system pressures and the impact of Covid-19.

Decision required

Trust Board is provided with the paper and action plan for assurance of oversight of the actions and improvements.

For Board and Board Committees:	Public Trust Board 21st December, 2021	
Paper sponsored by:	Anne Scott, Director of Nursing, AHP's and Quality	
Paper authored by:	Deanne Rennie, Associate Director of AHPs and Quality Jane Howden Head of Quality, Compliance and Regulation	
Date submitted:	9th December 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):	Strategic Executive Board 5th November 2021 Quality Assurance Committee 30th November 2021 Audit and Assurance Committee 3rd December, 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	Single report to the Audit and Assurance Committee	
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	
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	

Governance table

CQC Action Plan- Must Do'd

Ref No:	Must Do Actions	Theme	Service	Improvement / Objective	Update following inspection	Actions Required	Lead (Executive & Local)	Deadline	Action Status / RAG Rating	Governance/ Approving Committee
MD1 - Page 8, 51 MD 11- Page 9	The trust must ensure it immediately reviews arrangements of dormitory accommodation with a view to eliminating this in line with national guidance. (Regulation 10(1)	Dormitories - Estates	Trust wide (Well Led)	The Trust will eliminate all dormitory accommodation in line with National guidance	Update: -The Trust reviewed its dormitory accommodation reprovision plan immediately post inspection. There is no potential for acceleration of the existing planned timescale. Agreed timeline for the programme of works is to be concluded by 2023. There is a clear governance process in place to ensure the progress of the plan is kept under review at the Estates and Medical Equipment Committee (EMEC) and any risks are escalated through to the Finance and Performance Committee (FPC). Post inspection an action plan was developed and shared with the CQC with further updates sent on the 25/11/21. This plan detailed actions taken to improve the dignity and privacy of patients, improve storage and laundry facilities. The two remaining actions from the Dormitory action plan on implementation of laundry facilities for Aston and Ashby Ward and permanent storage for the Bradgate Mental Health Unit and Willows are aligned to the delivery of the dormitory reprovision accommodation plan.	1. Review of dormitory accommodation reprovision plan to establish if timescales can be brought forward.	Richard Wheeler/Richard Brown	12/08/2021		Estates and Medical Equipment Committee, DMH DMT and Executive Boards.
MD2 - Page 8 MD14 - Page 9	The trust must ensure that patients are able to summon for staff assistance effectively in all wards, to include communal areas and dormitories. (Regulation 12(1)).	Call Systems - Estates	Trust wide (Well Led)	The Trust will ensure that patients have access to call alarms to summon for staff assistance	Update: -We immediately reviewed the current usage and access of personal safety call alarms across all acute wards against the CQC Brief Guide on 'Call systems in mental health inpatient services for patients/service users and visitors' (July 2020). -We have a communication plan in place for ensuring ward staff are aware of process of utilising existing wrist pits and Standard Operating Procedure. -we have strengthened risk assessment processes. -An action plan was developed immediately and shared with the CQC post inspection with updates provided tot he CQC on the 25/11/21. -We have purchased additional wrist pits to strengthen accessibility for all patients on every ward to summon assistance. -we reviewed current usage and access of personal safety call alarms across all wards for visitors. - we have commissioned surveys on our estates to ensure alarms can be used and identify where upgrades are required.	1. Installation of new receivers 2. Implementation of newly purchased wrist pits to strengthen accessibility for all patients on every ward to summon assistance if they are alone temporarily on the ward based on individual clinical risk assessment. This gives full capacity for 100% usage if required.	Richard Brown/Michelle Churchard Smith	31/01/2022		Estates and Medical Equipment Committee, Directorate Management Team Meetings and Executive Boards.
MD3 - Page 8	The trust must ensure environmental risks are identified and mitigated against including checks of the communal garden at Stewart House. (Regulation 15(1)(2)(a)(b)).	Environmental Risks / Estates	Rehabilitation	The Trust will have environmental risk assessments in place which includes communal garden areas.	Update: -The systematic checking of the garden was placed on the daily Ward Environmental Checklist. - A weekly check of compliance is now carried out by the Ward Sister / Charge Nurse. - Work was immediately undertaken to tidy the area and the Trust estates gardening team continue to maintain the horticulture.	1. A new 6 weekly Quality Round will be undertaken by Ward Sister / Charge Nurse and Matron.	Fiona Myers / Helen Perfect	31/01/2022		Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards

Ref No:	Must Do Actions	Theme	Service	Improvement / Objective	Update following inspection	Actions Required	Lead (Executive & Local)	Deadline	Action Status / RAG Rating	Governance/ Approving Committee
MD4 - Page 8	The trust must ensure there are effective systems and processes in place to audit risk assessments across the service and action taken to address short falls in clinical documentation. (Regulation 17(1)(2)(a)).	Auditing system - Risk Assessments	Rehabilitation	The Trust will have an effective system in place where risk assessments are audited and actioned to improve clinical documentation	Update: - A review of the current systems and processes has been completed using the PDSA approach as a quality improvement project 7th June 2021 - There is a process in place to review risk assessments and care plans, the PDSA identified further actions to achieve continued improvement re: risk assessment and care plans being updated following an incident.	1. The peer review audit tool will be amended to include questions on risk assessments. 2. Monthly audits will be carried out and the results entered onto AMaT. 3. Results will be monitored at the service line Quality and safe meeting.	Fiona Myers / Helen Perfect	31/01/2022		Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards
MD5 - Page 8	The trust must ensure there are effective systems and processes in place to audit care plans across the service and action taken to address short falls in clinical documentation. (Regulation 17(1)(2)(a)).	Auditing system - Care Plans	Rehabilitation	The Trust will have an effective system in place where care plans are audited and actioned to improve clinical documentation	Update: - A review of the current systems and processes has been completed using the PDSA approach as a quality improvement project 7th June 2021 - There is a process in place to review risk assessments and care plans, the PDSA identified further actions to achieve continued improvement re: risk assessment and care plans being updated following an incident.	1.A peer review care plan audit will be carried out monthly. 2. The results will be entered onto AMaT. 3. Results will be monitored at the service line Quality and Safe meeting.	Fiona Myers / Helen Perfect	31/01/2022		Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards
MD6 - Page 8	The trust must ensure at the Willows staff consistently apply and record appropriate contemporaneous records for seclusion. (Regulation 17(1)(2)(c)).	Seclusion Records	Rehabilitation	Documentation at the Willows will demonstrate high standards of record keeping in relation to seclusion	Update: - All staff have been identified who have not received local training on the seclusion policy and they have been scheduled for training. - the seclusion audit on AMAT is completed by the Matron following every seclusion incident to monitor the quality of care and record keeping.	1. All staff who have not previously received the local training will be trained by 31st January 2022	Fiona Myers / Helen Perfect	31/01/2022		Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards
MD7 - Page 8	The trust must ensure that the privacy and dignity is protected around the respectful storage of patient's clothes; (Regulation 10(1)).	Storage - Privacy & Dignity	Rehabilitation	The Trust will have safe and respectful storage facilities for patients clothes	Update: - A review of all inpatient storage facilities was undertaken - The Trust invested in improving permanent storage facilities for patients personal belongings on the Rehabilitation wards, now completed on Acacia and Sycamore. -Access to plastic storage boxes/cupboards and laundry bins made available. - Patient lockers have been provided for personal items that need to be stored securely and items that may be considered a risk.	1. Storage cupboards work to start on Cedar Ward in December 2021	Fiona Myers / Helen Perfect	28/02/2022		Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards

Ref No:	Must Do Actions	Theme	Service	Improvement / Objective	Update following inspection	Actions Required	Lead (Executive & Local)	Deadline	Action Status / RAG Rating	Governance/ Approving Committee
MD8 - Page 8	The trust must ensure protected characteristic needs are identified, care planned and actioned. (Regulation 10(1)).	EDI - Protected Characteristics	Rehabilitation	Trust records will document / action and care plan patients needs around protected characteristics.	Update: -The patients individual care plan was reviewed and revised to encompass all of their individual needs. - The Rehabilitation wards welcome pack was reviewed by the Trust Equality, Diversity and inclusion group to include how the unit meets patients protected characteristic needs. - The Matron has worked with the lead at the Community Knowledge Framework for LGBTQ to acquire materials and signposting information to local networks for inclusion in patient resources at Stewart House.	1. The peer care plan audit tool within the AMaT is currently under review as part of the PDSA work. This will also include questions on recognising and meeting the equality and diversity needs of all patients. The tool will be updated by 31st December 2021	Fiona Myers / Helen Perfect	31/03/2022		Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards
MD9 - Page 9	The trust must use patient feedback to make improvements of the quality and variety of food available. (Regulation 17(1)(2)(a)(e)).	Food quality	Rehabilitation / Estates	The Trust will improve (according to patients) the quality and variety of food choices on the menus offered.	Update: -Estates and Facilities are reviewing the process for managing patients feedback on meals and menus more productively. - A trends and themes report is being submitted to the LPT Nutrition group meeting to allow for discussion and monitoring of the quality and choice of the food provided to wards which is being included at the shared service meeting with the external catering provider to identify trends and themes of feedback and improve the quality of service received from the provider. - the Rehabilitation wards have monthly patient community meetings facilitating feedback. the agenda has been amended to include you said / we did responses. - Updated posters, co-produced with service users, have been developed to display on the ward.	1. Across the Directorate the Matrons will collate feedback from all wards patient community meetings regarding quality and choice of food to the Trust Nutrition Group Meeting to enhance availability of quality food choices with the external provider	Fiona Myers / Helen Perfect / Richard Brown	28/02/2022		Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards Quality Forum
MD10 - Page 9	The trust must ensure staff are up to date with mandatory training including Mental Health Act training. (Regulation 18(1)).	Mandatory Training - MHA	Rehabilitation	The Trust will achieve mandatory training compliance of above 85% in the number of staff trained in the Mental Health Act	Update: - The Rehabilitation wards have reviewed mandatory training to support recovery of compliance since Covid-19 - The number and frequency of scheduled MHA training dates has been examined to ensure that they meet the requirements of the number of staff requiring training and additional sessions can be provided.	1. Ward sisters/Charge Nurses are implementing a plan to ensure staff that are out of date for all mandatory training including MHA training are scheduled protected time to undertake mandatory and clinical training on the next ward roster in Jan 2022	Fiona Myers / Helen Perfect	31/01/2022		Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards
MD12 - Page 9	The trust must ensure that the privacy and dignity of patients is always maintained. (Regulation 10(2)).	Privacy & Dignity	Acute / PICU	The Trust will maintain the privacy and dignity of all patients	Update: - Estates and Facilities have implemented a new system whereby the replacement/ hanging of curtains is prioritised as soon as the wards report an issue. - A daily environmental checklist is carried out on the wards which includes all curtains, window and bed spaces, and the ward sisters oversee the checking for compliance. Any concerns are escalated to the Team manager / Matron. - Spot checks are routinely undertaken. - All wards display temporary laminated signs on patient bedrooms to remind staff to knock. - A more permanent solution is in development.	1. Permanent signage on bedroom doors will be co-designed with service user feedback and is in development. Permanent signage will be in place by 28th February 2022.	Fiona Myers / Michelle Churchard Smith	28/02/2022		Acute and PICU Quality and Safety meeting, DMT, Executive Boards

Ref No:	Must Do Actions	Theme	Service	Improvement / Objective	Update following inspection	Actions Required	Lead (Executive & Local)	Deadline	Action Status / RAG Rating	Governance/ Approving Committee
MD13 - Page 9	Staff must ensure they routinely explain rights to informal patients, offer written information and record this. (Regulation 11(1)).	Patient Rights	Acute / PICU	Informal patients will be given information on their rights and that this will be clearly documented in the patients records	Update: - A new Bradgate Unit Welcome Pack, co-produced with patients, available on all wards which includes information for patients wanting to leave the ward. - Whilst the wards await full information packs to be distributed, leaflets regarding informal rights are available for patients on admission.	1. Immediately following inspection wards were supplied with information leaflets for informal patients as an interim measure until each ward is issued with the new information pack, including leaflets and posters, to be available by 31st December 2021. Ward Sisters / Charge Nurses will sign to confirm receipt of the information pack on distribution to the ward. 2. Offering informal patients a rights leaflet will be added to the admission check list, to confirm it has been provided to the patient and enabling auditing of the process. The first audit will be completed by January 2022	Fiona Myers / Michelle Churchard Smith	31/01/2022		Acute and PICU Quality and Safety meeting, DMT, Executive Boards
MD15- Page 9	The trust must ensure that all wards are properly maintained with requests being attended to in a timely way. (Regulation 15(1)).	Maintenance-Estates	Acute / PICU	The trust will have an effective system in place where wards report maintenance issues and Facilities attend to the repairs in a timely manner	Update: -A new environmental checklist has been developed which is being used by ward teams to identify repairs / maintenance requests in a timely manner. - The Ward sisters / charge nurses are maintaining a spreadsheet of all maintenance requests detailing job numbers for action with the estates and Facilities team. - A monthly estate meeting is now in place with site facilities coordinator, manager and estates link to review and escalate any outstanding works to the Business and Performance Meeting and Health and Safety Action group. - Trust Board have approved a business case and are investing in a facilities Management Transformation Programme.	1. The 6 weekly Matron / manager quality assurance audit tool will include questions on checking that the environment al checklists have been completed fully and relevant actions addressed. The first cycle will be completed by Jan 2022	Fiona Myers / Michelle Churchard Smith / Richard Brown	31/01/2022		Acute and PICU Quality and Safety meeting, DMT, Executive Boards
MD16 - Page 9	The trust must ensure that managers review incidents in a timely way, in line with trust policy. (Regulation 17(1)).	Incident Review	Acute / PICU	Incidents will be reviewed as per Trust Policy	Update: - The sign off of all incidents, to ensure closure is undertaken within required timescales, is an agenda item at the weekly directorate incident review meeting and reviewed at the Incident Oversight Group. - The format of the AFPICU Incident Review Meeting has been amended. - A highlight report is to be presented at the Directorate Quality and Safety meeting in January 2022.	1.All outstanding incidents for Acute and Forensic Services will be reviewed and will be signed off by the 31st Jan 2022 2. Incident management update training will be provided to all ward sisters / charge nurses and deputies to be completed by the 31st Jan 2022.	Fiona Myers / Michelle Churchard Smith	31/01/2022		Acute and PICU Quality and Safety meeting, DMT, Executive Boards
MD17 - Page 9	The trust must ensure the acute and psychiatric intensive care wards have consistent and effective management of contraband items – to include lighters. (Regulation 17(1)(2)).	Checks Policy	Acute / PICU	The acute wards for adults of working age and psychiatric intensive care units will have an effective process in place in relation to managing items of contraband, including lighters	Update: - We have improved compliance with checking and searching training. - The Quality Improvement project that focuses on checking and searching patients has commenced. - A new checklist has been developed for the wards to use which logs patients lighter use. - The quality improvement starter has been approved and the first audit on the use of patients lighters is to be disseminated in December 2021. - Spot checks have been undertaken to ensure compliance with Policy.	1. The 6 weekly Matron/ Manager quality assurance audit tool will include questions on checking that patients who smoke have a care plan in place, log the equipment used for smoking and that the lighter checklist is in use. The first cycle will be completed by January 2022	Fiona Myers / Michelle Churchard Smith	31/01/2022		Acute and PICU Quality and Safety meeting, DMT, Executive Boards

Ref No:	Must Do Actions	Theme	Service	Improvement / Objective	Update following inspection	Actions Required	Lead (Executive & Local)	Deadline	Action Status / RAG Rating	Governance/ Approving Committee
MD18 - Page 9	The trust must ensure that all patients have appropriate access to a range of psychological therapies. (Regulation 18(1)).	Psychology Access	Acute / PICU	Psychological therapy will be available to patients who require it as part of their treatment	Update: - Since inspection a series of recruitment exercises to therapy posts have been undertaken. - The vacancies in OT Support Worker posts have been successfully recruited to, recruitment will continue to support turnover. - Recruitment to bank OT has been successful and will be ongoing. - The Band 8c lead psychology post has been recruited into.	1. Following successful recruitment to the lead post the remaining psychology posts and vacancies will be advertised by the end of December 2021 2. Any vacant occupational therapy posts will be re-advertised by the end of December 2021.	Fiona Myers / Michelle Churchard Smith	28/02/2022		Acute and PICU Operational Management meeting, mental health Directorate Workforce group, DMT, Executive Boards
MD19 - Page 9	The trust must ensure that all clinical staff receive training in the Mental Health Act which is updated regularly. (Regulation 18(2)).	Mandatory Training - MHA	Acute / PICU	The acute wards for adults of working age and psychiatric intensive care units will achieve compliance of 85% or above of staff trained in the Mental Health Act	Update: - Since inspection the Acute and PICU wards have reviewed mandatory training to support recovery of compliance since Covid-19. - The number and frequency of scheduled MHA training dates has been examined to ensure that they meet the requirements of the number of outstanding staff requiring training.	1. Ward Sisters / Charge Nurses will implement a plan to ensure staff out of date for all mandatory training including MHA/MCA and life support training will be scheduled protected time to undertake mandatory and clinical training on the next ward roster in January 2022	Fiona Myers / Michelle Churchard Smith	28/02/2022		Acute and PICU Operational Management meeting, mental health Directorate Workforce group, DMT, Executive Boards
MD20 - Page 9	The trust must ensure that all clinical staff receive training in the Mental Capacity Act which is updated regularly. (Regulation 18 (2)).	Mandatory Training - MCA	Acute / PICU	The acute wards for adults of working age and psychiatric intensive care units will achieve compliance of 85% or above of staff trained in the Mental Capacity Act	Update: - Since inspection the Acute and PICU wards have reviewed mandatory training to support recovery of compliance since Covid-19. - The number and frequency of scheduled MHA training dates has been examined to ensure that they meet the requirements of the number of outstanding staff requiring training. - MCA training is available on U Learn.	1. Ward Sisters / Charge Nurses will implement a plan to ensure staff that are out of date for all mandatory training including MHA/MCA and life support training are scheduled protected time to undertake mandatory and clinical training on the next ward roster in January 2022	Fiona Myers / Michelle Churchard Smith	28/02/2022		Acute and PICU Operational Management meeting, mental health Directorate Workforce group, DMT, Executive Boards
MD21 - Page 9	The trust must ensure that all clinical staff are trained in basic life support, and qualified nurses undertake intermediate life support training. (Regulation 18(2)).	Mandatory Training	Acute / PICU	The acute wards for adults of working age and psychiatric intensive care units will achieve compliance of 85 % or above for clinical staff in BLS and 85% or above for Qualified Nurses in ILS	Update: - Since inspection the Acute and PICU wards have reviewed mandatory training to support recovery of compliance since Covid-19. - The number and frequency of scheduled MHA training dates has been examined to ensure that they meet the requirements of the number of outstanding staff requiring training. - Basic and ILS training within Covid secure guidelines has been restored.	1. Ward Sisters / Charge Nurses will implement a plan to ensure staff that are out of date for all mandatory training including MHA/MCA and life support training are scheduled protected time to undertake mandatory and clinical training on the next ward roster in January 2022	Fiona Myers / Michelle Churchard Smith	28/02/2022		Acute and PICU Operational Management meeting, mental health Directorate Workforce group, DMT, Executive Boards

Ref No:	Must Do Actions	Theme	Service	Improvement / Objective	Update following inspection	Actions Required	Lead (Executive & Local)	Deadline	Action Status / RAG Rating	Governance/ Approving Committee
MD22 - Page 9	The trust must ensure that all staff follow NICE guidance regarding the use of rapid tranquilisation and monitor side effects and the service user's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status. To protect patients from the risks of over sedation and possible loss of consciousness. (Regulation 12(2)(f)).	Rapid Tranquilisation - NICE guidance	Learning Disabilities	The Trust will adhere to NICE guidance in monitoring the physical health of each patient receiving rapid tranquilisation.	Update: - Records demonstrate compliance in training, 100% of all available Registered Nurses have completed the ulearn training on rapid tranquilisation. - 5 episodes of rapid tranquilisation were reviewed by the ward manager and unit matron. Documented care provided evidenced all care had been delivered as per the policy and NICE guidance. - Guidance on how to monitor side effects and complete the template on SystmOne has been implemented and shared with the team and a laminated flow chart is on display. - There are clear systems in place for monitoring and reviewing records. - There is a clear system in place to identify clinical staff who require an update on their return to work. - Pharmacy are providing a daily and weekly summary report to the Charge Nurse on the use of rapid tranquilisation, which is reviewed by the Matron. - Following each administration the Charge Nurse and Matron are reviewing practice and documentation of the event.	1. All remaining clinical staff who require an update on the use of rapid tranquilisation will complete the ulearn module on their return to work.	Helen Thompson / Zayad Saumtally / Francine Bailey	31/01/2022		Service line weekly meetings, monthly DMT and reporting to Executive Boards
MD23 - Page 9	The Trust must ensure that all staff are trained in basic life support and intermediate life support. (Regulation18(2)(a)).	Mandatory Training	Learning Disabilities	The wards for people with learning disability or autism will achieve compliance of 85% or above for clinical staff in BLS and trained nurses in ILS	Update: - Since inspection, the Unit has reviewed mandatory training to support recovery of compliance since Covid-19 by means of a designated member of staff who monitors staff training. - Monthly training compliance reports are being reviewed by the Team Manager and Charge Nurse and immediate actions being taken to ensure improved compliance. - There is now a process in place for the Charge Nurse and staff member designated to focus on training, are notifying staff when their training is due and supporting them to ensure they are booked on and compliant.	1. The outstanding members of available staff will be booked onto Immediate Life Support training, this is in progress with a completion date by the end of December 2021. 2. 3 available staff members will be booked onto Basic Life support training and will be completed by end of December 2021	Helen Thompson / Zayad Saumtally / Francine Bailey	31/01/2022		Service line weekly meetings, monthly DMT and reporting to Executive Boards
MD24 - Page 9	The trust must ensure there are effective systems and processes to monitor the quality of clinical records, in particular seclusion records, physical health monitoring post rapid tranquilisation (Regulation 17(2)(b)).	Clinical Record keeping audits	Learning Disabilities	The wards for people with learning disability or autism will have an effective system in place where clinical records are audited and actioned to improve the quality of clinical documentation.	Update: - Following each episode of rapid tranquilisation use, care records are being reviewed by the Charge Nurse. - In addition the Unit Matron is carrying out monthly reviews of all episodes of rapid tranquilisation administration and seclusion to quality check practice, documentation and adherence to policy and NICE guidance.	1. Monthly auditing of individualised patient records will be carried out to review all care, including physical health monitoring, and will be reviewed at service meetings to ensure sustained compliance	Helen Thompson / Zayad Saumtally / Francine Bailey	31/01/2022		Service line weekly meetings, monthly DMT and reporting to Executive Boards

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Leicestershire Partnership NHS Trust

Public Trust Board – 21 December 2021

Infection Prevention and Control Six-Monthly Report to Trust Board

Introduction

This six monthly report provides assurance from the Director of Infection Prevention and Control (DIPaC) that the trust has a robust, effective and proactive Infection Prevention and Control (IPC) strategy and work programme in place, that demonstrates compliance with the Health and Social Care Act 2008 (updated July 2015) also referred to as the Hygiene Code.

Background

The Infection Prevention and Control (IPC) team is currently has 5.1 Whole Time Equivalent (WTE) Infection Prevention and Control Nurses, supported and managed by the Assistant Director of Nursing and Quality/Deputy Director of Infection Prevention and Control (DDIPaC). Recruitment into the IPC team will take place in the new year due to two team members retiring (one had previously retired and returned) which will take the team to 3.7 WTE IPC nurses and a 0.8 WTE IPC administrator.

The Infection Prevention and Control Board Assurance Framework (BAF) was updated on the 12 February 2021. The revised document added/updated a further 32 Key Lines of Enquiry (KLoEs). The BAF was reviewed, and information and reports embedded within the self-assessment. The BAF self-assessments and subsequent updates have been shared with Trust and both NHS England & Improvement (NHSE & I) IPC leads and Care Quality Commission (CQC) as detailed in previous Trust board 6-month IPC reports, all BAF actions completed.

Purpose of the report

The aim of this report is to provide the Trust Board with assurance there is a robust, effective and proactive infection prevention and control programme in place, that demonstrates compliance with the Health and Social Care Act 2008 (updated July 2015) and to assure the board that all IPC measures taken are in line with government COVID-19 IPC guidance.

In addition the report provides updates on;

- Outcome and actions following the NHS England & Improvement (NHSE&I) Infection Prevention Control (IPC) visit on 14 October 2021.
- Information, quality improvement learning and actions for compliance in regard to Covid-19 outbreaks and nosocomial Covid-19.
- Actions and compliance for the notification of Legionella Anisa in the water systems at Coalville Community Hospital in November 2021.

- Podiatry decontamination update

Analysis of the issue

1. NHS England & Improvement (NHSE& I) IPC visit and action plan

1.1 Following the NHS E & I IPC visit on the 14 October 2021 the Trust was rated as GREEN. Appendix 1 is a copy of the letter following the visit. Overall, the trust was commended on its governance arrangements and improved standards of infection prevention and control. The response and welcome received from the staff in LPT was also acknowledged.

1.2 A small number of areas for improvement were identified at the visit and a plan developed to address these (Appendix 2).

2. Legionella Anisa identified in Coalville Community Hospital

2.1 Precautionary water treatment work is now under way at Coalville Community Hospital (CCH) following testing after routine planned preventative management identified increased temperatures during the monitoring phase. Water samples taken from CCH indicated the presence of legionella. As a precaution, immediate action across the whole building was undertaken with advice and support from our Trust water safety group and an independent water advisor (the authorising engineer). Further detail is provided under the water management section 7.

3. COVID-19 pandemic

3.1 The Covid-19 pandemic continues into its 21st month since being declared initially as a national level 4 incident within the United Kingdom.

3.2 Covid-19 is an infectious disease caused by a newly discovered coronavirus. Coronaviruses are a family of viruses that cause diseases in animals. Seven, including Covid-19 have made the jump to humans.

3.3 Covid-19 is closely related to Severe Acute Respiratory Syndrome (SARS) which swept around the world in 2002 to 2003.

3.4 National guidelines and communications issued continue be logged through the Trust Incident Control Centre and or Clinical Reference Group and action cards for staff guidance are updated to ensure as a Trust we have responded in an evidence-based way to maintain the safety of patients, staff, volunteers and contractors. A weekly Covid-19 bulletin is emailed out on a Wednesday afternoon with all recent updated guidance, advice and news and sent to all staff within the trust.

3.5 Lateral flow testing for all staff within LPT continues to be supported and has been successful in identifying a number of staff who had a positive result despite being asymptomatic.

3.6 LPT figures for Covid 30 March 2020 until 30 November 2021 are:

- Total number of positive cases – 726

- Total number of positive cases on the day of admission – 424
- Total number of cases positive after admission – 302

The positives after admission are broken down as follows: -

- Positive result within 2 days (Community onset) - 31
- Positive result between 3 and 7 days (Indeterminate Healthcare association) - 75
- Positive result between 8 and 14 days (Probable Healthcare Onset) - 55
- Positive result 15 days or later (Definite Healthcare association) – 141

3.7 Covid-19 outbreaks

They have been six Covid-19 Outbreaks between 1 July 2021 and 30 November 2021, the following information identifies the locations and numbers of patients and staff affected.

Area	Date identified	Date closed	Patient numbers	Staff Numbers
Community Mental Health Team (liaison based at UHL Staff only	09/08/21	07/08/21	0	3
Beacon Unit	24/08/21	25/09/21	2	2
CMHT Hawthorne centre Staff only	25/08/21	22/09/21	0	2
Willows Cedar ward	31/08/21	08/10/21	2	4
Mill Lodge	06/10/21	17/11/21	8	7
Coalville Ward 4	14/10/21	25/11/21	7	2

The outbreaks for Mill Lodge and Coalville ward 4 have been identified as Serious Incidents (SIs) and are currently undergoing the required review investigation processes to identify learning and actions to be shared widely to reduce the risk of further outbreaks.

Learning identified as part of the outbreak reviews (which will form a further learning board) included:

- Staff must have daily LFT's when working within an outbreak situation. This includes facilities and estates. When not in an outbreak, staff should be completing LFT's twice weekly.
- Screening and triaging of visitors
- Mask wearing in admin offices
- Social distancing at work
- Keeping desks clear and wiping down between use
- Carrying out symptom checks with patients that have been in contact with positive staff members
- Early visits from the IPC team in outbreak situations have been beneficial

- How we inform patients and their families that they have HCAI and how this is recorded
- Recording the use of offering patients masks, even if their physical/mental health doesn't allow and ensuring that this is recorded
- Sharing of equipment
- Staff using shared areas during outbreak situations such as lockers

3.8 Further guidance '*Infection prevention and control for season respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022*', was published by the government on the 24 November 21. The guidance is currently under review by the IPC team, to be discussed at the IPC group on 14 December 21 and a briefing to Operational Executive Board on 17 December 21.

3.9 The UK Health Security Agency (UKHSA), formerly Public Health England (PHE), has up-to-date genomic definitions for all variants of concern (VOCs) and variants under investigation (VUIs). A UKHSA technical briefing issued on 30 November 2021 outlined there are 5 current VOCs and 7 VUIs. The World Health Organization (WHO) designated B.1.1.529 as a VOC, named Omicron, on 26 November 2021.

The UKHSA issued a SARS-CoV-2 variant of concern: Omicron variant risk assessment on 8 December 2021. The risk assessment outlines that the Omicron variant is likely to outcompete the Delta variant in the UK. Is as least as transmissible as the Delta variant and there is not yet sufficient data to quantify either vaccine effectiveness or risk of re-infection.

4. Seasonal Flu vaccination programme

4.1 LPT is required to deliver an annual seasonal flu campaign, offering all staff the opportunity to have the seasonal flu vaccine.

4.2 For context, the flu vaccination programme runs between October and February every year. This year the flu vaccination programme is running alongside the Covid-19 vaccination and booster programme.

4.3 The figures below identify the current position of the trust for the uptake of the flu vaccine.

Accurate to 30 November 2021

		Influenza	
All staff	**No. staff**	**1 dose**	**Vaccine Uptake (%)**
Total	7349	3399	**46.3%**
Of which LPT staff	*6732*	*3167*	*47.0%*
Of which Workforce Bureau staff	*617*	*232*	*37.6%*
Staff with direct patient contact	5804	2591	**44.6%**
Of which LPT staff	*5187*	*2359*	*45.5%*
Of which Workforce Bureau staff	*617*	*232*	*37.6%*
Staff without direct patient contact	1545	808	**52.3%**
Of which LPT staff	*1545*	*808*	*52.3%*
Of which Workforce Bureau staff	*n/a*	*n/a*	*n/a*

4.4 The figures for the uptake of the vaccine have been broken down into staff groups which supports further Analysis and communication actions.

		Influenza	
Staff with direct patient contact by staff group (inc WFB) As reported to Public Health England each month	**No. staff**	**1 dose**	**Vaccine Uptake (%)**
Doctors	234	126	53.8%
Qualified Nurses, midwives and health visitors	2264	1074	47.4%
All other professionally qualified clinical staff	1008	571	56.6%
Support to Clinical Staff	2298	820	35.7%
Staff with direct patient contact	**5804**	**2591**	**44.6%**

4.5 The seasonal flu vaccine for staff has been delivered using a multi-pronged approach to support the flexibility and access opportunities for staff. Peer vaccinators continue to provide flu vaccinations as well as bookable and walk-in clinics. The opportunity to have the flu vaccination and the Covid booster at the same time has also been provided.

4.6 The table below outlines the FHCW uptake by directorate teams up the 30 November 2021.

By Directorate

		Influenza	
Directorate	**No. staff**	**1 dose**	**Vaccine Uptake (%)**
Bank	1120	315	28.1%
CHS	1720	910	52.9%
Enabling Services	587	332	56.6%
FYPC.LD	1529	783	51.2%
Hosted Services	232	126	54.3%
Mental Health Services	1544	701	45.4%
Workforce Bureau	617	232	37.6%
TOTAL	**7349**	**3399**	**46.3%**

4.7 Trust uptake data is further analysed including high and low uptake teams, teams with higher staff numbers with low uptake with a greater potential to improve/impact overall Trust performance.

4.8 Reasons for higher vaccination uptake triangulated with national data include key influencers within teams, committed leadership to the flu programme, flexibility, and a strong local peer vaccinator. Analysis of the uptake data by staff group identified that Allied Health Professionals staff are more likely to have their flu vaccine in comparison to medical and nursing staff. The trend in LPT is that many of the highest uptake teams are AHP teams/services.

5. Reporting and monitoring of HCAI Infections

5.1 There are four infections that are mandatory for reporting purposes:

- Meticillin Resistant Staphylococcus Aureus (MRSA) bloodstream infections.
- Clostridioides difficile infection (previously known as Clostridium difficile)
- Meticillin Sensitive Staphylococcus Aureus (MSSA) bloodstream infections.
- Gram Negative bloodstream infections (GNBSI)

5.2 **MRSA Blood stream infection rates**

The national trajectory is set at zero. The Trust performance for MRSA bacteraemia from April 2021 to November 2021 is zero.

5.3 **Clostridium difficile infection (CDI) rates**

The agreed trajectory for 2020/21 was 12 and is set internally by the Clinical Commissioning Group (CCG) (identified as EIA toxin positive CDI). There have been 4 cases of health care associated infection of CDI between April 2021 and November 2021:

- July 2021 – St Lukes, Ward 3
- September 2021 – Evington Centre, Beechwood Ward
  September 2021– Loughborough Hospital, Swithland Ward
- October2021 – Melton Hospital, Dalgleish Ward

5.4 All episodes of MRSA bacteraemia and CDI are identified and are subject to a Root Cause Analysis (RCA) investigation. All action plans developed as part of this process are presented to the Trust IPC meeting which supports the sign off of completed actions and an opportunity to share learning. Delayed sampling was identified as one of the learning points, and the need to consider infections other than Covid-19.

5.5 **MSSA Blood stream infection rates**

There is no identified Trust trajectory for MSSA, with national requirements focused on acute trust services only. However, the monthly data for this infection rate is submitted to the Clinical Quality Reporting Group (CQRG) as part of the quality schedule, this supports the overview of the infection rates and the potential of an increase which may need further review and investigation

5.6 **Gram Negative Blood Stream Infection (GNBSI) rates**

In 2017 the Secretary of State for Health launched an important ambition to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021 and reduce inappropriate antimicrobial prescribing by 50% by 2021.

From April 2018 the Gram Negative Bloodstream Infection rates include:

- E-Coli
- Klebsiella pneumonia
- Pseudomonas aeruginosa

5.7 There is no Trust trajectory for GNBSI, however monthly data for this infection rate is submitted to the Clinical Quality Report Group (CQRG) as part of the quality schedule reporting (Please note this captures E-Coli infection rates only). Due to the pandemic a number of planned workstreams to look at improving the reduction in rates had halted, work is now underway to re-establish the working groups.

6. Ventilation

6.1 As part of the Facilities Management (FM) transformation planning and in light of the ventilation requirements/restrictions relating to COVID-19, the Trust appointed an Authorising Engineer (AE) for ventilation directly rather than using the shared service (hosted by University Hospitals of Leicester (UHL).

6.2 Following the appointment of the AE (V) in April 2021, they are working with the Trust ventilation group to progress arising issues, asset and compliance data checks, reviewing management processes and organisational governance arrangements.

6.3 An initial Ventilation Safety Group took place in May 2021 and has met subsequently at agreed intervals and the work plan continues to be developed.

6.4 A full ventilation audit is required, and a brief is being developed to obtain quotations. This action is under review by the Ventilation group and forms part of the work being undertaken by Turner &Townsend, Facilities Management in 7.5 below.

6.5 Information regarding the maintenance and management of systems from the shared service – hosted by UHL is being reviewed by the AE.

6.6 The AE provides advice and recommendations to individual queries raised and work has been undertaken at the Electro Convulsive Therapy (ECT) suite at the Bradgate Unit to ensure that services can continue in a COVID-19 safe way. Minor works completed and the area is compliant for ventilation, further works planned to increase space and upgrade ventilation services due to age/condition.

6.7 There are no emerging or immediate risks identified for action.

7. Water Management

7.1 A serious incident report is in progress regarding the legionella previously reported and managed at the Bradgate Unit.

Precautionary water treatment work is now under way at Coalville Community Hospital (CCH) following testing after routine planned preventative management identified increased temperatures during the monitoring phase. Water samples taken from CCH indicated the presence of legionella. As a precaution, immediate action across the whole building was undertaken with advice and support from our water safety group and an independent water advisor (the authorising engineer).

7.2 During routine water testing at Coalville hospital, traces of a very low risk of Legionella Anisa were detected in the water. The drinking water remained safe, but the following actions were taken:

- immediate action to flush this out of the system.
- To maintain patient and staff safety as a precautionary measure, installation of filters to the taps were carried out
- Designated drinking water taps that have been clearly identified as safe.
- Patient admissions to the wards were held until the system has been flushed

The remedial work took place overnight on 24 November 2021 from 9pm for approximately four hours to minimise disruption to services across the hospital. This involved disinfecting the pipes

throughout Coalville hospital as part of our precautionary measures and continuing to flush it out until the pipe work is clean. All sinks and showers had signage to show they were not to be used, and additional water bottles for handwashing and drinking made available during that period.

7.3 Additional point of use (POU) filters which have been delivered to site and the remainder planned for 9 December 21. Once installed, if there are any residual bugs within the system that remain after the cleaning process, the filters will remove them. The POU filters are a temporary solution. Mitigating actions were undertaken to reduce the risk whilst the filters were unavailable

This has enabled LPT to trigger the re-sampling process, which is being arranged for GES to attend 08/12/21 Samples will take 14 days to obtain a full result. The longer-term solution will be addressed through the water management group in line with national recommendations

To note it has been confirmed that the Hawthorne centre which is based on the Coalville Community Hospital site has not been affected due to a separate water system

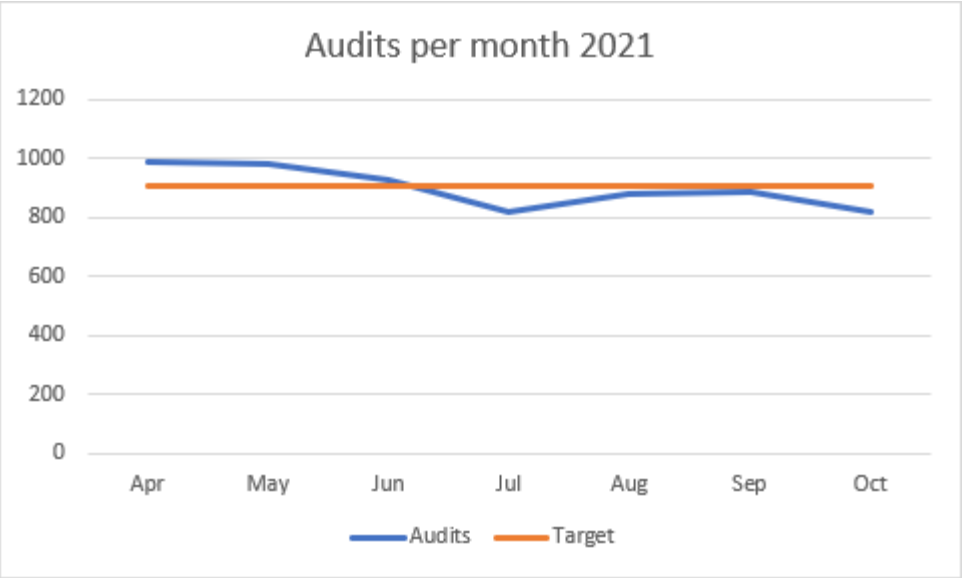
8.3 Risk 5064 has been developed and will be escalated as an organisational risk and the actions are being monitored through the Organisational Risk Register review process.

9. Hand hygiene

9.1 The total number of audits required per month by all teams equates to 1516 audits per month to ensure more robust representative auditing. The aim in 2021/22 was to maintain the total number of audits at 909 audits (60%).

9.2 In quarter 1 audits returned averaged 965 per month which dipped to an average of 863 for quarter 2. Quarter 3 data has started with a return of 821 audits for October 2021. Analysis and feedback have shown that this has been impacted by staff working from home, changes to link IPC staff and staffing challenges affecting time to audit and input. Every effort is being made to return the figures back to the expected level.

9.3 The graph indicates that despite all challenges faced that the number of audits remains close to, although slightly below the expected number of returns. Work continues to improve and sustain the number of audits and representativeness acknowledging the impact of staff working from home.



9.4 The quality improvement project aimed to improve adherence in handwashing as part of safe infection prevention and control practice across services in the organisation and for the Trust to increase the number of audits whilst maintaining an 85% compliance rate. The project is being supported through the Trust Quality Improvement Knowledge hub. The improvement interventions focused on data cleansing and quality, working with the directorates to improve accuracy of recording and governance monitoring. It also aimed to refocus mind sets and behaviours and the importance of hand hygiene. This is a continuous improvement cycle with a new reporting suite will be available by the end of Quarter 3.

9.5 In terms of practice and results of the audits, there has been sustained compliance performance for the year at 99%. It is anticipated and expected that as the number of audits increase there may be a decline in the overall performance as it is a more reflective representation of clinical practice.

9.6 The Trust Infection Prevention and Control team continue with the in-patient clinical support visits that include a quality assurance review of hand hygiene practice and adherence to Personal Protective Equipment (PPE).

10. Cleaning

10.1 Cleaning scores are audited bi-monthly and reported through the Trust IPC Group. Exceptions are highlighted with mitigation and actions to remedy included in the report. Work continues to ensure clinical leaders are present at the time of the audits to confirm and challenge as appropriate. In line with the national recommendations, two hourly touch point cleaning was implemented within inpatient areas. This process supported the reduction in outbreaks of infection, with specific reference to Covid-19. This process has been documented and audited to provide assurance. A business case was developed and a roving team for cleaning supported the introduction of a third clean as well as a quick response to outbreak/cleaning requirements.

10.2 A programme of work and actions continue to be put into place to address the issues identified from the audits of the cleaners' rooms and equipment. All areas have been provided with new cleaner's trolley's which include a lockable cupboard to store COSHH products; to maintain the health and safety of the occupants of the areas being cleaned.

10.3 The Trust has a twelve-month rolling deep clean programme in place and progress is monitored at the IPC Group and LPT monthly cleaning meeting, again this has been delayed due to the pandemic. Monitoring continues through the IPC group meeting.

10.4 The recent publication of the updated National Standards for Healthcare Cleanliness 2021 states that healthcare establishments must be able to demonstrate how and to what standard they are being cleaned. A programme of work has been developed to implement and monitor the levels of the standards. Reporting will be through the IPC group meetings.

11. Decontamination

11.1 During the review of several risks on the risk register, it was identified within Community Health Services that the risk regarding the decontamination processes for the Podiatry services, had not been reviewed for some time. The following issues were picked up:

- Decontamination compliance was audited in 2016 and then the actions had not been progressed
- There had been no further audit since 2016
- A risk was raised by the service lead in 2017, number 921. This risk should have been monitored through the directorate governance arrangements however, we have no access or data to support this.
- There has been no Decontamination Authorised Engineer audit for 3 years
- Lack of evidence within podiatry staff recording equipment compliance checks
- Lack of training on decontamination requirements

11.2 The following reasons were identified for the above gaps:

- Change in service leads within podiatry and CHS management
- Change in FM provision
- Volume of work

11.3 Following the issues being identified a series of meetings and the following actions have been completed:

- Risk assessment placed on the risk register – Score 6
- Dirty to clean workflow system in place
- Staff have access to single use instruments where risk is high i.e., contact with tissue fluid
- Where washer disinfector not available there is a separate sink and appropriate PPE for staff in place to scrub instruments
- Instruments are all cleaned in a separate room to clinic room
- Steam sterilisers are validated and maintained and operated in accordance with the HTM2010

11.4 The current known gaps in controls have been identified as:

- For some autoclaves there is an inability to empty the reservoir at the end of the day posing infection control risk due to stagnant water
- Washer disinfector not available in all clinics
- Missing documentation of the temperature recordings and holding times of the autoclaves

11.5 Several actions have been identified and are currently being developed and updated, with monitoring through the IPC group and the CHS governance route. These include, but not limited to:

- Audits to start on 1st December 2021 and complete by the end of January 2022
- Re-establishing the decontamination group with the first meeting scheduled for January 2022
- CHS decontamination operational meeting commencing 9 December 2021
- Roles and Responsibilities for Decontamination defined and agreed by January 2022
- Training needs analysis to be agreed in January 2022

11.6 A paper was submitted to the Strategic Executive Board meeting on the 3 December 2021 for oversight of the identified risks and actions with further detail.

12. Antimicrobial stewardship

12.1 Antimicrobial stewardship is reported to the Trust IPC group every six months, with associated annual reports and audits including prescribing and consumption.

Proposal

This six monthly report outlines assurance from the Director of Infection Preventon and Control (DIPaC demonstrating compliance with the Health and Social Care Act 2008 (updated July 2015) also referred to as the Hygiene Code. The report also highlights the impact of the COVID-19 pandemic to the business as usual IPC work programme and quality improvement in response to NHSE & I IPC visits.

Decision required

The board is asked to confirm a level of assurance that processes are in place to monitor and ensure compliance with the Health and Social Care Act 2008 (updated July 2015) also referred to the as the Hygiene Code and NHS England IPC Board Assurance Framework to ensure that all IPC measures are taken in line with PHE Covid-19 guidance to ensure patient safety and care quality is maintained.

Governance table

For Board and Board Committees:	Public Trust Board 21st December 2021
Paper sponsored by:	Anne Scott – Executive Director of Nursing, AHP and Quality
Paper authored by:	Amanda Hemsley – Lead Infection Prevention and Control Nurse

Date submitted:	9.12.21	
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):	Direct to trust board	
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	6 monthly report	
STEP up to GREAT strategic alignment*:	High **S**tandards	x
	Transformation	
	Environments	x
	Patient Involvement	
	Well **G**overned	x
	Single Patient **R**ecord	
	Equality, Leadership, Culture	
	Access to Services	
	Trustwide Quality Improvement	x
Organisational Risk Register considerations:	List risk number and title of risk	5
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	Yes	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:		

L

Leicestershire Partnership NHS Trust

Public Trust Board – December 2021

Report title

Patient Safety Incident and Serious Incident Learning Assurance Report for Oct – Nov 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.

The continued impact of Covid19 Pandemic and staffing resource challenges continues to impact on the compliance with NHS framework timescales of Serious Incident (SI) investigations. This has resulted with variables in compliance with the 60 working day deadline for submission to the CCG. We are also noting reallocations of investigations due to unplanned absence, increasing workloads and need to support staff due to lack of training/experience as part of the operational teams managing priorities.
AS we start to work towards the principles of the new patient safety investigation framework (PSIRF) we are working with the CCG to ensure processes are in place to enable their assurance from the process.

Timescale compliance of internal investigations remains extended to 50 working days, however many not completed before 60 days due to the increasing challenges as noted above. The timely closure and enactment of SI and internal action plans to close the investigation process also continues to be challenging. However all Directorates have embraced ownership of this and are working hard on improvements.
The risk described is well detailed within the Trust's risk register and continues with robust local monitoring processes and oversight within governance routes into the Quality Forum. The November Quality Forum agreed to further analyse the challenges noted using Quality Summit methodology which is planned early new year.

The Corporate incident investigator posts have now all been recruited to with 8 investigators coming into post during October/November and December. with a variety of skills and backgrounds. All of the investigators are leading investigations or supporting on investigations with resulting investigation reports of a high standard. The investigators fresh eyes are already bringing a greater opportunity for learning and system change.
In addition the CPST are providing training for all investigators from directorate and the Corporate team which is being evaluated well and supporting staff to 'think differently'. The investigators from directorate that have undertaken this training will form a wider safety Faculty and be supported by the corporate team.

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 October and November 2021

CPST continue to describe 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 even across the trust or a wider healthcare system. Our incident reporting remains consistent with timely upload to the national reporting and learning system (NRLS). The NHS again is awaiting the transition to a database that is more robust and advanced system allowing for improved and quicker identification of national/regional trends in themes, earlier national escalation and eventually learning; this has been interrupted by the Covid19 pandemic. CPST upload trust wide incidents at least once a week to the current NRLS database; this is to avoid 'peaks and troughs' on our nationally reported incident profile with corporate monitoring of NRLS reports via NHSE/I website.

There are occasions when our incidents that are reported as 'moderate harm and above' are uploaded to NRLS before local review of harm/incident; these are then seen by NHSE/CQC and can be included on the national NRLS reported. We have the ability to flag incidents for re-upload to NRLS once we have reviewed the level of harm.

The CPST Lead Nurse and Incidents Officer continues to act as a 'safety net' regularly reviewing and additional monthly reviewing/escalating any outstanding incidents still flagging at 'moderate harm and above' and encourage this review through the incident review process, or by checking and challenging harm levels not reviewed in conjunction with incident review and/or closure of incidents at directorate level.

The importance of directorate and speciality ownership for timely review of incidents identifying action and the accurate application of harm level assigned to them is paramount;
The CPST are developing a business case for a Ulysses manager to support the most effective use of Ulysses as well as improved training programme for Ulysses super-users in directorates to be responsible for training locally on managing incidents from induction through to refresher and supporting newly promoted leadership roles.

Review of Patient Safety Related Incidents
The overall numbers of reported incidents remains within expected range based on previous reporting patterns and can be seen in our accompanying appendices.

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

There continues to be inconsistent trend in the trajectory and the impact on patients with category 4 Pressure Ulcers that significantly increased in October 2021 prompting a Quality Summit.

This increase is also mirrored in Category 2 pressure ulcers that have showed special cause variation since February2021.

Following the Pressure Ulcer Quality Summit, 4 work streams have been developed reporting directly into CHS DMT. These are;

- Staffing and work force.
- Specific QI projects
- SI full investigation and QI plan
- Staff engagement and Communication

The SI investigation is reviewing the care of 3/4 patients who were thought may have been affected by the prioritisation plan and in particular deferred visits. Two of the Corporate investigators are undertaking this piece of work. On review of local investigations, further Category 4 pressure ulcers have been reported to StEIS for openness and transparency

The directorate have also arranged a series of listening events for staff which will include support from one of the corporate investigators with Human Factors expertise, consider the 'system learning' and identify any ways to support staff to make it easier for them to provide care.

All inpatient acquired category 4 pressure ulcers are reported as SI's, the Executive Director of Nursing notified and an additional sharing with the CQC; there was one reported to date for October/November 2021 which also coincided with escalation of care concerns by the patients family to the CQC.

Falls

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.

Inpatient Falls with harm Incident Investigations continue to be shared with the Executive Nurse and her deputies for review and sign off before sharing with CCG. This enables greater information in understanding challenges of inpatient falls prevention and how the patients and families are affected.

'Flat lifting' equipment has been successfully rolled out in many inpatient areas to enable staff to safely raise people, who have fallen, off the floor and thus reducing the risk of exacerbating any injury. 'Raizer chairs' are also being supplied to some wards e.g. Mill Lodge, as a less invasive way of lifting patients from the floor who has fallen and when no injury has occurred.

Post fall safety huddles are used to allow the team to rapidly identify and implement additional interventions to reduce the risk of repeat falls. Falls across the organisation are starting to show a positive downward trajectory include those with harm. This is positive and demonstrates the positive targeted work in areas such as MHSOP and Mill Lodge.

All Self-Harm including Patient Suicide & Progress

In October 2021 there was an increase in suicides with several patients sadly ending their own lives in public places including a local acute hospital. There is ongoing work and discussions for

'preventing suicide in public places' with British Transport Police. This includes fencing upgrades and engagement events planned in Loughborough and Sileby. In addition the CPST have identified some thematic similarities between several incidents over a period of time, for example patients with mental health challenges have all used a car park in Leicester City centre to either cause harm or make threats to the emergency services. This has been escalated through our system wide work in reducing suicide.

The LLR Suicide Prevention Group hasalsoidentified five incidents that have taken place over the last 12 months on one particular road near Loughborough with a system wide review of responses to this.

We continue to see variable numbers of self-harm incidents resulting in moderate harm and above with a significant increase in November from July 2021. The picture remains the same within the community mental health access services continuing to report increasing numbers of patients in crisis who have allegedly self-harmed or are planning to. This is distressing for patients, their families and the staff trying to offer support and share coping strategies.

Inpatient self-harm reporting across both CAMHS and adult mental health continues to demonstrate that it can fluctuate depending on individual patients and their individual risk profile. CAMHS inpatients have seen increased incidents of inpatient self-harm, many linked to a few patients only. The 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; head-banging, ingestion and ligature attempts being common attempts by many distressed patients.

'STORM' a bespoke Training package for training Suicide Awareness, Prevention and Postvention to support our staff to deliver high quality interventions and support patients in distress by thoughts to end their lives is a priority for the trust with a options appraisal paper is being submitted for approval in adult mental health with a need to recognise this across directorates.

In November 2021 we were informed that NHSE has commissioned the Samaritans to develop 'NHS Postvention Guidance' which is due to be published in Spring 2022 to assist in staff well-being and suicide Prevention along with the National Suicide Prevention Alliance who undertook initial scoping of the challenges faced in the universities, colleges and schools with supporting students in suicide prevention and have identified possible work-streams/solutions.

The inpatient 'ligature' group have identified learning in equipment use, storage and quick availability from our EMAS colleagues with the purchase of matching equipment. This is a good example of shared learning across the disciplines for some of the most distressing incidents to affect emergency workers and inpatient NHS staff.

Violence, Assault and Aggression (VAA)

The concerning trend of high numbers of VAA across the Trust continues. In October and November 2021 incidents of moderate harm have remained consistent.

Unfortunately, this category of incident continues to feature in all mental health, CAMHS inpatient and all learning disabilities top 5 incidents. However, the position is not unique as VAA has featured nationally across all aspects of the NHS in particular access services; however, this should not be accepted as the 'norm'. LPT's challenge is to understand the patient's impact of mental health wellbeing and risk mitigations in place.

A report on the new VAA standards and our approach has been presented to QAC from Health and Safety and clinical teams. . This was a self-assessment against the new VAA standards and to propose a twice yearly meeting to allow the different work streams to come together to assess progress and consider any joint pieces of work.

The LPT security specialist is also working with other key staff to run a live trial by March 2022 on body worn cameras similar to other NHS Trusts, Emergency departments and emergency workers as a deterrent and also to positively improve staff safety and training.

Medication incidents

There has been a drive to ensure that medicines management continues to be covered by the AMAT audit project; which is demonstrating encouraging involvement and results across the Trust that are regularly reviewed by directorates and by the medicines audit group. This work supports learning and why areas have variables that may not always demonstrated by incidents reported; medication error is often multifactorial. The pharmacy teams and senior nursing/medical staff are also focussing on medicines omissions. Working with Heads of Nursing, reports are being produced which allows visibility of the issues in their clinical areas to a sufficient depth to allow them to make improvements where necessary; again these omissions may not always be identified through incident reporting which is an area for improvement. The establishment of dedicated medication safety officer posts will help to allow the Trust to move to a more proactive footing on medicines safety and also provide medicines expertise to support incident follow-up to maximise learning from patient safety incidents.

Directorate Incident Information

Appendix 1

This 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.

Self-harm across CAMHS and inpatient adult mental health remains a feature in the top 5 along with safeguarding adults. Worryingly, the tissue viability incidents reported across CHS account for a significant number of the incidents with 941 of the 1188 being reported related to these incidents affecting our patients.

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

The CQC continues to receive 72hr reports for newly notified SI's, completed SI reports and action plans along with embedded evidence.

The position with 'new' provider collaboratives remains unchanged with the lack of formalised processes meaning there is an inconsistent approach to feedback submitted in relation to patient safety incident investigation (PSII) reports. CPST are working to develop relationships and agree processes and ensuring that the focus remains on achieving learning and supporting families/patients and staff and towards the principles of the Patient Safety Strategy.

The coroner has been requesting overdue SI reports for inquests; this has placed additional pressure on the CPST and the clinical directorates with these reports having to be virtually signed off in haste.

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 and extended the invitation to those in roles were 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'. There was a session planned for October to consider 'features of an outstanding organisation' unfortunately this did not go ahead due to competing priorities of attendees. This will be re-scheduled for the new year now.

Key learning themes from SI's:-

Emerging and Recurring themes (some remain unchanged):

- Record keeping consistently highlighted across all directorates either due to timing of entries (i.e. not contemporaneous), standard of record to provide and flow of knowledge **Action;** teams considering how audit can support the QI work in relation to this

- CMHT's have identified challenges with the MDT approach to updating and **Action;** this is being considered as part of the transformation work
- Mental Capacity and safeguarding knowledge of staff across the organisation **Action;** safeguarding team responding to the identified gaps in knowledge and understanding
- Medication quantity for regular prescriptions linked to risk taking behaviour of self-harm behaviour, knowledge **Action;** working group looking at a model for safe dispensing
- Lying and standing blood pressure and medication reviews in falls with harm **Action;** ANP's to action by asking staff for results as part of their review
- Feedback related to changes from face to face to virtual appointments has been identified by staff patients/families as a challenge for some patients and also makes assessment more difficult **Action;** reports to ensure we are clear 'patient seen on' to be specific on the methodology. Senior Nursing Team for DMH considering this emerging theme

Culture of Candour

There have been no statutory breaches identified. Any delays in best practice timescales are monitored and reported and reviewed for the purpose of learning and improvement and reported at Quality Forum. There is a continued improvement across all directorates in the timeliness (<10days of recognition of 'moderate harm' and above) and quality of letters/communication with our patients and families. Services continue to embrace the practice of the person who knows the patient/family should initiate the process of candour and openness. Final duty of candour communication to be undertaken by directors has seen a sustained and positive change for our patients, their families and our staff. We continue to see 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 and does add a positive contribution to the group; there has been request by other provider collaboratives to attend with variable contribution. The Medical Director is identifying senior medical colleagues to also contribute to this process. The meeting has seen an increased attendance and presentation by key staff in directorates including those who are wanting to 'listen and learn' as part of their next step patient safety incident investigation training.

The CPST Lead Nurse continues to deliver a short training session for band 6 and above staff to promote the importance of initial incident reviews and the need for quality to better inform decision making for next steps investigation. This monthly training support continues to be well received with 112 staff attending over 4 sessions in October/November 2021 and has resulted with an increase in team leaders presenting their incidents, sharing post incident learning and participating in the decision making for next steps for investigation.

In November 2021, a further 3 corporate PSSI investigators join the trust who are in the early phases of induction and inclusion in investigations according to their individual needs. Two are new to the NHS with backgrounds in the Legal and Network rail and one from East Anglia Ambulance service bringing variety to the CPST's knowledge and skills.

The CPST continues to deliver a PSII training programme which commenced in September 2021 for band 7 staff allocated by directorates to assist in the timely undertaking of investigations and supporting learning. There are planned programmes to continue well into 2022 along with refresher training for existing staff who have previously undertaken investigation training.

Incident Oversight and action plans post investigation

The incident oversight group continues to monitor the completion of PSSI investigation reports and action plans; there continues to be challenges faced by all directorates in relation to compliance and timely completion. There is a planned quality summit in the early new year to further explore the challenges around completion, quality and oversight.

In addition we are now monitoring on the timeliness and quality of initial service managers reports that inform next steps decision making for investigation.

Learning from Deaths (LfD)

The LfD process is now supported by a newly appointed Trust coordinator with expertise from the acute provider aspect of the NHS.. A process mapping exercise of the individual directorates is underway as part of working together to streamline processes from agendas to documents and in December 2021 will take over the role of administration of all LfD meetings across the organisation.

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 21.12.21	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Sue Arnold, Jo Nicholls, Tracy Ward (Corporate Patient Safety Team)	
Date submitted:	13/12/2021	
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-Incident Review Meeting	
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:		

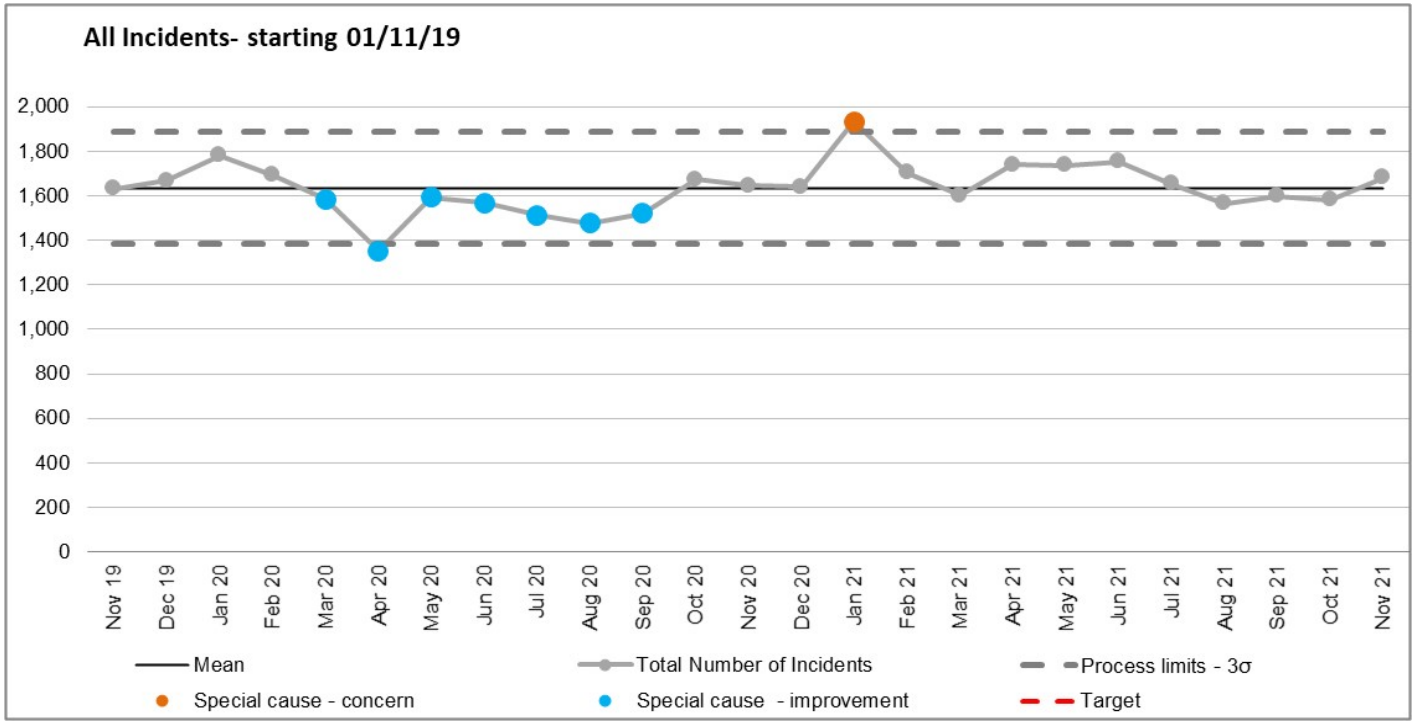
Appendix 1

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

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

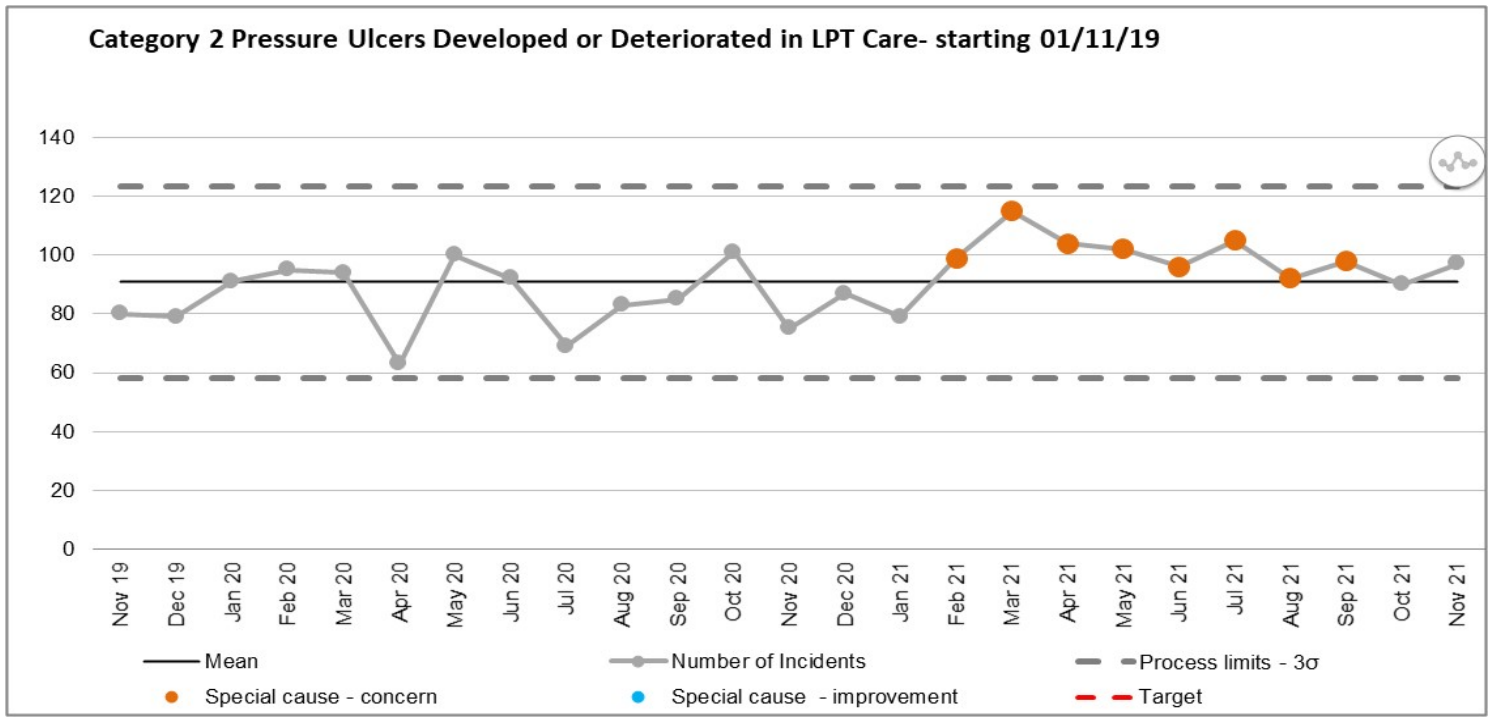
WeAreLPT
compassion respect
integrity trust

1. All incidents

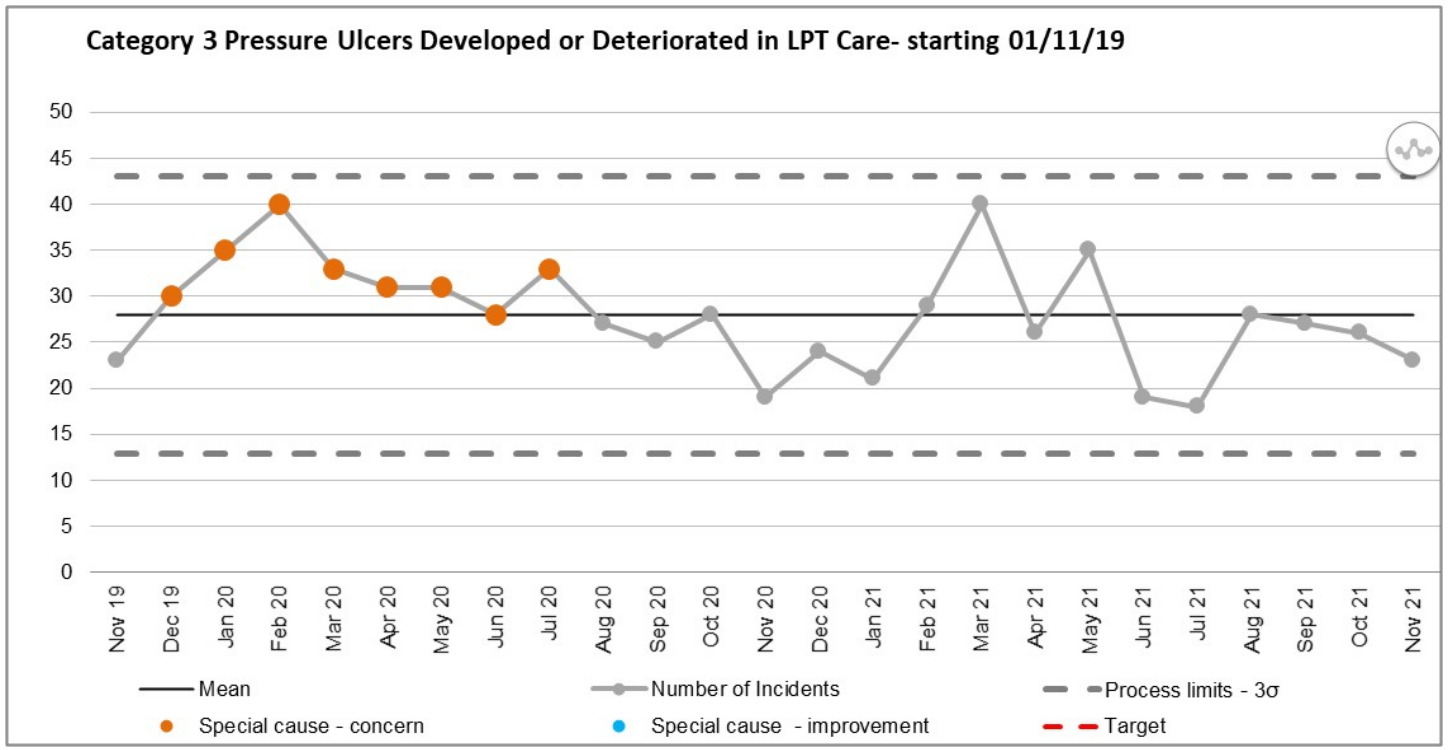


WeAreLPT
compassion respect
integrity trust

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

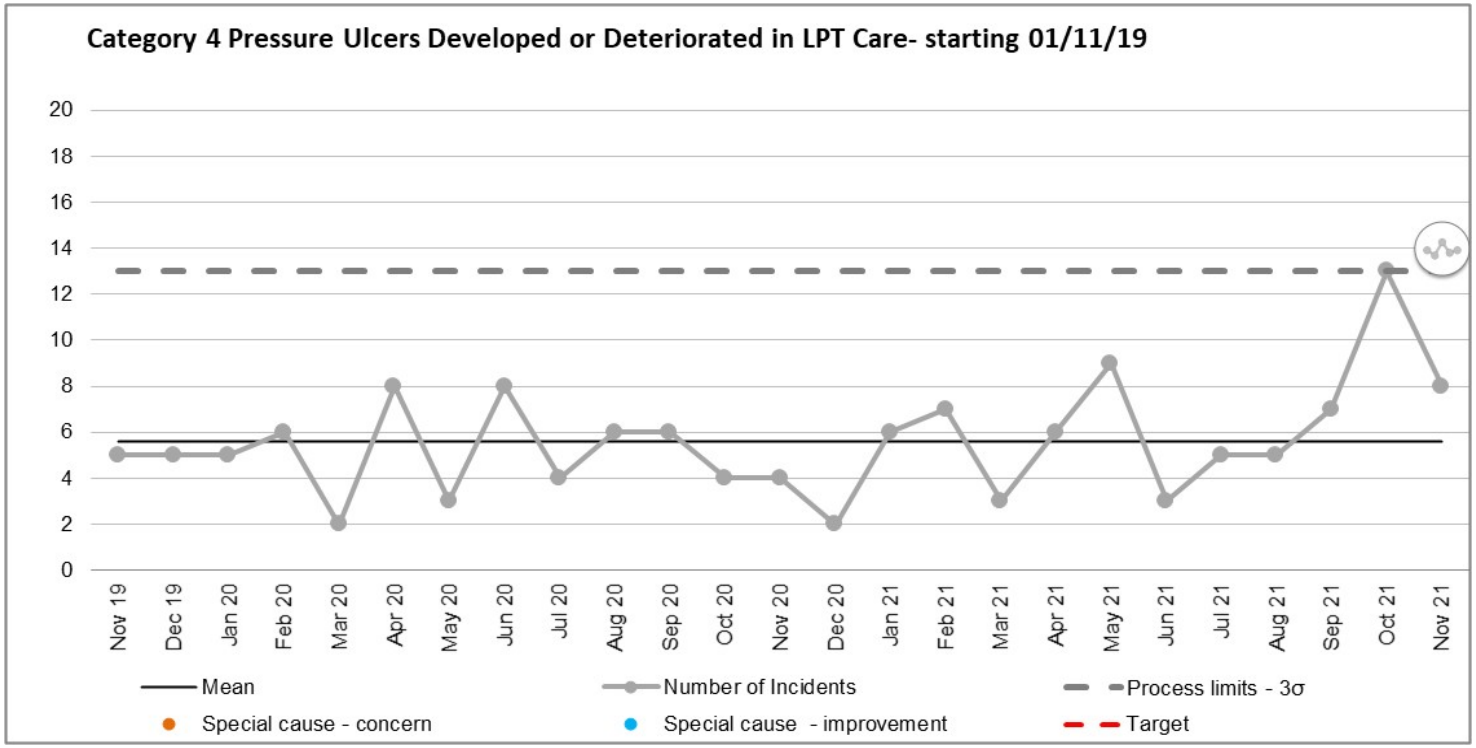


3. Category 3 Pressure Ulcers developed or deteriorated in LPT Care



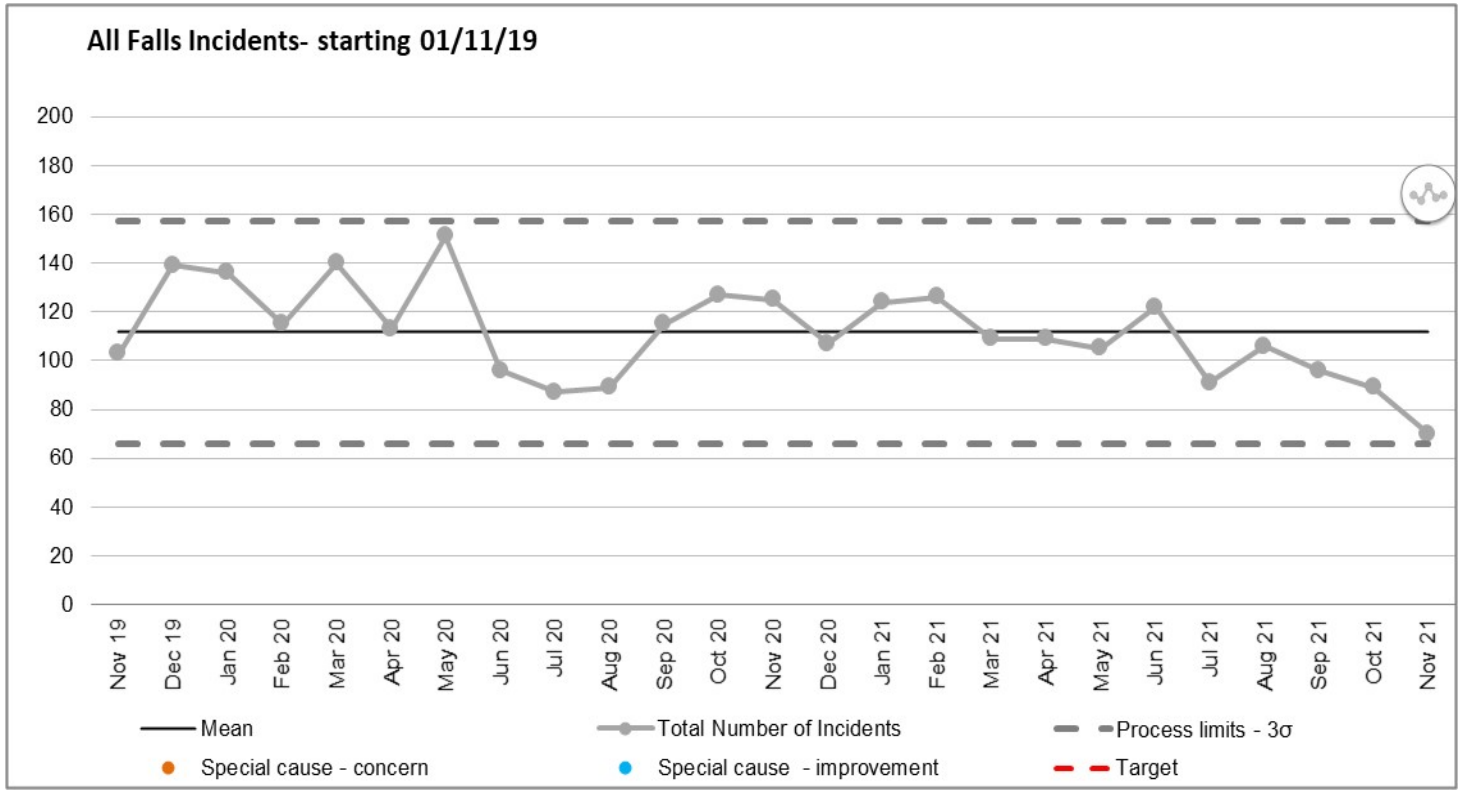
WeAreLPT
compassion respect
integrity trust

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

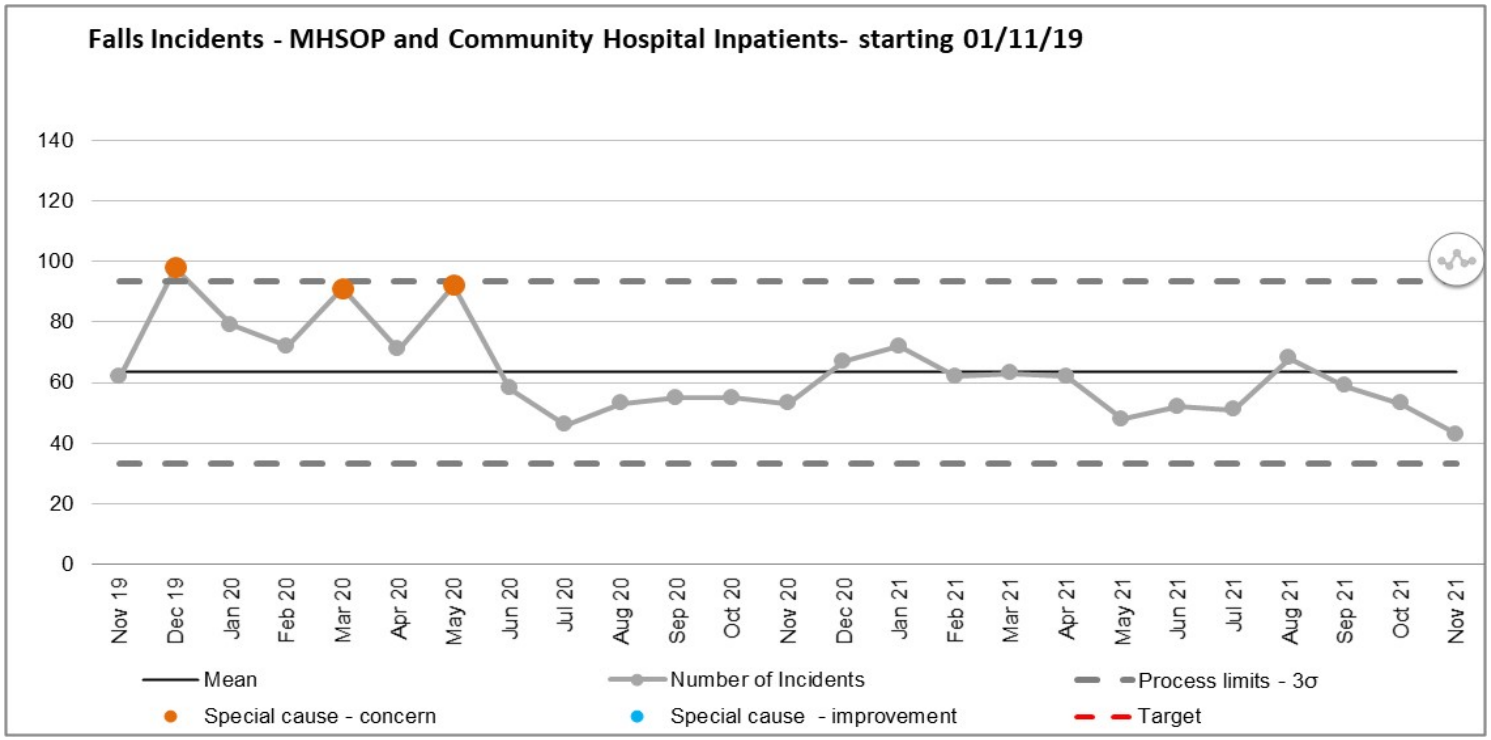


WeAreLPT
compassion respect
integrity trust

5. All falls incidents reported

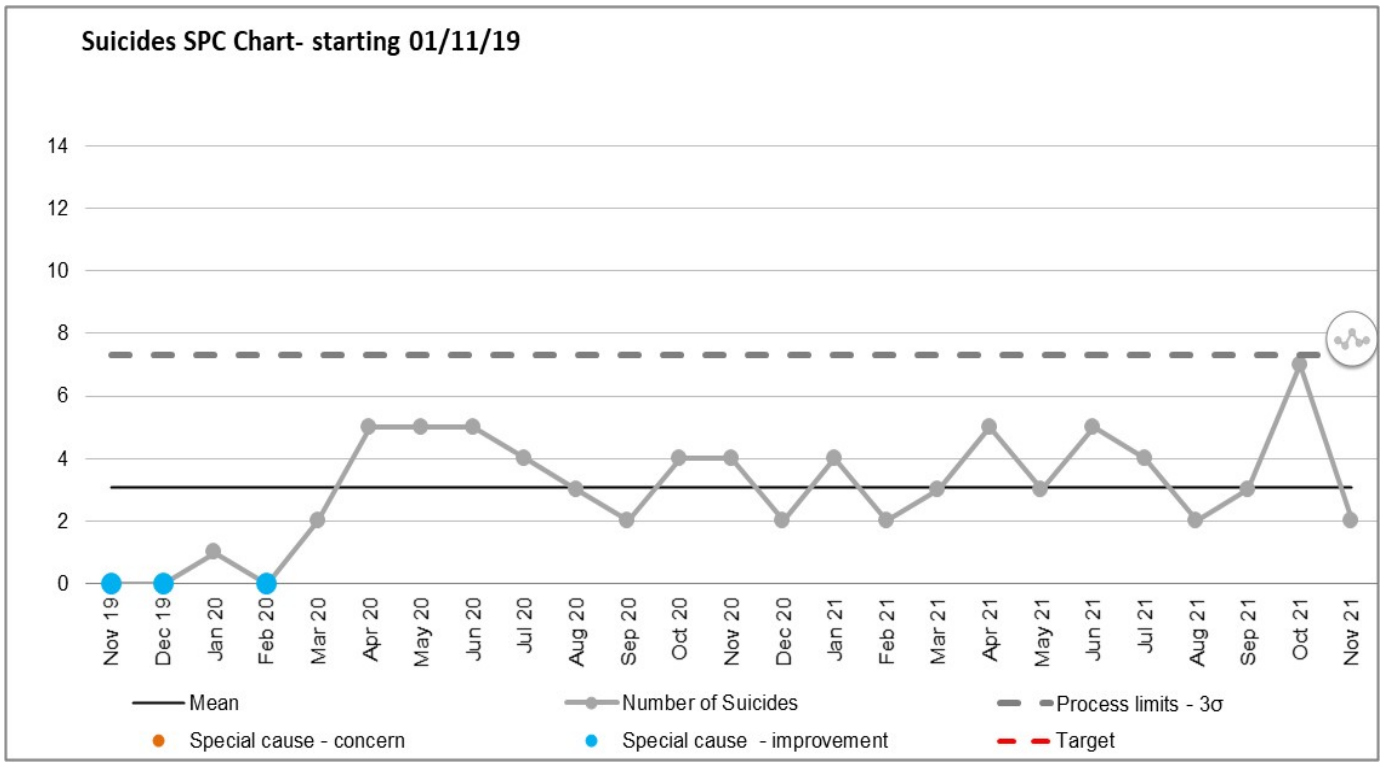


6. Falls incidents reported – MHSOP and Community Inpatients

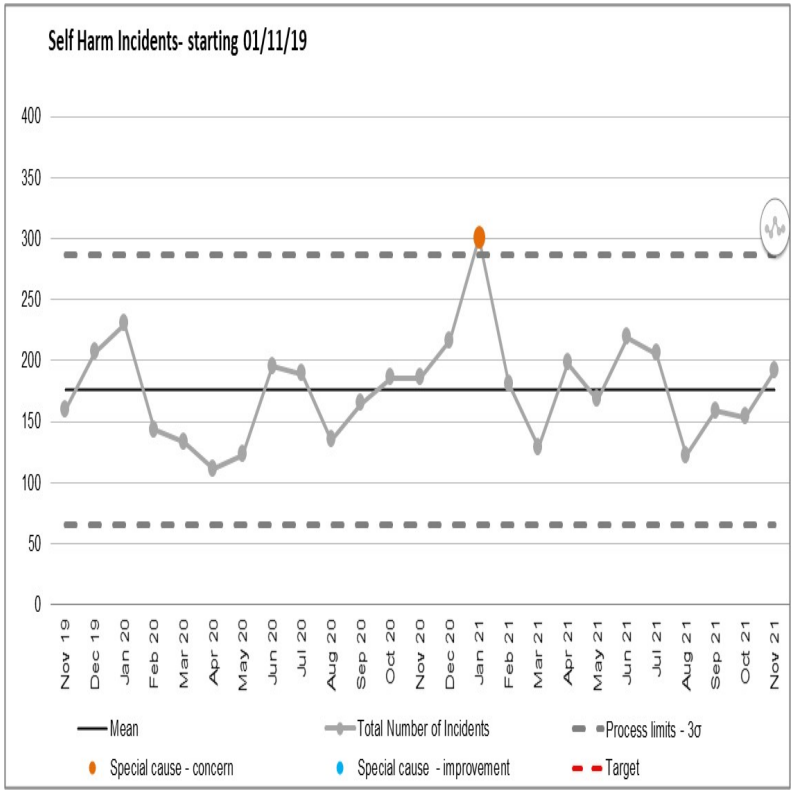


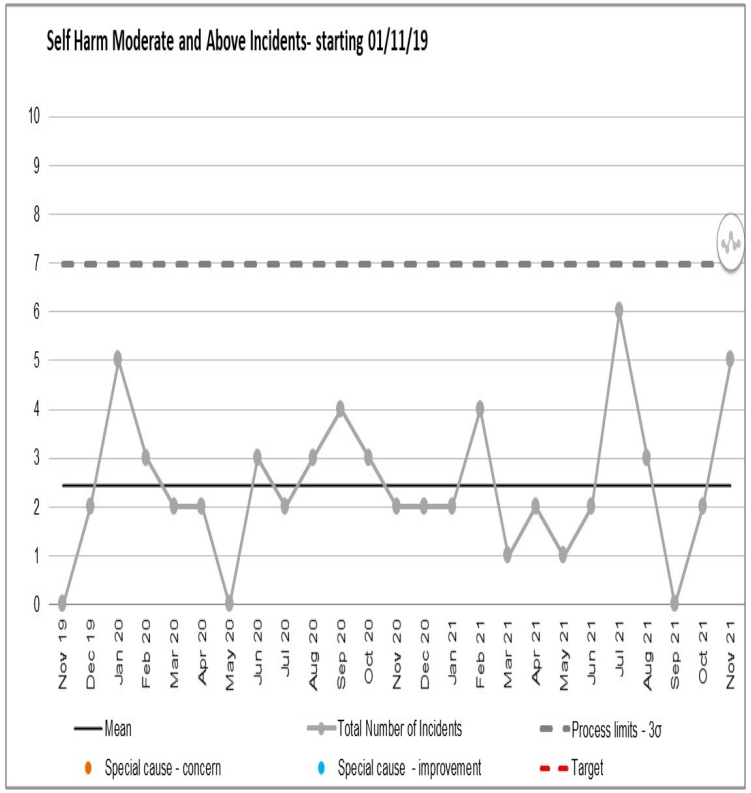
WeAreLPT
compassion respect
integrity trust

7. All reported Suicides

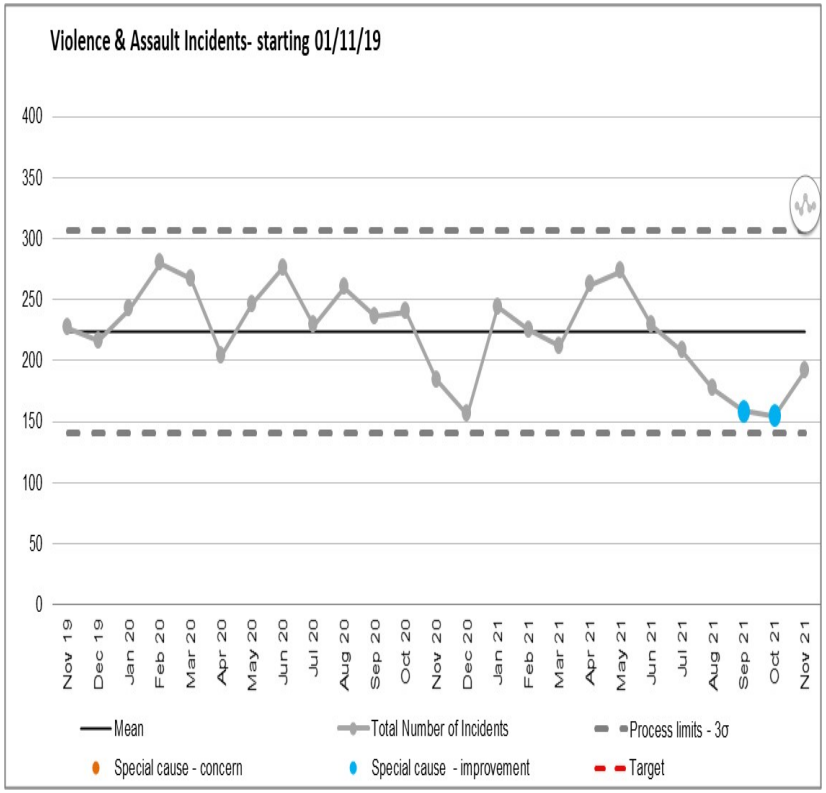


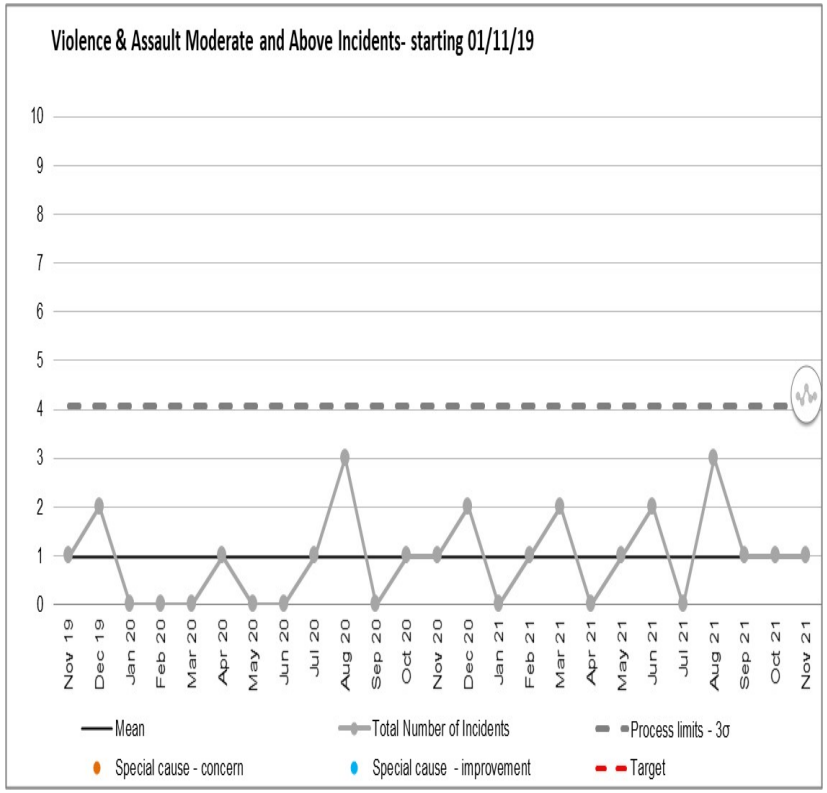
8. Self Harm reported Incidents





9. All Violence & Assaults reported Incidents





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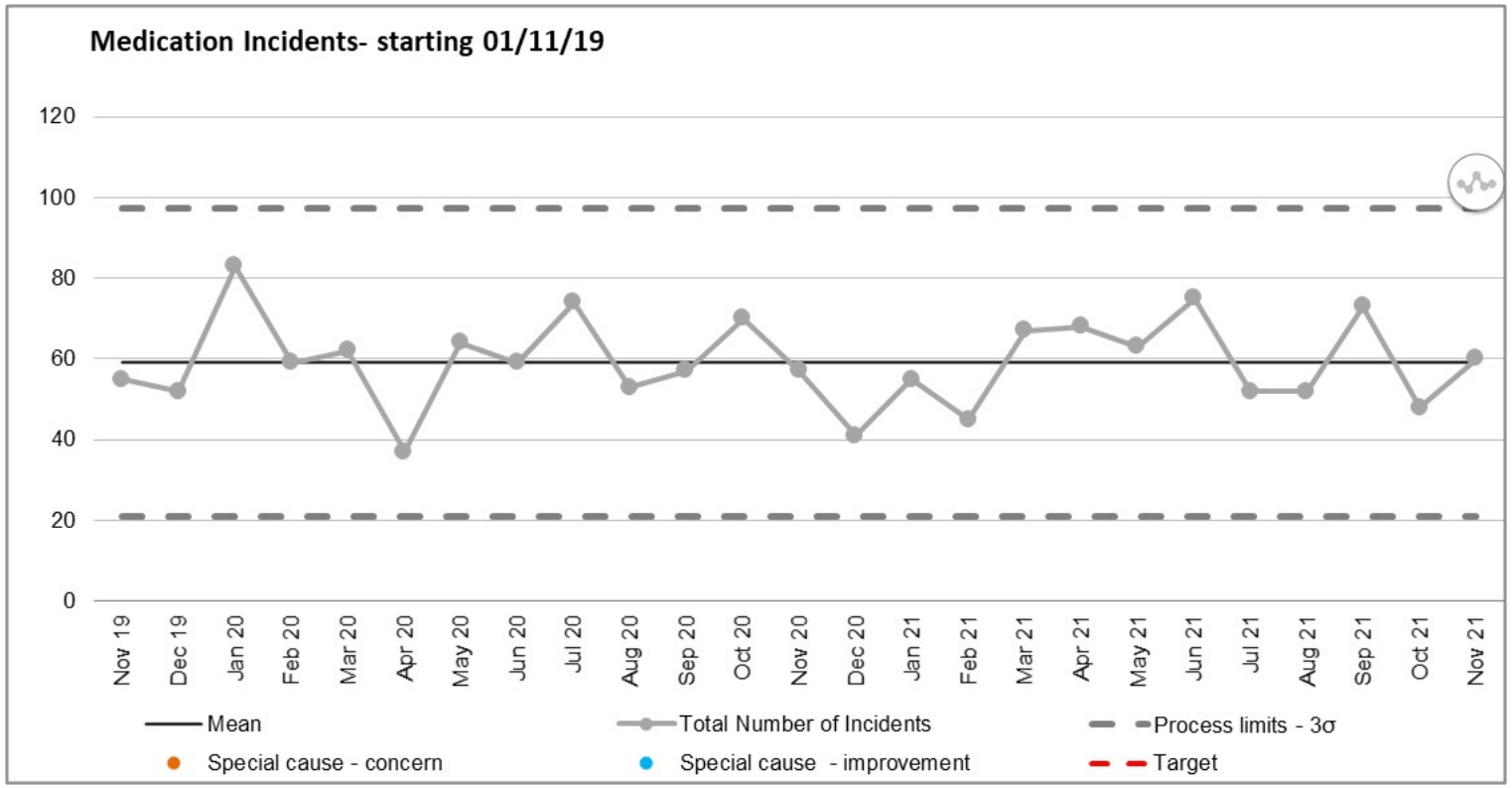
10. All Medication Incidents reported



11. Directorate Specialities describing Top 5 Incidents

Table 1: Mental Health: Community

Mental Health Non MHSOP Community - October	
Cause Group	**Total**
Self Harm	55
Violence/Assault	30
Patient Death	16
Safeguarding (Adults)	13
Infection Control	11

Mental Health Non MHSOP Community - November	
Cause Group	**Total**
Self Harm	61
Violence/Assault	32
Patient Death	16
Safeguarding (Adults)	15
Clinical Condition	11

Table 2: Mental Health: Inpatients

Mental Health Non MHSOP Inpatient - October	
Cause Group	**Total**
Violence/Assault	101
Self Harm	26
Staffing	26
Patient Falls, Slips, And Trips	25
Infection Control	18

Mental Health Non MHSOP Inpatient - November	
Cause Group	**Total**
Violence/Assault	102
Patient Falls, Slips, And Trips	23
Clinical Condition	22
Self Harm	21
Staffing	17

Directorate Specialities describing Top 5 Incidents

Table 3: MHSOP – Inpatients

MHSOP Inpatient - October	
Cause Group	**Total**
Patient Falls, Slips, And Trips	21
Clinical Condition	11
Violence/Assault	9
Medication	4
Security	3

MHSOP Inpatient - November	
Cause Group	**Total**
Patient Falls, Slips, And Trips	17
Clinical Condition	11
Violence/Assault	10
Infection Control	2
Non-Medical Equipment	2

Table 4: MHSOP – Community

MHSOP Community - October	
Cause Group	**Total**
Patient Death	7
Self Harm	3
Infection Control	2
Safeguarding (Adults)	2
Confidentiality	1

MHSOP Community - November	
Cause Group	**Total**
Patient Death	7
Safeguarding (Adults)	4
Case Notes & Records	3
Missing Patient	3
Infection Control	2

Directorate Specialities describing Top 5 Incidents

Table 5: Learning Disability – In-Patient

LD Agnes Unit - October	
Cause Group	**Total**
Violence/Assault	16
Fire	5
Staffing	2
Accident	1
Allegations Against Staff	1

LD Agnes Unit - November	
Cause Group	**Total**
Violence/Assault	40
Self Harm	13
Clinical Condition	2
Confidentiality	2
Fire	2

Table 6: Learning Disability - Community

LD Community - October	
Cause Group	**Total**
Case Notes & Records	4
Self Harm	4
Infection Control	3
Patient Falls, Slips, And Trips	3
Safeguarding (Adults)	3
Safeguarding (Children)	3

LD Community - November	
Cause Group	**Total**
Infection Control	6
Self Harm	5
Violence/Assault	5
Safeguarding (Adults)	4
Communication	3
Fire	3

Directorate Specialities describing Top 5 Incidents

Table 7: FYPC Inpatient CAMHS

FYPC CAMHS Inpatient - October	
Cause Group	**Total**
Self Harm	75
Mental Health Act	41
Infection Control	7
Staffing	7
Medication	3

FYPC CAMHS Inpatient - November	
Cause Group	**Total**
Self Harm	89
Mental Health Act	31
Staffing	11
Violence/Assault	8
Staff Falls, Slips, And Trips	2

Table 8: FYPC non LD Non CAMHS

FYPC Non LD Non CAMHS - October	
Cause Group	**Total**
Infection Control	24
Communication	14
Case Notes & Records	8
Safeguarding (Children)	8
Staffing	6

FYPC Non LD Non CAMHS - November	
Cause Group	**Total**
Infection Control	18
Case Notes & Records	9
Communication	9
Medication	9
Confidentiality	8

Directorate Specialities describing Top 5 Incidents

Table 10: CHS In-Patient

CHS Inpatient - October	
Cause Group	**Total**
Tissue Viability	34
Patient Falls, Slips, And Trips	32
Patient Death	11
Infection Control	10
Medication	7
Staffing	7

CHS Inpatient - November	
Cause Group	**Total**
Tissue Viability	45
Patient Falls, Slips, And Trips	26
Staffing	17
Medication	15
Patient Death	13

Table 11: CHS Community

CHS Community - October	
Cause Group	**Total**
Tissue Viability	397
Infection Control	16
Medication	14
Safeguarding (Adults)	9
Communication	5
Patient Falls, Slips, And Trips	5

CHS Community - November	
Cause Group	**Total**
Tissue Viability	465
Medication	22
Infection Control	19
Safeguarding (Adults)	12
Access, Admission, Appts, Xfer, Discharge	8

12. Ongoing - StEIS Notifications for Serious Incidents

2021/2022 - STEIS Notifications and Internal Investigations

		StEIS Notification	SI INVESTIGATIONS				Internal Investigations		
		Downgrade & removal requests	SIs declared DMH	SIs declared FYPC/LD	SIs declared CHS	Signed off in month	DMH	FYPC/LD	CHS
2021/22 Q1	April	0	11	2	2	5	4	2	6
	May	0	4	0	1	4	2	1	3
	June	0	11	5	2	6	2	2	6
2021/22 Q2	July	0	5	2	1	8	4	2	1
	August	0	3	3	2	14	1	1	7
	September	0	5	0	0	11	6	2	3
2021/22 Q3	October	0	11	1	2	15	6	3	3
	November	0	9	1	6	6	9	1	6
	December								
2021/22 Q4	January								
	February								
	March								
YTD			39	12	8	48	19	10	26

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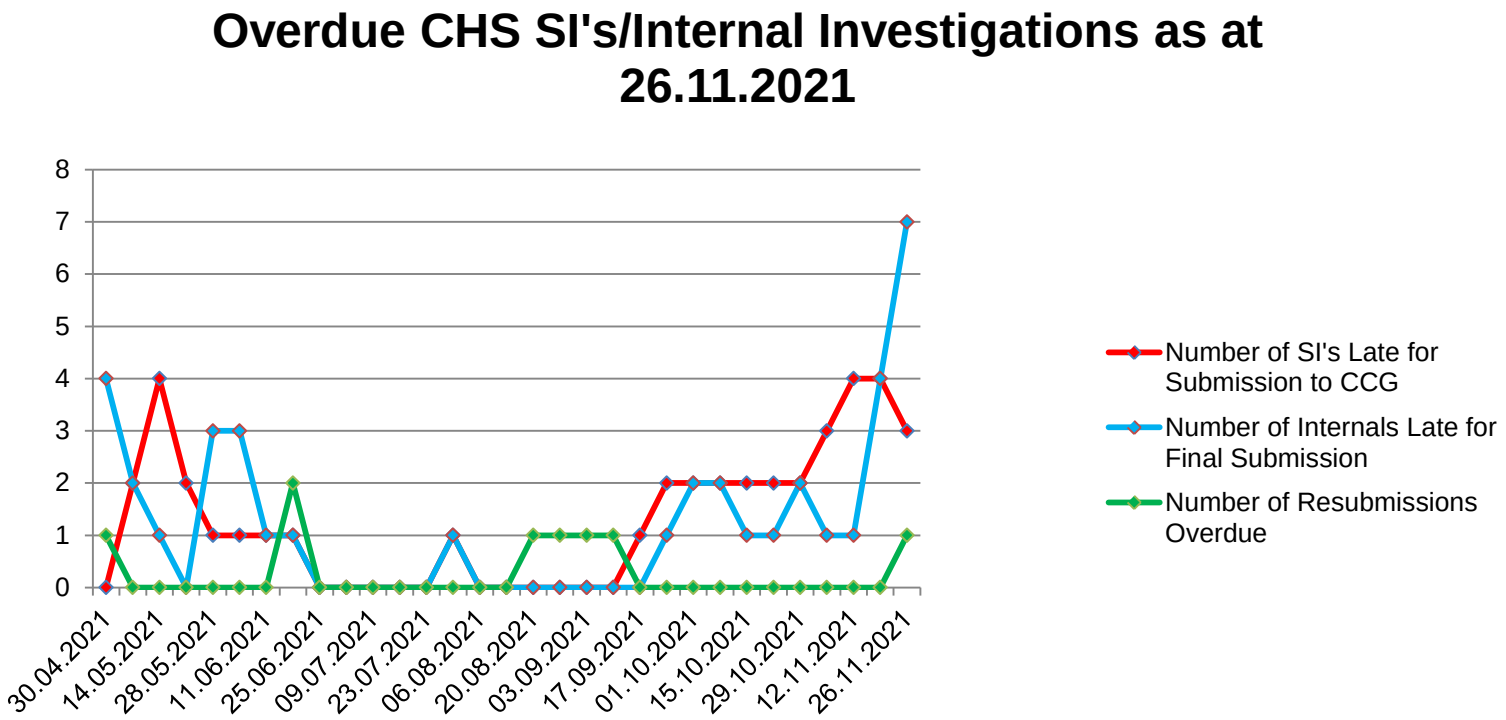
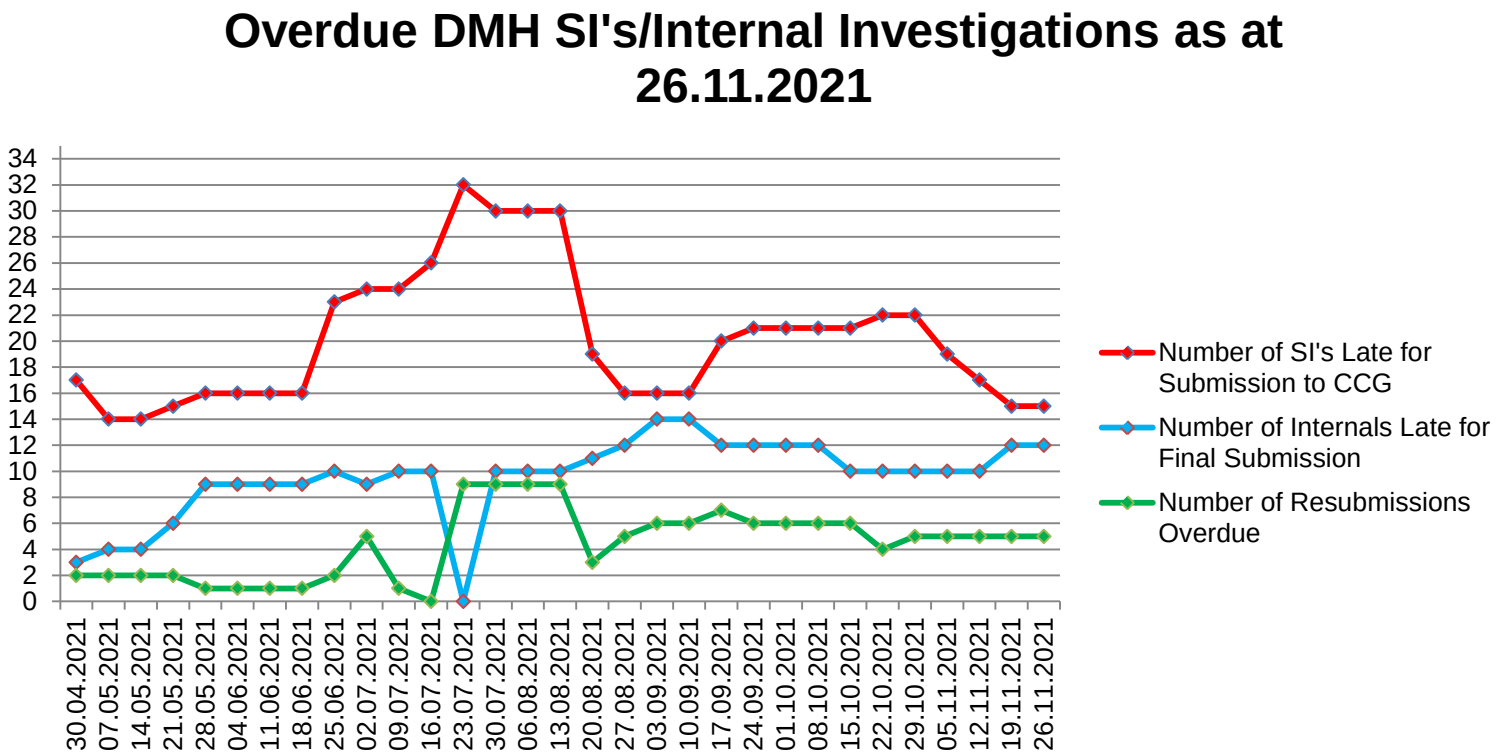
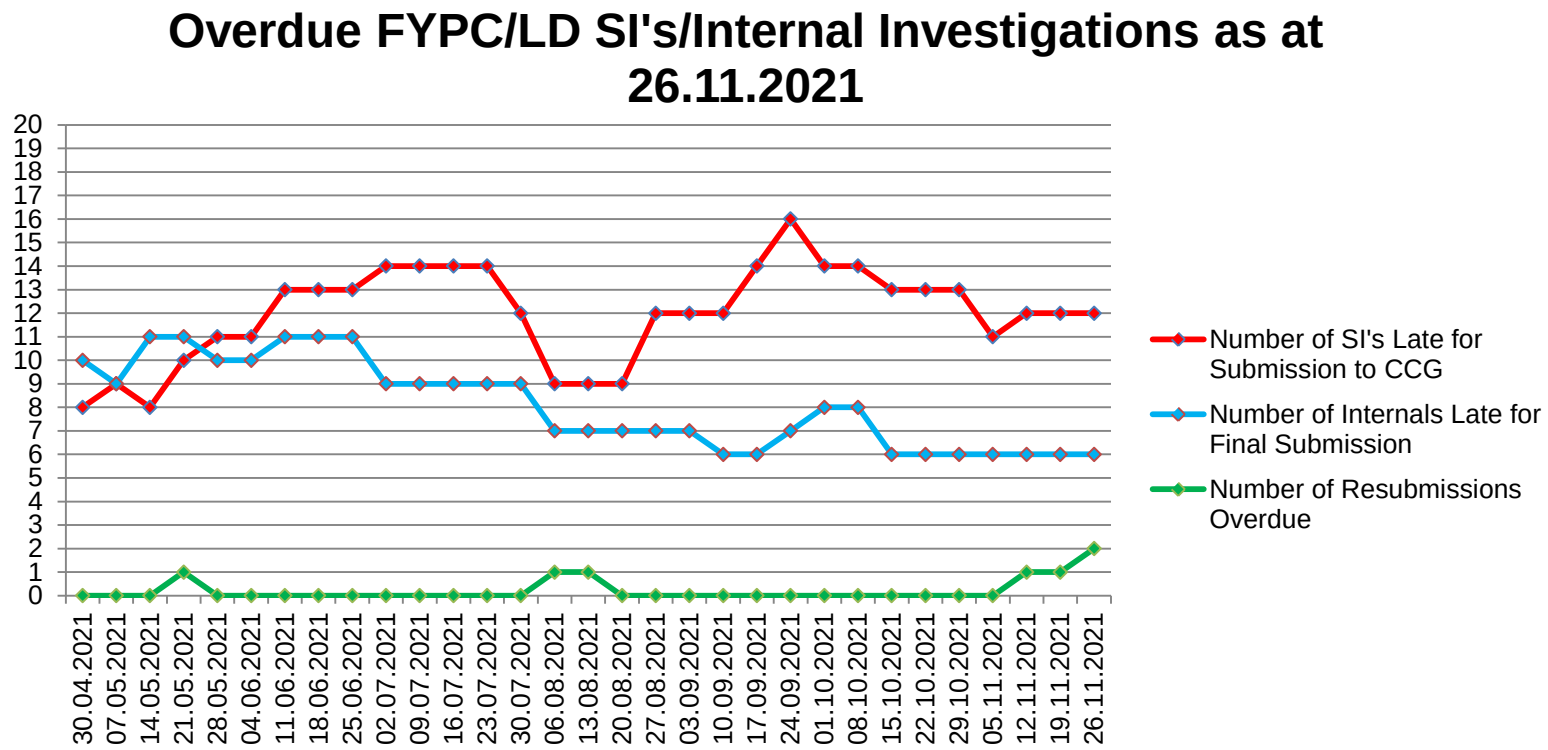
12a. Overdue Serious Incidents/Internal Investigation & CCG resubmissions(includes totals) - CHS



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



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



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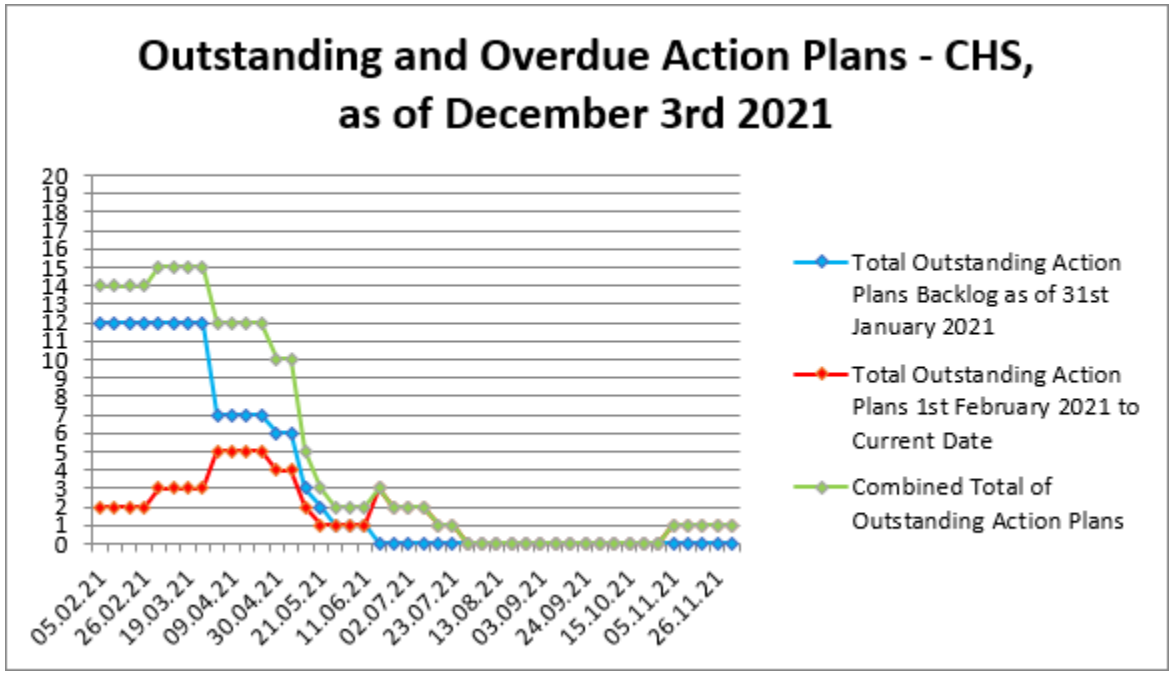
12.b Directorate SI Action Plan Compliance Status 2020/21 to date - CHS



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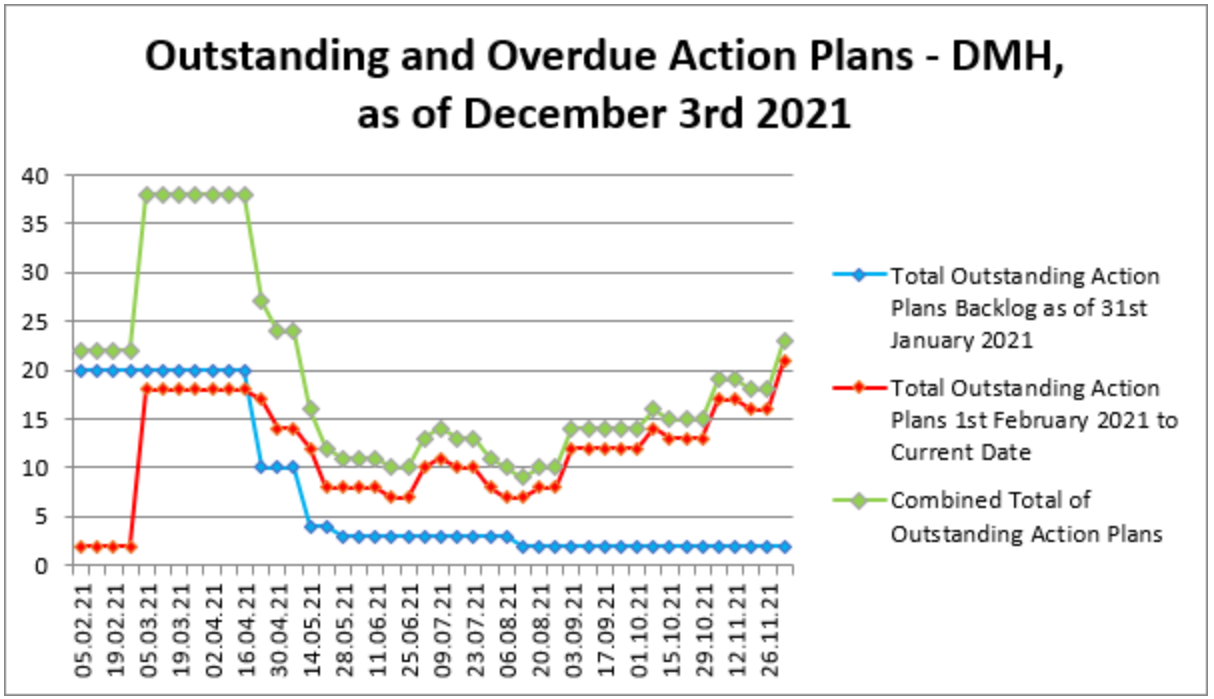
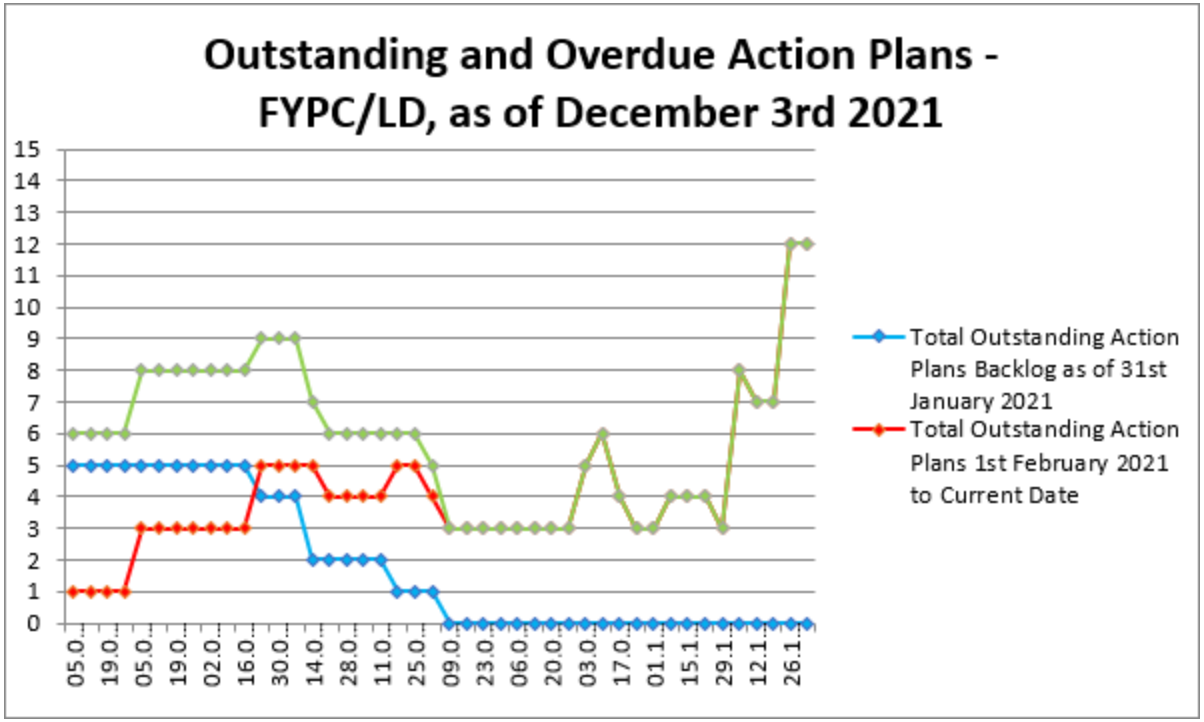
12.b Directorate SI Action Plan Compliance Status 2020/21 to date - DMH



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



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12. Learning

Serious & Internal Incidents Emerging & Recurring Themes

•Record keeping consistently highlighted across all directorates either due to timing of entries (i.e. not contemporaneous), standard of record to provide and flow of knowledge **Action**; teams considering how audit can support the QI work in relation to this

•CMHT's have identified challenges with the MDT approach to updating and **Action**; this is being considered as part of the transformation work

•Mental Capacity and safeguarding knowledge of staff across the organisation **Action**; safeguarding team responding to the identified gaps in knowledge and understanding

•Medication quantity for regular prescriptions linked to risk taking behaviour of self-harm behaviour, knowledge **Action**; working group looking at a model for safe dispensing

•Lying and standing blood pressure and medication reviews in falls with harm **Action**; ANP's to action by asking staff for results as part of their review

•Feedback related to changes from face to face to virtual appointments has been identified by staff patients/families as a challenge for some patients and also makes assessment more difficult **Action**; reports to ensure we are clear 'patient seen on' to be specific on the methodology. Senior Nursing Team for DMH considering this emerging theme

12. Lessons Learned – Trust-wide process

- Increasing challenges with feedback from commissioners delaying closure of reports
- Earlier sharing of final draft serious incidents with families/staff at point of sharing with commissioners
- The benefit of the corporate investigators becoming involved in investigations bringing objectivity
- The importance of recognising early actions as part of the investigation process and being able to offer assurance to commissioners of enactment before report completion
- SystmOne is being reported by investigators as challenging to find their way the different modules/journals to gather and find information

M

Leicestershire Partnership NHS Trust

Public Trust Board of Directors

Safety and Quality in Learning from Deaths Assurance (Quarter 2)

1. Introduction

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) and NHS Improvement (NHS/I) Framework (2017). The NQB mandates NHS Trusts to collect and publish specified information on deaths on a quarterly basis. This report presents the data from July to September 2021 inclusive, as well as data reviewed from Q1 to represent the expected time lag. This report is additionally presented as evidence that the Leicestershire Partnership Trust (LPT) is continuing to improve and streamline its LfD process (Appendix 1, p. 6).

2. Aims

- To provide the Trust Board confirmation with assurance that there is thorough implementation of NQB Learning from Deaths guidance within the Trust.

3. Demographics

Knowing the demographics of our patients allows the identification of concerns and pre-disposing factors which affect specific populations, resulting in better informed interventions. Currently, demographic information is obtained manually by Directorates (Table 1). The collection of this information in a more robust way is being undertaken by the Quality Group.

Table 1: Q2 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	2	1	5	1	5	10	9	29	62
Male	4	2	2	2	2	12	15	11	23	73
Total	**4**	**4**	**3**	**7**	**3**	**17**	**25**	**20**	**52**	**135**

Future reports will include Disability, Religious orientation, Sexual orientation, and Ethnicity.

4. Mortality Data

In adherence with NHS/I (2017) recommendations, the percentage of deaths reviewed and completed for Q1 are shown in Table 2 (NB: these figures are deaths that have been reviewed in quarter, not the total number of deaths in quarter).

Table2: Time lag in reviewing of deaths by Directorate

Q1	Total number of deaths reviewed	Reviews		% of deaths subject to mSJR* Case record review	% of deaths subject to an SI investigation
		mSJR	SI		
	119	104	15	87%	13%
Breakdown by Directorate				Number and % of deaths subject to mSJR* case record review completed	Number and % of deaths subject to an SI investigation completed
		mSJR	SI		
CHS	34	34	0	100%	0%
DMH/MHSOP	73	69	4	95%	5%
FYPC/LD	12	11	1	92%	8%

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

5. Examples of good practice and What working well in Q2

Learning that has been identified from the review or investigation of deaths concluded in Q2 2021 and can be seen in Appendix 2 (p. 7). A coding and theming method has been implemented to categorise learning in Appendix 3 (p.9) Examples of good practice as a result of learning include:

- **CHS:** Identification of good practice in relation to completion of ReSPECT forms to be shared with primary care colleagues through representation at network group to encourage wider learning.
- **DMH:** Adequate care provided when received. Good assessment and discharge plan. Team offered several face-to-face appointments, support with social aspects – benefits etc, referral to services done.

- **FYPC:** Clear management plan if someone is going in and out of hospital on an ongoing basis with coordinator. To discuss with UHL communication around this issue. Identified themes – multi disciplinary working, communication with other agencies.
  Good end of life care by the Diane Team.

6. Number of deaths reported during Q2

Table 3 shows the number of deaths reported by each Directorate for Q2. Formal investigations consist of Serious Incident (SI) investigations and modified Structured Judgement Reviews (mSJR). The number of reviews completed is also presented.

- There were of 116 In-scope deaths for the Q2.
- There were 9 CDOP deaths which are distributed under "F", and are included in the total number of deaths in Table 3.
- There was 1 death in Q2 which was more likely than not to have been due to problems in the care provided.

Table 2: Number of deaths (Q2)

Q2 Mortality Data 2021										
Q2	**July**			**August**			**September**			**Total**
	C	**D**	**F**	**C**	**D**	**F**	**C**	**D**	**F**	
Number of Deaths	9	23	4	10	19	18	15	24	4	**126**
Consideration for formal investigation										
	C	**D**	**F†**	**C**	**D**	**F†**	**C**	**D**	**F†**	
Serious Incident	0	2	0	0	1	1	0	1	0	**3**
mSJR* Case record review	9	15	3	10	4	3	15		*17*	***53***
Number completed	9	21		0	6		0	0		**36**
Learning Disabilities deaths			1			1			2	***4***
Number of deaths reviewed/investigated and as a result considered more likely than not to be due to problems in care	0	0	0	0	0	1	0	0	0	**0**

KEY

C: Community Health Services; **D:** Directorate of Mental Health/MHSOP; **F:** Families Young Persons and Children/LD

***LPT implements a modified mSJR to review all deaths In-scope. In-scope and Out of scope deaths are defined in Section 4.0 of the Learning from Deaths Policy.

† FYPC case review all deaths and are included in the mSJR case record review total count.

7. Recommendations

We recommend that the Trust Board is assured that the LPT LfD Process is in line with NQB guidance and note steps have been taken:

- To ensure the sustainability of robust data comparable across all Directorates.
- To provide clear understanding of our current situation.
- To establish systems for gathering active learning.

8. Discussion

The LfD process is undergoing review. The LfD group is prioritising the following key areas:

- Improved reporting of mortality data.
- Transparency in report and review time lag.
- Establish a robust LfD process, which considers variation in practice amongst Directorates.

Collaborative working between the Patient Safety Team, Directorates, and their administration teams has introduced opportunities to embed the LPT *"Step up to Great"* ethos.

9. Conclusion

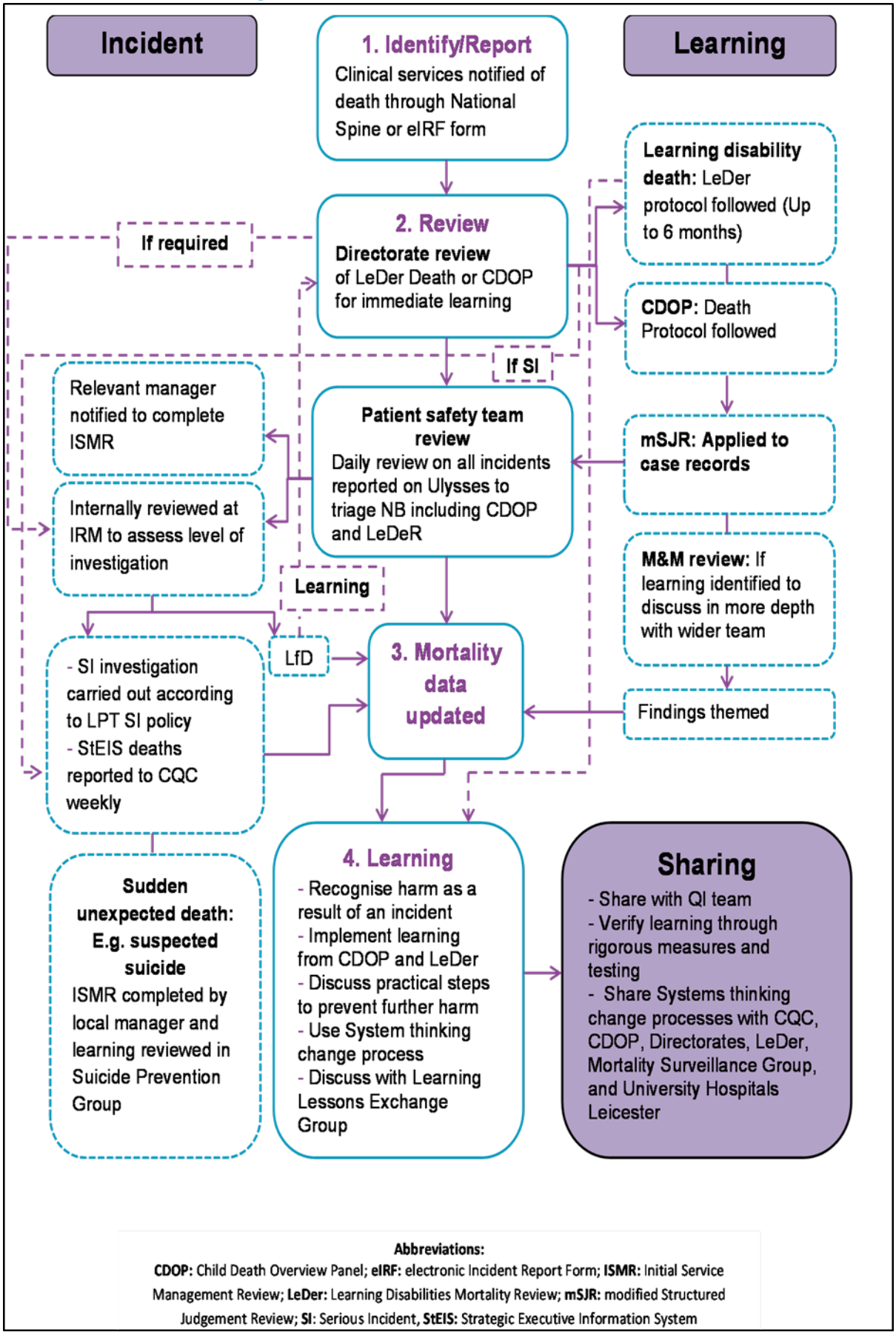
This quarter has presented the continuation of a transitionary period for the LfD process at LPT. The transition is a result of a review of the LfD process and a change in personnel. The recognition of variation and challenges associated with collecting and reviewing data have been a positive outcome. The need to place more focus on learning impact and implementing learning actions are our next priority.

10. Governance table

For Board and Board Committees:	Trust Board
Paper presented by:	Dr Avinash Hiremath
Paper sponsored by:	Professor Al-Uzri
Paper authored by:	Tracy Ward
Date submitted:	
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 (26th October 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:		
False and misleading information (FOMI) considerations:		
Positive confirmation that the content does not risk the safety of patients or the public		
Equality considerations:		

Appendix 1. **Learning from Deaths Process**



Appendix 2. Examples of learning

Learning Code/Theme	Learning Impact	Learning Action
CHS Q1		
E514**: End of life care, documentation, clinical documentation within the clinical record**	Last days of life paperwork not currently completed on electronic record – scanned onto system one. On structured review paperwork often missing or difficult to locate. Assurance required that it is being completed – assured that care carried out and paperwork completed as this is reflected in the patient notes.	A communication has gone out to ward clerks to ensure paperwork is scanned onto system one. Work being undertaken with IT to develop electronic version for completion in system one.
DMH/MHSOP: Q1		
C412: **Clinical care, discharge, discharge planning**	-Void in communication in physical care follow up. -Patients with substance misuse problem DNA. -Cancelled appointments can result in negative coping mechanisms.	-GP will receive a copy of the correspondence to patients to ensure GP checks on the patient's physical wellbeing. -Create an appointments code/theme to address DNA complications. -Outpatient booking systems needs review - Space needed for urgent reviews
C927: **Clinical care, Monitoring, recognition & Escalation/Ceiling of Care, escalation/ceiling of care.**	-Void amongst support workers in escalating health concerns when patients not compliant with medications (physical and mental health).	-Educating support workers in escalating to medics/senior clinicians when abnormal physical health parameters
C718: **Clinical care, multi-disciplinary team working, inter-speciality liaison/continuity of care/ownership**	- Supporting patients who have substance misuse and mental health problems.	-Share learning across primary and secondary care.
FYPC/LD: Q1		
E24**: End of Life, communication, patients & relatives, results/management/discharge plan**	Supporting families with bereavement.	-Reports to be shared with families when signed off by the CCG.
C720: **Clinical care, multidisciplinary team working**	Supporting staff to learn from deaths.	**-**Reports to be shared with staff when signed off by the CCG.

C1020: **Clinical care, transfer & handover**	- Resulting from an incident based on stepping down of care from CAMHS Crisis team to CAMHS outpatients team.	- Following stepping down care form a crisis, a follow up appointment should be negotiated and appointed as a safeguard. -Require an appointments theme to ensure a review of practice within CAMHS for patients who are not brought to appointments to ensure that practice is in line with policy.

Abbreviations

AHP: Allied Health Professional; **CAP:** Central Access Point, **OOH:** Out Of Hospital

Appendix 3. Themes Guidance

Cat	Th	Th Code	Theme & Sub Themes	Sub Theme Codes	Theming Code Combos
	Ass	**1**	**Assessment, Diagnosis & Plan**		
C or E	Ass		Assessment	1	C11 C12 C13 E11 E12 E13
C	Ass		Diagnosis	2	
C or E	Ass		Management plan	3	
	Com	**2**	**Communication – Patients & Relatives**		
C or E	Com		Results/Management / Discharge Plan	4	C24 C25 C26 E24 E25 E26
E	Com		Imminence of death, DNACPR, Prognosis	5	
C or E	Com		Reasonable adjustments	6	
	D&C	**3**	**Dignity & Compassion**		
C or E	D&C		ADL Assistance/ Reasonable Adjustments	7	C37 C38 C39 E37 E38 E39
C or E	D&C		Compassion / Attitude	8	
C or E	D&C		Environment	9	
	Dis	**4**	**Discharge**		
C	Dis		F/up management plan	10	C410 C411 C412 E410 E411 E412
C or E	Dis		Equipment/POC	11	
C or E	Dis		Discharge Planning	12	
	Doc	**5**	**Documentation - Paper & Electronic**		
C or E	Doc		Correspondence – with patients, other clinical teams	13	C513 C514 C515 E513 E514 E515
C or E	Doc		Clinician documentation within the clinical record	14	
C or E	Doc		Completion of clinical forms i.e. DNACPR, Consent, Nursing Assessments	15	
	Inv	**6**	**Investigations & Acting on Results**		
C	Inv		Investigations	16	C616 C617 E616 E617
C	Inv		Results	17	
	MDT	**7**	**Multi-Disciplinary Team Working**		
C or E	Mdt		Inter-speciality liaison/continuity of care/ownership	18	C718 C719 C720 E718 E719 E720
C or E	Mdt		Inter-speciality referrals/review	19	
C or E	Mdt		Inter team issues (within same specialty)	20	
	Med	**8**	**Medication**		
C or E	Med		Prescribing	21	C821 C822 C823 C824 E821 E822 E823 E824
C or E	Med		Supply	22	
C or E	Med		Administration	23	
C or E	Med		Review	24	
	Mon	**9**	**Monitoring, Recognition & Escalation/Ceiling of Care**		
C or E	Mon		Monitoring	25	C925 C926 C927 E925 E926 E927
C or E	Mon		Recognition	26	
C or E	Mon		Escalation / Ceiling of Care	27	
	Tr	**10**	**Transfer & Handover**		
C or E	T&H		Delays to correct speciality/setting	28	C1028 C1029 C1030 E1028 E1029 E1030
C or E	T&H		Inappropriate Outlying / Transfer arrangements incl where pt not clinically fit for transfer, or inappropriate transfer arrangements to take into account level of acuity	29	
C or E	T&H		Omissions/Errors in Handover communication	30	

Abbreviations: ADL: Activities of Daily Living; **POC:** Point of Care; **DNACPR:** Do Not Attempt Cardio Pulmonary Resuscitation

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Leicestershire Partnership NHS Trust

Trust Board – 21st December 2021

Patient and Carer Experience and Involvement (PCEI) Quarterly Report (including Complaints) Quarter 2, 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 2.
- To provide assurance to the Trust Board.

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 2, the Trust formally registered 63 complaints in total, which is an increase of 9 from the previous quarter or 54 and an increased compared to 49 registered in the same period last year. 7 complainants got back in touch to raise outstanding concerns compared to 12 in Q1 and 4 in the same period last year.

Following the carefully considered decision made in quarter 4 of 2020/2021, the Complaints Team and Directorates have continued to work on a complaint timeframe of 45 working days or a date agreed with the complainant. As was the case in Q1 and due to the extension of investigation timeframes for complaints, we have noted that the some complaints logged in Q2, which are still under investigation, will be carried into Q3 figures. However, we hope that with the reduced timeframe of 35 working days or a date agreed with the complainant which commenced on 1 October 2021, will help reduce the time formal complaints remain in the system. There will be a

further reduction of complaint timeframe from 35 working days to 30 working days by the end of Q3 and a return to a standard 25 working days, or timescale agreed with the complainant by the end of Q4.

The number of complaints which were responded to within the timescale agreed with the complainant increased in Q2 (31/64) compared to Q1 (13/54). This increase meant that more complaints were being processed within the quarter. It should be noted that as the response timescale for Q was still at 45 days there are a number of complaints that were received in the period but are not completed as their 45 working day timescale will take them into Q3 figures.

Quarter 2 saw a significant increase in District Nursing complaints due to several factors including staffing, however, the Complaints Team have worked closely with the directorate to ensure they are ahead of any possible trends and are now copied into the weekly staffing level communications. Both the Complaints and PALS Teams continue to work collaboratively to resolve concerns informally in the first instance.

In September 2021, following the Trust's rollout of the Covid-19 Booster Vaccination Programme and the 12-15 year old Vaccination Programme, complaints and concerns have increased. The issues were recognised early and an agreement was made between the Vaccination Programme Leads, the Complaints Team and the PALS Team to try to engage with the complainants as early as possible and endeavour to resolve their concerns informally. This ensured that issues being raised due to a short term problem were resolved as efficiently and effectively as possible. Both the PALS Team and the Complaints Team remained in constant contact with one another and shared information with the programme leads, which helped resolve the increased contact within two weeks.

Going into Q3, we continue to implement the phased reduction in complaint timeframes for investigations and continue to work closely with the directorates in respect of any challenges/ pressures they may be facing. By continuing to have open, honest and productive conversations with members of staff, this has enabled us to react quickly to increases in contact and resolve matters informally. The aim for Q3 is that we can continue to work efficiently and effectively with the PALS Team to reduce the need for complaints to be formalised, especially when the issues raised can be resolved with a call or meeting. Whilst in quarter 1 and quarter 2, we saw a reduction of complaints being formalised due to the length of time it would take to investigate, 50% of all complaints in Q2, it will remain to be seen whether the reduced timeframe will change the complainant's attitude towards a formal investigation.

Complaints Activity Data – July 2021 – September 2021

Key Performance Indicator	Q2 21/22	Q1 21/22
% of complaints acknowledged within three working days	92%	94%
% of complaints responded to within the date agreed with the complainant	100%	100%
Number of complaints upheld or partly upheld in quarter	21	7
Number of reopened complaints	7	12
Number of complaints formally investigated by the PHSO	0	0
Number of complaints upheld or partly upheld by the PHSO	0	0

The number of PALS contacts received in Q2 were 405, this is a 49% increase on the numbers received in Q1 (200). This increase is mainly due to the number of signposting enquiries received into the PALS Team which related to University Hospitals of Leicester (UHL) services, up 49% from 104 in Q1 to 213 in Q2. The rise in signposting queries related mainly to contacts seeking information on services relating to University Hospitals Leicester, 140 contacts received in Q2 compared to 53 in Q1. When reviewing the reason for the increase it was found that a combination of GP Practices, NHS Choices and NHS 111 providing contacts with the wrong information when patients wished to contact UHL, they were instead provided with the LPT PALS contact details. This was further impacted by the incorrect contact information being provided on the NHS Choices website. These issues have now been resolved and it is hoped that there will be a reduction in the signposting contacts in Q3.

Themes from complaints, concerns and compliments

The key themes for concerns and complaints received in the quarter were in relation to Communications 28% (n=72); Appointments 13% (n=33); Patient Care 13% (n=34). In response to the continuing trends in relation to complaints and concerns in relation to communications, it has been agreed by the Complaints Review Group that a deep dive review of 5 complaints from each directorate be undertaken where communications have been sighted as a primary issue. This deep dive will aim to identify any further detail trends in respect of what communication issues patients and carers are reporting, or if, in fact, there needs to be a review of the communications categorisation. The results of this review will be presented to the Complaints Review Group in December 2021.

The Directorate of Mental Health received 122 complaints, concerns, comments and enquiries in Q2. This was a slight increase from Q1 at 103. Adult Community Mental Health Teams continued to see the highest number of issues with 49 contacts which is in line with Q1 (44). Concerns mainly focused on poor communication between the services and their service users (10) and patient care (10). This data is currently being triangulated with the results from the 2021 Community Mental Health Survey and will be shared with service leads in order to help them identify any areas for action. This will then be presented to the Directorate Management Team for further discussion. The number of concerns and complaints in relation to inpatient wards was slightly higher in Q2 (24) compared to 19 in Q1.

Community Health Services Directorate received 50 concerns and complaints which is a small reduction from Q1 (56). As set out earlier in this report District Nursing continues to receive a high number of concerns, these mainly relate to the provision of poor patient care, sighting catheter and wound care as key areas for concern. There will be a Quality Summit held in early November by the Directorate to look at the concerns within the District Nursing Service. Complaints and concerns will be included in this summit to provide evidence in terms of patient experience.

For Families, Children, Young People and Learning Disabilities the total number of concerns received was 65 which like CHS is a small reduction to those seen in Q1 (71). CAMHS Services, including the Beacon Unit continue to see a majority of the concerns for the directorate, along with Paediatric Medical Services (15). For the Paediatric Medical Service the key theme for concern was in relation to accessing treatment and appointments, whilst in the CAMHS Services communication and access to treatment and drugs were the main concerns. The Beacon Unit held a focus group in October to discuss with the young people in the Unit, to share the feedback that had been provided through a survey. As a result to the feedback provided by the young people, improvements are being made in relation to activities in the Unit, advocacy support and patient property.

17 concerns were received were in relation to Quality and Professional Practice and Corporate Services. Of these 17; 13 contacts resulted in a signposting to another organisation as the concerns

did not relate to LPT, the remaining 8 contacts to access to medical records (2), Covid-19 (1) and policies and procedures (1).

5 MP enquiries were received in the quarter.

Activity data – 1 July 2021 – 30 September 2021

	PALS concerns	Complaints	Compliments
Number	191	63	141
Top 3 Themes	• Communications • Appointments • Patient Care	• Patient Care • Communications • Access to Treatment	• Staff Attitude • Customer Service • End of Life Care

Good news story

We received a complaint into CAMHS regarding Care and Treatment. During the investigation and as a result of the contact the complainant had with the staff, the complainant then withdrew the complaint. This was followed this up with a compliment regarding how the staff members involved had dealt with and resolved her complaint, showing her kindness, empathy and respect. She asked for this to be passed on to staff and for us to also let them know they were very grateful for this.

Keys areas of concern

Risks	Mitigations
As we move from a timeframe of 45 working days to 35 working days for complaints management in Q3, there may be a direct impact on those services who are currently experience staff capacity issues to manage their investigations	• Weekly one to one meetings to review capacity and monitor live complaints between directorates and the complaints team • Overview and assurance through the Complaints Review Group

Assurance

- The Complaints and PALS work reports into the Complaints Review group which then reports into the Quality Forum, Quality Assurance Committee and Trust board for assurance.

Friends and Family Test

Overview

In Q2 the Trust received 5376 individual responses to the FFT question which equated to a response rate of 6%. Of these responses 78% reported a positive experience of care and a 12% response rate recording negative or poor experience of care. The full breakdown of date received in Q2 is available in Appendix 1.

Breakdown of responses received:

Question 1. Thinking about your experience with Leicestershire Partnership Trust [x setting, overall, how was your experience of our service

Method of collection	Rating Received	Response Rate
Electronic tablet / kiosk at point of discharge	360	0.040%
Individual Voice Message	764	00.84%
Online Survey Once Patient is home	161	00.18%
Paper Survey	48	00.05%
SMS/Text	4063	04.56%
Total	5376	06.40%

Question 2. Please can you tell us why you gave your answer?

Method of collection	Rating Received	Response Rate
Electronic tablet / kiosk at point of Discharge	297	00.33%
Individual Voice Message	449	00.50%
Online Survey Once Patient is home	32	00.04%
Paper Survey	100	00.11%
SMS/Text	3401	0.3.82%
Total	4276	0.4.80%

The focus for Q2 has been understanding how to analyse FFT data to look at themes and trends, and one- off responses where it highlights a need for improvements.

Joanne Loughlin-Ridley and Terry Morgan from NHS England & NHS Improvement held a Q&A session on 31 August to answer questions from the video they produced. The session offered tips and advice on the different approaches to analysing data

During the quarter we also ran two drop-in clinics and training requests on how to extract FFT reporting data from Envoy, and training on survey building

There were some issues in respect of reporting of data for some services during the quarter. This has now been rectified with the service provider and it is envisaged that all monthly reports from October onwards should be displaying the correct service information and FFT data collected.

Key Areas of concern

Risks	Mitigations
For some of our FYPC Services, due to the sensitivity of sending our SMS messages to some young people, some exclusions have been put in place, meaning those services are currently not collecting their FFT data	• Colin Purves from our Informatics Team will be reviewing exclusions on SystmOne in November • A meeting has been set up with Service Leads affected to look at alternative solutions for collecting their FFT data

Good news story

The quarter also saw the launch of our FFT Board competition where wards and services were invited to share photos of their FFT Board which displays the feedback collected and any improvements made as a result of what patients and carers said.

All entries were judged by our Patient and Carer Leader panel and we are delighted to announce Mill Lodge as the winners who will receive £100 voucher to spend on patient activities.

Here is what Grant and Tasha said about the poster:

'They have been innovative in presenting their Friends and Family board quite imaginatively! Really felt the use of creativity was there when designing this board and when thinking of their patients and the theme of movies playing on the Ward. Think this board has scope to grow with many fun and interactive comments coming from all.'

'I choose the movies screen from Mill lodge as I feel that people we take time to look at it and not think it just another boring notice board'

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

Our service user and carer network continues to grow and we now have over 140 people registered on the network working with us at various levels of involvement in order to improve services.

In the quarter we launched our first Involvement Prospectus which included all our training and development opportunities for the involvement network members, in order to better support and equip people to be able to get involved at various levels across the Trust. This also included the opening up of our staff Health and Wellbeing sessions to include our volunteers, and those working on involvement projects with us. Our second cohort of patient leaders also successfully completed Patient Leadership training which included the below modules;

- Understanding patient involvement and leadership in practice
- Diversity in patient involvement and leadership
- Influencing people in meetings
- Sharing patient experiences

We also launched an introduction session on what it means to get involved in partnership with the Recovery College, the session is co-delivered with someone with lived experience who talks about their involvement journey with us. The sessions have been very well received and have been a great approach in registering people to the involvement network, and then matching them to projects.

Two patient involvement initiatives have achieved national recognition as finalists in the annual Patient Experience Network (PENNA) Awards 2021. The Recovery and Collaborative Care Planning Cafes were shortlisted in the "Strengthening the Foundation" award category and the Mental Health

and Wellbeing Workbook in the "Support for Caregivers" award category. The Recovery and Collaborative Care Planning Cafes were runners up in their category.

We now have over 50 projects registered onto the Life QI system with some level of patient involvement including gaining patient/carer insight or patient and carer leaders working collaboratively with staff as part of the project team. We have also developed a weekly involvement huddle where we discuss QI projects and the best approach for involvement, resources available, and have a patient leader attending these to give a lived experience perspective, ensuring that the patient is at the heart of all the improvements we make. I have included an example of a collaborative QI project.

Involvement in Research

PINMED (Patient Involvement in Medication Decisions) is an electronic tool that can help service-users be more involved in decisions about their care. The PINMED project is an outcome of research carried out at the Trust by one of the mental health pharmacists. PINMED is currently being developed in an App and web-based format where service-users will be able to download the App onto their mobile phones or access it via a secure website, and can help service users prepare for their out-patient appointments, provide information about mental health conditions and their treatments to help them make an informed choice and make a valuable contribution to discussions about their care. Two patients with lived experience have been working closely with the pharmacist and app developers in order to develop and provide feedback on the app. More engagement will be sought as the app is tested and the two patients will continue to support the evaluation of the app.

Involvement in Adult Mental Health

For world suicide prevention day in September the Safety Planning service user group, working alongside the LPT Suicide Prevention lead, held a patient led creative workshop focusing on Creating Hope Through Action which was opened up to anyone to attend. It was a great session with many great discussions on what Hope looked, and felt like to different people. Many creative pieces were made, along with poems of Hope which have been sent into the team who are regrouping to plan next steps and how this will feed into resources to support personal safety planning. Two people with lived experience that attended the workshop have now also registered for involvement and joined the patient safety working group.

Involvement in Community Health Services

No update.

Involvement in Families, Children and Young People and Learning Disabilities

Families, Children and Young People Services

- Online surveys developed for CYP with SEND as one approach to receiving feedback around transitions and SEND support within Health. Focus group attendance and session will also take place to support feedback via local SEND groups
- Healthy Together 2.5 year parent/carer questionnaire has been sent out across LLR via S1.
- Feedback from 63 parents attending the "Lets get Talking" attend anywhere appointments has been gained via an envoy survey sent via SystmOne. Draft report has been shared with service leads before wider sharing (to report themes and impact next month)
- Following a meeting with Healthy Together Early Start Health Visitor around patient experiences and digital access a **QI** conversation starter has been submitted by the team to explore digital poverty and a solution to online access.

- SALT Patient experience survey is now live to capture the views of families after accessing the “communicating together” workshop. The workshop is due to go live at the end September/October.
- Similar feedback surveys are underway for SALT signs and symbols workshop
- Work has begun to capture the views of those attending OT early years clinics, feedback questions have been developed to understand the experiences of these clinics, to be delivered via survey/telephone call TBC.

Learning Disabilities

- Meeting taking place with Short Breaks Charge nurse to create a pathway for feedback opportunities, and to ensure that any feedback already received is documented.
- Phoenix charity continues to visit with a variety of animals, for patients to spend time with and learn about. Some patients have been able to visit and help out on the farm also during their S17 leave access.
- Continued representation of people with learning disability in interview panels despite challenges with in the digital offer.
- The service are working with Ellie Pratt from the Community Knowledge Service and established sharing routes for patients, families and staff
- QI to involvement training session in a box was delivered to staff from LD services during September
- Mop up sessions for Easy read widget training is underway.so far 90 staff members have been trained
- LD Talk and Listen patient group have been working on developing the FFT paper version to support those who are unable to access digital feedback options.
- A bid is underway for 2 x staff to work within LD as “community engagement and opportunities officers” who will support Experts by Experience/patient leaders within this role.

Leicestershire Adult Eating Disorders Service

- The service continues the development of stepdown care following inpatient admission with a panel discussion with past service users and holding focus groups with current inpatients.
- A questionnaire has been written to determine peer-support requirements. A link to this (on the ENVOY system) will be sent via Systm1 to all current patients and carers
- Posters have been produced for the inpatient and outpatient areas highlighting outcomes from the patient experience questionnaires. Example included below

Good news story

During the quarter a discussion paper written in partnership with three patient leaders with lived experience on developing a lived experience framework was presented to the Operational Executive Board. The paper set out the proposal to develop a framework for co-production and developing lived experience roles across the Trust. Following a good discussion the approach to develop lived experience across the Trust was fully endorsed and work develop the framework should commence. A small group including three patient leaders with lived experience will be working closely with the Trust and a national lead for this work over the coming months.

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

The Council continue to meet as a group on a monthly basis and fortnightly with the Leadership Team.

The Council are undertaking their annual review of membership alongside a recruitment campaign to attract new members from across local voluntary and community sector organisations and patient sand carers with lived experience.

The Council met with Sam Wood, Head of Transformation to discuss the refresh of the Step up to Great Strategy.

The Council have now confirmed their three priorities for 2021-22, these are:

- Step up to Great Mental Health
- Equality, Diversity and Inclusion
- Personalisation of Care

Task and finish groups are being established to focus on these three areas and will be lead jointly by a member of the Council from the voluntary and community sector members and a patient/carer leader.

The Council submitted a formal response to the Step up to Great Mental Health consultation.

Lots of marketing and communication activities continue to take place, online via Facebook and Twitter.

LPT Youth Advisory Board (YAB)

YAB contributed to a session with the Mental Health in Schools Team service to support pulling together gender identity FAQs for staff within the service to refer too and use when working with CYP.

YAB contributed and produced the attached presentation below in support of the communication teams across LLR. This is to support the covid-19 vaccination roll out programme for 12-15 year olds. Digital engagement is ongoing with the covid-19 vaccination programme team, next month digital engagement lead Oliver Kyle will join the YAB to discuss developing a new video to support YP who are hesitant in taking up the vaccine.

Sam Wood- LPT Head of Strategy attended YAB to present and engage with YP around their ideas on the Step Up to Great refresh. Sam will be returning to the group to follow up the ideas and suggestions around details YP discussed within each area of the plan.

YAB had contributed to views and ideas for FYPC LD SMT which focused on voice, engagement, participation, and the Lundy model principles. The slides from this session have been shared across the directorate.

Good News Story

YAB have been successfully nominated for an award in the CYP national 2021 awards. The YAB are one of 7 entries within the "working in Partnership" category as a group established between Health and Local Authorities.

The YAB were successful in being nominated within the 'Volunteer of the Year' category for the LPT Covid Hero Awards 2021. 5 YAB members are due to attend the awards held on 1st October.
1 YAB member continues to be part of the LPT Peoples council, feeding back into both groups either way. 2 YAB members have been supported to join the Leicester City Council Health Scrutiny Panel and attended a first meeting in September.

Assurance

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

Equality, Diversity and Inclusion (EDI) Patient Experience and Involvement

The EDI Patient Experience and Involvement Group has been running for 12 months. The group which reports into the Patient and Carer Experience Group has been established to provide the drive and determination to significantly improve under-representation of the reported experience and involvement opportunities of patients and carers who use or are impacted by the services provided by the Trust. The Group will strive to embed a culture of inclusion, engagement and collaboration, where all staff and patients feel valued and recognised as we Step up to Great.

The Group will aim to place the Trust at the vanguard of equality, diversity and inclusion work within the public sector, leading the way in fostering innovation and high performance.

The Group has membership from across all directorates of the Trust alongside three Patient and Carers with Lived Experience, chaplaincy and volunteering. It has been proposed that the quarterly patient experience and involvement report provides regular updates on the work of the group.

The work of each directorate through their respective EDI structures is brought to the meeting for assurance, discussion and identification of actions if required. In addition to this the group has identified some key areas of focus over the coming year and these include:

- audit/review of religious and faith materials and space across the Trusts inpatient areas
- Advancing mental health equality collaborative
- Accessible Information Standard (via the Inclusive Communications Group)
- Equalities Data

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 21st December 2021	
Paper sponsored by:	Anne Scott, Director of Nursing, AHPs and Quality	
Paper authored by:	Alison Kirk, Head of Patient Experience and Involvement	
Date submitted:	21st December 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):	PCEG 29th October 2021 Quality Forum 11th November 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		
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 Q2 – 1 July – 30 September 2021

	Q1	Jul 2021	Aug 2021	Sept 2021	Total Q2	Total 21/22
Mental Health Service	22	14	14	6	34	56
Community Health Services	20	3	9	4	16	36
Families, Young People and Children & LD	12	5	6	2	13	25
Total Received	**54**	**22**	**29**	**12**	**63**	**117**
Complaints vs Patient Activity (Complaints Rate as a %)*	0.05	0.02	0.02	0.01	0.05	0.05
% of complaints acknowledged within three working days	94	100	86	91	92	93
Number of complaints responded to within the date agreed with the complainant****	13	18	13	0	31	44
Number of complaints responded to in 45 working days	13	18	13	0	31	44
Number of complaints responded to in a date agreed with the complainant	3	0	0	0	0	3
Number under investigation at the end of the Quarter	38	2	16	12	30	68
% of complaints responded to within the date agreed with the complainant ****	100	90	100	100	97	97
Number of complaints upheld or partly upheld in quarter	7	13	8	0	21	28
Number of complaints ongoing after 3 months**	3	2	2	2	2	6
Number of complaints ongoing after 6 months***	0	0	0	0	0	0
Number of reopened complaints	12	4	1	2	7	19
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

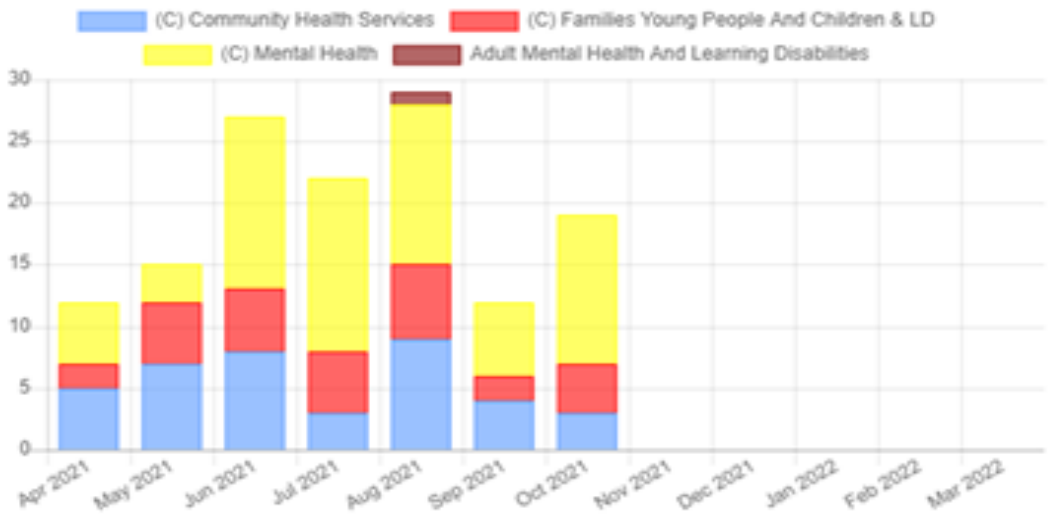
*Patients attended and seen

**Complaints ongoing after 3 months at the end of Q2

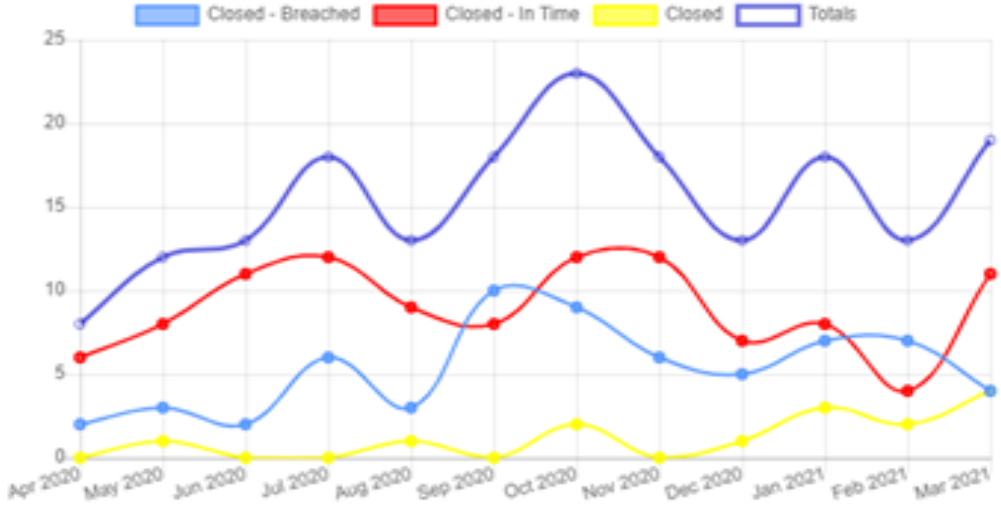
***Complaints ongoing after 6 months at the end of Q2. These do not include those complaints included in the ongoing after 3 months section.

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

Complaints Received by Directorate (financial year)



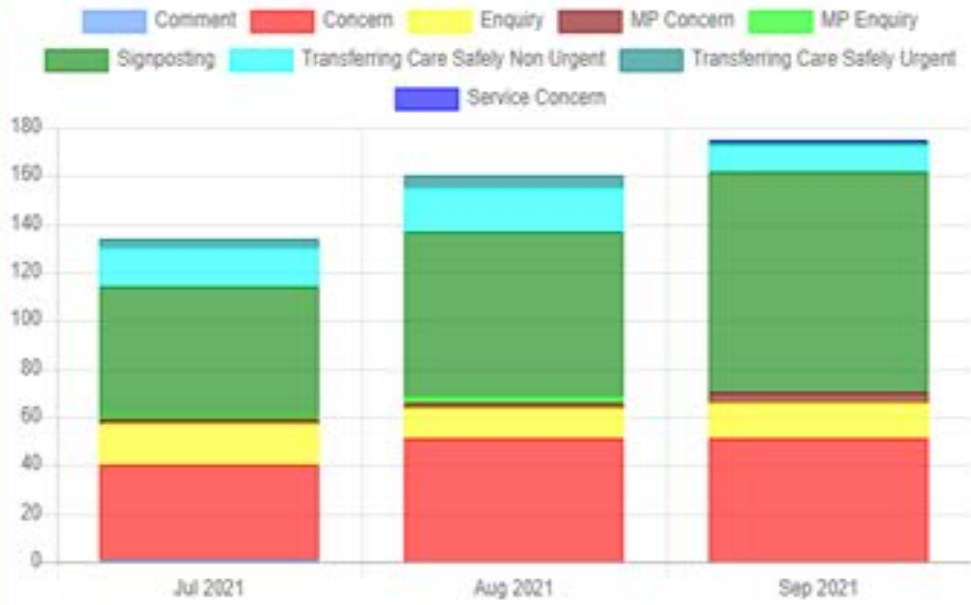
Complaints Performance (financial year)



Complaints and PALS received by Service area:

		Complaints	Concerns
Directorate of Adult Mental Health	ADHD Service	2	3
	CMHT's City	1	13
	CMHT's County	7	27
	Crisis Resolution Team	6	4
	Central Access Point	3	14
	Bed Management Team	1	1
	Inpatient Wards	8	16
	Dynamic Psychology	1	1
	Forensic CMHT	1	
	Francis Dixon Lodge	1	3
	CBT	1	
	Memory Service West		1
	Mental Health Urgent Care Hub	1	
	Mill Lodge		1
	Pine		1
	MHEDP CMHT County	1	3
Community Health Services	District Nursing – City	7	12
	District Nursing – County		4
	District Nursing – Wards	2	3
	Community Therapies	2	2
	Integrated Specialist Palliative Care	2	2
	SPA	1	1
	CHS Management		1
	Advanced Nurse Practitioner		1
	Phlebotomy	1	1
	MSK Physiotherapy		2
	Continence		1
	Inpatient Wards	2	4
Families, Children and Young People and Learning Disabilities	CAMHS – City		5
	CAMHS Beacon		2
	CAMHS – County	4	5
	Children's Therapies	1	1
	FYPC Area 1		2
	FYPC Area 3		1
	Healthy Together Administration	1	2
	Nutrition and Dietetics	1	1
	FYPC Blaby		2
	FYPC Oadby and Wigston		1
	FYPC Harborough		1
	FYPC Hinckley and Bosworth		1
	FYPC North West Leicestershire		2
	FYPC Melton, Rutland & Harborough		2
	FYPC South Charnwood	1	
	FYPC North Charnwood		1
	Ealing Drumbeg Outpatients		1
	LD Psychiatry	2	
	Homeless families Service		1
	LD Community Services		1
	School Immunisations		1
	Paediatric Medical Servicing	2	11
	Paediatric Admin		1
	Neurodevelopmental Team		1
	SALT – Children's	1	2

Breakdown of PALS Contacts by Contact Type



FFT Responses – July – September 2021

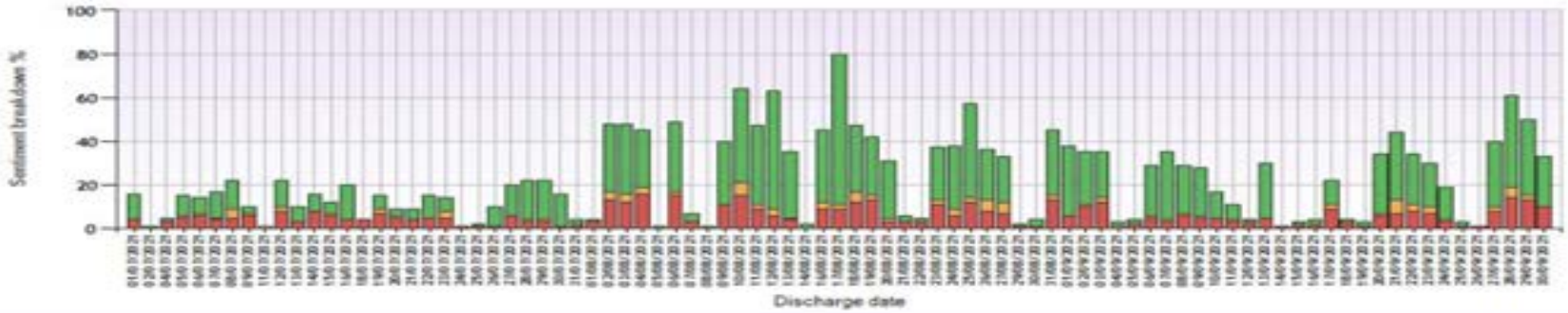
Response and Ratings by Directorate

	Response Rate	Positive	Negative
Directorate of Mental Health	5%	55%	31%
Community Health Services	8%	86%	6%
Families, Children, Young People & Learning Disabilities	4%	76%	15%

6%
Response Rate

Positive: 78.47%
Negative: 12.47%
Ratings

FFT Sentiment Analysis – all Services July – September 2021

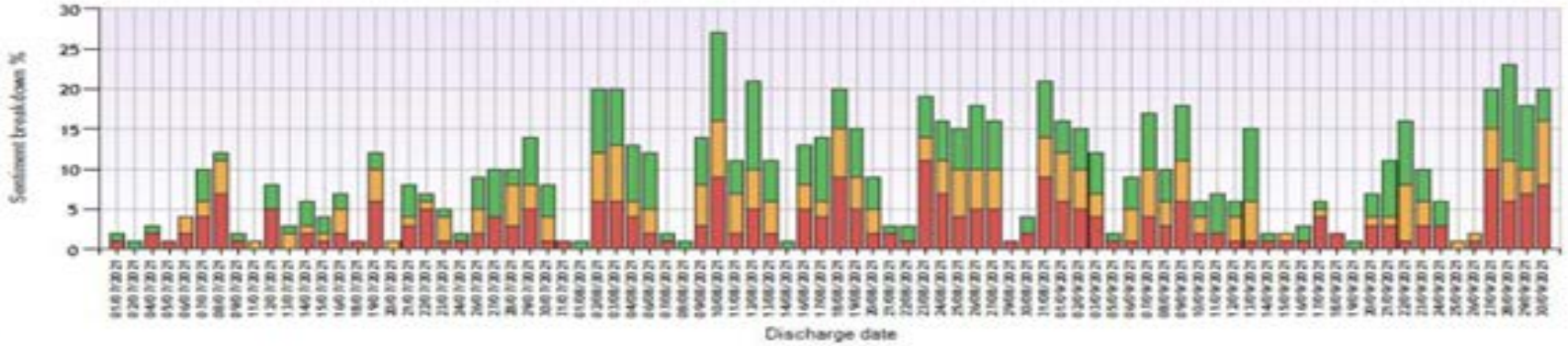


FFT Sentiment Analysis – all Services July – September 2021

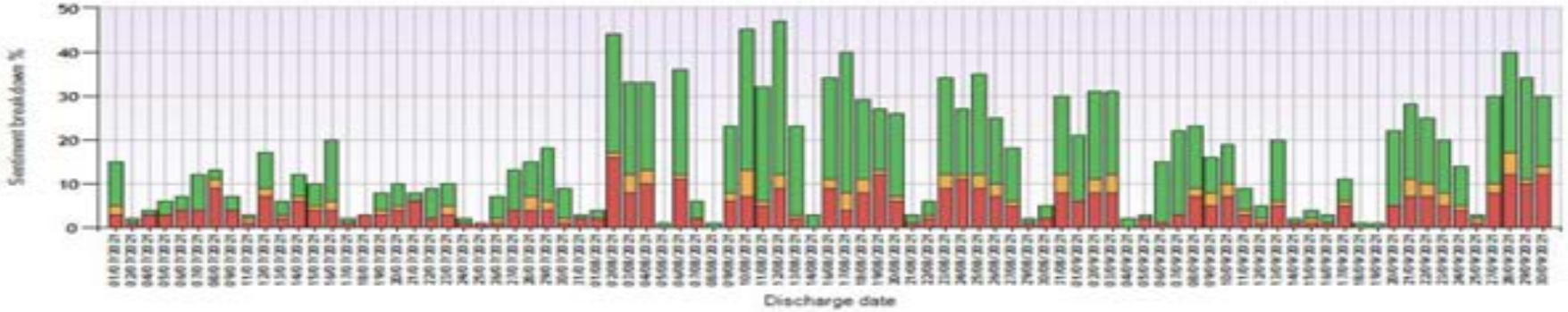
Legend

- Positive
- Neutral
- Negative

Environment



Implementation of Care



Compliments Received July - September 2021

Compliments by Directorate	
Directorate of Mental Health	28
Community Health Services	92
Families, Young People, Children's & Learning Disabilities	21

Compliment by theme	
Staff Attitude	32
Care and Treatment	54
Customer Service	4
End of Life Care	28
Communications	4
Service Provision	6
Other	13

Compliments received during the quarter

"We would like to bring to your attention the outstanding service our son and the family have received from the CAMHS Crisis Team."

"I really wanted to write to thank you for all that you did and have helped me with. You have changed the way I think and have given me hope. I also feel that you have allowed me to find out who I am and be okay with that. Work is so much easier now because of this and hopefully this has begun to translate into my personal life as well."

" I'd just be grateful if you could pass on to Dr and the Admin Team my very grateful thanks for organising the District Nursing care I've had over the past six weeks or so when I couldn't have managed the round trip to the surgery every other day. The nurses were wonderful and the post-op wound has healed beautifully. Thank you so much."

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Leicestershire Partnership NHS Trust

Public Trust Board - 21st December 2021

Safe Staffing- October 2021 review draft

Purpose of the report

This report provides an overview of nursing safe staffing during the month of October 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; 4.19% reported at 39.43% overall and Trust wide agency usage slightly increased this month by 1.12% to 16.21% overall.
- In October 2021; 26 inpatient wards/units utilised above 6% agency staff to meet safe staffing levels, this equates to 81.25% of our inpatient Wards and Units, changes from last month; Welford 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.
- The key in-patient areas to note in regard to current staffing challenges with high risk and potential impact to quality and safety; Beacon, Agnes Unit, Mill Lodge & Coleman.
- There are thirteen community team 'areas to note', Healthy Together City, County, notably Blaby team, Looked After Children Team, Diana team, City Community Nursing hub, the memory service, changes from last month; CRISIS and Central Access Point.
- A quality summit has been convened to take place on 2 November 2021 facilitated by the Executive Director of Nursing, AHPs and Quality due to continued operational pressure across community nursing CHS and increasing concerns linked to patient outcomes/harm and potential impact to safety, quality of care and staff well-being.
- Weekly safe staffing forecast meetings with Interim Assistant Director of Nursing and Quality, 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.

- Safe staffing Risk deep dive was presented to the Quality Forum on the 14 October 2021 identifying actions to mitigate the risks to patient safety, quality of care and experience.

Right Skills

- During Covid-19 the compliance renewal date for each mandatory and role essential topic was extended by 6 months. Correct to 1 November 2021 Trust wide substantive staff;
    - Appraisal at 78.1% compliance AMBER
    - Clinical supervision at 77.3% compliance AMBER
    - All core mandatory training compliance GREEN except for Information Governance AMBER at 89.4%
- Clinical mandatory training compliance for substantive staff, to note;
    - BLS increased compliance by 2.2 % to 81.2% compliance AMBER
    - ILS increased compliance by 1.9 % to 75.2% compliance AMBER
- Clinical mandatory training compliance for bank only workforce remains low;
    - BLS 49.6 % at RED compliance
    - ILS 35 % at RED compliance
- Compliance with face-to-face mandatory training is reported through the education and training governance structures Training Education Development and Strategic Workforce Committee. There are Learning & Development operational actions plans and each directorate is undertaking a deep dive into their services. The key theme being actioned is non-attendance at training and DNA rates currently above 50% for courses.

Right Place

- The Covid-19 risk managed wards are North, Beaumont, Wakerley, Ward 4 at Coalville and Mill lodge. 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 opened in September 2021 to support Covid-19 positive patients in DMH.
- A deep dive of actual planned staffing data taken from Health roster in August 2021 demonstrated an increase in Ward Sister/Charge Nurse hours pulled through to the actual RN hours as a standard. Whilst this is reflective in many areas of the daily actual support to clinical teams during the pandemic response, further work continues to take place to ensure health roster accurately differentiates supervisory clinical hours and actual hours to support safe staffing changes planned from 1 December 2021.
- Fill rates above and 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 17.81CHPPD in October 2021, with a range between 6 (Ashby ward) and 70.4 (Gillivers) 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 November 2021;

Absence by directorate	Sickness absence	Self-Isolation – Working from home	Self-Isolation – Unable to work from home	Total
Community Health Services	5.4%	0.3%	0.5%	6.2%
Enabling Services	1.7%	0.2%	1.2%	3.1%
FYPC	4.1%	0.8%	0.9%	5.8%
Hosted Service	4.0%	0.8%	0.5%	5.3%
Mental Health Services	5.3%	0.7%	0.9%	7.0%
LPT Total	**4.6%**	**0.6%**	**0.8%**	**5.9%**

Table 1 – COVID-19 and general absence – 1 November 2021

In comparison to the previous month total absence has increased by 0.9% associated with an increase in general absence overall.

In-patient Staffing

Summary of inpatient staffing areas to note;

Wards	August 2021	Sept 2021	October 21
Hinckley and Bosworth East Ward	X	X	x
Hinckley and Bosworth North Ward	X	X	x
St Lukes Ward 1	X	X	x
St Lukes Ward 3	X	X	x
Beechwood	X	X	x
Clarendon	X	X	x
Coalville Ward 1	X	X	x
Coalville Ward 4 (ward 2)	X		x
Rutland	X	X	x
Dalgleish	X	X	x
Swithland		X	x
Coleman	X	X	x
Kirby	X	X	x

Wards	August 2021	Sept 2021	October 21
Welford		X	x
Wakerley	X	X	x
Aston	X	X	x
Ashby	X	X	x
Beaumont	X	X	x
Belvoir	X	X	x
Griffin	X	X	x
Phoenix	X	X	x
Heather	X	X	x
Watermead	X	X	x
Mill Lodge	X	X	x
Agnes Unit	X	X	x
Langley	X	X	x
Beacon (CAMHS)	X	X	x
Thornton	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, Beaumont, Coalville ward 4, Mill Lodge, Wakerley 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.

Weekly safe staffing forecast meetings with Deputy Director of Nursing and Quality, 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 and review of the risks and actions to mitigate the risks.

The following areas are identified as key areas to note/high risk areas;

FYPC/LD

Beacon Unit (CAMHS) due to high levels of bank and agency staff to meet planned safe staffing and increased staffing to support increased patient acuity. Due to deceased substantive staff numbers, the unit currently has capacity to safely staff 7 beds; this has been agreed until December 2021. The unit continues to progress with the quality Improvement plan with oversight to QAC.

CHS

Community Hospitals reported operating at an amber risk overall, however it was noted that there is an increased number of shifts with 50% temporary staffing and occasions

where there is only one registered nurse on shift, on these shifts the risk profile changes to a high-risk rating.

DMH

Mill Lodge has 7 RN vacancies and 5 HCSW vacancies, resulting in high temporary workforce utilisation impacting continuity of care. It is noted that the Ward regularly runs with one RN at night for 14 patients, supported by staff from Stewart House. A number of actions are in place terms of recruitment to support continuity of staffing across the unit 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 and a follow up quality summit was held in October 2021; a quality improvement plan is in place focusing on leadership, culture, and staffing with oversight to QAC.

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	August 2021	Sept 2021	October2021
City East Hub- Community Nursing	X	X	x
City West Hub- Community Nursing	X	X	x
East Central		X	x
Healthy Together – City (School Nursing only)	X	X	x
Healthy Together County	X	X	x
Looked After Children	X	X	x
Diana team		X	x
South Leicestershire CMHT	X	X	x
Charnwood CMHT	X	X	x
Memory service		X	x
Assertive outreach	X	X	x
ADHD service	X	X	x
LD Community Physiotherapy	X	X	x
Mental Health Liaison team	X		
Crisis team			x
Central Access Point (CAP)			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 City, County, Diana service and Looked After Children (LAC) teams continue to be rated to be at moderate to high risk due to vacancies and a number of staff retiring, leading to a reduced service delivery and revision of prioritisation models/waiting list reviews and RAG rating.

Healthy Together (HT) teams have been unable to provide the full Healthy Child Programme and are exploring all options for a reduced sustainable Healthy Child Programme offer. An updated Quality Impact Assessment (QIA) and conversation with Public Health (PH) Commissioners has taken place and the options agreed. County Healthy Together are progressing recruitment to 8 WTE band 5 RN posts.

Blaby team is a county HT area to note due to only 17.2% substantive staffing levels and a safeguarding caseload for thirty children on a safeguarding plan/ Looked After Children. Actions to date include:

- Reallocation of safeguarding cases from the Blaby team to designated Health Visitor's (HV's) across county
- Quality Impact Assessment (QIA) and Equality QIA completed with agreed reduction in service offer
- Movement of staff from city to county & utilisation of temporary workforce
- Ongoing recruitment and retention to include incentive schemes 4 & 8
- All available Clinical Team Leader's and Family Service Manager's carrying out clinical face to face contacts
- Incidents, concerns, staff feedback and performance will continue to be monitored

The Diana team/service is an ongoing area to note due to staff absence due to Covid-19 and or sickness in October 2021. Due to the specific staff skills and knowledge required to deliver care and family support the service is not able to utilise temporary/agency workers to meet demand and planned staffing. As a result of staff absence there is currently reduced care hours and respite offer and no new referrals are being taken as a control measure. The service is looking to recruit to Band 4 posts in the new year.

Looked After Children team are operating at a high-risk level due to only 35% substantive staffing available to work, this has resulted in a reduced service offer and impact to initial health assessment contacts. Potential risks due to delayed assessment, risks continue to be monitored within the Directorate on a weekly basis. Commissioners have been in discussion with service and a plan has been implemented.

Learning disabilities community physiotherapy continues to be rated amber, the team continue to assess and treat all red and amber RAG rated referrals. Recruitment process is ongoing as there are challenges across all community services in recruiting qualified staff into vacancies

CHS Community

Throughout October 2021, Community Nursing has been reporting operating between OPEL levels 2 – 4, primarily level 3. The patient acuity levels during this time have been very challenging across all community nursing teams. Bank nurse shift fill for County teams has remained low with no improvement in agency shift fill within the city. Absence and sickness continue to impact on service provision. The city community hub remains key area to note.

Business continuity plans continue including patient assessments being reprioritised and some clinic appointments have been reprioritised and rescheduled in line with available staff capacity. Community hub clinics have continued. The reprioritised assessments include wound and holistic assessments. Additional support from specialist teams including Tissue Viability and Podiatry has been provided to the city hub/teams. All planned and essential care has continued to be carried out within agreed timescales for all community patients.

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

- Continue to work together with the transformation team regarding additional requirements and 'Fixes for the new OPEL report template
- Continuous review and monitoring of staff absence, flexing teams to prioritise visits,
- Reviewing caseloads to prioritise urgent and essential visits
- Supporting the health and well-being of staff given the noted increased levels of stress and anxiety across the service line,
- Staying connected with Centralised Staffing Solutions to secure bank and agency shift fill
- Continue to monitor and collate data on known clinical activity vs clinical resource (staff) to strengthen understanding of further pressures on service line
- Ongoing targeted recruitment campaign to band 5 RNs, Health Care Support Workers, assistant practitioner and nursing associates continues. This month the focus is upon Royal Collage of Nursing (RCNi) job listing. Recruitment process continues with Interviews taking place this month for Registered Nurses (RN's) and Health care Support Workers (HCSWs).

In September 2021 it is was noted that three serious incidents have occurred where essential visits were accidentally cancelled resulting in delayed assessments and pressure ulcer harm as a consequence. The Executive Director of Nursing, AHPs and Quality met with the senior clinical team on 4 October 2021 and a quality summit is planned for 2 November 2021.

MH Community

The Central Access Point (CAP) and the Crisis Team continue to experience high levels of routine referrals. The Crisis Resolution and Home Treatment team is an area for concern due to high number (40%) of RN vacancies. 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.

Other key areas to note are Charnwood CMHT, South Leicestershire CMHT, the ADHD Service and Assertive Outreach and Memory service, Mental Health Services for Older People (MHSOP).

Proposal

Considering the triangulated review of workforce metrics, nurse sensitive indicators, patient feedback and outcomes in October 2021 it is proposed that staffing challenges continue to increase and there is emerging evidence that current controls and implementing business continuity plans are not fully mitigating the impact to the quality and safety of patient care across all services, at all times.

Whilst there has been no evidence through the in-patient monthly triangulated review of Nurse Sensitive Indicators that staffing is a contributory factor to patient harm, there is a level of concern about pressure ulcer harm in community nursing, reduced respite offer in the Diana service and in Healthy Together teams and Looked After Children services a potential for unknown risks and impact to outcomes and harm linked to reduced service offer/health assessments, all of which are being reviewed and risk managed.

Decision required

The board is asked to confirm a level of assurance that processes are in place to monitor inpatient and community staffing levels and actions in place to try to mitigate the risk of impact to patient safety and care quality.

October 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 (Early & Late Shift) Average % fill rate registered nurses >=80%	Nurse Day (Early & Late Shift) Average % fill rate care staff >=80%	Nurse Night Average % fill rate registered nurses >=80%	Nurse Night Average % fill rate care staff >=80%	AHP Day Average % fill rate registered AHP -	AHP Day Average % fill rate non-registered AHP -	% Temporary Workers (NURSING ONLY) Total <20%	Bank	Agency	Overall CHPPD (Nursing And AHP)	Medication Errors	Falls	Complaints	PU Category 2 (Month in arrears)	PU Category 4 (Month in arrears)
AMH Bradgate	Ashby	21	20	104.4%	119.8%	103.1%	70.6%			36.0%	25.6%	10.4%	6.0	↓2	↓0	→0		
	Aston	19	16	115.8%	185.7%	97.4%	140.2%			45.2%	29.8%	15.4%	8.0	↑2	↑2	→0		
	Beaumont	22	19	88.2%	148.5%	101.3%	132.1%			52.5%	37.7%	14.7%	13.1	↑3	↑4	↑1		
	Belvoir Unit	10	9	130.9%	188.2%	197.8%	155.0%			50.4%	32.9%	17.4%	21.3	↓0	↓0	→0		
	Heather	18	17	86.1%	248.8%	103.0%	164.5%			53.3%	30.0%	23.3%	8.4	→0	↑2	↑1		
	Thornton	14	14	79.7%	204.6%	98.2%	126.4%			35.6%	30.6%	5.0%	8.8	→0	↑3	→0		
	Watermead	20	19	94.4%	217.9%	110.0%	182.7%		100.0%	31.8%	18.1%	13.8%	7.8	↓1	↑1	→0		
	Griffin - Herschel Prins	6	6	103.7%	201.3%	101.6%	503.9%			57.6%	38.6%	19.1%	28.0	→0	↓0	→0		
AMH Other	Phoenix - Herschel Prins	12	12	120.0%	157.4%	104.5%	148.6%		100.0%	45.5%	27.7%	17.8%	12.0	→0	→0	↑1		
	Skye Wing - Stewart House	30	25	143.9%	113.7%	131.8%	155.5%			34.8%	31.6%	3.2%	6.5	→0	→1	→0		
	Willows	9	9	131.9%	122.4%	101.1%	124.5%			33.1%	29.4%	3.7%	13.4	↓0	→0	→0		
	Mill Lodge	14	12	84.7%	99.9%	127.1%	160.1%			72.8%	43.9%	28.9%	15.2	↓0	↓12	→0		
CHS City	Kirby	23	21	67.4%	120.7%	120.6%	185.0%	100.0%	100.0%	39.1%	28.2%	10.9%	8.6	→1	↓5	→0	→0	→0
	Welford	24	20	73.6%	111.1%	133.3%	202.4%			23.5%	19.8%	3.7%	7.0	↑2	↑10	→0	→0	→0
	Beechwood Ward - BC03	23	20	110.6%	122.6%	99.7%	126.1%	100.0%	100.0%	30.3%	14.7%	15.6%	9.7	↓0	↑5	↑1	→1	→0
	Clarendon Ward - CW01	21	17	100.7%	120.0%	127.1%	102.0%	100.0%		32.0%	8.6%	23.5%	11.3	→2	↑5	→0	↑3	→0
	Coleman	21	17	83.9%	252.1%	157.5%	552.0%	100.0%	100.0%	63.4%	35.7%	27.8%	18.7	↓0	↑5	→0	→0	→0
	Wakerley (MHSOP)	21	14	130.5%	115.2%	161.3%	147.9%			49.0%	30.2%	18.8%	15.6	↑1	↓1	→0	→0	→0
CHS East	Dalgleish Ward - MMDW	17	15	120.4%	94.0%	100.1%	99.9%	100.0%	100.0%	21.2%	7.8%	13.4%	8.5	→0	↑5	→0	→1	→0
	Rutland Ward - RURW	17	13	102.3%	112.4%	91.9%	104.8%	100.0%	100.0%	30.1%	19.2%	10.9%	9.2	→1	↑3	→0	↓0	→0
	Ward 1 - SL1	18	15	90.0%	108.9%	98.0%	143.4%	100.0%	100.0%	23.3%	16.0%	7.4%	11.6	→1	↓2	↓0	→1	→0
	Ward 3 - SL3	13	12	144.3%	108.8%	100.0%	195.9%	100.0%	100.0%	18.7%	9.2%	9.5%	10.8	↓1	→1	→0	↑3	→0
CHS West	Ellistown Ward - CVEL	15	13	109.3%	94.7%	104.6%	98.4%	100.0%	100.0%	11.6%	5.6%	6.0%	15.9	↓1	↓0	→0	↑2	→0
	Snibston Ward - CVSN	18	15	100.2%	140.6%	98.3%	164.1%	100.0%	100.0%	20.7%	10.9%	9.9%	12.4	→0	↓4	→0	↓0	→0
	East Ward - HSEW	23	20	102.9%	127.9%	96.4%	132.4%	100.0%	100.0%	29.1%	12.1%	17.0%	10.1	→0	↓3	→0	→0	→0
	North Ward - HSNW	18	12	113.0%	100.7%	99.8%	101.1%	100.0%	100.0%	30.3%	10.5%	19.9%	13.6	→0	↑3	→0	↑2	→0
	Swithland Ward - LBSW	18	15	114.2%	91.8%	98.0%	114.5%	100.0%	100.0%	9.1%	3.6%	5.5%	10.5	↓0	→1	→0	↓0	→0
FYPC	Langley	15	12	148.0%	99.7%	124.7%	128.0%	100.0%		39.7%	34.4%	5.3%	11.2	→0	→0	→0		
	CAMHS Beacon Ward - Inpatient Adolescent	16	7	113.5%	146.1%	140.0%	226.5%	100.0%		67.3%	33.6%	33.7%	27.3	↑3	↓0	→0		
LD	Agnes Unit	4	2	165.0%	210.3%	182.9%	260.8%			56.4%	24.6%	31.8%	68.9	→0	→0	→0		
	Gillivers	1	1	52.0%	75.5%	78.6%	90.3%			3.0%	3.0%	0.0%	70.4	→0	→0	→0		
	1 The Grange	3	1	-	162.9%	-	99.1%			11.1%	11.1%	0.0%	0.0	→2	↑1	→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	Average no. of Occupied Beds	Average % fill rate registered nurses	Average % fill rate care staff	Average % fill rate registered nurses	Average % fill rate care staff	Total	Bank	Agency	CHPPD	Medication Errors	Falls	Complaints
		>=80%	>=80%	>=80%	>=80%	<20%						
Ashby	20	104.4%	119.8%	103.1%	70.6%	36.0%	25.6%	10.4%	6.0	↓2	↓0	→0
Aston	16	115.8%	185.7%	97.4%	140.2%	45.2%	29.8%	15.4%	8.0	↑2	↑2	→0
Beaumont	19	88.2%	148.5%	101.3%	132.1%	52.5%	37.7%	14.7%	13.1	↑3	↑4	↑1
Belvoir Unit	9	130.9%	188.2%	197.8%	155.0%	50.4%	32.9%	17.4%	21.3	↓0	↓0	→0
Heather	17	86.1%	248.8%	103.0%	164.5%	53.3%	30.0%	23.3%	8.4	→0	↑2	↑1
Thornton	14	79.7%	204.6%	98.2%	126.4%	35.6%	30.6%	5.0%	8.8	→0	↑3	→0
Watermead	19	94.4%	217.9%	110.0%	182.7%	31.8%	18.1%	13.8%	7.8	↓1	↑1	→0
Griffin - Herschel Prins	6	103.7%	201.3%	101.6%	503.9%	57.6%	38.6%	19.1%	28.0	→0	↓0	→0
Totals										↓8	↑12	↑2

Table 4 - Acute inpatient ward safe staffing

All ward/units have utilised a high percentage of temporary workforce in October 2021, notably the psychiatric intensive care units, this is due to high/complex patient acuity and to meet planned safe staffing levels due to increased vacancies due to promotions internally supporting the urgent care pathway and sickness/absence.

The fill rate for RN's on Thornton ward is slightly below the threshold > 80% due to HCSW's filling for the third RN on shift i.e., 2 RN's and 1 HCSW instead of 3 RN's. This is still within safe parameters of staffing (2 RNs), HCSW fill rate is high at 204.6% as a result.

There were 12 falls reported in October 2021, which is an increase from 8 in September 2021. Of these 12 falls, six were first falls and six repeat falls. 5 male and 7 females experienced falls, with 11 falls being unwitnessed and 1 witnessed. Themes were found to be patients feeling dizzy and faint, slips both inside, outside and sedation.

There were 8 medication incidents reported which is a decrease from 12 in September 2021. Analysis has shown that four incidents were prescribing errors that did not result in an administration error. 1 incident was an E-CD error, 2 were misplaced/dropped medication.

There was an incident of a patient giving another patient's name and therefore an administration error occurred, the medication error policy was followed, patient and staff supported. A review of the incident highlighted that there was no regular qualified staff on the ward and the nurse was unfamiliar with the patient and the ward, the nurse has reflected on this and identified learning; this will be further mitigated by roll out of patient ID checking use of bracelets or photographs.

There have been two complaints received during October2021. There has not been any direct correlation with staffing.

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	12	120.0%	157.4%	104.5%	148.6%	45.5%	27.7%	17.8%	12.0	→0	→0	↑1
Totals										→0	→0	↑1

Table 5- Low secure safe staffing

Phoenix continues to use a higher proportion of agency staff in October 2021 to support planned staffing due to staff vacancies and waiting for newly recruited staff to start. There were no medication errors or falls reported in October 2021.

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	25	143.9%	113.7%	131.8%	155.5%	34.8%	31.6%	3.2%	6.5	→0	→1	→0
Willows	9	131.9%	122.4%	101.1%	124.5%	33.1%	29.4%	3.7%	13.4	↓0	→0	→0
Mill Lodge	12	84.7%	99.9%	127.1%	160.1%	72.8%	43.9%	28.9%	15.2	↓0	↓12	→0
TOTALS										↓0	**↓13**	→0

Table 6 - Rehabilitation service safe staffing

Mill Lodge continues to utilise a high percentage of temporary workforce to meet planned staffing levels due to the amount of RN and HCSW vacancies. The HCSW vacancies have been recruited to and are awaiting start dates. In October 2021 the use of temporary

workforce has been affected by a Covid-19 outbreak where there were several substantive staff needing to isolate and sickness. A number of actions are in place to support continuity of staffing across the unit and daily operational management to ensure that the unit meets its planned safe staffing levels.

There have been no medication incidents in October 2021 which is a decrease from two medication incidents reported in September 2021

There were 13 patient falls in October 2021 which is a slight decrease from 17 compared to September 2021. Analysis has shown that one fall was reported at Stewart house whereby a patient was unsteady when they got up from their chair and fell backwards.

There were 12 falls experienced by patients at Mill Lodge which is a decrease from 15 in September 21. Analysis of the patient falls at Mill Lodge has shown 10 of these falls were experienced by 2 patients who were having to self-isolate in their bedrooms due to an outbreak of covid 19 on the ward.

On one occasion a fall was experienced from sitting to standing where all other falls were a roll out of an ultra-low profiling beds onto a crash mats which had been positioned by the sides of the patient's bed for safety reasons. No injuries were observed, and therapeutic observations were reviewed and changed due to the patients isolating, no incidents were linked to staffing levels or skill mix.

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	PU Category 2	PU Category 4
BC Kirby	21	67.4%	120.7%	120.6%	185.0%	39.1%	28.2%	10.9%	8.6	→1	↓5	→0	→0	→0
BC Welford	20	73.6%	111.1%	133.3%	202.4%	23.5%	19.8%	3.7%	7.0	↑2	↑10	→0	→0	→0
Coleman	17	83.9%	252.1%	157.5%	552.0%	63.4%	35.7%	27.8%	18.7	↓0	↑5	→0	→0	→0
Wakerley	14	130.5%	115.2%	161.3%	147.9%	49.0%	30.2%	18.8%	15.6	↑1	↓1	→0	→0	→0
TOTALS										**↑4**	**↓12**	→0	→0	→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 Kirby, and Welford Wards. The staffing establishment on these wards consist of a Medication Administration Technician (MAT) and on Kirby Ward a Mental Health Practitioner (MHP), which does not fall within the registered nurse numbers. The ward skill mix also includes a registered nursing associate.

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.

There were no pressure ulcer incidences reported in October 2021 and no complaints received.

Analysis of the medication errors has shown none of the incidents were related to safer staffing, incidents that occurred were related to a dispensing error by substantive member of staff who mis identified the patient, process has been followed to learn from this incident and share learning further across the inpatient group.

There is an overall decrease of falls since September 2021; analysis continues to show that patient demographic and acuity of patients is a factor with experiencing falls and repeat falls amongst specific patients. There was no theme identified to indicate staffing impacted or was a contributory factor.

The falls process was followed in each case and physiotherapy involved was established prior to the falls occurring in most cases. Where Physiotherapy support was not established a referral was made post fall for advice and support. To note there was one patient fall on Kirby that resulted in a fracture and is subject to a falls investigation.

All MHSOP wards are due to welcome 2 international recruited nurses to their workforce in the coming months which, once inducted will support safer staffing across the service.

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	PU Category 2	PU Category 4
MM Dalgliesh	15	120.4%	94.0%	100.1%	99.9%	21.2%	7.8%	13.4%	8.5	→0	↑5	→0	→1	→0
Rutland	13	102.3%	112.4%	91.9%	104.8%	30.1%	19.2%	10.9%	9.2	→1	↑3	→0	↓0	→0
SL Ward 1	15	90.0%	108.9%	98.0%	143.4%	23.3%	16.0%	7.4%	11.6	→1	↓2	↓0	→1	→0
SL Ward 3	12	144.3%	108.8%	100.0%	195.9%	18.7%	9.2%	9.5%	10.8	↓1	→1	→0	↑3	→0
CV Ellistown 2	13	109.3%	94.7%	104.6%	98.4%	11.6%	5.6%	6.0%	15.9	↓1	↓0	→0	↑2	→0
CV Snibston 1	15	100.2%	140.6%	98.3%	164.1%	20.7%	10.9%	9.9%	12.4	→0	↓4	→0	↓0	→0
HB East Ward	20	102.9%	127.9%	96.4%	132.4%	29.1%	12.1%	17.0%	10.1	→0	↓3	→0	→0	→0
HB North Ward	12	113.0%	100.7%	99.8%	101.1%	30.3%	10.5%	19.9%	13.6	→0	↑3	→0	↑2	→0
Swithland	15	114.2%	91.8%	98.0%	114.5%	9.1%	3.6%	5.5%	10.5	↓0	→1	→0	↓0	→0
CB Beechwood	20	110.6%	122.6%	99.7%	126.1%	30.3%	14.7%	15.6%	9.7	↓0	↑5	↑1	→1	→0
CB Clarendon	17	100.7%	120.0%	127.1%	102.0%	32.0%	8.6%	23.5%	11.3	→2	↑5	→0	↑3	→0
TOTALS										↓6	↑32	↑1	↑13	**→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 monthly 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.

The increased fill rate for HCA on night shifts is due to increased acuity and dependency due to patients requiring enhanced observations, one to one supervision.

Temporary workforce usage has reduced compared to September 2021 with the exception of Rutland, Ward 1 St Luke's, Dalgleish, East, North, Beechwood and Clarendon wards, this is due to increased patient acuity and dependency, patients requiring enhanced observations due to one-to-one care, annual leave, vacancies, maternity leave and sickness.

A review of the Nurse Sensitive Indicators (NSIs) for the community hospital wards has identified an increase in the number of falls incidents from 26 in September 2021 to 32 in October 2021 comprising of 29 first falls, 3 repeat falls. Ward areas to note are North Ward, Beechwood, Clarendon, Rutland and Dalgleish ward. The wards continue to see an increase in patient dependency and 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 community hospital wards has decreased from 14 in September 2021 to 6 in October 2021. A review of these incidents has identified these relate to prescribing, administration and procedural errors and there was no direct correlation with staffing.

The number of category 2 pressure ulcers developed in our care has increased from 11 for September 2021 to 13 for October 2021. Areas to note are St Luke's Ward 3, Elliston, Clarendon, and North Ward. A quality improvement project has commenced to review the pressure ulcer prevention pathway.

There has been one complaint received during October for Beechwood Ward. There has not been any 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	3	148.0%	99.7%	124.7%	128.0%	39.7%	34.4%	5.3%	11.2	→0	→0	→0
CAMHS	7	113.5%	146.1%	140.0%	226.5%	67.3%	33.6%	33.7%	27.3	↑3	↓0	→0
TOTALS										↑3	↓0	→0

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

Inpatient areas continue to increase temporary worker utilisation for both Langley and CAMHS to meet planned staffing levels due to vacancies and complex patient care needs associated with high levels of patient acuity.

Recruitment to vacant posts has been progressed in both areas. The Beacon Unit has successfully recruited to a variety of positions with a trajectory to increase bed capacity and reduce temporary workforce utilisation over the next 5 months.

The Beacon unit currently has capacity to safely staff 7 beds and this has been agreed until December 2021. The unit continues to progress with the quality Improvement plan with oversight to QAC.

There were three medication errors on the CAMHS Beacon Unit. The first incident related to a young person who declined oral medication and was given medication intra-muscularly (IM) when in an acute state of distress. The prescription was only for oral medication. The young person's care plan stated that it needed to be given IM when they were distressed, the patient's medication chart was changed the following day to prescribe this medication as IM.

The second incident was a prescription error. The consultant added TTO's to the main prescription. No medication was given, and this was removed from the chart.

The third incident was for a young person who stated they were a different patient (knowingly), gave their date of birth and were given the wrong patients medication. In response to this incident (as patients do not wear wrist bands due to risk to self and/or others), patient photos were taken and are displayed in the office and treatment room, so all staff including temporary staff are aware who the young people are.

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	165.0%	210.3%	182.9%	260.8%	56.4%	24.6%	31.8%	68.9	→0	→0	→0
Gillivers	1	52.0%	75.5%	78.6%	90.3%	3.0%	3.0%	0.0%	70.4	→0	→0	→0
1 The Grange	1	-	162.9%	-	99.1%	11.1%	11.1%	0.0%	0.0	→2	↑1	→0
TOTALS										→2	↑1	→0

Table 10 - Learning disabilities safe staffing

Patient acuity on the Agnes Unit has increased following admission of new patients and staffing is reviewed and increased to meet patient care needs, this is reflected in high utilisation of temporary workforce staff deployed against planned levels and high CHPPD. Agnes Unit are progressing recruitment to Registered Nurse and HCSW vacancies.

Short breaks: Staffing includes both RNs and HCSWs due to the complex physical health needs. During October 2021 both areas continued to support one patient in respite, staffing

was managed well and adjusted to meet the individual patient's care needs, and this is reflected in the fill rate. There were 2 medication errors on The Grange, and this has not increased from September 2021. Review of the NSIs has not identified any staffing impact on the quality and safety of patient care/outcomes. There was one patient fall incident and on a review of the NSIs this has not identified any staffing impact on the quality and safety of patient care/outcomes.

Governance table

For Board and Board Committees:	Public Trust Board 21.12.21	
Paper sponsored by:	Anne Scott, Executive Director of Nursing, AHPs and Quality	
Paper authored by:	Emma Wallis, Interim Deputy Director of Nursing & Quality, Elaine Curtin Workforce and Safe Staffing Matron	
Date submitted:	21.12.2021	
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	√
	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:		

Public Trust Board – 21st December 2021

Safe Staffing November 2021 Interim highlight report

Purpose of the report

This report provides an interim overview of safe staffing, key areas to note, during the month of November 2021, staffing challenges with moderate/high risk of potential impact to quality, safety, and experience. This is an interim report format as the Trust staffing scorecard data including workforce metrics; fill rates, Care Hours Per Patient Day (CHPPD) and Nurse Sensitive Indicators (NSIs) is not available for analysis and review to meet the Trust board deadline in December 2021, as it is an earlier Trust board meeting this month.

The interim report is based on the weekly safe staffing situational and forecast meeting reviews. The full triangulated monthly safe staffing review for November 2021 will be submitted to Trust board in January 2022.

Background

A safe staffing organisational risk deep dive was presented to the Quality Forum in October 2021, situation report and discussion held at Strategic Executive Board on the 5 November 2021 with a further presentation at the Trust Board development session on the 26 November 2021.

Self-assessment against; Key actions Winter 2021 preparedness: Nursing and midwifery safer staffing (NHS, November 2021) assurance framework is submitted separately to the Trust Board, including a summary report, GAP analysis and actions to enhance assurance against Key Lines of Enquiry (KLOE).

Analysis of the issue

Areas to note throughout November 2021 as identified/discussed by exception at the weekly safe staffing meetings, reported using the NHSI Developing Workforce Safeguards risk ratings:

- Low risk (green) staffing is safe. Ward/community teams are managing their workload
- Moderate risk (amber) – caution: staffing is at 50% trust RN and 50% bank/agency
- High Risk (red) – depleted: trust considers area to be high risk, actions may include part or full closure of a service or reduced provision, for example, wards, beds, teams, realignment, or change to skill mix

The table below outlines the moderate and high-risk key areas to note for both community

and inpatients.

Area	Situation	Actions /mitigations	Rag /Assurance
Beacon Unit (CAMHS)	Increased acuity and dependency with significant vacancies and reduced substantive staff members, ongoing impact	Bed capacity reduced to 7, until December 2021. High utilisation of bank and agency staff to meet planned safe staffing with enhanced staffing model. Unit continues to progress with Quality Improvement plan (with QAC oversight). Block booking of bank and agency. Successful recruitment to band 7 /6/5 in progress. Evidence based establishment review completed and presented to DMT. All staff in non-patient facing roles with a clinical qualification working within the staffing establishment to support continuity of care.	
Agnes unit	Increased acuity and dependency, with increased new admissions, significant vacancies	High utilisation of bank and agency and increased enhanced staffing model to meet increased patient acuity. Block booking of bank and agency staff. Recruitment progressing to RN's and HCSW vacancies. Establishment review in progress. All staff in non-patient facing roles with a clinical qualification working within the staffing establishment to support continuity of care.	
CHS in patients	Increased patient acuity and dependency requiring	Daily safe staffing review and substantive staff movement	

	enhanced observations and high vacancies, sickness, maternity leave. All in patient wards operating at amber due to staffing at 50% trust RN and 50% bank/agency. Key areas to note; North and East ward, Beechwood, Clarendon, Rutland and Dalgleish (North ward also Covid 19 risk managed).	across the service to ensure substantive RN cover. Block booking of temporary workers. Planned additional flexible workers at night to cover last minute cancellations/shortfalls. Establishment reviews in progress. Recruitment ongoing with 16 international nurses recruited to a number of Wards.	
DMH in patients	Increased vacancies, sickness, and absence (Covid and non-Covid related) increased acuity and complexity. Increased internal movement and promotions to urgent care pathway roles and step up to great mental health transformation. Key areas to note; Mill Lodge, Griffin, Beaumont, and Belvoir Unit.	Mill lodge – partial closure to admissions due to staffing with daily directorate review, high utilisation of bank and agency to meet planned staffing, establishment review in progress, recruitment ongoing to include international nurse's and HCSW's. High utilisation of bank and agency to meet planned safe staffing levels. Block booking where possible. Movement across service to support substantive cover. Flexible worker to cover last minute cancellations/shortfalls. Establishment reviews in progress.	
CHS Community Teams	Increased patient acuity across all teams with increased caseload, high vacancies absence and sickness. Operating at OPEL 3, with higher risk in the city community nursing hub.	Business continuity plans in place including caseload review, urgent and essential visits, reprioritisation of patient assessments/clinics/wound and holistic assessments.	

	Key areas to note; City East, City West and East Central.	Support from Tissue Viability and Podiatry, close monitoring of all data and clinical activity. Quality Summit held in November 2021 in response to potential pressure ulcer harm. Targeted bespoke community nursing recruitment continues.	
FYPC/LD community Teams	High vacancies, increased number of staff retirements, staff absence due to sickness (covid and non-covid). Key areas to note; Healthy Together City and County teams notably Blaby. Looked After Children and Diana team.	Healthy Together city/county reduced service offer, caseload review, movement of staff, utilisation of temporary workforce, mangers/team leaders working clinically, all incidents, concerns and staff feedback monitored closely. Quality Impact assessment in place. Looked After Children; reduced service offer, close weekly monitoring within directorate. Diana team; reduced respite service offer, unable to use temporary workforce due to specialist skills /competencies.	
MH Community	High vacancies across all teams, higher demand of routines referrals, internal staff movement/promotion as part of transformation work (destabilising other parts of the service) Key areas to note; Crisis Resolution & Home Treatment team, Central Access Point (CAP), South Leicestershire/Charnwood, Assertive Outreach. ADHD and	Crisis Resolution and Home treatment team experiencing high vacancies 40% of substantive staff, unable to use temporary workforce due to specialist skills/competencies. Central Access Point, CMHTs, memory service all with control measures in place to try to mitigate risks to quality, safety & experience. (Moderate risk)	

	memory service.		

Proposal

Considering the highlighted key areas to note in November 2021 it is proposed that staffing challenges continue and there is emerging evidence that current controls and implementing business continuity plans are not always mitigating the impact to the quality and safety of patient care across all services.

Decision required

The board is asked to confirm a level of assurance that processes are in place to monitor inpatient and community staffing levels and that actions are in place to try to mitigate the risks to patient safety and care quality.

Governance table

For Board and Board Committees:	
Paper sponsored by:	Anne Scott, Executive Director of Nursing, AHPs and Quality
Paper authored by:	Emma Wallis, Interim Deputy Director of Nursing &

	Quality, Elaine Curtin Workforce and Safe Staffing matron	
Date submitted:	21.12.2021	
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	Interim monthly report. Full report to be provided to January 2022 Trust Board	
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:		

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Leicestershire Partnership NHS Trust

Public Trust Board – 21.12.21

Key Actions: NHS Winter 2021 preparedness: Nursing and midwifery safer staffing 12 November 2021

Purpose of the report

The purpose of the report is to provide an overview of the Trust self-assessment against Key Actions: NHS Winter 2021 preparedness: Nursing and Midwifery safer staffing 2021 assurance framework.

Background

The Winter 2021 guidance focuses on preparedness, decision making and escalation processes to support safer nursing and midwifery staffing as the winter period approaches, building on the previous guidance issued in relation to COVID-19 workforce models and the fundamental principles for the nursing and midwifery workforce as set out in the National Quality Board (NQB) Safe Sustainable and Productive staffing guidance.

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 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 the Quality Assurance Committee as part of the Director of Nursing report in March 2021. To note; no gaps were identified following self-assessment and review.

Analysis of the issue

The Key Actions NHS Winter 2021 preparedness Nursing and midwifery safer staffing Board Assurance Framework (BAF) version 1 (appendix 1) has been self-assessed against the BAF Key Lines of Enquiry (KLoEs) and identified four areas that require further action to strengthen assurance.

The action plan will be reported and monitored through the Trust Strategic Workforce Committee and summary updates included in the 6 monthly safe and effective staffing review updates to Trust Board.

A summary table is included below, and full action plan included as appendix 2 for assurance:

KLOE	Action to improve assurance	Status
1. Quality impact assessments are undertaken where there are changes in estate or ward function or staff roles (including base staffing levels)	EQIA's are held centrally, and a draft policy informs clear process for review and sign off	**On track** Draft policy in progress and process in review
2. Agency staff receive a local induction to the area and patients that they will be supporting	Review of local induction checklist and circulation of document	**On track**
3. The trust has clear and effective mechanisms for reporting staffing concerns or where the patient needs are outside of an individual's scope of practice.	To develop a Trust wide escalation process and ensure that staff are aware how to report staffing concerns	**On Track** Policy in draft including an escalation process/flow chart and listening events held to inform change
4. Due to staffing pressures, the trust considers novel mechanisms outside of incident reporting for capturing potential physical or psychological harm caused by staffing pressures	The trust to increase the number of staff trained as Professional Nurse Advocates in recognition of the burn out, mental health problems and widespread stress experienced by staff	**On Track** Applications received and progressed for next cohort

Each directorate has a surge plan that sets out how they will manage staff and services in the event of a surge in Covid-19. These plans are under continuous review to ensure they are fit for purpose in the current scenario.

Staffing escalation plans have been reviewed and LPT have delivered four Surge Preparedness Exercises, each in preparation for seasonal change or forecasted escalation in Covid-19 or any other seasonal virus such as Flu. The redeployment process established in the first wave is shared through the ICC and reviewed at the gold and silver meetings. Surge plans incorporate a phased increase in bed capacity rather than the opening of surge wards as undertaken in Phase One of Covid-19. This is on review and reflection of the limited available skilled workforce for redeployment.

Services have undertaken and reviewed quality impact assessments (QIAs) and review/ update where changes are made. The implementation of a policy will support a clear process for services to follow. Further work to agree, holding QIA's centrally in the Trust to facilitate regular review, update and sign off by Director of Nursing/Medical Director.

Proposal

It is proposed that the Winter Preparedness BAF action plan is monitored through the Strategic Workforce group, progress against the action included in the six-monthly updates to Trust Board.

Decision required

The Trust Board is asked to confirm a level of assurance considering the report and actions to ensure robust assurance.

Appendix 1: Winter 2021 preparedness Nursing and midwifery safer staffing BAF version 1

Appendix 2: Winter preparedness BAF self-assessment – GAP analysis and action plan

Governance table

For Board and Board Committees:	Public Trust Board 21st December 2021	
Paper sponsored by:	Anne Scott, Executive Director of Nursing, AHPs and Quality	
Paper authored by:	Louise Evans, Interim Assistant Director of Nursing & Quality	
Date submitted:	10.12.21	
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):	Strategic Executive Board- Highlight report	
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	One off	
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:	Considered	

Appendix 1

NHS Winter 2021 preparedness: Nursing and midwifery safer staffing
12 November 2021

Assurance framework – nursing and midwifery staffing – LPT self-assessment – Version 1 - 6.12.21

Leicestershire Partnership NHS Trust

Ref	Details	Controls	Assurance (positive andNegative)	Residual Risk Score / Risk registerreference	Further actionneeded	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
	Guidance notes	*Outline the current Controls (controls are actions that mitigate risk include policies, practice, process and technologies)*	*Detail both the current positive and negative assurance position to give a balanced view of the current position. Assurance is evidence that the control is effective – or conversely is evidence that a control is ineffective / there are still gaps. Recurrent forms of assurance are audit results, key performance indicators, written reports, intelligence, and insight. Effective Assurance should be a triangulated picture of the evidence (staff shortages, sickness absence, patient outcomes, complaints, harm reviews)*	*What is the remaining risk score (using the trusts existing risk systems and matrix)?* *Are these risks recorded on the risk register?*	*Where there are identified gaps in either control or assurance, outline the additional action to be undertaken to mitigate the risk.* *Where the organisation is unable to mitigate fully, this should be escalated to the LRF/region/ national teams and outlined in the following column*	*Provide oversight to the board what the current significant gaps are outline those risks that are currently not fully mitigated /needing external oversight and support*	*Due to the likely prevailing nature of these risks, outlines through what operational channels and how are this active risk being monitored (e.g., daily silver meetings via safe staffing heatmap)*
1.0 Staffing Escalation / Surge and Super Surge Plans							
1.1 1.1	Staffing Escalation plans have been defined to support surge and supersurge plans which includes triggersfor escalation through the surge levels and the corresponding deployment approaches for staff. Plans are detailed enough to evidence delivery of additional training and competency assessment, and expectations wherestaffing levels are contrary to required ratios (i.e intensive care) oras per the NQB safe staffing guidance	Detailed plans are in place as per NQB safe staffing guidance	Each directorate has a surge plan that sets out how they will manage staff and services in the event of a surge in C-19. These plans are under continuous review to ensure they are fit for purpose in the current scenario on analysis of workforce data, nurse sensitive indicators, and performance data. Redeployment checklist is undertaken prior to redeployment to identify individual's skill set, scope of practice, risk assessment and any additional training needs to be completed. Line management involvement and staff	ORR 60 & 61	Trust wide sharing of staffing escalation plans and updates from Directorates to Trust Board	Reduced skilled workforce available to be redeployed. Surge capacity is 2 beds at a time with a trajectory of 5-10-15 beds in-alignment with available workforce for redeployment.	Monthly Safe staffing report to Trust Board, Silver and ICC review.

Ref	Details	Controls	Assurance (positive andNegative)	Residual Risk Score / Risk registerreference	Further actionneeded	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
cont.			side included where staff member has concerns re: redeployment.				
1.2	Staffing escalation plans have been reviewed and refreshed with learning incorporated into revised version in preparation for winter.	Plan in place should we need to revisit urgently	LPT have delivered 4 Surge Preparedness Exercises, each in preparation for seasonal change or forecasted escalation in C-19 or any other seasonal virus such as Flu and RSV	N/A	Circulate suite of rapid responses with team	N/A	Ongoing monitoring of escalation plans through ICC silver and gold, revised in line with workforce availability.
1.3	Staffing escalation plans have been widely consulted and agreed with trust' staff side committee	Plans have been shared	Yes	N/A	We have not explicitly included staff side in development or agreement of any escalation plans and would need to ensure we consult at an earlier stage.	N/A	Resighting staff side on the escalation plans
1.4 1.4	Quality impact assessments are undertaken where there are changesin estate or ward function or staff roles (including base staffing levels) and this is signed off by the CN/MD	QIA are undertaken	Services are expected to undertake quality impact assessments and review/ update where changes are made. These are signed off by Director of Nursing and Medical Director. Decision making tool to close beds has been signed off by DoN. It is an expectation that QIAs have been completed where linked to redeployment and changes to staffing requirements. (Healthy Together) Trust standard template for EQIA's. EQIA's are not held corporately for staffing function. No policy in place currently re: QIA	None	Review of all EQIA's to be undertaken within each Directorate and updated accordingly. EQIA policy in development outlining process for expectation of completion of EQIA and process of sign off.	N/A	Held in Directorate for monitoring and review. Internal audit following presentation and review in Directorate and CRG.

Ref	Details	Controls	Assurance (positive andNegative)	Residual Risk Score / Risk registerreference	Further actionneeded	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
cont.			process although EQIA's reviewed at DMT's for staffing functions and Trust CRG in response to restoration of services.				
2.0 Operational delivery							
2.1	There are clear processes for review and escalation of an immediate shortfall on a shift basis including a documented risk assessment which includes a potential quality impact. Local leadership is engaged and where possible mitigates the risk. Staffing challenges are reported atleast twice daily via Silver.	Safer staffing plans are escalated into silver	The ICC produces a daily OPEL report that is a trust wide report and highlights areas of pressure of which staffing both medical and nursing are reported. This report is circulated to the executive team for oversight and a report is submitted to the LLR UEC Team that reports on staffing.	None	Directorate staffing and bed management SOPs to be reviewed. Escalation process for individual areas is being incorporated into a trust wide safer staffing policy. This is in draft and requires review, sign off, adoption and implementation.	Report submitted to LLR UEC	Review of safer staffing, incidents, escalation in adherence to local policy.
2.1 cont.			In hours staffing issues are manged in the directorates with a route of escalation through the ICC if the situation worsens This is discussed at silver Out of hours there is an on-call framework in place 24/7 to support with any staffing issues, this has an escalation route into the LLR Health and Care system command group. There are ICS led daily system calls and frequency is determined by system pressures- OPEL levels are discussed and the partners work collectively to respond to demands & mitigate risk. LPT attend all systems calls.	None	Implementation of safe care deployment module on health roster to provide timely data intelligence, identification of shortfalls in staffing based on acuity / dependency and shift staffing levels	N/A	NSI metrics – falls, medication errors and complaints. Exception reporting for one trained nurse red flag.
2.2	Daily and weekly forecast position is	ORR 60 &61	LPT are currently	None	Weekly safer staffing	N/A	Review of business

Ref	Details	Controls	Assurance (positive andNegative)	Residual Risk Score / Risk registerreference	Further actionneeded	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
	risk assessed and mitigated where possible via silver / gold discussions. Activation of staffing deployment plans are clearly documented in theincident logs and assurance is gained that this is successful and that safe care is sustained.		operating under the Major Incident Plan and following the command-and-control structure that layer's leadership at the strategic, tactical, and operational levels. LPT have an established Incident Coordination Centre (ICC), the function of the ICC is to support the coordination of a trust wide response to a surge response, this includes logging and discharging actions through an action log,and logging key decisions in the ICC decision log. Trust wide or complex clinical decisions are escalated to the clinical reference group (CRG) for senior clinical review.		output to be shared with silver/ gold command as part of weekly forecast		continuity plans to ensure redeployment plans are included to support safe care delivery
2.3 2.3 cont.	The Nurse in charge who is handing over patients are clear in their responsibilities to check that the member of staff receiving the patientis capable of meeting their individual care needs.	Policy -	Staff are required to work within their scope of professional practice. Staff provide care in a variety of settings, shift patterns and clinical specialties and the complexity of the provision of care puts extra emphasis on the quality of information shared when one team or clinician hands over responsibility of care to the next. The information contained within this document contains the minimum standard expected within the scope of the policy.	None	Further actions to be progressed is review of Nurse In Charge (NIC) checklist	N/A	Audit of handovers and review of handover policy

Ref	Details	Controls	Assurance (positive andNegative)	Residual Risk Score / Risk registerreference	Further actionneeded	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
			Minimal Registered Nurse to patient ratio is reviewed and escalated to CDM out of hours to support redeployment of suitably trained staff, Nurse in charge provides in depth handover and works to the handover policy and the delegation policy.				
2.4	Staff receiving the patient (s) are clear in their responsibilities to raiseconcerns if they do not have the skillsto adequately care for the patients being handed over.	Policy	Registered Nurses report safe staffing incidents and escalate concerns to line manager/ manager on call (out of hours), where a lack of skills to care safely for a patient has been identified immediate review of staffing and patient needs/ acuity/ dependency levels. Preceptorship programmes in place for newly qualified staff. New staff are provided with an induction programme, and this includes undertaking mandatory core training and role essential training. Staff are supported/ supervised (where applicable) to ensure competencies are met.	None	Trust wide safe staffing policy clearly describes staff responsibilities for patient care handover and escalation process. Staff have the required skills to meet patient needs. Induction programmes in all areas are reviewed and enhanced.	N/A	Monthly mandatory training compliance, clinical, managerial & safeguarding supervision monitored. Review of safe staffing incidents undertaken by Matrons& Lead Nurses
2.4 cont.			Safe staffing models implemented across services. Evidence based Safer Staffing Establishment reviews are undertaken and identify gaps in staffing -				

Ref	Details	Controls	Assurance (positive andNegative)	Residual Risk Score / Risk registerreference	Further actionneeded	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
			propose safe staffing models and include training needs, Registered Nurse to patient ratio and continuous care delivery hours per patient per day. High temporary workforce utilisation can result in staff being redeployed to areas of the Trust whether they haven't worked previously and this requires individual assessment on arrival to an area by NIC.				
2.5 2.5 cont.	There is a clear induction policy for agency staff There is documented evidence that agency staff have received a suitable and sufficient local induction to the area and patients that they will be supporting.	Policy	Local inductions are provided to agency staff on arrival to the area of work to include a full handover at the beginning of the shift. Induction checklist is completed with individual agency staff members and an orientation to the ward environment is conducted by a substantive staff member. Bank and agency orientation checklist Listening events conducted with temporary workforce and themes raised to support the need to enhance redeployment experience and strengthen inductions and orientation in ward areas.	N/A	Review and enhance bank and agency induction checklist and align across services	None	Audit of agency induction checklist across inpatient areas
2.6	The trust has clear and effective	N/A	Formal routes are	None	Implementation of the	N/A	Review of safe staffing

Ref	Details	Controls	Assurance (positive andNegative)	Residual Risk Score / Risk registerreference	Further actionneeded	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
	mechanisms for reporting staffing concerns or where the patient needsare outside of an individual's scope of practice.		available for raising staffing concerns -line manager-through the eIRF reporting system, safer staffing meeting and patient safety. Redeployment checklist is undertaken prior to redeployment to identify individual's skill set, scope of practice, risk assessment and any additional training needs to be completed. Line management involvement and staff side included where staff member has concerns re: redeployment.		safe staffing policy to formally guide the escalation tool and use of redeployment checklist, individual training needs analysis prior to any redeployment in response to surge activity.		incidents/ staff concerns and measures in place to mitigate.
2.7	The trust can evidence that the mechanisms for raising concerns about staffing levels or scope of practice is used by staff and leadershave taken action to address these risks to minimise the impact on patient care.	ORR 60 & 61	As above	As per ORR	As above	N/A	As above
2.8 2.8 cont.	The trust can evidence that there are robust mechanisms in place to support staff physical and mental wellbeing. The trust is assured that these mechanisms meet staff needs andare having a positive impact on the workforce and therefore on patient care.	ORR 27	Health and wellbeing is a risk on the ORR – 27 –actions are included as part of that risk. Comprehensive health and wellbeing offer is in place both at a Trust level and a system level through the mental health and wellbeing hub Initiatives implemented at the start of C-19 to support staff wellbeing continue to be in place and staff encouraged to access. Effectiveness of HWB is	As per ORR	Review of recent staff survey and understanding of staff feedback on their HWB and triangulation of findings. Directorates to produce action plans in response	N/A	Monthly review of staff absence and analysis of themes.

Ref	Details	Controls	Assurance (positive andNegative)	Residual Risk Score / Risk registerreference	Further actionneeded	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
			measured through the staff survey and also through the TrpleR programme work where staff were asked about HWB and the support available.				
2.9 2.9 cont.	The trust has robust mechanisms for understanding the current staffing levels and its potential impact on patient care. These mechanisms take into account both those staff who are absent from clinical duties due to required self Isolation, shielding, andthose that are off sick. Leaders and board members therefore have a holistic understanding of those staff not able to work clinically not just puresickness absence.	Safer staffing and daily OPEL	Monthly holistic triangulated safer staffing review is reported to Trust Board. This includes staffing levels across all areas and sickness/ absence rates. Information is shared at local level, silver and Directorate DMT. Risk assessments and reporting are undertaken for all staff who test positive or have C-19 symptoms. Monthly workforce meeting provides a report of staff members who are self- isolating. Quality Forum deep dive paper provided discussion to describe staffing and impact (October, November 5th SEB and November Quality Assurance Committee)- Trust Board Development session on 23.11.21 led by Head of HR and DoN	As per Daily OPEL	To explore how weekly safer staffing report can be shared through ICC and silver	Daily SITREP	Daily review and frequency increased based on escalation and OPEL level
2.10	Staff are encouraged to report incidents in line with the normal trust processes. Due to staffing pressures, the trust considers novel mechanisms outsideof	N/A	Ulysses supports reporting of all incidents and the Trust policy guides all staff follow incident reporting process.	N/A	Continue to recruit to the PNA role and support debriefing across LPT in alignment with models used in other organisations.	None	Review of eIRF's and staff feedback/ tipping points highlighted through weekly safer staffing meeting.

Ref	Details	Controls	Assurance (positive andNegative)	Residual Risk Score / Risk registerreference	Further actionneeded	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
	incident reporting for capturing potential physical or psychological harm caused by staffing pressures (e.g use of arrest or peri arrest debriefs, use of outreach team feedback etc) and learns from this intelligence.		The trust is increasing the number of staff trained as Professional Nurse Advocates in recognition of the burn out, mental health problems and widespread stress experienced by staff. The training provides practitioners with the skills to facilitate restorative supervision to colleagues and teams within services the work within and beyond. Review of data and themes from absence reporting and actions taken to support practitioners. Team Huddles, forums for teams to feed into.		Enhance the need for staff to feel confident in raising concerns about their mental health and impact of lived experience throughout the pandemic.		
3.0 Daily Governance via EPRR route (when/if required)							
3.1 3.1 cont.	Where necessary the trust has convened a multidisciplinary clinical and or workforce /wellbeing advisorygroup that informs the tactical and strategic staffing decisions via Silver and Bronze to provider the safest and sustained care to patients and its decision making is clearly documented in incident logs or notes of meetings.	N/A	This function is discharged through the ICC to coordinate an MDT action, this will include consultation and input from a number of ICC subgroups to complete an action. Any decision taken will be logged and signed off by a strategic group. The CRG are a decision-making group that review clinical instructions, make strategic recommendations, and make clinical decisions based on the scope of the organisation	Non	Non	Daily minimal reporting	Minimal daily review through silver/ gold command
3.2	Immediate, and forecast staffing challenges are discussed and	Process	This is managed at directorate level	Non	N/A	minimal daily reporting -sitrep and OPEL	Minimal daily review through silver/ gold

Ref	Details	Controls	Assurance (positive andNegative)	Residual Risk Score / Risk registerreference	Further actionneeded	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
	documented at least daily via the internal incident structures (bronze, silver, gold).		(Tactical, silver) through the DMT. There is an escalation route into the ICC for further action. Business continuity plans are in place for all services and updated as change occurs.				command- sitrep
3.3	The trust ensures system workforce leads and executive leads within the system are sighted on workforce issues and risks as necessary. The trust utilises local/ system reliance forums and regional EPRR escalation routes to raise and resolve staffing challenges to ensure safe care provided to patients.	ORR	LPT are active members of the LLR Health and Care system. LPT are represented at the Strategic Coordinating Group (SCG) and Tactical Coordinating Group (TCG). Any staffing issues are discussed in these groups with recommendations worked up in the TCG and presented to the SGG for executive system provider sign off. The SCG / TCG structure has subgroups that continually focus on key areas of patient safety such as workforce and the discharge hub.	ORR 60 &52			
3.4	The trust has sufficiently granular, timely and reliable staffing data to identify and where possibly mitigatestaffing risks to prevent harm to patients.	ORR 60&61	There is an LLR people and culture board and delivery subgroup. This group discusses the people plan and staffing/ workforce issues across the system. LPT attend and represent at the group. Strengthening workforce information as part of tipping factors as per workforce safeguards Implementation of the	As per ORR	The safer staffing policy will provide process and clarity for escalating staffing risks	Non	Weekly safer staffing review - NSI metrics – falls, medication errors and complaints. Exception reporting for one trained nurse red flag

Ref	Details	Controls	Assurance (positive andNegative)	Residual Risk Score / Risk registerreference	Further actionneeded	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
			safe care pilot will support staffing and redeployment to areas identified as in need- timely data				
4.0 Board oversight and Assurance (BAU structures)							
4.1	The quality committee (or other relevant designated board committee) receives regular staffingreport that evidences the current staffing hotspots, the potential impact on patient care and the short and medium term solutions to mitigate the risks.	N/A	Board development session held 23 November focused on workforce, staffing hotspots and review of actions to mitigate risks Bi-Monthly reports are received into the quality committee detailing staffing areas to note and mitigation plans. Monthly reports are submitted to Trust Board and ORR on the register	As per reporting system	Safe Care Module will support enhanced timely data reporting within committee and Trust Board report	N/A	Monthly reporting to QAC and Trust Board
4.2	Information from the staffing report is considered and triangulated alongside the trusts' SI reports, patient outcomes, patient feedback and clinical harms process.	N/A	NSI metrics – falls, medication errors and complaints. Exception reporting for one trained nurse red flag.	N/A	Further work to triangulate findings from SI's where directly related to staffing to be included in six monthly review	Non	Weekly safer staffing review - NSI metrics – falls, medication errors and complaints. Exception reporting for one trained nurse red flag
4.3 4.3 cont.	The trusts integrated Performance dashboard has been updated to include COVID/winter focused metrics. COVID/winter related staffing challenges are assessed and reported for their impact on thequality of care alongside staff wellbeing and operational challenges.	N/A	The performance dashboard does not include specific data in relation to patients in inpatient wards with Covid-19. However, the daily sitrep provides this level of detail on a separate data report though ICC and into national system. Trust board report does include the collective summary of Covid-19 patients prior to and during admission- hospital acquired infection rate is reported.	N/A	As above	Non	Daily sitrep and review of dashboard and as above-

Ref	Details	Controls	Assurance (positive andNegative)	Residual Risk Score / Risk registerreference	Further actionneeded	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
4.4	The Board (via reports to the quality committee) is sighted on the key staffing issues that are being discussed and actively managed viathe incident management structuresand are assured that high quality care is at the centre of decision making.	N/A	Include deep dives and ongoing focus. Monthly reporting highlights areas to note and informs response through quality summit.	N/A	Non- any actions are implemented on review and escalation	Sickness/ Absence and vacancy levels	As above and triangulated with findings from SI's
4.5	The quality committee is assured that the decision making via the Incident management structures (bronze, silver, gold) minimises any potential exposure of patients to harm than may occur delivering care through staffing in	ORR	Monthly report and Deep dive Monthly nurse sensitive indicators (where triangulation of data and concerns indicate staffing concerns, there is a clear methodology to focus on staffing. Quality Committee, commissioners and CQC are notified.	ORR 60&61	Continuous review and triangulations of findings from NSI metrics – falls, medication errors and complaints. Exception reporting	As per highlight reporting	Sitrep and daily updates via Silver and Gold Includes temporary workforce utilisation
4.6	The quality committee receives regular information on the system wide solutions in place to mitigaterisks to patients due to staffing challenges.	As per ORR	As above.	As per ORR	Ongoing monthly review of risks and routine scanning for emerging risk		Routine review at all committees and the Trust Board
4.7 4.7 cont.	The Board is fully sighted on the workforce challenges and any potential impact on patient care via the reports from the quality committee. The Board is further assured that active operational risks are recordedand managed via the trusts risk register process.	Risk Management Policy / Training / Ulysses System / routine reporting	The trust board receives a highlight report from the Quality Committee Form which details any areas to note and mitigations. Highlight reports from the level 2 and 1 Committees provide consistently high assurance. The Audit and Assurance Committee provides a high assurance rating over the arrangements in place to manage risk to the Trust on a quarterly basis	.N/A	Ongoing monthly review of risks and routine scanning for emerging risk	none	Routine review at all committees and the Trust Board
4.8	The trust has considered and where necessary, revised its appetite to both workforce and quality risks given the sustained pressures and novel risks	The Trust's risk appetite was revised in November 2021. Appetite for 'People' and	The revised appetite was developed and approved by the Trust Board and has been	N/A	Annual Review of appetite following any strategic objective refresh	None	Appetite drives discussions around residual risk scores on a monthly basis with the

Ref	Details	Controls	Assurance (positive andNegative)	Residual Risk Score / Risk registerreference	Further actionneeded	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
	caused by the pandemic The risk appetite is embedded and is lived by local leaders and the Board (i.e risks outside of the desired appetite are not tolerated without clear discussion and rationale and are challenged if longstanding)	'Quality' is Seek – this is a significant appetite leading to a tolerance score between 16-20. The application of appetite is used via the tolerance levels on each risk on the ORR and is used in discussions at committee and Trust Board level.	approved and rated green (high assurance) by the level 1 Committees (Quality Assurance Committee and the Finance and Performance Committee) in November 2021.				operational and executive director risk owners.
4.9	The trust considers the impact of any significant and sustained staffing challenges on their ability to deliver on the strategic objectives and theserisks are adequately documented on the Board Assurance Framework	The impact of staffing on the achievement of strategic objectives has been a core component of the ORR refresh (following the strategic objective refresh) in November 2021. It also forms part of ongoing discussions. There are two staffing related risks on the ORR, and the impact of staffing on other ORR risks is discussed by committees. All assurance reports contain a governance table which makes reference to the relevant ORR risk number to aid discussion	The ORR refresh was driven by and approved by the Trust Board, and was approved by the level 1 committees in November 2021 which gave the ORR high assurance (green rating) on the highlight report for Trust Board	ORR risks 60 and 61 have a residual score of 12. These are being mitigated in line with / below appetite	Annual Review of the impact of staffing on our strategic objectives as part of the ORR refresh.	None	On-going monthly review of progress against actions to mitigate the risks
4.10	Any active significant workforce risks on the Board Assurance Framework inform the board agenda and focus	The ORR and regular staffing reports are received by the Trust Board at each meeting. Additional items are discussed at agenda planning meetings which include executive director level input and the Chair of the Trust to ensure that significant risks are adequately addressed on the Trust Board agenda.	The Trust Board is assured over the arrangements in place to determine the agenda, and receive assurance over the management of workforce risks on the ORR	As per ORR	N/A	Shred through highlight report, daily OPEL and weekly safe staffing report and highlighted to Trust Board through current reporting mechanisms	Ongoing review of workforce risk at Trust Board
4.11	The Board is assured that where necessary CQC and Regional NHSE/I	CQC notifications reported through Exec	There is a clear process for formal notification to	N/A	Non	Via current reporting and escalation	Trust Board safer staffing and daily sitrep

Ref	Details	Controls	Assurance (positive andNegative)	Residual Risk Score / Risk registerreference	Further actionneeded	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
	team are made aware of any fundamental concerns arising from significant and sustained staffing challenges		CQC regarding any quality concerns. There are regular engagement meetings with the CQC, CEO and Director of Nursing AHP's and Quality where concerns can be raised. The CQC are informed of any quality summits the Trust is undertaking. Furthermore, where concerns are raised by staff or patients directly to CQC or FTSU guardian, these are fully investigated and responded to by LPT.			processes	through silver and gold commend

Appendix 2

Winter Preparedness November 2021 Board Assurance Framework – GAP analysis and action plan V1 6.12.21

KLOE identified gap in assurance	Action to improve assurance	Action owner	Date	Evidence	Progress
1.4 Staffing Escalation/ Surge Plans Quality impact assessments are undertaken where there are changes in estate or ward function or staff roles (including base staffing levels) and this is signed off by the CN/MD These are signed off by Director of Nursing and Medical Director. It is an expectation that QIAs have been completed where linked to redeployment and changes to staffing requirements.	To develop a Trust policy for the review of EQIA's outlining process for expectation of completion of EQIA and process of sign off and central holding of all EQIAs	Service Leads from Directorate and DHoN/ HoN	January 31st 2022	EQIA's are up to date and assurance received from service that EQIA has been reviewed in alignment with winter preparedness 2021. All EQIA's are signed off by DoN and MD. EQIA policy drafted and shared for implementation across the Trust EQIA's are held centrally and evident where changes to service/ staffing roles and estate have been undertaken	EQIA's are not held corporately for staffing function. No policy in place currently re: QIA process although EQIA's reviewed at DMT's for staffing functions and Trust CRG in response to restoration of services Associate Director AHP & Quality is progressing a draft policy which will include process for expectation of completion. Each Directorate has been directed to undertake a review and update of EQIA's and ensure sign off by DoN/MD

KLOE identified gap in assurance	Action to improve assurance	Action owner	Date	Evidence	Progress
2.5 Operational Delivery There is documented evidence that agency staff have received a suitable and sufficient local induction to the area and patients that they will be supporting.	To review the current bank and agency workforce induction checklist and align and embed across all services.	Deputy Heads of Nursing & Workforce Systems Manger	20 December 2021	Directorates can evidence local induction is provided to agency staff and provide confirmation (checklist) and audit of this.	Induction checklist recirculated across inpatient services. Working with Centralised Staffing Solutions Developing a comms plan
2.6 Operational Delivery The trust has clear and effective mechanisms for reporting staffing concerns or where the patient needs are outside of an individual's scope of practice.	To develop a Trust wide safe staffing policy including a Trust wide process to report staffing concerns using the toolkit safe staffing SBAR NHSE & I principles To agree a Trust process to share the weekly situational and safe staffing forecast information with wider exec team	Workforce and Safe Staffing Matron Assistant Director of Nursing & Executive team Assistant Director	31 January 2022 15 December 20	Safe Staffing operating policy is implemented. Redeployment checklist reviewed and updated Confirmation that safe care deployment module is implemented across the Trust following pilot Process agreed and notes of meeting shared	Redeployment checklist recirculated for review. Standard operating policy for safe staffing in now in its first draft. Implementation of safe care deployment module pilot on health roster

KLOE identified gap in assurance	Action to improve assurance	Action owner	Date	Evidence	Progress
	To include staffing and skills/scope of practice within the Trust handover policy standards and Nurse in Charge Checklist.	of Nursing & Quality	March 2022	Handover policy clearly describes the importance of Nurse in Charge considering the skill set or staff members at handover and delegates in accordance to individuals scope of practice	Handover policy currently under review
2.10 Operational Delivery Staff are encouraged to report incidents in line with the normal trust processes. Due to staffing pressures, the trust considers novel mechanisms outside of incident reporting for capturing potential physical or psychological harm caused by staffing pressures	Staff wellbeing and support- or psychological harm caused by staffing pressures- The trust to increase the number of staff trained as Professional Nurse Advocates in recognition of the burn out, mental health problems and widespread stress experienced by staff. (Training provides practitioners with the skills to facilitate restorative supervision to colleagues and teams within services the work within and beyond). To develop a Trust PNA learning council group to share learning and provide support to PNA's	Assistant Director of Nursing & Quality	March 2022	The Trust continues to identify and support Professional Nurse Advocate training to support staff reporting physical or psychological harm. . Feedback from staff demonstrates that the organisation responds to staff concerns and referral to PNA's takes place	Trust has supported 10 trainee PNAs across 2 academic cohorts (currently training) 3 applicants have been supported to apply for the January Cohort

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Leicestershire Partnership NHS Trust

Trust Board – 21st December 2021

Freedom to Speak Up: half yearly report

The role of the Freedom to Speak Up (FTSU) guardian is to work alongside the trust leadership teams to support the Leicestershire Partnership NHS Trust in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely. In practice this role can be seen to have 2 key strands: reactive work supporting staff to speak up to improve patient care and the staff experience and proactive work to raise awareness and embed the key FTSU messages making 'speaking up is business as usual'. This report will provide assurance in both of these areas.

Purpose

This paper is a half yearly report to the Trust Board of Directors to ensure the board is aware of Freedom to Speak Up cases raised with the FTSU guardian during Q1 and Q2 2021-22 and for Oct and Nov 2021-22 (for up-to-date information). It also includes a breakdown of concerns, along with analysis of themes or trends within the organisation and actions being taken.

In addition, the paper contains details of activities carried out in the Trust as part of the Freedom to Speak Up work stream, updates from the National Guardians Office (NGO) and the FTSU self-review working document using the NHS England & NHS Improvement (NHSEI) and NGO guidance tool (Appendix 1).

Analysis of the Issue

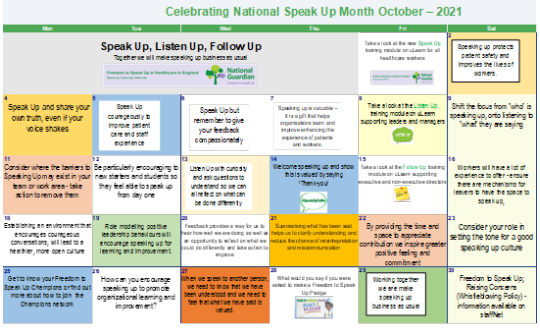
FTSU Guardian Activity

Raising Awareness

In response to the national COVID guidelines, the FTSUG continues to work from home linking in through virtual means and engaging with individual members of staff, teams and networks as appropriate. However, face to face attendance at corporate induction sessions has been maintained to ensure that all new starters, returners, bank staff and aspirant nurses are aware of the role and have opportunity to meet the Guardian in person embedding key speaking up messages from the start of their career with LPT.

Face to face drop-in style sessions have also taken place in areas where there have been complex issues raised or areas where there is a high level of change reported e.g., BMHU and Perinatal team.

October 2021 – Speak Up Month – Speak Up, Listen Up, Follow Up.



Speak Up – Core training for all workers
Listen Up – Training for all Managers
Follow Up - Training for Senior Leaders

During October FTSUG engaged staff through a calendar of daily messages on social media (Twitter and Facebook) highlighting the importance of speaking up and sharing the message that 'speaking up is about anything that gets in the way of doing a great job'. Each week a different article was written for the LPT bulletin promoting the HEE & NGO training programmes for all health care workers available on the local training platform uLearn. Feedback has generally been positive, and a number of people have contacted the FTSUG after seeing the articles in the bulletin which is heartening. Unfortunately, there are low numbers in terms of completion of training modules. This data will be examined further to establish how this can be improved in the context of workforce capacity, accessibility and communications.

Freedom to Speak Up Champions

Leicestershire Partnership Trust is committed to developing a Freedom to Speak Up (FTSU) Champion network that is diverse and representative of our organisation. There are currently 22 FTSU Champions in the Trust with representatives from all staff support networks. The profile data is monitored and continually reviewed to confirm the representativeness of FTSU Champion network and identify where there may be gaps so that we can actively recruit more Champions.

There have been 2 recent FTSU Champions forum events leading to the co-production of a Champions support pack which includes advice and information to enable appropriate signposting and supportive action, and views on how the network can be developed in the future. Additional recruitment is ongoing with specific staff groups and aligned networks to be encouraged to take up this voluntary opportunity for example Change Champions and Health and Wellbeing Champions.

Freedom to Speak Up Strategy

The Trust refreshed Step up to Great strategy 2021-2025 and Our People Plan 2021-2023 includes many references, as an intrinsic part of both documents, to creating confidence to speak up, utilising feedback surveys, listening to staff experience and improving culture and leadership through responding to staff voice. However, in response to the Board's request, the FTSUG is working collaboratively with FTSUG from Northampton Healthcare Foundation Trust and consulting with key stakeholders to co-produce a comprehensive, up to date strategy/action plan to improve FTSU culture with particular reference to the four pillars of support as described in the NGO Strategic Framework published in 2021.

Freedom to Speak Up Self-Assessment Review

The NHSI/E FTSU self-assessment is a live working document and this was reviewed and updated at the Board development session in December 2021. A number of stretch actions have been identified and these are included in the final document in Appendix 1. Progress on these actions will be assessed at the quarterly update meetings between CEO, Chair, NED and FTSUG.

<u>National Guardian Office (NGO) updates</u>

National Guardian
Freedom to Speak Up

Clinical leader and registered nurse, Dr Jayne Chidgey-Clark, has been appointed as the new National Guardian for Freedom to Speak Up in the NHS in England. Dr Chidgey-Clark has more than 30 years' experience in the NHS, higher education, voluntary and private sectors. Her most recent roles include as non-executive director at NHS Somerset Clinical Commissioning Group (CCG) where she was a Freedom to Speak Up Guardian.

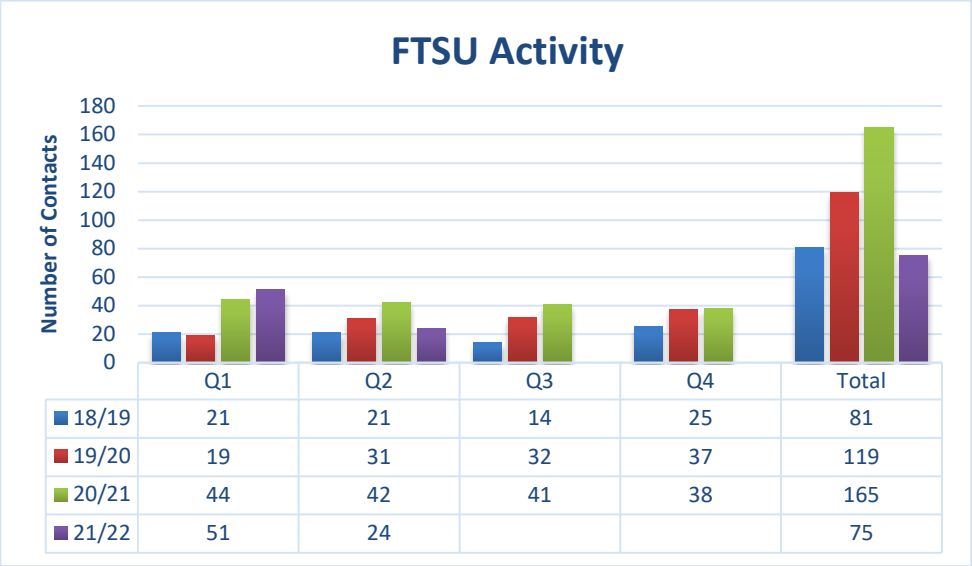
NGO Case Review

The NGO published the most recent case review of speaking up culture and arrangements at Blackpool Teaching Hospitals in October 2021. This identifies areas for learning to improve speaking up experiences of health workers. This case review is scheduled to be examined as part of a gap analysis exercise jointly with colleagues from NHFT and local patient safety team during Q4 21/22.

https://nationalguardian.org.uk/2021/10/14/blackpool-teaching-hospitals-case-review/

Utilisation of the FTSU Process

As seen in the table below there is an upward trend in the numbers of staff that are contacting the FTSU guardian highlighted in the year on year comparison. There has been a significant increase in concerns raised through the FTSU process which suggests an increasingly healthy culture where staff feels safe and able to speak up.



	Q1	Q2	Q3	Q4	Total
18/19	21	21	14	25	81
19/20	19	31	32	37	119
20/21	44	42	41	38	165
21/22	51	24			75

FTSUG Activity and Speaking Up

In the last 2 complete quarters (Q1 & Q2 2021-22), 75 members of staff have spoken up to raise concerns either individually or as part of a larger group. There is a wide cross-section of the Trust workforce, that have contacted the FTSU guardian, from a variety of professional groups and levels of seniority.

The majority request that their issue be dealt with confidentially however with support and reassurance many have felt confident to be identified and further-more discuss issues openly with their senior leaders or managers through an informal 'listening meetings'.

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

Service Area	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22
DMH	11	13	28	7
CHS	12	12	3	5
Enabling	0	3	2	0
FYPC/LD	18	7	18	12
Hosted	0	3	0	0
TOTAL	**41**	**38**	**51**	**24**

	No. of Contacts	Internal	External	Anonymous
Q1 21/22	51	47	4	5
Q2 21/22	24	21	3	3

Themes *	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22
Patient Safety	24	14	34	12
Worker Safety	30	27	36	12
Attitudes & Behaviours	20	27	23	9
Bullying/Harassment	10	9	7	3
System/Process	31	20	38	14
Infrastructure/Environment	6	2	11	5
Cultural	11	13	19	5
Leadership	21	25	33	15
Senior Management Issue	7	2	9	1
Middle Management Issue	12	11	26	11

Speak Up cases often contain multiple themes, therefore data sets do not always equate together.

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

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

Discussion of Themes

There were 7 concerns raised directly with CQC and reported anonymously. The responses to these have been co-ordinated locally and provided by the compliance team.

Patient safety, worker safety, system/process and leadership behaviours relating to middle management issues were the highest categories of concern during Q1 & Q2.

Learning and Actions

The FTSU guardian has been asked to provide specific information relating to the concerns raised across each directorate. This has been included as intelligence in the context of wider staff listening events and discussed as part of the response and action planning particularly within CAMHs outpatient team, Health Visiting team and Beacon Unit. Feedback has been given to the individuals and learning shared within service areas as appropriate.

In addition, information about the staff experience and concerns that has been reported through FTSU guardian has been shared at a number of Quality Summits including Bradgate Mental Health Unit, Mill Lodge and Community Nursing. It is encouraging that FTSU is becoming embedded into this model of exploring a wide range of issues, ensuring that the individual and collective staff voice is heard in the broad context and information triangulated from a range or reporting routes. Action plans and learning is agreed as a part of the summit and these are reviewed to provide a framework for the response, resolution and assurance. There are several more summits arranged for the

New Year in relation to Directorate of Mental Health and these will also include information provided by colleagues through the FTSU route.

All issues and potential themes have been reported to the appropriate Directorate Management Teams or delegated representatives and managed at a local level. Staff that have spoken up have received ongoing feedback on the progress made to resolve issues or on the final outcome as appropriate, observing confidentiality. Concerns that are raised to external agencies by a staff member are included in the FTSU record log to ensure information is triangulated and provides opportunity for early recognition of any wider theme.

Decision required

- Trust Board is asked to note the activity and actions relating to FTSU undertaken in Q1 & Q2 (2021-22)
- Confirm assurance that issues of concern are being raised and dealt with in line with the Freedom to Speak Up: Raising Concerns (Whistleblowing) policy and that the Trust Board is aware of themes and trends emerging in the organisation.
- Confirm assurance that the Trust Board is actively involved in shaping the Trust's vision and strategy for Freedom to Speak Up and are proactive in supporting a speaking up culture in the Trust (Appendix 1)
- Acknowledge the national updates and revision to FTSU Champions Networks

Presenting Director: Angela Hillery

Author(s): Pauline Lewitt

14/12/21

Governance table

For Board and Board Committees:	Trust Board 21.12.21	
Paper sponsored by:	Angela Hillery, CEO	
Paper authored by:	Pauline Lewitt, Freedom to Speak Up Guardian	
Date submitted:	21/12/21	
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):	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	6 Monthly	
STEP up to GREAT strategic alignment*:	High **S**tandards	Yes
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	
	Single Patient **R**ecord	
	Equality, Leadership, Culture	Yes
	Access to Services	
	Trustwide Quality Improvement	Yes
Organisational Risk Register considerations:	List risk number and title of risk	
Is the decision required consistent with LPT's risk appetite:		
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	

APPENDIX 1

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

July 2019

Leicestershire Partnership NHS Trust
Review Date – December 2021

How to use this tool

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

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

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

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

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

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

NHSI are happy to support trusts on any aspect of the review process or the improvement work it reveals.

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Review date		
Behave in a way that encourages workers to speak up					
Individual executive and non-executive directors can evidence that they behave in a way that encourages workers to speak up. Evidence should demonstrate that they: • understand the impact their behaviour can have on a trust's culture • know what behaviours encourage and inhibit workers from speaking up • test their beliefs about their behaviours using a wide range of feedback • reflect on the feedback and make changes as necessary • constructively and compassionately challenge each other when appropriate behaviour is not displayed	Section 1 p5	**Fully – Dec 2021**	Dec 2022	• The CEO and Chair articulate, via a recorded message at Corporate Induction sessions, their commitment to creating a positive and open culture where staff are encouraged and enabled to speak up. They include in these messages what the Trust vision and values mean to them and how they uphold the leadership behaviours (This has been adapted through virtual presentations due to COVID 19). • The Board have been involved at all stages of the culture project 'Our Future, Our Way' – including the co-production of the Leadership Behaviours framework which identified behaviours that may encourage or conversely inhibit workers from speaking up. • Video messages, webchats, all staff listening events and all staff communications include positive encouragement to speak up. Specific listening events have also taken place to understand where there may be specific barriers to speaking up with particular reference to equality, diversity and inclusion and protected characteristics. • Staff voice at Board meetings enables staff to tell the Board what it is like to work in LPT. • Staff are encouraged to speak openly, and feedback is brought into Board and Committee meetings and escalated to the Directorate as required. • Trust wide invitations to focussed question and answer sessions for example: Our Road to Recovery, Triple R (Reflect, Rebuild and Reset), the People Plan and Angela's Team Brief on the Road (virtual attendance or through StaffNet page) with publicised responses and follow-up feedback sessions • LPT has 5 active Staff Support Networks and each one has an executive sponsor. Staff are invited to share their lived experience – both positive and negative experiences are acknowledged and valued as a mechanism to promote improvement. • Operational Executives, the Medical Director and Director	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Review date		
				of Nursing have been visible and present in the clinical services more recently following the initial response to the pandemic • The organisation encourages an open culture of feedback reflected through complaints/compliments and Friends and Family programme • Positive messaging through communications relate to feedback from 2019 staff survey highlighting the actions taken to improve services and illustrate Trust response to feedback • Leadership behaviours for all - The introduction of specific model (CUBE) to facilitate giving and receiving feedback is included in the leadership behaviours programme to assist all staff across the workforce to challenge each other in a constructive and compassionate manner when appropriate behaviour is not displayed. • All Executive and Non-Executive directors (NED) engage in NHSI/E appraisal scheme.	
Demonstrate commitment to FTSU					
The board can evidence their commitment to creating an open and honest culture by demonstrating: • there are a named executive and non-executive leads responsible for speaking up • speaking up and other cultural issues are included in the board development programme they welcome workers to speak about their experiences in person at board meetings • the trust has a sustained and ongoing focus on the reduction of bullying, harassment and incivility • there is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made • the trust continually invests in leadership development	p6 Section 1 Section 2 Section 3	**Fully – Dec 2021**	Dec 2022	• Executive Lead and Non-executive lead both named in Trust policy including contact details and quarterly FTSU up-date meetings take place with CEO, Chair, NED and FTSUG (Records available) • Freedom to Speak Up review included as a reflection tool and assurance mechanism as part of the comprehensive Trust board development programme in Dec 2021. • Other aspects of the LPT culture work have been presented at Board Development sessions as an integral part of the Step Up to Great strategy. Work to improve our culture continues around 9 priorities (A Clear Vision, Leadership, Valuing One Another, No Bullying, Blame-free Culture, Compassionate Policies, Meaningful Data, Remove Silo Working and Supportive Appraisals). The development and use of the recently launched compassionate policies is an intrinsic aspect in creating a 'Just and Learning' culture. • Staff are enabled to present their experiences personally	*ACTION –* *FTSUG to work with Director of HR to ensure robust processes are in place to review claims of detriment if they are made.*

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Review date		
• the trust regularly evaluates how effective its FTSU Guardian and champion model is • the trust invests in a sustained, creative and engaging communication strategy to tell positive stories about speaking up.				at Trust board to support understanding and learning. • FTSU Guardian is a member of the Anti-Bullying and Harassment Service (ABHS) help-line focus group although meetings have been paused currently as data from the trust wide LiA event around B&H is analysed and interpreted to develop future action planning and next steps phase of the No Bullying priority. • Regular meetings between HR and FTSU guardian to ensure detriment is not experienced by staff after speaking up. Detriment can be reported by those who speak up directly or be observed by another party (NGO guidelines) • The Trust has a leadership and development framework offer available for leaders and managers. This provides opportunities for leadership growth through the Leading Together – SL Forums (now open to Band 7 and above), the line manager pathway and talent management • A fundamental part of the 'Step Up to Great' strategy is the philosophy of collective leadership, and this is embedded through the Leadership Behaviours which is further embedded in the messaging 'It starts with me'. This builds on the trust values introduced in the induction programme and highlighted in the Trust values video. • Guardian report presented to SEB quarterly to provide update on themes and updates from National and local feedback. • The Audit and Assurance Committee evaluate the FTSG and FTSU Champions model annually in line with the national requirements - NHS Audit Committee Handbook - Chapter 5: Working with Other Committees, Auditors and Regulators (5.7) • Quarterly meetings are held with the CEO, Chair, NED and FTSUG to ensure there is a focus on key issues and includes updates on both national and local updates or learning. • Quarterly forums with FTSU Champions to discuss roles, issues, actions and associated business and provision of ongoing training and support as appropriate.	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Review date		
				• Quarterly Friends and Family Test survey to measure confidence in speaking up process. • FTSU communication strategy includes monthly articles relating to FTSU matters in the staff newsletter and communications via social media platforms identifying positive messaging about speaking up as appropriate. • Celebration of Speak Up month – October 2021 – Speak Up, Listen Up, Follow Up. Training modules available from HEE through local uLearn platform.	
Have a strategy to improve your FTSU culture					
The board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture. Evidence should demonstrate: • as a minimum – the draft strategy was shared with key stakeholders • the strategy has been discussed and agreed by the board • the strategy is linked to or embedded within other relevant strategies • the board is regularly updated by the executive lead on the progress against the strategy as a whole • the executive lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.	P7 Section 4	**Partially - 2021**	Dec 2022	• There is no individual FTSU strategy as FTSU is implicit in the LPT Step Up to Great strategy and Trust Vision - OFOW engagement events included staff, service users, volunteers and stakeholders who were consulted through focus groups to identify 9 priority areas to help improve the culture at LPT. Change Champions continue to support the action plans relating to each priority linking back into the key stakeholders and staff groups as appropriate. • The Step up to Great strategy was discussed and agreed by the Board. • FTSU messages are an intrinsic part of the Starts With Me - Leadership Behaviours and speaking up is recognisable and embedded within the indicators across all themes. • FTSU messages are included in leadership development programmes including Leading Together and the enhanced training for managers relating to compassionate conversations, supportive management behaviours, appraisals and supervision. • The Board receives a report from the Executive Lead and FTSUG twice per year The Quality Assurance Committee receives a report from the FTSUG twice per year. Quarterly reports to the Strategic Executive Board (SEB) Annual presentation to the Audit Committee to provide assurance on the effective ness of the policy and process	*ACTION –* *Consult with key stakeholders and co-produce a comprehensive, up to date strategy/action plan to improve FTSU culture with particular reference to the four pillars of support as described in the NGO Strategic Framework published in 2021 and how that links in with the refreshed Step Up to Great Strategy and Our People Plan.*

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Review date	of FTSU within the trust. • Annual review of LPT self-review document which is jointly prepared by the FTSUG, CEO and Board members as part of Board Development session. Evaluation methods o Monthly 1:1 meeting with CEO o Quarterly Meetings with CEO, Chair, NED and FTSUG o Quarterly data reports to NGO (includes number of cases, open or anonymous reporting method, patient safety concern, bullying and harassment and staff group and feedback as to whether person would speak up again) o National Staff Survey results o FTSU index, o FFT (Friends and Family Test) o Model Hospital o Feedback from uLearn - Local eLearning module o Individual feedback to FTSUG o CQC staff focus groups • Making sure staff are empowered to speak up and ensuring that when they do, their concerns and contributions will be listened to is a recurring theme within the WE ARE THE NHS: People Plan. FTSUG is linking in with OD and HR colleagues to support this aspect of the LPT People Plan to ensure speaking up is business as usual and implicit across all aspects of the plan.	
Support your FTSU Guardian					
The executive team can evidence they actively support their FTSU Guardian. Evidence should demonstrate: • they have carefully evaluated whether their Guardian/champions have enough ring-fenced time to carry out all aspects of their role effectively	p7 Section 1 Section 2 Section 5	**Fully – Dec 2021**	Dec 2022	• FTSU Guardian works 0.9 WTE in the role and was appointed following a fair and open recruitment process. • There are currently 25 FTSU Champions across the Trust each having received core training and ongoing development opportunities within the role. The Champions are allowed time within their normal role to	*ACTION –* *Continue with refresh of FTSU Champions - Update comm's plan to raise awareness of Champions role focussing on recruitment campaign. Falling numbers of Champions due to*

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Review date		

• the Guardian has been given time and resource to complete training and development
• there are regular meetings between the Guardian and key executives as well as the non-executive lead.
• there is support available to enable the Guardian to reflect on the emotional aspects of their role
• individual executives have enabled the Guardian to escalate patient safety matters and to ensure that speaking up cases are progressed in a timely manner
• they have enabled the Guardian to have access to anonymised patient safety and employee relations data for triangulation purposes
• the Guardian is enabled to develop external relationships and attend National Guardian related events
				extend the reach of the FTSU messages within their circle of influence and assist colleagues to access support through appropriate signposting.
				• There are regular meetings between the FTSUG and key executives –
				  • Monthly 1:1 meetings between FTSU guardian and Executive lead
				  • Monthly 1:1 between FTSU guardian and Director of OD & HR
				  • Quarterly meeting with CEO, Chair, NED and FTSU
				• Formal meetings provide an opportunity for reflection and additional support if requested. FTSU has access to other pastoral support such as AMICA, Chaplaincy and Occupational Health.
				• The FTSUG is enabled to engage with Director of Nursing, Community Health Service, Families, Young People & Children's Service and Learning Disability Service, Directorate for Mental Health and the Medical Director to escalate patient safety matters ensuring these cases are progressed in a timely manner when required
				• Monthly meetings with HR, EDI and H&W lead provide opportunities to triangulate information and data to support early identification of potential 'hotspot' areas and support timely case progression when indicated.
				• Attendance at Patient Safety Improvement Group, Patient experience meeting and EDI meeting provides opportunity to share information and access to anonymised data when requested.
				• FTSUG has completed all training to the required level and attended development sessions as appropriate.
				• FTSUG is an active member of the Midlands FTSU network, attends the NGO quarterly meetings for network Chairs and Trainers Group and provides 'buddy' support for FTSUG's in other primary care services including Defense Primary Healthcare (MOD) and the Leicestershire and Rutland Local Dental Committee (LDC) and Nottinghamshire MH Trust.
					staff leaving the organisation.
					Target other Champion groups including health and wellbeing and Change Champions who may have prerequisite knowledge and skills to support this agenda

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Review date		
Be assured your FTSU culture is healthy and effective					
Evidence that you have a speaking up policy that reflects the minimum standards set out by NHS Improvement. Evidence should demonstrate: • that the policy is up to date and has been reviewed at least every two years • reviews have been informed by feedback from workers who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Guardian.	P8 Section 8 National policy	**Fully – Dec 2021**	Dec 2022	• Freedom to Speak Up: Raising Concerns (Whistleblowing) policy updated in January 2019. This was circulated to the Senior Management Teams, Staff-side and adopted at the Workforce and Wellbeing Group • NHS Improvement was expected to publish an updated policy template in early 2020. This is now expected in early 2021. It is recommended that the LPT policy be reviewed in Jan 2022 and then updated based on feedback from ▪ FTSU Champions ▪ Staff who have spoken up ▪ Staff-side representatives ▪ HR colleagues ▪ Patient Safety Team ▪ Communications • Gap Analysis will be undertaken through presentation to Directorate governance teams through Patient Safety Improvement Group and Big Conversation to ensure learning from case reviews. (Commence December 2021 – Blackpool Teaching Hospital Case review – October 2021)	*ACTION –* *At this time NGO & NHS I/E suggest waiting for the revised policy template as consultation was finalised in October 2021.* *However, work is in progress to update LPT policy to ensure this is reviewed in line with internal review date and further amendments can be made when template is received.*
Evidence that you receive assurance to demonstrate that the speaking up culture is healthy and effective. Evidence should demonstrate: • you receive a variety of assurance • you map and assess your assurance to ensure there are no gaps and you flex the amount of assurance you require to suit your current circumstance • assurance in relation to FTSU is appropriately triangulated with assurance in relation to patient experience/safety and worker experience. • you have gathered further assurance during times of change or when there has been a negative outcome of an investigation or inspection	P15 Section 6	**Fully – Dec 2021**	Dec 2022	• Assurance is provided through a variety of means including reports received at ➢ Public Board meeting (six-monthly) ➢ Quality Assurance Committee (six-monthly) ➢ Audit Committee (annually) ➢ Strategic Executive Board (quarterly) ➢ Patient Safety Improvement Group (quarterly) These reports routinely include qualitative narrative on identified themes and trends and numeric data in respect of specific indicators required by NGO. • The Board require that FTSU reporting is embedded within and mapped across the LPT Governance Framework • Additional assurance is gleaned from ➢ Case figures reported to NGO (quarterly) ➢ Friends and Family Test	*ACTION -* *Case review to be completed collaboratively with FTSUG from NHFT to provide external assurance of systems and process* *ACTION –* *To ensure speaking up culture is health and effective staff are made aware of their role in speaking up and how this will create a more open and transparent culture they will be supported to undertake additional training which will identify what to expect from the speaking up process..*

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Review date		
• you evaluate gaps in assurance and manage any risks identified, adding them to the trust's risk register where appropriate.				➢ National Staff Survey ➢ Freedom to Speak Up Index ➢ Model Hospital ➢ CQC feedback and action plan • Speaking Up is also an agenda item at the SEB, SWC and PSIG quarterly within the existing rotation where themes and trends are highlighted providing specific opportunities to input to subsequent planning and actions.(see examples below) ➢ Quality Summit – Bradgate Mental Health Unit – new model of working due to COVID ➢ Quality Summit – Mill Lodge – patient safety and staffing ➢ Quality summit – City Community Nursing – Pressure wound assessments/care • Staff drop-in or engagement sessions have been held in specific areas that are experiencing change or pressures. Examples are BMHU, Beacon Unit and Agnes Unit • FTSUG to share themes and highlight trends monthly providing opportunity to triangulate data with Patient Safety Team, Complaints and legal services. Regular meetings with Patient Experience Lead, Patient Safety Lead and Workforce and Wellbeing Group creating ongoing dialogue, evaluate gaps in assurance to ensure potential risks are identified and added to the trusts risk register. • Triangulation with People Team – hosted by OD and includes FTSU, H&W Lead, HR and EDI.	*The FTSUG to work with Executive Director of Nursing/AHP's & Quality and Director of HR and OD to look at ways to encourage staff to complete the national Speak Up training through local learning platform.*
The board can evidence the Guardian attends board meetings, at least every six months, and presents a comprehensive report.	P8 Section 7	**Fully – Dec 2021**	Dec 2022	The requirement for the presentation of the FTSU report is acknowledged and agreed by the Board and is included in the Governance Framework. Board paper authored and presented at the public section of Trust Board in person by the FTSU guardian in January, and July 2021 as evidenced by Board minutes. FTSUG to attend Board development session in December 2021 to prepare evaluation with Board prior to presenting paper at Board meeting Jan 2022.	
The board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and	Section 1 NGO JD	**Fully – Dec 2021**	Dec 2022	FTSU guardian was recruited through open recruitment process (January 2019) following 2 year secondment to role	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Review date		
other guidance published by the National Guardian.					
The board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.	Section 7	**Fully – Dec 2021**	Dec 2022	Most recent case review reports highlighted and embedded within the FTSU Board and QAC reports – NGO updates section. Published case review reports discussed with relevant Directors and Senior Managers to share learning and highlight best practice. Further focus identified to appropriate work areas where necessary for example Human Resources (HR), Equality, Inclusion and Diversity (EDI). Spreadsheet has been produced and held by FTSUG to record findings, comments and recommendations from NGO case reviews. This is to be used to identify LPT actions/response.	*ACTION -* *FTSUG will be sharing the most recent NGO Case Review of Blackpool Teaching Hospital with the directorate governance representatives to ensure specific learning is considered through the Patient Safety Improvement Group. In addition, the review will be discussed in a big conversation to share the recommendations provided in the report to facilitate appropriate learning across LPT and complete gap analysis.* *Joined up working with NHFT on this piece of work to support the big conversation.*
Be open and transparent					
The trust can evidence how it has been open and transparent in relation to concerns raised by its workers. Evidence should demonstrate: • discussion at the public board • discussion with relevant oversight organisation • discussion within relevant peer networks • content in the trust's annual report • content on the trust's intranet website • welcoming engagement with the National Guardian and her staff	P9	**Fully – Dec 2021**	Dec 2022	• FTSU Board report presented and discussed openly at the Public board. • FTSUG was interviewed as part of the Well-led inspection during 2021 and provided documentary evidence as required. FTSU meetings can be arranged with CQC as and when requested with open access to local CQC inspector. • Themes shared with staff side colleagues at the LPT and directorate Staff Partnership Forums (SRF) o FTSUG attends all staff support network meetings liaising regularly with the chairs/lead advocates	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Review date		
				and works closely with the Equality, Diversity and Inclusion Team supporting listening events as appropriate o Continue to maintain strong links with our local WRES Expert network (LPT does not currently have a WRES expert) • Content on FTSU is included in the trust's annual report and Quality Account • Dedicated page to Freedom to Speak Up on the staff intranet eSource including links to stand alone documents :- policy, leaflets, flowcharts, and 5 steps approach information when responding to concerns • FTSUG was invited by NGO to be a member of the stakeholder engagement panel during the recruitment process for the new National Guardian which took place in October 2021 – National FTSU Guardian - Jayne Chidgey-Clarke (appointed November 2021)	
Individual responsibilities					
The chair, chief executive, executive lead for FTSU, Non-executive lead for FTSU, HR/OD director, medical director and director of nursing should evidence that they have considered how they meet the various responsibilities associated with their role as part of their appraisal.	Section 1	**Fully – Dec 2021**	Dec 2022	Senior leaders comply with requirements of annual appraisal identifying evidence to meet the various responsibilities associated with their role including culture and leadership behaviours as part of the revised appraisal expectations and 'Step Up to Great' strategic plan. The CEO and Chair have received 360 feedback from the board and stakeholders as part of their appraisal.	*Recommendation from NGO & HEE for all Board members to complete training modules Speak Up & Listen Up for all health workers. When Follow Up training is available Board members are encouraged to complete this as part of their own CPD.*

R

Leicestershire Partnership NHS Trust

Finance and Performance Committee 30th November 2021

Highlight Report

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

Agenda Item:	Assurance level:		Committee escalation:	ORR Risk Reference:
Director of Finance Update – Verbal Including: 20/21 Reference Costs – Paper C	High		H2 plan submission is in and the focus is now on the efficiency plan for next year. 20/21 Reference Costs – Paper C Final paper received confirming reference costs completed in line with guidelines. Service line profitability will be considered and the QIA process is embedded into the efficiency programme. Three main strands this year – Trust wide, Transformation and value approach and service savings. FPC approved the 20/21 reference costs paper.	70, 71
CFO – Strategic Estates Update – Verbal	NA		CQC actions and progress against them continues to be monitored; successful cleaning audit recently took place; safety evaluation audits are now complete with minor remedial works to be undertaken; all work streams are on track and increased capacity for estates and sustainability planned.	65, 66, 67
Director of Strategy and Business Development Update – Verbal	NA		Update contained within Business Pipeline paper (Paper H).	64, 72
Finance Report Month 7 - Paper D	H	M	Income and expenditure remains at breakeven over all with LD having a material overspend which is being monitored and discussions are ongoing. There will be a reduction in capital charges at the year-end due to the high level of cash held. Agency spend is at £2.6m in month 7 and operational executive board are monitoring this closely and actions are being taken with safety over winter a priority. BPPC performance has dipped in month 7. Plans	70, 71

Agenda Item:	Assurance level:		Committee escalation:	ORR Risk Reference:
			are also being put in place to try to address DMH medical locums – safe patient care is paramount. The patient acuity is a national picture and not expected to reduce. Issues around recruitment are ongoing. FPC approved the amendments to the capital programme detailed in the paper and received a split high medium assurance – we are forecasting break-even but this may not be the case next financial year.	
Fleet Management (Lease Cars) Tender Report - Paper E	High		Contract approvedFPC approved the tender report with recommendation to approve the preferred bidder to go to Trust Board.	65
MEVPN Non MEPVN – Paper F	High		FPC approved the tender report with recommendation to approve the preferred bidder to go to Trust Board	65
Archiving Records Management – Paper G	H	M	FPC approved the tender report with recommendation to approve the preferred bidder to go to Trust Board. Split assurance for contract management /lessons learned to build into procurement activity.	65
Business Pipeline – Paper H	High		Range of activity across directorates. FPC received the report for information and note the planned actions and readinss to respond to all relevant tenders/ opportunities.	64, 72
Performance Report Month 7 - Finance and Performance Metrics - Paper I	Medium		There has been an increase in covid infections following admission but no links between outbreaks have been identified. Trust continues to test, screen and triage all patients and use a risk assessment process to minimise /eliminate these.Waiting times shows a mixed picture - some deteriorated and some improved. Performance review meetings continue to look at the detail and track progress against planned trajectories. FPC approved the report and received a medium assurance as there are still metrics which require further refinement and to resolve issues with.	68, 69
Waiting Times Report Month 7 - Paper J Including included Strategic Waiting	M	L	Discussion included Strategic Waiting Time and Harm Review Committee Highlight Report (Paper S) – Improvements evident on the report, services with national targets remain a challenge. Improvements are based on QI in directorates and increased	75

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
Time and Harm Review Committee Highlight Report (Paper S)		recruitment of staff. Keeping well whilst waiting structures are consistently applied to all service lines. The narrative around this issue is complex and triangulation from the patient experience team is being used. A drop in performance will be evident whilst the waiting lists are addressed. FPC received split assurance from the report with confidence in the robust process giving medium assurance and current wait times and progress on tackling these giving low assurance. Deep dive planned for Jan 2022 Joint QAC and FPC Committee.	
Provider Collaborative Performance - Paper K	High	AED Provider Collaborative evolving well with good governance in place and clear impact of working together. Length of stay has been reduced from average of 201 days on 2020/21 to 135 days YTD. Creation of a single point of referral for AED giving a collabraive wide view.	57, 70, 71
Organisational Risk Register - Paper L	High	The ORR refresh is summarised in the report and the new tolerance levels are described within the report. The decision was made to close 5, create 5 and keep 14. FPC approved in principle the revised tolerance levels and proposed risks and risk changes.	All
FPC Mid-Year Review – Paper M	High	FPC have fulfilled their TORs and have seen increased directorate representation to support the committee. The committee has been effective.	57
Estates and Medical Equipment Committee Highlight Report 13th October 2021	Medium	Concerns were registered about an emerging risk around supply chain issues and potential impact. An update on month 6 capital position was noted as significant underspend against plan – committee is tracking all issues closely.	65, 66
Transformation Committee Highlight Report 15th October 2021 – Paper O	High	The committee has agreed Exec Membership and ToR signed off to reflect changes.	64, 65, 66, 67, 72
IM&T Committee Highlight Report 15th October 2021– Paper P	Medium	One low assurance – NHS.net – revised comms are being launched this week to support the transfer.	68

Agenda Item:	Assurance level:		Committee escalation:	ORR Risk Reference:
Data Privacy Committee Highlight Report 14th September 2021– Paper Q	Medium		FOI compliance at 100% in Aug after slight dip in Jul 2021. Subject Access requests are at 64% below the expected 80% target mainly due to the number and complexity of these. Process change in place to improve this. Goverence Team scrutinising the high number of recalls for paper files from storage. Committee not aware of potential risk of emails being lost during transfer to NHS.Net but will explore further and track issue.	68
Capital Management Committee Highlight Reports 22nd September & 23rd November 2021 – Paper R	Medium		The delivery of the capital spend and supply chain national issues remain a concern. IT equipment lead times now at least 8 weeks e.g. laptops potential to impact productivity hence need for timely orders. Owing to capacity issues with Estates Contractor committee looking into use of other contractors to complete some schemes – under review.	65, 70, 71
Strategic Waiting Time and Harm Review Committee Highlight Report 24th September 2021– Paper S –	M	L	Discussed earlier with Paper J. FPC received split assurance – medium for the process and low for the current outcomes.	75

Chair of Committee:	Faisal Hussain

S

Leicestershire Partnership NHS
NHS Trust

Finance Report for the period ended
30 November 2021

For presentation at the
Trust Board
21st December 2021

Contents

Executive Summary and overall performance against targets

Introduction

1. This report presents the financial position for the period ended 30 November 2021 (Month 8). A small net income and expenditure surplus of £60k is reported for the period, which relates to the gain on disposal of Rubicon Close.

2. Note that the property disposal gain of £60k cannot be counted towards NHS Control Total Performance. Excluding this from the position results in a breakeven for M8 in line with plan.

3. Within this overall position, net operational budgets report a £78k overspend. Directorate overspends include LD Services (£127k), DMH (£77k), Estates (£61k) and Enabling (£51k). Hosted services are underspending by £123k, CHS by £85k and FYPC services by £30k.

4. Central reserves report an underspend against some smaller unallocated budgets, which offsets the operational overspends.

5. Closing cash for November stood at £38.1m. This equates to 47.9 days' operating costs.

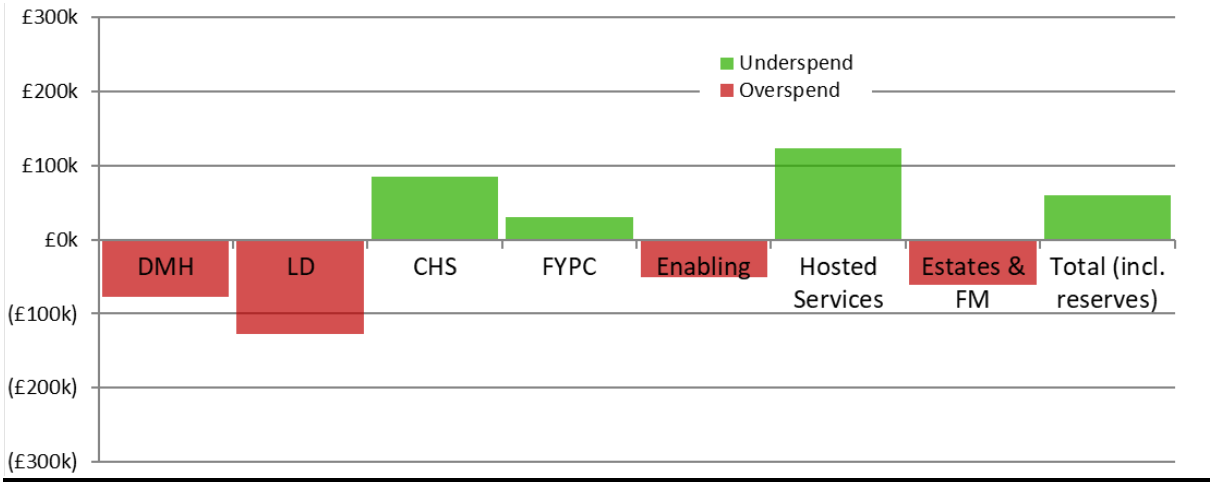
Performance against key targets and KPIs

NHS Trust Statutory Duties	Year to date	Year end f'cast	Comments
1. Income and Expenditure break-even.	G	G	Excluding the £60k disposal gain, the Trust is reporting a financial break-even position at the end of November 2021. **[see 'Service I&E position' and *Appendix A*]**.
2. Remain within Capital Resource Limit (CRL).	G	G	The capital spend for November is £4.7m, 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 current cash level is £38.1m. The year-end forecast has increased by £2m to £23m.

Secondary targets	Year to date	Year end f'cast	Comments
5. Comply with Better Payment Practice Code (BPPC).	R	G	The target is to pay 95% of invoices within 30 days. Cumulatively the Trust achieved 3 of the 4 BPPC targets in November.
6. Achieve Efficiency Savings targets.	n/a	G	The Trust has an efficiency target of £2.6m for H2. Alongside the current savings on travel costs, central efficiency savings have been identified sufficient to deliver this target in full by the end of the year.
7. Deliver a financial surplus	n/a	n/a	As with H1, the planning requirement for H2 (and therefore the year as a whole) is to deliver financial 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 £38.1m was achieved at the end of November 2021. **[See 'cash and working capital']**
10. Deliver capital investment in line with plan (within +/- 15% YTD planned spend levels)	R	G	Capital expenditure totals £4.7m at the end of Month 8; this is £3.3m (42%) below the YTD planned level of £8m **[See 'Capital Programme 2021/22']**

Income and Expenditure position

The month 8 position shows a net operational overspend against year-to-date budgets, offset by an underspend within reserves.



The Mental Health directorate is overspending by £77k at the end of Month 8 due to the continued use of locums, bank, and agency nurses to cover current high vacancy levels. There is slippage against other investments (e.g., MHIS) due to increasing recruitment challenges, but there is an expectation that any underspend will be re-used within the system through the implementation of alternative schemes. There is no financial benefit relating to any MHIS underspend reflected in the LPT position. The non-pay overspend has reduced and income over recovery has increased due to late inflationary uplifts on some income streams and an increase in out of county patient income.

The FYPC financial position has improved in month 8 to now report a slight underspend. The Beacon Unit continues to face staffing pressures, along with medical equipment costs within the Diana service (a potential recharge of costs to CCG is being explored). Healthy Together budgets continue to report an underspend due to staff vacancies although posts have been recruited to in the County. The FYPC service as a whole is carrying a significant level of investment slippage at present due to workforce shortages and discussions are ongoing regarding the carry forward of these funds into the new financial year (slippage underspends are not reflected in the current year position).

The LD financial position also improved in month, but the significant cost pressures associated with the Agnes Unit remain. All 5 pods are currently in use and there is a continued reliance on agency staff at present with forecast agency costs for the Unit of circa. £2m for the year. In contrast, Community services remain underspent, mainly due to vacancies and this is off setting the Agnes overspend.

The CHS Directorate remains underspent, although bank and agency spend continues to run high, particularly within the inpatient service due to the increased number of acute patients that are being admitted. Additional cover is also required for vacancies and staff

sickness within the wards. These financial pressures are being offset by the high level of vacancies within the community nursing and therapy services.

Efficiency savings

Within LLR, the H2 target efficiency rate is c. 1.5%, equating to an LPT savings target of £2.6m. This level of efficiency requirement was anticipated throughout the H2 planning process and the measures put into place in the H2 plan are expected to deliver this target in full.

Forecast position

The forecast position for the year is an I&E break-even, in line with the plan submitted for the second half of the financial year.

The Trust is currently reporting material underspends against a number of investment budgets. It is expected that the majority of these underspends will be returned to commissioners for appropriate re-use with the LLR system, and monthly block payments to LPT are already now being reduced to reflect this clawback of funding. As such, these underspends will ultimately not feature in the year end financial position.

Similar to the run up to the last financial year end, significant additional income is currently being allocated to the Trust from a variety of sources. This includes the late notification of training income from Health Education England. Being able to fully spend new funding at this stage of the year, and in the current climate, represents a significant challenge. All efforts are being made to spend this money on the specific schemes for which it has been allocated, but where income is not returnable, and spend options are limited, this will clearly be a challenge. Under accounting rules, options for carrying forward funding are very limited and in many cases non-existent. The risk to the wider financial position would therefore be that the Trust underspends against the agreed financial envelope, which, although not a breach of statutory financial duties, would not be an acceptable position in as far as NHSE/I are concerned.

Other financial pressures do continue to emerge, and the Trust has options to accelerate other areas of expenditure. Currently therefore, it is still anticipated that the additional gains can be offset by further expenditure and Trust budgets will break even at 31st March.

Adult Eating Disorders Provider Collaborative

Sitting outside of the Trust's own budgets (but forming part of the Trust's overall reported financial position) is the Adult ED provider collaborative. Currently, the collaborative as a whole is underspending, with a potential year end underspend of £1.7m. Specific options to defer or carry forward the unspent element (to reflect the general aim of the collaborative to be able to re-invest surpluses where, and in which period, they are needed) are currently being explored. The current assumption with the LPT financial forecast is that some form of deferral will be transacted, but this will require the support of our external auditors, and so should be viewed as an additional underspend risk in the current financial year.

Additional agency expenditure analysis

For the period April to November, total expenditure on agency staff was £14.9m. The forecast for the year is £23.4m (£21.8m excluding Covid), which again reflects an increase on previous forecasts. The inclusion of further additional funding (to support backlog reduction) and the difficulty in recruiting associated staff continues to drive up agency usage. ***Appendix C*** provides an overall monthly breakdown of agency costs by directorate.

The table below compares forecast agency costs for the year with those incurred in 2019/20 (being the last full year before Covid began to have an impact). To allow for meaningful comparison, Covid costs are excluded from the 2021/22 figures. The analysis also then allows for the exclusion of the significant agency costs linked to the large amount of investment this year.

The resulting comparable costs are shown as £18.8m in the current year (forecast) versus £10.6m in 2019/20 – a 77% increase across the 2-year period.

An estimate is also given for underlying agency costs, which seeks to remove any other obvious non-recurrent agency expenditure.

Directorate	2019/20	2021/22 including new investm.	2021/22 investments	2021/22 excluding new investm.	Movement 19/20 to 21/22		Estimated underlying agency positon 1st April 2022
	£000	£000	£000	£000	**£000**	Comment on movement	£000
DMH	**3,400**	9,005	-2,216	**6,789**	**3,389**	Continued higher level of Medical Locums at Adult City West and Crisis Team. Increased use of agency staff at Heather and Wakerley wards. Move of substantive staff to new investment posts creates additional vacancies which in turn then need to be filled with agency staff	6,789
CHS	**4,341**	5,318	0	**5,318**	**977**	High level of vacancies, cover for sickness, increased specialling for more acute patients. Agency staff used to ensure adequate staffing for Surge Wards	4,463
FYPC	**2,059**	4,415	-738	**3,677**	**1,618**	Locums still required to cover vacancies within CAMHs consultant services; additional agency used to address CAMHs wait times, provide Hub & CAP staff, address higher levels of acuity on the Beacon ward and also Langley ward, support use of level 1 obs, support for Children at UHL, increased sickness cover.	3,317
LD	**301**	2,353	0	**2,353**	**2,052**	Cover for Forensic Service prior to appointment of permanent Consultant - non recurrent. Agnes Unit operating at 5 pods combined with vacancies & sickness within funded establishment and acuity levels on the Unit, Level of acuity and care requirements for new admissions may require patients to require single pod use which will necessiate agency support - potential recurrent.	1,021
Enabling / Hosted	**541**	724	-24	**700**	**159**	Agency costs predominantly relate to pressures within HR teams.	575
TOTAL:	**10,642**	**21,815**	**-2,978**	**18,837**	**8,195**		**16,165**

DMH continues to show the highest forecast increase compared to 2019/20 (£3.4m increase)- related to additional medical locum cover and a general increase in cover for nursing vacancies.

The LD agency increase from 19/20 (£2.1m) continues to be driven by increased locum cover and the pressure with the Agnes Unit.

The FYPC increase of £1.6m is mainly due to the CAMHS vacancies, tackling wait times, staffing for Hub & CAP, and pressures within Beacon and Langley wards.

Statement of Financial Position (SoFP)

PERIOD: November 2021	2020/21 31/03/21 Audited £'000's	2021/22 30/11/21 November £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	178,757	177,152
Intangible assets	2,438	2,166
Trade and other receivables	1,129	1,129
Total Non Current Assets	**182,324**	**180,447**
CURRENT ASSETS		
Inventories	574	557
Trade and other receivables	8,304	8,186
Cash and Cash Equivalents	24,139	38,078
Total Current Assets	**33,017**	**46,821**
Non current assets held for sale	**280**	**0**
TOTAL ASSETS	**215,621**	**227,268**
CURRENT LIABILITIES		
Trade and other payables	(21,587)	(34,154)
Borrowings	(296)	(297)
Capital Investment Loan - Current	(189)	(107)
Provisions	(2,851)	(2,032)
Total Current Liabilities	**(24,923)**	**(36,590)**
NET CURRENT ASSETS (LIABILITIES)	**8,374**	**10,231**
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**	**178,715**
TAXPAYERS' EQUITY		
Public Dividend Capital	95,441	95,440
Retained Earnings	37,055	37,116
Revaluation reserve	46,158	46,159
TOTAL TAXPAYERS EQUITY	**178,654**	**178,715**

Non-current assets

Property, plant, and equipment (PPE) amounts to £177.2m. Capital additions of £4.7m are offset by November's depreciation charge.

Current assets

Current assets of £46.8m include cash of £38.1m and receivables of £8.2m.

Non-current assets held for sale

the Trust does not have any non-current assets held for sale.

Current Liabilities

Current liabilities amount to £36.6m and mainly relate to payables of £34.2m.

Net current assets / (liabilities) show net assets of £10.2m.

Working capital

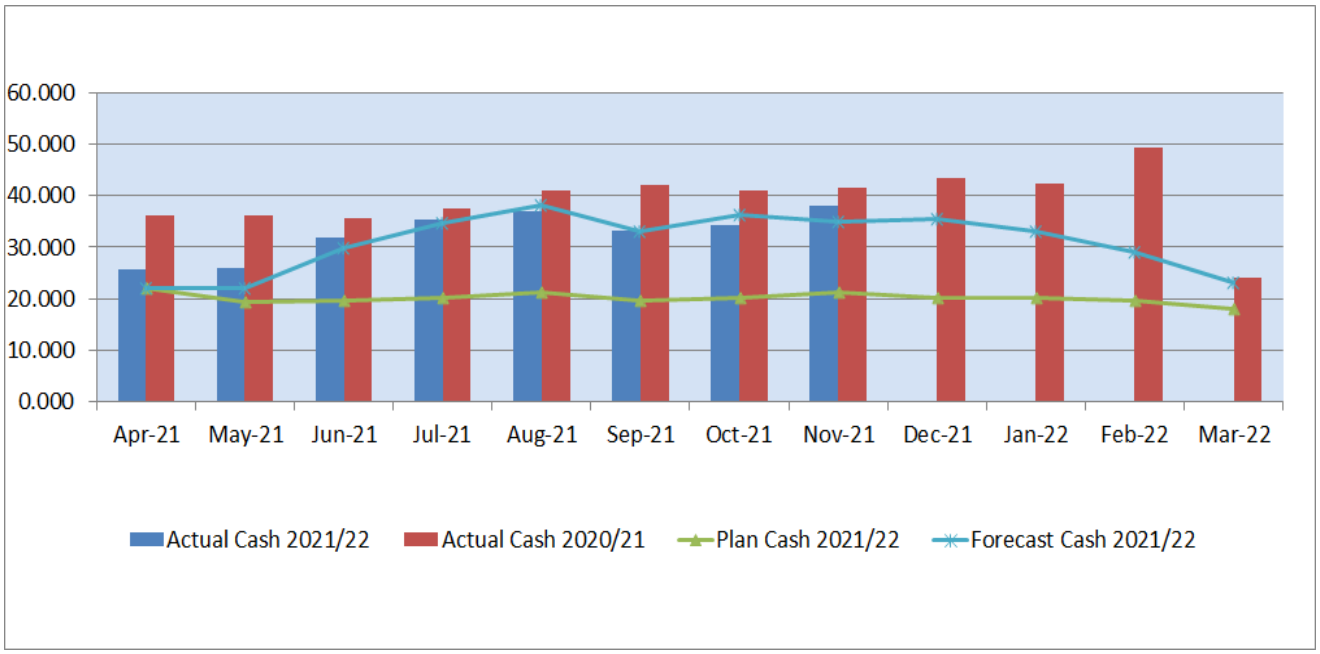
Cash and changes in working capital are reviewed on the following pages.

Taxpayers' Equity

November's surplus of £60k 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 November was £38.1m, an increase of £3.9m during the month.

The year-end cashflow forecast is now £23m; an increase of £2m compared to last month's forecast of £21m. This increase is mainly due to revised cashflow assumptions for the covid vaccination income (previously assumed Q4 income would be received in 2022/23).

Changes to the current yearend forecast of £23m are still likely; uncertainties around capital spend due to external factors e.g., supply chain issues, site access restrictions due to covid, and potential new investment monies are all likely to have an impact on the closing cash position at the end of the financial year.

A cash-flow forecast is included at ***Appendix D.***

Receivables

Current receivables (debtors) total £8.2m; a decrease of £2.7m during the month and £0.1m since the start of the year.

Receivables	Current Month November 2021					
	NHS £'000	Non NHS £'000	Emp's £'000	Total £'000	% Total	% Sales Ledger
Sales Ledger						
30 days or less	592	1,819	2	**2,413**	**25.9%**	**59.8%**
31 - 60 days	553	118	0	**671**	**7.2%**	**16.6%**
61 - 90 days	17	157	12	**186**	**2.0%**	**4.6%**
Over 90 days	297	271	198	**766**	**8.2%**	**19.0%**
	1,459	2,365	212	**4,036**	**43.3%**	**100.0%**
Non sales ledger	2,075	2,075	0	**4,150**	**44.6%**	
Total receivables current	**3,534**	**4,440**	**212**	**8,186**	**87.9%**	
Total receivables non current		1,129		1,129	**12.1%**	
Total	**3,534**	**5,569**	**212**	**9,315**	**100.0%**	**0.0%**

Debt greater than 90 days increased by £75k since October and now stands at £766k. Receivables over 90 days should not account for more than 5% of the overall total receivables balance. The proportion at Month 8 is 8.2% (last month: 5.7%). The non-current receivables balance of £1.1m 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 8 is £34.0m, an increase of £2.1m since October. Expenditure accruals have increased to cover the receipt of goods and services where invoices have not yet been received or approved. It is normal practice to have higher payable balances at this time of year, and then reduce in the final quarter of the year.

Provisions

Trust provisions have reduced by £819k since the start of the year and now stand at £3.4m. The largest utilisation so far this year relates to the enhanced annual leave overtime payments of £277k, paid to staff in September.

Better Payment Practice Code (BPPC)

The specific target is to pay 95% of invoices within 30 days. Cumulatively the Trust achieved 3 of the 4 BPPC targets and in month the Trust achieved 2 of the 4 BPPC targets at Month 8. The non-compliant targets relate to both the number of NHS and Non-NHS invoices paid within 30 days. The reasons for non-compliance have been reviewed and action has been taken to improve processes to aid faster approval of invoices. With continued effort and focus on the prompt payment of NHS invoices, the Trust can still achieve all four cumulative BPPC targets by the end of the year. Further details are shown in ***Appendix B***.

Capital Programme 2021/22

Capital expenditure totals £4.7m for the first eight months of the year.

	Annual Plan	Nov Actual	Year End Forecast	Revision to Plan
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**
Depreciation & technical adjustments	9,500	4,423	9,500	0
Dormitory elimination - Bradgate (PDC)	4,112	0	4,112	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	0	(1,000)
System-wide capital (funding tbc)	2,560	0	0	(2,560)
PDC IM&T Shared Care Records	0	0	2,278	2,278
Charitable funds (reflection gardens)	0	0	41	41
Total Capital funds	**17,552**	**4,703**	**16,311**	**(1,241)**
Application of Funds	**£'000**	**£'000**	**£'000**	**£'000**
Estates & Innovation				
Estates service improvements	(5,019)	(1,145)	(4,191)	828
Estates backlog	(2,395)	(544)	(3,037)	(642)
Estates other rolling programmes	(1,950)	(441)	(1,128)	822
Estates staffing	(360)	(494)	(410)	(50)
Estates & FM transformation	(699)	0	(100)	599
Medical devices	(120)	(124)	(236)	(116)
	(10,543)	**(2,748)**	**(9,102)**	**1,441**
IT Programme				
Rolling programmes	(1,865)	(849)	(2,190)	(325)
Other projects	(595)	(107)	(385)	210
PDC IM&T Shared Care Records	0	(181)	(2,278)	(2,278)
	(2,460)	**(1,137)**	**(4,853)**	**(2,393)**
Other				
Directorate capital investment projects	**(1,689)**	**(205)**	**(1,616)**	**73**
System-wide capital	**(2,560)**	**0**	**0**	**2,560**
Revenue to capital transfers	**0**	**(613)**	**(613)**	**(613)**
Contingency	**(300)**	**0**	**(127)**	**173**
Total Capital Expenditure	**(17,552)**	**(4,703)**	**(16,311)**	**1,241**
(Over)/underspend	**0**	**0**	**0**	**0**

Month 8 capital expenditure of £4.7m represents 29% of total forecast annual spend. This is £3.3m less than the cumulative planned spend of £8m for the first eight months. Spend against several estate's schemes (including the dormitory elimination project) are currently below plan, however as in previous years it is anticipated that expenditure will accelerate in the final quarter of the financial year.

Compared to planned capital expenditure of £17.6m, the revised annual forecast of £16.3m reflects a £1.2m reduction in spend since the start of the year. This reduction is mainly due to

- Removal of the system capital limit (not cash backed) - £2.6m
- Elimination of the Trust's cash contribution - £1m
- Additional PDC for LLR shared care records (funding tbc) + £2.3m
- Charitable Funds Grant + £41k

The capital contingency of £300k set at the start of the year is now £127k. There is still £11.6m left to spend in the last four months of the year and it is anticipated that there will be further slippage on several capital schemes. Plans are in place to further mitigate against slippage, to ensure a balanced capital programme at the end of the year. These include bringing forward the purchase of next year's IT rolling replacement programme equipment and progressing with new capital bids that can be delivered by 31st March 2022.

Changes made to the capital schemes in month 8 are shown below.

Ref	Scheme	Dept	Plan or Previous Forecast	Forecast	Change (Inc) / Dec	Reason
			£000	£000	£000	
Changes to existing schemes - Estates						
6C05	Bradagte Unit - External decoration, soffit repairs	Est	(144)	(145)	(1)	Final payment
6C43	Bradagte Unit - External access to roof voids (RIDDOR)	Est	(67)	(12)	55	Supply chain issue - steel delivery now 22/23
6C33	Loughborough Hospital - Phase 1 – Ward distribution boards	Est	(105)	(35)	70	Site access - scheme completion now 22/23
6C04	Loughborough Hospital - Phase 2 - Boiler room refurbishmen	Est	(360)	(367)	(7)	Scheme value adjusted to match GMP
6C76	Narborough Health Centre - Drainage Replacement	Est	(10)	(30)	(20)	Stage 1 fee to include ACCO drain
6C45	Mawson Lodge issues	Est	(100)	(80)	20	Scheme slippage to be deferred into 2022/23
6C87	Site wide - Electrical remedial work following 5 year fixed test	Est	(100)	(50)	50	Scheme slippage to be deferred into 2022/23
6C09	Site wide - IPC Audit Actions	Est	(80)	(50)	30	Scheme slippage to be deferred into 2022/23
6C82	Estates & FM Transformation - capital requirements	Est	(200)	(100)	100	Scheme slippage to be deferred into 2022/23
6C36	AMH ECT Suite	Est	(50)	(10)	40	
6C42	CHS Fielding Palmer disabled toilet	Est	(50)	(100)	(50)	Scheme value adjusted to match GMP
			(1,266)	**(979)**	**287**	
Changes to existing schemes - IM&T						
6C62	Single EPR System		(385)	(340)	45	Underspend identified
6C79	S1 obs		(94)	(78)	16	Underspend identified
6C20	Developing and delivering digital offer		(200)	(192)	8	Underspend identified
			(679)	**(610)**	**69**	
Revenue to capital transfers						
2514	Revenue to Capital transfers - IT hardware	Rev	0	(128)	(128)	IT equipment purchased via revenue
2514	Revenue to Capital transfers - Furniture	Rev	0	(11)	(11)	Furniture equipment purchased via revenue
			0	**(139)**	**(139)**	
Total changes from contingency - M8					**217**	
Capital Contingency						
M7 contingency					(90)	
M8 changes impacting on contingency					217	
M8 contingency					**127**	

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 30 November 2021	YTD Actual M8 £000	YTD Budget M8 £000	YTD Var. M8 £000
Revenue			
Total income	230,400	227,235	3,165
Operating expenses	(227,004)	(223,839)	(3,165)
Operating surplus (deficit)	**3,396**	**3,396**	**0**
Investment revenue	642	642	0
Other gains and (losses)	60	0	60
Finance costs	(718)	(718)	0
Surplus/(deficit) for the period	**3,380**	**3,320**	**60**
Public dividend capital dividends payable	(3,320)	(3,320)	0
I&E surplus/(deficit) for the period (before tech. adjs)	**60**	**0**	**60**
NHS Control Total performance adjustments			
Exclude gain on asset disposals	**(60)**	**0**	**(60)**
NHSE/I I&E control total surplus	**0**	**0**	**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:	**60**	**0**	**60**
Trust EBITDA £000	**10,108**	**10,108**	**0**
Trust EBITDA margin %	**4.4%**	**4.4%**	**-0.1%**

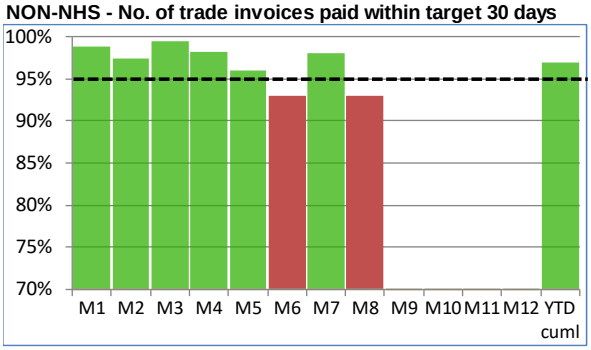
APPENDIX B – BPPC performance

Trust performance – current month (cumulative) v previous

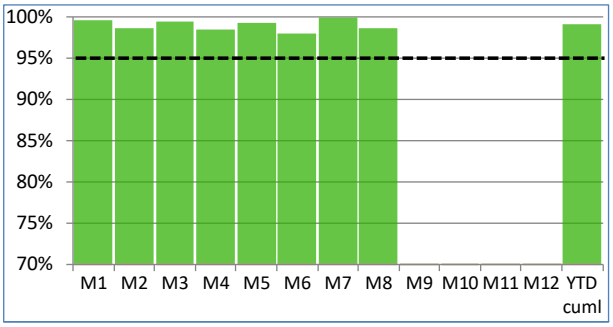
Better Payment Practice Code	November (Cumulative)		October (Cumulative)	
	Number	£000's	Number	£000's
Total Non-NHS trade invoices paid in the year	20,998	77,211	18,267	66,201
Total Non-NHS trade invoices paid within target	20,263	76,532	17,725	65,666
% of Non-NHS trade invoices paid within target	**96.5%**	**99.1%**	**97.0%**	**99.2%**
Total NHS trade invoices paid in the year	609	41,618	525	36,006
Total NHS trade invoices paid within target	570	40,597	498	35,183
% of NHS trade invoices paid within target	**93.6%**	**97.5%**	**94.9%**	**97.7%**
Grand total trade invoices paid in the year	21,607	118,829	18,792	102,207
Grand total trade invoices paid within target	20,833	117,129	18,223	100,849
% of total trade invoices paid within target	**96.4%**	**98.6%**	**97.0%**	**98.7%**

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

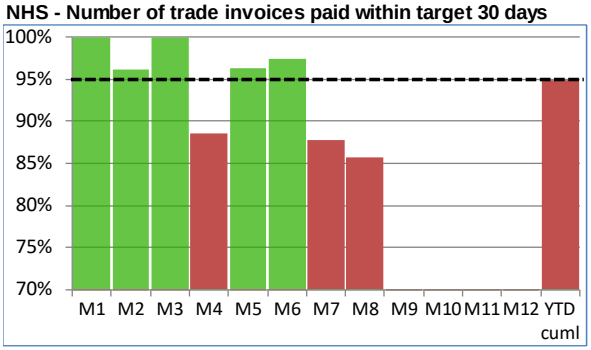
NON-NHS - No. of trade invoices paid within target 30 days



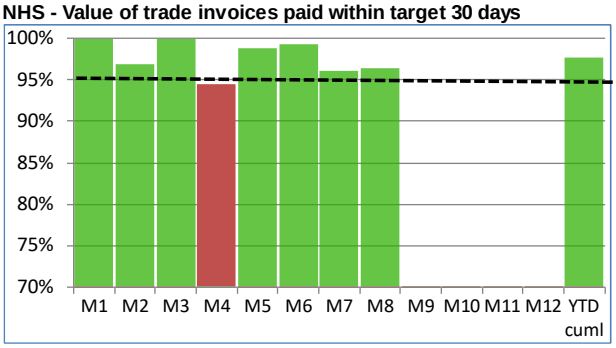
NON-NHS - Value of trade invoices paid within target 30 days



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 £000s Actual	2020/21 £000s Actual	2021/2 2 M1 £000s Actual	2021/2 2 M2 £000s Actual	2021/2 2 M3 £000s Actual	2021/2 2 M4 £000s Actual	2021/2 2 M5 £000s Actual	2021/2 2 M6 £000s Actual	2021/2 2 M7 £000s Actual	2021/2 2 M8 £000s Actual	2021/2 2 M9 £000s F'Cast	2021/2 2 M10 £000s F'Cast	2021/2 2 M11 £000s F'Cast	2021/2 2 M12 £000s F'Cast	21/22 YTD £000s Actual	21/22 Year End £000s F'cast
DMH																
Agency Consultant Costs	-2,561	-213	-290	193	-520	-265	-219	-98	-577	-391	-340	-320	-300	-280	-2,167	-3,407
Agency Nursing	-2,642	-220	-344	-265	-301	-422	-432	-548	-552	-486	-486	-486	-486	-486	-2,865	-5,297
Agency Scient, Therap. & Tech	-152	-13	-19	-14	-14	-25	-11	-17	-16	-17	-20	-20	-20	-20	-115	-212
Agency Other clinical staff costs				-11	-16	-11	1	0	0	-11	-20	-20	-20	-20	-37	-129
Agency Non clinical staff costs	-187	-16	-21	-32	-54	-21	-36	-62	2	-29	-29	-29	-29	-29	-223	-367
Sub-total for Directorate - DMH	**-5,541**	**-462**	**-673**	**-129**	**-905**	**-743**	**-698**	**-725**	**-1,143**	**-935**	**-895**	**-875**	**-855**	**-835**	**-5,016**	**-9,411**
Agency Spend relating to Investments			-57	-88	-115	-130	-198	-203	-220	-234	-243	-243	-243	-243	-1,245	-2,216
Agency spend relating to COVID			-59	-97	-150	-40	-6	-15	-5	-14	-5	-5	-5	-5	-386	-466
LEARNING DISABILITIES																
Agency Consultant Costs	-48	-4	-12	-8	-10	-13	-12	0	5	0	0	0	0	0	-51	-51
Agency Nursing	-761	-63	-129	-135	-156	-165	-156	-183	-295	-183	-220	-220	-220	-220	-1,402	-2,262
Agency Scient, Therap. & Tech	-85	-7	-13	-8	4	-1	0	0	0	0	0	0	0	0	-18	-18
Agency Non clinical staff costs	0	0	0	0	0	0	0	0	0	-3	0	0	0	0	-3	-3
Sub-total for Directorate - LD	**-894**	**-74**	**-154**	**-151**	**-162**	**-178**	**-168**	**-184**	**-290**	**-186**	**-226**	**-226**	**-226**	**-226**	**-1,474**	**-2,354**
Agency Spend relating to Investments			0	0	0	0	0	0	0	0	6	6	6	6	0	6
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	-494	-492	-451	-485	-470	-450	-430	-400	-3,264	-5,014
Agency Scient, Therap. & Tech	-375	-31	-36	-36	-50	-42	-22	-38	-67	-65	-70	-70	-70	-70	-356	-636
Agency Non clinical staff costs	-28	-2	-5	-10	-11	0	0	0	0	0	-3	-3	-3	-3	-25	-37
Sub-total for Directorate - CHS	**-4,371**	**-364**	**-279**	**-401**	**-399**	**-453**	**-515**	**-531**	**-518**	**-550**	**-543**	**-523**	**-503**	**-473**	**-3,646**	**-5,688**
Agency Spend relating to Investments			0	0	0	0	0	0	0	0	6	6	6	6	0	6
Agency spend relating to COVID			-56	-18	-10	-21	-22	-23	-20	-60	-50	-40	-30	-20	-230	-376
FYPC																
Agency Consultant Costs	-816	-68	-70	-17	-48	-63	-44	-110	-83	-67	-72	-72	-72	-72	-502	-780
Agency Nursing	-2,546	-212	-241	-259	-232	-245	-330	-364	-335	-263	-310	-310	-310	-300	-2,268	-3,498
Agency Scient, Therap. & Tech	0	0	0	0	0	-3	-1	-4	-1	-2	0	0	0	0	-11	-11
Agency Non clinical staff costs	-10	-1	-5	-14	-6	-11	3	-8	-15	-10	-20	-20	-5	-5	-67	-117
Sub-total for Directorate - FYPC	**-3,371**	**-281**	**-315**	**-290**	**-287**	**-322**	**-372**	**-485**	**-435**	**-341**	**-402**	**-402**	**-387**	**-377**	**-2,848**	**-4,416**
Agency Spend relating to Investments			0	0	0	0	-58	-100	-100	0	-126	-126	-126	-126	-258	-236
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	-13	-2	4	-2	-2	-2	-2	-10	-18
Agency Nursing	-8	-1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Agency Scient, Therap. & Tech	-83	-7	-5	-10	-8	-28	-43	-19	-32	-22	-19	-19	-19	-19	-168	-244
Agency Non clinical staff costs	-977	-81	-105	-131	-158	-49	-56	-85	-220	-58	-110	-110	-110	-110	-862	-1,302
Sub-total for Directorate - Enab/Host	**-1,069**	**-89**	**-110**	**-141**	**-166**	**-78**	**-99**	**-116**	**-254**	**-76**	**-131**	**-131**	**-131**	**-131**	**-1,041**	**-1,565**
Agency Spend relating to Investments			0	0	-5	0	0	-13	-2	4	-2	-2	-2	-2	-16	-24
Agency spend relating to COVID			-76	-76	-79	-111	-47	-77	-94	-13	-60	-70	-65	-50	-576	-841
TOTAL TRUST																
Agency Consultant Costs	-3,433	-286	-371	168	-578	-341	-276	-221	-657	-454	-414	-394	-374	-354	-2,730	-4,266
Agency Nursing	-9,915	-826	-953	-1,013	-1,028	-1,243	-1,411	-1,588	-1,634	-1,417	-1,486	-1,466	-1,446	-1,406	-10,286	-16,092
Agency Scient, Therap. & Tech	-696	-58	-73	-68	-69	-99	-77	-78	-116	-106	-109	-109	-109	-109	-686	-1,122
Agency Other clinical staff costs				-11	-16	-11	1	0	0	-11	-20	-20	-20	-20	-49	-129
Agency Non clinical staff costs	-1,202	-100	-135	-188	-230	-81	-89	-154	-233	-100	-162	-162	-147	-147	-1,210	-1,626
Total	**-15,246**	**-1,270**	**-1,532**	**-1,113**	**-1,920**	**-1,775**	**-1,852**	**-2,041**	**-2,639**	**-2,087**	**-2,151**	**-2,151**	**-2,036**	**-2,036**	**-14,960**	**-23,435**
Total Trust Agency Spend relating to Investments	-	-	-57	-88	-120	-130	-256	-316	-322	-230	-365	-365	-365	-365	-1,519	-2,376
Total Trust Agency Spend relating to Covid-19	2,578	215	-193	-191	-239	-172	-75	-115	-119	-87	-135	-115	-100	-75	-1,194	-1,615
Total excluding Covid-19 and Investmen	**-12,668**	**-1,055**	**-1,281**	**-834**	**-1,560**	**-1,473**	**-1,521**	**-1,610**	**-2,198**	**-1,771**	**-1,632**	**-1,672**	**-1,632**	**-1,597**	**-12,247**	**-18,838**

Agency costs for November were £2.1m. Excluding Covid and investment funded posts, costs were £1.8m.

The forecast costs for the year are £23.4m.

Additional detail on agency staff expenditure has been provided in the main body of the report.

APPENDIX D – Cash flow forecast

2021/22 CASH-FLOW FORECAST	NOV	NOV	NOV	DEC	JAN	FEB	MAR	YTD	21/22
	FORECAST	ACTUAL	VARIANCE	FORECAST	FORECAST	FORECAST	FORECAST	ACTUAL	FORECAST
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
OPENING BALANCE	**34,222**	**34,222**	**0**	**38,078**	**35,480**	**33,022**	**28,915**	**24,139**	**24,139**
INCOME									
Leicester & Leicesteshire CCG block contracts	22,409	23,044	**635**	23,067	21,899	21,899	19,899	185,870	272,634
Other CCG block contracts	469	469	**0**	294	294	294	294	2,364	3,540
East Midlands Provider Collaborative - CAMHS	142	142	**0**	142	142	142	142	1,136	1,704
Local Authorities block contracts	1,474	758	**(716)**	1,442	1,442	1,442	1,442	10,136	15,904
NHS England	2,171	1,976	**(195)**	783	2,323	783	4,167	9,018	17,074
UHL contract	464	0	**(464)**	464	232	232	232	1,392	2,552
MADEL	4,179	4,179	**0**	0	0	1,478	0	9,216	10,694
HIS income	100	268	**168**	200	200	200	200	1,614	2,414
360 Assurance income	100	148	**48**	100	300	100	136	1,058	1,694
UHL rental income	341	0	**(341)**	463	0	0	0	635	1,098
Previous year's income	0	7	**7**	0	0	0	0	4,970	4,970
VAT	329	393	**64**	426	250	250	250	3,623	4,799
Property sales	0	0	**0**	0	0	0	0	341	341
PDC for capital investment	0	0	**0**	2,016	0	0	4,374	0	6,390
Other income	488	813	**325**	626	588	588	563	4,914	7,279
Total Receipts	**32,666**	**32,197**	**(469)**	**30,023**	**27,670**	**27,408**	**31,699**	**236,287**	**353,087**
PAYMENTS									
Payroll	20,349	19,386	**(963)**	20,051	20,224	20,232	20,259	152,837	233,603
Capital	843	1,235	**392**	1,500	1,500	2,000	4,068	3,623	12,691
Non pay general expenditure	5,526	5,101	**(425)**	5,526	5,196	6,080	7,198	43,010	67,010
UHL - Estates & FM Services	1,880	940	**(940)**	1,880	940	940	940	6,580	11,280
UHL - Other contracts	145	0	**(145)**	290	145	145	145	1,015	1,740
NHS Property Services rents	1,200	52	**(1,148)**	1,448	305	300	300	1,902	4,255
Community Health Partnerships rents	335	227	**(108)**	226	118	118	118	836	1,416
HCL Agency Nursing Costs	1,600	1,285	**(315)**	1,700	1,700	1,700	1,700	9,369	16,169
Out of Area (OOA) costs for patients placed in private hospitals	0	0	**0**	0	0	0	0	161	161
Public dividend capital payment (PDC)	0	0	**0**	0	0	0	2,886	2,785	5,671
Other finance costs (inc loan interest and principal repayments)	115	115	**0**	0	0	0	0	230	230
Total Payments	**31,993**	**28,341**	**(3,652)**	**32,621**	**30,128**	**31,515**	**37,614**	**222,348**	**354,226**
CLOSING CASH BOOK BALANCE	**34,895**	**38,078**	**3,183**	**35,480**	**33,022**	**28,915**	**23,000**	**38,078**	**23,000**

APPENDIX E – Covid-19 expenditure, November 2021

Cost of Covid response

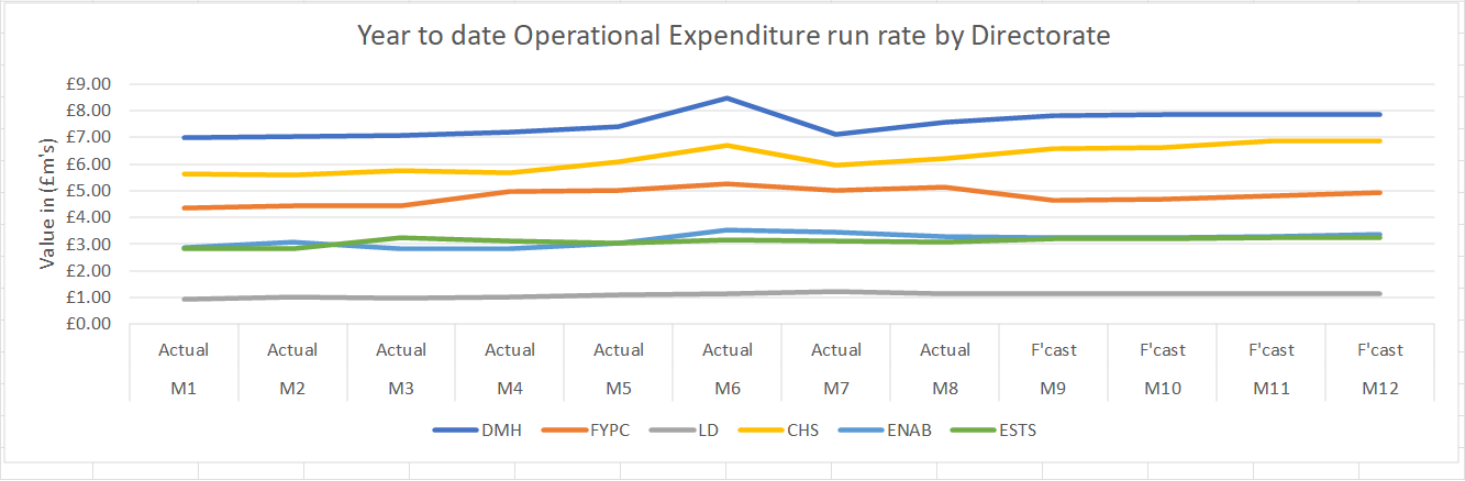
CATEGORY	DMH	CHS	FYPC	LD	ESTS	ENAB	HOST	RSRVS	TOTAL
PAY	£000	£000	£000	£000	£000	£000	£000	£000	£000
Expand NHS Workforce - Medical / Nursing / AHPs / Hcare Scientists / Other									
Substantive	4	1	0	0	0	8	0	0	**13**
Bank	115	37	0	0	0	33	0	0	**185**
Agency	14	60	0	0	0	0	0	0	**74**
Existing workforce additional shifts									
Substantive	0	0	0	0	0	0	0	0	**0**
Bank	0	0	11	8	0	0	0	0	**19**
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	1	0	0	**1**
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	12	3	0	0	**15**
Decontamination	0	0	0	0	0	0	0	0	**0**
Additional Ambulance Capacity	0	0	0	0	0	0	0	0	**0**
Enhanced Patient Transport Service	2	0	0	0	0	0	0	0	**2**
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	0	0	0	0	**0**
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	15	0	0	**15**
Furniture, fittings, office equip for staff home working	1	0	0	0	0	0	0	0	**1**
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 M8 COVID COSTS:	**136**	**98**	**11**	**8**	**12**	**60**	**0**	**0**	**325**
TOTAL M1 to M7 COVID COSTS:	1,706	507	90	59	83	500	24	0	2,969
TOTAL YTD COVID COSTS:	**1,841**	**605**	**101**	**67**	**95**	**560**	**24**	**0**	**3,293**

Covid Vaccination costs

Total Covid vaccination costs incurred to date (April to November) are £4.24m. Virtually all the costs relate to staffing. The Vaccination Programme forecast has now been extended to March 2022. The Trust plan assumes total vaccination costs of £8.02m for the financial year, however, following the national call to action across December, it is anticipated that costs will increase significantly and the forecast will be updated accordingly. Vaccination costs are currently direct funded based on actual costs incurred, so the programme is forecast to have no impact on the Trust bottom line financial position.

APPENDIX F – Operational expenditure run-rate, April to November

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	F'cast	F'cast	F'cast	F'cast	F'cast
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
DMH	7.0	7.0	7.1	7.2	7.4	8.5	7.1	7.6	*7.8*	*7.9*	*7.9*	*7.9*	*90.4*
FYPC	4.4	4.5	4.4	5.0	5.0	5.3	5.0	5.1	*4.6*	*4.7*	*4.8*	*4.9*	*57.8*
LD	1.0	1.0	1.0	1.0	1.1	1.1	1.2	1.1	*1.2*	*1.2*	*1.2*	*1.2*	*13.1*
CHS	5.6	5.6	5.8	5.7	6.1	6.7	6.0	6.2	*6.6*	*6.6*	*6.9*	*6.9*	*74.6*
ENAB	2.9	3.1	2.8	2.8	3.0	3.5	3.4	3.3	*3.2*	*3.2*	*3.3*	*3.4*	*38.0*
ESTS	2.8	2.8	3.3	3.1	3.0	3.2	3.1	3.1	*3.2*	*3.2*	*3.2*	*3.2*	*37.3*
TOTAL	**23.7**	**24.0**	**24.4**	**24.8**	**25.7**	**28.3**	**25.8**	**26.4**	***26.6***	***26.8***	***27.2***	***27.4***	***311.2***



The actual expenditure run-rate for operational directorates is shown (left). Most clinical areas show a general increasing trend which reflects the additional investment relating to MHIS, SDF and SR schemes. The 'spike' in month 6 reflects the payments relating to the pay award (plus arrears) which were made in that month.

With the exception of LD, directorates continue to forecast that they will deliver a year end financial position broadly within budget. The increasing cost within the Agnes Unit is the main cause of the LD pressures, and this has been factored into run-rates.

Leicestershire Partnership NHS Trust

Trust Board – 21/12/21

Month 8 Trust finance report

Purpose of the Report

- To provide an update on the Trust financial position, including revisions to the capital programme

Proposal

- The Committee is recommended to review the summary financial position and receive assurance that financial performance is in line with the H2 financial plan, and the overall plan for the year.

Decision required: none

Governance table

For Board and Board Committees:	Trust Board 21/12/2021	
Paper sponsored by:	Sharon Murphy, Acting Director of Finance	
Paper authored by:	Amjad Kadri, Acting Head of Corporate Finance Jackie Moore, Financial Controller	
Date submitted:	14/12/2021	
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, 17/12/2021	
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	

T

Leicestershire Partnership NHS Trust

Trust Board – 19.11.21

Board Performance Report October 2021 (Month 07)

Purpose of the report

To provide the Trust Board with the Trust's performance against KPI's for October 2021 Month 7.

Analysis of the issue

The report is presented to Operational Executive Team each month, prior to it being released to level 1 committees.

Proposals

The Trust Board is asked to note the updates below:

- Quality Account Metric relating to Readmission Rates has been reviewed as a result of rates being high. The technical methodology has altered but a technical issue within the reporting script was identified which had resulted in the data reflecting all readmissions.

- Some of the Quality metrics under 'Quality Account', 'Quality and Safety' and 'Patient Flow' have been updated for the Report with further work to update the 'Workforce/HR' metrics for the next Report (Month 8).

- NHSE/I have released the NHS System Oversight Framework Segmentation with LLR ICS as segment 3, and LPT as Segment 3 with mandated support as a result of ongoing concerns raised by CQC along with the Requires Improvement rating. This will be reflected in the Report for November 2021 (Month 8).

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.

Decision required

The Trust Board is asked to

- Approve the performance report

Governance table

For Board and Board Committees:	Trust Board 21.12.21	
Paper sponsored by:	Sharon Murphy, Interim Director of Finance and Performance	
Paper authored by:	Sam Kirkland, Head of Data Privacy	
Date submitted:	13.12.21	
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):		
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 3/5 Performance meetings	Assurance re actions being taken as at Month 5	Update as at month 7	New escalation areas from month 7 Performance meetings	Assurance re actions being taken
FYPC				
Backlog and waiting times Suitable Estate to do additional clinics	Confirmation of backlog funding. Services are extending fixed term contracts, employing agency staff and scheduling additional hours clinics to improve waiting times and backlogs. Monitored through performance paper at Sustainability DMT and deep dives through Silver. CAMHS ED – Recovery plan is in progress including recruitment for MHIS. Work is underway with NHFT with a plan to introduce more standardisation and consistency. Raised at SPG and EMEC	Services are utilising funding to improve backlog, due to issues with recruitment and recovery trajectory's some of these are being financially risk manged into next financial year Not yet fully recruited to all posts. Recovery trajectory is on plan to complete July next year. Regional System work being undertaken with NHFT and the East Midlands Shared Alliance Lease for rooms at Westcotes Health Centre is being processed which will give additional space for CAMHS services.	Potential financial risk if further backlog funding not available next year. Recovery will be on-going into 2022/23	Reviewed our priority services for the Access and Keeping Patients Safe Committee meeting to include those services that are not showing sustained recovery to include: Community Paediatrics CAMHS ED Adult ED (new) Children's Physiotherapy (new) LD Access (new) LD Community Nursing (new) Healthy Together County 2-year checks (new)

Community Paediatrics: Large legacy backlog of new and follow ups. In addition second diagnostician for ASD has required a remedial plan.	Additional clinics from the backlog investment, additional SALT/Psychology to support ASD pathway.	Remedial plans are in place, however, these are only slowing the impact of increased referrals and expanding caseloads. There is a requirement to continue with these plans into the next financial year to support 1. Second diagnostician for ASD 2. Increase the number of ADHD Nurses for the increasing ADHD caseload. 3. Continue with WLI clinics on Saturdays 4. Continue with Agency Paediatrician Business cases are being prepared for System decision for next year's financial plan	Performance continues to deteriorate due to increased demand and numbers of CYP requiring follow-up due to ADHD. A small number of children will breach 52 week wait for a first appointment as a result.	
Recruitment/workforce High turnover on the Beacon Ward.	Safer staffing levels	Recruitment of workforce in all areas remains difficult. Several		Step up to Great workforce project has been initiated

Healthy Together 0-19 vacancies and impact	Delay in recovery to pre-covid service offer, Prioritisation of caseloads in place	areas are now operating incentive schemes to support. There are action plans to improve on-boarding and retention		focussing on plan to improve recruitment
Staff wellbeing Staff not having access to hot desks and facilities	H&WB leads in SMT and services; H&WB plans progressing and embedded in appraisals 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; Backlog funding will support re-balance of caseloads and facilitate access Supporting staff to work in a blended way Raised through Triple R programme and spaces becoming available across LLR	Nothing additional to report. Continuing to support services to have systems in place to manage caseload size centrally and not with individuals Continuing to support staff to work safely at home and/or base.		

Finance on the wards Not achieving directorate financial balance	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 Specialist wards month 5 position discussed, as detailed in the inpatient finance and recovery plan. Mitigating actions reviewed and confirmed through Operational Executive Board	All 3 wards have an action plan to increase the levels of substantive staff and to over recruit to HCW's to allow for turnover and reduce the reliance on agency staff Month 7 position discussed which shows an improvement in financial performance in FYPC and LD, supported by the allocation of the backlog funding.	The Agnes unit continues to show a deteriorating financial position	Developing business case for the future clinical model at the Agnes Unit
DMH				
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 consultation is now complete. The findings are being drawn together	*ADHD* The ADHD Service continues to experience increasing waits for assessment and treatment. A non-consultant-led	*Memory Service* The service is not delivering against the planned trajectory. Waiting times have deteriorated in the memory service as it was	

	and will then be analysed. This work will help inform longer term plans to develop sustained reduction in waits. The two services with increasing waits are the ADHD Service and the TSPPD Service. The ADHD service continues to work towards full establishment following additional recurrent investment last year – currently there are vacancies and challenges around recruitment which the team are working to resolve through considering developmental roles and involvement of other disciplines in the pathway The tender process to procure additional capacity to support a reduction in the ADHD waiting list closed on 1st October. The service is now working through the outcomes with the procurement team The TSPPD service completed a fourth 'assessment week' in September. All patients waiting have now been offered a triage assessment. This triage process was important to keep people safe, as	pathway now in situ. Has increased efficiency but vacancies impeding impact on numbers waiting and sustained reduction in the length of wait. Recruitment is ongoing. Due to difficulties in recruiting to specialist posts, the service is developing alternative roles including a pharmacy role and training roles. Further non-recurrent capacity is required through out-sourcing to support clearing the historic backlog of cases. A tender went out to market and closed on 1st October; however, this was unsuccessful. A revised procurement exercise is currently in development. The service is exploring different models of service delivery with system partners and commissioners. An options paper will be	suspended during the early stages of the pandemic – this led to a large backlog of cases. At 1st November 1063 currently on the RTT pathway, of those 267 have been seen for an initial assessment and are awaiting treatment. PDSA improvement plan is in place and recorded using LifeQI – more streamlined patient pathway (reduced need for imaging), maximising clinical activity through job plans and detailed analysis of capacity required. Additional capacity agreed to support reducing the backlog – recent recruitment partly successful, however, there are still vacant posts. Future posts to be recruited to substantively to assist with successful recruitment.	

	patients requiring urgent support were redirected to urgent care services. The process also supported the identification of those patients who did not require secondary care and could be better supported by primary care/ IAPT. A further assessment week is planned for November – this will identify any patients who DNA'd/ did not respond and still require assessment. 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. 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.	presented to DMH DMT in December. *TSPPD* 52 week waits are reducing, however, The number of treatment waiters over 52 weeks is projected to rise significantly over coming months as the capacity to take patients on for treatment under current plans does not outweigh the increase in demand from those being assessed and moving to the treatment waiting list. Psychological skills group pilot started in November. A rolling schedule of groups is now in place. These are taking place via MS Teams and are limited to 8 participants over 12 weeks. The number of groups is limited by the ability to free staff up from the historical/ existing treatment offers which are resource-		

		intensive and lengthy in nature. Current plans continue to evolve – the current focus is on providing training to the first cohort of staff across locality teams using 'The Decider' skills (procured externally). This will enable those trained to begin providing psychological skills groups across locality teams from December. Staff from the TSPPD service will support this and provide supervision. All other services remain broadly on track against the planned trajectories, with the exception of the Memory Service.		
workforce (recruitment)	The directorate is reinstating the Recruitment and Retention Group to maintain oversight of recruitment issues and challenges. This meeting will be chaired by Helen Perfect, Head of Service. In the interim John Edwards, Head	No updates	No escalation	

	of Business Development and Transformation, is linking in with the recruitment team to look at specific recruitment challenges within the directorate.			
Underspends on investment funding	Projections continue to predict slippage against investment funds 2021/22. Additional schemes have been identified which will be funded from slippage. The directorate will continue to identify and take forward appropriate schemes to reduce underspend.	Spend on investment funding is closely tracked. Where there is likely to be slippage, alternative non-recurrent schemes have been developed. Current projections predict an underspend of £1.4m on investment funds in 21/22. Projections continue to predict slippage against investment funds 2021/22. Additional schemes have been identified which will be funded from slippage. The directorate will continue to identify and take forward appropriate schemes to reduce underspend. Work is underway to 'carry forward' monies not spent.		
IPS performance	The employment support service	*IPS*		

	operates in line with the individual placement and support model to enable patients to get back into paid employment. The development of the team is in line with the ten year implementation programme and funded by NHS England. In LLR we have been allocated funds to increase access to the service in 2021/22. The service will be recruiting additional employment specialists to support this increase in access. Compliance with the IPS approach is established through a fidelity review carried out each year. The LPT fidelity review was completed and resulted in an overall resulting in fair fidelity. An action plan has been put in place to increase the fidelity score. Current status: The service has successfully integrated into the CMHT's, AO and PIER despite the difficulties of COVID, the team scored highly for integration, and they have managed this integration through Microsoft teams. There were some delays in	An IPS Grow Partnership Fidelity Review Action Plan is in place which the service is working through. The first meeting of the Steering Group met this week. The team are continuing to recruit workers to support the increase in access to services.		

	recruitment which have been addressed. The fidelity model also advocates face to face appointments which have had to be adapted throughout the pandemic. Templates and access to system one has been established, further developments are planned. The service was relaunched via teams which involved service user testimonies. LPT have also successfully secured the next wave of funding and recruitment for the further Band 5 workers has commenced.			
Physical healthchecks – LLR system performance	***Mental Health Facilitators*** An integrated task and finish group focusing on Physical Health checks for people on the SMI register has begun to meet to collaboratively build a plan and trajectory to achieve the 60% target. LPT will submit a MHF and DMH Community plan to help achieve this. Ensure the service resumes face to face contact from 11th October 2021 where clinically safe to do so and clinical space is available. Carrying out a demand and capacity review. Developing follow-up plans and an	An action plan is in place which the service review on a weekly basis. The team are continuing to work collaboratively with commissioners and meet weekly, focusing on physical health checks for people on the SMI register. Business Support Officer who will be supporting data analysis and use of technology to collect information commenced		

	agreed process for each service user who does not respond or want input from the service. Utilisation of peer support workers aligned to the PCNs. Ensuring the MHFs are phlebotomy trained. Recruitment of additional posts to support and release clinical capacity to carry out checks (Admin and Data Analyst). SystmOne units configured to capture the required data across the system. Validation of SMI registers. Collaboration with experts by experience to improve attendance for PH checks To utilise neighbourhood MDT networks (e.g. VCSE) support) to identify organisations and practitioners working with individual who can promote and engage people in health checks.	in post on 13th December 2021.		
EIP Performance			NCAP (National Clinical Audit of Psychosis) conducts an annual national audit to ensure the access, waiting time targets and five additional quality standards are met.	

			The standard requires "level 3 - performing well" on all domains to demonstrate adherence. LPTs EIP service obtained an overall score of "level 2 - needs improvement" with some standards scored "level 1 – greatest need for improvement". -Caseloads outside of expectation (c.25 instead of 15-20) -Physical health assessments and interventions scored at level 1 -Employment support scored at level 2 -Provision of carer education and support scored at level 2 -Recording of at least two outcome measures – DIALOG, HoNOS, QPR at least twice – at level 2 -Absence of ARMS provision across all three age ranges -In addition, although we scored level 4 in CBTp and level 3 in Family	

			Interventions, loss of qualified staff means action is required to avoid these scores dropping for 2021/22. To address these issues the service has implemented a robust action plan which is monitored internally, via the local management team and at DMT. Actions include additional recruitment, caseload reviews are taking place and a performance monitoring dashboard is in development.	
Perinatal Service– Access Rate			Concerns have been raised by both NHSI/E and local commissioners in relation to the Perinatal Service access performance. The service has been identified nationally as an outlier in terms of performance. During both 2020/21 and 2021/22 the access rate has fallen below the specified target for a number of reasons:	

			-Response to pandemic. -Use of virtual technology. -Migration of IT systems from RiO to SystmOne. -Parameters around the inclusion of activity - 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. -Data quality errors. - Analysis of the referral data indicates that the service will receive an adequate number of referrals. However, the acceptance rate is running at around 75% which is resulting in a shortfall of referrals. - The average number of referrals accepted into the service each month has reduced since 2020/21, making it more difficult for the service to achieve the required performance	

			targets. *Recovery Plan* The service is working closely with commissioners to address issues raised and ensure communication is maintained. A recovery plan has been developed which addresses all of the issues identified. This is reviewed regularly at DMT and a weekly performance review meeting is in place to ensure that the service remains on track. Based on current referral rates if all new patients referred were seen face to face or virtually for the remainder of this financial year, the maximum rate the service could achieve on a 12-month rolling performance basis is circa 7%.	
CHS				
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	• Urgent compliance is 100%. • Longest waiters are reducing	Nothing to escalate	

	Performance reviewed in DMT with deep dive and clear trajectory in place reliant on current staff capacity, increased locum capacity and a balance of community and clinic capacity. Routine compliance on track with trajectory. Numbers waiting has reduced however not in line with planned trajectory due to clinic and locum capacity available (3 locums currently in place) Additional clinic opening to improve capacity.	• It is unlikely the service will reach 95% compliance by February due to a decrease in locum availability • The transformation plan is being reviewed to explore opportunities to bridge the gap		
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. Waiting List has started to reduce and patient contact time has increased. Additional nursing and admin staffing has been secured. Triage	• Quality improvement pilots in place. • Waiting list continues to decrease • Number of 1st assessments increasing • Preventing 52 week breaches continues to be a key focus for the service.	No additional issues raised	

	has been strengthened and alternative providers are being scoped to help with this (UHL approached). Additional estate and clinic rooms requested to increase clinic capacity and create a one stop shop.			
Number of pressure ulcers	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. Harm profile has increased in month due to the business continuity /essential visiting arrangement that is in place as service has been on OPEL level 3 with significant staffing challenges over the last 3 months. Quality summit chaired by DON	• Quality Improvement work is continuing • Quality summit completed with good attendance and positive outcomes • Directorate workstreams have started to progress the actions form the quality summit A further summit is planned for February 2022 to review progress	No additional issues raised	

	2.11.21 NHFT OD session with City DN team 25.10.21 Weekly rapid action meetings lead by Head of Nursing and Director of CHS which will inform the quality summit			
Falls	Planned discussion with the service	• First falls increased in October but have remained below the median since April 2021. • Repeat falls reduced in October • We are reviewing the number and use of sensor mats to ensure all wards have access to these • The induction checklist for temporary staff has been updated to cover responsibilities when completing enhanced observations		
Workforce	Managed through DMT and	As before		

	Corporate workforce Where there are escalation areas these are being managed via task and finish groups			
Breathlessness Rehabilitation			Breathlessness rehabilitation service Waiting times have increased and actions to address are being progressed	
LD				
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	LPT Exec to CCG Exec meeting scheduled for 20th Oct to confirm commissioning response to shortfall in income. Number of inpatients increased to 8 generating additional spend. Impact team clear they have no intention of commissioning additional beds at the Agnes Unit as suggested for exploration by CCG colleagues. Acuity based tool in place to support ongoing confirm and challenge by		Await outcome of mtg 20th Oct Review recruitment and retention premia use at DMT on 25th Oct

		CCG of staffing arrangements/use of Pods if required. Senior nursing team continuing to ensure staffing levels and Pod usage minimised.		
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	H2 recovery funding plans under development and implementation as appropriate. Data analysis completed for all but 1 service area following revision of processes to meet SystmOne requirements. 6 week checks in place for patients waiting.	Confirm waiting time projections and develop response plans for service lines as necessary – includes community nursing team and psychology. Continue SystmOne optimisation work.	SystmOne process changes and data analytics nearing completion. H2 funding plans being led by Service Manager SysmOne optimisation work progressing with information team support - incudes 6 week check compliance reporting.

Leicestershire Partnership NHS
NHS Trust

Trust Board
21 December 2021

Board Performance Report
October 2021 (Month 7)

Highlighted Performance Movements - October 2021

Improved performance:

Metric	Performance	
Aspergers - 18 weeks (complete pathway)	100.0%	
72 hour Follow Up after discharge Target is 80% (reported a month in arrears)	82.6%	Target met after 2 months below target

Deteriorating Performance:

Metric	Performance	
Therapy Service for People with Personality Disorder - Treatment waiters over 52 weeks	395	Highest number reported

Other areas to highlight:

Metric	Performance (No)	
Serious Incidents	5	Increased from 1 reported last month
No. of episodes of seclusions >2hrs *Target decreasing trend*	8	Decreased from 24 reported last month
No. of episodes of sideline restraint *Target decreasing trend*	9	Decreased from 22 reported last month
No. of repeat falls *Target decreasing trend*	39	Decreased from 45 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	Trust Position																					
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	Aug-21	Sep-21	Oct-21	Sparkline
	Total Admissions	404	353	389	330	374	366	368	381	377	347	396	377	406	398	437	418	404	412	391	436	
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	Aug-21	Sep-21	Oct-21	Sparkline
	Total Covid +ve Admissions	18	49	31	11	5	4	2	28	41	44	66	31	11	1	0	3	6	20	12	13	
	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%	4.9%	3.1%	3.0%	
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	Aug-21	Sep-21	Oct-21	Sparkline
	0-2	1	4	2	2	0	0	0	2	5	4	5	4	0	0	0	0	0	1	1	2	
	3-7	2	9	9	1	1	0	1	0	7	12	20	8	1	0	1	0	0	2	1	1	
	8-14	1	8	9	2	0	0	0	0	1	15	9	5	2	0	0	0	0	1	0	3	
	15 and over	11	14	5	2	0	0	0	7	5	29	18	35	9	1	0	0	0	2	2	11	
	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%	0.7%	0.5%	3.2%	
	• 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.*																					
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	Aug-21	Sep-21	Oct-21	Sparkline
	Total Covid +ve Admissions	33	84	56	18	6	4	3	37	59	104	118	83	23	2	1	3	6	26	16	30	
	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%	6.3%	4.1%	6.9%	

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 through 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 were eleven definite and three probable nosocomial cases reported in October 2021. This is broken down into three probable and two definite cases on Coalville Ward 4 and eight definite cases at Mill Lodge. These have been managed as patient and staff Covid-19 outbreaks. A further patient was identified on Wakerley Ward. There is no linkage between either outbreak or the isolated Wakerley Ward patient. All of the patients affected have made a full recovery.

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. Gwendolen Ward can be opened as a red/high risk ward and was opened for two positive patient cases in August 2021 and reopened in September 2021.

The campaign Hands, Face, Clean your space launched on the 15 July 2021, 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 an increase in Covid-19 outbreaks to ensure lessons learnt and actions are widely shared.

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>May-21</td><td>Jun-21</td><td>Jul-21</td><td>Aug-21</td><td>Sep-21</td><td>Oct-21</td></tr><tr><td>98.8%</td><td>100.0%</td><td>100.0%</td><td>100.0%</td><td>100.0%</td><td>100.0%</td></tr></table></td><td rowspan="3"></td><td>  </td><td>  </td></tr>
<tr><td colspan="2">Over the series of data points being measured, key standards are being delivered inconsistently</td></tr>
<tr><td></td></tr>
<tr><td rowspan="3">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 rowspan="3"><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 rowspan="3">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></td></tr>
<tr><td rowspan="3">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>May-21</td><td>Jun-21</td><td>Jul-21</td><td>Aug-21</td><td>Sep-21</td><td>Oct-21</td></tr><tr><td>0.0%</td><td>0.0%</td><td>0.0%</td><td>0.0%</td><td>0.0%</td><td>0.0%</td></tr><tr><td colspan="6">Age 16 or over</td></tr><tr><td>10.1%</td><td>9.5%</td><td>5.1%</td><td>9.7%</td><td>9.0%</td><td>6.0%</td></tr></table></td><td rowspan="3">This indicator is currently on hold and being reworked to reflect the correct methodology as agreed at FPC.</td><td>n/a</td><td>n/a</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td></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.

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<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>May-21</td><td>Jun-21</td><td>Jul-21</td><td>Aug-21</td><td>Sep-21</td><td>Oct-21</td></tr>
<tr><td>1082</td><td>1146</td><td>1051</td><td>960</td><td>1001</td><td>967</td></tr>
<tr><td>62.3%</td><td>65.0%</td><td>61.7%</td><td>59.0%</td><td>60.6%</td><td>60.2%</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>May-21</td><td>Jun-21</td><td>Jul-21</td><td>Aug-21</td><td>Sep-21</td><td>Oct-21</td></tr>
<tr><td>1</td><td>10</td><td>4</td><td>8</td><td>7</td><td>13</td></tr>
<tr><td>0.1%</td><td>0.9%</td><td>0.4%</td><td>0.8%</td><td>0.7%</td><td>1.3%</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>Apr-21</td><td>May-21</td><td>Jun-21</td><td>Jul-21</td><td>Aug-21</td><td>Sep-21</td></tr>
<tr><td>89.5%</td><td>79.2%</td><td>87.5%</td><td>78.3%</td><td>72.4%</td><td>75.0%</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><td>Sep-21</td></tr>
<tr><td>60.0%</td><td>58.0%</td><td>96.0%</td><td>94.0%</td></tr>
</table>
EIP Services
<table>
<tr><td>Mar-20</td><td>Sep-20</td><td>Mar-21</td><td>Sep-21</td></tr>
<tr><td>93.0%</td><td>-</td><td>97.0%</td><td>-</td></tr>
</table>
Community Mental Health Services on CPA (arrears)
<table>
<tr><td>Mar-20</td><td>Sep-20</td><td>Mar-21</td><td>Sep-21</td></tr>
<tr><td>-</td><td>34.0%</td><td>-</td><td>54.0%</td></tr>
</table>
</td><td>Comments on September 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>May-21</td><td>Jun-21</td><td>Jul-21</td><td>Aug-21</td><td>Sep-21</td><td>Oct-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)*	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21		?	UP
	89.5%	79.2%	87.5%	78.3%	72.4%	75.0%		Over the series of data points being measured, key standards are being delivered inconsistently	
6-week wait for diagnostic procedures (Incomplete) Target is >=99% *(reported a month in arrears)*	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	In line with national COVID-19 guidance, this service was suspended. It was re-established in October 2020 but due to COVID restrictions can only work at 60% previous activity. We are continuing to support the additional audiologists with the COVID backlog finance until March 2022. The original recovery trajectory was to report a positive KPI in July/August 2021. There has however been a surge in referrals over the last few months and this is now expected March 2022. The position will then be sustainable if the COVID restrictions are lifted	YES	DOWN
	72.0%	75.2%	68.6%	58.7%	49.9%	58.2%		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%		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Although significant improvement has been made over the last few months the service has deviated from the planned trajectory. There are several work packages through SUTG MH which will support a review of the trajectory and this work is currently being brought together to inform a revised action plan / trajectory.	N/A	N/A
	Complete	59.8%	69.6%	60.3%	57.2%	66.7%	60.9%			
	Incomplete	66.0%	63.8%	58.1%	47.8%	45.3%	56.6%		NO	NO CHANGE
									Key standards are not being delivered and are deteriorating/ not improving	
Memory Clinic (18 week Local RTT) Target is 95%		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-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 service has had 2 WTEs on long term sick leave from May to September which has impacted on progress. Both members of staff have returned during September. Memory clinic performance deep dive taking place at DMT in November 2021.	N/A	N/A
	Complete	25.9%	43.8%	25.5%	48.5%	51.6%	49.1%			
	Incomplete	64.8%	68.1%	68.5%	68.7%	69.7%	70.6%		N/A	N/A
ADHD (18 week local RTT) Target is: Complete - 95% Incomplete - 92%		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	The tender process for outsourcing part of the waiting list backlog is currently being reassessed and plans are in development to take this forward. Other elements of the ADHD improvement plan continue to be progressed, although rcruitment remains challenging.	N/A	N/A
	Complete	25.0%	5.6%	18.2%	20.0%	12.5%	15.4%			
	Incomplete	37.3%	37.6%	39.9%	36.9%	34.3%	33.9%		N/A	N/A

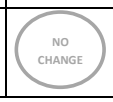
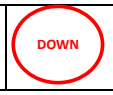
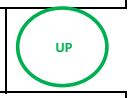
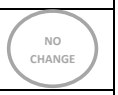
4(b). Access - Waiting Time Standards - CHS

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%	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Urgent compliance is consistently 100%. Trajectory and action plan in place to meet 95% by March 2022. It is expected that compliance will reduce before it consistently increases, due to the increased ratio of patients seen who have already breached. End of Oct position - predicted 23 off the net list position, however have exceeded this with 52 and thus exceeded the trajectory	N/A	N/A
	27.6%	36.6%	30.8%	31.9%	26.2%	20.7%			
Continence (Complete Pathway) Target is 95%	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Improvement plan in place with trajectory to increase productivity and reduce the number of patients waiting. It is expected that compliance will reduce before it consistently increases, due to the increased ratio of patients seen who have already breached. In September, the WL reduced by 261 pts (compared to the month before) The WL is at its lowest since December 2020 We have seen a month on month increase in assessments completed since January 2020	N/A	N/A
	13.6%	40.6%	33.7%	44.0%	50.1%	46.0%			

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%		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-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.		
		33.3%	0.0%	30.0%	50.0%	100.0%	85.7%		Over the series of data points being measured, key standards are being delivered inconsistently	
CAMHS Eating Disorder – four weeks (complete pathway) Target is 95%		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-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.		
		50.0%	33.3%	42.9%	22.2%	30.0%	42.9%		Over the series of data points being measured, key standards are being delivered inconsistently	
Children and Young People's Access – four weeks (incomplete pathway) Target is 92%		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	The service are now consistently meeting this target		
		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%		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	The KPI is now being met following a sustained effort by the team to get the waiting list into the ideal number range. The service has increased the available slots in the third quarter to meet the expected surge of referrals when schools go back		
		69.3%	71.5%	74.8%	89.2%	100.0%	100.0%		Over the series of data points being measured, key standards are being delivered inconsistently	
Aspergers - 18 weeks (complete pathway)	Wait for Treatment	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-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
		93.1%	97.9%	100.0%	92.9%	93.8%	100.0%			
	No. of Referrals	42	68	30	63	45	57			
LD Community - 8 weeks (complete pathway)	Wait for Assessment	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21		N/A	N/A
		91.4%	87.5%	89.2%	89.1%	88.3%	81.0%			
	No. of Referrals	97	112	126	118	97	143			

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	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	92 weeks	The CBT improvement plan remains effective in supporting the number of 52 week waiters to fall.	NO	DOWN
	45	38	47	36	27	23			Key standards are not being delivered but are improving	
Dynamic Psychotherapy	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	116 weeks	The number of 52 week waiters are 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
	23	20	19	13	13	14			Key standards are not being delivered but are improving	
Therapy Service for People with Personality Disorder - Treatment waiters over 52 weeks	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	218 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 December. The number of patients waiting for treatment is rising, as the service works through the assessment waiting list of over 52 week waits.	NO	UP
	214	241	325	364	380	395			Key standards are not being delivered and are deteriorating/ not improving	
Therapy Service for People with Personality Disorder - assessment waits over 52 weeks (a month in arrears)	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	135 weeks	The service has been working through the historical backlog of long waiters for assessment using focussed 'assessment weeks'. These have been effective in reducing the number of waiters over 52 weeks.	N/A	N/A
	628	660	523	502	486	403				
CAMHS	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	94 weeks	As at 4th November there were 82 waiting over a year, 28 for treatment and 54 for neuro-developmental diagnosis. This is a sustained improvement position. Both lists are performing against the expected trajectory.	NO	NO CHANGE
	250	219	218	233	192	125			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%	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-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.	?	DOWN
	79.0%	82.0%	77.7%	79.4%	78.4%	81.6%		Over the series of data points being measured, key standards are being delivered inconsistently	
Occupancy Rate - Community Beds (excluding leave) Target is >=93%	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	The Trust is below the local target rate of 93%. In October work has been done to identify the reasons for delayed discharges to LPT and now working collaboratively to ensure patients are not delayed going forwards. Extended criteria to admit patients awaiting packages of care with a start date (this may contribute to increased length of stay going forwards).	?	DOWN
	82.8%	81.1%	84.1%	80.0%	86.3%	82.2%		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.	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	The Trust consistently is below the national benchmark of 25 days.	YES	NO CHANGE
	16.6	17.7	18.2	15.7	19.7	17.8		Key standards are being consistently delivered and are improving/ maintaining performance	
Delayed Transfers of Care Target is <=3.5% across LLR	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-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.	?	DOWN
	2.7%	2.9%	1.9%	3.1%	2.5%	3.1%		Over the series of data points being measured, key standards are being delivered inconsistently	
Gatekeeping Target is >=95%	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21		?	NO CHANGE
	98.8%	100.0%	100.0%	100.0%	100.0%	100.0%		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)*	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21		N/A	N/A
	80.4%	88.1%	87.6%	79.1%	78.0%	82.6%			
Perinatal - Number and Percentage of women accessing service Target is 8.6%	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-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
	502	480	481	488	484	466		N/A	N/A
	4.0%	3.8%	3.8%	3.9%	3.9%	3.7%			

7. Quality and Safety

Target	Trust Performance	RAG/ Comments on recovery plan position	SPC Flag	
			Assurance of Meeting Target	Trend
Serious incidents	May-21: 2; Jun-21: 18; Jul-21: 8; Aug-21: 5; Sep-21: 1; Oct-21: 5		N/A	NO CHANGE
			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%	May-21: 14.3%; Jun-21: 50.0%; Jul-21: 66.5%; Aug-21: 22.2%; Sep-21: 25.0%; Oct-21: 9.0%		?	DOWN
			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	Day: May-21: 7; Jun-21: 7; Jul-21: 5; Aug-21: 5; Sep-21: 6; Oct-21: 4 Night: May-21: 0; Jun-21: 1; Jul-21: 1; Aug-21: 1; Sep-21: 1; Oct-21: 2	Kirby & Welford Ward adjust skill mix to include Medicines Administration technicians and Mental Health Practitioners. Gillivers adjusted the RN levels due to reduced occupancy. A review of Thornton and Beechwood to be included in the monthly safe staffing analysis.	NO	NO CHANGE
			Key standards are not being delivered and are not improving *SPC based on day shift*	
Care Hours per patient day	May-21: 12.3; Jun-21: 12.3; Jul-21: 12.5; Aug-21: 12.4; Sep-21: 12.2; Oct-21: 12.2		N/A	N/A
			Key standard has no target; however performance is consistent	
No. of episodes of seclusions >2hrs Target decreasing trend	May-21: 32; Jun-21: 28; Jul-21: 16; Aug-21: 7; Sep-21: 24; Oct-21: 8	Apositive shift over the past 3 months in the reduction of times being spent in seclusion. There are some outliers that are prolonged episodes, due to patients being nursed in our PICUs that are waiting for medium secure beds. Seclusion was not used in FYPC/LD in October.	N/A	NO CHANGE
			Key standard has no target; however performance is consistent	
No. of episodes of supine restraint Target decreasing trend	May-21: 4; Jun-21: 9; Jul-21: 6; Aug-21: 17; Sep-21: 14; Oct-21: 17	Side lay often gives the number of patients being given Rapid Tranquilisation under restraint and the patient needs to be put into supine before they can be moved into side lay.	N/A	NO CHANGE
			Key standard has no target; however performance is consistent	
No. of episodes of side-line restraint Target decreasing trend	May-21: 5; Jun-21: 29; Jul-21: 16; Aug-21: 13; Sep-21: 22; Oct-21: 9		N/A	NO CHANGE
			Key standard has no target; however performance is consistent	
No. of episodes of prone (unsupported) restraint Target decreasing trend	May-21: 0; Jun-21: 1; Jul-21: 0; Aug-21: 0; Sep-21: 0; Oct-21: 2	Since October 2021 all incidents of prone (both supported and unsupported) are reviewed post incident to understand the rational for use. Analysis has shown; one incident used in error by an agency nurse, another was to manage a patient who needed to be searched prior to seclusion being started. The team are working with the ward to ensure use of the safety pod to reduce this type of incident. Two incidents were to manage patients who required rapid tranquilisation and staff could not put them into side lay.	N/A	NO CHANGE
			Key standard has no target; however performance is consistent	
No. of episodes of prone (supported) restraint Target decreasing trend	May-21: 5; Jun-21: 5; Jul-21: 3; Aug-21: 2; Sep-21: 5; Oct-21: 2		N/A	DOWN
			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)		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	The Pressure Ulcer Quality Improvement (QI) Group, established in September 2020, continues to identify and deliver interventions in order to reduce the number of pressure ulcers (of any category) that develop and deteriorate in our care and importantly, to improve patient outcomes and reduce patient harm. associated with poor health.	N/A	UP
	Category 2	105	103	98	105	93	98		N/A	NO CHANGE
	Category 4	5	7	3	4	5	6		*Key standard has no target; however performance is consistent for category 2 and consistent for category 4*	
No. of repeat falls Target decreasing trend		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-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
		43	46	64	47	45	39		*Key standard has no target; however performance is consistent*	
LD Annual Health Checks completed - YTD Target is 75%		May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Year To date from 1 April 2021, 1316 AHC's completed.	N/A	N/A
		255	430	583	702	968	1316			
LeDeR Reviews completed within timeframe		May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	New LeDeR system is in place – need to redefine.	N/A	N/A
	Allocated				10	16	13		N/A	N/A
	Awaiting Allocation				16	15	11		N/A	N/A
	On Hold				16	15	6		N/A	N/A

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
	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21		?	UP
MH Data quality Maturity Index Target >=95%	91.5%	91.3%	91.0%	91.4%	92.6%	92.9%		Over the series of data points being measured, key standards are being delivered inconsistently	

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%	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	The Trust is below the ceiling set for turnover.	YES	DOWN
	8.8%	9.1%	9.1%	9.1%	9.3%	9.5%		Key standards are being consistently delivered and are improving performance	
Vacancy rate Target is <=7%	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21		NO	UP
	12.4%	12.2%	11.6%	11.5%	11.3%	11.1%		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%	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21		NO	NO CHANGE
	4.4%	4.6%	5.1%	5.3%	5.2%	5.1%		Key standards are not being delivered and are deteriorating/ not improving	
Health and Well-being Sickness Absence Costs (1 month in arrears) Target is TBC	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21		n/a	n/a
	£580,557	£639,392	£668,739	£717,582	£748,440	£709,372			
Health and Well-being Sickness Absence YTD (1 month in arrears) Target is <=4.5%	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21		n/a	n/a
	4.4%	4.5%	4.7%	4.9%	5.0%	5.0%		Not applicable for SPC as measuring cumulative data	
Agency Costs Target is <=£641,666 (NHSI national target)	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21		NO	UP
	£1,556,256	£1,919,728	£1,775,099	£1,852,385	£2,040,719	£2,639,144		Over the series of data points being measured, key standards are being delivered inconsistently	
Core Mandatory Training Compliance for substantive staff Target is >=85%	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	The Trust is meeting the target set for Core Mandatory Training.	YES	UP
	94.6%	94.2%	92.5%	92.0%	92.6%	92.9%		Key standards are being consistently delivered and are improving/ maintaining performance	
Staff with a Completed Annual Appraisal Target is >=80%	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21		YES	DOWN
	89.5%	89.9%	85.2%	84.8%	83.2%	78.2%		Key standards are being delivered but are deteriorating	
% of staff from a BME background Target is >= 22.5%	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	The Trust is meeting the target set.	?	UP
	23.7%	23.7%	23.9%	24.1%	24.0%	24.0%		Over the series of data points being measured, key standards are being delivered inconsistently	
Staff flu vaccination rate (frontline healthcare workers) Target is >= 80%	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21		n/a	n/a
						31.9%			
% of staff who have undertaken clinical supervision within the last 3 months Target is >=85%	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21		NO	NO CHANGE
	88.1%	85.4%	75.9%	69.1%	75.7%	77.3%		Key standards are not being delivered and are deteriorating/ not improving	
Health and Wellbeing Activity - Number of LLR staff contacting the hub in the reporting period (1 month in arrears)	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21		N/A	N/A
	135	148	240	1080	130	139			

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 – October 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
C Diff
STEIS action plans completed within timescales
Agency Cost
C Occupancy rate – community beds (excluding leave)
% of staff from a BME background
MH Data Quality Maturity Index

Key standards not being delivered but improving

Dynamic Psychotherapy over 52 weeks
Cognitive Behavioural Therapy over 52 weeks

Key standards not being delivered but deteriorating/ not improving

C Adult CMHT Access six week routine (incomplete)
Safe Staffing
Personality Disorder over 52 weeks
CAMHS over 52 weeks
Vacancy rate
% of staff who have undertaken clinical supervision within the last 3 months
Sickness Absence

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
Admissions to adult facilities of patients under 16 years old

Governance table

For Board and Board Committees:	Trust Board	
Paper sponsored by:	Sharon Murphy - Interim Director of Finance and Performance	
Paper authored by:	Information Team	
Date submitted:	10/12/2021	
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:		

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Leicestershire Partnership NHS Trust

TRUST BOARD – 21 December 2021

AUDIT AND ASSURANCE COMMITTEE held 3 December 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 Ref
Internal Audit Progress Report	**High**	The committee was assured on the progress being made on the 2021/22 plan. The follow up rate was now at 89% for 2020/21 which is an increase since the last meeting.	62,70 & 71*
External Audit Progress Report	**High**	Since the last Committee meeting, external audit have had meetings with the finance team to discuss what went well with the 2020/21 audit and what could be done to improve the process. A plan for the 2021/22 external audit planning will be presented the next AAC.	62,70 & 71*
Counter Fraud Progress Report	**High**	The Committee received the progress report and noted progress.	62,70 & 71*
Counter Fraud, Bribery and Corruption Policy	**High**	The Committee received and approved the policy.	62*
Risk Management Arrangements	**High**	The Committee received an update on risk management arrangements which included; • The ORR has been refreshed • The risk appetite has been refreshed based on the updated metrix provided by the Governance Institute. • Tolerance levels have been introduced to support risks. • A new module has been introduced within Ulysses to support component 3 of the counter fraud risk assessment.	62*

Report	Assurance level*	Committee escalation	ORR Risk Ref
Risk Management Policy	**High**	The Committee received and approved the Risk Management Policy	62*
Legal and Regulatory Issues	**High**	The Committee noted two legal and regulatory issues which were; • Risk around being prepared around the national public enquiry for the Covid pandemic. • The CQC Community Survey for 2021 giving a low assurance on the way LPT is performing.	62*
Internal and External Audit Actions	**High**	The first follow up implementation rate for internal audit is currently 89%, which shows an increase. It was noted that only two outstanding actions were now O/s from first follow up. For external audit actions, the ISA 260 report for 2020/21 made seven recommendations; of these four have been implemented and three are ongoing. The committee was assured on the progress being made on the internal and external audit actions.	62,70 & 71*
Freedom to Speak Update	**High**	Annual assurance review of the freedom to speak up process. The Committee was assured that freedom to speak up is embedded, working and fully supported within the Trust.	62*
Financial Waivers	**High**	The Committee was assured with the position of financial waivers.	62,70 & 71*
CE Waiver Process Proposed Changes	**High**	It is proposed that certain areas of spend that do not necessarily require a CE waiver are covered by a shorter, less onerous form to ensure that the spend is still recorded and monitored by the procurement team and ultimately the Trust. The Committee approved the proposed changes.	62,70 & 71*
Annual Financial Accounts Timetable	**High**	The Committee was asked for approval on three key areas where changes have been made or a different approach has been proposed. The first recommendation was for the Committee to agree to the proposed 2021/22 land and buildings revaluation exercise and the deferral of hypothetical building valuations to 2022/23. The second recommendation was to support the accounting treatment process being undertaken for capital IT/digitisation investments. The third recommendation was to support the approach in this year's accounts for the asset verification exercise. The Committee was assured and supported all the	62,70 & 71*

Report	Assurance level*	Committee escalation	ORR Risk Ref
		recommendations except for the accounting treatment in relation to the TIF Funding, which had yet to be finalized.	
Treasury Management Policy & Bank Mandates	**High**	The Committee received and approved the policy and mandates.	62,70 & 71*
Chairs of QAC / FPC updates on key issues	**High**	The Committee was fully assured by updates provided by FPC and QAC chairs.	62,70 & 71*
Auditor Panel Update	**High**	The Committee received an update on the progress of the auditor panel. After a competitive process, KPMG have been awarded the contract as our external auditors.	62
In-depth review of topic - CQC Inspection Report Follow up Process	**High**	This paper outlines the key findings of the CQC Well Led and Core inspection completed over May / June and July 2021 and the follow up activities to be undertaken. The report has been to QAC and was fully supported as a robust process. The Committee was assured and noted the follow up process for items highlighted by the CQC.	62,70 & 71*

***principal risk(s) shown but will also cover other risk on ORR**

Chair	**Darren Hickman**