Leicestershire Partnership NHS Trust

Public Meeting of the Trust Board
25th January 2022 9.30am
Microsoft Teams

Agenda

Time		Item	Paper	Lead
9.30	1.	Apologies for absence and welcome to meeting: The Trust Board Members	A	Chair
9.35	2.	Patient voice film – Community Health Services	Verbal	Sam Leak
9.40	3.	Staff voice – Community Health Services	verbal	Sam Leak
9.55	4.	Declarations of interest in respect of items on the agenda	verbal	Chair
	5.	Minutes of the previous public meeting 21st December 2021	B	Chair
	6.	Matters Arising	C	Chair
	7.	Chair's Report	D	Chair
	8.	Chief Executive's Report	Verbal	Angela Hillery
Governance and Risk				
10.05	9.	Organisational Risk Register	E	Chris Oakes
Strategy and System Working				
10.15	10.	Service Presentation – Community Health Services – Coping With Covid Pressures	F	Sam Leak
10.25	11.	Group Update and Joint Working Group Highlight Report • Group Terms of Reference	G	Chris Oakes
10.30	12.	Step Up To Great Strategy Refresh	H	David Williams
10.35	13.	Break		
10.40	14.	NHS Net Zero Green Plan Approval	I	Mark Powell
Quality Improvement and Compliance				
10.50	15.	CQC Update	J	Anne Scott
10.55	16.	Patient Safety Incident and Serious Incident Learning Assurance Report	K	Anne Scott
11.00	17.	Safe Staffing Monthly Review – November 2021	Li	Anne Scott
	18.	Safe Staffing Monthly Review – December 2021 – Interim Report	Lii	Anne Scott
Performance and Assurance				

11.05	19.	Finance Monthly Report – Month 9	M	Sharon Murphy
11.15	20.	Performance Report – Month 9	N	Sharon Murphy
11.20	21.	Charitable Funds Committee Highlight Report – 14th December 2021	O	Cathy Ellis
11.25	22.	Review of risk – any further risks as a result of board discussion?	verbal	Chair
	23.	Any other urgent business	verbal	Chair
	24.	Papers/updates not received in line with the work plan: NA	verbal	Chair
	25.	Public questions on agenda items	verbal	Chair
11.30	26.	**Next public meeting: 29th March 2022 Microsoft Teams**		Chair

Our Trust Board

As of January 2022

NHS
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 Paterson
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

Leicestershire Partnership NHS Trust

Minutes of the Public Meeting of the Trust Board
21st December 2021 9.30 am - Microsoft Teams Live Stream

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

In Attendance:

Mr Richard Wheeler Chief Finance Officer
Ms Sam Leak Director of Community Health Services
Mrs Fiona Myers Director of Mental Health
Mrs Sarah Willis Director of Human Resources & Organisational Development
Mr Chris Oakes Director of Governance and Risk
Mr David Williams Director of Strategy and Business Development
Mr Mark Farmer Healthwatch
Mrs Kay Rippin Corporate Affairs Manager (Minutes)

TB/21/161	**Apologies for absence:** Ms Helen Thompson Director Families, Young People & Children Services & Learning Disability Services, Kate Dyer Deputy Director of Governance and Risk. **Welcome to meeting:** John Edwards – Paper H, Pauline Lewitt – Paper Q, Kevin Paterson (observing); Pradeep Khuti (observing) and Asha Day (observing) **Staff Voice:** Emma Day – Team Manager Individual Placement and Support service and Therapy services for people with personality disorder, Peter Smith – Team Lead for Employment and Support Services, Charlotte Yates - Employment support specialist. The Trust Board Members – Paper A The chair confirmed that public questions would be heard at the end of the meeting. Due to the level 4 national incident all papers will be taken as read during this meeting with focus on the 6 priority areas: 1) Covid-19 2) Quality and Safety 3) Health and Wellbeing of Staff 4) Risk 5) Finance and Impacts on Performance 6) Statutory requirements.
TB/21/162	Patient voice film – Adult Mental Health - Getting Into Employment – a film was shown – Erin's story – a service user since aged 15 now receiving support from the employment support service to get into work. With LPT's support and a wellness action plan Erin has now been offered a role with LPT as a peer support worker starting in January 2022, supporting her recovery and moving her life forward.
TB/21/163	Staff voice – Adult Mental Health - Employment Services - Emma Day – Team Manager Individual Placement and Support service and Therapy services for people with personality disorder, Peter Smith – Team Lead for Employment and Support Services, Charlotte Yates - Employment support specialist delivered a PowerPoint presentation which will be shared after the meeting with Trust Board members and

	on the Trust's website. The service use a research based model offering individual placement support which is recovery orientated, person centred and needs led. The team is increasing in size and makes a real difference to people's lives – gaining employment is a key predictor of good outcomes for service users. In November alone 18 service users were starting work which is a total of 66 since April. Faisal Hussain asked how successful the work in partnership with other agencies has been and the team described the journey with a steering group whose membership is growing. Angela Hillery praised the team for their compassion and commented that this was a good example of partnership working and this could be shared more widely within the ICS. It was important to see the fidelity to the programme.
TB/21/164	Patient Voice – People's Council and Health Watch Report – Paper B – Mark Farmer presented Paper B confirming that the People's Council met again last night with Angela Hillery in attendance. The group plan to offer a focus on assurance moving forward, ensuring the patient carer voice is heard – especially during the period of this level 4 incident where groups are standing down.
TB/21/165	Declarations of interest in respect of items on the agenda – Verbal – no declarations.
TB/21/166	Minutes of the previous public meeting: 26th October 2021 – Paper C **Resolved:** The minutes were approved as an accurate record of the meeting.
TB/21/167	Action Log & Matters arising – Paper D **Resolved:** The action log was agreed and the complete items approved to be closed.
TB/21/168	Chair's Report – Paper E – The Chair presented the report which was taken as read – it showcases excellent innovation across the Trust and great work in the area of diversity and inclusion and health inequalities. The chair thanked Kevin Harris for all his work in the Trust and wishes him well in his retirement from LPT
TB/21/169	Chief Executive's Report – Paper F – Angela Hillery presented the report which was taken as read. All staff were thanked for their continued hard work in this pressured situation as the omicron transmission rates present a significant risk for staff absences. The ICC is now operating 7 days a week and there has been a call to action to support the vaccination programme. Mark Farmer commented that the patient and carer voice needs continued involvement during this period and it was confirmed that the patient and carer voice is embedded within the levels of ICS governance and we will continue to ensure that this remains robust.
TB/21/170	Governance Arrangements – Additional Paper – this paper was circulated and uploaded to the public website yesterday in response to the Level 4 incident. Chris Oakes presented the paper confirming that there will be a stepping down of some level 2 and 3 committees and groups during this level 4 incident to free up time for operational work. Level 1 committees will remain and will focus on the 6 priority areas -1) Covid-19 2) Quality and Safety 3) Health and Wellbeing of Staff 4) Risk 5) Finance and Impacts on Performance 6) Statutory requirements. Level 2 and 3 committees and groups will step down apart from some level 2s that will need to continue with essential business. The ICC will work 7 days a week. Executive Boards and Strategic Gold meetings will continue. This will ensure that agile, robust plans are in place for governance. Mark Farmer commented that the patient and carer voice needs continued involvement during this period, in particular where patients/carers are represented at meetings of level 2 and 3 committees. Chris Oakes confirmed that the patient and carer voice is embedded within the levels of ICS governance and the escalation of significant matters will apply**Resolved:** The Trust Board supported the approach detailed in the paper.
TB/21/171	Organisational Risk Register – Paper G – Chris Oakes presented the paper which describes the in depth review process that has taken place in the Board development session on 23rd November and 1:1 with Executives. The ORR has been through the QAC and FPC meetings and is now at Trust Board for consideration.

	Darren Hickman commented that some of the staffing risk tolerance levels are quite high and Chris Oakes explained that this reflects the risk the Trust are willing to take to ensure that the workforce is in place – it relates to levels of innovation for example. This risk remains dynamic and managing it will change depending on needs. This is considered daily in the ICC. Angela Hillery added that system discussions around staffing are agile and processes are robust to ensure the risk remains mitigated. Sarah Willis added that the ICC move staff to the locations where they are needed most to keep services running. The Chair added that staffing risks were considered extensively at the Trust Board development session deep dive held in November. Ruth Marchington commented that the level of maturity of the ORR was evident and it is clear if actions are having an impact on controls and gaps in controls. Risk 72 shows a gap in control and no action to address this and David Williams commented that work is ongoing around data quality in the Data Quality Committee and this is also discussed in department meetings to support improvements. The Chair suggested that the risk sore for risk 70 (financial position) was high given the level of controls in place as evidenced by the year end external / internal audits and this could be considered further moving forward. **Resolved:** The Trust Board received the report for assurance.
TB/21/172	Step Up To Great (SUTG) MH Business Plan –Paper H – Fiona Myers confirmed that this was the outcome of the recent consultation which had been approved by the CCG governing body on 14th December 2021. John Edwards confirmed that a staff engagement event took place on 15th December attended by over 100 staff and this was very positive. David Williams added that the voluntary and community sector have been involved in the process throughout and this is a great example of Reaching out within the Step Up To Great Strategy. Angela Hillery thanked all staff involved in this piece of work and specifically thanked John for his leadership commenting that it is a strong mandate from our population which we need to use well. Mark Farmer asked how patients and carers will be involved in the implementation phase and if flexibility in approach will be maintained throughout. John Edwards confirmed that co-design continues to be key and the consultation included a rich diversity of views and experiences. Flexibility in the model was agreed at the consultation – one size does not fit all and flexibility is paramount. Faisal Hussain asked how the communities who may not have been reached will contribute and John Edwards confirmed that through the voluntary and community groups including faith groups the reach was wide but work will continue to reach others such as the travelling community who may have been under represented. **Resolved:** The Trust Board supported the SUTG MH Business Plan.
TB/21/173	Quality Assurance Committee Highlight Report 30th November 2021 – Paper I – Moira Ingham presented the report confirming that whilst there are medium assurance items contained in the repots, the committee had high assurance over the grip in these areas and will continue to receive updates at future meetings. All areas of risk are highlighted and are identified on the ORR. **Resolved:** The Trust Board Received assurance from the report.
TB/21/174	CQC inspection report and action plan – Paper J – Anne Scott presented the report noting that key findings of inspections and action plans including the must do action plan are detailed within the report. There is a robust governance process with clearly identified areas for improvement. The Chair noted the number of amber rated must dos due for the 31st January and Anne Scott confirmed that these are amber until there is evidence of embeddedness and the next report will detail this more clearly. Fiona Myers added that audits are being carried out over the next 6 weeks to evidence embeddedness in the 3 core services that were inspected.. **Resolved:** The Trust Board received the report for assurance.

TB/21/175	Infection Prevention & Control (IPC) 6 Monthly Report – Paper K – Anne Scott presented the report detailing a robust, effective and proactive IPC strategy. There have been 6 covid outbreaks between July and November 2021 all have been well managed, 2 identified as serious incidents (SIs) and initial learning has been shared. The staff flu vaccination rate is currently at 56% and the covid booster vaccination is being delivered within this vaccination programme. The Flu Group continues to have oversight. The Water Management Group have oversight of the legionella issues at the Bradgate Unit and Coalville hospital where immediate action was taken. The Chair enquired about the podiatry decontamination issue, Anne Scott advised that within podiatry this is being overseen by the IPC committee, at directorate level and in executive boards and will be subject to an SI investigation with quick responses, alternative methods of treatment and actions in place. **Resolved:** The Trust Board received the report for assurance.
TB/21/176	Patient Safety Incident and Serious Incident Learning Assurance Report – Paper L – Anne Scott presented confirming that compliance in the SI investigations remains variable, all directorates are working hard on improvements and the Quality Assurance Committee (QAC) is well sighted on the matter. A quality summit on SIs is planned for the new year. There has been an increased in category 4 pressure ulcers and 4 work streams have been developed to address this and a quality summit has been held. There has been a decrease in falls particularly in MHSOP and Mill Lodge services. The LLR Suicide Prevention Group is leading on work around the increased numbers of suicides during October 2021. QAC continues to monitor issues around violence and aggression. Moira Ingham asked if the 8 new SI investigators present the opportunity to look at how learning is shared across the Trust and Anne Scott confirmed that this would be part of their role, to ensure learning is both robust and embedded. The Chair asked about the pace of backlog investigations with the new team, Anne Scott advised that the investigators will be taking on new cases (not backlog cases). **Resolved:** The Trust Board received the report for assurance.
TB/21/177	Learning from Deaths Q2 Report – Paper M – Avinash Hiremath presented the report which describes the processes in place for gathering information and how this information is processed and shared. There are no significant changes in trends reported. The Chair requested that more demographic information will be included in the report from next year. **Resolved:** The Trust Board received the report for assurance.
TB/21/178	Patient and Carer Experience, Involvement and Complaints Quarter 2 Report – Paper N – Anne Scott presented the report which is an overview and update of quarter 2 where there has been a slight increase in complaints. The working day response is reducing from 45 to 35 for quarter 3 and this will be overseen at the Quality Forum and QAC. Compliments have also been received and good news stories are shared in the report. Mark Farmer asked how learning from complaints is shared to avoid repetition and how this is measured and monitored and Anne Scott confirmed that the Complaints Group monitor this and have representatives from all directorates attend and invited Mark Farmer to attend the group to visit. The Chair asked about the increased number of complaints around district nursing services, Anne Scott advised that was directly linked to staffing levels and quality summit had been held in November and a robust plan is in place to address this. **Resolved:** The Trust Board received the report for assurance.
TB/21/179	Safe Staffing Monthly Report – Paper O – Anne Scott presented the paper which contains the October report and a briefing for November. The full November report will come to the January Trust Board meeting. Areas to note in November are detailed within the paper and include both community and inpatients. The Chair noted that in the October report nearly all wards were meeting the exception criteria and asked if there were plans to do things differently and Anne

	Scott confirmed that daily safe staffing meetings take place to have dynamic risk assessments of these areas. Ruth Marchington asked if there was a tipping point to escalate to the system and asked if there was an ambition to reduce the use of agency staff at some point. Anne Scott confirmed that tipping points can vary on a daily basis and she is in regular contact with regional and local chief nurses. The ORR is updated regularly and we have robust and resilient staff and innovative thinking which helps to manage the situation well. Agency staff are a core group, often block booked to ensure consistency. There are high levels of both supervision and training that they adhere to. The Chair noted the importance to ensure the staff are supported to stay well and resilient. Angela Hillery commented that it is important that the Trust Board are clear that this is a system position and cannot be solved by LPT alone. Safety huddles are an important feature of how we work with clear risk escalation. Faisal asked how we mitigate when agency staff cannot be used e.g. for specialised areas and Anne Scott confirmed that this is managed on a risk based approach by prioritising and wrapping around teams. Sam Leak confirmed that tissue viability nurses have been supported in this way by podiatry, allowing them to focus on their specialised areas. **Resolved:** The Trust Board note the position and received assurance from the report.
TB/21/180	BAF Winter 2021 preparedness: Nursing and midwifery safer staffing - Paper P – Anne Scott presented this overview of the Trust's self-assessment, key actions have been reviewed and there are 4 areas which require further action – this will be monitored through the Strategic Workforce group (who will continue to meet in a condensed format during the level 4 incident period) and the governance structure. **Resolved:** The Trust Board received assurance from the report.
TB/21/181	Freedom To Speak Up Guardian 6 Month Report – Paper Q – Pauline Lewitt presented the report and outlined that the self-assessment had been considered by the board at their November development meeting. Pauline Lewitt confirmed that guidance on self-assessment gap analysis was released yesterday and so the report is to be updated accordingly. The FTSUG has had input into quality summits supporting triangulation and quarterly meetings continue to take place with Angela Hillery, Darren Hickman and the Chair. Angela Hillery thanked the FTSU champions and staff for speaking up which is important for a healthy culture. **Resolved:** The Trust Board received assurance from the report and noted the strategy to be developed moving forward.
TB/21/182	Finance and Performance Committee Highlight Report – 30th November 2021 – Paper R – Faisal Hussain presented the report confirming where there are medium assurance levels there is grip with clear systems and processes in place. These areas will continue to be monitored. A national issue around suppliers is an emerging risk for estates and procurement of IT and FPC will continue to monitor this. **Resolved:** The report was received for assurance.
TB/21/183	Finance Monthly Report – Month 8 – Paper S – Sharon Murphy presented this report confirming that the current revenue year end forecast is break even. There has been slippage on investment and mitigations are being managed as a system. There is a recurrence of income received at short notice and mitigations to manage this are in place. Agency costs remain a risk factor, this month the vacancy rate has decreased but sickness absence remains an issue. Agency staff are often used to cover sickness so we would expect an improved underlying position next year. Capital remains in a volatile position with one third of the plan spent to date. This feeds into the scoring for risk 70 that was mentioned earlier by the Chair. The laptop replacement programme has been brought forward into this year because of procurement lead times and the ability to use capital. 22/23 financial planning

	guidance is expected this week and work with system partners continues in this regard. Moira Ingham asked if there was any leverage available to carry over late allocated monies from Health Education England and Sharon Murphy confirmed that all work possible was being done around this. The Chair noted the significant agency growth and asked what work was being done to convert agency staff into bank or permanent LPT team members. Sarah Willis confirmed that there is a regular call out to recruit substantially, posters on wards, initiatives offered etc... This staff group are our flexible work force and it is a competitive market and personal choice. Resolved: The Trust Board received the report for assurance.
TB/21/184	Performance Report – Month 7 – Paper T – Sharon Murphy presented the report which is month 7. Month 8 report had missed the paper deadline, a key theme from the month 8 report continues to be waiting times and an increase in long waits – this continues to be reviewed and monitored by directorates. Performance review meetings continue to monitor waiting time trajectories; how this is undertaken during the revised governance arrangements will be agreed. **Resolved:** The Trust Board received the report for assurance.
TB/21/185	Audit and Assurance Committee Highlight Report – 3rd December 2021 – Paper U – Darren Hickman presented the report confirming all items received high assurance. **Resolved:** The Trust Board received the report for assurance.
TB/21/186	Review of risk – any further risks as a result of board discussion? Darren Hickman stated that the level 4 incident and omicron variant is an emergent risk as discussed throughout the meeting – with staffing risk key. Is there a further risk arising from the mandatory vaccines for NHS staff? This will be closely monitored through executive team meetings and brought back to Trust Board as needed.
TB/21/187	Any other urgent business – no other business raised.
TB/21/188	Papers/updates not received in line with the work plan: All items received.
TB/21/189	Public questions on agenda items: (1) Do you think there should be regular mental health check-up appointments to help diagnose mental health issues in early stages because some people will not even recognise that they are suffering from mental health problems until the doctor has told them? (anon) Answer - Fiona Myers confirmed that we would like to increase awareness of the public on mental health (alongside Public health initiatives) and would expect them to talk to friends, family and if needed their GP surgery. Promoting raising concerns to your GP at other routine health check-ups and screening programmes is important. Most mild mental health matters can be managed in primary care and if not, they will be referred to secondary care and we will be happy to assess. Screening the population for mental health wellbeing is not in place though we have other measures for example like supporting postnatal mums and those who are pregnant, and also dads. Children can raise concerns to teachers or FYPC have school nurses and teachers who have basic awareness to recognise where a child may be struggling with mental health or emotional issues. Social care colleagues and other agencies are trained in mental health first aid, which includes recognising some of the symptoms and signs of mental health issues in colleagues and people they work with. This training has also been promoted to employers with larger numbers of staff. There are also many voluntary agencies that we work alongside who can also help and we plan to do this even more with our step up to great strategy. (2) I'd very much like to ask a question....I'd like to know who…I can contact to arrange a covid vaccine for my 15 year old daughter who cannot attend busy clinics? She hasn't been contacted by anyone… (she is) vaccine hesitant, but

	hasn't been invited for one, nor even been able to access centres when enquiring due to unmet needs? (Name supplied) Answer – The Chair confirmed that the mother was contacted yesterday and her daughter was vaccinated in her own car at an LPT vaccination centre and this was a very positive outcome.

C

Leicestershire Partnership NHS Trust

TRUST BOARD 25th January 2022

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)
948					

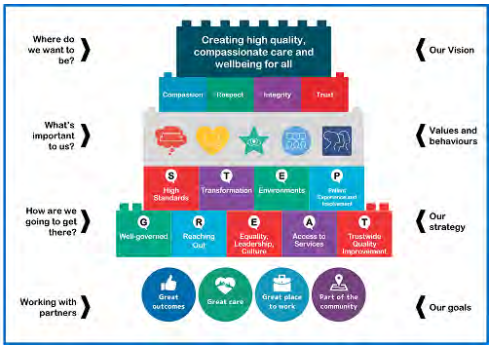
D

Leicestershire Partnership NHS Trust

Trust Board – 25th January 2022 – Chair's report

Purpose of the report

Chairs report for information and accountability, summarising activities and key events From 21st December 2021 to 25th January 2022



Hearing the patient and staff voice	• The Chair and Non-Execs Boardwalks are currently postponed to minimise the risk of community transmission of the covid-19 virus onto our wards.
Promoting Equality Leadership & Culture	• Together Against Racism : Joined the BAME network refection event to follow up on the John Ameci masterclass • As the Health & Wellbeing Guardian (HWBG), I continue to promote Wellbeing Wednesdays with my weekly blog and have connected with the Midlands Region HWBG network. We continue to prioritise staff wellbeing in LPT.
Building strong Stakeholder relationships	• Focus on Covid19, vaccination delivery and waiting times recovery through NHS England & Improvement (NHSEI) Regional Director calls with Midlands and LLR Chairs • Attended LLR Integrated Care Board (ICB)meeting to focus on current operational priorities for the ICS • Part of the interview panel for the ICB Non-Executive appointments into 4 new roles for Audit, Quality, Health Inequalities and People. • Chaired the monthly LLR ICS Finance Committee meetings focusing on future revenue spend, capital programme and key risks. • 1:1 stakeholder meetings with John MacDonald Chair of UHL, David Sissling Chair of LLR ICS, Mark Farmer Chair of LPT's Peoples Council
Good Governance	• Chaired the interview panel for a Consultant Psychiatrist in CAMHS
Non-Executive Directors (NED)	• New guidance on NED champion roles was published by NHSEI in December 2021. This is being reviewed and implemented through our governance structure. The proposed roles will be formally recommended to the Board for approval in March 2022.

Governance table

For Board and Board Committees:	Trust Board 25.1.22	
Paper sponsored by:	Cathy Ellis	
Paper authored by:	Cathy Ellis	
Date submitted:	18 January 2022	
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
	Reaching out	X
	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	

E

Trust Board – 25 January 2022

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

The Trust has implemented a number of interim arrangements for key meetings and forums within the Trust governance structure, and a number of measures to reduce the burden of reporting and release capacity to manage the COVID-19 pandemic in response to the new variant of COVID-19 and the level 4 status. The ORR has been updated to reflect any significant changes; this month there has been an increase in two current risk scores for risks 59 and 62 from 12 to 16 as detailed below.

There are 21 risks on the refreshed ORR. Of these, 11 (52%) have a high current risk score.

January 2022

There have been several key changes this month;

- Risk 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'

  The risk score has changed from 12 to 16 to reflect the staffing pressures, this risk will remain under ongoing oversight at the Incident Oversight Group which has not been paused under the interim governance arrangements due to the critical nature of its work programme.

- Risk 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'.

  This risk has been reviewed in light of the impact of staffing pressures on key deliverables such as mandatory training. The risk score has increased from 12 to 16. The risk appetite for this risk is between 9-11. This risk will continue to be monitored closely by the Quality Forum.

- The Public Inquiry Programme Board. This programme of activity is currently on pause during the omicron wave of the COVID-19 pandemic. This may impact on the timescales for the delivery of actions. The current risk score is 12, and the tolerance for this risk is between 9-11. The Trust is therefore tolerating a slight increase over its appetite for this risk during the next two months. This will be reviewed in February 2022.

ORR risks (at 18 January 2022)

No.	Title	SU2G	Initial risk	Current risk	Residual Risk	Tolerance
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 Standards	12	12	8	16-20

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 Standards	12	12	8	16-20
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 Standards	12	16	8	16-20
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 Standards	16	16	**12**	16-20
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 Standards / Equality, Leadership, Culture	16	16	12	16-20
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 Standards	12	16	8	9-11
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.	High Standards / Equality, Leadership, Culture	12	12	8	16-20
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.	Transformation	12	12	9	9-11
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.	Environments	16	16	12	16-20
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.	Environments	12	12	8	16-20
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.	Environments	12	12	9	9-11
68	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.	Well Governed	16	16	12	9-11
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 Governed	8	8	4	9-11
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 Governed	15	15	10	9-11
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.	Well Governed	15	15	10	9-11
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.	Reaching Out	16	16	12	16-20
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	12	12	9	16-20
74	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.	Equality, Leadership and Culture	9	9	6	16-20
75	Increasing numbers of patients on waiting lists and increasing	Access to	16	16	8	16-20

	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.	Services				
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.	High Standards	20	20	15	16-20
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.	Well Governed	12	12	8	9-11

Proposal

- On-going refinement and maintenance of the ORR
- On-going horizon scanning

Decision required

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

Leicestershire Partnership NHS Trust

Governance Table

For Board and Board Committees:	Trust Board 25 January 2022	
Paper sponsored by:	Chris Oakes, Director of Governance and Risk	
Paper authored by:	Kate Dyer, Deputy Director of Governance and Risk	
Date submitted:	18 January 2022	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	None	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Regular	
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	15/01/22
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 local clinical 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 for CHS. Recruitment in progress.	Amber
	Mar 22	Delivery of CQC Must Do actions	DR	• CQC action plan in place and in delivery phase.	
	Jan 22	Develop year long programme for the review of current structures to ensure integration	DR	• Initial review initiated.	

Risk No: 58	Date included	29 November 2021	Date revised	12/01/22		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	• 2021 -2023 work programme to be implemented	All - Safeguarding Dept	• Work programme approved safeguarding committee • Action from external review on track	Amber
	Mar 22 Feb 22	• Implement and embed recommendations from the external review. • Training capacity and offer to be reviewed		• The training offer reintroduces face to face training from January 2022. This is blended with e-learning.	

Risk No: 59	Date included	29 November 2021	Date revised	17/01/22				
Objective: S	High Standards							
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							
Risk owner:	Exec: Director of Nursing, AHPs and Quality and Operational Executive Directors		Local: Head of Patient Safety					
Governance:	IOG, Quality Forum, 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:	• Centralised SI reporting and oversight process • Incident reporting policy • Additional SI investigators recruited for newly reported SI's • Governance arrangements for escalation			
	Gaps:	• Directorate staff capacity for reviewing reported incidents and undertaking SI investigations from the backlog. See staffing vacancies risk 60 and the impact of covid on staffing risk 74. • Implementation of identified actions resulting from SI investigations			
Assurances	Internal:	Source: • Incident Oversight Group (IOG) • Quality Forum • Quality Assurance Committee • Incident Review Meeting (IRM) • Operational risk 4620 managed at IOG	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 • IRM to determine an SI		Assurance Rating Amber
	External:	Source: • CQC Inspection 2021 • CCG sign off and feedback for SI reporting	Evidence: • CQC feedback The trust must ensure that managers review incident in a timely way, in line with trust policy. (Reg17 (1)) • CCG – number of reports signed off / number returned for additional work		Assurance Rating Amber
	Gaps:	• Internal assurance / evidence to demonstrate learning			

Actions	Date: Feb 22 Jan 22 Ongoing	Actions: Quality Summit focussing on SI investigation process Delivery of CQC actions –must do 16 Incident investigation training monthly rolling programme	Owner: A.Scott F.Myers/ Michelle Churchard T.Ward	Progress: Planned 3 Feb 2022 CQC action plan agreed and monitored, see risk 60 Directorate training in place	Status Amber

Risk No: 60	Date included	29 November 2021	Date revised	06/01/22		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:	LPT controls • 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	**System Controls in response to increased sickness levels due to covid (6 Jan 22)** • Each organisation has risk assessed staffing • Implemented escalation & mitigation plans • NHSE&I – winter assurance plans completed • Origination Accountable Officers Letter – about positive risk taking • NMC & Four Chief Nursing Officer letter to all registrants – acknowledging the current risks • System Workforce Cell • Workforce Sharing Agreement • Chief Nurses and Deputies regular communication • System escalation for Clinical Executive • System discussion and joint decision making prior to significant derogation from NQB staffing levels/ skill mix
	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: Daily safe staffing huddle 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 Trust wide local induction checklist for bank and agency staff	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
	External:	• The Department of Health and Social Care's group annual governance statement – NHSI • CQC Inspection 2021	• Noted in the organisational risk and monthly reporting.
	Gaps:		

Actions	Date:	Actions:	Action Owner:	Progress:	Status
	Jan 22	• Proposal for super enhancing recruitment and attraction campaign	John Edwards	Ongoing	Amber
	Jan 22	• All age MH standard recruitment to working planning capacity	Elaine Curtin	Policy drafted, under consultation	
	Jan 22	• To develop a Trust wide safe staffing policy	Louise Evans	Task and finish group set up	
	Jan 22	• Consideration of staff redeployment from low priority areas to support safe staffing	ICC		
	Mar 23	• Recruit additional 44 international nurses	Emma Wallis		

Risk No: 61	Date included	29 November 2021	Date revised	17/01/22		Consequence	Likelihood	Combined
Objective: S	High Standards and Equality, Leadership, Culture				Current Risk	4	4	16
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.				Residual Risk	4	3	12
Risk owner:	Exec: Director of Nursing, AHPs and Quality and Director of HR & OD		Local: Head of Education, Training and Development		Tolerance level Significant 16-20 (Appetite Quality-Seek)			
Governance:	SWC, QAC / Board - Monthly Review							

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 / E rostering in place across inpatient services and community • On-going recruitment programme		
	Gaps:	• National tools to measure therapy staffing for patient acuity and dependency • Low compliance to ILS and BLS mandatory training		
Assurances	Internal:	Source: • SWC , Directorate Workforce groups , retention working group • Quarterly workforce triangulation to ops exec - hotspots and 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:	• NHS retention support and benchmarking data		Assurance Rating Green
	Gaps:			

Actions	Date:	Actions:	Action Owner:	Progress	Status
	Jan 22	1. New process for amending compliance requirements to position numbers	Head of Education Training/Dev	Since previous month -improvement seen in resus courses by 2-3%, drop in compliance with MAPA course by 2-3 %	Amber
	Jan 22	2. Remove 6 month topic refresher extension from 1st January		Overall Trust position for all mandatory topics (including e-learning) remains good	
	Jan 22	3. Recovery of Mandatory Training compliance action log reported to Training Education and Development Group monthly		Received at ops exec and actions underway	
	Dec 21	4. Manager compliance and DNA reports live on ulearn	Amrik Singh / Emma Wallis	Underway – current progress remains static – no change from last month (17/01/2022)	
	March 22	5. Pilot safe care and review establishment	A Scott		
		6. Implementation of bespoke training days for Bank staff to complete BLS and mandatory training compliance	Emma Wallis		
		7. Workstream as part of Deteriorating Workforce and Sepsis Group to progress and review training and compliance for ILS and BLS			
		8. Consideration of staff redeployment from low priority areas to support safe staffing			

Risk No: 62	Date included	29 November 2021	Date revised	6/01/22			
Objective: S	High Standards						
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.						
Risk owner:	Exec: Director of Nursing, AHPs and Quality		Local: Lead for Quality, Compliance and Regulation				
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 Moderate 9-11 (Appetite Regulation-Cautious)

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:	06/01/22 The Trust is required to respond to the Covid-19 pandemic and escalated to level 4 restriction which may detrimentally impact on achieving the CQC must and should do action plan, in particular relation to: Attendance at required meetings Achieving training compliance Process of auditing against compliance Safe staffing of inpatient areas with increased staff incidence.		

Actions	Date: Multiple March 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: Date deferred to March 2022 due to required trust response to Covid-19 level 4 status	Status Amber

Risk No: 63	Date included	29 November 2021	Date revised	17/01/22				
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 • Covid having an impact on trainers capacity and attendees			
Assurances	Internal:	Source: Operational exec Training and education group ted QAC Safe staffing reports monthly Weekly staffing reviews DMT review in workforce meetings DMT have local action plans in place	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	17/01/22				
Objective: T	Transformation							
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.							
Risk owner:	Exec: Director of Strategy and Business Development			Local: Head of Strategy				
Governance:	Transformation Committee / FPC / Board - Monthly Review							

	Consequence	Likelihood	Combined
Current Risk	4	3	12
Residual Risk	3	3	9
Tolerance Level Moderate 9-11 (Appetite Financial-Cautious)			

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 • Project development risk registers			
	Gaps:	• SUTG delivery plans			
Assurances	Internal:	Source: Transformation Committee Joint Working Group (JWG) of LPT & NHFT Executive, board meetings & board development sessions Finance and Performance Committee	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 Business pipeline report		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: Jan 22 Ongoing	Actions: SUTG delivery plans Regular attendance at ICS Board meetings, transition and steering groups	Owner: David Williams Chair & CEO	Progress: In draft – delayed to Jan due to covid Achieving (this action will be on-going)	Status Green

Risk No: 65	Date included	29 November 2021	Date revised	17/01/22			
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: Amber

Risk No: 66	Date included	29 November 2021	Date revised	17/01/22		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 Amber
	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 - remains on plan • In draft	Status Amber

Risk No: 67	Date included	29 November 2021	Date revised	17/01/22			
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:			

	Date:	Actions:	Owner:	Progress:	Status
Actions	Jan 22	Funding approval for sustainability posts	RW	Currently with banding panel – delayed due to staffing pressures. Estimated January 2022 and remains under review	Amber
	Mar 22	Outline chapters drafted and shared with provisional chapter leads	RW	CFO taking the lead on research to support draft chapters	
	Jan 22	Consideration of PMO support	RW	Support to establish a structure programme across estates	
	Jan 22	Draft Green Plan produced for Board	RW	Drafted	

Risk No: 68	Date included	29 November 2021	Date revised	12/01/22		Consequence	Likelihood	Combined
Objective: G	Well Governed				Current Risk	4	4	16
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.				Residual Risk	4	3	12
Risk owner:	Exec: Director of Finance & Performance		Local: Head of Information		Tolerance Level Moderate 9-11 (Appetite Regulatory-Cautious)			
Governance:	FPC / Board - Monthly Review							

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	24/12/21Reducing the burden letter stated external audit of quality accounts not required for 21/22	

Risk No: 69	Date included	29 November 2021	Date revised	12/01/22		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	Feb 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	
	Jan 22	• Review of Information Team capacity & delivery model	SM	Assurance Lead now in post.	
	Apr 22	• Quality accounts reporting & management of actions	SM	Options paper going to OEB 21/01/22 21/12/21 Reducing the burden letter stated external audit of quality accounts not required for 21/22	

Risk No: 70	Date included	29 November 2021	Date revised	12/01/22			
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	
	Mar 22	Mitigation plans for capital and revenue to ensure plans are delivered	SM	On track	

Risk No: 71	Date included	29 November 2021	Date revised	12/01/22				
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 • 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 – April • Efficiency plans continue to be presented to Transformation Committee • Final Trust board plan sign off target date 19/04/22	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:				

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

Risk No: 72	Date included	29 November 2021	Date revised	17/01/22
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	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	14/01/2022
Objective: E	Equality, Leadership, Culture			
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.			
Risk owner:	Exec: Director of HR & OD		Local: Head of Equality, Diversity and Inclusion	
Governance:	SWC, QAC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	3	4	12
Residual Risk	3	3	9
Tolerance Level Significant 16-20 (Appetite People - Seek)			

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:			

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

Risk No: 74	Date included	29 November 2021	Date revised	17/01/22		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	12/01/22
Objective: A	Access to Services			
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.			
Risk owner:	Exec: Medical Director		Local: Operational Executive Directors	
Governance:	Waiting List and Harm Prevention Committee, FPC and QAC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	4	16
Residual Risk	4	2	8

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

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 • Report to triangulate evidence of harm with Trust wide data from Patient Safety and Patient Experience	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:			

Actions	Date:	Actions:	Owner:	Progress:	Status
	Jan 22	Understanding the outputs of the demand and capacity modelling and feeding into the transformation programme	Director of MH AS/AvH	East Midlands MH alliance working with NHSEI to develop MH capacity planning model – moved for an update in Jan 22 Agreed joint working approach between LLR and Northants system to undertake demand and capacity modelling	Amber
	Jan 22	Consideration of avoidable harm measures including impact of partial or full COVID related closures		Actively considered and covered in regular reports – to review for closure in Jan 22	

Risk No: 76	Date included	December 2021	Date revised	17/01/22
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 • Regulations passed through Parliament and into law on 6 January 2022 • NHSE guidance 'VCOD phase two – implementation' 14/1/2022 • VCOD task and finish group • LPT Strategic Flu and Covid Vaccination Strategic Board • Weekly LLR Workforce Cell meeting • FAQs		
	Gaps:	• Some ongoing work to confirm roles in and out of scope • Some ongoing work around validation of data		
Assurances	Internal:	Source: Mandatory Covid Vaccination Task and Finish Group Strategic Flu and Covid Trust Group.	Notes and actions from T&F Group – now supported by Trust's PMO Directorate reports for ICC twice weekly focused on business continuity and risk Twice Weekly Sitrep report (Monday and Wednesday) Highlight report from Strategic Flu and Covid Trust Group 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 VCOD reporting to commence shortly	Assurance Rating Amber
	Gaps:			

Actions	Date:	Actions:	Action Owner:	Progress:
	Jan 22	1. Directorates to be supported with resources and training to increase capability to undertake vaccine confidence conversations.	SC/KBa	Guidance issued to assist managers in holding supportive conversations. Available on staffnet. Inbox also set up for queries
	Jan 22	2. Drop in events to be held for staff / managers	Kbu/KBa	Events held on 21 December and 17 January
	Jan 22	3. Directorates to revisit which roles are in and out of scope	Ops leads	Initial work done – being revisited in light of updated guidance
	Jan 22	4. Letter to be sent to staff to support uptake and validation of data.	Kbu	Initial letter sent in January – further letter to be sent by 20 Jan 21
	Dec 21	5. FAQs to be finalised	Kbu	Action completed although regularly updated
	Jan 22	6. Policy and template letters to be finalised	Kbu	
	Jan 22	7. Clear timeline for next steps in HR process post 4 Feb to be determined	KBu	

Status: Amber

Risk No: 77	Date included	1 December 2021	Date revised	17/01/22			
Objective: G	Well Governed						
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.						
Risk owner:	Exec: Deputy Chief Executive		Local: Deputy Director of Governance and Risk				
Governance:	Public Inquiry Programme Board / SEB / Trust Board - monthly review						

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

Tolerance level Moderate 9-11 (Appetite Reputational–Cautious)

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:	• Public Inquiry Programme and Project Board paused under the interim governance arrangements – subject to review in Feb 22 • National Public Inquiry Terms of Reference • Local strategy for the National Public Inquiry		
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: Mar 22 Apr 22	Actions: Development of a local strategy. Implementation of the Public Inquiry IM&T strategy	Action Owner: Sandra Mellors /Kate Dyer SM/KD	Progress: Paused. In draft – paused

URGENT COMMUNITY RESPONSE

LEICESTER, LEICESTERSHIRE AND RUTLAND

Leicestershire County Council

Leicester City Council

Rutland County Council

NHS Leicestershire Partnership NHS Trust

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

NHS

Our journey in Leicester, Leicestershire and Rutland (LLR)

System wide redesign of community services

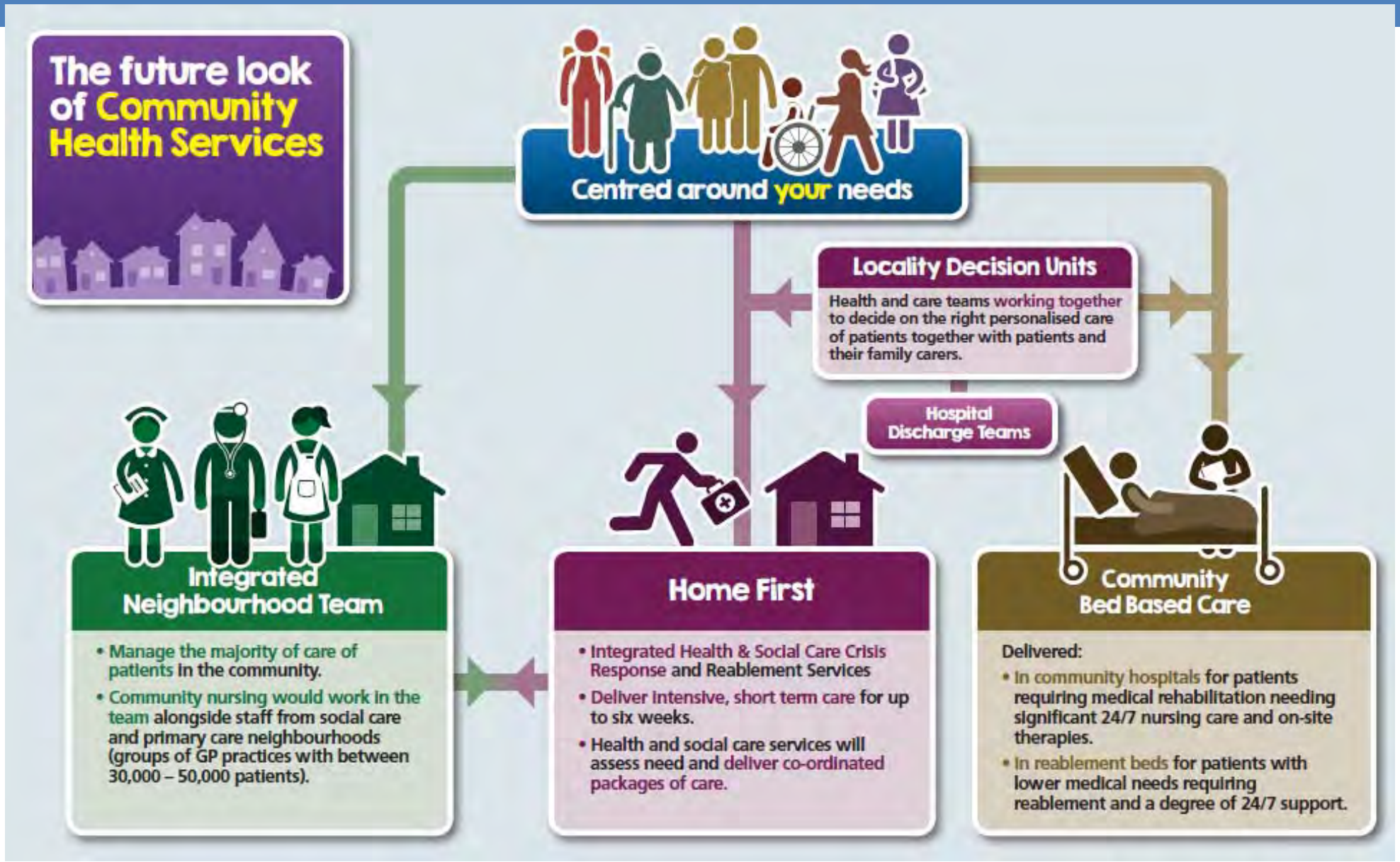
- One community trust
- Three Adult social care departments
- Three clinical commissioning groups (CCGs)
- LLR-wide vision and place based operational model

Urgent Crisis Response

- Integrated health and care model
- Deliver 2-hour response
- Two day reablement
- Step up and step down

Home First model

- Mobilised December 2019
- Community Health services reorganisation
- Different integration agendas in each place
- 2-3 year change programme


The future look of Community Health Services
Centred around your needs
Locality Decision Units
Health and care teams working together to decide on the right personalised care of patients together with patients and their family carers.
Hospital Discharge Teams
Integrated Neighbourhood Team
• Manage the majority of care of patients in the community.
• Community nursing would work in the team alongside staff from social care and primary care neighbourhoods (groups of GP practices with between 30,000 – 50,000 patients).
Home First
• Integrated Health & Social Care Crisis Response and Reablement Services
• Deliver intensive, short term care for up to six weeks.
• Health and social care services will assess need and deliver co-ordinated packages of care.
Community Bed Based Care
Delivered:
• In community hospitals for patients requiring medical rehabilitation needing significant 24/7 nursing care and on-site therapies.
• In reablement beds for patients with lower medical needs requiring reablement and a degree of 24/7 support.

Crisis Response Services – National overview

- By end March 2022, everyone over the age of 18 in England will have access to a crisis response service within two hours, 8am-8pm, seven days a week. This was set out in the NHS Operational Planning and Contracting Guidance 2021/22, building on the commitments in the NHS Long Term Plan
- Leicester is one of 7 accelerator sites delivering the national standards for 2 hour crisis response services at scale. The Leicester team have shared their learning and experiences with other parts of the country to support the national roll out of these services.
- As at October 2021 25 ICS areas have rolled out the 7 day and 12-hour requirements, including the accelerator sites. This is expected to be 26 ICSs by the end of this month.
- The two-hour crisis response standard aims to improve patient outcomes by meeting their urgent care needs at home or usual place of residence, which could include a care home, in a timely way. Providing crisis care within the community aims to **prevent avoidable hospital admissions and support people to remain independent for longer.**

Delivering the 2hr standard: LLR's rapid response model

1. Access and referral	2. Response and Assessment	3. Care and support delivery	4. Service discharge
• A single point of access • A streamlined referral process and inclusion and exclusion criteria	• Personalised, holistic assessment of physical health, mental health and social care needs delivered in partnership with the person	• Integrated multi-skilled team supports timely delivery of care • Pathways support onward referral and other care and support needs	Onward referral or discharge

Creating an effective 2 hour UCR

Culture – focus on taking the patient home with crisis response for the first 72 hours, the rest follows

Shared system risk, responsibility and accountability with regard to capacity and management

Encourage creativity through the application of new ways of working

Shared principle of promoting independence at every level.

Multiskilled team approach reduces duplication, improves efficiency and supports better patient experience

Shared vision and objectives have developed transparency and trust across system

Impact of the Urgent Community Response in LLR

Successes

- Ageing Well accelerator site – developing the urgent care response (UCR) standard and sharing learning with other ICS's
- Working across three places with one vision
- Pre-covid: Reduction in admissions in frailty HRGs (5%)
- Project £1.6m pa savings
- 7 day Home First model including therapy
- Crisis response role development and multi-skilled team
- UCR on DOS and available from 111/999

Challenges

- Recruitment and building capacity in teams
- Data quality and CSDS reporting
- Integrated IT – visibility of capacity, documentation and reporting as a system on performance
- 'Describe don't prescribe' approach is hard to embed in practice
- Differing pace of integration
- Impact of reorganisation on teams and established relationships
- Pull of capacity to UCR reduces focus on anticipatory care.

Next steps

- Developing a single workforce approach (shared recruitment and hybrid roles)
- Increase capacity in community services further, particularly post-COVID
- Consistent patient-centred outcomes collection across health and social care
- Develop the use of technology in homes
- Strengthening the MDT approach between hospital based specialists and home first pathway
- Unscheduled Care Coordination Hub to direct patients from EMAS/ DHU stack (Cat 3/4 calls) in to more appropriate pathways delivered by UCR providers

Case Study 1: Two-hour Urgent Community Response (UCR)

Referral

14:14 GP telephone phone call referral via Local Decision Unit (LDU) direct to UCR clinician for Mrs A following fall, back pain and unable to mobilise.
History of recurrent falls, dementia and diabetic.

Outcome:
- Triaged in LDU as a 2 hour UCR
- Response from the health and social care team put in place

Response

14:45 Face to face assessment completed at home by Occupational Therapist and Crisis Response Service (CRS)

Outcome: need for crisis package of care (POC), ongoing therapy, urgent equipment (bed) and referral to nursing

- Referred to equipment provider for urgent bed (delivered within 2 hours)
- 18:47 Registered nurse face to face visit - education and liaison with GP re: diabetes management
- Crisis POC commenced same day to help remain at home safely
- Further daily therapy interventions over the next week plus temporary crisis POC

Outcome

- **Hospital admission avoided**

- No ongoing care needs
- Improvement in back pain and diabetes management
- Independently mobile with frame/transfers, no longer requiring hospital bed.

Case Study 2: Two-hour UCR

Referral

WC is a 69-year-old female involved in a road traffic accident at a young age resulting in long term physical injuries. After a period of short-term support from Adult Social Care in 2013, WC continued to live at home independently alone without the requirement of services.

2/2/21 at 06:56 WC pressed her assistive technology (lifeline) to activate an emergency response as she was struggling with her mobility. The integrated crisis response service (ICRS) was deployed to assess the level of support WC required.

Outcome:

- Triaged as a 2 hour UCR
- The team arrived at WC's home address at **07:40 on the day**

Response

Assessment of immediate needs

Outcome: deterioration in mobility and unable to transfer, red swollen leg, no equipment at home, fearful of admission to hospital

Case discussed at **daily MDT** 2/2/21

- GP same day intervention – Antibiotics for cellulitis, 1 week review and further course prescribed
- Nursing team – observations, dressings to leg applied
- Therapy team assessment - input from occupational therapist and physio
- Urgent equipment ordered and delivered within 24 hours
- Social care assessment – further support to aid recovery and reduce further deterioration in health and well-being – package of care (POC) for 3 calls, review in 3 months

Outcome

- **Hospital admission avoided**

- WC's wishes to remain at home whilst accessing the UCR supported
- Case then transferred to locality team to enable planned work to continue by adult social care
- Regular therapy input delivered for 3 weeks to improve mobility and independence
- **WC remains at home**.

Case Study 3 – Unscheduled Care Coordination DHU Home Visiting Service (HVS) to ICRS/LPT Therapy

Referral

10/01/22 HVS referral received from GP

Presenting complaint - left shoulder and arm pain, bruising following fall 3 days ago, wrist pain

13:30 Triage within Unscheduled Care Coordination Hub

Outcome: May benefit from increased POC
Video call by physiotherapist to assess wrist for ?fracture

Response

Dispatch of ICRS carer to patients home with video call arranged for therapist.

ICRS attended property - arrival 14:45 (1hr 15 response)

15:00 Video consultation by Physiotherapist facilitated by ICRS carer (1 hr 30 response)
Outcome:

- Fracture ruled out
- Mobility assessment completed
- Environmental assessment completed

Outcome

- ED avoidance
- Direction to most appropriate pathway (from HVS to Home First Urgent Community response services
- Ongoing input put in place from ICRS and Community Therapy in order to support to continue to remain at home

G

Leicestershire Partnership and Northamptonshire Healthcare Group

Purpose of the report

The purpose of this paper is to provide an overview of the work of the Group Model and the benefits it is delivering, and to present Terms of Reference for its Committee in Common and Joint Working Group for approval.

Analysis of the issue – Developing a Group Model

Across the NHS in England, organisations are being increasingly encouraged to work together within and across different health economies. This is in advance of a change in legislation (scheduled later in 2022) which will bring into being the Integrated Care Systems (ICS) and a formal legislative requirement for NHS and other organisations to work collaboratively to improve services for patients in a defined geographical region.

NHFT has already embraced this new way of working. Angela Hillery was appointed as joint CEO of both NHFT and LPT in 2019. At the time, this arrangement underpinned a formal buddy relationship between both Trusts, supported by NHSE/I.

NHFT and LPT have developed a strong bond through this arrangement and in April 2021 the buddy relationship transitioned into a Group Model (the Leicestershire Partnership and Northamptonshire Healthcare Group).

Developing a Programme of Joint Strategic Priorities

A key principle underpinning the establishment of the Group Model is the intention to benefit and improve both organisations through partnership working. By working together, each is stronger and can build greater resilience; in addition they can strive for excellence to better develop and share good practice.

One of the early tasks for both Trusts was together to identify a number of joint priorities which would enable them to strengthen their respective position, scope, reach and influence within each Integrated Care System, the East Midlands and beyond.

As a result the Group Model has developed a three year programme starting with eight strategic priorities which both organisations believe can create significant benefits for our stakeholders from the two organisations working so closely together. Each priority is led by a member of our executive teams and the strategic ambitions of each plan are summarised here:

- **Innovation & research** - Create centres of academic excellence that grow our contribution to innovation and funding income
- **Together against racism** - Be nationally recognised leaders on race equality and anti-racism in the NHS and employers of choice.
- **Talent management** – As inclusive employers, widen opportunities for our workforce to develop and progress across our Group
- **Leadership & organisational development** – Have great leaders at all levels within both organisations, skilled and trained to meet the needs of our joint workforces, leading compassionately and inclusively to create a culture that supports Trusts individual missions
- **Strong governance** - Be outstanding Well Led organisations, delivering best practice governance across the Group and contributing to system governance and enabling agile and effective decision making
- **Strategic finance** - Use our financial strength to build back better for the benefit of our populations
- **Strategic estates** - Build new therapeutic environments which improve outcomes for people using services by supporting joined up, person-centred care, a positive, effective working environment for NHS staff and stronger and greener NHS buildings.
- **Quality improvement** - Be outstanding organisations in the quality of the care we provide and all that we do to enhance our patient and populations' health.

Building on Existing Joint Work

The strategic priority programme builds on joint working from the buddy relationship between LPT and NHFT. We want to grow this type of collaboration and the benefits it can deliver to us as a Group. Appendix 1 showcases some of our work to date.

Some of the benefits colleagues have highlighted about their joint work

- **Fresh ideas**
- **Access to new or helpful insight**
- **Gaining a different perspective**
- **Building confidence and connections**
- **Reducing duplication and optimising use of our limited resources**
- **Colleagues in each Trust can contribute their knowledge, learning, talent and skills**
- **Enhanced solutions through joint problem solving and support**
- **Identifying and growing new ideas together**
- **Learning from each other**
- **Optimising opportunities for change and improve together at an accelerated pace than we would individually**

Our buddying relationship and Group model has given rise to a number of shared Directors in addition to the joint Chief Executive, namely joint Chief Finance Officer, joint Director of Strategy and Partnerships and joint Director of HR & OD/Director of Governance, and plans are underway to create more joint posts in the future to further cement the relationship between each Trust.

At each Board meeting, a highlight report (Appendix 2) will be presented which will formally document the progress of each of the eight joint priorities and also showcase other joint working initiatives underway between both Trusts. In addition, each Trust Board will annually review the programme of joint work and make recommendations for change – for example the addition of new priorities.

Our Governance Arrangements

The Group Model is governed through two identical Committees in Common (CiCs), one in each Trust, that come together as a Joint Working Group (JWG) to oversee the delivery of the programme of joint priorities which have been previously been agreed by both Boards. The JWG is accountable to each Board through each Trust's respective CiC and the members of the JWG are comprised of the membership of each Trust's CiC and include:

- Both Trust Chairs (at each JWG meeting, one Chair will take the lead in chairing the meeting)
- The Joint Chief Executive
- Both Trust Deputy Chief Executive Officers
- An equal number of Non-Executive Directors from NHFT and LPT
- The Joint Group Model Directors, namely:
    - Director of Governance & Risk (LPT) and Director of HR & OD (NHFT)
    - Director of Strategy & Partnerships
    - Chief Finance Officer

All of these governance arrangements are enshrined in a Memorandum of Understanding between LPT and NHFT and the terms of reference for both the CiC and the JWG are presented at Appendices 3 and 4 respectively.

As the relationship between the two Trusts develops and matures and the delivery of the Group Model strengthens, more opportunities for joint working will be identified. Priorities can be updated at any time and formally agreed through a recommendation to each Trust Board via its respective CiC. The Group Model programme of work will be formally revisited at least annually by each Trust Board.

The CiCs, operating as a JWG, are responsible for overseeing the Group priorities and have no delegated authority to exercise powers of LPT or NHFT.

Proposal

- The updated Terms of Reference for LPT's Committee in Common and the LPT – NHFT Joint Working Group be approved by Trust Board.
- Be assured and the progress and benefits of Leicestershire Partnership and Northamptonshire Healthcare Group programmes of work.

Decision required

The Board is invited to receive assurance that good progress is being made on the delivery of the Group Model between LPT and NHFT and a number of benefits are emerging. The

highlight report attached at Appendix 2 formally documents the delivery of eight strategic priorities identified for joint delivery by both Trusts over the next three years and will form part of the suite of assurance reports presented to each Board meeting.

The Board is also invited to approve the Terms of Reference for the CiC and the JWG which underpin the transformation programme of the Leicestershire Partnership and Northamptonshire Healthcare Group.

Governance Table

For Board and Board Committees:	Trust board 25th January 2022	
Paper sponsored by:	David Williams	
Paper authored by:	Amanda Johnston, Fiona Barr	
Date submitted:	18 January 2022	
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:	LPT-NHFT Committees in Common Joint Working Group 10th January 2022	
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	LPT-NHFT Committees in Common	
STEP up to GREAT strategic alignment*:	High **S**tandards	x
	Transformation	x
	Environments	x
	Patient Involvement	
	Well **G**overned	X
	Reaching Out	X
	Equality, Leadership, Culture	X
	Access to Services	
	Trustwide Quality Improvement	X
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:		
Positive confirmation that the content does not risk the safety of patients or the public		
Equality considerations:		

Leicestershire Partnership and
Northamptonshire Healthcare Group

NHS

Our broader joint work together and benefits

Leicestershire Partnership and
Northamptonshire Healthcare Group

NHS

A positive response to our first LPT and NHFT masterclass

As the first of our quarterly masterclasses to support all our staff in their learning and development – the classes are an important part of our commitment to be together against racism.

Feedback from delegates attending from both our Trust has been incredibly positive and there is something for everyone to hear and learn from in this powerful session.

Our first masterclass is a big hit

Talking privilege with John Amaechi

More than 250 colleagues across LPT and NHFT attended a masterclass with the renowned organisational psychologist, John Amaechi, on 28 September. As the first of our quarterly masterclasses to support our staff in their learning and development – the classes are an important part of our commitment to be together against racism. Feedback has been incredibly positive and there is something for everyone to hear and learn from in this powerful session.

The masterclass theme was 'Becoming comfortable with being uncomfortable – let's talk privilege.' It's a theme John Amaechi has explored for some time as he shared and discussed the idea that feeling uncomfortable gets in the way of being together against racism.

Last year he explained the concept of white privilege for a short video on the BBC's Bitesize, a popular homework site for children. The video clip went viral with children, parents, teachers and the media discussing what white privilege means. Read and hear more at John's BBC blog here.

Born in Boston in the United States, John grew up much closer to home in Stockport, Manchester. It was there that he first played basketball at 17-years old before moving to Ohio to play high school basketball. This was the beginning of his basketball career which made John the first British National Basketball Association star.

From a young age, John had a passion for motivational public speaking and mentoring young people. Today he works with public and private organisations and educational institutions to help inspire positive change. As an international ambassador for human rights and best-selling author, it really was an honour for John to host our first masterclass.

If you missed the masterclass (or would like to see it again), watch here. It will be available to watch up until Christmas using the password LPTNHFT21.

Watch out for news on our next masterclass

Making the most of our first masterclass

- Put aside some time and listen to the recording in team meetings and discuss with your colleagues.
- Talk about any issues raised with your line manager if you are touched by them or found them challenging.
- Remember our Freedom to Speak Up Guardians, Equality, Diversity and Inclusion service and health and wellbeing services are all on hand.

Leicestershire Partnership and
Northamptonshire Healthcare Group

NHS

Rising to the challenge together
Shaping a new model of working in school nursing across our trusts

Collaboration between LPT's and NHFT's Children's 0-19 Services is a great example of the benefits of working together.

- Earlier this year, Children's 0-19 Service Leads in NHFT were trying to meet the challenges of reductions in resource and increase in demand. This was especially difficult in safeguarding children of school age.
- Looking for new solutions and approaches – Louisa Russell, NHFT's Head of Service, reached out to her counterpart in LPT. Jo Cheeseman, LPT's Public Health Nursing Lead, shared that LPT was experiencing the same problems. They had developed a new model of working in school nursing to try and address them.
- Louisa's and Jo's conversation was the start of a series of meetings between our Trusts. "It was great to be able to connect and share practice. I'm sure this will be the start of a really productive relationship between our two services," said Jo.

Working together has helped to build a stronger relationship across our trusts and the teams are now regularly sharing learnings and looking at ways to tackle common challenges

"It was great to be able to connect and share practice. I'm sure this will be the start of a really productive relationship between our two services," said Jo.

Leicestershire Partnership and Northamptonshire Healthcare Group

NHS

Our OD and LD teams are connecting and sharing ideas

- NHFT and LPT have met to discuss how new staff are supported through on-boarding arrangements in both Trust's and how Corporate Induction is facilitated.
- During the Covid pandemic it has been great that we have been able to stay connected and share examples of what each Trust has been doing to support staff and at the same time share learning and best practice.
- Fiona McNamee, Head of Organisational Development at LPT explained: LPT have developed 2 great resources to support managers and new staff joining LPT called The First 90 days and My First 90 Days . These documents support managers to ensure everything is put in place to support a new employee when joining the Trust and also a resource for employees called My First 90 Days so they know what to expect within the first 90 days.

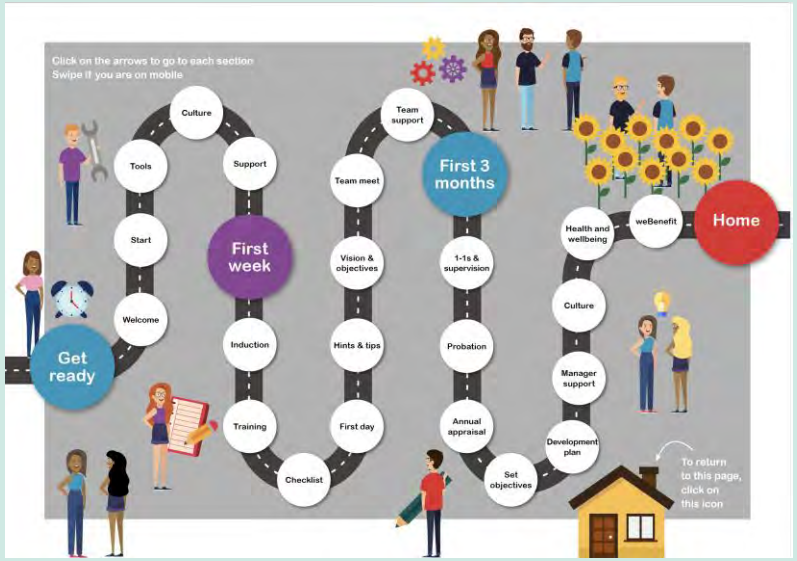
Whilst there are many similarities and some differences in how we support new staff joining each Trust. It has been very clear through our discussions that the staff experience is at the heart of what we do to support new staff joining our organisations. ***- Robert Freund, Acting Head of Learning & Development at NHFT***

NHFT are now also looking at adopting the 90 days resources for both managers and new employees. ***- Fiona McNamee, Head of Organisational Development at LPT***

Leicestershire Partnership and
Northamptonshire Healthcare Group

NHS

An example of some joint work regarding Trust Inductions and On-boarding

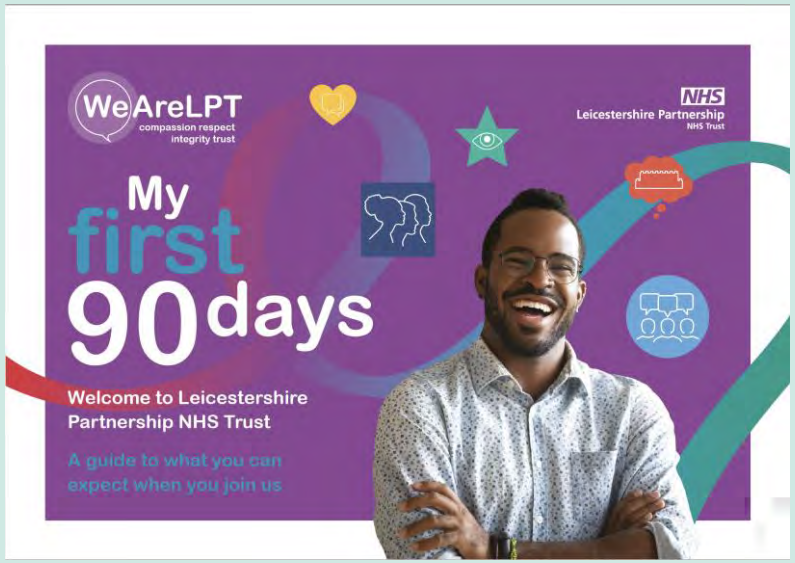


- A vibrant, interactive PDF guide for line managers
- To help managers support new starters in their first 90 days

Leicestershire Partnership and
Northamptonshire Healthcare Group

NHS

An example of some joint work regarding Trust Inductions and On-boarding



- And an interactive version to warmly welcome and engage new starters
- For ease of orientation, and a productive start to work at LPT

Leicestershire Partnership and Northamptonshire Healthcare Group

NHS

Interviews underway to appoint our first Joint Head of Research

- Medical Directors in both Trusts, **Dr Avinash Hiremath, Medical Director LPT and *Dr Itai Matumbike, Consultant Forensic Psychiatrist, Executive Medical Director*** have created and advertised a new Joint Head of Research and Innovation for both Trust within the Group
- The post is part of our Group strategic plan for research and Innovation
- Our ambition as a Group is to create centres of academic excellence that grow our contribution to innovation and funding income

"This is an exciting opportunity for both organisations to innovate and share expertise. Our ambition is to develop centres of research excellence by expanding our pool of researchers and academics. By joining forces, we can apply for research funding as a group giving us an edge over our competitors as well as having the capacity to conduct studies across multiple centres."

- Dr Itai Matumbike

Consultant Forensic Psychiatrist, Executive Medical Director

Benefit Attract bigger pots of funding income for research and clinical trials

Benefit Facilitate larger scale research studies

Benefit Improve the profile of our R&I

Benefit Enable cost efficiencies through reduced delivery overheads and elimination of duplication

Benefit Opportunity to spread innovation faster across both organisations

Benefit Attracting skilled/talented workforce once centres of excellence developed

Leicestershire Partnership and Northamptonshire Healthcare Group

NHS

Our Joint Head of Research & Innovation role

This Role…..

Due to the recent launch of our Leicester Partnership and Northamptonshire Healthcare Group, we have created an exciting new joint Head of Research and Innovation role and seek a new leader for our teams across both Trusts within the Group.

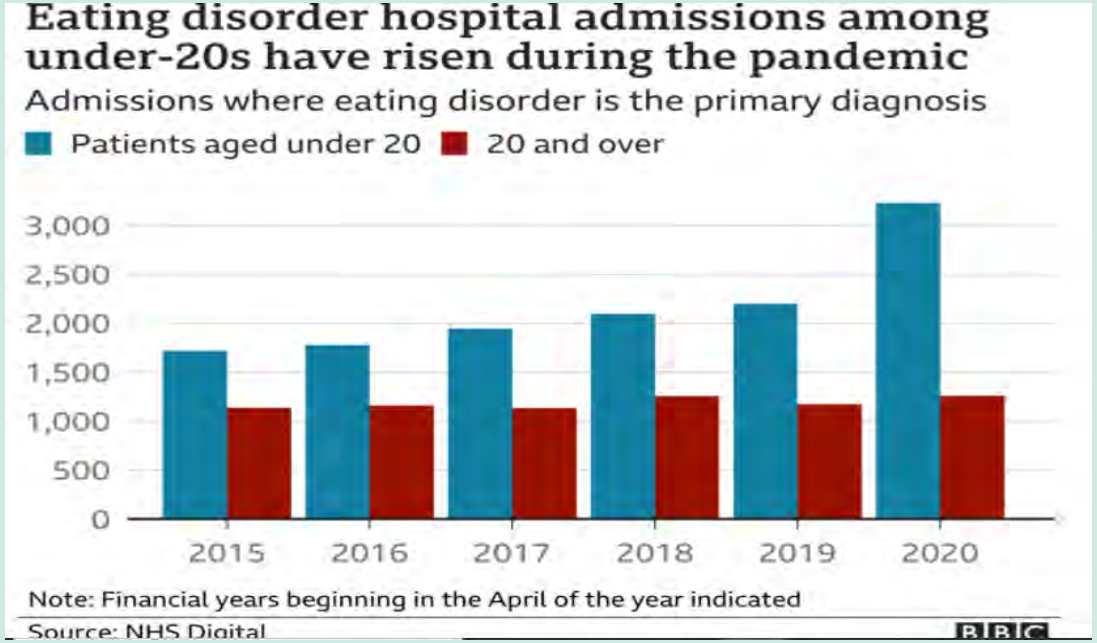
The Joint Head of Research and Innovation will lead and develop research and innovation capability across both Trusts within the Group, while taking responsibility for the management and administration of all aspects of the teams' functions. This new joint role will work at a strategic level with both Medical Directors within the Group to create centres of academic excellence that grow our contribution to innovation and funding income with the objectives to:

Leicestershire Partnership and
Northamptonshire Healthcare Group

NHS

Some of the shared national challenges facing Children's Eating Disorder services

There were 19,562 new referrals of under-18s with eating disorders to NHS-funded secondary mental health services in 2020, a rise of 46% from the 13,421 new referrals in 2019.



Leicestershire Partnership and Northamptonshire Healthcare Group

NHS

Opportunities for alignment workshop for Children's Eating Disorders Services

- Deputy Chief Execs, Mark Powell and David Maher were joined by 38 colleagues from both Trust's Children's Eating Disorders services on the17th November to talk about shared challenges and opportunities for alignment, learning and collaboration.

Our next steps will be collating the feedback from our conversation, drawing up high level plans and holding another event to review progress and celebrate our success together

- Paul Williams, Head of Service at LPT

Leicestershire Partnership and Northamptonshire Healthcare Group

NHS

The benefits of a joint Gold Command during the pandemic

Throughout the pandemic both Trust Incident Control Centres kept in touch to:

- Share mutual ways of working
- Held a weekly joint strategic gold meeting
- This gave Joint Chief Executive, Angela Hillery a unique single strategic oversight of the pandemic across Northamptonshire, Leicester, Leicestershire and Rutland, how it was impacting and how best to marshal our response

Leicestershire Partnership and Northamptonshire Healthcare Group

NHS

Procurement

- A lot is happening with Social Value & Net Zero
  - Our procurement leads, Cathy Headland and Sarah Holliehead are attending webinars and staying connected on this regarding sustainability
- Our current procurement contract portfolios have also been exchanged and some work taking place to identify future joint procurement opportunities
- Working together on achievement of HM Government Commercial Continuous Improvement Assessment Framework (a new single procurement standard for the public sector)

Leicestershire Partnership and Northamptonshire Healthcare Group

NHS

Appendix 2

LPT-NHFT Committees in Common (CiC) Joint Working Group (JWG) HIGHLIGHT REPORT 13th Dec 2021 to 10th Jan 2022

Purpose of Report

The LPT Committee in Common and NHFT Committee in Common (CiC) Terms of Reference hold each CiC accountable to their respective Trust Board.

This Highlight report aims to provide each Trust Board with assurance on the delivery of the Group model and the Group Strategic Priorities and any other the business of the Leicestershire Partnership and Northamptonshire Healthcare Group:

Leicestershire Partnership and Northamptonshire Healthcare Group - Strategic Priorities	
1. Leadership and Organisational Development	5. Strategic Financial Leadership
2. Talent Management	6. Strategic Estates
3. Together Against Racism	7. Quality Improvement
4. Joint Governance	8. Research & Innovation

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
Pre-approval	Grey – there is a draft plan in development and actions agreed to ready it for approval to proceed
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
1. Attended & Apologies	N/A	Listed in the CiC meeting tracker	N/A
2. Action Tracker	High	The 13th 2021 December meeting of the CiCs discussed actions 17, 22, 24, 26 and 28 on the agenda and a review of the action log shows actions 1 -19 are complete and can be closed.	N/A
3. Highlight Report Previous meeting	High	The CiCs supported the Trust Board Highlight reports as an accurate record.	N/A
4. Group Model a. Governance Assurance Framework	High	Refreshed Terms of Reference for the Committees in Common and Joint Working Group have been prepared. These will be presented with a supporting positioning paper for approval by LPT and NHFT Trust Boards in January 2022. The Committees in Common agreed that coming to the Joint Working Group, should be an operational programme risk register at each of its meetings. This risk register has been refreshed accordingly and now comprised of the risks to the delivery of each of the	N/A

Report	Assurance level	Committee escalation	ORR Risk Reference
		joint priorities, including any missed opportunity risks should plans not be fully delivered. The risks are formed and updated from the standard highlight / progress reports which the joint priority leads complete and submit. The 13th December CiC agreed that the JWG dates should be formally scheduled into the corporate calendars for NHFT and LPT and those meetings will move to every two months and of 1.5 hours duration. Strategy and Governance teams will plan the forward schedule to ensure the output of the JWG flows into the next public Board meeting A regular Strategy and Governance sub meeting has been established to support evolution of the Group model.	
4b.Group Employment model development		There are some existing joint appointments across both Trusts and as our work within the Group model matures and evolves, further opportunities have been identified for the wider employment of people across the Group. On the 8th November 2021 the Committees in Common supported proposals for the wider employment of people across the Group and the JWG supported a MoU agreement in respect of this at the December 2021 meeting. The next step is for the Joint Employment proposal and MoU Agreement to go to each Trust's Board for approval in January 2022.	
5. Group Strategic Priorities Programme a. Plans supported for delivery	High	The eight plans within the Group Strategic Priority Programme are now in the delivery phase. The proposed JWG Terms of Reference referred to in section 4a outline the recommended approach for overseeing the delivery phase of the programme. Delivery Highlight reports for Leadership & OD and for Talent Management plans were received by the committees in common at the 13th December 2021 meeting by way of delivery assurance. Proposals for a deep dive evaluation of selected Strategic Priorities scheduled for the 10th January 2022 JWG will be carried forward to the next meeting in March 2022. Planning is underway to agree a schedule of attendance of Strategic Priority joint leads at future JWG meetings to assure on progress, risk and benefits	

Report	Assurance level	Committee escalation	ORR Risk Reference
		delivery.	
KPIs Programme Delivery **%** of Group Strategic Priorities Plans rated as on track (green) or off track but expected to recover (amber) off track and unrecoverable (red) in development (grey)	High	Group Strategic Priority Plans were RAG rated by the CiCs at the JWG meeting as follows: **KPI Target = 100% of plans Green** There are eight strategic priority plans in 2021/22 0% In Development 0 100% Green 8 0% Amber 0 0% Red 0	N/A
6. Our Other Joint Work	High	A case study presentation resource has been developed to showcase some example areas of joint working across both Trusts. Further work is planned to develop the case study portfolio and provide a deeper understanding and evidence base of benefit delivery.	
7. Group News	High	Our Group Newsletter was set up to talk about our work together and the difference this can make for our colleagues, patients and service users. The Group newsletter is being developed to include a regular feature on other joint working beyond the eight strategic priorities and this will include a call to action for staff to connect with their counterparts and to share stories where they have been inspired to work together. The first feature will cover the joint work on the 0-19 School Nurse model development	N/A

G Appendix 3

Leicestershire Partnership NHS Trust

Terms of Reference for LPT's Committee in Common (ToR)

1. Background

1.1. The Boards of Leicestershire Partnership NHS Trust (LPT) and Northamptonshire Healthcare NHS Foundation Trust (NHFT) (together the Trusts) have both approved these Proforma terms of reference in accordance with their Memorandum of Understanding (MoU) dated 25th March 2021 for Group Model arrangements. They have undertaken to use this template to develop their own terms of reference for their Committee in Common.

1.2. Under the MoU the Trusts have agreed to appoint a committee in common to further their Group Model structure delivered as a Joint Working Group.

2. Accountability

2.1 The committee in common will be accountable to the Board of LPT.

3. Responsibility and operation

3.1 The committee in common is responsible for the Trusts' Group strategic transformation programme priorities.

3.2 The committee in common will focus on strategic areas in common which have been approved by each Trust Board as joint priorities for delivery under the Group Model Structure. These may grow over time according to experience and the developing relationship.

3.3 The committee in common can make recommendations to each Trust Board for further opportunities for joint working such as shared roles and wider group benefits.

3.4 Priorities can be updated at any time and will be revisited at least annually by each Trust Board.

3.5 The committee in common shall operate as part of a joint working group and have no delegated authority to exercise powers of LPT or NHFT.

4. Membership

4.1. The members of the committee in common shall comprise LPT's chair and chief executive officer together with relevant, identified Board members.

4.2. The core members are:

- Chair - Cathy Ellis
- Chief Executive - Angela Hillery
- Deputy Chief Exec - Mark Powell
- Non-Executive Director - Ruth Marchington
- Director of Governance and Risk – Chris Oakes
- Director of Strategy & Business Development - David Williams
- Chief Finance Officer - Richard Wheeler

5. Attendees

5.1 The members of the committee in common may agree that other persons may attend any of their meetings.

6. Conflicts of Interest

6.1. Each member of the committee in common has a duty to avoid a situation in which he/she has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust and has a duty not to accept a benefit from a third party by reason of being a member of the committee in common or doing (or not doing) anything in that capacity.

6.2. If a member of the committee in common has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the member must declare the nature and extent of that interest to the other members and must make further declarations if his/her interest changes.

6.3. If a member has any doubt about the relevance or materiality of an interest, this should be discussed with the chair with reference to the Trust's Conflicts of Interest policy [and Trust Constitution].

6.4. Any such declaration must be made before the Trust enters into the transaction or arrangement (except where the director is not aware of an interest, transaction, or arrangement).

6.5. In the event a member has a conflict of interest with an item on the agenda of a meeting of the committee in common, he/she should notify the chair in advance of the meeting. The conflict of interest should be declared at the start of the meeting. When the agenda item is reached the member concerned should withdraw from the meeting and play no part in the relevant discussion or decision if they have declared a prejudicial interest.

6.6. Interests that are declared as personal but not prejudicial will be noted but will not necessarily necessitate withdrawal from the relevant discussion and/or decision. (Prejudicial interests are those that a member of the public with knowledge of the relevant facts would reasonably regard as so significant that it is likely to prejudice the member's judgement of the public interest and/or interests of the Trust.)

6.7. During the course of a meeting of the committee in common, if a prejudicial conflict of interest arises, the member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.8. A member need not declare an interest:

6.8.1. If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

6.8.2. If, or to the extent that, it concerns terms of the member's appointment that have been or are to be considered by either a meeting of the Board of Directors or by a Committee of the directors appointed for the purpose [under the constitution].

6.9. The committee in common shall have, and maintain as current, a register of interests of the members of the committee and any co-opted members. As a minimum, the register of interests will be reviewed annually.

7. Meetings

7.1. The committee in common shall meet at intervals of not less than six monthly or otherwise as the members agree is appropriate

7.2. Meetings of the committee in common may be held in person or by telephone, video or other electronic means, as the Committee in Common (operating as the Joint Working Group) determines.

8. Quorum

8.1 The Meetings of the committee in common will be deemed quorate when not less than half the members are present, including at least one Non-Executive Director and at least one Executive Director.

9. Chair

9.1 The LPT and NHFT Chairs will rotate the chairing of the Joint Working Group by mutual agreement.

10. Administrative Support

10.1 The Trusts will provide administrative support as appropriate to the committee in common.

11. Agenda, papers and minutes of meetings

11.1 The agenda and papers will be agreed by the Chair of the Joint Working Group. The agenda and papers will be distributed to members and those invited to attend by email only and by no later than three clear working days before each meeting. Late and tabled papers will only be accepted on agreement of the Chair.

12. Minutes

12.1 The minutes of all meetings shall be recorded and will be shared within five working days of the meeting.

13. Reporting

13.1 Reports of any groups/work-streams established by the committee in common will be submitted to meetings of the committee in common for their consideration.

13.2 The Chair will agree with the committee in common what matters are to be reported by them and will subsequently submit a joint written a report, including any recommendations the committees in common make, to the relevant Board.

14. Review

14.1 These Terms of Reference will be formally reviewed by the board on a regular basis and recommendations for any agreed amendments are to be discussed with the Joint Working Group prior to being considered by the Committee in Common and Board.

15. Approval

15.1 Approved by the board of directors on: 23rd March 2021

Memorandum of Understanding Annex B- Key focus of the committees in common

The proposed priorities for the Group Model during 2021/22, are set out below in figure 1 and will be revisited and agreed on an annual basis in accordance with the LPT-NHFT Group model Memorandum of Understanding.

Working in a Group Model aims to provide the opportunity to identify, develop and deliver joint programmes of transformation that are of benefit to both LPT and NHFT.

LPT-NHFT Group Priorities (as at March 2021)

Figure 1

Terms of Reference for Group Model Joint Working Group

1. Background

1.1. The Boards of Leicestershire Partnership NHS Trust (LPT) and Northamptonshire Healthcare NHS Foundation Trust (NHFT) (together the Trusts) have each established a Committee in Common (CiC) in accordance with the Memorandum of Understanding (MoU) dated 25 March 2021 for the Group Model arrangements.

1.2. Under the MoU the Trusts have agreed that the CiCs can operate as a Joint Working Group (JWG) to oversee the delivery of programme of joint priorities which have been agreed under the Group Model structure by both Boards.

2. Accountability

2.1 The JWG is accountable to each Board through the Trusts' respective CiC.

3. Responsibility and operation

3.1 *The JWG will focus on strategic areas in common which have been approved by each Trust Board as joint priorities for delivery under the Group Model Structure. These will be reviewed by the JWG and will grow over time according to experience and the developing relationship.*

The JWG can make recommendations to each Trust Board through its respective CiCs for further opportunities for joint working such as shared roles and wider group benefits.

Priorities can be updated at any time and will be revisited at least annually by each Trust Board.

3.2 The JWG has authority from both Trust Boards to monitor the delivery of the programme of joint priorities under the Group Model structure and provides:

I. senior strategic oversight and direction of the joint strategic priorities.
II. a forum for collaboration.
III. A mechanism for performance review, regular reporting, re-prioritisation and consideration of new opportunities for group benefit.
IV. accountability for delivery through a "star chamber" approach whereby Trust programme leads are held to account for progress.

3.3 As part of the annual planning process within both organizations, each Trust Board can make recommendations for joint priorities to be delivered by each Trust under the Group Model structure (earmarking the necessary investment and resource to support this).

3.4 The JWG has no delegated authority to exercise powers on behalf of LPT or NHFT though it will operate as a mechanism through which both Trusts can explore the level of support for business cases to enable the delivery of joint priorities.

3.5 Investment and resourcing decisions and/or business cases to support the delivery of the joint priorities will to be approved by each Trust Board at a scheduled Board meeting.

3.6 An annual review of the governance arrangements, and the effectiveness of JWG will be undertaken to ensure that they continue to reflect the benefits of joint working.

4. Membership

4.1. The members of the JWG shall be comprised of membership of the CiCs.

4.2. The membership of the JWG is therefore:

i. NHFT Trust Chair – Crishni Waring
ii. LPT Trust Chair – Cathy Ellis
iii. Joint Chief Executive - Angela Hillery
iv. NHFT Deputy Chief Exec - David Maher
v. LPT Deputy Chief Exec – Mark Powell
vi. NHFT Non-Executive Director - Maria Wogan
vii. LPT Non-Executive Director – Ruth Marchington
viii. Director of Governance and Risk (LPT) and Director of HR and OD (NHFT) – Chris Oakes
ix. Director of Strategy & Business Development - David Williams
x. Chief Finance Officer - Richard Wheeler

5. Attendees

5.1 To demonstrate progress and report on any risks or issues to delivery, the programme leads responsible for delivering each of the joint priorities will invited to attend a JWG "star chamber".

5.2 This approach encourages joint working and accountability as the programme leads have to produce and submit a joint highlight report in advance of the meeting and attend the meeting together.

5.3 Through the review of a programme highlight report and discussion with the joint programme leads through a "star chamber" approach, all members of the JWG have the opportunity to ask questions and seek assurance on the progress and delivery of the joint priorities.

5.4 From this the JWG will produce an amalgamated assurance report back to each Trust Board through each respective CiC. This report will also highlight any proposed changes to milestones, timescales or deliverables for consideration and approval by each Trust Board.

5.5 The JWG will also consider an overall operational programme risk register at each meeting though the strategic risk relating to the delivery of the programme of joint priorities will be held on each Trusts' respective Organisational Risk Register (ORR).

6. Conflicts of Interest

6.1. Each member of the JWG has a duty to avoid a situation in which he/she has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust and has a duty not to accept a benefit from a third party by reason of being a member of the JWG or doing (or not doing) anything in that capacity.

6.2. If a member of the JWG has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the member must declare the nature and extent of that interest to the other members and must make further declarations if his/her interest changes.

6.3. If a member has any doubt about the relevance or materiality of an interest, this should be discussed with the chair with reference to the Trust's Conflicts of Interest policy [and Trust Constitution].

6.4. Any such declaration must be made before the Trust enters into the transaction or arrangement (except where the director is not aware of an interest, transaction, or arrangement).

6.5. In the event a member has a conflict of interest with an item on the agenda of a meeting of the committee in common, he/she should notify the chair in advance of the meeting. The conflict of interest should be declared at the start of the meeting. When the agenda item is reached the member concerned should withdraw from the meeting and play no part in the relevant discussion or decision if they have declared a prejudicial interest.

6.6. Interests that are declared as personal but not prejudicial will be noted but will not necessarily necessitate withdrawal from the relevant discussion and/or decision. (Prejudicial interests are those that a member of the public with knowledge of the relevant facts would reasonably regard as so significant that it is likely to prejudice the member's judgement of the public interest and/or interests of the Trust.)

6.7. During the course of a meeting of the JWG, if a prejudicial conflict of interest arises, the member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.8. A member need not declare an interest:

i. If it cannot reasonably be regarded as likely to give rise to a conflict of interest;
ii. If, or to the extent that, it concerns terms of the member's appointment that have been or are to be considered by either a meeting of the Board of Directors or by a Committee of the directors appointed for the purpose [under the Constitution].

6.9. The JWG shall have, and maintain as current, a register of interests of the members of the committee and any co-opted members. As a minimum, the register of interests will be reviewed annually.

7. Meetings

7.1. The JWG shall meet at intervals of not less than six months or otherwise as the members agree is appropriate.

7.2. Meetings of the JWG may be held in person or by telephone, video or other electronic means.

8. Quorum

8.1 The meetings of the JWG will be deemed quorate when not less than half the members are present, including at least one Non-Executive Director and at least one Executive Director from each Trust.

9. Chair

9.1 The LPT and NHFT Chairs will rotate the chairing of the Joint Working Group by mutual agreement.

10. Administrative Support

10.1 The Trusts will provide administrative support as appropriate to the JWG.

11. Agenda, papers and minutes of meetings

11.1 The agenda and papers will be agreed by the Chair of the JWG. The agenda and papers will be distributed to members and those invited to attend by email only and by no later than three clear working days before each meeting. Late and tabled papers will only be accepted on agreement of the Chair.

12. Record of Meeting

12.1 A written record of each JWG meeting will be produced and shared within five working days of the meeting.

13. Reporting

13.1 Following each JWG meeting, under the direction of the Chair for that meeting, the JWG will produce an amalgamated assurance report on the overall programme position on each of the joint priorities.

13.2 This assurance report will be drawn from the individual highlight reports on each of the joint priorities (produced and submitted in advance by the programme leads) and following the JWG's considerations of them during each "star chamber" meeting.

13.3 Each Trust Board will receive this assurance report via its respective CiC at a meeting in public (from January 2022) in the same way as any other Committee assurance report would be received by the Board.

13.4 The assurance report will set out progress against the joint priorities and recommend any changes for approval and highlight risks or concerns as required.

13.5 Each Trust Board remains ultimately accountable for the delivery of the programme of joint priorities agreed under the Group Model structure.

13.6 Each year, both Trust Boards will consider and approve a programme of joint priorities for delivery.

14. Review

14.1 These Terms of Reference will be formally reviewed by each Trust Board on a regular basis following their review by the JWG. Each Trust Board will approve any recommendations proposed by the JWG for amending these Terms of Reference.

15. Approval

Approved by NHFT Trust Board of Directors on XXX
Approved by LPT Trust Board of Directors on XXX

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Leicestershire Partnership NHS Trust

Trust Board – 25th January 2022

STEP up to GREAT Trust Strategy

Purpose of the report

- The Trust's refreshed strategy known as 'STEP up to GREAT' has been produced to ensure the organisation has a fit for purpose strategic plan for how it will get from its current position to great, taking into account the learning from the past 2 – 3 years as well as the changing national and local system context.
- The final strategy content has been supported by Trust Board but a fully designed version is being brought today for visibility.
- The report also outlines the proposed delivery plan approach and next steps.

Analysis of the issue

Strategy

- The Trust strategy was supported by Board and launched in November 2021 and the final designed and launched version of the Strategy is attached. A process of communication and engagement has since been undertaken with support of communication team colleagues including e-shots, short video clips, Big Conversations and attendance at various cross-organisational meetings.

Next Steps - Delivery Plan

- Annual strategic delivery planning is an organisational management activity that is used to set priorities, focus energy and resources, strengthen operations and ensure that employees and other stakeholders are working toward common goals. The exercise has also established intended outcomes/results/impact, and how this will be measured.
- The delivery plan also supports the Trust in delivering the strategic priority of being well-governed and acts as a barometer for how well the Trust is delivering against it's strategic goals. NHS Trusts are also required to submit annual operational plans and the strategy lead for the Trust has been working closely with the planning lead to ensure alignment.
- A first iteration of the delivery plan has been co-produced with each Executive brick lead and aligned to the Trust Strategy which identifies how values, goals, enablers and cross-cutting issues will be taken forward.
- The delivery plan has also been developed with support of the Trust PMO and the governance team to ensure systems and processes are in place to monitor the plan and report accordingly. It covers the remainder of 2021/22 and as far into 2022/23 as feasible subject to clarity of planning guidance received 24th December 2021. It was agreed that the delivery plan would be reviewed again in April 2022 in line with the completion of the National Operational Planning timeline.

Proposal

- Trust Board are asked to support the next steps as outlined above with the approach of the strategic delivery plan as a tool for the organisation in monitoring delivery of the Trust strategy.

Decision required

- The Trust Board are recommended to support the strategic delivery planning approach.

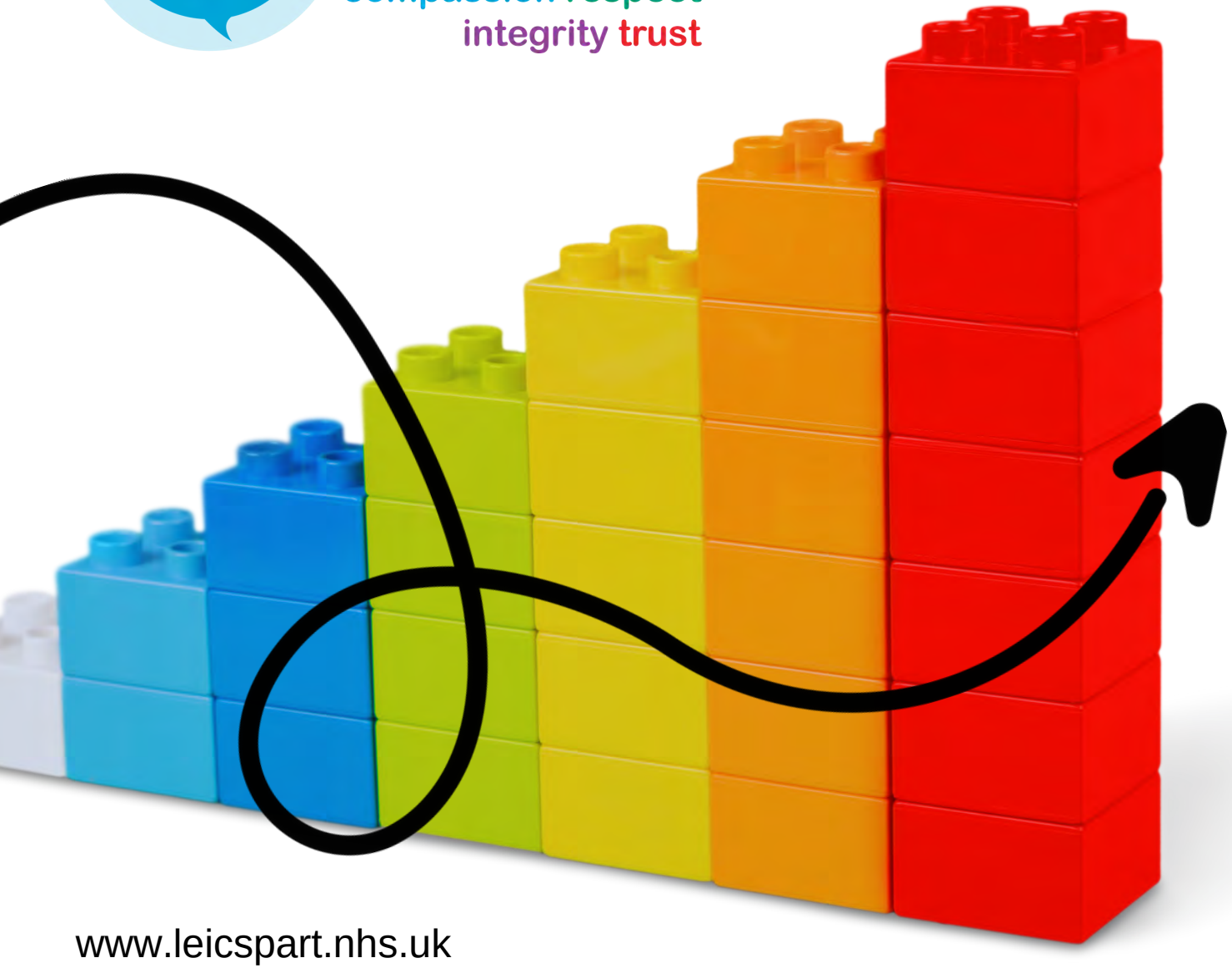
Governance table

For Board and Board Committees:	Trust Board 25.1.22	
Paper sponsored by:	David Williams - Director of Strategy & Partnerships	
Paper authored by:	Samantha Wood – Head of Strategy	
Date submitted:	19th January 2022	
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):	Trust Board reviewed final strategy content and supported in 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:	Final content has also been supported by Strategic Executive Board in October 2021.	
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	An update on the delivery of the Trust Strategy will be brought to Trust Board in April 2022 and then regular updates each quarter following.	
STEP up to GREAT strategic alignment*:	High **S**tandards	✓
	Transformation	✓
	Environments	✓
	Patient Involvement	✓
	Well **G**overned	✓
	Reaching Out	✓
	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:	No	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:	Addresses equality and health inequality.	

WeAreLPT

compassion respect
integrity trust

NHS
Leicestershire Partnership
NHS Trust



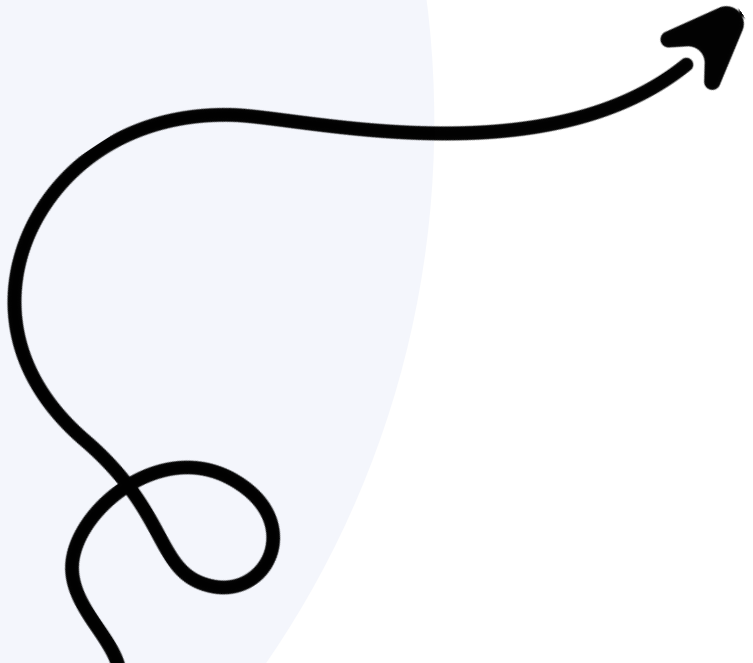
2021-24

Our Strategy

Creating high quality, compassionate care and wellbeing for all

www.leicspart.nhs.uk

Contents



Executive summary

Our vision is to create high quality, compassionate care and wellbeing for all. We have refreshed our Step up to Great strategy for the next three years (up to 2024), to continue working towards this vision, by developing a great organisation, that is able to deliver great outcomes, with great people as part of our local communities.

People remain at the heart of what we do, and their views on what matters most – whether you are a service users, staff member or partner – have been captured over the last year to help refresh what we do next to continue to Step up to Great.

We recognise that the next few years will be challenging for health and social care services, as we continue to deal with the Covid pandemic, and the recovery of our services, to achieve the NHS Long Term Plan. We cannot do this on our own and neither should we. We are committed to working in partnership with others to deliver integrated care together with our service users, families and carers, the wider NHS, local authorities and voluntary and community partners, not only in Leicester, Leicestershire and Rutland but across our region and beyond.

Introduction

By Angela Hillery, chief executive and Cathy Ellis, chair

We are proud of our staff and how they have stepped up to great since the launch of this strategy in 2019. Although initially introduced as an organisational strategy in response to our last CQC inspection, we know that staff have embraced it to focus on nine key improvement areas, which has led to positive changes in quality and safety. We know we have more to do. Our refreshed **Step up to Great** strategy outlines how we will build on the solid foundation it has created, to help our LPT family deliver our vision of 'creating high quality compassionate care and wellbeing for all' with our partners.

Safety has always remained our number one priority, and never has this been more poignant since the Covid-19 pandemic hit the world in 2020. During the pandemic, alongside the rest of the NHS, we re-focused our strategy to "preserving life." We took elements from our Step Up to Great Strategy that would have the greatest impact on supporting our staff and helping the population through these challenging times. For example, we advanced our digital transformation programme enabling staff to work from home and other locations and to continue to provide great patient care. We provided patients access to our services through on-line and telephone consultation; we supported those experiencing mental health crisis through the introduction of a central access point (in partnership with Turning Point). We were also able to open an urgent mental healthcare hub, avoiding greater attendances in Accident & Emergency, and keep those with long term respiratory conditions safe at home and out of hospital through virtual wards.

During 2021 we took some time to reflect, reset and rebuild our strategy with the learning and experience we have gained during Covid-19. We've had some great engagement through 'BIG conversations' with staff, volunteers service users and feedback from our stakeholders. Staff and patient feedback has helped to inform the recovery of our people and their health and wellbeing, transforming working lives, and transforming our quality of care and service delivery. Our stakeholders have told us that our staff are compassionate and have a positive commitment and leadership behaviours to deliver and improve healthcare. All this feedback has been used to inform the refresh of our Step up to Great strategy – and your continued engagement will be key to our collective success.

In 2021 NHS England outlined the establishment of Integrated Care Systems, to give "people the support they need, joined up across local councils, the NHS, and other partners. It removes traditional divisions between hospitals and family doctors, between physical and mental health, and between NHS and council services. In the past, these divisions have meant that too many people experienced disjointed care."

The people of Leicester, Leicestershire and Rutland deserve high quality, compassionate care and wellbeing for all, and we are committed to being an active leader in our integrated care system to deliver this.

Our updated Step up to Great strategy is therefore a culmination of our collective learning, achievements, feedback and national and local priorities, bringing together our focus for the next three years. We have retained eight of our nine original Step up to Great bricks and refocused the remaining brick from ‘Single Electronic Patient Record’ (implemented in November 2020) to ‘reaching out.’

You will also see the four goals of how Step Up to Great will help us to fulfil our Trust’s vision as an active player in our system. Through Step Up to Great strategy we will focus together on Great Health Outcomes, through Great Care, a great place to work and being an important part of our community. We are all leaders at LPT and can make a difference.

Through the coming pages we have outlined our strategic priorities to Step Up to Great. At the end of the document is our operational plan until March 2022, which will be updated at the start of every financial year. We hope you find this document useful in helping you understand how you can support us in delivering our strategy for creating high quality, compassionate care and wellbeing for all.

We are proud of our LPT family and look forward to continuing to work together with our staff, volunteers, partners and patients to Step up to Great.

Angela Hillery
Chief executive

Cathy Ellis
Chair

Working with others for integrated care

We want our population to have the best experience of their care, regardless of which set of organisations deliver it. Delivering integrated care helps to ensure our local communities have the support they need, joined up across local councils, the NHS, and other partners. It removes traditional divisions between hospitals and family doctors, between physical and mental health, and between NHS and council services. In the past, these divisions have meant that too many people experienced disjointed care.

We are committed to ensuring we have joined up services within LPT and between us and other organisations, to create high quality, compassionate care and wellbeing for all. There will be a system wide plan (called an Integrated Care System or ICS) that we are contributing to and developing with others.

To aid our thinking about our wider role in the system and within our communities and to be clear about how this connects to our Step up to Great strategy we have described 4 goals that support us to achieve our vision and strategy in partnership with these wider stakeholders.

Great health outcomes

For everyone in every community across Leicester, Leicestershire and Rutland (LLR). Tackling health inequalities, working together to ensure there are safe, healthy places for people to live and work are important elements of the integrated care we can provide with others.

Great care

We want every service user and their family to have great care, we are playing our role in that by improving on the areas we know we need to improve on and seeking feedback and learning from our communities on other changes and improvements we can make.

Great place to work

Our 6,500 staff and volunteers provide services through over 100 in-patient and community settings, as well as in people's homes, across Leicester, Leicestershire and Rutland. We want to continue to develop LPT to be a great place to work and be an employer of choice. Having a great place to work helps us all to keep improving the quality of care we can provide.

Part of the community

With over 76,000 health and care employees in LLR we play an important role in our communities. The actions we take along with other providers, local authorities, universities etc. have a real influence on how we develop our communities. Through our strategy we are committing to think more about the impact on our communities and the decisions we can make to benefit them.

Group priorities

Leicestershire Partnership and Northamptonshire Healthcare Group

After two years of buddy support between LPT and Northamptonshire Healthcare NHS Foundation Trust (NHFT), we formalised this relationship in April 2021 through an NHS group model, to learn and work together on some key priorities. Whilst both organisations retain our own identities, we recognise that by doing some things through collaboration we will be able to achieve more, for the benefit of our staff and local populations.

For 2021/22 we have identified eight group priorities and we are working with NHFT to deliver these together.

Each priority is led by an executive director from LPT or NHFT and our group meetings are chaired by the chairs of LPT and NHFT in rotation.

"We have so much strength in our diverse staff and patient groups that racism undermines and destroys. Being actively anti-racist and celebrating diversity is a must for us."

Dr. Sam Hamer, clinical director

Together against racism
Be nationally recognised leaders on race equality and anti-racism in the NHS and employers of choice.

Talent management
As inclusive employers, widen opportunities for our workforce to develop and progress across our Group.

Leadership and organisational development
Have great leaders at all levels, leading with compassion and inclusivity within both organisations, skilled and trained to meet the needs of our people.

Innovation and research
Create centres of academic excellence that grow our contribution to innovation and funding income.

Quality improvement
Be outstanding organisations in the quality of the care we provide and all that we do to enhance our patient and populations' health.

Strong governance
Be outstanding Well Led organisations, delivering best practice governance across the Group and contributing to system governance and enabling agile and effective decision making.

Strategic finance
Use our financial strength to build back better for the benefit of our populations.

Strategic estates
Build new therapeutic environments which improve outcomes for people using services by supporting joined up, person-centred care; a positive, effective working environment for NHS staff and stronger and greener NHS buildings.

We are Together Against Racism - see the pledges from our Trust Board:

Cathy Ellis, chair:

I believe that equality matters, really matters, and I want LPT to be a place where everyone feels welcome. I show my commitment by listening to the experiences of our staff and influencing for equality at every opportunity.

Angela Hillery, chief executive:

People matter and I know we need to take steps to create a culture of inclusion and belonging for all. I show my commitment by leading, setting expectations and using my voice to challenge every day.

Mark Powell, deputy chief executive:

I want to be part of an organisation that actively embraces equality, diversity and inclusion, where my thinking can be challenged by positively drawing upon peoples' diverse experiences which enables a better place to work and provide care. I show my commitment by not tolerating any form of racism at LPT.

Faisal Hussain, non-executive director and deputy chair:

I believe in social justice and a society which is rooted in fairness and equity irrespective of the colour of a person's skin. I show my commitment by ensuring that I help create an environment which recognises and values diversity and enables an inclusive culture where we have a workforce that reflects the communities we belong to and serve.

Moira Ingham, non-executive director

While colleagues and service users experience any form of discrimination, we need to ensure that equality, diversity and inclusion are actions not just words. I show my commitment by actively listening to those who have experienced discrimination, then challenging myself to speak out and have brave conversations with others, in order to play my part in changing that experience.

Kevin Harris, non-executive director:

I believe that equality, diversity and inclusion is integral to a successful modern healthcare environment and improves the care of the patients. It allows LPT to attract a diverse range of high quality staff and identifies LPT as a progressive and innovative workplace that mainstreams equality, diversity and inclusion. I show my commitment by striving to continuously improve the way LPT delivers equality, diversity and inclusion.

Ruth Marchington, non-executive director:
I'm committed to be together against racism because I want all staff and patients to feel safe and confident to be themselves and the Trust to be a place where difference is valued and celebrated. I show my commitment to be together against racism by striving to be a more effective white ally, supportively challenging assumptions and learning from those with lived experiences.

Darren Hickman, non-executive director:
I believe it is important that everybody feels engaged and respected. Their contributions are encouraged, listened to, and taken into account to deliver an enhanced outcome for the organization and society. I show my commitment by being respectful and courtesy, treating everybody as an individual and recognizing there is always more to learn and understand. Questioning and improving where things are unfair and unjust.

Sharon Murphy, interim director of finance:
I want everyone to thrive and feel that they work in a culture that supports them every day 100%, whoever they are and whatever their background. I show my commitment by continuing to learn how to be anti-racist and ensuring that my behaviours always align with those values.

Sam Leak, director of community health services:
It is important to take positive action to prevent racial discrimination of any kind. I shall educate myself and others in race and racism and stand up against racism; calling it out whenever and wherever I see it. I will at all times respect individuals; as individuals and ensure that everyone has a voice and is listened to.

Fiona Myers, interim director of adult mental health:
We can only move forward if we work together to progress racial justice. I show my commitment by adopting the practice of self-reflection and asking ourselves to what extent are our behaviours aligned with our values, speaking up and recognising the impact of unconscious bias.

Sarah Willis, director of human resources and organisational development:
We need to eliminate injustice, particularly racial, for our staff and the communities we serve. I show my commitment by listening and challenging behaviours I see with compassion and empathy, ensuring I look within to understand my experiences and potential privileges.

Chris Oakes, director of corporate governance and risk:
I want to help to create an organisation and society that enables everyone to be included for who they are and embraces diversity and all the rich creativity and depth of experience this brings. I show my commitment by listening to people's experience and seeking to understand on the deepest level and to continue to challenge myself to use this to support change to create a more inclusive and diverse organisation.

Avinash Hiremath, medical director:
I want to work in an organisation where the diversity of background, experience and thought is nurtured, and thrives to grow an organisational culture of compassion, respect and inclusive development. I show my commitment by actively participating in ventures to foster inclusive growth, and by truly understanding and celebrating diversity.

David Williams, director of strategy and business development:
Racism is wrong, it harms all of us. I show my commitment by championing equality and speaking out against racism when I can.

Anne Scott, director of nursing, AHPs and quality:
I abhor racism of any kind "Our ability to reach unity in diversity will be the beauty and the test of our civilization" (Ghandi) and with every breath we take, we must commit to being that change, creating a better, more just world for everyone. I show my commitment by actively being an anti-racist and recognising privilege and the ways racism can be denied -through continuing learning and having the courage to live by my values and demonstrate these through my behaviors.

Helen Thompson, director of families, young people and children's services and learning disabilities services
Every interaction, everyday shapes the culture of LPT and by working together against racism, we will build a culture of fairness and equity with our staff and the communities we serve. I show my commitment by making time to listen and understand, recognising my own privilege and ensuring that racism is identified, explored and challenged.

Richard Wheeler, chief finance officer:
Ignoring systemic racism impacts work to eliminate health inequalities. I show my commitment by acknowledging diversity, celebrating difference and championing equality.

High Standards

It is important that all of our patients and service users receive a high standard of care from us. We work with a range of national organisations to regulate and accredit our care, ensuring that we deliver health and wellbeing services of the highest possible quality.

The Care Quality Commission (CQC) regulates our services, as the independent regulator of all health and social care services in England. It checks all NHS providers in England to make sure they're meeting national standards in all aspects of care, including whether they are safe, effective, caring, responsive and well-led.

We will know we're Great when...

We are consistently receiving positive feedback from the people who use our services and their carers. We will also be receiving assurance and positive feedback from our core regulators such as the Care Quality Commission (CQC) that we are providing a high standard of care.

To achieve a culture of great care we will focus on five key enablers supported by a detailed delivery plan:

- **Continuous focus on our trust vision of creating high quality, compassionate care and wellbeing for all.**
- **Aligned goals at every level, which we deliver through our values and leadership behaviours.**
- **Service user involvement and employee engagement.**
- **Continuous learning and quality improvement.**
- **Team working, cooperation and integration.**

We have listened to what patients and service users, staff and partners tell us are most important to them and have agreed four key commitments to high standards:

- We will deliver safe care and reduce harm.
- We will reduce variation and create a safety learning culture.
- We will transform our patients' experience of care - making no decision about them, without them.
- We will create the conditions for quality.

"I am constantly amazed how much patient care and staff relationships improve when we work together and boundaries disappear."

Michelle Churchard-Smith, deputy chief nurse

Transformation: of services

Providing community healthcare services in your home and locally

No one should stay in hospital for longer than is necessary. Step up to Great focuses on how best to develop our services to keep people well at home, with the best care we can. Ensuring that everyone can continue their lives in their home is vital for long-term wellbeing.

We will know we're Great when...

People can live at home for longer and better manage their health and well-being with support from health and care providers. People are supported to restore their health, wellbeing and independence after illness or hospital admission.

In order to achieve this, we will:

- Remain focused on ensuring safe high quality delivery of care by reviewing our clinical staffing models
- Develop and implement a Winter plan that is integrated into system delivery
- Progress our Ageing Well accelerator work
- Address our waiting lists, particularly in relation to continence and Neuro

Our home first model, delivered through local integrated health and social care teams, provides people with support at home as part of their recovery wherever possible. We also want to make sure that our patients are supported to return to their home for assessment.

Our remote monitoring programme enable us to monitor patients at home by asking them to complete questions and teaching them how to take vital signs readings, including oxygen saturation levels.

This can be seen in real-time by the patient's clinician, allowing for immediate intervention if needed. With the ability to video call and message a patient, we can provide additional assurance and support very quickly.

We are a national accelerator for the Ageing Well programme. This involves transforming our services to ensure that older patients have a two hour or 48-hour response to any deterioration in their health condition.This will allow people to stay in their home safely and for longer.

We want to develop a comprehensive waiting well programme to support those who are waiting for care. This programme supports patients and service users with self-help tools and to plan and prepare for their treatment and subsequent rehabilitation.

"This virtual Covid ward is an extension of our current urgent respiratory services to help build capacity and flow through our system. We are proud to play our part in emerging solutions for our health economy."

Dr. Sudip Ghosh,
deputy medical director

Transformation: of services

Improving services for people who need mental health support

Mental health represents the largest single cause of disability in the UK. Evidence suggests that one in four adults' experience at least one diagnosable mental health condition in any given year. Through our Step up to Great Mental Health consultation in 2021 we have been listening to what people want from their local mental health services so that we can implement improvements.

We will know we're Great when...

Patients/service users and staff share positive experiences, demonstrating patient-centred and joined up high quality, safe care which is accessible when and where it is needed.

Our plan is to build on the engagement work from the consultation we conducted in 2021 and work with our partners, including community groups in the delivery of the transformation of mental health services.

We are committed to investing in and improving mental health services for people in Leicester, Leicestershire and Rutland when their need is urgent or they need planned care and treatment.

Our priority is to join up mental health services with physical health and social services to improve the health and wellbeing of local people. Our plan focuses on how best to improve care – in people's homes, the community and hospital. Wherever possible, we want people to be seen at home or in the community to avoid them being admitted to hospital.

To achieve our priority, we will respond to the outcome of the public consultation in relation to proposals for:

- **Self-help, guidance and support**
- **Introducing a Central Access Point**
- **Expanding and strengthening the role of crisis cafes**
- **Improving and expanding the Crisis Services**
- **Expanding the hours and use of the triage car**
- **Introducing a mental health urgent care hub**
- **Introducing an acute mental health liaison service**
- **Joined up support for vulnerable groups**
- **Joined up community mental health services**

Transformation: of services

Improving services for children, young people and families and people with a learning disability

The building blocks for lifelong emotional and physical health are laid down in the earliest years of life. Early childhood is recognised as critical for building strong and healthy communities for the future. We are committed to our work in early prevention and the identification of population health needs to give every child the best chance of positive outcomes and life chances for the future. Children and young people deserve the best start for life, and we will work with our system partners to develop more accessible local services through family hubs, focusing on the first 1001 critical days. Many of our children and young people require additional support to achieve their full potential. We are committed to improving engagement across all sectors and are testing out new ways of working together. We will continue to work closely with our Youth Advisory Board to improve this engagement.

We will know we're Great when...

Children, young people and their families share decision making with our staff and have easy access to the right support, at home and at school.

In order to achieve this we will:

- **have clear evidence of the children, young people and their families 'voice' in the planning of provision in their local communities.**
- **have consistent high quality Education, Health and Care plans in place to meet children's needs.**

Improving mental health services for children, young people and families

Children and young people must have access to great mental health care when they need it. We know that nationally, there has been an increase in the number of children and young people requiring support with their mental health and emotional well-being during the pandemic. As part of the 'future in mind' programme we are working with system partners to develop an integrated approach to support children, young people and their families.

We are developing our community neighbourhood offer through the mental health support teams that will deliver direct care to children in their school settings. For children who need more specialist care we have increased our 'Crisis' support to offer support in emergency care alongside the Central Access Point (CAP) and Mental Health Urgent Care Hub. Our new CAHMS 'Beacon' unit and intensive community mental health support will be providing care for young people with eating disorders to keep children closer to home for specialist care.

We have developed a system neurodevelopment delivery model to improve the outcomes for children and young people with Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) and plan to jointly operationalise this with system partners to improve the service user experience and access to specialist support when needed.

We will know we're Great when...

Our Children and Young People (CYP) are accessing care when they need it.

In order to achieve this we will:

- **Increase access and reducing inequalities in mental health provision**
- **Provide early intervention into schools and neighbourhood working**
- **Provide crisis intervention 24 hours a day 7 days a week**
- **Implement the delivery model for neurodevelopmental conditions**

Improving services for adults with a learning disability

We want to ensure everyone with a learning disability gets the right support at the right time and place. We will deliver our shared three year plan with our local authority, voluntary sector and commissioning colleagues to ensure that people with a learning disability are better supported to live fulfilling lives in the community, and have speedy access to our services when they need it. If someone needs to be cared for in hospital we will ensure that this happens as close to their home as possible and that they stay in hospital only for as long as is medically necessary. We have created new, improved care pathways and services with our system partners and service users, and we will implement these together to achieve these aims.

We will know we're Great when...

More support for people with a learning disability to improve their health and wellbeing is available in the community, our service users tell us they are happy with our services, and fewer people with a learning disability need to be admitted to hospital.

Improving services for people with Autism

We are committed to working with our multiagency system partners to deliver a joint three year plan to reduce the health inequalities experienced by local autistic people. This work includes our role in leading the commissioning, provision and improvement of services that will support autistic people to live fulfilling lives in our communities and access our services more quickly when required. If admission to hospital is necessary we are committed to ensuring that they are cared for in environments suited to their needs, by staff with enhanced knowledge and skills.

We will know we're Great when...

Our service users with Autism have a positive experience of our services and are supported to live well in the community. They will wait less time to receive care when they need it and will be supported to stay out of hospital as much as possible.

Transformation: digital

Our experience of delivering care through the Covid-19 pandemic has shown us how much digital innovations can improve both the quality of care and our reach to local communities and staff.

Nationally the NHS has created a framework for the transformation of services towards digital services providing and supporting how we work. In LPT our initial focus is on delivering this framework and playing our role in the transformation across Leicester, Leicestershire and Rutland.

Digital transformation is important to us because we know the potential it has for helping us to address some of our biggest challenges. Our digital transformation will help us focus on our culture, implementation, digitally empowering patients and service users, and integration and interoperability.

We will know we're Great when...

We have the technology and support for staff and our communities to access services digitally that improves care, with support and alternatives for those who cannot.

Our key priorities for making digital innovation a reality are:

- **To lead a clear digital plan that makes sure digital transformation is owned by LPT and that through our journey we place citizens, staff and frontline services at the centre.**
- **Strong foundations or bricks upon which we build our digital future is essential. We are good but we want to be great, making sure our services are accessible, inclusive, reliable, modern, secure, sustainable, flexible and resilient.**
- **Our digital transformation will support our goal to be "a great place to work"; we will encourage a digital first approach - we have already enabled staff from different organisations to work flexibly and remotely where appropriate. We will ensure through a shared care record and other systems that staff have the information they need to do their job safely and efficiently at the point of care.**
- **We also know how important digital innovation is in supporting the continuation of providing blended ways of working, helping us to attract the best and most talented staff to come and work in our organisation because they can work beyond geographical boundaries.**

Environments

Having great environments helps us to deliver great care and have a great place to work for our staff. Without clear development of our estate, we know we will not have the foundations we need to meet all of our strategic goals over the coming years because we need our teams to be able to work in an environment that makes it easier for them to do their job properly. The form of our estate must follow our service and transformation plans and we know that these need to be delivered at pace.

We will know we're Great when...

We have welcoming, clean and safe buildings that reduce risk of harm to patients and improve their privacy and dignity.

To deliver this we have three key strategic aims for developing our estate which are:

- **Therapeutic environments that improve outcomes for people using services by supporting safe, joined up, person-centred care**
- **A positive and effective working environment for all staff**
- **Greener NHS buildings and identifying our route to net zero**

It is important that our strategic approach acknowledges that before we commit to expensive capital projects, we should make the best use of our existing buildings - using space in smarter ways to maximise capacity where it's needed. To support this, we will work with partners and with Northamptonshire Healthcare NHS Foundation Trust to better understand our estate, building a foundation of data on which to make informed decisions.

Using technology is vital for estate usage too. Our desk booking software roll out will enable us to flexibly book sessional space for blended working approaches and track and report on utilisation. This can enable more informed estate management and encourage better behaviour around using space, and crucially, save the Trust time and money and allow services to be delivered in the right places for patients and service users.

"We have an ethical responsibility to leverage our size and influence to drive our own emissions reductions and serve as a model for others. We have the potential to play a vital role resulting in reductions in emissions and enhanced patient care, staff satisfaction, and cost savings."

Kathryn Hinds,
quality coordinator

Patient Experience and Involvement

It is important that our patients and service users have the best experience of our services. We know that a patient's experience is positive when we provide high quality, compassionate care and wellbeing for all, and we involve them in our decision-making. Patients and service users have also told us that their experiences start from their very first contact with the health and care system, right through to their last, which may be years after their first treatment, and can include end-of-life care.

We will know we're Great when...

Patient involvement is at the core of everything we do and our patient satisfaction, and feedback reflects this.

Alongside an inclusive leadership culture, we are committed to continuing our drive towards a whole system approach to collecting, analysing, triangulating, using and learning from patient feedback for quality improvement. That is because, without this approach, it is much more difficult to track, measure and drive improvement in the care we provide.

To ensure that patient involvement is at the core of everything we do and our patient satisfaction, and feedback reflects this, we have co-designed these three aims with patients, carers and staff:

- **We will make it easy and straight forward for people to share their experiences**
- **We will increase the numbers of people who are positively participating in their care and service improvement**
- **We will improve the experience of people who use or who are impacted by our services**

"The People's Council welcomes the patient and carer voice being put at the very heart of this strategy. We look forward to continuing to work with the Board and staff of Leicestershire Partnership NHS Trust to ensure that LPT are great for all."

Mark Farmer,
chair of People's Council

Well-governed

We are committed to our patients and service users receiving a good quality experience of care that is both safe and effective. It is important that we build on the foundations we have built for an open and honest organisational culture where staff at every level can have healthy debate and solid judgement.

Our Board is passionate about building strong relationships and have a key role in shaping how other organisations and communities work together to support better patient care and reduced health inequalities. Over the past two years we have learnt that sharing ideas and working together with Northamptonshire Healthcare NHS Foundation Trust (NHFT) can help us and them make improvements and strengthen our governance. Our strategic financial work with NHFT will support our knowledge and actions to ensure we continue to step up to great.

We know that Covid-19 has increased pressures on our organisation and wider system and that we will continue to face difficult questions about prioritising resources. Our decision making will be driven by identifying and promoting the best health and wellbeing interests of our communities and people.

We will know we're Great when...

We feel clear and confident about how we are governed, and we use these practices consistently across the Trust. When we are an outstanding Well Led organisation, delivering best practice governance across our Group and system, demonstrating agile and effective decision making.

Our aims to deliver this will focus on:

- **Providing leadership for ongoing improvement across our Well Led framework, informed by learning from others**
- **Contributing to the delivery of joint governance objectives under the Group Model with NHFT.**
- **Contributing to the development of ICS governance and risk systems.**

Finance

We know that having stable finances can contribute towards the 'triple aim' of better health and wellbeing for everyone, better quality of health services for all individuals, and sustainable use of NHS resources. To ensure the stability of our finances, we have developed our 2021/22 financial plan. We are also ensuring that we deliver our statutory financial duties and that we continue to focus on delivering value for money in both the way we spend our money and in the way that we deliver our services.

Knowing how much our estate means to the delivery of great quality and safe services, we will continue to invest capital funding to provide and maintain a safe, secure and healthy environment for our patients/service users and staff. We will also develop and implement our new medium term financial plan. The plan will be developed in association with system partners, as we collectively finalise the Leicester, Leicestershire and Rutland Integrated Care System financial strategy. The plan will set out how we will work together so that all partners in the strategy can be financially sustainable into the long term.

We will be focusing on:

- **the way we invest in our resources to deliver optimal health outcomes**
- **how we spend public money in the most efficient and effective way**

Data quality

Great quality data is important to us as it can lead to improvements in patient care and patient safety. One of our leadership behaviours is about taking personal responsibility. This is important as we all have a role to play in maintaining good data quality so that together we can keep improving services and decision making, as well as being able to identify trends and patterns, which allows us to better plan for the future.

We will be focusing on two key areas of data quality over the coming years:

- Data quality for clinical decision making – our frontline staff need to know that the information they use will help them to make the safest and most effective clinical decision.
- Data quality for planning – we need to make sure we have great quality data to ensure we can plan for the future and use our resources in the best way to deliver great care.

We will know we're Great when...

We have high quality data that is reflected through accuracy in recording data and active methods of data validation. We all take responsibility for promptly responding to identified errors.

We will ensure we achieve this by:

- **Engaging our staff in making sure we have a clear and consistent understanding of what good data quality is**
- **We have a clear data quality framework that guides our delivery of great data quality**
- **We have a clear and deliverable Data Quality Plan that supports us to deliver the framework**
- **We have explored and considered the resource required to deliver the Data Quality Plan and the maintenance of great data quality**

Reaching Out

LPT is a values-led organisation. That is why, contributing to the long-term health and wellbeing of our population, in a sustainable way through our actions, decisions and partners, is important to us. This includes our role in ensuring everyone gets to live a long and healthy life.

We will do this by 'reaching out' to use our influence and play our part to:

- ensure a sustainable local community,
- create a sustainable planet,
- support the reduction of poverty through employment and job creation, anchoring wealth in LLR through our procurement processes and
- positively supporting economic and regeneration policies and practices that will support the most vulnerable within our society.

We will know we're Great when...

We are positively contributing to local communities to help reduce inequalities.

The COVID-19 pandemic has laid out in stark focus the depth of the inequalities that exist and the devastating impacts they can have on our families and communities. As we come together in LLR as an Integrated Care System, we are committed to implementing the evidence-based actions needed to increase health equity in our society and reduce or eliminate health inequality together. We want the people of Leicester, Leicestershire and Rutland to be healthier with everyone having a fair chance to live a long life in good health. This is why we will focus the work we do to level up and reduce the gap in health, wellbeing and our part in public service provision.

With over 6500 people employed and volunteering within LPT, our reach into our communities is far greater than simply our provision of healthcare and well-being services. We are leading a well-being hub, providing support across Leicester, Leicestershire and Rutland to anyone employed by a health and care organisation who needs additional support and advice on managing their personal wellbeing.

Finally, through the procurement decisions we make, and our joint working with others, we know we can reach out and positively influence the economic and regeneration plans for our communities.

Equality, Leadership, Culture

Our people are our most important asset. Ensuring that they have a great experience of working at LPT is essential for achieving our vision of creating high quality, compassionate care and wellbeing for all.

The arrival of COVID-19 acted as a springboard, bringing about an incredible scale and pace of cultural transformation, highlighting the enormous contribution of all our NHS people. We are committed to build on this momentum and continue to transform, keeping people at the heart of all we do.

We have developed a People Plan which shows our dedication to making LPT a great place to work and receive care. It promises that we will lead with compassion and inclusivity, with the health and wellbeing of our staff at the heart of all we do. It shows how we will work together to create an inclusive culture, where there is no discrimination or bullying. Through effective workforce planning we will nurture and support our staff to progress and flourish, offer them opportunities to deliver care through new models and in new roles.

Our plan reflects the National People Plan which sets out practical actions for employers and systems, as well as the actions that NHS England and NHS Improvement and Health Education England will take, over the remainder of 2020/21.

Our People Plan will focus intently in 2021 on these priority areas:

- Our people are safe and supported to be physically and mentally healthy and well.
- We are open and inclusive, and staff have a voice.
- Making the most of the skills in our teams.
- Recruiting and retaining our people.

We will continue to co-design with our people improvements to our culture, inclusion and leadership in order to create high quality, compassionate care and wellbeing for all. We will achieve in these areas:

Looking after our people
We will make LPT a better place to work by ensuring staff are safe and healthy, physically and mentally well and able to work flexibly.

Creating a sense of belonging
We will take action to ensure our Trust engages staff well to hear their voices, and is inclusive and diverse - a place where discrimination, violence and bullying do not occur.

Foster new ways of working and delivering care
We will do this by making effective use of the full range of our people's skills and experience.

Growing for the future
We want to capitalise on the unprecedented interest in NHS careers and higher numbers of applications to education and training.

We will know we're Great when...

We value inclusive, compassionate behaviours and show pride in our collective leadership and in our Trust.

We will achieve this through:

- **Delivery of the Trust's People Plan**
- **Our joint work with NHFT focused on working Together Against Racism, leading to improvements in our Workforce Race Equality Standard (WRES).**
- **Improving our culture, leadership and inclusion with the Our Future Our Way programme, and embedding our Leadership Behaviours for All staff.**
- **Our group focus on talent management, leadership and organisational development.**
- **Improving employment and development opportunities for our Black, Asian and Minority Ethnic people.**
- **Through changes in everything we do, we will also see improvement in our Workforce Disability Equality Standards (WDES) as well.**

"The strategy for me focuses on people. We know that when our staff feel happy and well supported, the care we provide for patients improves. I will know that we have achieved this target when all of our staff feel that LPT is a place they can grow and develop in, where they don't feel that their options are limited because of their race and they know and understand that LPT is actively committed to growth and development of all of its staff."

Saskya Falope,
deputy head of nursing

"Our workforce is of a very multicultural nature and being nationally recognised leaders on race equality would provide a high sense of fairness and equality being embedded as the norm."

Nish Thakrar,
costings accountant

Our Future Our Way

Improving culture, leadership, inclusion

Access to Services

The NHS was founded on the principals of providing universal access to healthcare.

The social and economic environment in which we are born, grow up, live, work and age, as well as the decisions we make for ourselves can collectively have a bigger impact on our health. The Covid-19 pandemic has highlighted that while life expectancy continues to improve for the most affluent 10% of our population, it has either stalled or in some cases fallen for the most deprived 10%. Women in the most deprived parts of England spend 34% of their lives in poor health, compared to 17% in the wealthiest areas.

Some parts of our population including our BAME communities and our veterans are at substantially higher risk of poor health and early death. On average, adults with a learning disability die 16 years earlier than the general population and people with severe mental health illnesses tend to die 15-20 years earlier than those without.

We are committed to taking practical measures which will contribute to improving access to health services for all people who experience health inequalities

We will know we're Great when...

We are delivering services that meet people's needs and are accessible to all, evidenced through meeting our local and national targets.

We will improve uptake and delivery of our health services to reduce health inequalities by:

- **Identifying the barriers to equitable access.**
- **Determining the link between local barriers to access and health inequalities.**
- **Developing a best practice approach to supporting community organisations to address these barriers.**
- **Embracing the role of cultural brokerage in reducing barriers.**
- **Improving how people access our services.**
- **Conducting capacity and demand modelling based on new blended ways of delivering patient contacts.**
- **Reviewing access targets.**

Quality Improvement

We want to be an outstanding organisation in the quality of the care we provide and all that we do to enhance our patient and populations' health. We hold ourselves accountable for the quality of care we provide and are committed to driving quality improvement which translates into improved health outcomes and reduced health inequalities.

Quality Improvement is a formal approach to analysing performance and systematic efforts to improve. At LPT we have co-designed our own WeImproveQ methodology and guiding principles. Improving quality is about continuously evaluating and iteratively improving what we do to make it better, ensuring that we do the right thing at the right time for every patient. Always learning and improving is also one of our leadership behaviours.

We are passionate about research and we are committed to creating centres of academic excellence in Leicester, Leicestershire and Rutland and with Northamptonshire Healthcare NHS Foundation Trust. Doing this will grow our contribution to research, provide new opportunities for innovation and create new sources of income.

We will know we're Great when...

All our people are empowered to lead and make improvements in their everyday work. When performance and outcomes are measured and monitored in a systematic manner that leads to quality improvements being delivered and sustained.

Using the NHS 7 step model, we will build on WeImproveQ to inform our quality improvement strategy and priorities:

- **Setting clear direction and priorities**
- **Bringing clarity to quality**
- **Measuring and publishing quality**
- **Recognising and rewarding quality and learning**
- **Maintaining and improving quality**
- **Building capability for improvement**
- **Staying ahead**

Want to know more?

For more information about our Trust and our strategy please head to our website:

www.leicspart.nhs.uk

Follow us on social media to keep up with the latest:

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Leicestershire Partnership NHS Trust

Trust Board – 25 January 2022

NHS Net Zero Green Draft Plan

Purpose of the report

To meet the NHS contractual, policy and planning requirements to have a draft Green Plan supporting the NHS commitment to Net Carbon Zero targets
The draft plan is structured in line with the NHS Greener Plan guidance Greener NHS » Organisations (england.nhs.uk).
The guidance requires each trust and integrated care system to have a Green Plan which sets out their aims, objectives, and delivery plans for carbon reduction.
In each case, this should be signed off by the Trust Board, with a board-level 'net zero lead' responsible for overseeing its delivery.
Given the pivotal role that integrated care systems (ICSs) play, each system will also need to develop its own Green Plan, based on the strategies of its member organisations.

Analysis of the issue

The Draft Green Plan 2022-2025 for LPT is attached to this report, which has been developed through engagement with chapter and clinical leads.

Consideration has not been possible through a sub-committee of the Trust Board, given the short timescales for the plan's development, although updates have been provided to Trust Board Development sessions.

Proposal

It is proposed that the draft Green Plan and next stages in its development is supported by the Trust Board.

The next stages of the draft plan's development comprise:

1. Consideration of the draft by Trust Board
2. Building engagement across the organisation
3. Establishing baseline environmental data
4. Ratifying proposed actions and co-producing target dates for implementation

Decision required

The Trust Board is asked to

- Support the draft Green Plan and next stages of development
- Support the submission of the draft Green Plan to the ICS as part of the wider development of the ICS Green Plan
- Consider the governance oversight as the plan develops

Governance table

For Board and Board Committees:	Trust Board 25.1.22	
Paper sponsored by:	Richard Wheeler, Chief Finance Officer	
Paper authored by:	Richard Wheeler, Chief Finance Officer with engagement from Chapter leads	
Date submitted:	18/1/22	
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):	Sustainability chapter leads 14/1/22 Trust Board Development sessions	
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	Update to be provided as directed by Trust Board	
STEP up to GREAT strategic alignment*:	High **S**tandards	
	Transformation	✓
	Environments	✓
	Patient Involvement	
	Well **G**overned	✓
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	✓
	Trustwide Quality Improvement	✓
Organisational Risk Register considerations:	List risk number and title of risk	67 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
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None Staff engagement will be important to validate the proposals in the draft plan	
Positive confirmation that the content does not risk the safety of patients or the public	Green Plan is aimed at improving patient safety	
Equality considerations:	Green Plan would improve equality	

NHS
Leicestershire Partnership
NHS Trust

Green Plan
2022-25

Draft version 3

HEALTHIER PLANET
HEALTHIER PEOPLE

Contents

Introduction to LPT

In April 2011, mental health and learning disability services in Leicester, Leicestershire and Rutland were brought together with local community services and families, children and young people's services to create Leicestershire Partnership NHS Trust as we know it today.

We provide community health and mental health support to over 1 million people living in Leicester, Leicestershire and Rutland. Our services touch the lives of all ages (from health visiting to end of life care), from head to foot (from mental health to podiatry) and everything in between. We have 6,500 staff (including bank staff) who provide this care through three clinical directorates:

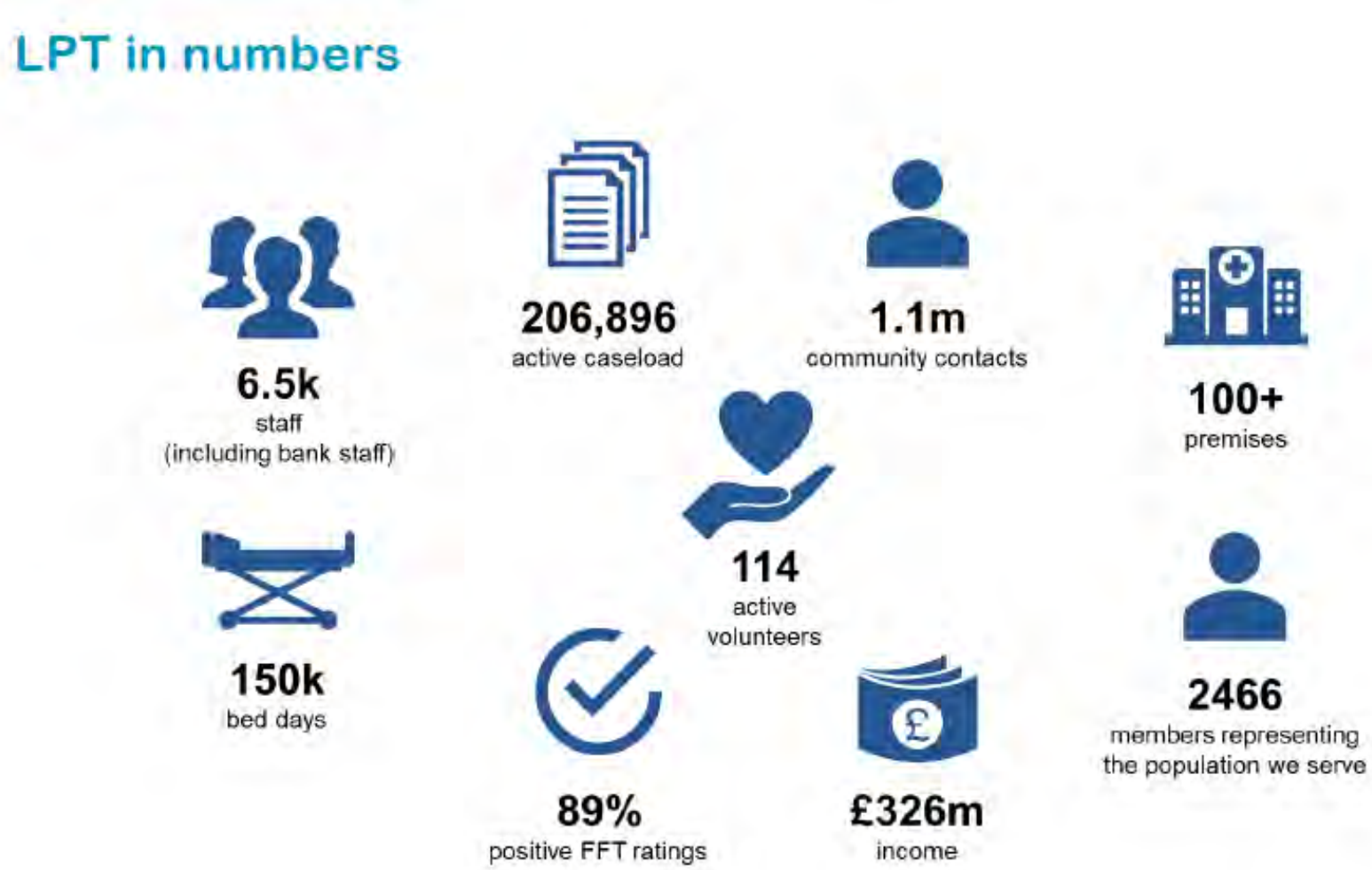
- Adult mental health services
- Families, young people and children's services and adult learning disabilities services
- Community health services

Their work would not be possible without our enabling and corporate services staff, alongside our hosted service providers and around 500 volunteers.

During 2020-21 LPT provided and/or subcontracted 99 relevant health services. Mental Health and Learning Disabilities account for 56 services and Community Health Services make up the remaining 43.

Our vision is to create high quality, compassionate care and wellbeing for all

Introduction – LPT in numbers



Organisational Vision, Values and Strategy

Leicestershire Partnership NHS Trust

Our vision is to create high quality, compassionate care and wellbeing for all. We have refreshed our Step up to Great strategy for the next three years (up to 2024), to continue working towards this vision, by developing a great organisation, that is able to deliver great outcomes, with great people as part of our local communities.

People remain at the heart of what we do, and their views on what matters most – whether you are a service users, staff member or partner – have been captured over the last year to help refresh what we do next to continue to Step up to Great.

We recognise that the next few years will be challenging for health and social care services, as we continue to deal with the Covid pandemic, and the recovery of our services, to achieve the NHS Long Term Plan. We cannot do this on our own and neither should we. We are committed to working in partnership with others to deliver integrated care together with our service users, families and carers, the wider NHS, local authorities and voluntary and community partners, not only in Leicester, Leicestershire and Rutland but across our region and beyond.

Introduction to Green Plan

In response to the updated NHS standard contract, NHS ambitions, policy and planning guidance Leicestershire Partnership NHS Trust (LPT) have produced this Green Plan. The Plan sets out how the Trust will support the transition to a Net Zero NHS and help achieve the ambitious Net Zero targets.

The Trust has recognises the importance of environmental sustainability and the role it must play in reducing the impacts of climate change. The Delivering a Net Zero NHS report established two new targets for the NHS.

1. To reach Net Zero for emissions it can directly control by 2040.
2. To reach Net Zero for indirect emissions it can influence by 2045.

Service providers are expected to contribute to the achievement of these goals, as such this Green Plan sets out the steps already taken by the Trust and its future plans.

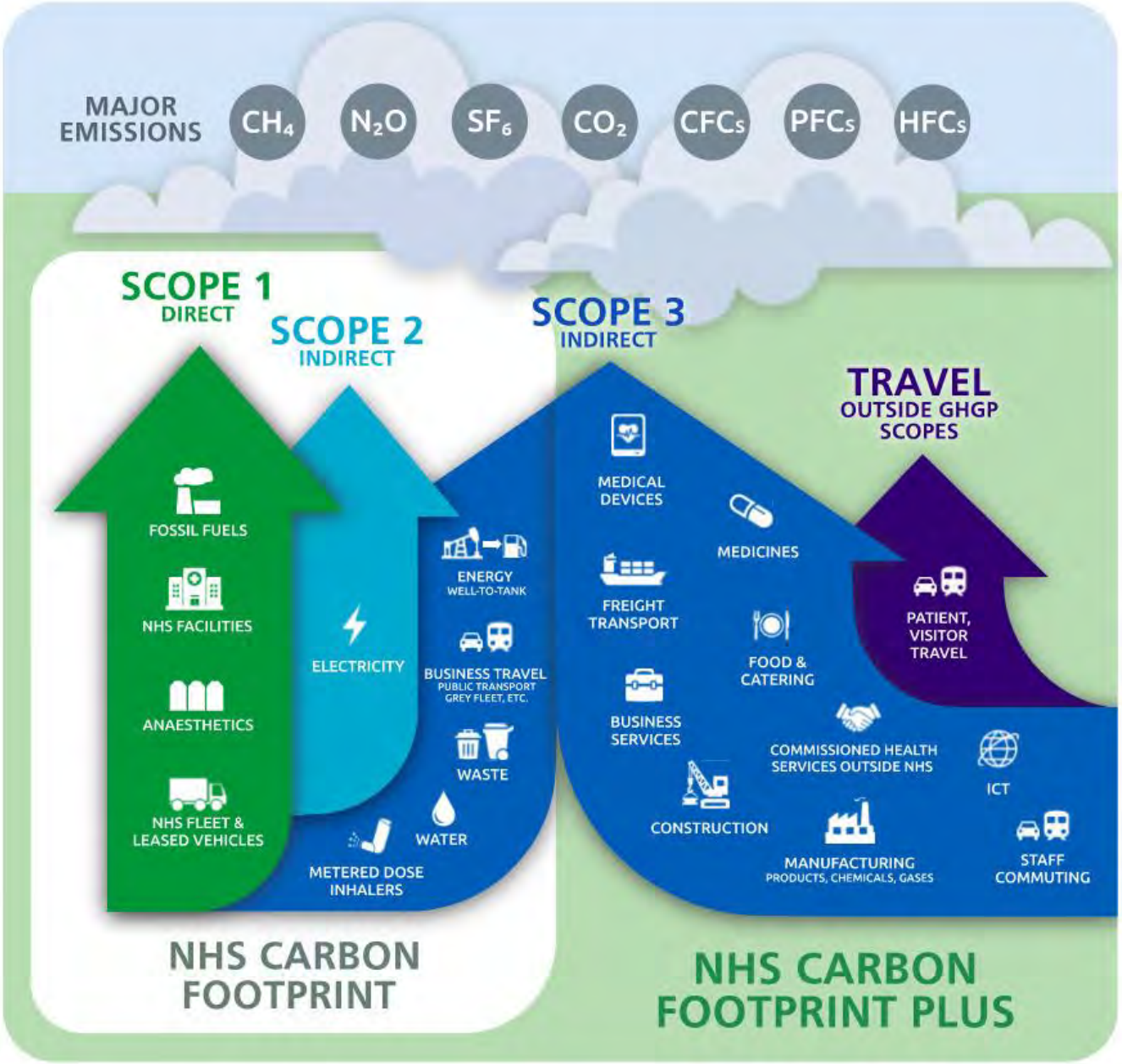
Development of data to support the plan is one key aspect as currently limited historic data is available.

Section 5 of this Green Plan lays out the Trust's nine areas of focus. Each sub-section details the purpose and proposed actions for the Trust to reduce carbon emissions. There has been limited time to engage fully in the development of this plan and agreement of timescales and measures of success for the proposed actions will form the next step of the plans development.

Approved on behalf of the LPT Board of Directors 25 January 2022

GREENER NHS – National Ambitions

Leicestershire Partnership NHS Trust



Climate change and human health are inextricably linked.

NHS became the first in the world to commit to delivering a net zero national health system.

With around 4% of the country's carbon emissions, and over 7% of the economy, the NHS has an essential role to play.

NHS Footprint – Net Zero by 2040

Footprint plus Net Zero by 2045

Workforce and System Leadership

Leicestershire Partnership NHS Trust

LPT produced a Corporate Social Responsibility Strategy in 2016 and is pleased to be part of the first health system in the world to set a target to reach net zero carbon, because climate change threatens the health and wellbeing of the patients we serve now and in the future. Engagement and embedding net carbon zero thinking in everyday healthcare business to support the huge interest to deliver health and sustainability benefits is our aim.

	Proposed actions	Measure of success
WSL1	Governance • Embed sustainability into business and change cases, to avoid it becoming a standalone function • Create a sustainability task and finish group to provide initial focus on Green Plan development • Leadership provided by the Chief Finance Officer	Net carbon zero becomes part of business as usual
WLS2	Engagement • Develop a communications plan to support a co-produced vision and priorities for carbon reduction and sustainable development. • Explore with the Peoples Council, Staff Side and other stakeholders to understand their most important issues	Greener champions Recognised impact of Greener Plan

WSL3	Training
	• Consider the merits and availability of training.
	  • https://carbonliteracy.com/
	  • https://sustainablehealthcare.org.uk/
		Better understanding from Board to Ward

Sustainable Models of Care

Leicestershire Partnership NHS Trust

Embedding net zero principles across all clinical services is critical, with this section considering carbon reduction opportunities in the way care is delivered. It aligns with the Clinical Strategy to ensure we are providing Value-based health care which helps people to: Improve their health; Reduce incidence and effects of chronic disease; Self-manage and live healthier lives

	Proposed actions	Measure of success
SMC1	Step up to Great Mental Health • Support the environmental impact assessment for the decision making business case	Impact assessment completed
SMC2	Value Based Healthcare • Develop data sources and methodology to capture the environmental benefits from this approach	Debulking of pathways
SMC3	Explore potential for university internships to create capacity in supporting value based healthcare and greener focus.	Capacity across health and management roles
SM4	Research published evidencing value based healthcare approach. Current examples include: • Virtual COVID-19 ward to accelerate the supported discharge of patients from an acute hospital setting [1] • Urgent MH Care Hub	Research publications

1 https://www.magonlinelibrary.com/doi/full/10.12968/bjhc.2021.0073

Digital Transformation

The direct alignments between the digital transformation agenda and a net zero NHS are clear. This section seeks to focus on ways to harness existing digital technology and systems to streamline our service delivery and supporting functions.

During the pandemic we advanced our digital transformation programme enabling staff to work from home and other locations and to continue to provide great patient care, alongside providing patients access to our services through on-line and telephone consultation.

A Single Patient Record went live in November 2020 and future developments including community e-prescribing are being explored, alongside telemedicine.

	Proposed actions	Measure of success
DT1	Homeworking is enabled under Changing Working Lives programme and the sustainable future work within the IM&T strategy. Pilots have been developed to explore and evaluate continued blended working	Staff wellbeing and engagement
DT2	Full use of Single Patient Record, including video, remote patient monitoring and telemedicine to be explored.	Virtual consultation and enabled patients
DT3	Recycling IT equipment in support of reducing digital exclusion and waste	Reduced waste and community benefit
DT4	Consider metrics to evaluate electronic working, including paper usage, home working, virtual outpatients	Identification of data and metrics
DT5	System Shared Care Record infrastructure plans implemented in line with the Charter for Collaborative Success	Platform for shared care records created

Travel and Transport

Leicestershire Partnership NHS Trust

This chapter outlines plans to reduce the carbon emissions arising from the travel and transport for our staff and patients. The health & social care system accounts for a significant proportion of road traffic in England, with 5% of all travel attributed to the NHS. This in turn accounts for 13% of the total NHS carbon footprint.

The Trust participates in the Cycle to Work scheme which enables staff to save between 25% - 39% on a bike and accessories through a salary sacrifice scheme.

	Proposed actions	Measure of success
TT1	Changing Working Lives • Capture the carbon reduction from travel changes	Financial and net zero savings
TT2	Lease Car Scheme • Explore the current Co2 cap and potential to move to ultra-low emission / electric only	Encourage take up of ultra-low emission or zero emission cars
TT3	Workplace Parking Levy – Leicester City Council • Explore the benefits which could be achieved if a workplace parking levy is introduced in the City	Partnership working with city council to support health delivery
TT4	Active Travel Plan • Undertake a travel survey and post code analysis to support development of an active travel plan • Infrastructure for cycle to work, e.g. cycle racks and showers	Better data to support travel plan development Improved infrastructure to enable travel choice
TT5	Identify benefits from auto-planner for community staff visits and volunteer drivers pilot	Reduced mileage

Estates and Facilities

Leicestershire Partnership NHS Trust

Trust has submitted an Expression of Interest under the Governments New Hospital Programme which would support more sustainable infrastructure alongside the net zero carbon agenda.
The Beacon Unit, new CAMHS unit is a BREEAM rated development. These are more sustainable environments that enhance the well-being of the people who live and work in them and help protect natural resources.
Faculties Management Transformation Business Case is in progress to improve safety and quality

	Proposed actions	Measure of success
EF1	Six Facet Survey • Completion of the survey to establish baseline environmental data	Baseline environmental data
EF2	Renewable energy • Switch in progress to take effect from 1 April 2022. Crown Commercial Services ERF Renewable for Business tariff	Renewable energy purchased
EF3	Energy usage • Consider electricity kwh usage per site to benchmark and provide focus for energy efficiency and half hour metering • Capture current heating and hot water system carbon emissions	Energy use certification and baseline data for buildings
EF4	New Hospitals Programme Refresh business case for New Hospitals Programme, including energy centre, design and net zero improvements	Business case development and approval
EF5	Waste management • Review existing waste management and recycling contracts	Establish baseline position

Medicines

Leicestershire Partnership NHS Trust

This chapter examines the key opportunities to reduce the carbon emissions related to the organisation's prescribing and use of medicines and medical products.
The single largest component of the NHS carbon footprint is pharmaceuticals, which encompasses a number of facets, including transport, waste and involves cross system working.

	Proposed actions	Measure of success
M1	Anaesthetic gas • Every trust to reduce its use of desflurane in surgery to less than 10% of its total volatile anaesthetic gas use, by volume.	Not applicable to LPT delivered services
M2	Inhalers • Every ICS to develop plans for clinically appropriate prescribing of lower carbon inhalers.	ICS leading this area of focus
M3	E-Prescribing opportunities Evaluate integration of existing inpatient e-prescribing with SystmOne as set out in LPT Digital Strategy Business case development for e-prescribing system across community services Robotic dispensing of medicines case in development	Reduced waste
M4	Transport • Gather data on commissioned transport contracts, including pharmacy delivery arrangements	Reduced transport

Supply Chain and Procurement

Leicestershire Partnership NHS Trust

The NHS supply chain accounts for approximately 62% of total carbon emissions and is a clear priority area for focus in every Green Plan. This chapter considers how NHS organisations may use their individual or collective purchasing power and decisions to reduce carbon embedded in their supply chains.

Work is underway to develop ideas across the LPT /NHFT Group and LPT Head of Procurement has the lead for sustainability across ICS procurement.

The Trust has committed to the use of recycled paper for all written communications both internally & externally. To achieve this the Trust now only purchases recycled paper.

	Proposed actions	Measure of success
SCP1	Reduce Single Use Plastics Reuse, Reduce, Repurpose and Recycle (4R) wherever possible. Categorise clinical supplies under the 4R headings	Reducing Use of High Greenhouse Gas Intensity Procured Items
SCP2	Embrace new technologies and innovations • Cardboard based waste containers • PPE innovations • Remanufacturing	Reduced plastics
SCP3	Ensure suppliers are meeting the zero carbon agenda • By implementing controls in tendering and contracting • all NHS tenders will adopt the Government's Social Value Model, a minimum of 10% scoring criteria assessing how suppliers will contribute to the NHS' net zero targets and social value in contract delivery [1]	Public services delivering best value

1 New 'Social Value' contracts to revolutionise government procurement - GOV.UK (www.gov.uk)

Food and Nutrition

Leicestershire Partnership NHS Trust

This chapter consider ways to reduce the carbon emissions from the food made, processed or served within the organisation. Where possible, this may include reducing overall food waste and ensuring the provision of healthier, locally sourced and seasonal menus high in fruits and vegetables, and low in heavily processed foods.
In the Patient-Led Assessment of the Care Environment (PLACE) LPT scored 90.52% for Food and Hydration against a national average of 92.19%. An independent review of food was published in October 2020[1]

	Proposed actions	Measure of success
FN1	Full catering service review against the Independent Hospital Food guidance	Leadership and food culture
FN2	Evaluate progress against the Trust Board pledge in January 2020 to no longer purchase or reduce use of: • single-use plastic stirrers and straws, except where a person has a specific need; plastic cutlery, plates or single-use cups made of expanded polystyrene or oxo-degradable plastics; single-use plastic food containers and other plastic cups for beverages – including covers and lids	Reduced plastic usage
FN3	Explore introducing digital menus and food ordering systems which can factor in a patient's dietary and cultural requirements, and nutritional needs	Reduced waste

1 https://www.gov.uk/government/publications/independent-review-of-nhs-hospital-food

Adaptation

Leicestershire Partnership NHS Trust

This section summarises our plans to mitigate the risks or effects of climate change and severe weather conditions on its business and functions. This may include plans to mitigate the effects of flooding or heatwaves on the organisation's infrastructure, patients, and staff.

Government policy information is set out in

- Climate change adaptation: policy information, Published 21 June 2021 [1]
- Climate change: second national adaptation programme (2018 to 2023) [2]

Key risks considered in the policy documents are: flooding, high temperatures, public water supply, natural capital, food production, pests and diseases.

Key issues impacting health:

- Risks to public health and wellbeing from high temperatures
- Potential benefits to health & wellbeing from reduced cold
- Risks to health and social care delivery from extreme weather
- Risks to health from changes in air quality
- Risks to health from vector-borne pathogens
- Risks to health from poor water quality

	Proposed actions	Measure of success
A1	Review the UK climate change risk assessment to consider the risks and opportunities from climate change.	Identify risks
A2	Respond as required to PHE, DHSC, NHS England and the Local Government Association (LGA) who will develop a single adverse weather and health plan by 2022.	Develop response

1 Climate change adaptation: policy information - GOV.UK (www.gov.uk)

2 Climate change: second national adaptation programme (2018 to 2023) - GOV.UK (www.gov.uk)

Conclusion and Next Stages

Leicestershire Partnership NHS Trust

This draft Greener Plan for Leicestershire Partnership NHS Trust establishes proposed actions under each of the core Greener Chapters.

Tackling climate change through reducing harmful carbon emissions will improve health and save lives.

- Air pollution is the single greatest environmental threat to human health in the UK, accounting for 1 in 20 deaths.
- Reducing emissions will mean fewer cases of asthma, cancer and heart disease.
- To promote sustainable care, psychiatry needs to bolster primary, secondary and tertiary prevention efforts. [1]

The next stages of the plans development are

1. Consideration of the draft by Trust Board
2. Building engagement across the organisation
3. Establishing baseline environmental data
4. Ratifying proposed actions and co-producing target dates for implementation.

1 The College's position on Sustainability | Royal College of Psychiatrists (rcpsych.ac.uk)

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Leicestershire Partnership NHS Trust

Trust Board – 25th January 2022

Care Quality Commission Update

Purpose of the report

This report provides assurance on our compliance with the CQC fundamental standards and an update following the CQC inspection of the Trust over May/ June/ July 2021. The Trust continues to prioritise quality improvement, patient care and compliance with the Care Quality Commission (CQC) fundamental standards in all care delivery.

Analysis of the issue

The CQC assurance action plan accompanies this report, to accurately reflect the achievements to date against the 'must do' actions.

Scrutiny and Governance

Following consolidation of all previous high level action plans onto one single CQC assurance action plan, the governance and reporting is detailed below:

- The must and should do actions are discussed at Directorate Management Team meetings for oversight and assurance.
- Ongoing weekly meetings with key nominated leads from the Directorates and the Quality Compliance and Regulation team, to update and examine evidence on the must and should do actions. This includes evidence of embeddedness and sustained governance and oversight.
- Any action considered to have been achieved will then have the evidence examined to gain assurance of completeness and presented to the Executive Director of Nursing, AHP's and Quality for sign off.
- The Quality Compliance and Regulation team hold a repository of evidence for each action.
- Each action is coded as green, amber or red:

A green rating determines the action is complete. Once signed off and agreement reached that the action has been achieved the green rating also includes the word 'complete'. Actions that are active and progressing to plan remain amber until such time that they are achieved.

Actions with a red rating illustrate that sufficient progress has not been made or there are significant challenges to achieving the action. An explanation of being classified a red action is provided in the update on the action plan.

- Progress is being reported to Executive Board meetings for oversight and scrutiny.
- Progress against the actions is being provided to the CQC on a monthly basis, as agreed with the CQC. This is being submitted, following scrutiny at the CQC assurance meeting, sign off

by the Director Nursing, Allied Health Professions and Quality and once shared with Strategic Executive Board.

- The actions pertaining to the well led domain are being held on an overarching CQC action plan with additional oversight by the Deputy Director of Governance and Risk and Transformation Committee.

Action Plan Summary

1. All actions are progressing; however there is a potential that the timescales of completion may be impacted by the current COVID-19 pandemic. Work is underway to identify the potential and actual risk and ensure these are mitigated.
2. Estates and Facilities work in relation to dormitories and call bells remains on track.
3. There is a firm grip on all actions; the groundwork and preparation required to achieve the actions has been undertaken and steady progress is being made.

Potential Risks

1. 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. Escalation and mitigation is required should any of the improvement activities be delayed or not achieved. A risk log is being developed to ensure clear identification of potential and actual risks due to the impact of the pandemic.

2. 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.

3. The current required Level 4 response to the Covid-19 pandemic and the stand down of level 2 and 3 committees has the potential to impact on the governance of actions in the CQC Assurance action plans. Mitigation is being put into place by the directorates to prevent delays to the actions.

4. The current staffing challenges due to absence relating to COVID-19 has the potential to impact on the release of staff for mandatory training. The Trust has maintained a position that all essential training will continue; however where safe staffing and patient safety ultimately is at risk this may impact on a staff member being released. The organisational risk is being regularly updated to capture the risks and identify actions to mitigate any risks.

Decision required

Trust Board is asked to note the oversight of the progress against the action plan. The paper also highlights the potential risks to impact on progress against these risks due to the current COVID -19 pandemic.

Governance table

For Board and Board Committees:	Public Trust Board 25th January, 2022	
Paper sponsored by:	Anne Scott, Director of Nursing, AHP's and Quality	
Paper authored by:	Quality Jane Howden Head of Quality, Compliance and Regulation	
Date submitted:	11/01/22	
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 13th January 2022	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning		
STEP up to GREAT strategic alignment*:	High **S**tandards	Yes
	Transformation	Yes
	Environments	Yes
	Patient Involvement	Yes
	Well **G**overned	Yes
	Reaching Out	Yes
	Equality, Leadership, Culture	Yes
	Access to Services	Yes
	Trustwide Quality Improvement	Yes
Organisational Risk Register considerations:	List risk number and title of risk	Risk 62
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:	Yes	

CQC Action Plan

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	Complete	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. (Regulation1 8(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

Trust Board 25th January 2022

Report title

Patient Safety Incident and Serious Incident Learning Assurance Report

Purpose of the report

This document is presented to the Trust Board bi-monthly *(just for the month of Dec this time to align reporting*) 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; these are owned and monitored through each directorate's governance route.

There has been a significant impact of the current national and local spread of the Omnicron variant of Covid19 infection on our patient's environment. This has also resulted with significant staffing challenges which is reflected in our compliance with NHS framework timescales of Serious Incident (SI) investigations which continues to be really challenging with the continued variables in compliance with the 60 working day deadline for submission to the CCG/other commissioners.

We continue to see reallocations of investigations due unplanned absence, increasing workloads and the increasing for the need of the CPST to support staff due to lack of training/experience as part of the operational teams juggling investigations for other investigations such as complaints and human resources. With sustained CPST input we are trying to reduce the investigations being required to be resubmitted to satisfy closure along with challenging of the feedback if it is outside the scope of the investigation. CCG delays continue due to their safeguarding and the national teams processes creating lengthy feedback delays. Our local LLR CCG patient safety team is currently affected by deployment to assist in the Covid19 booster vaccination response. The delays have also caused an increase in the requests from the Coronal service who require the report as part of their review process. The Legal team are appraising HM Coroner of our current position and the steps we are taking to maintain/address.

The national picture around patient safety incident investigation progress is unchanged due to the impact of Covid19 with planned changes through the patient safety investigation framework.

Internal investigations timescale compliance of remains extended to 50 working days, with many not completed before 60 days due to the increasing challenges of clinical workload and investigating to ensure local learning.
The CPST key message has been 'keep families and patients informed of the delays in investigations and them included in the investigation'; and, on many occasions now driving the sharing of the report at point of sharing with CCG to ensure they have right to reply earlier on.

The 8 Corporate investigators are all now in post (ranging from 3 months to one month in post). They are all undertaking investigations and this is starting to impact on Directorates releasing clinical staff back to care.

As described the above Covid19 situation has an added 'knock-on' for the timely closure and enactment of SI and internal action plans to close the investigation process continues to be challenging. Where reports have been significantly delayed for submission and closure to commissioner's request for action plan evidence/assurance that there is good progress has been requested; this is not unreasonable and the drive at the CPST investigation training has been 'if you identify an action that needs addressing or commencing before the completion of the report feed that back to the responsible senior team at that point'.

The Directorates have embraced ownership and are continuing to work hard to improve this. Additional scrutiny from the Trust senior team, CQC and the risk detailed on the Trust's risk register continues with local monitoring processes for backlog reporting regularly into local and Trust wide groups. Continuing scrutiny at local level for managing the action plan progress formerly at governance meetings needs to commence with pace and be the same across all directorates included as a standing agenda item.

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. This is evident by the significant increase in incidents reported in December 2021 (& likely January 2022) due to Covid19 and its impact on our staff and services.

Our incident reporting remains consistent with timely upload to the national reporting and learning system (NRLS). The NHS continues to await 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 continues to 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 and to manage the incident management database Ulysses.

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. This is in addition, to where possible, daily review of all the previous incidents via a triage report. CPST this is also a support action for depleted senior teams where managing there incidents is often delayed over providing direct patient care. This however does not remove the directorate and speciality ownership for timely review of incidents and the harm level assigned to them is paramount.
The ORR risk has been updated to reflect the challenges at every level of the incident reporting process and the risk increased from 12 to 16 to reflect the deteriorating position. There will be a quality summit early in February to consider further actions required

Review of Patient Safety Related Incidents
The overall numbers of reported of all incidents have increased above the expected range based on previous reporting patterns and can be seen in our accompanying appendices. Covid19 has increased the reporting pattern by 300 such incidents in just 2 weeks (latter of December 2021) which equates to approximately 20 incidents per day. This has also had the incidental effect of there being 2086 incidents reported last month, which is the first time we've had incident numbers above 2000. For comparison; in November there were 1788 incidents reported, and the previous highest month ever reported (January 2021) had 1936. The reporting for infection control appears for all services Top 5 incident category for the first time ever in December 2021.

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 is also mirrored in Category 2 pressure ulcers that have sat consistently above trajectory since February2021. December 2021 has identified the highest ever reported numbers of category 2 pressure ulcers that have affected patients and have developed whilst in LPT care.

We continue to share the reporting of Category 3 pressure ulcers that have developed in LPT care and the continued plan should be the focus for preventative care planning to understand why pressure ulcers then further deteriorate to category 4 for our patients in our care leading to significant harm, distress and an increase in healthcare resources.

Category 4 pressure ulcers continue to be of concern since May 2021 with a significant increase in reported injury in October 2021 with many escalated to StEIS for openness and transparency due to very early identification of significant care gaps mirroring the concerns raised by clinical teams due to changes in visiting schedules, reducing staff, changes to operational practice. We have continued to see the reduction in visits and inconsistent visiting approach implicated in the deterioration of patient's existing pressure ulcers to category 4. We have continued to have category 4 pressure ulcers that have developed in LPT care and impacted on our patients wellbeing that have been previously manage through local review escalated to StEIS due to the concern and learning identified. December 2021 identified a further downward trend alike November, from October 2021.

(NB the service have informed us that due to the challenges in the tissue viability team there may be a lag in confirming Category 4 pressure ulcers for December)

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 have been none reported for December 2021.

Falls

Inpatient Falls with harm Incident Investigations continue to be reviewed at incident review meeting (IRM), a 72hr report developed and are reviewed by the Executive Nurse and her before sharing with CCG. This provides information in understanding challenges of inpatient falls prevention and how the patients and families are affected.

The 'flat lifting' equipment that has been successfully rolled out in many inpatient areas over the previous few months to enable staff to safely raise people, who have fallen, off the floor and thus reducing the risk of exacerbating any injury. These have been described as being used appropriately in falls incidents and feedback is positive from the clinical staff.

Our falls across the organisation in patient areas have unfortunately shown an increase in the month of December 2021; the likely impact from challenges with staffing, patient acuity and the increased reliance on temporary staffing due to the challenges of managing the current Covid19 response.

All Self-Harm including Patient Suicide & Progress

We continue to see an increasing numbers of self-harm incidents resulting in moderate harm and above with a significant increase in November and even further increases way above our' expected baseline' in December 2021. The picture continues within the community mental health access services who are continuing to report increasing numbers of patients in crisis who have allegedly self-harmed or are planning to. This is so 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 and are linked to a few patients only in December. The incidents are impacted by one young person who requires significant input and interventions due to her eating disorder. These continue to 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 of foreign objects and ligature attempts being common themes, some patients requiring review by our acute care colleagues.

'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 awaits approval in adult mental health with a need to recognise this across directorates.

Violence, Assault and Aggression (VAA)

The worrying trend of high numbers of VAA across the Trust continues with significant increase December 2021 incidents of moderate harm.

Unfortunately, this category of incident features continues to feature in all mental health, CAMHS inpatient and all learning disabilities top 5 incidents. Our position is not unique as VAA have 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.

LPT security specialist is continues to provide expert support to those incidents being investigated under the serious incident framework supporting our corporate investigators. CPST looks forward with 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

December 2021 has seen a significant increase in medication incidents, in particular related to prescribing concerns this is following the combined work of the CPST lead nurse, incidents officer & pharmacy to alter the reporting criteria to make prescribing errors easier/clear to report for the

nursing teams. AMAT audit project related to medication safety compliance in the clinical areas continues to demonstrate encouraging involvement and results across the Trust that are regularly reviewed by directorates and by the medicines audit group. The CPST and senior pharmacy team look forward to the Trust moving forward with the establishment of a dedicated medication safety officer posts 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 continues to be 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 continues to feature across CAMHS and inpatient adult mental health remains a feature in the top 5 along. As previously reported, worryingly, the tissue viability incidents reported across CHS account for a significant number of the incidents with 531 of the 774 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 evidence.

The position with 'new' provider collaboratives remains unchanged with no current documented formal processes with us with continued inconsistent approach to feedback/documentation to completed submitted Patient safety incident investigation (PSII) reports.

This also creates a challenge around agreeing appropriate Terms of Reference and ensuring that the focus remains in achieving learning and supporting families/patients and staff.

Learning Lessons and Action Plan Themes

Learning Lessons Exchange

The Learning Lessons exchange group has not met due to the current challenges and changes in the governance rhythm, however will get back on track once routine governance rhythm returns.

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 a flow of knowledge
- Updated risk assessments and their application to clinical practice and from a MDT approach, emerging theme in outpatient mental health
- Mental Capacity and safeguarding knowledge
- Lying and standing blood pressure and medication reviews in falls with harm
- Feedback related to changes from face to face to virtual appointments has been feedback identified from patients/families as a challenge for some patients and also makes assessment more difficult

- Involving families in care decisions related to consent, confidentiality & information sharing in mental healthcare and suicide prevention which very topical following the publication of a national report form Zero Suicide Alliance in August 2021.
- The inconsistent use of data to monitor quality and performance

- **Focused themes and learning themes from Pressure Ulcer category 4 (unchanged)**
- Inconsistent approach to photography/documentation of wounds and to use the photography to inform care/escalation
- Recognition and timely escalation for additional supporting pressure ulcer relieving equipment
- Lack of timely holistic patient assessments, updating and sharing care needs consistently with patients, carers and families
- Timeliness of obtaining equipment to assist in prevention of further tissue injury
- Unchanged recognition by staff for the need of mental capacity assessments on initial admission to caseloads and when patient's conditions change featuring where 'patient compliance' has been described as a factor in ulcer development/decline.
- The allocation of visits and working processes needs to be streamlined to maximise nursing time to care

Focused themes and learning from falls with harm

There continues to be key unchanged learning themes from the Falls Steering Group:

1. **Reassessment of Patients who have fallen** - Consider reassessing a patient who has fallen, even if they did not incur harm, 24 hours after their initial fall to check for delayed pain or change of condition.
2. **Nursing observation intervention** – not being adhered to or not assessed correctly/timely when there are patient changes
3. **Monitoring of physical health status** – i.e. lying and standing blood pressure and recognition that change in wellbeing/medication matters

Culture of Candour

There have been no Statutory breaches of Duty of Candour.

CPST continue to report continued improvement across all directorates in the timeliness (<10days of recognition of 'moderate harm' and above (in Directorate and via IOG to QF)) 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. We have seen some challenges in Directorate of Mental Health due to complex incidents whereby next of kin and Police investigations have impacted on best practice compliance times.

Trust board support for final duty of candour communication to be undertaken by directors of services 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. We are promoting a change in culture amongst existing investigators of much earlier family/patient contact to increase their voices in reports and earlier 'right to reply' at point of sharing with CCG or earlier.

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 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. Feedback is good and should be seen in a gradual change in cultural towards safety investigations and the decision making involved. We continue to see more team leaders presenting their incidents, sharing post incident learning and participating in the decision making for next steps for investigation and that is despite the challenges of staffing and impact of Covid 19. The provision of allocated timed slots makes this easier for this to be undertaken

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. In addition to working with Directorate of Mental Health inpatient teams on Incident management as part of their leadership/safety function.

The CPST continues to deliver a PSII training programme which commenced back in September 2021 for band 7 staff allocated by directorates to assist in the timely undertaking of investigations and supporting learning. Planned programmes will continue well into 2022 along with refresher training for existing staff who have previously undertaken investigation training. Directorates have however not always been able to release staff to attend.

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 continues to be a proposed planned quality summit in early February 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. Her expertise from the acute provider aspect of the NHS and the LFD process has allowed her to quickly settle and start familiarising herself with the process in LPT. A process mapping exercise of the individual directorates has been completed as part of the next steps to inform working plan going forward in 2022 to streamline processes to ensure robust reporting, ability to further learn and share information against the national expectations and local policy.

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:	Trust board 25.1.22	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Sue Arnold, Tracy Ward (Corporate Patient Safety Team)	
Date submitted:	16/01/2022	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	PSIG-Learning from deaths-Incident oversight	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Assurance of the individual work streams are monitored through the governance structure	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	One –off monthly reporting as part of required reporting to executive team	
STEP up to GREAT strategic alignment*:	High **S**tandards	X
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	X
	Reaching Out	
	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 December 2021

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

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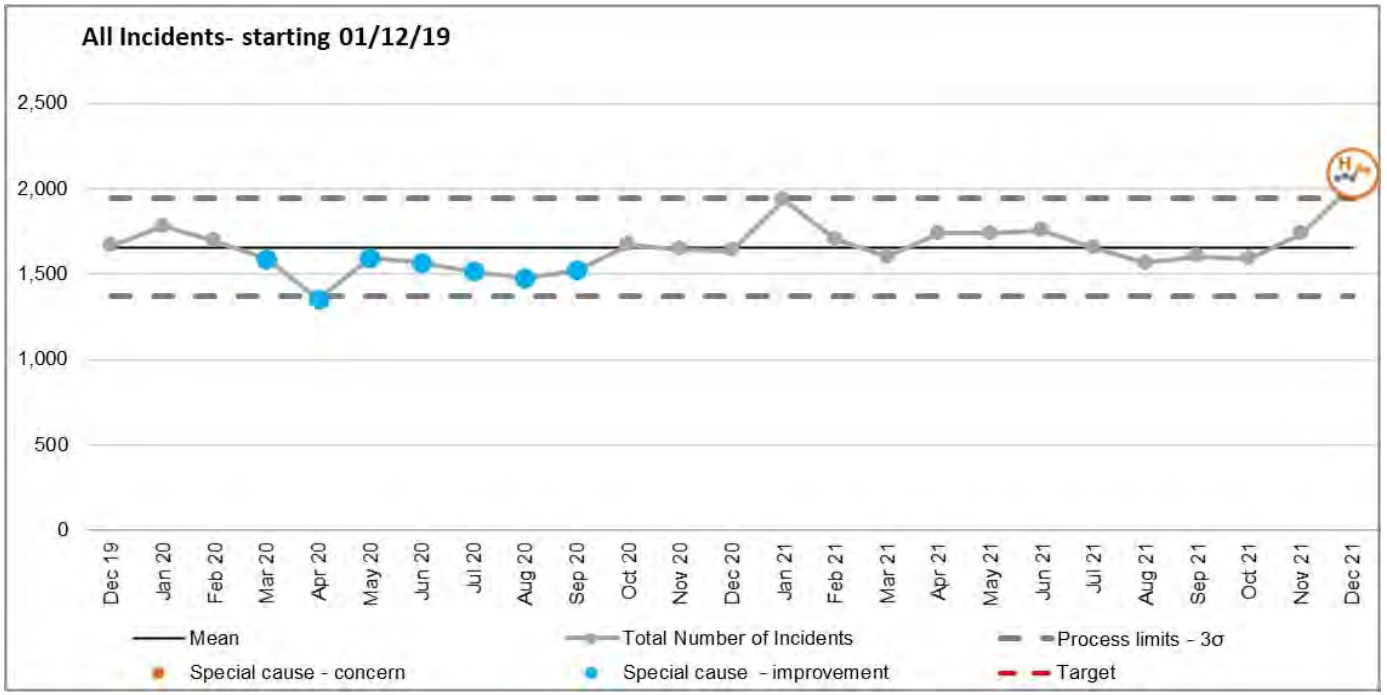
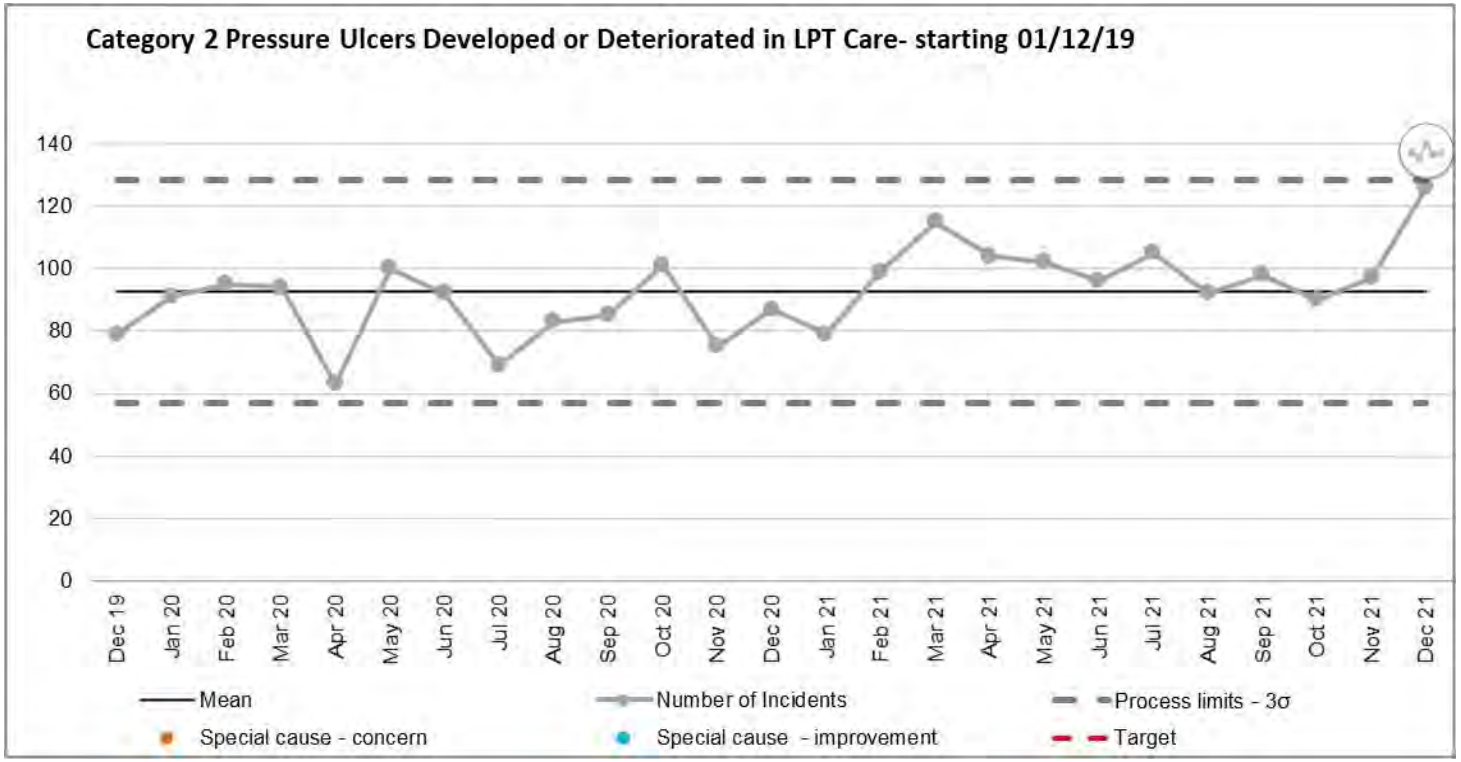
integrity trust

1. All incidents



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



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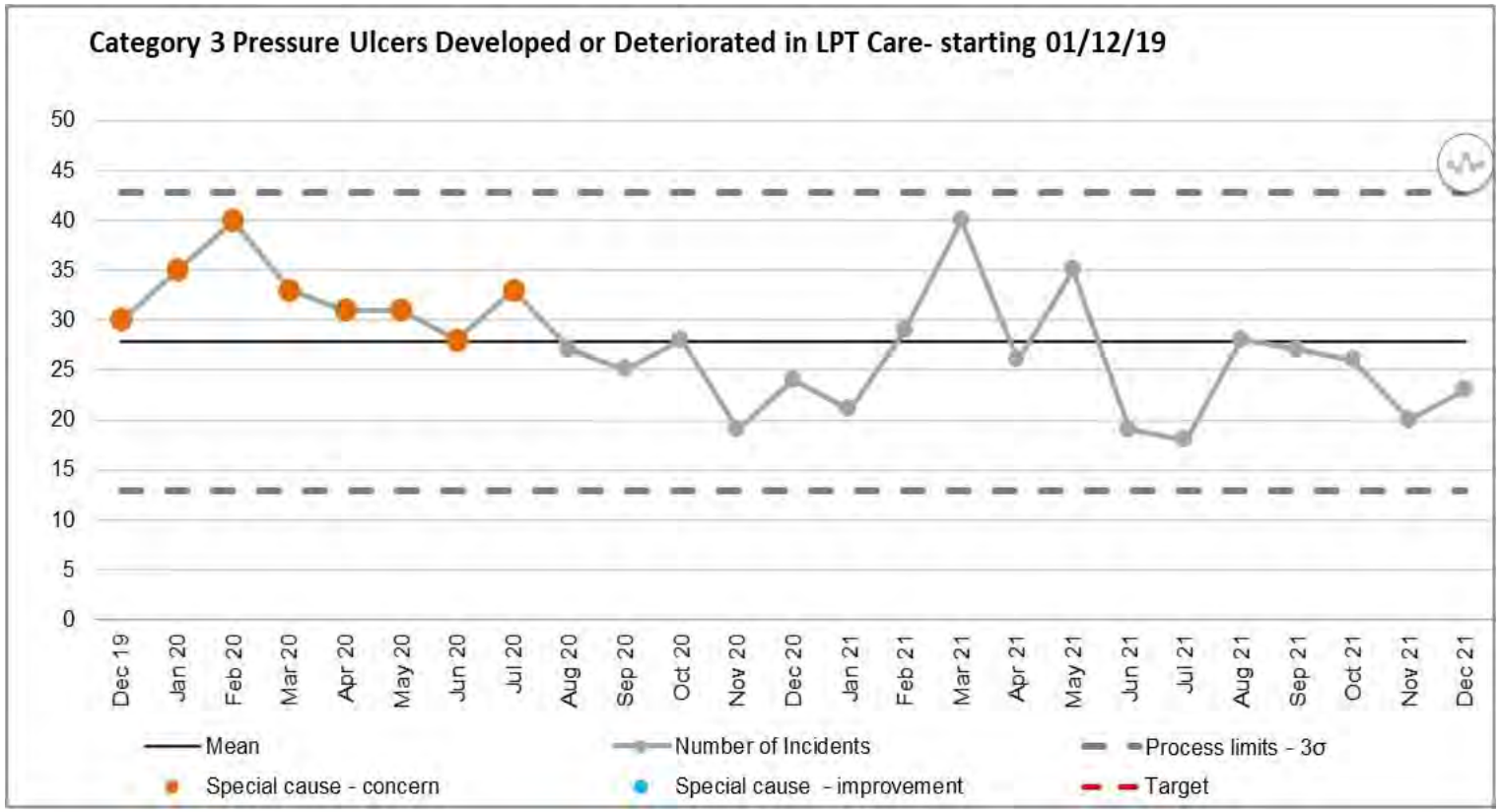
3. Category 3 Pressure Ulcers developed or deteriorated in LPT Care



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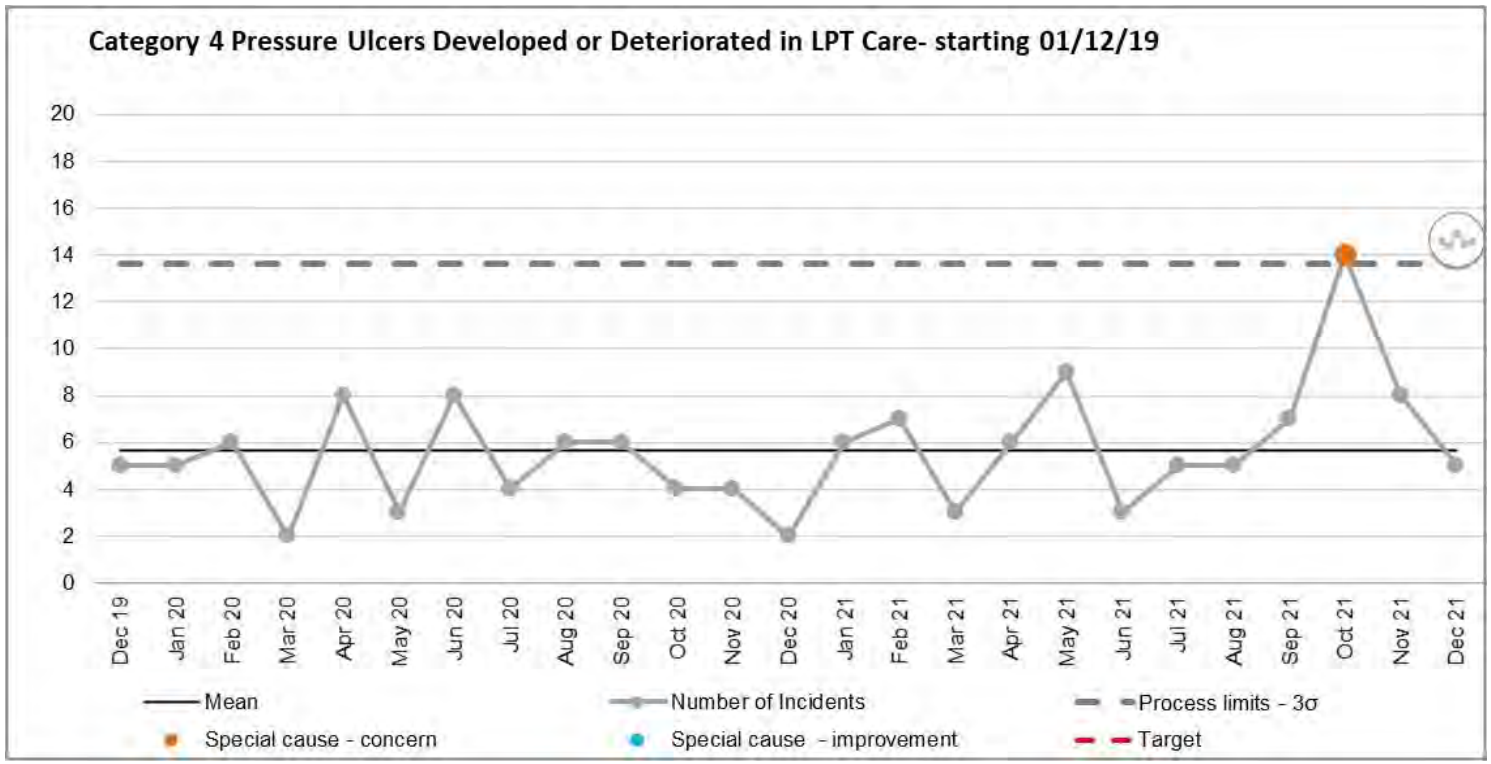
4. Category 4 Pressure Ulcers Developed or deteriorated in LPT Care



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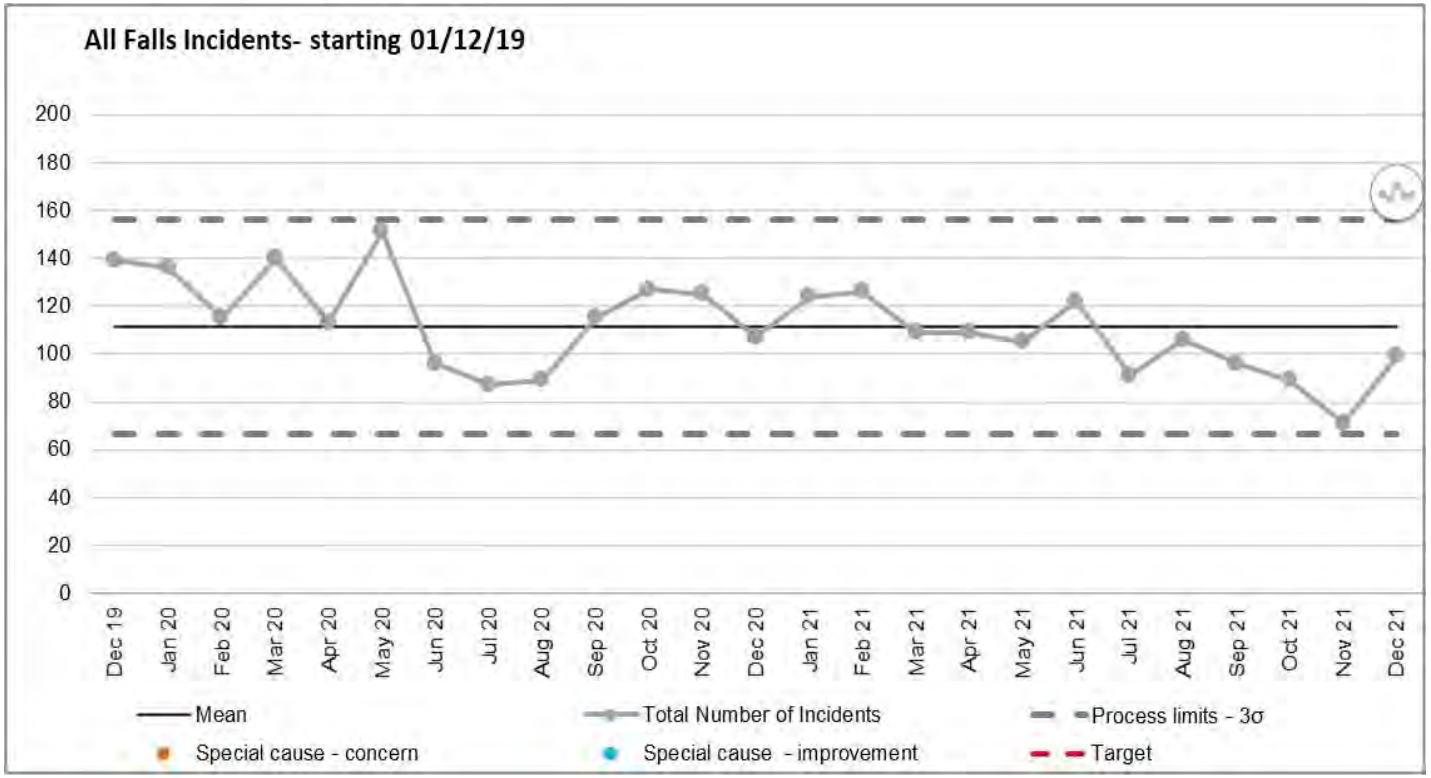
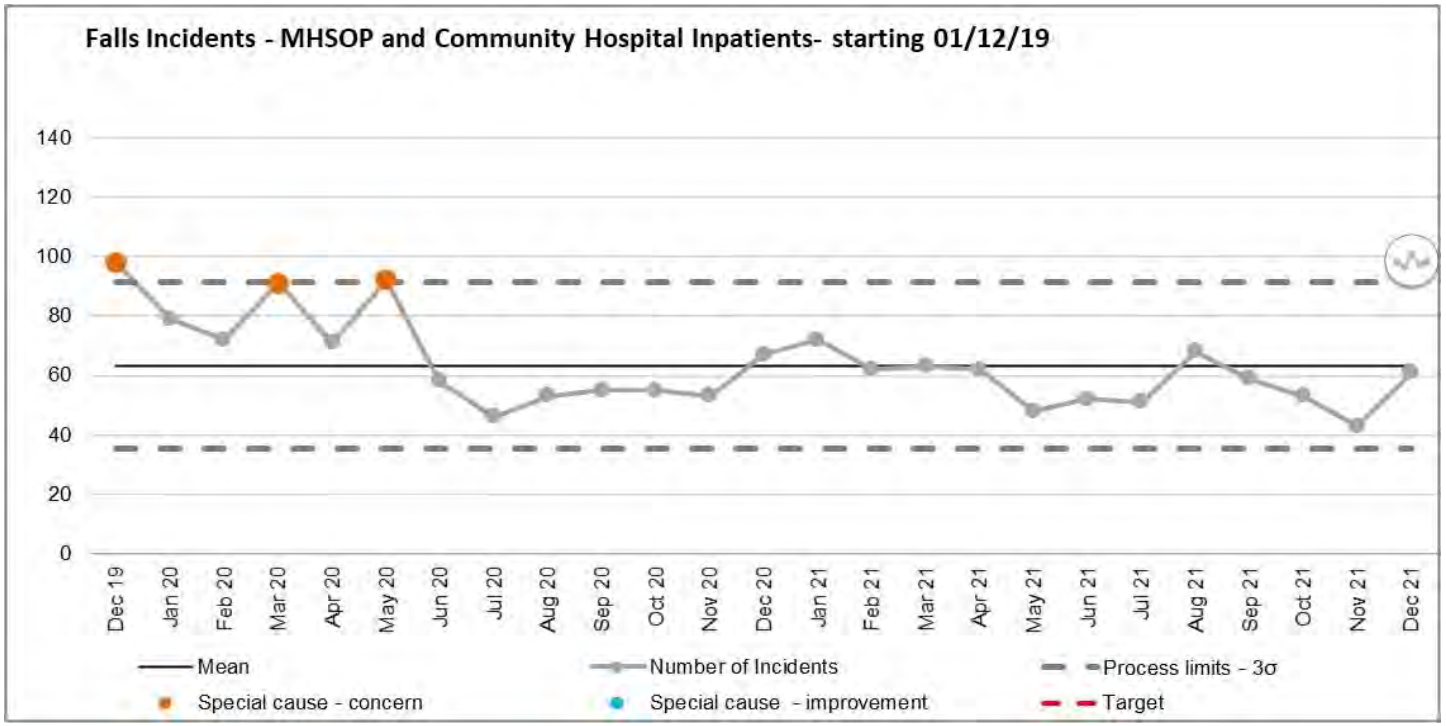
5. All falls incidents reported



6. Falls incidents reported – MHSOP and Community Inpatients



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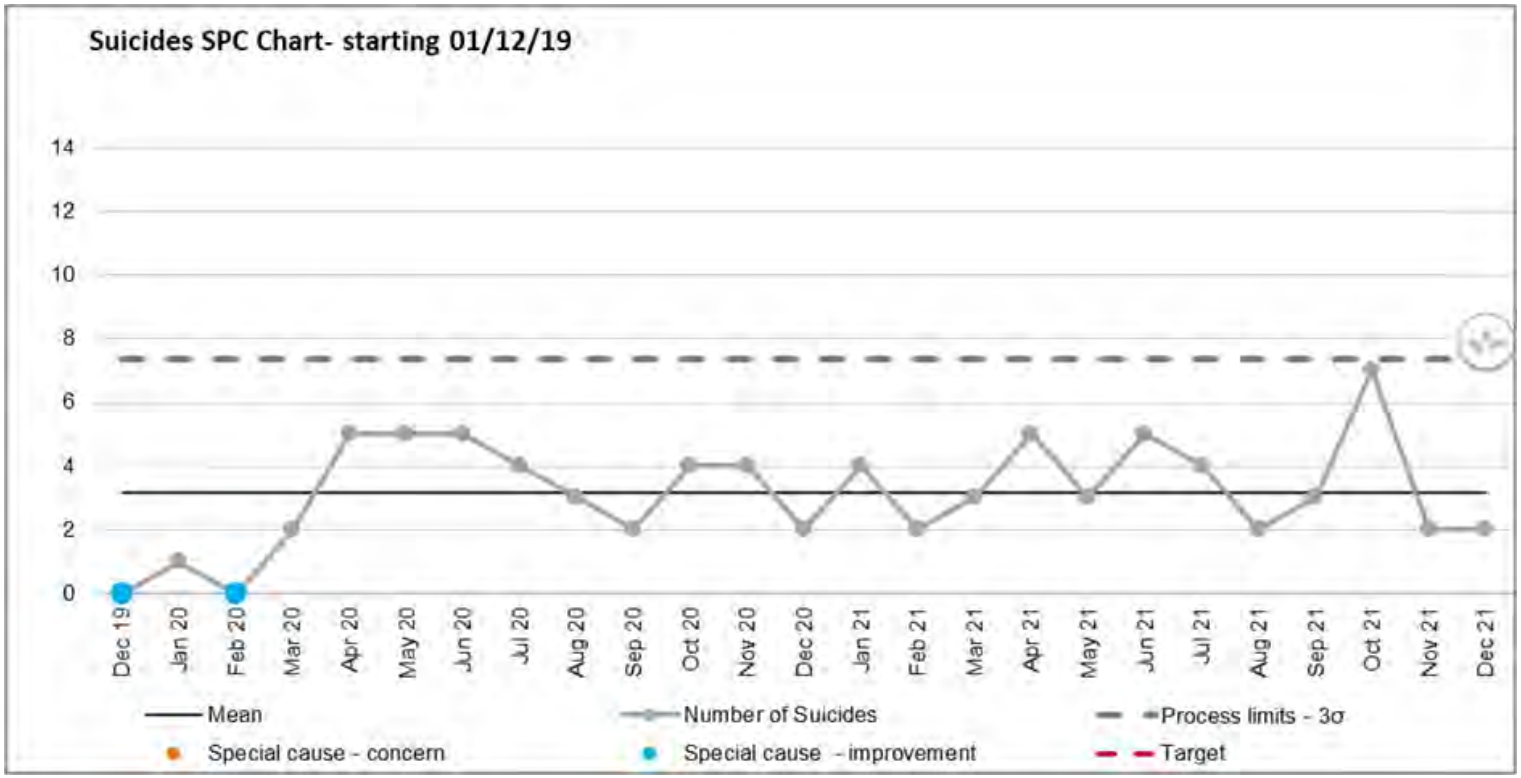
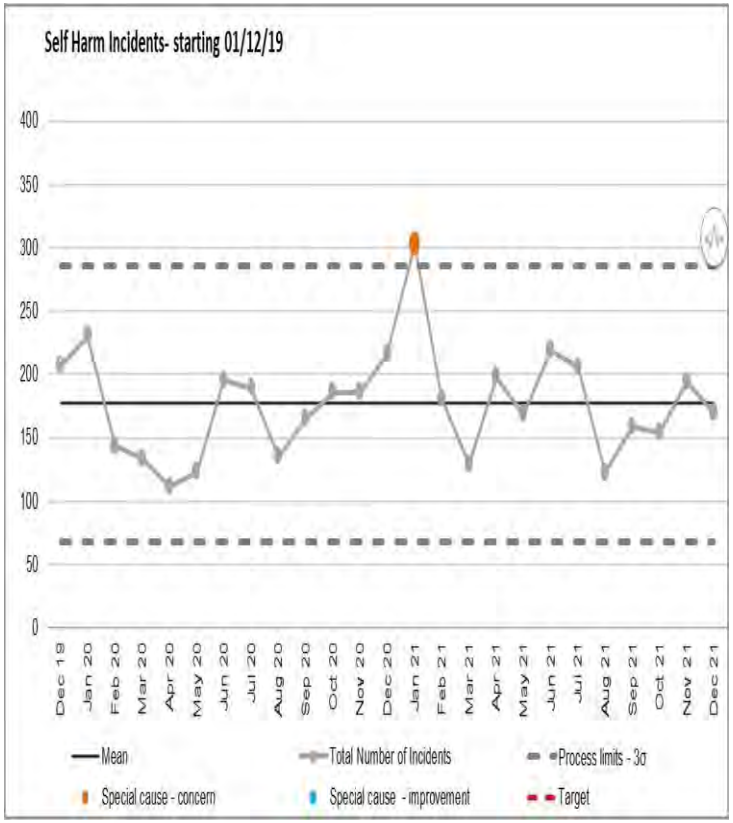
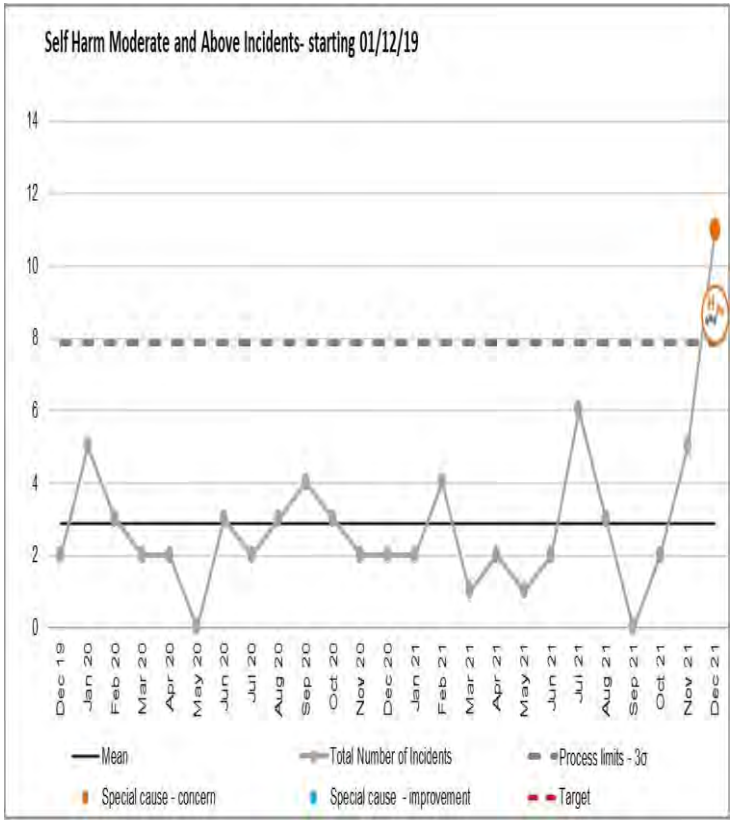
7. All reported Suicides



8. Self Harm reported Incidents





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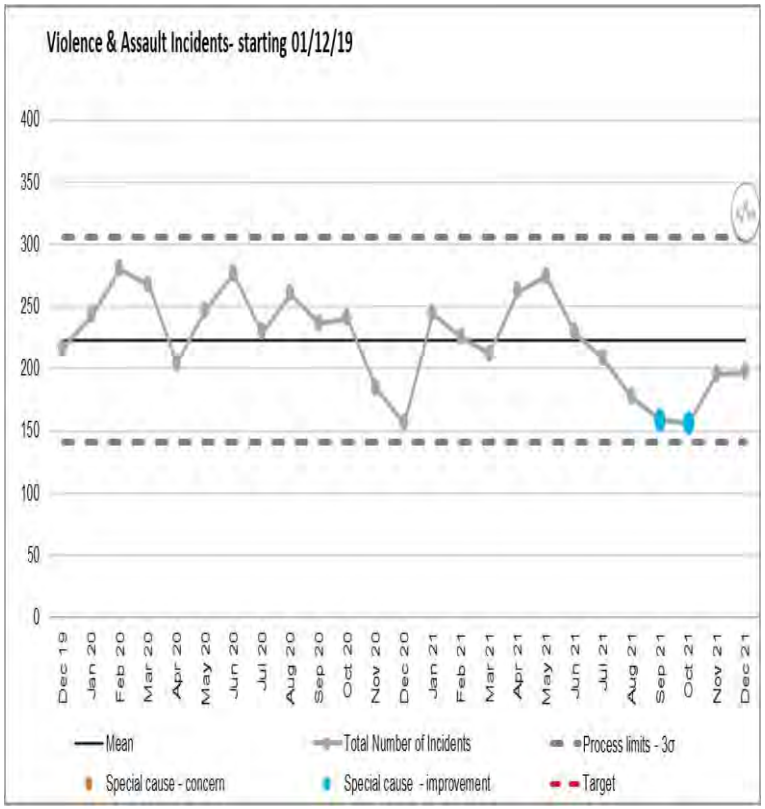
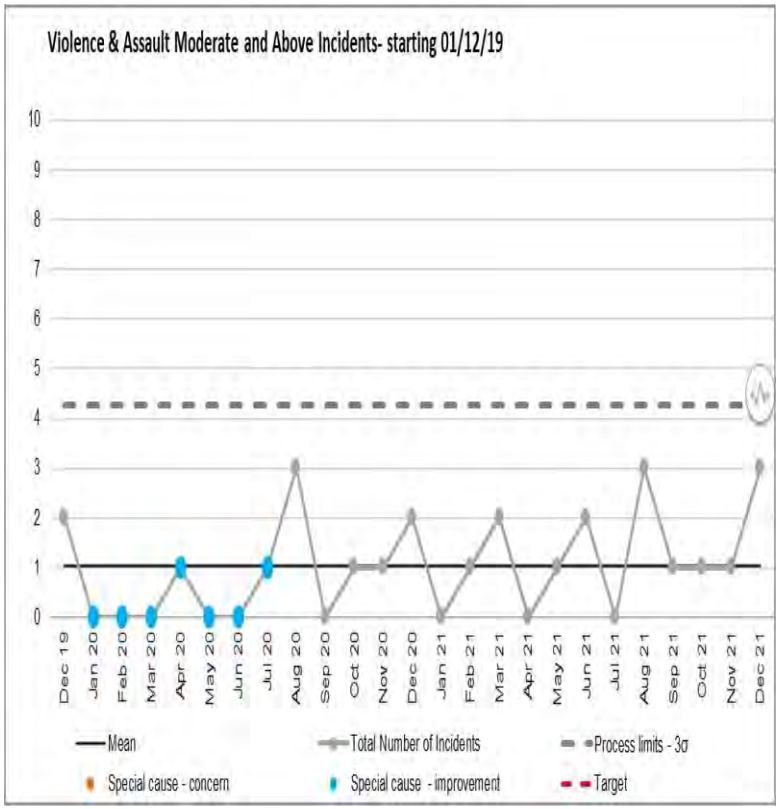
9. All Violence & Assaults reported Incidents





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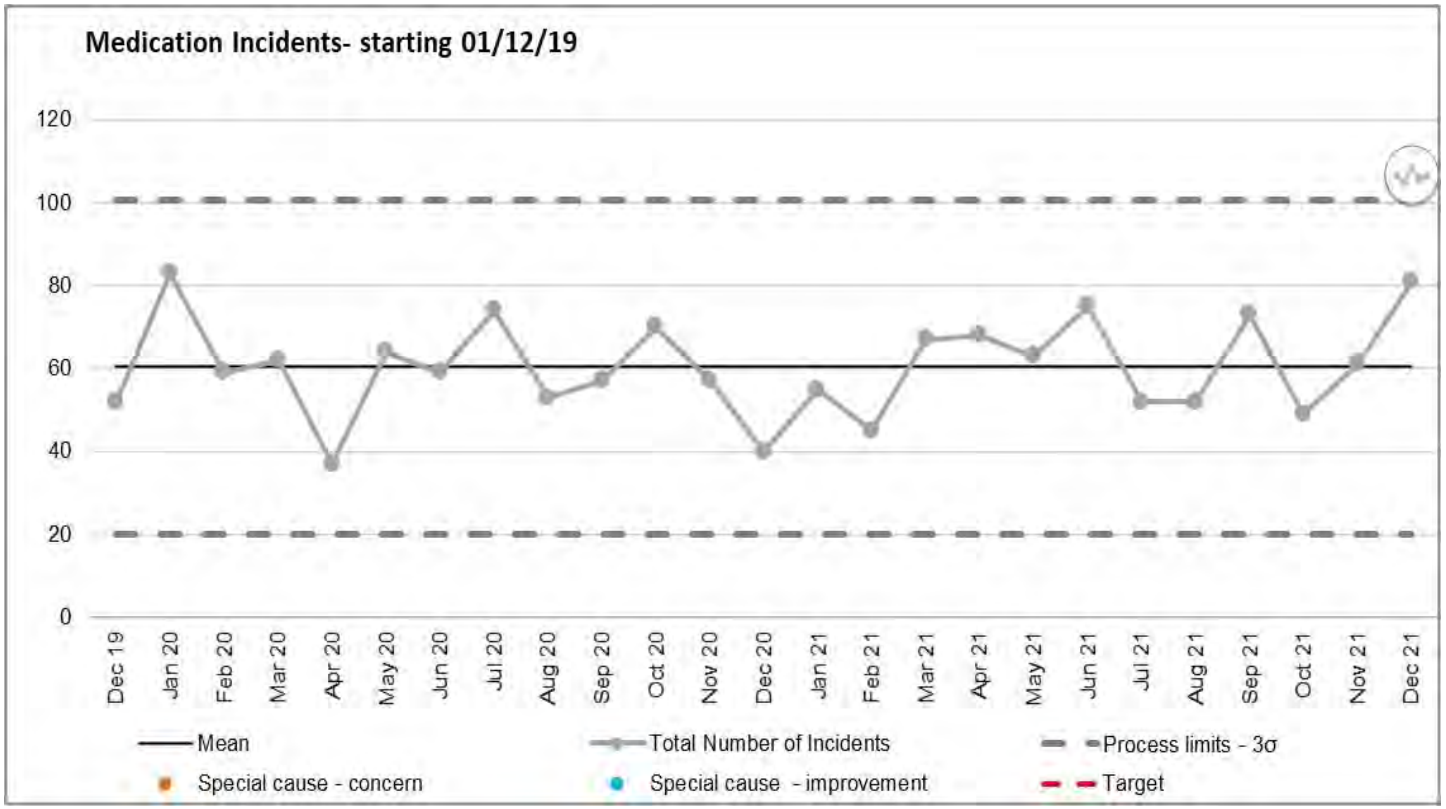
10. All Medication Incidents reported



11. Directorate Specialities describing Top 5 Incidents

Table 1: Mental Health: Community

Mental Health Non MHSOP Community - December	
Cause Group	Total
Self Harm	55
Infection Control	49
Violence/Assault	32
Safeguarding (Adults)	16
Staffing	13

Table 2: Mental Health: Inpatients

Mental Health Non MHSOP Inpatient - December	
Cause Group	**Total**
Violence/Assault	89
Self Harm	34
Infection Control	27
Security	19
Clinical Condition	18

Directorate Specialities describing Top 5 Incidents

Table 3: MHSOP – Inpatients

MHSOP Inpatient - December	
Cause Group	**Total**
Violence/Assault	23
Patient Falls, Slips, And Trips	21
Clinical Condition	8
Infection Control	7
Medication	5

Table 4: MHSOP – Community

MHSOP Community - December	
Cause Group	**Total**
Infection Control	7
Patient Death	6
Self Harm	4
Patient Falls, Slips, And Trips	3
Safeguarding (Adults)	3

Directorate Specialities describing Top 5 Incidents

Table 5: Learning Disability – In-Patient

LD Agnes Unit - December	
Cause Group	**Total**
Violence/Assault	28
Self Harm	6
Allegations Against Staff	2
Clinical Condition	2
Infection Control	2
Missing Patient	2

Table 6: Learning Disability - Community

LD Community - December	
Cause Group	**Total**
Violence/Assault	14
Infection Control	13
Patient Falls, Slips, And Trips	6
Self Harm	5
Case Notes & Records	4
Safeguarding (Adults)	4

Directorate Specialities describing Top 5 Incidents

Table 7: FYPC Inpatient CAMHS

FYPC CAMHS Inpatient - December	
Cause Group	**Total**
Self Harm	61
Mental Health Act	28
Infection Control	13
Violence/Assault	11
Clinical Condition	4

Table 8: FYPC non LD Non CAMHS

FYPC Non LD Non CAMHS - December	
Cause Group	**Total**
Infection Control	49
Case Notes & Records	11
Communication	10
Safeguarding (Children)	10
Medication	9

Directorate Specialities describing Top 5 Incidents

Table 10: CHS In-Patient

CHS Inpatient - December	
Cause Group	**Total**
Infection Control	68
Tissue Viability	60
Patient Falls, Slips, And Trips	40
Medication	17
Patient Death	16

Table 11: CHS Community

CHS Community - December	
Cause Group	**Total**
Tissue Viability	471
Infection Control	59
Medication	21
Case Notes & Records	11
Safeguarding (Adults)	11

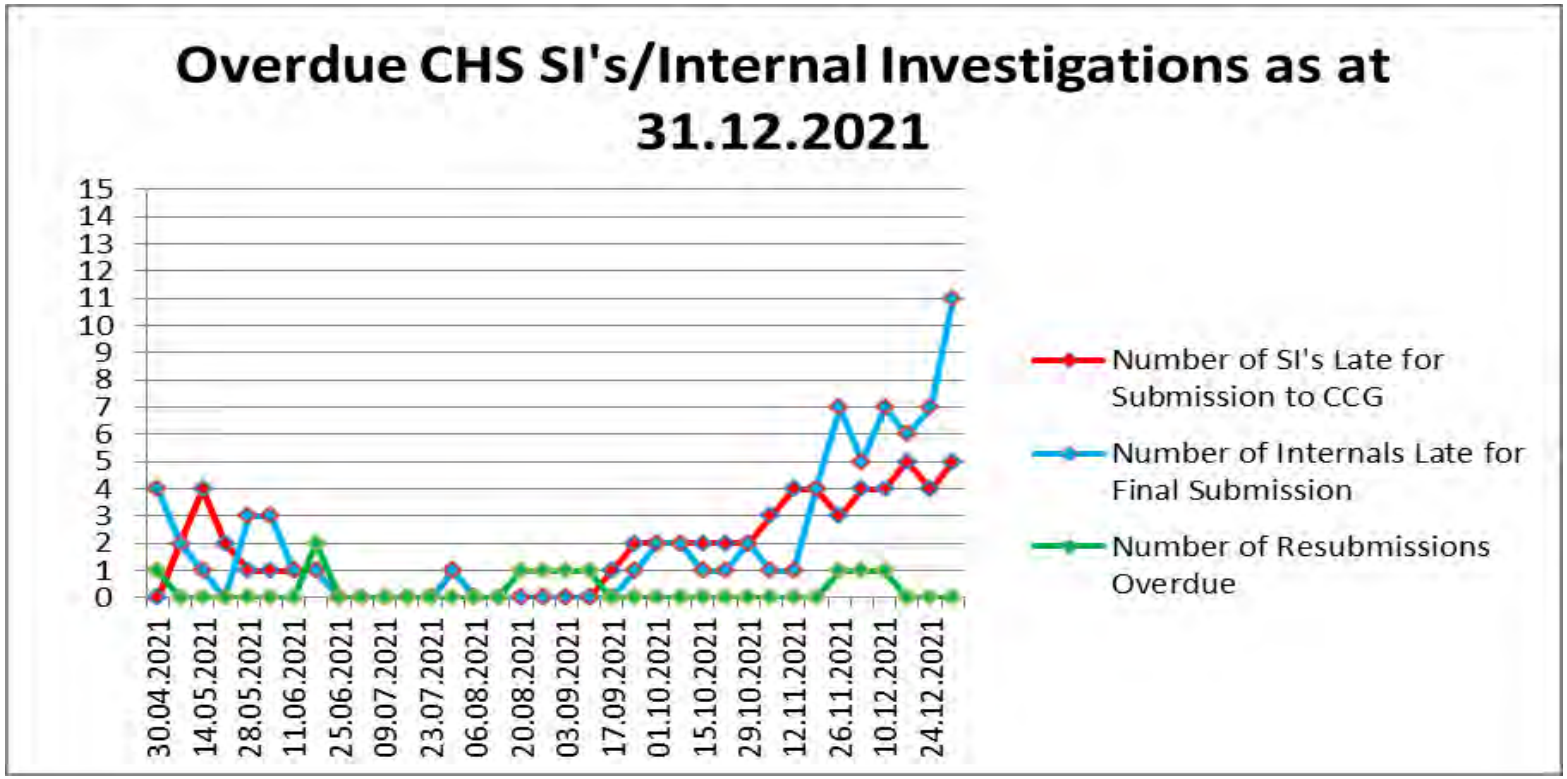
12. Ongoing - StEIS Notifications for Serious Incidents

2021/2022 - STEIS Notifications and Internal Investigations

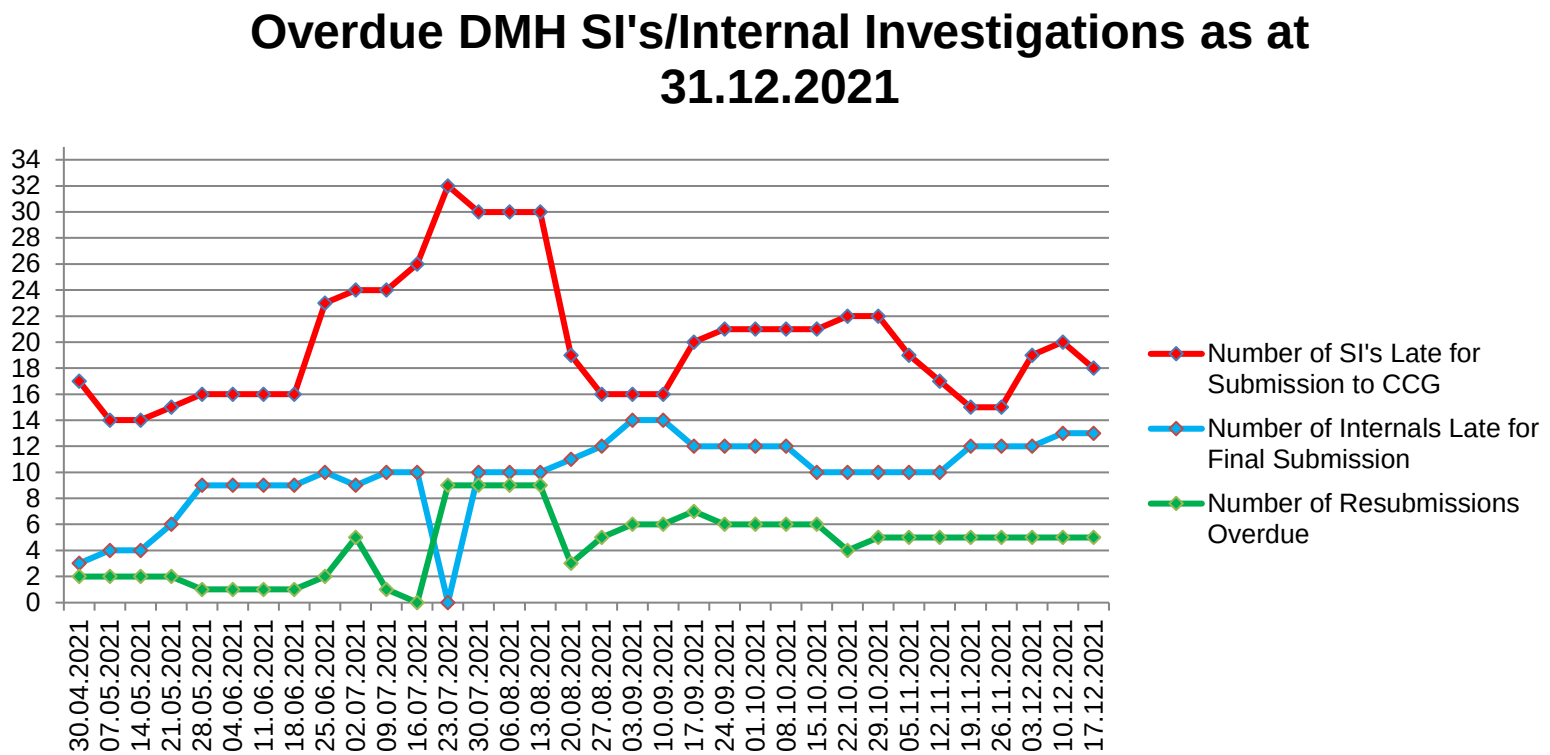
		StEIS Notification	SI INVESTIGATIONS				Internal Investigations		
		Downgrade & removal requests	SIs declared DMH	SIs declared FYPC/LD	SIs declared CHS	Signed off in month	DMH	FYPC/LD	CHS
2021/22 Q1	April	0	11	2	2	5	4	2	6
	May	0	4	0	1	4	2	1	3
	June	0	11	5	2	6	2	2	6
2021/22 Q2	July	0	5	2	1	8	4	2	1
	August	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	0	6	1	6	6	7	2	7
2021/22 Q4	January								
	February								
	March								
YTD			65	15	22	75	41	16	42

WeAreLPT
compassion respect
integrity trust

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



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



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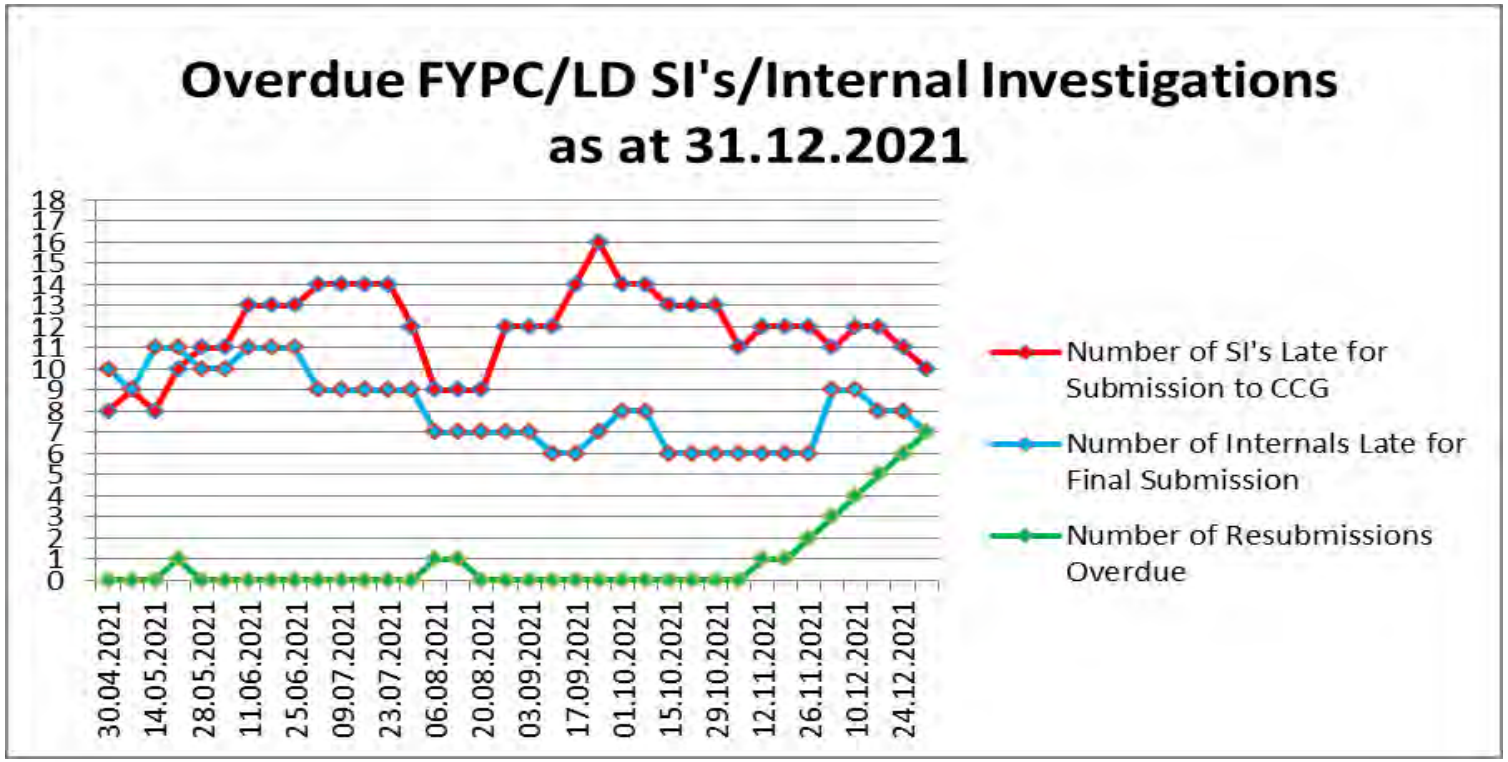
12a. Overdue Serious Incidents/Internal Investigations & CCG resubmissions (includes totals) - FYPCLD



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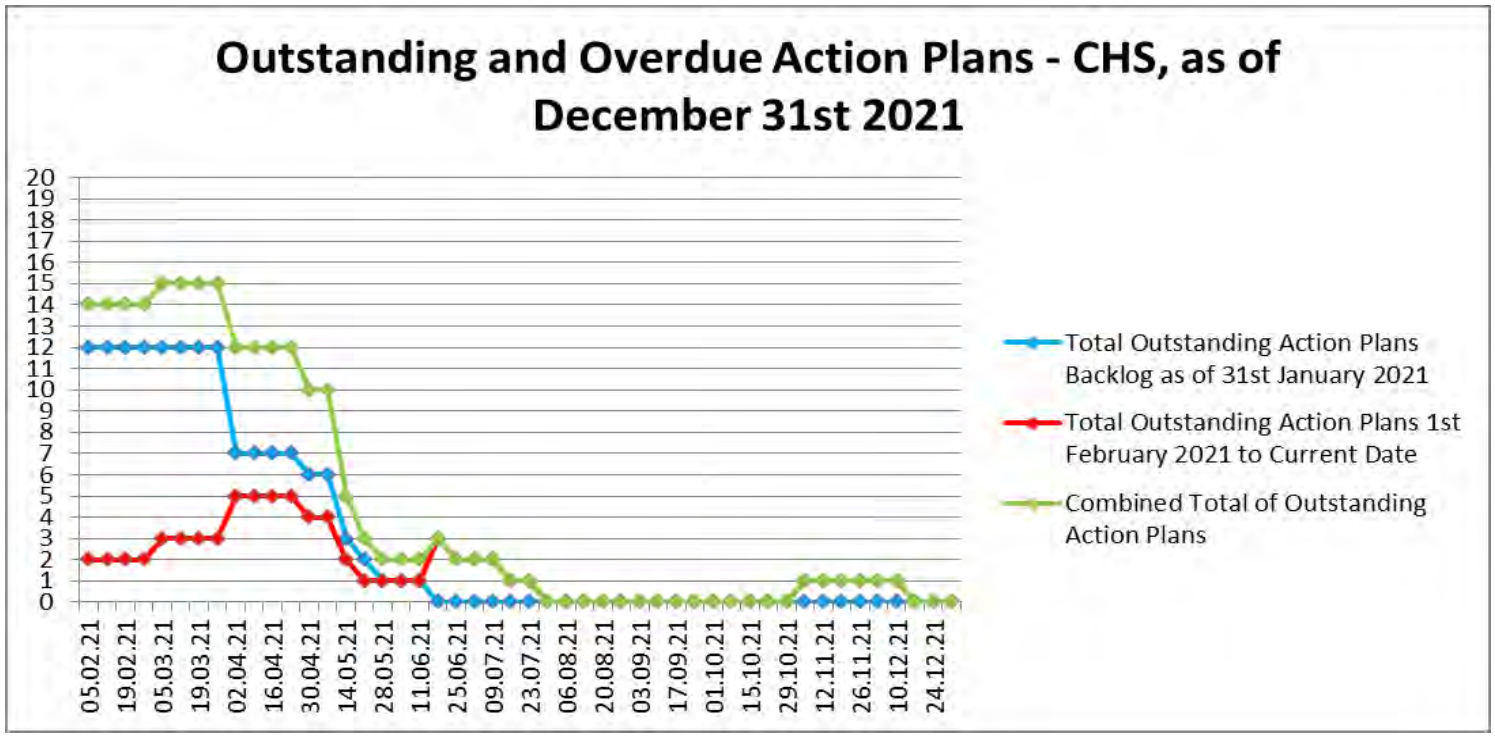
12.b Directorate SI Action Plan Compliance Status 2020/21 to date - CHS



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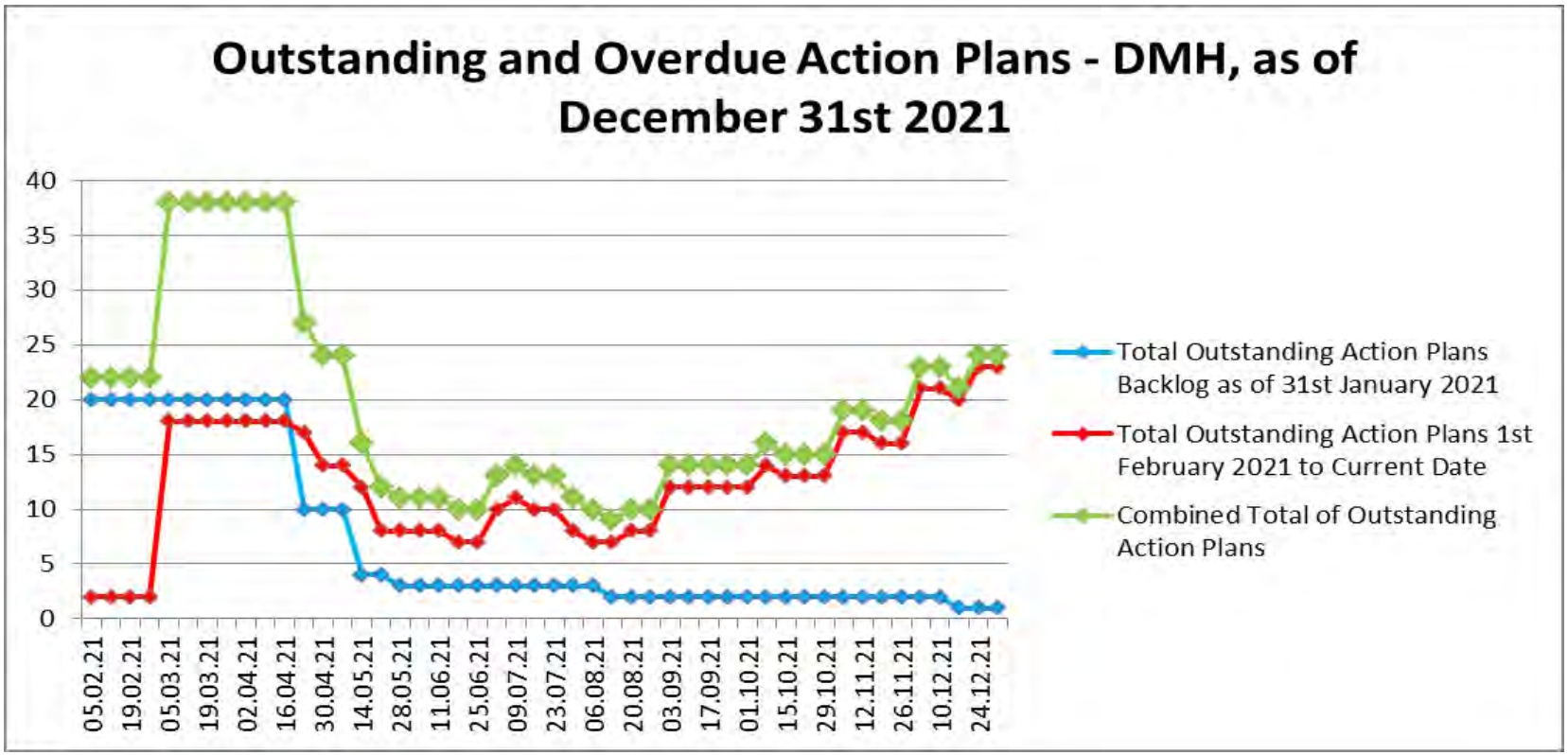
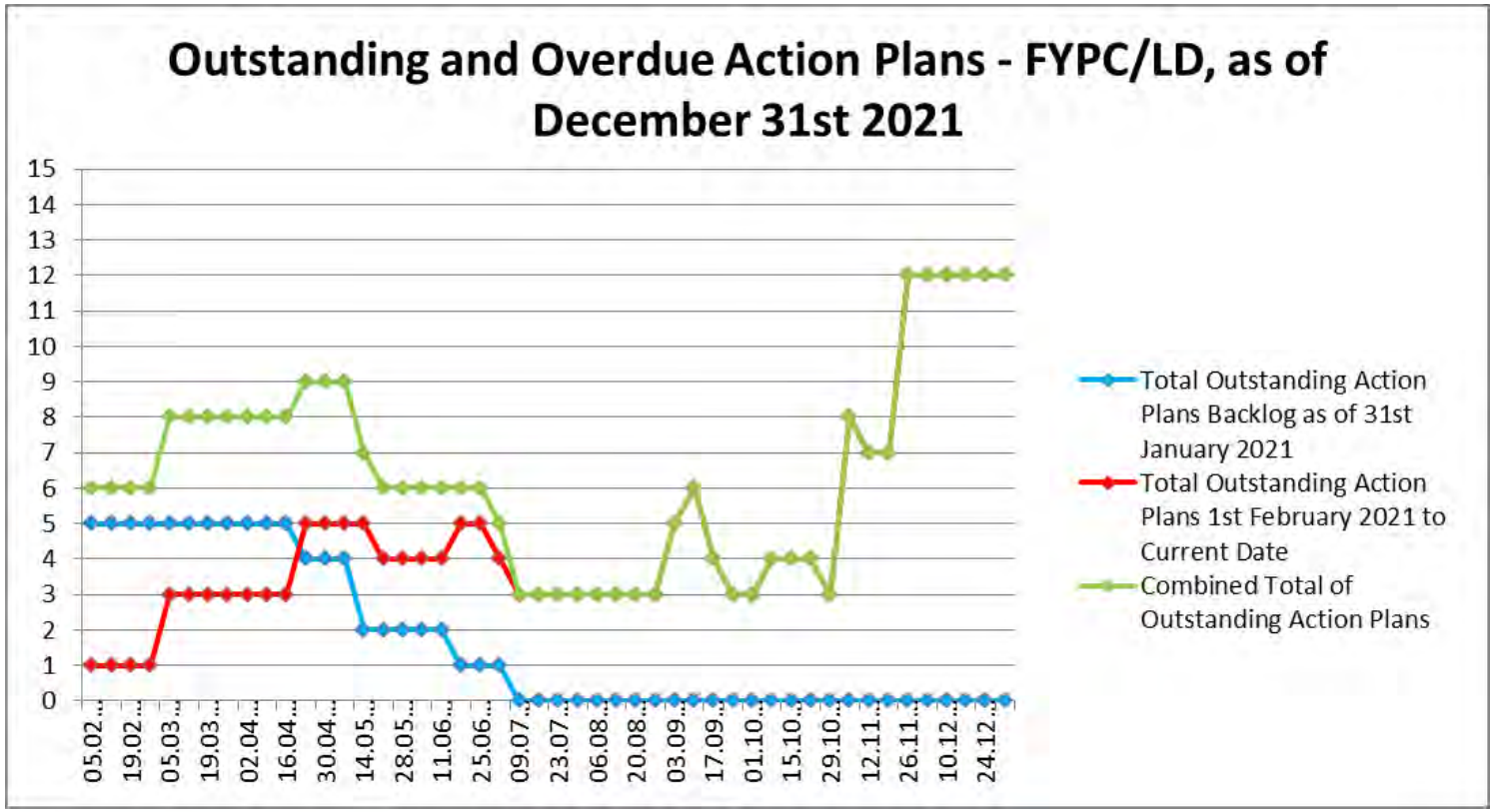
12.b Directorate SI Action Plan Compliance Status 2020/21 to date - DMH



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



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integrity trust

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 a flow of knowledge
- Updated risk assessments and their application to clinical practice and from a MDT approach, emerging theme in outpatient mental health
- Mental Capacity and safeguarding knowledge
- Lying & standing blood pressure and medication reviews in falls with harm
- Feedback related to changes from face to face to virtual appointments has been feedback identified from patients/families as a challenge for some patients and also makes assessment more difficult
- Involving families in care decisions related to consent, confidentiality & information sharing in mental healthcare & suicide prevention which very topical following the publication of a national report form Zero Suicide Alliance in August 2021

12. Lessons Learned – Trust-wide process

- Continues to be increasing challenges with feedback from commissioners delaying closure of reports
- Continued promotion of 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 & supporting delayed/reallocated starting of investigations
- The continued promotion of 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 increasingly being reported by investigators as challenging to find their way the different modules/journals to gather and find information and inconsistent places/approach to recording patient contact

Li

Leicestershire Partnership NHS Trust

Public Trust Board – 25 January 2022

Safe Staffing- November 2021 review

Purpose of the report

This report provides a full overview of nursing safe staffing during the month of November 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. An interim report for safe staffing November 2021 was submitted to Trust Board held 21 December 2021 with an overview of key areas to note and actions to mitigate risks based on the weekly safe staffing situational and forecast reviews.

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 decreased this month; 0.13% reported at 39.3% overall and Trust wide agency usage slightly increased this month by 0.74% to 16.95% overall.
- In November 2021; 27 inpatient wards/units utilised above 6% agency staff to meet safe staffing levels, this equates to 81.25% of our inpatient Wards and Units, no changes from last month.
- 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, Griffin, Beaumont, Belvoir, North and East wards, Beechwood, Clarendon, Rutland and Dalgleish
- 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, CRISIS Resolution and Home Treatment team and Central Access Point (CAP) South Leicestershire/Charnwood, Assertive outreach, ADHD and memory service
- A quality summit took 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 situation report and discussion was held at the Strategic Executive Board on the 5 November 2021 with Workforce and Safe Staffing presented to the Trust Board development session on the 23 November 2021 identifying systems/processes, plans and actions in place to mitigate the risks to patient safety, quality of care and experience.
- Self-assessment against; Key actions Winter 2021 preparedness: Nursing and midwifery safer staffing (NHS, November 2021) assurance framework was submitted separately to the Trust Board on 21 December 2021 including a summary report, GAP analysis and actions to enhance assurance against Key Lines of Enquiry (KLOE).

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 76% compliance AMBER
    - Clinical supervision at 78.6% compliance AMBER
    - All core mandatory training compliance GREEN except for Information Governance AMBER at 90.7%
- Clinical mandatory training compliance for substantive staff, to note;
    - BLS increased compliance by 2.6 % to 83.8% compliance AMBER
    - ILS increased compliance by 4.8 % to 80% compliance AMBER
- Clinical mandatory training compliance for bank only workforce remains low;
    - BLS 52.4% % at RED compliance
    - ILS 37.7 % 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, Welford 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 18.16 CHPPD in November 2021, with a range between 5.1 (Stewart House) and 70.3 (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

Absence by directorate	Sickness absence	Self-Isolation - Working from home	Self-Isolation - Unable to work from home	Total
Community Health Services	6.7%	0.4%	0.9%	8.0%
Enabling Services	1.8%	0.0%	0.6%	2.3%
FYPC	4.2%	0.5%	1.1%	5.8%
Hosted Service	4.0%	0.0%	0.5%	4.5%
Mental Health Services	6.2%	0.6%	0.7%	7.6%
LPT Total	**5.3%**	**0.4%**	**0.8%**	**6.5%**

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

In comparison to the previous month total absence has increased by 0.6% associated with an increase in general absence overall.

In-patient Staffing

Summary of inpatient staffing areas to note.

Wards	Sept 2021	October 21	November 21
Hinckley and Bosworth East Ward	X	x	x
Hinckley and Bosworth North Ward	X	x	x
St Luke's Ward 1	X	x	x

Wards	Sept 2021	October 21	November 21
St Luke's 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	
Rutland	X	x	x
Dalgleish	X	x	x
Swithland	X	x	x
Coleman	X	x	x
Kirby	X	x	x
Welford	X	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	

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, Welford and Mill Lodge. 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. Block booking of bank and agency and successful recruitment to staff in bands 5,6 and 7 is in progress. Evidence based establishment review completed and presented to FYPC.LD DMT. All staff in non -patient facing roles with a clinical qualification are currently working within the staffing establishment to support continuity of care.

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. Daily safe staffing reviews and substantive staff movement across the service to ensure substantive RN cover and block booking of temporary workers is in place. Recruitment is on-going with 16 international nurses recruited to a number of wards.

DMH

Mill Lodge continues with high utilisation of temporary workforce 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. Mill Lodge experienced partial closure to admissions (in November 2021) due to staffing with daily Directorate review. A number of actions are in place in 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. The annual safe staffing establishment review is in progress 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	Sept 2021	October2021	November 2021
City East Hub- Community Nursing	X	x	x
City West Hub- Community Nursing	X	x	x
East Central	X	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	x
South Leicestershire CMHT	X	x	x

Charnwood CMHT	X	x	x
Memory service	X	x	x
Assertive outreach	X	x	x
ADHD service	X	x	x
LD Community Physiotherapy	X	x	x
Crisis team		x	x
Central Access Point (CAP)		x	x

Table 3 – Community areas to note

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

FYPC/LD Community

Healthy Together 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. 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 November 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 November 2021, Community Nursing has been reporting operating at OPEL 2 working to level 3 actions. 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, East Central and Hinckley hubs remain key areas 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 the hub leadership teams have been mobilised. 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, supportive conversations being held with staff to agree returning to work plans
- Reviewing caseloads to prioritise urgent and essential visits, flexing teams to prioritise visits,
- Working together with staff to keep up to date with safe planning /staffing and with new processes for example, same day referral and embedding firmly within triage function
- 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 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 held a quality summit on the 2 November 2021. A quality improvement plan is in place focusing on workforce, learning from serious incident investigation, a pressure ulcer QI programme and staff engagement and communication with oversight to QAC.

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 November 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

November 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	Nurse Day – Average % fill rate care staff	Nurse Night – Average % fill rate registered nurses	Nurse Night – Average % fill rate care staff	AHP Day – Average % fill rate registered AHP	AHP Day – Average % fill rate non-registered AHP	% Temporary Workers (NURSING ONLY) – Total	Bank	Agency	Overall CHPPD (Nursing And AHP)	Medication Errors	Falls	Complaints	PU Category 2	PU Category 4
				>=80%	>=80%	>=80%	>=80%	-	-	<20%							(Month in arrears)	
AMH Bradgate	Ashby	15	14	96.9%	184.5%	104.5%	114.8%			43.2%	25.2%	17.9%	8.4	↓0	→0	→0		
	Aston	19	18	114.8%	207.5%	106.0%	157.8%			46.4%	26.0%	20.3%	7.9	↓0	↓0	→0		
	Beaumont	22	17	96.4%	130.5%	97.6%	130.7%			47.6%	33.7%	13.9%	13.5	↓1	↑6	↓0		
	Belvoir Unit	10	9	131.2%	198.8%	108.1%	228.4%			51.0%	31.7%	19.3%	22.8	↑1	→0	→0		
	Heather	18	16	100.0%	202.1%	104.9%	147.5%			53.1%	33.1%	20.1%	8.1	↑1	↓1	→1		
	Thornton	12	12	92.9%	199.7%	101.1%	109.2%			29.4%	27.3%	2.1%	10.2	→0	↓0	→0		
	Watermead	20	20	101.2%	203.4%	115.2%	167.3%		100.0%	34.8%	16.9%	17.9%	7.3	↓0	↑6	↑1		
	Griffin - Herschel Prins	6	5	113.6%	244.1%	101.5%	591.2%			60.6%	30.6%	30.0%	35.3	→0	→0	↓0		
AMH Other	Phoenix - Herschel Prins	12	12	120.6%	154.9%	104.5%	139.1%		100.0%	43.7%	24.7%	19.0%	11.7	→0	→0	↓0		
	Skye Wing - Stewart House	30	30	130.4%	101.5%	132.3%	137.8%			29.4%	27.1%	2.2%	5.1	→0	↑3	→0		
	Willows	9	9	139.9%	132.5%	109.1%	140.6%			42.1%	35.6%	6.5%	14.8	↑1	→0	→0		
	Mill Lodge	14	12	100.5%	96.7%	134.2%	138.8%			69.1%	43.4%	25.7%	15.5	→0	↓7	→0		
CHS City	Kirby	23	19	63.2%	121.3%	129.4%	147.0%	100.0%	100.0%	38.3%	30.3%	8.1%	9.0	→1	→5	→0	→0	→0
	Welford	24	21	73.0%	120.3%	131.1%	231.2%			26.5%	18.7%	7.8%	7.1	↓0	↓7	→0	→0	→0
	Beechwood Ward - BC03	23	21	109.8%	113.1%	99.2%	116.5%	100.0%	100.0%	32.9%	13.3%	19.6%	8.8	↑2	↓1	↓0	→1	→0
	Clarendon Ward - CW01	21	19	98.8%	114.0%	106.6%	108.4%	100.0%		33.6%	12.7%	20.9%	10.2	↑4	↓3	→0	↓0	→0
	Coleman	21	15	86.5%	199.3%	161.8%	389.3%	100.0%	100.0%	54.6%	37.0%	17.5%	18.6	→0	↓0	→0	→0	→0
	Wakerley (MHSOP)	21	11	128.7%	102.8%	166.7%	146.8%			41.9%	25.8%	16.1%	19.6	↓0	↑5	→0	→0	→0
CHS East	Dalgleish Ward - MMDW	17	15	122.4%	87.6%	106.7%	91.7%	100.0%	100.0%	23.6%	9.4%	14.3%	8.3	↑1	↓3	→0	↑2	→0
	Rutland Ward - RURW	16	14	108.6%	111.7%	86.7%	110.0%	100.0%	100.0%	32.6%	19.3%	13.2%	9.5	↓0	↓2	→0	↑3	→0
	Ward 1 - SL1	19	15	88.2%	122.1%	100.2%	146.9%	100.0%	100.0%	18.2%	12.1%	6.1%	12.2	→1	↓1	↓0	↓0	→0
	Ward 3 - SL3	13	11	139.8%	104.5%	97.9%	202.7%	100.0%	100.0%	20.4%	11.8%	8.6%	12.1	↓0	↑3	→0	↓1	→0
CHS West	Ellistown Ward - CVEL	15	13	108.2%	119.7%	100.0%	99.2%	100.0%	100.0%	11.1%	6.3%	4.8%	12.2	↑2	↑3	→0	↓1	→0
	Snibston Ward - CVSN	18	15	92.4%	139.2%	96.6%	165.2%	100.0%	100.0%	23.5%	9.6%	13.9%	12.2	→0	↓3	→0	→0	→0
	East Ward - HSEW	23	20	98.0%	114.0%	118.8%	143.8%	100.0%	100.0%	27.1%	9.0%	18.1%	10.1	↑2	↓2	→0	↑2	→0
	North Ward - HSNW	18	13	113.0%	104.0%	96.7%	106.7%	100.0%	100.0%	29.8%	9.7%	20.0%	12.8	↑3	↓2	→0	→0	→0
	Swithland Ward - LBSW	18	16	112.5%	106.6%	100.0%	138.3%	100.0%	100.0%	13.3%	3.6%	9.6%	10.6	→0	↑3	→0	↓0	→0
FYPC	Langley	15	13	145.1%	106.3%	124.7%	153.3%	100.0%		41.9%	36.4%	5.5%	11.4	↑1	↑1	→0		
	CAMHS Beacon Ward - Inpatient Adolescent	16	7	125.6%	165.8%	137.8%	327.1%			71.4%	26.0%	45.4%	32.9	↓1	→0	→0		
LD	Agnes Unit	4	2	185.3%	215.3%	173.9%	278.7%			55.1%	23.9%	31.1%	69.0	→0	→0	→0		
	Gillivers	1	1	64.7%	58.2%	71.1%	128.9%			8.4%	8.4%	0.0%	70.3	→0	→0	→0		
	1 The Grange	3	1	85.0%	95.6%	-	97.9%			19.4%	19.4%	0.0%	63.9	↓0	↓0	→0		

Annexe 2: Inpatient Ward triangulation staffing and NSIs.

Trust thresholds are indicated below.

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

Mental Health (MH)

Acute Inpatient Wards

Ward	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	14	96.9%	184.5%	104.5%	114.8%	43.2%	25.2%	17.9%	8.4	↓0	→0	→0
Aston	18	114.8%	207.5%	106.0%	157.8%	46.4%	26.0%	20.3%	7.9	↓0	↓0	→0
Beaumont	17	96.4%	130.5%	97.6%	130.7%	47.6%	33.7%	13.9%	13.5	↓1	↑6	↓0
Belvoir Unit	9	131.2%	198.8%	108.1%	228.4%	51.0%	31.7%	19.3%	22.8	↑1	→0	→0
Heather	16	100.0%	202.1%	104.9%	147.5%	53.1%	33.1%	20.1%	8.1	↑1	↓1	→1
Thornton	12	92.9%	199.7%	101.1%	109.2%	29.4%	27.3%	2.1%	10.2	→0	↓0	→0
Watermead	20	101.2%	203.4%	115.2%	167.3%	34.8%	16.9%	17.9%	7.3	↓0	↑6	↑1
Griffin - Herschel Prins	5	113.6%	244.1%	101.5%	591.2%	60.6%	30.6%	30.0%	35.3	→0	→0	↓0
Totals										↓3	↑13	→2

Table 4 - Acute inpatient ward safe staffing

The majority of wards have utilised a high percentage of temporary workforce in November 2021, 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.

There were 13 falls reported in November 2021, which is a slight increase from 12 in October 2021. Analysis has shown that of the 13 falls, four were first falls for patients and 8 were repeat falls, involving 6 patients, with a contributory theme identified linked to dizziness, sedation medication and reduced mobility.

Further analysis has identified a theme linked to incomplete falls pathway documentation, the physical health nurses are working with ward managers to understand the reasons for gaps in documentation and speaking to staff to find out if there is anything that needs to change in the process that will support them on the wards to improve documentation.

There were 3 medication incidents reported which is a decrease compared to October 2021. Analysis has shown that 1 incident was an E-CD error, 1 was misplaced/dropped medication

and 1 was an extra dose given. Investigation into this incident has highlighted that the error occurred by a temporary member of staff who was not familiar with the Wellsky system and how it flags maximum doses over a period. This staff member has been supported in their development and learning.

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	120.6%	154.9%	104.5%	139.1%	43.7%	24.7%	19.0%	11.7	→0	→0	↓0
Totals										→0	→0	↓0

Table 5- Low secure safe staffing

Phoenix continues to use a higher proportion of agency staff in November 2021 to support planned staffing due to staff vacancies and sickness. There were no medication errors or falls reported in November 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	30	130.4%	101.5 %	132.3%	137.8%	29.4%	27.1%	2.2%	5.1	→0	↑3	→0
Willows	9	139.9%	132.5 %	109.1%	140.6%	42.1%	35.6%	6.5%	14.8	↑1	→0	→0
Mill Lodge	12	100.5%	96.7%	134.2%	138.8%	69.1%	43.4%	25.7%	15.5	→0	↓7	→0
TOTALS										↑1	↓10	→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 with start dates through December 2021 and January 2022.

Willows use of temporary staff is higher due to the acuity of one of the wards, which is a step down from acute wards requiring adjusted skill mix and staffing.

There has been 1 medication incident in November 2021 which is a slight increase from zero medication incidents reported in October 2021. This reported incident was not a medication error but a process error regarding management of drugs keys.

There were 10 patient falls in November 2021 which is a slight decrease from 13 in October 2021.

Of the 10 falls reported for the Rehabilitation service, 8 of these falls occurred in the bedroom, 7 were patients with repeat falls and 3 patients with first falls.

Seven of the ten falls were reported at Mill lodge, which is a decrease from previous months; all incidents were repeat falls. The 7 falls were all located in the bedroom and were in relation to 3 patients.

There were 3 falls reported in November at Stewart House; all first falls in care.

Analysis has shown that there is no link between staffing levels and skill mix regarding these incidences.

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	19	63.2%	121.3%	129.4%	147.0%	38.3%	30.3%	8.1%	9.0	→1	→5	→0	→0	→0
BC Welford	21	73.0%	120.3%	131.1%	231.2%	26.5%	18.7%	7.8%	7.1	↓0	↓7	→0	→0	→0
Coleman	15	86.5%	199.3%	161.8%	389.3%	54.6%	37.0%	17.5%	18.7	↓0	↑5	→0	→0	→0
Wakerley	11	128.7%	102.8%	166.7%	146.8%	41.9%	25.8%	16.1%	15.6	↓0	↓1	→0	→0	→0
TOTALS										↓1	↑18	→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. Kirby has 6 vacancies for HCSW and Welford 2. All the wards have vacancies for registered nurses , advert is currently out for HCSW and Registered Nurse recruitment..

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 November 2021 and no complaints received.

Falls 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.

There was one medication error in November 2021 which happened in the community whilst a patient was on leave and was not impacted by staffing levels.

Each MHSOP ward is planning to welcome two international nurses on 20 December 2021 to their workforce 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	122.4%	87.6%	106.7%	91.7%	23.6 %	9.4%	14.3 %	8.3	↑1	↓3	→0	↑2	→0
Rutland	14	108.6%	111.7%	86.7%	110.0%	32.6 %	19.3 %	13.2 %	9.5	↓0	↓2	→0	↑3	→0
SL Ward 1	15	88.2%	122.1%	100.2%	146.9%	18.2 %	12.1 %	6.1%	12.2	→1	↓1	↓0	↓0	→0
SL Ward 3	11	139.8%	104.5%	97.9%	202.7%	20.4 %	11.8 %	8.6%	12.1	↓0	↑3	→0	↓1	→0
CV Ellistown 2	13	108.2%	119.7%	100.0%	99.2%	11.1 %	6.3%	4.8%	12.2	↑2	↑3	→0	↓1	→0
CV Snibston 1	15	92.4%	139.2%	96.6%	165.2%	23.5 %	9.6%	13.9 %	12.2	→0	↓3	→0	→0	→0
HB East Ward	20	98.0%	114.0%	118.8%	143.8%	27.1 %	9.0%	18.1 %	10.1	↑2	↓2	→0	↑2	→0
HB North Ward	13	113.0%	104.0%	96.7%	106.7%	29.8 %	9.7%	20.0 %	12.8	↑3	↓2	→0	→0	→0
Swithland	16	112.5%	106.6%	100.0%	138.3%	13.3 %	3.6%	9.6%	10.6	→0	↑3	→0	↓0	→0
CB Beechwood	21	109.8%	113.1%	99.2%	116.5%	32.9 %	13.3 %	19.6 %	8.8	↑2	↓1	↓0	→1	→0
CB Clarendon	19	98.8%	114.0%	106.6%	108.4%	33.6 %	12.7 %	20.9 %	10.2	↑4	↓3	→0	↓0	→0
TOTALS										↑15	↓26	↓0	↓10	→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 increased compared to October 21 with the exception of Ward 1 St Luke's, Ward 2 CCH and Swithland Ward, 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 a reduction in the number of falls incidents from 32 in October 2021 to 26 in November 21 comprising of 22 first falls, 3 repeat falls and 1 patient placed on the floor. Ward areas to note are St Luke's Ward 3, Ellistown and Swithland 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 increased from 6 in October 2021 to 15 in November 21. A review of these incidents has identified these relate to prescribing, administration, and procedural errors in relation to the electronic CD register and there was no direct correlation with staffing.

The number of category 2 pressure ulcers developed in our care has decreased from 13 for October 2021 to 7 in November. Areas to note are Rutland and East Ward. A quality improvement project has commenced to review the pressure ulcer prevention pathway within the hospital wards.

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	Falls	Complaints
Langley	13	145.1%	106.3%	124.7%	153.3%	41.9%	36.4%	5.5%	11.4	↑1	↑1	→0
CAMHS	7	125.6%	165.8%	137.8%	327.1%	71.4%	26.0%	45.4 %	32.9	↓1	→0	→0
TOTALS										↓2	↑1	→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 3 months.

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

There was one medication error on the CAMHS Beacon Unit in November, this is a reduction from the previous month and was not impacted by staffing levels.

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	185.3%	215.3%	173.9%	278.7%	55.1%	23.9%	31.1%	69.0	→0	→0	→0
Gillivers	1	64.7%	58.2%	71.1%	128.9%	8.4%	8.4%	0.0%	70.3	→0	→0	→0
1 The Grange	1	85.0%	95.6%	-	97.9%	19.4%	19.4%	0.0%	63.9	↓0	↓0	→0
TOTALS										↓0	↓0	→0

Table 10 - Learning disabilities safe staffing

Patient acuity on the Agnes Unit has increased 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 continue to focus recruitment to Registered Nurse and HCSW vacancies.

Short breaks: Staffing includes both RNs and HCSWs due to the complex physical health needs. Staffing was managed well and adjusted to meet individual patient's care needs, and this is reflected in the fill rate. There were no medication errors on The Grange. Review of the NSIs has not identified any staffing impact on the quality and safety of patient care/outcomes.

Governance table

For Board and Board Committees:	Trust Board 25.01.22	
Paper sponsored by:	Anne Scott, Interim Executive Director of Nursing, AHPs and Quality	
Paper authored by:	Emma Wallis, Interim Deputy Director of Nursing and Quality and Elaine Curtin, Workforce and Safe staffing Matron	
Date submitted:	25.01.2022	
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	√
	Reaching Out	
	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:		

Leicestershire Partnership NHS Trust

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Public Trust Board – 25 January 2022

Safe Staffing December 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 December 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 (annexe 1) including workforce metrics; fill rates, Care Hours Per Patient Day (CHPPD) and Nurse Sensitive Indicators (NSIs) was issued on 11 January 2021 however detailed directorate, service analysis will not be completed to meet the Trust board deadline in January 2022. The full triangulated monthly safe staffing review for December 2021 will be submitted to Trust board in February 2022.

The interim report is based on the weekly safe staffing situational and forecast meeting reviews however from 20 December 2021 meetings were stepped up to daily in response to significant staffing challenges and to ensure safe nurse staffing levels were reviewed and risks escalated throughout the Christmas and New Year period, daily meetings will continue into January 2022.

Background

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

A briefing paper was submitted to the Trust Incident Co-ordination Command centre (ICC) on the 24 December 2021 identifying the Trust's response to severe nurse staffing pressures, linked to increased Covid-19 staff absence (4.6% up to 11.1%) due to increased community transmission and outbreaks within our in-patient services.

Directorate staffing business continuity plans enacted, clinical and enabling directorate service prioritisation reviews completed with quality impact assessments signed off at the Trust Clinical Reference Group. Staff were identified for redeployment with Directorates identifying MDT reserve lists to deploy to support safe staffing.

Following a risk, qualities and equalities impact assessment on 24 December 2021 the decision was made to temporarily close Rutland Ward at Rutland Memorial Hospital in response to the impact of significantly reduced staffing and inadequate registered nurses to deliver safe patient care due to a Covid 19 outbreak. The ward reopened on 4 January 2022.

Daily Trust safe staffing cell huddles at 4.30pm are led by the Assistant Director of Nursing, senior oversight by the Director/Deputies of Nursing, AHPs and Quality with membership including Heads/Deputy Heads of Nursing, EPRR lead and Head of Workforce support, the meeting can be stepped up to twice daily if any unmitigated risk areas are identified through directorate review in the morning. A united trust wide approach taken to review staffing, actions to mitigate the risks, nurse to patient ratios and skill mix to ensure patient and staff safety with a daily governance route to the ICC to escalate any unmitigated risk areas.

On 30 December 2021 following the system quality summit, Directors of Nursing were asked to complete system risk assessments for visiting, staff deployment to hospital vaccine hubs considering reduced demand and activity and nurse and midwifery patient ratios that fall below national quality board/professional standards. The visiting risk assessment has been added to the ICC risk log and staffing system controls and actions reflected in the organisational risk for staffing.

The Royal College of Nursing (RCN) wrote to all Chief Executives on 11 January 2022 to outline concerns raised by RCN members regarding working under extreme pressure, nurse to patient ratios that compromise patient safety and concerns that disciplinary action may be taken if something was to go wrong, and this context not adequately reflected in potential investigations.

Simultaneously the four Chief Nursing Officers and Nursing Midwifery Council (NMC) issued a joint statement to all Directors of Nursing outlining collective actions to help strengthen nursing workforce capacity including opening of the temporary register to encourage employers to make use of professionals who volunteered to join it who had recently left the NMC's register and professionals from overseas awaiting their final assessment in the UK. It also recognises the current high pressured situations staff are working in and reassures members that the NMC Code in conjunction with professional judgement is there to guide and support and then when staff depart from established procedures this does not necessarily mean that registrants are breaching the Code but implies a higher level of risk when making difficult decisions. Reassurance that should in a rare circumstance a matter is referred to the NMC they will consider this current context in all its fitness to practice decision making.

Both letters have been received and logged at the Trust ICC for consideration and response and further action.

Analysis of the issue

Areas to note throughout December 2021 as identified/discussed by exception at the weekly/daily 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

Table 1 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 with increasing staff absence due to covid related staff isolation and sickness exacerbated by omicron variant Covid outbreak on 25.12.2021 with visiting suspended. Increased acuity and dependency, with increased new admissions, significant vacancies and increasing sickness.	Business continuity plans enacted in addition to pre-existing actions currently in place for example, single ward sites to have additional RN and HCA staff to support Bed capacity reduced to 7, until December 2021. High utilisation of bank and agency staff to meet planned safe staffing with enhanced staffing model. Block booking of bank and agency. All staff in non-patient facing roles with a clinical qualification working within the staffing establishment to support continuity of care. Daily directorate prioritisation of services and business continuity plans enacted to support safe staffing levels /use of bank and agency temporary staffing	
Agnes unit	Increased acuity and dependency, with increased new admissions, significant vacancies and increasing sickness.	Business continuity plans enacted as part of directorate and trust wide approach. 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.	

		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 enhanced observations and high vacancies, maternity leave and increasing staff absence due to covid related staff isolation and sickness exacerbated by omicron variant 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, Rutland, and St Luke's ward 1 North ward is the Covid 19 risk managed ward. Covid outbreaks on Rutland, Beechwood, East and St Luke's ward 1	Business continuity plans enacted in addition to pre-existing actions/mitigations Daily safe staffing review and substantive staff movement 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 and to cover shifts on single site wards Beechwood ward closed to admissions. Rutland ward closed on the 24 December 2021 due to outbreak and staffing impact.	
DMH in patients	Increased acuity and complexity, vacancies, sickness, and increasing staff absence due to covid related staff isolation and sickness exacerbated by omicron variant Increased internal movement	Business continuity plans enacted in addition to pre-existing actions/mitigations for example additional staff planned at BMHU Mill lodge – continues with daily directorate review, high utilisation of bank and agency	

	and promotions to urgent care pathway roles and step up to great mental health transformation. Key areas to note; Mill Lodge, Watermead, Heather and Coleman wards Covid outbreaks on Watermead 18.12.21, Coleman 27.12.21, Heather 28.12.21, Welford 29.12.21 and Kirby 30.12.21 Watermead Ward changed to an all Red – Covid-19 positive Ward	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. Outbreak wards closed to admissions except Kirby.	
CHS Community Teams	Increased patient acuity across all teams with increased caseload, high vacancies and increasing staff absence due to covid related staff isolation and sickness exacerbated by omicron variant Operating at OPEL 3, with higher risk in the city community nursing hub. Key areas to note; City East, City West and East Central.	Business continuity plans in place including caseload review, urgent and essential visits, reprioritisation of patient assessments/clinics/wound and holistic assessments. 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. Quality improvement plan in place Targeted bespoke community nursing recruitment continues.	
FYPC/LD community Teams	High vacancies, increased number of staff retirements, staff absence due to sickness	Business continuity plans enacted in addition to pre-existing actions/mitigations	

	(covid and non-covid). Key areas to note; Healthy Together City and County teams notably Blaby. Looked After Children, Phlebotomy and Diana team, CAMHS Crisis on call rota, Community Paediatrics impacting waiting list.	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, training programme temporarily suspended and 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 memory service CAP team staff Covid-19 outbreak 28.12.21	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)	

The table below details Covid-19 and general absence as of 31 December 2021 with the greatest pressure points highlighted in red. In comparison to the previous month total absence has increased by 4.6% to 11.1%.

Absence by directorate	Sickness absence	Self-Isolation - Working from home	Self-Isolation - Unable to work from home	Total
Community Health Services	7.8%	3.0%	4.2%	15.0%
Enabling Services	2.3%	2.5%	1.9%	6.7%
FYPC	4.5%	2.4%	3.4%	10.4%
Hosted Service	1.4%	1.0%	1.0%	3.3%
Mental Health Services	5.4%	2.1%	2.9%	10.5%
LPT Total	**5.4%**	**2.4%**	**3.2%**	**11.1%**

Table 2 – COVID -19 and general absence – 31 December 2021

Proposal

Considering the highlighted key areas to note in December 2021 and high levels of staff sickness absence significant staffing challenges continue, concerns that current controls and business continuity plans are not always mitigating the impact to the quality, safety, and experience of patient care across all services. As a direct result of the level of pressure across the Trust and LLR system in this unprecedented period, a united Trust and system - wide approach is being taken to ensure patient safety.

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.

Annexe- score card
December 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	Nurse Day – Average % fill rate care staff	Nurse Night – Average % fill rate registered nurses	Nurse Night – Average % fill rate care staff	AHP Day – Average % fill rate registered AHP	AHP Day – Average % fill rate non-registered AHP	% Temporary Workers (NURSING ONLY) – Total	Bank	Agency	Overall CHPPD (Nursing And AHP)	Medication Errors	Falls	Complaints	PU Category 2 (month in arrears)	PU Category 4 (month in arrears)
				>=80%	>=80%	>=80%	>=80%	-	-	<20%								
AMH Bradgate	Ashby	14	14	83.4%	180.3%	98.1%	110.7%			40.7%	25.5%	15.3%	8.3	0	2	0		
	Aston	19	19	97.5%	186.6%	112.3%	161.9%			58.0%	26.9%	31.1%	7.1	1	2	0		
	Beaumont	22	20	91.4%	131.2%	103.0%	129.5%			49.8%	35.4%	14.4%	11.4	4	1	2		
	Belvoir Unit	10	10	108.7%	188.0%	101.5%	215.9%			53.7%	32.4%	21.3%	20.8	1	1	0		
	Heather	18	18	75.3%	211.5%	99.7%	148.0%			57.5%	34.1%	23.4%	6.9	1	2	0		
	Thornton	13	12	76.4%	194.1%	102.9%	123.2%			38.4%	31.2%	7.2%	9.5	0	0	0		
	Watermead	20	19	82.6%	228.2%	109.8%	212.3%		100.0%	47.1%	15.6%	31.5%	8.0	3	3	1		
	Griffin - Herschel Prins	6	6	105.8%	202.2%	103.8%	486.6%			55.5%	32.8%	22.7%	28.7	1	0	0		
AMH Other	Phoenix - Herschel Prins	12	12	104.6%	169.1%	105.3%	162.8%		100.0%	43.5%	24.9%	18.6%	12.7	0	0	0		
	Skye Wing - Stewart House	30	29	106.6%	99.2%	127.7%	140.0%			30.6%	26.7%	4.0%	4.8	1	0	0		
	Willows	9	8	140.5%	126.5%	102.3%	147.8%			42.9%	36.5%	6.3%	15.5	0	1	1		
	Mill Lodge	14	10	83.0%	92.0%	131.4%	134.4%			65.5%	42.5%	23.0%	16.0	0	7	0		
CHS City	Kirby	23	20	50.6%	110.1%	122.6%	153.1%	100.0%	100.0%	40.4%	33.1%	7.4%	7.5	0	5	0	0	0
	Welford	24	20	62.1%	102.3%	126.9%	137.6%			14.6%	11.6%	3.0%	6.1	2	1	0	0	0
	Beechwood Ward - BC03	23	19	88.2%	107.4%	101.0%	123.6%	100.0%	100.0%	37.3%	13.5%	23.8%	9.6	6	3	0	1	0
	Clarendon Ward - CW01	21	19	81.4%	110.9%	99.5%	119.8%	100.0%	100.0%	33.1%	10.3%	22.8%	9.5	0	6	0	2	0
	Coleman	21	14	69.3%	139.2%	133.3%	238.7%	100.0%	100.0%	39.0%	24.4%	14.5%	14.1	1	7	0	0	0
	Wakerley (MHSOP)	21	16	104.6%	118.5%	152.6%	185.0%			47.3%	28.0%	19.3%	14.0	2	8	0	0	0
CHS East	Dalgleish Ward - MMDW	17	15	104.1%	85.0%	105.1%	107.1%	100.0%	100.0%	21.2%	9.2%	11.9%	8.3	1	0	0	2	0
	Rutland Ward - RURW	17	12	54.7%	86.3%	67.7%	72.2%	100.0%	100.0%	31.5%	19.0%	12.5%	10.4	0	0	1	0	0
	Ward 1 - SL1	17	14	72.2%	104.9%	96.6%	145.1%	100.0%	100.0%	22.3%	13.2%	9.0%	11.5	1	3	0	0	0
	Ward 3 - SL3	13	11	107.3%	109.0%	94.8%	177.7%	100.0%	100.0%	19.8%	11.9%	7.9%	11.1	1	4	0	0	0
CHS West	Ellistown Ward - CVEL	15	13	95.2%	110.2%	93.5%	123.2%	100.0%	100.0%	13.8%	7.7%	6.2%	10.9	3	2	0	1	0
	Snibston Ward - CVSN	18	15	80.1%	126.2%	101.6%	116.4%	100.0%	100.0%	18.1%	6.4%	11.8%	11.3	0	1	0	0	0
	East Ward - HSEW	23	19	93.2%	108.6%	124.0%	147.7%	100.0%	100.0%	29.4%	4.3%	25.1%	10.0	2	11	1	0	0
	North Ward - HSNW	18	14	101.1%	97.6%	103.3%	106.2%	100.0%	100.0%	30.1%	9.1%	21.0%	11.5	1	6	0	0	0
	Swithland Ward - LBSW	18	16	98.3%	95.1%	87.4%	142.8%	100.0%	100.0%	14.3%	5.3%	9.0%	9.7	1	5	0	0	0
FYPC	Langley	15	14	143.6%	87.5%	146.2%	126.2%	100.0%		43.0%	33.1%	9.9%	10.8	1	0	0		
	CAMHS Beacon Ward - Inpatient Adolescent	16	7	135.0%	159.0%	156.1%	316.6%			72.3%	21.7%	50.6%	33.2	0	0	0		
LD	Agnes Unit	4	2	117.6%	96.1%	141.1%	137.3%			58.2%	24.4%	33.8%	70.1	1	0	0		
	Gillivers	2	1	95.5%	72.3%	107.5%	90.3%			6.6%	6.6%	0.0%	68.6	0	1	0		
	1 The Grange	3	1	86.7%	83.3%	-	102.7%			12.9%	11.7%	1.2%	57.3	1	5	0		

Governance table

For Board and Board Committees:	Public Trust Board 25.01.22	
Paper sponsored by:	Anne Scott, Executive Director of Nursing, AHPs and Quality	
Paper authored by:	Emma Wallis, Interim Deputy Director of Nursing & Quality, Louise Evans, Assistant Director of Nursing & Quality & Elaine Curtin Workforce and Safe Staffing matron	
Date submitted:	25.01.2022	
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	√
	Reaching Out	
	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:		

Leicestershire Partnership NHS
NHS Trust

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Finance Report for the period ended
31 December 2021

For presentation at the
Trust Board
25th January 2022

Contents

Executive Summary and overall performance against targets

Introduction

1. This report presents the financial position for the period ended 31 December 2021 (Month 9). 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 position for the period, in line with plan.

3. Within this overall position, net operational budgets report a £344k overspend. Directorate overspends include DMH (£356k), LD Services (£162k), Estates (£68k), FYPC services (£60k) and Enabling (£34k). Hosted services are underspending by £258k and CHS by £78k.

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

5. Closing cash for December stood at £35.2m. This equates to 44.3 days' operating costs.

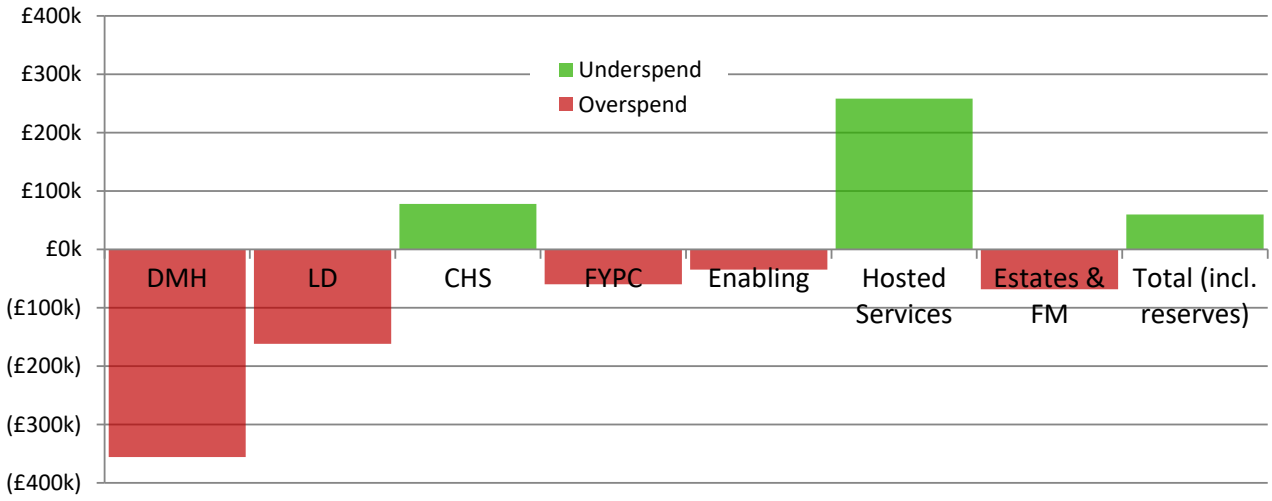
Performance against key targets and KPIs

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 December 2021. **[see 'Service I&E position' and *Appendix A*]**.
2. Remain within Capital Resource Limit (CRL).	G	G	The capital spend for December is £6.2m, 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 £35.2m. 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	A	The target is to pay 95% of invoices within 30 days. Cumulatively the Trust achieved 3 of the 4 BPPC targets in December. The Year to date dip in performance for NHS invoices introduces some risk to delivery of the NHS metric.
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 £35.2m was achieved at the end of December 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 £6.2m at the end of Month 9; this is £3.1m (33%) below the YTD planned level of £9.3m **[See 'Capital Programme 2021/22']**

Income and Expenditure position

The month 9 position shows a net operational overspend against year-to-date budgets, offset by an underspend within reserves.



The Mental Health directorate is overspending by £356k at the end of month 9 - an adverse movement of £279k since month 8. This is largely due to an increase in the use of agency staff to cover significantly high vacancy levels and wait times. The non-pay overspend has increased relating to UHL invoices being higher than expected, plus international nurses' additional charges and old year drugs invoices. Income continues to report an over recovery relating to out of county patient income.

The FYPC financial position worsened in month 9 to report a slight overspend. The Beacon Unit continues to face staffing pressures with increased agency usage, along with medical equipment budgets within the Diana service (a potential recharge of costs to CCG is currently being explored). Significant costs were also incurred for the provision of agency staff supporting children at the LRI with c.£135k being charged to LPT. Healthy Together budgets continue to report an underspend due to staff vacancies although posts have been recruited to in the County.

The LD financial position worsened in the month as the Agnes Unit incurred greater agency costs due to staff sickness, acuity on the ward and managing activity over all 5 pods. In contrast, Community services remain underspent, mainly due to vacancies.

The CHS Directorate is reporting an underspend of £78k at month 9, which is a minor adverse movement from month 8. The pressures within the Inpatient service continue and are currently being offset by the significant vacancies that exist within the community nursing and therapy services. The Directorate remains on track to deliver a balanced position. As anticipated, the bank and agency use within the Inpatient wards remained high over the holiday period, due to the increased number of acute patients that are being

admitted and cover required for the high level of vacancies and staff sickness within the wards.

Efficiency savings

Full achievement of the 1.5% (£2.6m) efficiency target set for H2 remains on target. Savings had already been identified and were being delivered prior to confirmation of the target (including a continuation of travel savings, VAT reclaims, balance sheet gains, underspends against internal investment budgets and other income gains), and so no formal efficiency programme was required for 2021/22.

Forecast position

The likely 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.

Whilst there are expected to be some individual variances across Directorates at the end of the year, the combined operational position is expected to be a break-even. Initial underspends against central reserves are forecast, but expected year end cost pressures are likely to offset these, such that the overall Trust forecast position remains in target with the break-even plan.

A summary analysis of the best, likely and worse case financial forecasts is included in ***Appendix F***

Adult Eating Disorders Provider Collaborative

As reported last month, the Adult Eating Disorders Provider Collaborative (hosted by the Trust) is currently reporting a significant underspend, now forecast to be c. £1.9m by the end of the financial year. The intention within the collaborative is for any underspends to be reinvested. This would require a carry forward of the unspent monies. NHS England have produced some guidance around the carrying forward of funds, which will be used to support our year end approach.

The approach will be discussed with our external auditors in advance of year end. Until the audit discussions have concluded, this could be an underspend risk in the current financial year.

Additional agency expenditure analysis

For the period April to December, total expenditure on agency staff was £17.7m. The forecast for the year is £24.6m (£23m excluding Covid), which again reflects an increase on previous forecasts. On top of the previously reported additional agency staff to support backlog reduction, the increasing levels of absence have further driven up agency forecasts. ***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 provide a clearer basis for comparison with the 2019/20 position, Covid costs are excluded from the 2021/22 figures. Within the analysis, further adjustments are made for the significant agency costs linked to the large amount of investment this year, which would otherwise further distort the comparison with 2019/20.

The resulting comparable costs are shown as £20m in the current year (forecast) versus £10.6m in 2019/20 – an 89% 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**	9,678	-2,213	**7,465**	**4,065**	Continued use of locums and agency staff to cover vacancies. Vacancy levels have further increased. Bank and Agency usage increased to cover reduce wait times.	7,465
CHS	**4,341**	5,541	0	**5,541**	**1,200**	Bank and Agency usage continues to increase due to high number of vacancies and staff sickness within the wards. Bank and Agency required to adequate staff the Surge Wards	4,463
FYPC	**2,059**	4,507	-738	**3,769**	**1,710**	Increased level of vacancy within CAMHs consultant services; addressing CAMHs wait times; Hub & CAP staff; high usage of agency on the Beacon ward due to acuity of patients, use of agency on Langley due to acuity of patients	3,409
LD	**301**	2,449	0	**2,449**	**2,148**	Agency costs increase due to staff sickness, acuity on the ward and operating all 5 pods. Higher level of acuity and care requirements for new admissions neessiate continous agency support - potential recurrent.	1,021
Enabling / Hosted	**541**	902	-34	**868**	**327**	Agency costs predominantly relate to pressures within HR teams. The underlying position assumes a return to slightly higher baseline levels.	575
TOTAL:	**10,642**	**23,077**	**-2,985**	**20,092**	**9,450**		**16,933**

DMH continues to show the highest forecast increase compared to 2019/20 (£4.06m 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 staff pressures with the Agnes Unit.

The FYPC increase of £1.7m 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: December 2021	2020/21 31/03/21 Audited £'000's	2021/22 31/12/21 December £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	178,757	177,860
Intangible assets	2,438	2,132
Trade and other receivables	1,129	1,129
Total Non Current Assets	**182,324**	**181,121**
CURRENT ASSETS		
Inventories	574	547
Trade and other receivables	8,304	8,876
Cash and Cash Equivalents	24,139	35,150
Total Current Assets	**33,017**	**44,573**
Non current assets held for sale	**280**	**0**
TOTAL ASSETS	**215,621**	**225,693**
CURRENT LIABILITIES		
Trade and other payables	(21,587)	(32,579)
Borrowings	(296)	(297)
Capital Investment Loan - Current	(189)	(107)
Provisions	(2,851)	(2,032)
Total Current Liabilities	**(24,923)**	**(35,015)**
NET CURRENT ASSETS (LIABILITIES)	**8,374**	**9,558**
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 £177.9m. Capital additions of £6.2m are offset by December's depreciation charge.

Current assets

Current assets of £44.6m include cash of £35.2m and receivables of £8.9m.

Non-current assets held for sale

the Trust does not have any non-current assets held for sale.

Current Liabilities

Current liabilities amount to £35m and mainly relate to payables of £32.6m.

Net current assets / (liabilities) show net assets of £9.6m.

Working capital

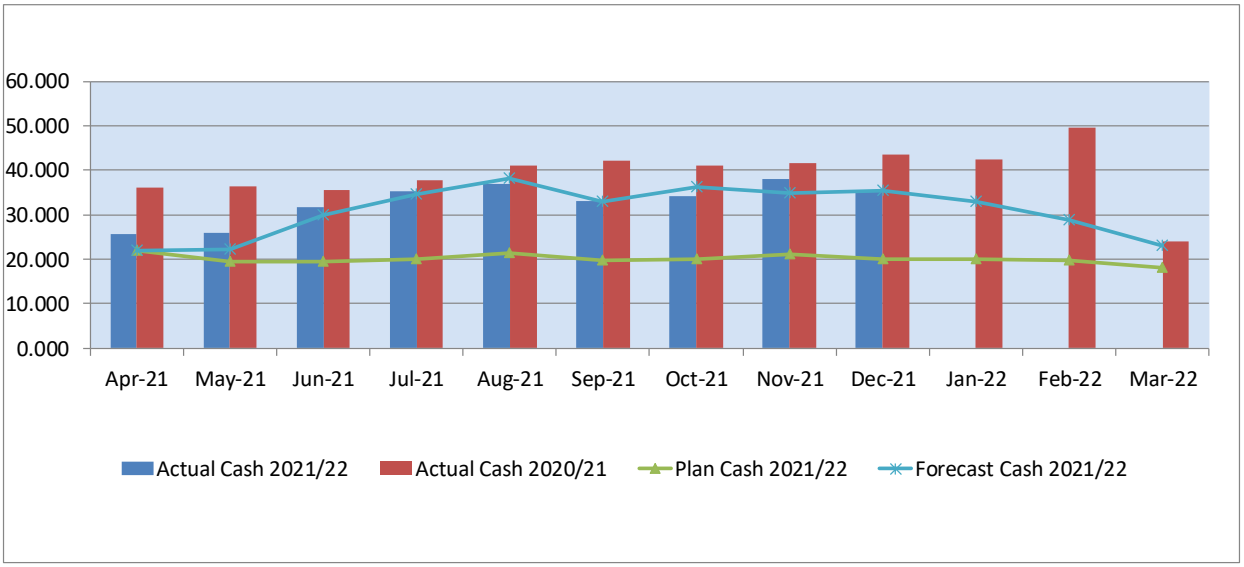
Cash and changes in working capital are reviewed on the following pages.

Taxpayers' Equity

December'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 December was £35.2m, a decrease of £2.9m during the month.

As reported last month, the year-end closing cash balance forecast is now £23m. Changes to the current year-end forecast are still likely; uncertainties around capital spend due to external factors e.g., supply chain issues, site access restrictions due to covid, and utilisation of 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 £8.9m; a decrease of £0.7m during the month and an increase of £0.6m since the start of the year.

Receivables	Current Month December 2021					
	NHS	Non NHS	Emp's	Total	% Total	% Sales Ledger
	£'000	£'000	£'000	£'000		
Sales Ledger						
30 days or less	1,590	1,161	32	**2,783**	**27.8%**	**65.5%**
31 - 60 days	182	218	2	**402**	**4.0%**	**9.5%**
61 - 90 days	153	85	1	**239**	**2.4%**	**5.6%**
Over 90 days	244	376	203	**823**	**8.2%**	**19.4%**
	2,169	1,840	238	**4,247**	**42.4%**	**100.0%**
Non sales ledger	2,084	2,545	0	**4,629**	**46.3%**	
Total receivables current	**4,253**	**4,385**	**238**	**8,876**	**88.7%**	
Total receivables non current		1,129		1,129	**11.3%**	
Total	**4,253**	**5,514**	**238**	**10,005**	**100.0%**	**0.0%**

Debt greater than 90 days increased by £57k since November and now stands at £823k. Receivables over 90 days should not account for more than 5% of the overall total receivables balance. The proportion at Month 9 is 8.2% (last month: 8.2%). 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 9 is £32.6m. This is a decrease of £1.6m since November and an increase of £11m since the start of the year. Expenditure accruals and deferred income liabilities have increased during the year – these accruals are required to cover the receipt of goods and services where invoices have not yet been received, and to reduce income when cash has been received but relates to future periods. 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 9. 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. For NHS invoices, initial actions have been taken to improve processes to aid faster approval of invoices. 100% compliance will now need to be achieved in Quarter 4 to support the achievement of the cumulative NHS target, which adds considerable risk to achievement of the target for the year overall. Given this increased risk, a further deep dive is now being undertaken to identify any other possible areas of weakness in current processes or any capacity issue within teams in terms of managing invoice volume peaks and troughs

The late payment of pharmacy invoices is contributing to the non-compliance of the non-NHS target. These invoices are batched together and paid via an automated ledger feed. For these types of payments, we are reviewing the invoice receipt date that is currently being used for the BPPC calculation. The current process could be negatively impacting on our delivery of the target. Any change to the calculation will be discussed with KPMG auditors as part of their interim audit. 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	Dec Actual	Year End Forecast	Revision to Plan
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**
Depreciation & technical adjustments	9,500	5,920	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**	**6,200**	**16,311**	**(1,241)**
Application of Funds	**£'000**	**£'000**	**£'000**	**£'000**
Estates & Innovation				
Estates service improvements	(5,019)	(1,363)	(4,445)	574
Estates backlog	(2,395)	(745)	(3,036)	(641)
Estates other rolling programmes	(1,950)	(571)	(1,140)	810
Estates staffing	(360)	(340)	(413)	(53)
Estates & FM transformation	(699)	0	(100)	599
Medical devices	(120)	(124)	(236)	(116)
	(10,543)	**(3,143)**	**(9,370)**	**1,173**
IT Programme				
Rolling programmes	(1,865)	(1,706)	(3,040)	(1,175)
Other projects	(595)	(135)	(373)	222
PDC IM&T Shared Care Records	0	(222)	(2,278)	(2,278)
	(2,460)	**(2,063)**	**(5,691)**	**(3,231)**
Other				
Directorate capital investment projects	**(1,689)**	**(249)**	**(1,548)**	**141**
System-wide capital	**(2,560)**	**0**	**0**	**2,560**
Revenue to capital transfers	**0**	**(745)**	**(745)**	**(745)**
Contingency	**(300)**	**0**	**1,043**	**1,343**
Total Capital Expenditure	**(17,552)**	**(6,200)**	**(16,311)**	**1,241**
(Over)/underspend	**0**	**0**	**0**	**0**

Month 9 capital expenditure of £6.2m represents 38% of total forecast annual spend. This is £3.1m less than the cumulative planned spend of £9.3m for the first nine months. Spend against several estates 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 over-committed by £1m. this is manageable as there is still £10.1m left to spend in the last quarter of the year and it is expected that there will be further slippage on several capital schemes, due to supply chain issues and site access restrictions due to Covid-19. Plans have already been activated 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.

The capital plan does not currently include any TIF digital investments. Inclusion in this year's programme is still to be confirmed with NHSE&I.

Work is progressing with the finalisation of next year's capital plan. New capital bids for all services have been reviewed and prioritised by the Capital Management Committee. Once completed, the draft plan will be presented to the Finance and Performance Committee, for approval.

Changes made to the capital schemes in month 9 are shown below.

Ref	Scheme	Dept	Plan or Previous Forecast	Forecast	Change (Inc) / Dec	Reason
			£000	£000	£000	
New Schemes						
	Lough Vaccination Clinic walk-way	Est	0	(195)	(195)	Emergency bid to support vaccination clinics
			0	**(195)**	**(195)**	
Changes to existing schemes - Estates						
6C65	Staff room upgrades - 20/21 schemes c/f	Est	(10)	0	10	Scheme value adjusted to match GMP
6C99	Trust wide emergency lighting replacement (inc Waterme	Est	(126)	(179)	(53)	Scheme value adjusted to match GMP
6C18	Capital scheme investigative fund (pre-approval)	Est	0	(21)	(21)	Scheme value adjusted to match GMP
1088	Loughborough vaccination clinic walkway	Est	(195)	(190)	5	Scheme value adjusted to match GMP
6C43	Bradagte Unit - External access to roof voids (RIDDOR)	Est	(12)	(37)	(25)	Scheme value adjusted to match GMP
6C22	Coalville Community Hospital - Ward 2 radiator covers an	Est	(239)	(247)	(8)	Scheme value adjusted to match GMP
6C26	Hinckley & Bosworth Community Hospital - Therapy Block	Est	(50)	(52)	(2)	Scheme value adjusted to match GMP
6C30	Loughborough Hospital - Phase 1 – Emergilite self-test en	Est	(50)	0	50	Scheme slippage to be deferred into 2022/23
6C04	Loughborough Hospital - Phase 2 - Boiler room refurbishm	Est	(367)	(374)	(7)	Scheme value adjusted to match GMP
6C06	Mawson House - Boiler replacements	Est	(38)	(40)	(2)	Scheme value adjusted to match GMP
6C41	Narborough Health Centre - Electrical installation – Replac	Est	(276)	(306)	(30)	Scheme value adjusted to match GMP
6C44	Valentine Centre - Electrical Switchgear and distribution b	Est	(25)	(23)	2	Scheme value adjusted to match GMP
6C50	Springfield Road - remainder of roof to recover	Est	(193)	(206)	(13)	Scheme value adjusted to match GMP
6C71	Evington Centre - Ward entrance doors	Est	(18)	(26)	(8)	Scheme value adjusted to match GMP
6C12	Rutland Memorial Hosp - Basement boilers	Est	(8)	(32)	(24)	Scheme value adjusted to match GMP
6C80	Winstanley Drive - Structural repairs throughout. External;	Est	(80)	(20)	60	Scheme slippage to be deferred into 2022/23
6C89	OSL House toilets	Est	(119)	(118)	1	Scheme value adjusted to match GMP
6C45	Mawson Lodge issues	Est	(80)	(74)	6	Scheme value adjusted to match GMP
6C35	Coalville roof phase 1 (from 20/21)	Est	(74)	(73)	1	Scheme value adjusted to match GMP
6C01	Site wide - CQC projects	Est	(144)	(147)	(3)	Scheme value adjusted to match GMP
6C08	Site wide - H&S - Fire	Est	(367)	(366)	1	Scheme value adjusted to match GMP
6C03	Site wide - Statutory Compliance	Est	(37)	(39)	(2)	Scheme value adjusted to match GMP
6C11	Site wide - Anti-barracade	Est	(340)	(348)	(8)	Scheme value adjusted to match GMP
6C91	CDM Principal Designer	Est	(25)	(29)	(4)	Scheme value adjusted to match GMP
1085	Cost Advisor	Est	(25)	(24)	1	Scheme value adjusted to match GMP
6C25	AMH Airlock door system – Herschel Prins Low Secure Ur	Est	(30)	(31)	(1)	Scheme value adjusted to match GMP
6C34	AMH Bradgate Unit air conditioning	Est	(112)	(74)	38	Scheme value adjusted to match GMP
6C36	AMH ECT Suite	Est	(10)	(14)	(4)	Scheme value adjusted to match GMP
6C51	FYPC Westcotes Lodge	Est	(30)	(22)	8	Scheme value adjusted to match GMP
6C23	Reception counters HSE issues	Est	(51)	(52)	(1)	Scheme value adjusted to match GMP
6C90	Willows substance misuse	Est	(39)	(38)	1	Scheme value adjusted to match GMP
6C84	Beacon swing doors & shelves	Est	(115)	(90)	25	Scheme value adjusted to match GMP
6C85	Beacon classroom doors	Est	(41)	(40)	1	Scheme value adjusted to match GMP
6C78	Lockers	Est	(90)	(89)	1	Scheme value adjusted to match GMP
			(3,416)	**(3,421)**	**(5)**	
Changes to existing schemes - IM&T						
6C17	Rolling Replacement Programme	IT	(1,250)	(2,100)	(850)	Additional orders to utilised scheme slippage
6C49	S1 obs	IT	(78)	(58)	20	Underspend identified
6C79	Learning management and appraisal software	IT	(40)	(48)	(8)	VAT to be included
			(1,368)	**(2,206)**	**(838)**	
Revenue to capital transfers						
2514	Revenue to Capital transfers - IT hardware	Rev	0	(121)	(121)	IT equipment purchased via revenue
2514	Revenue to Capital transfers - Furniture	Rev	0	(11)	(11)	Furniture equipment purchased via revenue
			0	**(132)**	**(132)**	
Total changes from contingency - M9					**(1,170)**	
Capital Contingency						
M8 contingency					127	
M9 changes impacting on contingency					(1,170)	
M9 contingency					**(1,043)**	

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 31 December 2021	YTD Actual M9 £000	YTD Budget M9 £000	YTD Var. M9 £000
Revenue			
Total income	257,389	252,572	4,817
Operating expenses	(252,743)	(247,926)	(4,817)
Operating surplus (deficit)	**4,646**	**4,646**	**0**
Investment revenue	0	0	0
Other gains and (losses)	60	0	60
Finance costs	(767)	(767)	0
Surplus/(deficit) for the period	**3,939**	**3,879**	**60**
Public dividend capital dividends payable	(3,879)	(3,879)	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	**12,116**	**12,116**	**0**
Trust EBITDA margin %	**4.7%**	**4.8%**	**-0.1%**

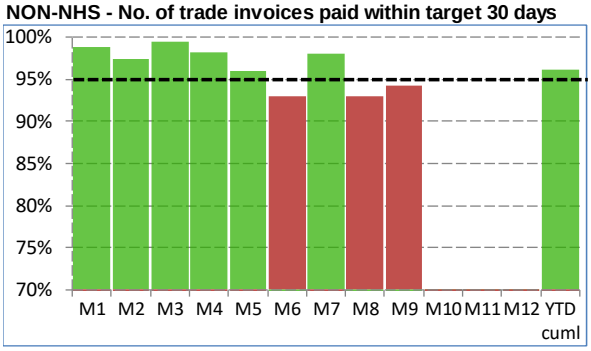
APPENDIX B – BPPC performance

Trust performance – current month (cumulative) v previous

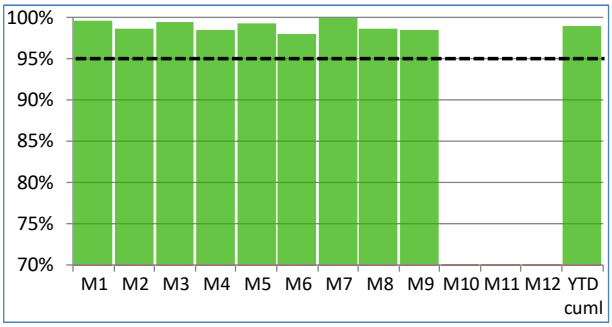
Better Payment Practice Code	December (Cumulative)		November (Cumulative)	
	Number	£000's	Number	£000's
Total Non-NHS trade invoices paid in the year	24,165	90,099	20,998	77,211
Total Non-NHS trade invoices paid within target	23,250	89,228	20,263	76,532
% of Non-NHS trade invoices paid within target	**96.2%**	**99.0%**	**96.5%**	**99.1%**
Total NHS trade invoices paid in the year	750	48,009	609	41,618
Total NHS trade invoices paid within target	700	46,782	570	40,597
% of NHS trade invoices paid within target	**93.3%**	**97.4%**	**93.6%**	**97.5%**
Grand total trade invoices paid in the year	24,915	138,108	21,607	118,829
Grand total trade invoices paid within target	23,950	136,010	20,833	117,129
% of total trade invoices paid within target	**96.1%**	**98.5%**	**96.4%**	**98.6%**

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

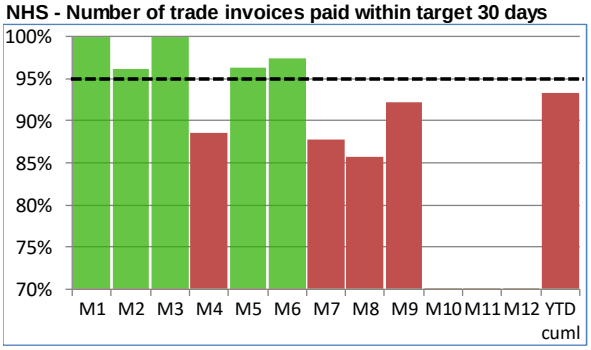
NON-NHS - No. of trade invoices paid within target 30 days



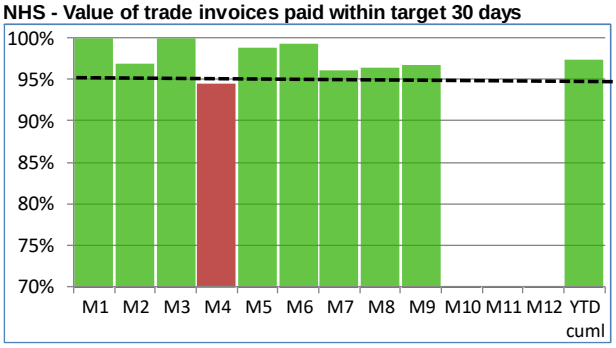
NON-NHS - Value of trade invoices paid within target 30 days



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 Avg mth £000s Actual	2021/22 M1 £000s Actual	2021/22 M2 £000s Actual	2021/22 M3 £000s Actual	2021/22 M4 £000s Actual	2021/22 M5 £000s Actual	2021/22 M6 £000s Actual	2021/22 M7 £000s Actual	2021/22 M8 £000s Actual	2021/22 M9 £000s Actual	2021/22 M10 £000s F'Cast	2021/22 M11 £000s F'Cast	2021/22 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	-491	-320	-300	-280	-2,658	-3,558
Agency Nursing	-2,642	-220	-344	-265	-301	-422	-432	-548	-552	-486	-656	-656	-656	-656	-4,007	-5,975
Agency Scient, Therap. & Tech	-152	-13	-19	-14	-14	-25	-11	-17	-16	-17	-15	-20	-20	-20	-147	-207
Agency Other clinical staff costs				-11	-16	-11	1	0	0	-11	47	-20	-20	-20	-1	-61
Agency Non clinical staff costs	-187	-16	-21	-32	-54	-21	-36	-62	2	-29	-10	-10	-10	-10	-262	-293
Sub-total for Directorate - DMH	**-5,541**	**-462**	**-673**	**-129**	**-905**	**-743**	**-698**	**-725**	**-1,143**	**-935**	**-1,125**	**-1,026**	**-1,006**	**-986**	**-7,076**	**-10,094**
Agency Spend relating to Investments			**-57**	-88	-115	-130	-198	-203	-220	-234	**-240**	**-243**	**-243**	**-243**	-1,485	**-2,213**
Agency spend relating to COVID			-59	-97	-150	-40	-6	-15	-5	-14	-15	-5	-5	-5	-401	**-416**
LEARNING DISABILITIES																
Agency Consultant Costs	-48	-4	-12	-8	-10	-13	-12	0	5	0	-10	-8	-8	-8	-61	-85
Agency Nursing	-761	-63	-129	-135	-156	-165	-156	-183	-295	-183	-260	-240	-220	-220	-1,662	-2,342
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	-1	0	0	0	-4	-4
Sub-total for Directorate - LD	**-894**	**-74**	**-154**	**-151**	**-162**	**-178**	**-168**	**-184**	**-290**	**-186**	**-271**	**-248**	**-228**	**-228**	**-1,746**	**-2,450**
Agency Spend relating to Investments			0	0	0	0	0	0	0	0	**0**	**0**	**0**	**0**	0	**0**
Agency spend relating to COVID			-1	0	0	0	0	0	0	0	0	0	0	0	-1	**-1**
CHS																
Agency Consultant Costs	-9	-1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Agency Nursing	-3,959	-330	-239	-354	-338	-411	-494	-492	-451	-485	-629	-490	-460	-430	-3,894	-5,274
Agency Scient, Therap. & Tech	-375	-31	-36	-36	-50	-42	-22	-38	-67	-65	-56	-70	-70	-70	-412	-622
Agency Non clinical staff costs	-28	-2	-5	-10	-11	0	0	0	0	0	0	-3	-3	-3	-25	-34
Sub-total for Directorate - CHS	**-4,371**	**-364**	**-279**	**-401**	**-399**	**-453**	**-515**	**-531**	**-518**	-550	**-685**	**-563**	**-533**	**-503**	**-4,331**	**-5,930**
Agency Spend relating to Investments			0	0	0	0	0	0	0	0		**0**	**0**	**0**	0	**0**
Agency spend relating to COVID			-56	-18	-10	-21	-22	-23	-20	-60	-69	-40	-30	-20	-299	**-389**
FYPC																
Agency Consultant Costs	-816	-68	-70	-17	-48	-63	-44	-110	-83	-67	-29	-72	-72	-72	-531	-747
Agency Nursing	-2,546	-212	-241	-259	-232	-245	-330	-364	-335	-263	-417	-310	-310	-300	-2,685	-3,605
Agency Scient, Therap. & Tech	0	0	0	0	0	-3	-1	-4	-1	-2	-7	-4	-4	-4	-19	-31
Agency Non clinical staff costs	-10	-1	-5	-14	-6	-11	3	-8	-15	-10	-18	-20	-10	-10	-85	-125
Sub-total for Directorate - FYPC	**-3,371**	**-281**	**-315**	**-290**	**-287**	**-322**	**-372**	**-485**	**-435**	**-341**	**-472**	**-406**	**-396**	**-386**	**-3,320**	**-4,508**
Agency Spend relating to Investments			0	0	0	0	-58	-100	-100	0	**-120**	**-120**	**-120**	**-120**	-378	**-738**
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	-6	-2	-2	-2	-17	-23
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	-22	-19	-19	-19	-190	-247
Agency Non clinical staff costs	-977	-81	-105	-131	-158	-49	-56	-85	-220	-58	-171	-120	-120	-120	-1,033	-1,393
Sub-total for Directorate - Enab/Host	**-1,069**	**-89**	**-110**	**-141**	**-166**	**-78**	**-99**	**-116**	**-254**	**-76**	**-199**	**-141**	**-141**	**-141**	**-1,240**	**-1,663**
Agency Spend relating to Investments			0	0	-5	0	0	-13	-2	4	**-12**	**-2**	**-2**	**-2**	-28	**-34**
Agency spend relating to COVID			-76	-76	-79	-111	-47	-77	-94	-13	0	-70	-65	-50	-576	**-761**
TOTAL TRUST																
Agency Consultant Costs	-3,433	-286	-371	168	-578	-341	-276	-221	-657	-454	-537	-402	-382	-362	-3,267	-4,413
Agency Nursing	-9,915	-826	-953	-1,013	-1,028	-1,243	-1,411	-1,588	-1,634	-1,417	-1,962	-1,696	-1,646	-1,606	-12,248	-17,196
Agency Scient, Therap. & Tech	-696	-58	-73	-68	-69	-99	-77	-78	-116	-106	-100	-113	-113	-113	-786	-1,125
Agency Other clinical staff costs				-11	-16	-11	1	0	0	-11	47	-20	-20	-20	-1	-61
Agency Non clinical staff costs	-1,202	-100	-135	-188	-230	-81	-89	-154	-233	-100	-200	-153	-143	-143	-1,410	-1,850
Total	**-15,246**	**-1,270**	**-1,532**	**-1,113**	**-1,920**	**-1,775**	**-1,852**	**-2,041**	**-2,639**	**-2,087**	**-2,752**	**-2,384**	**-2,304**	**-2,244**	**-17,712**	**-24,645**
Total Trust Agency Spend relating to Investments	-	-	**-57**	**-88**	**-120**	**-130**	**-256**	**-316**	**-322**	**-230**	**-372**	**-365**	**-365**	**-365**	-1,891	**-2,985**
Total Trust Agency Spend relating to Covid-19	2,578	215	**-193**	**-191**	**-239**	**-172**	**-75**	**-115**	**-119**	**-87**	**-84**	**-115**	**-100**	**-75**	-1,278	**-1,568**
Total excluding Covid-19 and Investment costs	**-12,668**	**-1,055**	**-1,281**	**-834**	**-1,560**	**-1,473**	**-1,521**	**-1,610**	**-2,198**	**-1,771**	**-2,296**	**-1,905**	**-1,840**	**-1,805**	**-14,543**	**-20,092**

Agency costs for December were £2.8m (the highest spend ever recorded and 117% higher than the average monthly spend during 2020/21) Excluding Covid and investment funded posts, costs were £2.3m.

The forecast costs for the year are £24.6m.

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, December 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	-58	2	0	0	0	0	0	0	**-56**
Bank	131	41	0	0	0	0	0	0	**172**
Agency	15	67	0	0	0	0	0	0	**82**
Existing workforce additional shifts									
Substantive	0	0	0	0	0	3	0	0	**3**
Bank	0	0	15	17	0	48	0	0	**80**
Agency	0	0	0	0	0	0	0	0	**0**
Backfill for higher sickness absence									
Substantive	0	0	0	0	0	0	0	0	**0**
Bank	0	0	0	0	0	0	0	0	**0**
Agency	0	0	0	0	0	0	0	0	**0**
Sick pay at full pay (all staff types)	0	0	0	0	0	0	0	0	**0**
NON-PAY	£000	£000	£000	£000	£000	£000	£000	£000	£000
NHS Staff Accommodation - if bought outside of national process	0	0	0	0	0	0	0	0	**0**
PPE - locally procured	0	0	0	0	0	0	0	0	**0**
PPE - other associated costs	0	0	0	0	0	0	0	0	**0**
Increase ITU capacity (incl hospital assisted respiratory / mech. ventilation)	0	0	0	0	0	0	0	0	**0**
Remote management of patients	0	0	0	0	0	0	0	0	**0**
Support for patient stay at home models	0	0	0	0	0	0	0	0	**0**
Segregation of patient pathways	0	0	0	0	0	0	0	0	**0**
Plans to release bed capacity	0	0	0	0	0	0	0	0	**0**
Decontamination	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	1	0	0	0	0	0	0	0	**1**
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	11	0	0	0	**11**
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	0	0	0	**0**
Furniture, fittings, office equip for staff home working	0	0	0	0	0	0	0	0	**0**
Internal and external communication costs	0	0	0	0	0	0	0	0	**0**
Covid Testing	0	0	0	0	0	0	0	0	**0**
Business Case (SDF) - Ageing Well - Urgent Response Accelerator	0	0	0	0	0	0	0	0	**0**
Direct Provision of Isolation Pod	0	0	0	0	0	0	0	0	**0**
PPN / support to suppliers (continuity of payments if service is disrupted)	0	0	0	0	0	0	0	0	**0**
TOTAL M9 COVID COSTS:	**90**	**110**	**15**	**17**	**11**	**51**	**0**	**0**	**294**
TOTAL M1 to M8 COVID COSTS:	1,841	605	101	67	95	560	24	0	3,293
TOTAL YTD COVID COSTS:	**1,931**	**715**	**116**	**84**	**106**	**611**	**24**	**0**	**3,588**

Covid Vaccination costs

Total Covid vaccination costs incurred to date (April to December) are £4.46m. 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 £8.29m for the financial year. This forecast includes additional costs following the national call to action. Vaccination costs are direct funded based on actual costs incurred, so the programme is forecast to have no impact on the Trust bottom line financial position.

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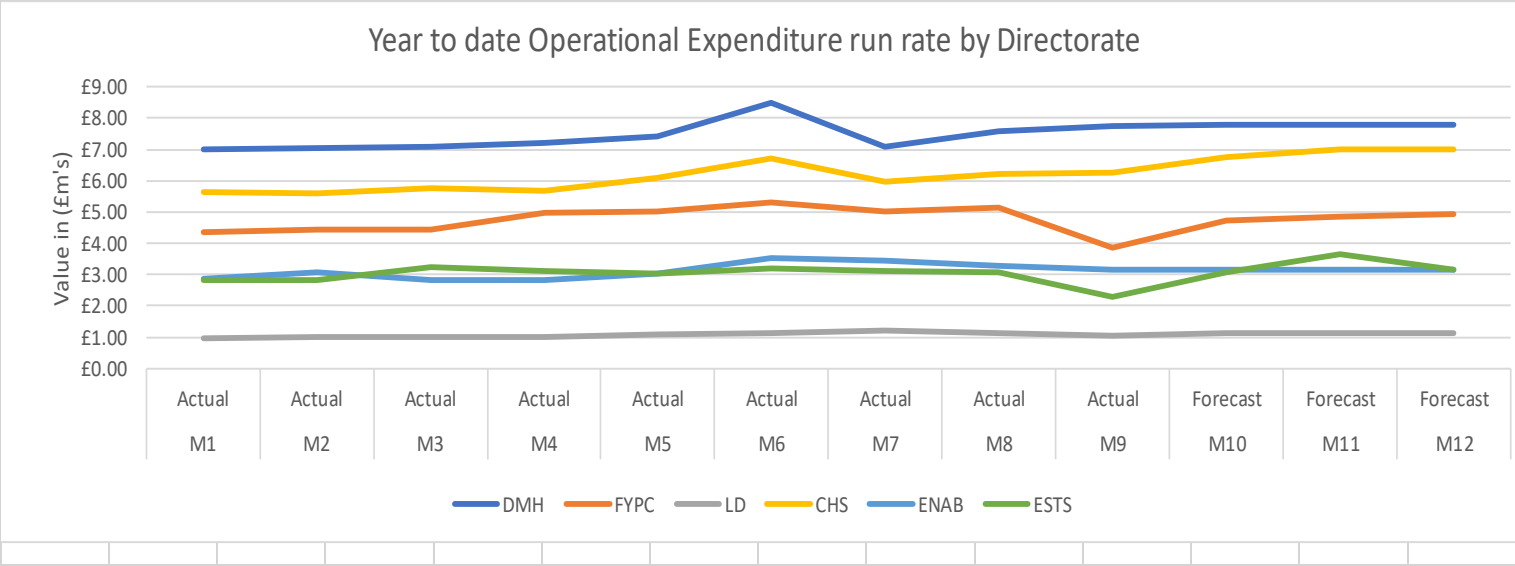
APPENDIX F – Summary of year end forecast (best/likely/worst case)

SUMMARY BY MANAGEMENT AREA / ADDITIONAL PRESSURE OR GAIN	£'000 BEST	£'000 LIKELY	£'000 WORST
DMH	0	-300	-400
Community Health Service	300	50	-100
HIS	700	300	100
Enabling	300	150	-150
Estates	250	50	-120
FYPC	200	0	-200
Learning Disabilities	0	-200	-400
Sub-total operation position:	**1,750**	**50**	**-1,270**
Reserves underspends (central efficiencies, income over-recoveries)	3,862	3,862	3,862
IT asset write-offs (must do, range of estimates)	-500	-650	-750
IT asset write-offs (potential additional based on affordability)	-650	-650	0
Additional identified year end provisions	-1,384	-1,534	-1,589
Potential additional revenue investment (medical equip etc)	-505	-160	0
Revenue impact of Targetted Investment Fund (based on affordability)	-368	-368	0
Revenue costs identified within capital programme	0	-200	-350
Additional 'flu vaccination costs not funded	0	-100	-150
Potential additional year end expenditure / accrual options	-1,125	-250	-45
TOTAL TRUST FORECAST YEAR END POSITION:	**1,080**	**0**	**-292**

APPENDIX G – Operational expenditure run-rate, April to December

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	Forecast	Forecast
	£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	7.7	7.8	7.8	7.8	90.4
FYPC	4.4	4.5	4.4	5.0	5.0	5.3	5.0	5.1	3.8	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	1.0	1.1	1.1	1.1	13.1
CHS	5.6	5.6	5.8	5.7	6.1	6.7	6.0	6.2	6.2	6.8	7.0	7.0	74.6
ENAB	2.9	3.1	2.8	2.8	3.0	3.5	3.4	3.3	3.2	3.2	3.2	3.2	38.0
ESTS	2.8	2.8	3.3	3.1	3.0	3.2	3.1	3.1	2.3	3.1	3.6	3.2	37.3
TOTAL	**23.7**	**24.0**	**24.4**	**24.8**	**25.7**	**28.3**	**25.8**	**26.4**	**24.3**	**26.6**	**27.6**	**27.2**	**311.2**



The actual expenditure run-rate for operational directorates is shown (left). Most clinical areas continue to show the generally 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.

As reflected in the forecast scenarios in ***appendix F*** the directorate operational position is broadly a break-even position. Underspends within central reserves are expected to be used to fund a number of year end pressures, resulting in the overall Trust break-even likely case.

Trust Board – 25/01/22

Month 9 Trust finance report

Purpose of the Report

- To provide an update on the Trust financial position

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: n/a

Governance table

For Board and Board Committees:	Trust Board 25/01/2022	
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:	18/01/2022	
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, 21/01/2022	
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	

N

Leicestershire Partnership NHS Trust

Public Trust Board – 25.01.22

Board Performance Report December 2021 (Month 09)

Purpose of the report

To provide the Trust Board with the Trust's performance against KPI's for December 2021 Month 9.

Analysis of the issue

Due to the way deadlines have fallen, the Month 9 report has been submitted for presentation to Trust Board without any incorporated feedback from Operational Executive Team. A verbal update will be provided.

Proposal

The following should be noted by the Trust Board with their review of the report and looking ahead to the next reporting period:

- The Readmission metric has been redefined in line with national requirements with age breakdowns now included.
- Metrics under 'Quality and Safety' have been updated for the report
  - Addition of 'Total number of Restrictive practices'
  - Removal of 'Number of episodes of supine restraint' and 'Number of episodes of side-line restraint'

Decision required

The Trust Board is asked to

- Approve the performance report

Governance table

For Board and Board Committees:	Trust Board 25.1.22	
Paper sponsored by:	Sharon Murphy, Interim Director of Finance and Performance	
Paper authored by:	Prakash Patel, Acting Head of Information	
Date submitted:	18.01.22	
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:	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
	Reaching Out	
	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	

Leicestershire Partnership NHS
NHS Trust

Trust Board
25 January 2021

Board Performance Report
December 2021 (Month 9)

Highlighted Performance Movements - December 2021

Improved performance:

Metric	Performance	
Gatekeeping Target is >=95%	100.0%	
Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral Target is >=60% (reported a month in arrears)	89.5%	

Deteriorating Performance:

Metric	Performance	
Therapy Service for People with Personality Disorder - Treatment waiters over 52 weeks	473	Lowest performance reported
Delayed Transfers of Care Target is <=3.5% across LLR	3.8%	Last reported over target in Feb 2021

Other areas to highlight:

Metric	Performance (No)	
Serious Incidents	5	Decreased from 8 reported last month
No. of episodes of seclusions >2hrs *Target decreasing trend*	9	Increased from 7 reported last month
No. of episodes of prone (Unsupported) restraint	0	Decreased from 1 reported last month
No. of repeat falls *Target decreasing trend*	25	Decreased from 32 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	Nov-21	Dec-21	Sparkline
	Total Admissions	404	353	389	330	374	366	368	381	377	347	396	377	406	398	437	418	404	412	391	436	403	379	
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	Nov-21	Dec-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	12	17	
	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%	3.0%	4.5%	
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	Nov-21	Dec-21	Sparkline
	0-2	1	4	2	2	0	0	0	2	5	4	5	4	0	0	0	0	0	1	1	2	1	3	
	3-7	2	9	9	1	1	0	1	0	7	12	20	8	1	0	1	0	0	2	1	1	1	8	
	8-14	1	8	9	2	0	0	0	0	1	15	9	5	2	0	0	0	0	1	0	3	1	7	
	15 and over	11	14	5	2	0	0	0	7	5	29	18	35	9	1	0	0	0	2	2	11	0	38	
	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%	0.2%	11.9%	
	• 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	Nov-21	Dec-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	15	73	
	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%	3.7%	19.3%	

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

The increase in definite nosocomial cases is linked to increased community transmission of the new variant of concern; Omicron. Tthis has resulted in an increased number of Covid-19 outbreaks with the Trust currently reporting and managing 14 outbreaks, 13 of which are in in-patient settings affecting both staff and patients. All outbreaks are reported and managed in line with national guidance. Early learning has identified some key themes for learning that have been shared at Trust wide clinical and professional forms and included in our communication briefings to staff. Key themes include; adherence to being BBE, good hand washing tecniques, increased numbers of visitors who have subsequently tested positive following contact, car sharing, uniform and work wear adherence, PPE fatigue.

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. Visiting limited to exceptional circumstances only, continued in-patient testing and patient placement according to risk, staff lateral flow testing, increased touch point cleaning.

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>Jul-21</td><td>Aug-21</td><td>Sep-21</td><td>Oct-21</td><td>Nov-21</td><td>Dec-21</td></tr><tr><td>100.0%</td><td>100.0%</td><td>100.0%</td><td>100.0%</td><td>97.2%</td><td>100.0%</td></tr></table></td><td rowspan="3"></td><td>?</td><td>UP</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><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 inpatients discharged with a subsequent inpatient admission within 30 days</td><td>Age 0-15<table><tr><td>Jul-21</td><td>Aug-21</td><td>Sep-21</td><td>Oct-21</td><td>Nov-21</td><td>Dec-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></table>Age 16 or over<table><tr><td>7.9%</td><td>9.2%</td><td>6.9%</td><td>6.2%</td><td>8.0%</td><td>4.5%</td></tr></table></td><td rowspan="3"></td><td>n/a</td><td>n/a</td></tr>
<tr><td colspan="2"></td></tr>
<tr><td></td></tr>
</table>

2. Quality Account

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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>Jul-21</td><td>Aug-21</td><td>Sep-21</td><td>Oct-21</td><td>Nov-21</td><td>Dec-21</td></tr>
<tr><td>1008</td><td>903</td><td>937</td><td>928</td><td>1054</td><td>1138</td></tr>
<tr><td>60.9%</td><td>57.6%</td><td>58.5%</td><td>57.4%</td><td>58.9%</td><td>56.8%</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>Jul-21</td><td>Aug-21</td><td>Sep-21</td><td>Oct-21</td><td>Nov-21</td><td>Dec-21</td></tr>
<tr><td>4</td><td>8</td><td>7</td><td>7</td><td>11</td><td>8</td></tr>
<tr><td>0.4%</td><td>0.9%</td><td>0.7%</td><td>0.8%</td><td>1.0%</td><td>0.7%</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>Jun-21</td><td>Jul-21</td><td>Aug-21</td><td>Sep-21</td><td>Oct-21</td><td>Nov-21</td></tr>
<tr><td>87.5%</td><td>78.3%</td><td>72.4%</td><td>75.0%</td><td>66.7%</td><td>89.5%</td></tr>
</table>
</td><td></td><td>?</td><td>NO CHANGE</td></tr>
<tr><td colspan="3">Over the series of data points being measured, key standards are being delivered inconsistently</td></tr>
<tr><td rowspan="2">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 rowspan="2">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 rowspan="2">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 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>Jul-21</td><td>Aug-21</td><td>Sep-21</td><td>Oct-21</td><td>Nov-21</td><td>Dec-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.

<table>
<tr><th rowspan="2">Target</th><th colspan="6" 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">Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral

Target is >=60%
(reported a month in arrears)</td><td>Jun-21</td><td>Jul-21</td><td>Aug-21</td><td>Sep-21</td><td>Oct-21</td><td>Nov-21</td><td rowspan="3"></td><td rowspan="2">?</td><td rowspan="2">NO CHANGE</td></tr>
<tr><td>87.5%</td><td>78.3%</td><td>72.4%</td><td>75.0%</td><td>66.7%</td><td>89.5%</td></tr>
<tr><td colspan="6"></td><td colspan="2">Over the series of data points being measured, key standards are being delivered inconsistently</td></tr>
<tr><td rowspan="3">6-week wait for diagnostic procedures (Incomplete)

Target is >=99%

(reported a month in arrears)</td><td>Jun-21</td><td>Jul-21</td><td>Aug-21</td><td>Sep-21</td><td>Oct-21</td><td>Nov-21</td><td rowspan="3">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. If COVID restrictions remain we will need to maintain the current over staffed position to maintain KPI</td><td rowspan="2">YES</td><td rowspan="2">DOWN</td></tr>
<tr><td>68.6%</td><td>58.7%</td><td>49.9%</td><td>58.2%</td><td>64.9%</td><td>72.9%</td></tr>
<tr><td colspan="6"></td><td colspan="2">Key standards are being delivered but are deteriorating</td></tr>
</table>

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%		Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	The total numbers of waiters for an assessment in November 2021 was 402. Although significant progress has been made, this is indicative of an underperformance against the planned trajectory of 350. Actions to address the shortfall against trajectory have been put in place including: - Additional staff recruited and staff offered overtime hours. - new assessment approach is being implemented across the CMHTs. - Consultant desk top paper caseload review commenced in December 2021. - Task and Finish Group which will explore supporting transition into primary care to be established. Practice Development Nurse to support with this. - 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. - Quality summit taking place which will support a deep dive into CMHTs.	N/A	N/A
	Complete	60.3%	57.2%	66.7%	60.9%	68.4%	66.6%			
	Incomplete	58.1%	47.8%	45.3%	56.6%	68.8%	73.5%		NO	UP
									Key standards are not being delivered but are improving	
Memory Clinic (18 week Local RTT) Target is 95%		Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-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. Substantive recruitment to 2.0WTE posts agreed.	N/A	N/A
	Complete	25.5%	48.5%	51.6%	49.1%	39.5%	51.4%			
	Incomplete	68.5%	68.7%	69.7%	70.6%	77.1%	79.5%		N/A	N/A
ADHD (18 week local RTT) Target is: Complete - 95% Incomplete - 92%		Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	A tender to outsource part of the waiting list went out to market and closed on 1st October, however, this was unsuccessful. A revised procurement exercise is currently in development. Other elements of the ADHD improvement plan continue to be progressed, although recruitment remains challenging, therefore, alternative roles are being explored.	N/A	N/A
	Complete	18.2%	20.0%	12.5%	15.4%	21.4%	18.5%			
	Incomplete	39.9%	36.9%	34.3%	33.9%	31.4%	29.7%		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%	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Urgent compliance is consistently 100%. Trajectory and action plan in place to meet 95% by March 2022, however service is currently off trajectory and therefore improvement plan is being reviewed with further actions to bring compliance back in line with trajectory.	N/A	N/A
	30.8%	31.9%	26.2%	20.7%	21.3%	20.9%			
Continence (Complete Pathway) Target is 95%	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Improvement plan in place to increase productivity and reduce the number of patients waiting. It is expected that compliance will decrease before it consistently increases, due to the increased ratio of patients seen who have already breached. Numbers on waiting list are reducing and number of 1st assessments are increasing.	N/A	N/A
	33.7%	44.0%	50.1%	46.0%	39.7%	46.1%			

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%		Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-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 In Nov. 5 out of 6 children passed and one was seen at 10 days due to difficulty contacting family and not lack of available appointments.	?	NO CHANGE
		30.0%	50.0%	100.0%	85.7%	77.8%	83.3%		Over the series of data points being measured, key standards are being delivered inconsistently	
CAMHS Eating Disorder – four weeks (complete pathway) Target is 95%		Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-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. Current progress is ahead of trajectory.	?	DOWN
		42.9%	22.2%	30.0%	42.9%	20.0%	30.8%		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%		Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	The service are now consistently meeting this target	?	UP
		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%		Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	The KPI is now being met following a sustained effort by the team to get the waiting list into the ideal number range.	?	NO CHANGE
		74.8%	89.2%	100.0%	100.0%	100.0%	100.0%		Over the series of data points being measured, key standards are being delivered inconsistently	
Aspergers - 18 weeks (complete pathway)		Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-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
	Wait for Treatment	100.0%	92.9%	93.8%	100.0%	95.8%	97.1%			
	No. of Referrals	30	63	45	57	47	88			
LD Community - 8 weeks (complete pathway)		Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21		N/A	N/A
	Wait for Assessment	89.2%	89.1%	88.3%	81.0%	79.2%	84.2%			
	No. of Referrals	126	118	97	143	104	93			

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	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	103 weeks	The CBT improvement plan remains effective in supporting the number of 52 week waiters to fall.	NO	DOWN
	47	36	27	23	17	24			Key standards are not being delivered but are improving	
Dynamic Psychotherapy	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	125 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
	19	13	13	14	21	21			Key standards are not being delivered but are improving	
Therapy Service for People with Personality Disorder - Treatment waiters over 52 weeks	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	227 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
	325	364	380	395	460	473			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)	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	143 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
	523	502	486	403	360	341				
CAMHS	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	105 weeks	As at 31st December 100 waiting over a year, 49 for treatment and 51 for neuro-developmental diagnosis. This is a sustained improvement position. Both lists are performing against the expected trajectory. Average wait for an ND assessment is 28 weeks down from a peak of 38 weeks	NO	NO CHANGE
	218	233	192	125	141	169			Key standards are not being delivered and are deteriorating/ not improving	
All LD - No's waiting over 52 weeks	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	157 weeks		N/A	N/A
	18	21	25	24	21	14				

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%	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Occupancy levels are closely monitored and actions taken in line with the covid surge plans to ensure adequate capacity is available on a day to day basis.	?	NO CHANGE
	77.7%	79.4%	78.4%	81.6%	81.3%	85.4%		Over the series of data points being measured, key standards are being delivered inconsistently	
Occupancy Rate - Community Beds (excluding leave) Target is >=93%	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	The Trust is below the local target rate of 93%. Work continues 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
	84.1%	80.0%	86.3%	82.2%	85.1%	84.3%		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.	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	The Trust consistently is below the national benchmark of 25 days.	YES	NO CHANGE
	18.2	15.7	19.7	17.8	18.3	18.2		Key standards are being consistently delivered and are improving/ maintaining performance	
Delayed Transfers of Care Target is <=3.5% across LLR	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	NHS Digital has advised this national metric is being paused to release resources to support the COVID-19 response. We will continue to monitor locally.	?	NO CHANGE
	1.9%	3.1%	2.5%	3.1%	3.3%	3.8%		Over the series of data points being measured, key standards are being delivered inconsistently	
Gatekeeping Target is >=95%	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21		?	UP
	100.0%	100.0%	100.0%	100.0%	97.2%	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)*	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21		N/A	N/A
	87.6%	79.1%	78.0%	82.6%	89.9%	86.1%			
Perinatal - Number and Percentage of women accessing service Target is 8.6%	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Access for this indicator is defined as requiring a face to face or video consultation i.e. telephone contacts are excluded. The service has an agreed trajectory for improvement in place and are working through an action plan which is monitored at DMT.	N/A	N/A
	481	488	484	466	495	522		N/A	N/A
	3.8%	3.9%	3.9%	3.7%	4.0%	4.2%			

7. Quality and Safety

<table>
<tr><th rowspan="2">Target</th><th rowspan="2">Trust Performance</th><th rowspan="2">RAG/ Comments on recovery plan position</th><th colspan="2">SPC Flag</th></tr>
<tr><th>Assurance of Meeting Target</th><th>Trend</th></tr>
<tr><td>Serious incidents</td><td><table><tr><th>Jul-21</th><th>Aug-21</th><th>Sep-21</th><th>Oct-21</th><th>Nov-21</th><th>Dec-21</th></tr><tr><td>8</td><td>5</td><td>1</td><td>5</td><td>8</td><td>5</td></tr></table></td><td>There is a robust process for escalating to serious incident and we are aiming to investigate only were there is a clear requirement or opportunity for learning. The investigation methodology is also developed to obtain learning in the most efficient way and reduce the burden on clinical staff time.</td><td>?</td><td>NO CHANGE
Over the series of data points being measured, key standards are being delivered inconsistently</td></tr>
<tr><td>STEIS - SI action plans implemented within timescales (in arrears)

Target = 100%</td><td><table><tr><th>Jul-21</th><th>Aug-21</th><th>Sep-21</th><th>Oct-21</th><th>Nov-21</th><th>Dec-21</th></tr><tr><td>66.5%</td><td>22.2%</td><td>25.0%</td><td>9.0%</td><td>0.0%</td><td>TBC</td></tr></table></td><td>The three directorates are all bringing the oversight of SI action plans into their formal governance process to provide the oversight required to ensure timely closure of actions.</td><td>?</td><td>DOWN
Over the series of data points being measured, key standards are being delivered inconsistently</td></tr>
<tr><td>Safe staffing
No. of wards not meeting >80% fill rate for RNs

Target 0</td><td><table><tr><th></th><th>Jul-21</th><th>Aug-21</th><th>Sep-21</th><th>Oct-21</th><th>Nov-21</th><th>Dec-21</th></tr><tr><td>Day</td><td>5</td><td>5</td><td>6</td><td>4</td><td>3</td><td>7</td></tr><tr><td>Night</td><td>1</td><td>1</td><td>1</td><td>2</td><td>1</td><td>1</td></tr></table></td><td>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.</td><td>NO</td><td>NO CHANGE
Key standards are not being delivered and are not improving
SPC based on day shift</td></tr>
<tr><td>Care Hours per patient day</td><td><table><tr><th>Jul-21</th><th>Aug-21</th><th>Sep-21</th><th>Oct-21</th><th>Nov-21</th><th>Dec-21</th></tr><tr><td>12.5</td><td>12.4</td><td>12.2</td><td>12.2</td><td>12.4</td><td>11.6</td></tr></table></td><td></td><td>N/A</td><td>N/A
Key standard has no target; however performance is consistent</td></tr>
<tr><td>No. of episodes of seclusions >2hrs

Target decreasing trend</td><td><table><tr><th>Jul-21</th><th>Aug-21</th><th>Sep-21</th><th>Oct-21</th><th>Nov-21</th><th>Dec-21</th></tr><tr><td>16</td><td>7</td><td>24</td><td>8</td><td>7</td><td>9</td></tr></table></td><td>A positive 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.</td><td>N/A</td><td>NO CHANGE
Key standard has no target; however performance is consistent</td></tr>
<tr><td>No. of episodes of prone (Supported) restraint

Target decreasing trend</td><td><table><tr><th>Jul-21</th><th>Aug-21</th><th>Sep-21</th><th>Oct-21</th><th>Nov-21</th><th>Dec-21</th></tr><tr><td>3</td><td>2</td><td>5</td><td>2</td><td>2</td><td>1</td></tr></table></td><td rowspan="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.</td><td>N/A</td><td>DOWN
Key standard has no target; however performance is consistent</td></tr>
<tr><td>No. of episodes of prone (Unsupported) restraint

Target decreasing trend</td><td><table><tr><th>Jul-21</th><th>Aug-21</th><th>Sep-21</th><th>Oct-21</th><th>Nov-21</th><th>Dec-21</th></tr><tr><td>0</td><td>0</td><td>0</td><td>2</td><td>1</td><td>0</td></tr></table></td><td>N/A</td><td>NO CHANGE
Key standard has no target; however performance is consistent</td></tr>
<tr><td>Total number of Restrictive Practices</td><td><table><tr><th>Jul-21</th><th>Aug-21</th><th>Sep-21</th><th>Oct-21</th><th>Nov-21</th><th>Dec-21</th></tr><tr><td>164</td><td>174</td><td>226</td><td>194</td><td>272</td><td>204</td></tr></table></td><td></td><td>N/A</td><td>N/A</td></tr>
</table>

No. of Category 2 and 4 pressure ulcers developed or deteriorated in LPT care Target decreasing trend (RAG based on commissioner trajectory)		Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-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	NO CHANGE
	Category 2	98	105	93	98	90	97		N/A	NO CHANGE
	Category 4	3	4	5	6	11	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		Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-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	DOWN
		64	47	45	39	32	25		*Key standard has no target; however performance is consistent*	
LD Annual Health Checks completed - YTD Target is 75%		Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Year To date from 1 April 2021	N/A	N/A
		9.2%	14.7%	17.9%	27.5%	30.8%	39.4%			
LeDeR Reviews completed within timeframe		Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	New LeDeR system is in place – need to redefine.	N/A	N/A
	Allocated		10	16	13	12	12		N/A	N/A
	Awaiting Allocation		16	15	11	19	29		N/A	N/A
	On Hold		16	15	6	3	1		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
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21		?	UP
MH Data quality Maturity Index Target >=95%	91.0%	91.4%	92.6%	92.9%	93.0%	93.2%		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%	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	The Trust is below the ceiling set for turnover.	YES	NO CHANGE
	9.1%	9.1%	9.3%	9.5%	9.6%	9.4%		Key standards are being consistently delivered and are improving performance	
Vacancy rate Target is <=7%	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	The vacancy rate has been below average for most of the last 12 months. The rates increased significantly from April 2021 onwards. This is due to the creation of new posts from additional investment that have not yet been recruited to.	NO	UP
	11.6%	11.5%	11.3%	11.1%	10.5%	11.4%		Key standards are not being delivered and are deteriorating	
Health and Well-being Sickness Absence (1 month in arrears) Target is <=4.5%	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Sickness absence is currently higher than the Trust target, all absence is being appropriately managed within the services with support from HR.	NO	UP
	5.1%	5.3%	5.2%	5.1%	5.4%	5.8%		Key standards are not being delivered and are deteriorating	
Health and Well-being Sickness Absence Costs (1 month in arrears) Target is TBC	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21		n/a	n/a
	£668,739	£717,582	£748,440	£709,372	£790,515	£848,444			
Health and Well-being Sickness Absence YTD (1 month in arrears) Target is <=4.5%	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Sickness absence is currently higher than the Trust target, all absence is being appropriately managed within the services with support from HR.	n/a	n/a
	4.7%	4.9%	5.0%	5.0%	5.1%	5.2%		Not applicable for SPC as measuring cumulative data	
Agency Costs Target is <=£641,666 (NHSI national target)	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	There is high use of agency staff throughout 2021, this has enabled us to ensure there is adequate supply of staff to services	NO	UP
	£1,775,099	£1,852,385	£2,040,719	£2,639,144	£2,086,944	£2,752,153		Key standards are not being delivered and are deteriorating/ not improving	
Core Mandatory Training Compliance for substantive staff Target is >=85%	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	The Trust is meeting the target set for Core Mandatory Training.	YES	UP
	92.5%	92.0%	92.6%	92.9%	93.4%	93.9%		Key standards are being consistently delivered and are improving/ maintaining performance	
Staff with a Completed Annual Appraisal Target is >=80%	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	There has been a decrease in rates over the last few months which could be a result of moving to a new system for recording appraisals and staff needing to get used to the new functionality. It could also be a result of increased annual leave, sickness absence and self-isolation.	YES	DOWN
	85.2%	84.8%	83.2%	78.2%	76.0%	75.0%		Key standards are being delivered but are deteriorating	
% of staff from a BME background Target is >= 22.5%	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	The Trust is meeting the target set.	?	UP
	23.9%	24.1%	24.0%	24.0%	24.4%	24.7%		Over the series of data points being measured, key standards are being delivered inconsistently	
Staff flu vaccination rate (frontline healthcare workers) Target is >= 80%	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21		n/a	n/a
				31.9%	46.3%	57.9%			
% of staff who have undertaken clinical supervision within the last 3 months Target is >=85%	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	There has been a decrease in rates over the last few months which could be a result of moving to a new system for recording appraisals and staff needing to get used to the new functionality. It could also be a result of increased annual leave, sickness absence and self-isolation.	NO	DOWN
	75.9%	69.1%	75.7%	77.3%	78.6%	72.7%		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)	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21		N/A	N/A
	240	1080	102	130	139	210			

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 – December 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
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
Adult CMHT Access six week routine (incomplete)

Key standards not being delivered but deteriorating/ not improving

Safe Staffing
Personality Disorder over 52 weeks
CAMHS over 52 weeks
% of staff who have undertaken clinical supervision within the last 3 months
Sickness Absence
Agency Cost
Vacancy rate

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:	18/01/2021	
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
	Reaching Out	
	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:		
False and misleading information (FOMI) considerations:		
Positive confirmation that the content does not risk the safety of patients or the public		
Equality considerations:		

O

Leicestershire Partnership NHS Trust

CHARITABLE FUNDS COMMITTEE– DATE 14th 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	Risk Reference
Review of Risk Register	High	1 risk and 1 risk assessment were reviewed; It was agreed that the risk & risk assessment would be retained and further actions taken to mitigate the risk around supporting services utilize grant funding in a timely way.	4618 4669
Fundraising Manager's report	High	The fundraising manager provided an update on activities to 6th December. Highlights against Raising Health strategic objectives noted were: (Visibility) Signage – work should be starting in January and we are looking for all signage to be up and installed by beginning of February 2022. (Income) Trusts and Foundations - dementia garden at Evington Centre, funded by the LLR community foundation, remains a risk due to the delay in starting the project. The committee update was that this project would be managed through the Trust's capital plan so there is more assurance that the project will be monitored and delivered. Let's Get Gardening Bid – we have submitted a National Lottery platinum jubilee fund for £50k, although noted that we do not fit into one of their priority groups. If unsuccessful it was recommended that we apply to their Reaching	4618 4669

Report	Assurance level*	Committee escalation	Risk Reference
		Communities Fund. It was noted that there were several appeals not achieving their income target so the Chair requested marketing work take place to focus on significant fundraising in 2022/23.	
Finance report – Q2	High	Total income was £254k in quarter 2, comprising realised income of £116k and an unrealised investment gain of £138k. Expenditure was £123k in the period. Future expenditure commitments total £493k. The cash balance was £602k at the end of September. Cash was expected to remain in a good position in the rolling 3 year cash flow forecast. Total funds available was £2.6m at the end of quarter 2, a reduction of £39k on the previous quarter. The income assumptions on the 3 year cash flow were discussed, noting that the 21/22 income generation was lower than expected. It was agreed that the income assumptions and the impact on cash balances for future years would be re-assessed. Within the finance paper, the committee formally approved a Carlton Hayes bid, which was over the trustee individual approval limit: CAMHS Eating Disorder Services of £5k. The committee also approved use of slippage on NHS Charities Together funding of £6k to fund Gardening bids which could not be accommodated within the Carlton Hayes allocation.	4618
Budget setting for running of Charity (22/23) including review of Raising Health overhead costs	Medium	The committee reviewed and approved the budget setting paper for 2022/23, noting that the fundraising costs were 24% of income and governance/support costs were 8% of forecast expenditure. It was agreed to undertake some benchmarking against other NHS charities to ensure overhead costs remained at appropriate levels.	4618
Review of CFC Internal Audit Report	High	The significant assurance report was received by the committee. The Committee thanked the finance and fundraising teams for this report. It was a real credit to the teams involved.	4618

Report	Assurance level*	Committee escalation	Risk Reference
Charitable Funds Accounts 2020/21	High	The 2020/21 accounts were approved at the last meeting and Trust Board. Since they were approved, we were made aware that NHS Charities Together expect all funds to be classified as restricted. Raising Health had classified them as unrestricted designated funds in our accounts. We have adhered to the conditions stated in the original award letters, which did not specify a restricted classification. Working with our auditors, it was agreed to include an explanatory note in the accounts to explain our treatment. The amendment was approved by the committee, and the accounts and annual report will be submitted to the Charities Commission, prior to the deadline of 31st January 2022	4618
Annual Assurance and review of Policies & Procedures	High	The policies and procedures for the charity had been reviewed and minor amendments were proposed, some of which incorporated recommendations from the internal audit report. It was agreed that a report would be brought to the next meeting to show progress against the three low risk recommendations from internal audit.	4618
New bids received	High	Two bids had been approved as part of the finance paper. No further bids received.	4618
New funds created	High	Eating Disorders Staff Wellbeing Fund - Langley Ward, following receipt of a legacy.	4618
Work plan	High	The work plan was reviewed and minor amendments made.	4618
Review of risk register	High	It was agreed to reinstate the income and costs risk (this had previously been a risk, which had reduced due to the significant value of receipts during the pandemic, but now appeared to be a medium term risk)	
AOB	High	None received.	4618

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