Leicestershire Partnership NHS Trust

Public Meeting of the Trust Board
29th March 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 – Learning Disabilities & Autism	verbal	Helen Thompson
9.45	3.	Staff voice - Learning Disabilities & Autism	verbal	Helen Thompson
10.00	4.	Patient Voice – Healthwatch Report	verbal	Mark Farmer
10.05	5.	Declarations of interest in respect of items on the agenda	verbal	Chair
	6.	Minutes of the previous public meeting 25th January 2022	B	Chair
	7.	Matters Arising	C	Chair
	8.	Chair's Report	D	Chair
	9.	Chief Executive's Report	E	Angela Hillery
Governance and Risk				
10.20	10.	Organisational Risk Register	F	Chris Oakes
10.30	11.	Documents Signed under Seal – Q3 Report	G	Chris Oakes
10.35	12.	Enhancing Board Oversight - NED Responsibilities & Champion Roles	H	Chris Oakes Chair
Strategy and System Working				
10.40	13.	Service Presentation – Learning Disabilities & Autism	verbal	Helen Thompson
11.00	14.	Break		
11.10	15.	Step Up To Great Implementation Plan	I	Fiona Myers
11.20	16.	Joint Working Group Highlight Report – 21st March 2022	J	Chris Oakes David Williams
11.25	17.	East Midlands Alliance Partnership Agreement	K	David Williams
11.30	18.	People Plan 6 monthly Update including assurance from Health & Wellbeing Guardian	L	Sarah Willis
Quality Improvement and Compliance				
11.35	19.	Quality Assurance Committee Highlight Report 22nd February 2022	M	Moira Ingham

11.40	20.	CQC Update Including Registration	N	Emma Wallis
11.45	21.	IPC BAF – Update	O	Emma Wallis
11.50	22.	Patient and Carer Experience, Involvement and Complaints Report Quarter 3 Report	P	Emma Wallis
11.55	23.	Patient Safety Incident and Serious Incident Learning Assurance Report	Q	Michelle Churchard Smith
12.00	24.	Ockenden Review	R	Michelle Churchard Smith
12.05	25.	Learning from Deaths Quarter 3 Report	S	Avinash Hiremath
12.10	26.	Safe Staffing Monthly Reviews	T	Emma Wallis
12.15	27.	Staffing Capacity and Capability 6m Report (NQB)	U	Emma Wallis
12.20	28.	Safeguarding Annual Declaration	V	Michelle Churchard Smith
Performance and Assurance				
12.25	29.	Finance and Performance Committee Highlight Report 22nd February 2022	W	Faisal Hussain
12.30	30.	Finance Monthly Report – Month 11	X	Sharon Murphy
12.35	31.	Performance Report – Month 11	Y	Sharon Murphy
12.45	32.	Audit and Assurance Committee Highlight Report 3rd March 2022	Z	Darren Hickman
12.50	33.	Charitable Funds Committee Highlight Report 15th March 2022	AAA	Cathy Ellis
12.55	34.	Review of risk – any further risks as a result of board discussion?	verbal	Chair
	35.	Any other urgent business	verbal	Chair
	36.	Papers/updates not received in line with the work plan	verbal	Chair
	37.	Public questions on agenda items	verbal	Chair
1.00	38.	**Next public meeting 31ST May 2022**		Chair

A

Our Trust Board

As of February 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

Recruitment Open
Non-executive director

Prof. Kevin Paterson
Non-executive director

Ruth Marchington
Non-executive director

Darren Hickman
Non-executive director and senior independent director

Paul Sheldon
Chief finance officer*

Sharon Murphy
Acting executive director of finance

Samantha Leak
Executive director of community health services

Fiona Myers
Interim executive director of adult mental health

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

Sarah Willis
Executive director of human resources and organisational development

Chris Oakes
Executive director of corporate governance and risk*

David Williams
Executive director of strategy and partnerships*

Dr. Avinash Hiremath
Executive medical director

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

B

Leicestershire Partnership NHS Trust

Minutes of the Public Meeting of the Trust Board
25th January 2022 - Microsoft Teams Live Stream

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

In Attendance:
Sam Leak Director of Community Health Services
Fiona Myers Interim Director of Mental Health
Helen Thompson Director Families, Young People & Children Services & Learning Disability Services
Sarah Willis Director of Human Resources & Organisational Development
Chris Oakes Director of Governance and Risk
David Williams Director of Strategy and Business Development
Mark Farmer Healthwatch and Chair of LPT People Council
Kate Dyer Deputy Director of Governance and Risk
Kay Rippin Corporate Affairs Manager (Minutes)

TB/22/001	Apologies for absence: Richard Wheeler Chief Finance Officer; Vipal Karavadra Non-Executive Director (resigned due to personal commitments). Welcome to the meeting: Professor Kevin Paterson Non-Executive Director; Kamy Basra- Associate Director of Communications. Staff Voice: Kristen Dy – Physiotherapist, LPT; Shanice Rattu – ICRS Senior Officer Leicester County Council; Tracy Arnott – Senior Nurse for Complex Care, LPT; Sara Lowe – Transformation Lead, LPT. Service Presentation - Melanie Rowland, Operational and Transformation Lead The Trust Board Members – Paper A
TB/22/002	Patient Voice Film – Community Health Services Mr and Mrs Popat's story - a video was shared describing the journey with the Home First support service who became involved in Mr Popat's care following a fall at home. This integrated service provided them with an assessment for the support and equipment required and offered home visits to support them in recovery. The family described what a positive experience of integrated care this was and how Mr Popat was able to remain at home rather than being admitted into hospital because of the service provision. This was followed by a video from Amanda Pritchard, NHS Chief Executive following her visit to see LPT's Integrated Community Response Team
TB/22/003	Staff voice – Community Health Services - Kristen Dy – Physiotherapist, LPT; Shanice Rattu – ICRS Senior Officer Leicester County Council; Tracy Arnott – Senior Nurse for Complex Care, LPT; Sara Lowe – Transformation Lead, LPT The team gave an overview of the system wide integrated working taking place. A

	holistic assessment approach is taken ensuring patient centered care is offered, working with CCG's, social services, and other teams and partners across the LLR system. The teams work in a multi-disciplinary way and are co-located with social care. Further enhancements are being made to SystmOne supported by training to improve data quality and generate electronic dashboards. The Chair thanked the team for the positive achievement on this ground-breaking national pilot and asked about their own health and wellbeing, the team felt very supported and team managers are on hand to ensure they are taking breaks and available to offer advice when required. Angela Hillery thanked the team for the success and asked what advice they would give other teams using this approach. The team considered being honest, building trust and being open were key. Faisal Hussain asked if Trust Board members could offer further support and the team requested that the continued investment of the Board would support the growth of this system method and help to ensure a consistent approach to assisted technology in virtual wards across LLR.
TB/22/004	Declarations of interest in respect of items on the agenda – no declarations received.
TB/22/005	Minutes of the previous public meeting 21st December 2021- Paper B **Resolved:** The minutes were agreed as an accurate record of the meeting.
TB/22/006	Matters Arising – Paper C **Resolved:** The action log was approved.
TB/22/007	Chair's Report – Paper D The Chair presented the report which was taken as read. The report highlighted attendance at the LLR Integrated Care Board (ICB) meeting to focus on current operational priorities for the ICS. The Chair has recently been part of the interview panel for the ICB Non-Executive appointments and recruitment has taken place into 4 new roles for Audit, Quality, Health Inequalities and People Boards.
TB/22/008	Chief Executive's Report – Verbal Update Angela Hillery gave a verbal update describing how the system is currently working at incident level 4. The Omicron variant has high case rates which have further impacted staffing levels and teams have adapted supporting absences, particularly in critical areas. Staff were thanked for their continuing commitment. As part of the level four incident, national notification has been received around reducing the burden and releasing capacity in the Trust to support the frontline during this stage of the pandemic to ensure we stay safe and focused during this time. The Integrated Care Board (ICB) will take effect as of 1st July 2022 and will continue to work on the priorities and planning for 2022/23 considering integrated working across the system and increasing capacity when required. The CQC report around Learning Disabilities – "Out of Sight – One Year On", focusses on the challenges faced in this area. David Williams, Director of Strategy and Partnerships is leading on this work across the LLR system and we are making strong progress. The schools' mental health programme continues to successfully expand. The Step up to Great Mental Health programme was approved on 14 December 2021 by the CCG governing body and the implementation will now be co-produced with our communities and partners. Angela Hillery thanked the participants for their contribution in this consultation. LGBTQ+ history month will be celebrated from the 21st February 2022 in conjunction with Northamptonshire Healthcare Foundation Trust. LPT have been nominated for a HSJ partnership award with UHL and Spirit.
TB/22/009	Organisational Risk Register – Paper E Chris Oakes presented the paper confirming that the interim governance arrangements have been applied in line with reducing the burden. ORR 59 – increased staffing pressures – the Incident Oversight Group continue to monitor this and ORR 62 continues to be monitored by the Quality Forum. Work on the Public Inquiry has been paused and this will be reviewed in February. Ruth Marchington asked about the level of risk appetite for ORR finance risks 70 &

	71 considering that the assurance and actions are all green. Sharon Murphy confirmed that the risks the Trust are managing remain unusual and whilst we now have the guidance, but we do not yet have the 2022/23 allocations information – once received there will be more certainty, and this will be reflected in the score. The Chair asked with regards to risk 76 – vaccination as a condition of deployment – how this was being carefully monitored by clinical services. Sarah Willis added that there was significant work ongoing as the 3rd February 1st dose deadline draws closer with daily monitoring in place. This includes support workshops for staff. Letters will be going out to staff this week before the formal process begins. The ICC continue to monitor the numbers. Anne Scott added that whilst a challenge there is robust monitoring ongoing from a safe staffing perspective. Ruth Marchington asked about the impact of the change in scope guidance relating to vaccination as a condition of employment and Sarah Willis confirmed that incidental contact had been removed from the guidance but that this has had little impact on the numbers in scope. **Resolved:** The Trust Board received assurance from the Report.
TB/22/010	Service Presentation – Community Health Services – Coping with Covid Pressures – Paper F. Melanie Rowland presented the slides circulated as Paper F describing the LLR journey in developing the urgent crisis response model which was developed from the Home First Service. Patient flow through the system is key, with collaboration and shared vision, a multi skilled approach and the use of digital technology supporting this. A rapid response is essential for the first patient contact, sometimes this is digital contact to give immediate support to the carer. Case studies are detailed in the paper for information. Success is measured by the number of patients who remain at home, avoid an admission to UHL and are taken out of the EMAS (East Midlands Ambulance Service) and DHU (Derbyshire Health United) category 3 and 4 referrals stack. The challenges are the lack of integrated technology and data quality. Angela Hillery thanked the team for the work and the local and national influence. She noted that the national team were very complimentary about our ICRS team. LLR remain challenged around supporting people getting home and an increase in capacity with the model could be considered. Melanie Rowland confirmed that the model of delivery works very effectively, and they are currently exploring offering the services in different ways to support increased capacity and an investment and planning for a longer-term approach. Faisal Hussain asked if the variation in pace of integration in Leicester City, Leicestershire County and Rutland is having an impact on the quality of care and Melanie Rowland confirmed that whilst the 3 places were at different starting points this works well as pilots can begin in 1 area and then be rolled out – it does not impact on quality of care. Sam Leak confirmed that the Home First board feeds into the System Flow Partnership Board and conversations are ongoing in around sustainability. Sharon Murphy confirmed that the Design Group meetings continue to consider what LPT need to do to deliver transformation in the services. The Chair noted that there is more emphasis on community service within the new planning guidance for 2022/23.
TB/22/011	Group Update and Joint Working Group Highlight Report including Group Terms of Reference – Paper G Chris Oakes presented the paper describing the close work that NHFT & LPT have been doing over the last few years with the buddy trust arrangement and the share director roles. The joint working group will build on the benefits of being a buddy trust and promote the sharing of ideas, the sharing of teams and

	collaboration. There are 8 priorities for the group, each led by an executive director, details of which are in the pack. **Resolved:** The Trust Board approved the Terms of Reference and received assurance on the progress of the group.
TB/22/012	Step Up to Great Strategy Refresh – Paper H David Williams presented the paper which is the final version of the strategy. The detail which will form the annual delivery plan is now being progressed and will be presented to Board in due course. The strategy contains the new brick -Reaching Out' – reaching out to all of our communities. Angela Hillery commented that this work builds on what the CQC noted on their visit, and this is our opportunity to build on this further from the strong position we are in now. There will be quarterly reports to the Board on implementation of the delivery plan. **Resolved:** The Trust Board received and approved the Step Up to Great Strategy Refresh
TB/22/013	NHS Net Zero Green Plan Approval – Paper I Mark Powell presented the paper describing how the plan aligns with the ambitions with the national requirements. Further work is ongoing around the implementation plan – the proposed actions are detailed in the report. There will be cross working on this using the LPT/NHFT Group and within the LLR ICS. The governance route will be through the Finance and Performance Committee to Board **Resolved:** The Trust board supported the development of the plan.
TB/22/014	CQC Update – Paper J Anne Scott presented the update and action plan contained within the appendix confirming that there was firm grip and steady progress on all actions. Mandatory training has been further impacted due to the current covid situation and the team continue to understand and mitigate the risk keeping the ORR updated in this regard. Mark Farmer asked how the patient and carer voice can be strengthened in delivering this action plan and Anne Scott confirmed that the People's Council can work together on this. Fiona Myers added that the patient and carer voice is the golden thread that runs through all implemented changes within the Trust. Ruth Marchington asked how we can ensure action following audits is embedded and Anne Scott confirmed that this is key and forms part of the signing off process. It is important that we use the audit process to ensure that we have sustainability in improvements. The Chair asked if the call bells target for action of the end of January is on track and Anne Scott confirmed that it was on track. **Resolved:** The Trust Board received the report and noted the oversight of the programme.
TB/22/015	Patient Safety Incident and Serious Incident Learning Assurance Report – Paper K Anne Scott presented the report which covers December 2021 confirming that covid has had a direct impact on serious incident investigations and these have been reallocated where possible and their timely closure continues to present a challenge. 8 investigators are now in post and the impact of this should be seen shortly. The ORR has been updated to reflect the challenges and deteriorating position. A quality summit is planned in this area for February 2022. The incident Monitoring Group continues to have good oversight of these areas. The Chair asked how the increase in incidents and the link to staffing are being monitored in terms of levels of patient harm and Anne Scott confirmed that triangulation across directorates and weekly incident review group meetings are held and further detail on this is in the Safe Staffing paper. Mark Farmer asked if the increase in pressure ulcers detailed in the paper is linked with an inconsistent approach to care in LLR for which Healthwatch have limited evidence of and Anne Scott confirmed that there is a quality improvement plan to

	support this following a quality summit in 2021 and there should be evidence of improvement in March's report. Sam Leak added that there are new workstreams in place for pressure ulcers and the process for allocation to district nursing and tissue viability teams has been reviewed leading to a more equitable approach. Mark Farmer commented that the self-harm figures are higher than predicted and why is this and Anne Scott confirmed that the incident review group has a focus on this, and this involves a limited number of patients in our care at this time but a higher number of incidents. Fiona Myers added that moving forward this data will be split to demonstrate this more clearly. **Resolved:** The Board received assurance around the systems and processes described in the report.
TB/22/016	Safe Staffing Monthly Review – November 2021 & December 2021 – Interim Report – Paper Li & Lii Anne Scott presented taking paper Li as read. Paper Lii is an interim report, and the full review will be presented at the next Trust Board public meeting. Safety huddles are now taking place daily (previously weekly) as a response to the significant staffing challenge – both Anne Scott and Avinash Hiremath attend to ensure executive oversight. December 2021 was a difficult month and a briefing was reported to the ICC (incident control centre) regarding the severe nursing and staffing pressures being experienced. Business continuity plans were enacted and some staff were redeployed to support the situation which was due to an increase in covid outbreaks in the community. This is now on the ICC risk log and continues to be monitored. January has seen a reduction in pressure and reduction in staff absence. Sarah Willis added that there is work ongoing internally and across the health and social care system – the Local Workforce Resilience Forum and the HR Workforce Cell – all systems partners are supporting finding resource to support services. **Resolved:** The Trust Board received assurance around the monitoring and mitigating of staffing levels.
TB/22/017	Finance Monthly Report – Month 9 – Paper M Sharon Murphy presented the paper confirming an operational overspend increase driven in part by agency costs and in part offset by hosted services cost savings. The H2 planning was undertaken prior to Omicron hence the unanticipated costs but forecasting for the year end remains at break even. The forecast outturns now detail a best- and worst-case scenario. Agency spend in month 9 is £2.8 million which is the highest value recorded – Christmas, new year and Omicron have impacted. This remains an area of concern and a deep dive is planned on agency. Capital spend is £6.2m so far and the programme is gathering pace with additional schemes ready to be deployed to manage this and ensure our forecast of £10m is spent by the year end. The Better Payment Practice Code achieved 2 out of 4 of the targets due to an issue with a backlog of invoices and extra measures have been put in place to address this – 3 out of the 4 targets are still being delivered cumulatively. 2022/23 planning guidance was released on 24th December and contains a return to more formal arrangements. Draft plans are to be submitted on 17th March and the final plan on 28th April 2022. Faisal Hussain asked if the provide collaborative Adult Eating Disorders underspend is being carried forward and Sharon Murphy confirmed that we are awaiting a response from KPMG on this matter as this is not the usual practice but that collaboratives are intended to be managed over the longer term. David Williams highlighted that the underspend has arisen because the collaborative has spent less on bed costs due to have a wider clinical model available in the community. **Resolved:** The Board received assurance from the report
TB/22/018	Performance Report – Month 9 – Paper N

	Sharon Murphy presented the paper which highlights an increase in hospital acquired infections with 14 outbreaks during December 2021 – key themes have been identified and actions taken to address. Whilst the November 2021 data showed some improvement the December 2021 shows more cause for concern due to operational pressures which will be investigated once this data is validated. The over 52 week wait rate remains stable and the long-term trend is decreasing in all areas, particularly personality disorder services. The longest waiters have shown an increase and this will be considered in the next round of directorate performance reviews. An increase in staff sickness absence and an increased vacancy rate has resulted in increased agency spend. Appraisal and supervision rates have deteriorated and will also be addressed in the next round of directorate performance reviews. Angela Hillery commented that the impact of Omicron on wait times continues to be analysed and it is important as a system partner that we get resources to manage our waiting lists in the same way that acute care will – this needs to be reinforced where possible. The Chair noted that the LD annual health check figure was at 49% in December 2021 and asked if it was likely that the 75% target will be met by year end. David Williams confirmed that this final quarter is key, the Omicron impact is as yet unknown and has been mitigated against with extra clinics and services – progress is visible and we are on track to achieve 70% currently. **Resolved:** The Trust Board received assurance from and approved the report.
TB/22/019	Charitable Funds Committee Highlight Report – 14th December 2021 – Paper O Cathy Ellis presented the paper confirming that the charity continues to support staff and patient well-being. The committee reviewed the overhead base which represents 24% of income. For 2022 there will be a focus on driving up the income and exterior signs are being placed in areas of significant footfall around LPT sites making it easier for people to see how to donate.
TB/22/020	Review of risk – any further risks as a result of board discussion? There are no additional risks as a result of this meeting but key risks from the ORR continue to be staffing, the level of incidents, the impact on waits and vaccination as a condition of deployment. Mitigations are in place and close monitoring continues.
TB/22/021	Any other urgent business – no other business was raised.
TB/22/022	Papers/updates not received in line with the work plan: NA
TB/22/023	Public questions on agenda items – no public questions were received.
	Close

C

Leicestershire Partnership NHS Trust

TRUST BOARD 29th March 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					

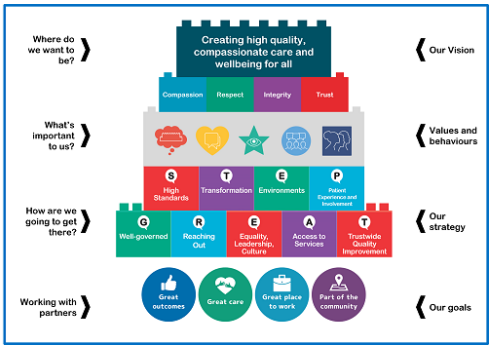
D

Leicestershire Partnership NHS Trust

Trust Board – 29th March 2022 - Chairs report

Purpose of the report

Chairs report for information and accountability, summarising activities and key events From 25th January 2022 to 29th March 2022



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

Hearing the patient and staff voice	• The Chair and Non-Executive Directors have been doing Boardwalks to meet staff and patients in frontline services. We have visited the following areas: Ashby Ward at the Bradgate Unit, the Mental Health Crisis Team, Mill Lodge for inpatients with Huntingdon's disease , the Diana service, Paediatric Phlebotomy • The Chair visited UHL's Emergency Department with the UHL Chair to review flow through the department and discharges into LPT community services. We have planned a series of joint visits to services in UHL and LPT.
Promoting Equality Leadership & Culture	• Attended LGBTQ+ history month celebration event • Joined the BAME network to discuss the Board's personal pledges which support our Together Against Racism work • Participated in several Women's Network sessions which celebrated International Women's Day • Participated in the Covid reflection event at Loughborough Hospital on 22nd March This event marked two years since the start of the pandemic and was held in the new reflection garden which has been funded by Raising Health. The speakers thanked staff for their significant contribution to delivering safe compassionate care and together we remembered all those who lost their lives to covid. • Signed the Armed Forces Covenant on behalf of LPT to recognise that we are a forces friendly health trust for serving personnel, veterans and their families. LPT received the Armed Forces Gold Award in 2019 and this resigning will maintain our gold award status • As the Health & Wellbeing Guardian (HWBG), I continue to promote Wellbeing Wednesdays with my weekly blog and have connected with the Midlands HWBG Network to engage in the regional "Be Well" strategy and big conversation.

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 strategic development of the ICS and the current operational priorities for the ICS • Chaired the monthly LLR ICS Finance Committee meetings focusing on 2022/23 plan development, revenue spend, capital programme and key risks. • Attended the Leicestershire Academic Health Partnership Board • 1:1 stakeholder meetings with John MacDonald Chair of UHL, David Sissling Chair of LLR ICS, Mark Farmer Healthwatch representative and Chair of LPT's Peoples Council • Attended University of Leicester Council meeting and Finance committee
Raising Health (LPT charity)	• Chaired the Charitable Funds committee which continues to support patient experience and staff wellbeing initiatives that provide "extras" above the core NHS offer. Refer to the committee highlight report to see details of the bids approved. • Met with Trustees from the Carlton Hayes Charity to agree processes for 2022/23 grant which supports activities for mental health and learning disability in-patients and service users in the community.
Good Governance	• Board development session held 25th February to consider provider collaboratives • Extraordinary Board meeting held 10th March to review the draft financial and operational plan, the final submission is due in April • Chaired the Joint Working Group for LPT & NHFT where we considered joint strategic priorities and risk • New guidance on NED champion roles was published by NHSEI in December 2021. This is being reviewed and implemented through our governance structure and is included within today's papers. • Pre-year end meeting with our Auditors KPMG to discuss LPT and LLR ICS financial positions • Attended Finance & Performance committee
Non-Executive Directors (NED)	• Darren Hickman has been appointed to the role of ICS Audit Chair, congratulations to Darren who starts his new role in June. • Launched recruitment campaign for 2 Non-Executive Director vacancies using the NHSEI website, Linked IN and Twitter. The shortlisting is underway with interviews scheduled for 12th April 2022.

Governance table

For Board and Board Committees:	Trust Board 29.3.22	
Paper sponsored by:	Cathy Ellis	
Paper authored by:	Cathy Ellis	
Date submitted:	22 March 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	

Leicestershire Partnership NHS Trust

E

Trust Board of Directors – 29 March 2022

Chief Executive's report

Purpose of the report

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

Analysis of the issue

National Developments

Ukraine

Our LPT family is here to support each other and our colleagues, service users, families and friends who may be experiencing any distress or trauma resulting from the situation in Ukraine.

The government has confirmed that all Ukrainians arriving in England will be able to access NHS healthcare free of charge, including GP and nurse consultations, hospital services, and urgent care centres. The changes, which came into force on the 17 March 2022 will also cover any treatment that has taken place since the start of the Russian invasion.

As part of the UK's offer to those Ukrainians coming to the UK, the government has committed to providing full access to a range of public services, including doctors, schools and full local authority support. They will also be offered COVID-19 vaccines and medical screenings. The new legislative measures introduced will ensure Ukrainians who are in the UK lawfully can access the NHS on a similar basis as other UK residents.

Covid-19

The global pandemic is not yet over and the Government's Scientific Advisory Group for Emergencies (SAGE) is clear there is considerable uncertainty about the path that the pandemic will now take in the UK. There has been a recent rise in COVID-19 admissions into hospitals following a period in which numbers were decreasing. With numbers reaching more than 10,000 for the first time in the last few months. The overall number of patients in hospitals with covid remains low compared to previous waves, a rise in admissions can have an impact on patient care.

The NHS continues to operate at incident level 4 and whilst this was expected to reduce, the latest figures may prevent this from any imminent change.

COVID-19 Response: Living with COVID-19

In February 2022, the Government published a plan for Living with COVID: this is a 60-page document on living with the virus, which includes removing the remaining legal restrictions while protecting people most vulnerable to COVID-19 and maintaining resilience. The plan sets out how it will continue to protect and support citizens by: enabling society and the economy to open up more quickly than many comparable countries; using vaccines; and supporting the National Health Service (NHS) and social care sector. It sets out how the Government will ensure resilience, maintaining contingency capabilities to deal with a range of possible scenarios.
COVID-19 Response: Living with COVID-19 - GOV.UK (www.gov.uk)

Regulations making COVID-19 vaccination a condition of deployment to end

On 31 January 2022, the Secretary of State for Health and Social Care announced to the House of Commons that it was no longer proportionate to require COVID-19 vaccination as a condition of deployment for NHS workers. Following a public consultation in February 2022 the government published the response to the consultation. In light of the scientific evidence, alongside a strong preference for revocation, the response confirmed that the vaccination as a condition of deployment policy would be revoked. The legal requirement for health and social care staff to be double jabbed will therefore be removed from 15 March 2022.

Health Secretary statement on spring COVID-19 booster vaccinations

On 21 February 2022 the Heath Secretary Sajid Javid released a statement on spring covid-19 booster vaccinations following updated advice form the Joint Committee on Vaccination and Immunisation. from spring, an additional COVID-19 booster jab to people aged 75 years and over, residents in care homes for older adults, and people aged 12 years and over who are immunosuppressed. Sajid Javid emphasised "we know immunity to COVID-19 begins to wane over time. That's why we're offering a spring booster to those people at higher risk of serious COVID-19 to make sure they maintain a high level of protection. It's important that everyone gets their top-up jabs as soon as they're eligible".

Care Quality Commission

It has been announced that Dr Sean O'Kelly will take on the role of Chief Inspector of Hospitals at CQC later in the Spring, taking over the position from Ted Baker, who announced his retirement in September 2021.

LPT Inspection

Following the Trust's core service and well led inspection in 2020, we have welcomed the CQC back into the Trust to re-inspect a number of key areas highlighted for improvement in our latest CQC report. We are awaiting the formal feedback from this visit and will update the Board when this is available.

Monitoring the Mental Health Act in 2020/21

In February 2022 the CQC issued a report 'Monitoring the Mental Health Act in 2020/21' which focuses on how providers are caring for patients, and whether patients' rights are being protected. The report highlights concerns that reduced access to community mental health services during the pandemic may have been a contributing factor in the increased number of people being detained under the MHA. The report found that the workforce is under extreme pressure, and Community Services are key to reducing levels of detention in hospital. There is also urgent action needed to address longstanding inequalities in mental health care.

2021 Maternity Survey findings

The 2021 Maternity survey results have also been published. Women who gave birth between 1 and 28 February 2021 were invited to take part in the survey. This was during the third national lockdown for the COVID-19 pandemic. This means that respondents will have gone through their antenatal, labour and birth, and postnatal stages under pandemic conditions. Therefore, results of this survey reflect experiences of care throughout the COVID-19 pandemic. Results have declined in many areas. This is likely reflecting the impact that the COVID-19 pandemic had on services and staff. Results show that areas particularly affected were involvement of partners, choice, information provision and staff availability.

Mental Health Units (use of force) Act 2018

The CQC expects that registered persons (providers and managers) comply with the Act and its statutory guidance when it comes into force on 31st March 2022. The Act aims to reduce the use of force and ensure accountability and transparency about its use in mental health units. The Act applies to all patients being assessed or treated for a mental health disorder in a mental health unit. This applies equally to both NHS and independent hospitals providing NHS-funded care.

Mental Health Units must appoint a 'responsible person' who is accountable for ensuring the requirements in the act are carried out. The Responsible Person must:

- publish a policy regarding the use of force by staff who work in that unit
- publish information for patients about their rights in relation to the use of force by staff who work in that unit

- ensure staff receive appropriate training in the use of force
- keep records of any use of force on a patient by staff who work in that unit unless the use of force is negligible.

The role of the responsible person does not require a new appointment, but it must be a permanent member of staff within the organisation and be a member of the organisation or trust board with the relevant skills and experience to undertake the responsibility of this role. The Responsible Person identified at LPT is Anne Scott, our Executive Director of Nursing, Allied Health Professionals and Quality.

The Department of Health and Social Care

Protections for people deprived of their liberty

The Department of Health and Social Care and Ministry of Justice have launched a consultation to update the Mental Capacity Act Code of Practice to better support those with dementia, acquired brain injuries, learning disabilities and autism who may need assistance with their everyday decision-making but lack mental capacity thereby requiring others to make decisions in their best interests.

These decisions could include where a person should live, whether assistive technology like sensors or keypad entry should be installed, setting times for refreshments or activities, whether they can leave the accommodation or restraint in certain circumstances among others.

The Mental Capacity Act Code of Practice sets out how carers and practitioners can make these decisions for others on a day-to-day basis while ensuring the individual is both protected and empowered.

This is part of the government's promise to ensure everyone receives the right care in the right place at the right time, as part of its reforms of the health and social care system.

The proposed changes will speed up processes and increase fairness, ensuring the balance between a person's human rights and freedoms and their need to receive the right care in the right place at the right time.

The new system will replace Deprivation of Liberty Safeguards, which have been in place since 2009, with the consultation starting on 17 March 2022

For further information please see follow the link Government to improve protections for people deprived of their liberty - GOV.UK (www.gov.uk)

Levelling Up White Paper

The Department for Levelling Up, Housing and Communities has published a White Paper, Levelling Up the United Kingdom, which sets out how the government intends to spread opportunity more equally across the UK. It provides an economic analysis of the drivers of geographical disparities across the UK and sets out the policy reforms intended to level up 'left behind' regions of the UK. It sets out medium-term 'missions' to be achieved collaboratively across government and key stakeholders at a national and local level.

Provider Selection Regime: consultation on the detail of proposals for regulations

The proposed Provider Selection Regime will be a new set of rules replacing the existing procurement rules for arranging healthcare services in England. The proposed rules will be introduced by regulations made under the Health and Care Bill.

This consultation builds on the engagement and consultation activity which NHS England has undertaken over the past 3 years, and seeks views from respondents to help develop the regulations for the Provider Selection Regime.

For more information on this consultation please visit the Department of Health and Social Care website Provider Selection Regime: supplementary consultation on the detail of proposals for regulations - GOV.UK (www.gov.uk)

Local Developments

Urgent and Emergency Care

LLR currently carries a system risk arising from ambulance handover delays which are a result of wider system performance particularly that of flow and not just a result of ambulance and ED performance. This is being managed collectively with all partners contributing to daily tactical command meetings and wider service transformational programmes. LPT recognises this as a priority due to the impact it has on patients and is supporting the system to enable improvements.

LPT focus has been on:

- Decreasing ED attendance
- Keeping people well at home
- Safe rapid transfer from UHL to Community beds
- Decreasing the number of Medically optimised for discharge patients in beds to enable constant flow
- Enabling a home first approach to ensure limited resource is used smartly

We have made positive impact in many areas including:

- Increased community bed occupancy from 80% to 90+%
- Streamlining referral processes from UHL to the community to ensure safe and effective processes
- 2 hr Urgent Community Response has seen significant improvement from 26% to 73% ensuring patients are seen quickly in the community and avoiding hospital admission
- Reduction in emergency care home admissions by circa 100 per month
- Clear alternative routes are in place for those in a mental health crisis that can be used by EMAS and other system partners to avoid the need for ED attendances
- We have increased the responsiveness of the Mental Health Liaison Team to ensure that patients in ED are seen within an hour.
- Advice and guidance to EMAS via the Mental Health Urgent Care Hub provides greater understanding of the patient needs and often negates the need for any further input.

Quality Improvement Support for St Andrew's Healthcare

We are pleased to be using our alliance with five community and mental health NHS Trusts across the East Midlands to provide quality improvement support to St Andrews Healthcare following its CQC inspection. The mental health charity, based in Northamptonshire, have buddied up with NHFT who is coordinating other trusts from Derbyshire, Leicestershire, Lincolnshire, Nottinghamshire and Northamptonshire to receive targeted support following their recent CQC report. The alliance will provide quality improvement support which aims to improve the quality of care at St Andrew's.

Nine workstreams have been set up to focus on patients, staff and culture. Each workstream has an NHS lead and a St Andrew's lead, meeting regularly to drive forward actions using the expertise and learning from the alliance trusts. LPT is providing specific workstream leadership support for the culture workstream and communications workstream.

Re-signing Armed Forces Covenant

LPT re-committed to the new Armed Forces Covenant, demonstrating our support of the armed forces community, by re-signing the Armed Forces Covenant in the company of MoD officials at County Hall on 16 March.

The trust received the Armed Forces Covenant Gold Award in 2019 and the re-resigning will maintain that gold award status. LPT is currently one of eight organisations in Leicester, Leicestershire and Rutland to hold the Gold Award, which is held with a high level of respect within the military for the support it provides as a civilian organisation.

The covenant is a pledge that local communities, business and public organisations acknowledge and understand that those who serve or who have served in the armed forces, and their families, should be treated with fairness and respect in the communities, economy and society they serve with their lives. We are committed to continuing our

support with the employment of veterans and spouses and partners and also support for staff who are members of the reserve forces and volunteers in military cadet organisations.

Move it Boom success

Move it Boom, the physical activity competition for primary school children across Leicester, Leicestershire and Rutland pioneered by LPT, broke all records in 2021. The latest edition of the competition, which has been running for six years, saw more primary schools involved and more physical activities logged than ever before.

Pupils from 152 primary schools took part in the competition which ran from Monday 4 October until Friday 17 December, with over 155,000 physical activities, ranging from ball games and dancing to playing at the park, yoga and running, being logged during this time.

With a variety of prizes on offer for the best performing schools from partners Leicester City in the Community, All Play Solutions, ME Sports in the Community, Leicester Riders, Loughborough Sport, Leicestershire County Cricket Club and Fox Soccer Academy, pupils were encouraged to get active and log their activities via the Move it Boom website to earn points for their school and new parts for their virtual robot avatars. Well done to all involved, particularly Latimer Primary School in Anstey who finished top of the leader board and won Move it Boom 2021!

Launch of mental health in schools service

A total of 48 primary and secondary schools across Leicester, Leicestershire and Rutland now have a dedicated educational mental health practitioner (EMHP) working with them to support their students' mental wellbeing and emotional resilience, as part of the new Mental Health Support Teams (MHST) in Schools programme.

In February's Children's Mental Health Week, LPT celebrated our newly qualified practitioners, who have completed their training following an initiation phase of the programme last year. They will now continue to provide early intervention support, helping children and young people with their mental health before problems start to build up or become severe, with struggles such as low mood, mild anxiety and worry. The programme, which includes individual and group work, is also expanding and looking to work with additional schools in the next school year.

EMHPs offer a number of focussed face-to-face or virtual sessions with children and young people at a time which suits them. They also work during the school holidays. Through the use of techniques such as cognitive behavioural therapy, support strategies, breathing techniques, problem solving and personal plans – covering things like practical steps to help with better sleep – schools are noticing big improvements in their students getting this early support, at the right time.

Expansion of Crisis Cafes

In January, LPT partnered with Voluntary Action LeicesterShire (VAL) to deliver the first expansion of its Crisis Cafes. Under the partnership, VAL will oversee a grant programme that will invite voluntary and community organisations to bid to run a café or a number of cafes on behalf of their community. This will see grants awarded to local organisations to increase the number of cafes from an initial three (the pilot projects) to 15 by the end of 2022. The final number of cafes will be in the region of 25 by the end of March 2023.

New Mental Health and Wellbeing fund launched

We have launched a new grant scheme as part of plans to transform mental health across Leicester, Leicestershire and Rutland through our Step up to Great Mental Health programme.

This innovative scheme will see circa £3M spent over the next three years by local voluntary and community sector organisations on their own projects, new or existing, in their own communities to support people's mental health and wellbeing. This scheme marks a step change in our delivery of mental health services. It is a true collaboration between the NHS, local authorities and the voluntary community sector that will see money being spent by the voluntary community organisations in their local area.

International Women's Day

To celebrate International Women's Day (Tuesday 8 March) our Women's Network ran a series of virtual sessions throughout the week to mark the occasion. The theme for this year was #BreakTheBias. We had a wide range of speakers who shared what this means to them through MS Teams sessions, alongside two evening twitter chats.

The sessions were well attended by men and women across LPT. Thank you to everyone for being so open and honest with your contributions, we have had so much positive feedback from everyone involved.

The network members will spend some time going through all the comments and suggestions from the week and turn this into some key actions to take forward this year.

LGBTQ+ history month

On Monday 21 February, colleagues from LPT and our Group partner NHFT came together for a virtual celebration of LGBTQ+ history month for the second year running. The theme of the event was 'Politics in Art' and this year was a special celebration, as we marked the 50th anniversary of the very first Pride March in the UK in 1972.

The event was opened by David Maher, NHFT deputy chief executive, who spoke about his personal experience and we also welcomed guest speaker Tara Hewitt from the Northern Care Alliance who spoke about trans talent and the importance of professional and personal allyship. Our outreach team lead in the LLR Mental Health & Wellbeing Hub delivered an energising boost with her health and wellbeing session and the event was brought to a close by Scott Adams, non-executive director at NHFT.

Awards

HSJ shortlist for remote monitoring

A joint remote monitoring scheme which has helped hundreds of Leicester, Leicestershire and Rutland patients be cared for in their own homes instead of hospital has been shortlisted for a national HSJ Partnership Award in the HealthTech category. The winner will be announced on March 24, 2022.

More than 1,000 patients have benefitted since the project was launched in April 2020, as a reaction to the newly emerging pandemic. The patients have experienced better health outcomes for their long-term conditions and reduced risks of catching Covid-19, while the NHS has seen reduced pressure on hospital beds.

The project is a joint initiative between Leicester-based Spirit Health University Hospitals of Leicester and LPT.

The patients involved had a variety of heart or lung conditions or had been in hospital with Covid-19. They were given medical devices so they could measure vital indicators such as blood pressure, temperature, and oxygen levels at home. This was fed into digital technology platform CliniTouch Vie, supplied by Spirit, and then passed to clinicians. They could see which patients were doing well, and which needed advice or further support including contact with hospital specialists for an expert opinion if required.

In some cases, this remote monitoring meant patients never needed a hospital appointment, in others it meant they could be discharged back to their own home early.

Digital Health Partnership Award – supporting people at home

LPT's Community Health Services have secured over £85,000 of funding to develop a virtual falls prevention programme following a successful bid to NHS Transformation. This 12-month project brings together Leicestershire Partnership Trust, Physitrack, a health technology company, and Channel 3 Consulting, a digital health and care consultancy to develop a new digital care pathway for Falls Prevention patients across Leicester, Leicestershire and Rutland.

By providing a virtual Falls Prevention offer, patients can benefit from evidence-based education and exercise, and a means of communication with other patients via a patient portal to improve mental health and support. The introduction of a virtual service delivery also gives patients greater choice in how they can access services and flexibility for the clinicians on how they support patients. The Digital Health Partnership Award helps NHS organisations in England to bid for funding to accelerate the adoption of digital health technologies that support patients at home.

Relevant External Meetings attended since last Trust Board meeting

February 2022	March 2022
Cllr Vi Dempster	Leicestershire Academic Health Partners Board
Mental Health Trusts CEO National Meeting	ICS Place Development Programme
NHS Providers Board Check In Meeting	LLR LHRP Meeting
Leicester City Board	Joint LLR HOSC
NHS System Leaders Webinar	LLR Prevention Board
Strategic Gold	NHS System Leaders Webinar
(Urgent & Emergency Care) UEC System Meetings	Strategic Gold
Midlands (Strategic Transformation & Recovery Board) STaR Board	(Urgent & Emergency Care) UEC System Meetings
Monthly BAME (Black & Minority Ethnic) Leaders Network Meeting with NHFT	Leicester, Leicestershire and Rutland NHS Integrated Care Systems Board
Leicester, Leicestershire and Rutland NHS Integrated Care Systems Board	Leicestershire, Leicester and Rutland Executive Group
Leicestershire, Leicester and Rutland Executive Group	East Midlands Alliance Chief Executives Meeting
East Midlands Alliance Chief Executives Meeting	Leicester, Leicestershire and Rutland Quarterly System Review Meeting
Leicester, Leicestershire and Rutland Joint Health Scrutiny Committee	Chair/CEO of UHL
LGBTQ+ History Month Event	NHS CEO catch ups
NHS CEO catch ups	Strategic Gold with NHFT
NHS Providers Finance & General Purpose – Business Planning Meeting	
NHS Midland Leaders Update Strategic Gold with NHFT Together Against Racism Group Meeting with NHFT	

Proposal

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

Decision required

None.

Governance table

For Board and Board Committees:	Trust Board 29 March 2022	
Paper sponsored by:	Angela Hillery, Chief Executive	
Paper authored by:	Kate Dyer, Deputy Director of Governance and Risk	
Date submitted:	22 March 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:	n/a	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Routine board report	
STEP up to GREAT strategic alignment*:	High **S**tandards	
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	Yes
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trust wide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	none
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed	
Equality considerations:	None	

Leicestershire Partnership NHS Trust

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Trust Board – 29 March 2022

Organisational Risk Register

Purpose of the report

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.

Analysis of the issue

A review of the linkages between the ORR and the Performance Report has been undertaken, and risks 60 and 61 include key performance measures which contribute to the internal assurance rating. Further KPIs will be introduced on the ORR over the coming months.

The ORR has been updated to include audits scheduled in the Internal Audit plan for 2022/23, outcomes from the audits will help to determine the external assurance ratings.

There are currently 22 risks on the ORR, of which, one is presented for closure. Of the 22 risks, eight (36%) have a high current risk score. All risks are being managed in line with appetite.

Closure

Risk 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'.

We are proposing the closure of this risk. On 31 January 2022, the Secretary of State for Health and Social Care announced to the House of Commons that it was no longer proportionate to require COVID-19 vaccination as a condition of deployment for NHS workers. Following a public consultation in February 2022 the government published the response to the consultation. In light of the scientific evidence, alongside a strong preference for revocation, the response confirmed that the vaccination as a condition of deployment policy would be revoked. The revocation of VCOD regulations for health and social care workers, will come into effect on 15 March 2022. This will remove the requirements already in place in care homes, as well as those that were due to come into force in health and wider social care settings on 1 April 2022.

There have been two changes to the ORR this month relating to the financial risks;

- **Risk 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).

  The current risk score has decreased in line with a revised residual score of five. The remaining actions ensure ongoing oversight and reporting until the accounts are closed in June 2022; at which time this risk will be evaluated for closure.

- **Risk 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.

The current risk score has decreased from 15 to 10 in line with the residual score; all actions are on track for April 2022.

ORR risks (at 18 March 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	Lack of staff capacity in causing delays in the incident management process, including the review and closure of a backlog of reported incidents, the investigation and report writing of SIs and the closure of resulting actions. This will result in delays in learning and could lead to poor quality care and patient harm as well as reputational damage.	High Standards	12	16	12	16-20
60	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	16	16	12	16-20
61	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
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	12	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 the NHS commitment to NHS Carbon Zero.	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	8	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	5	5	9-11
71	If we do not have a sufficiently detailed financial plan for 2022/23,	Well Governed	15	10	10	9-11

	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.					
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 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.	Access to Services	16	16	8	16-20
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*				
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
78	Inability to sustain the level of cleanliness required within the National Cleanliness Standards and Hygiene Code	Environment / High Standards	12	12	8	9-11

Proposal

- Closure of risk 76
- Continue with programme of assurance mapping, including key performance measures.

Decision required

- Closure of risk 76
- 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 29 March 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 March 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	10/03/2022
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 • Quality Schedule		
	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 completed. Recruitment in progress for CHS. New head of clinical and quality governance commenced post.	Green
	Mar 22	Delivery of CQC Must Do actions	DR/JH	• CQC action plan in place and in delivery phase.	
	TBC	Implementation of joint programme	DR	• Joint programme plan developed in partnership with NHFT to ensure oversight of quality and safety.	

Risk No: 58	Date included	29 November 2021	Date revised	07/03/2022		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. • External Consultant in place until end March 2022 to support on the QI delivery plan.		
	Gaps:	• The safeguarding training offer is not fully compliant with national standards and guidelines.		
Assurances	Internal:	Source: • Legislative Committee and Safeguarding Committee / QAC • The identified Safeguarding Lead Nurses access • Collaborative Safeguarding Report	Evidence: • Safeguarding report to Trust Board on request • Key Performance Indicators for the Legislative Committee and SG Committee	Assurance Rating Green
	External:	Source: • Internal Audit – Liberty Protection Safeguards (Advisory 2022/23) • External review by quarterly SCAT 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 (SCAT) Membership of four Local Safeguarding Boards, including the Boards' respective sub-committees , • External review completed and report accepted by the Trust.	Evidence: • CQC identified no major safeguarding concerns feedback from the CQC report published 10th November 2021. • Local Safeguarding Board reports and minutes • The collaborative assurance framework (SCAT) undertake with the CCG describes the review of assurances internally to external partners. • External consultant in place until end March 2022 to support on the delivery of the QI plan.	Assurance Rating Green
	Gaps:	• Training figures		

Actions	Date:	Actions:	Action Owner:	Progress:	Status
	Ongoing Apr 22 Apr 22	• 2021 -2023 work programme to be implemented • Multi-agency information processes (MARAC, MAPPA, Channel) • Implement and embed recommendations from the external review. • Training capacity and offer to be reviewed	All - Safeguarding Dept	• Work programme approved safeguarding committee • Action from external review on track • The training offer reintroduces face to face training from April 2022. This is blended with e-learning.	Amber

Risk No: 59	Date included	29 November 2021	Date revised	02/03/2022
Objective: S	High Standards			
Risk Title:	Lack of staff capacity in causing delays in the incident management process, including the review and closure of a backlog of reported incidents, the investigation and report writing of SIs and the closure of resulting actions. This will result in delays in learning and could lead to poor quality care and patient harm as well as reputational damage.			
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 • Incident investigation training monthly rolling programme
	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 Oversight of performance Feedback from Quality Summit	Evidence: • Reports/ minutes from Incident Oversight Group and Quality Forum • Quality Summit March 2022	Assurance Rating Amber
	External:	Source: • Internal Audit – Patient Safety Incident Response Framework and Plan due Q3 2022/23 • 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: April 22	Actions: Delivery of CQC actions	Owner: F.Myers/ Michelle Churchard	Progress: CQC action plan agreed and monitored, final delivery date moved to April 22	Status Amber

Risk No: 60	Date included	29 November 2021	Date revised	14/03/2022
Objective: S	High Standards			
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.			
Risk owner:	Exec: Director of Nursing, AHPs and Quality		Local: Associate Director of Nursing and Professional Practice	
Governance:	Quality Forum, SWC/QAC /Board - Monthly Review			

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

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

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 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 programme
- eRoster – early winter planning and roster sign off

System controls

- Each organisation has risk assessed staffing
- Implemented escalation & mitigation plans
- NHSE&I – winter assurance plans completed
- Origination Accountable Officers Letter – about positive risk taking
- Workforce Sharing Agreement
- 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 and monthly safe staffing reports to QAC/Trust Board
Trust wide local induction checklist for bank and agency staff
Safe staffing

KPIs

- No. of wards not meeting >80% fill rate for RNs Target = 0 (Feb 22 – Day = 4 Night = 0)
- Health and Well-being Sickness Absence - Target is <=4.5% (Jan 22 (1 month in arrears) = 5.9%)
- Vacancy rate - Target is <=7% (Feb 22 = 10.7%)

Evidence:

- Self-assessment complete 4 key themes to enhance assurance, action plan developed
- Staffing report and Highlight report from QAC significant assurance
- Weekly situational and forecast staffing meeting
- Month 11 Performance Report (February 2022)

Assurance Rating Amber

External:

- Internal Audit – Recruitment and Retention due Q1 2022/23
- Internal Audit – Agency Staffing due Q3 2022/23
- The Department of Health and Social Care's group annual governance statement – NHSI
- CQC Inspection 2021

Assurance Rating Green

Gaps:

Actions

Date:	Actions:	Action Owner:	Progress:	Status
Apr 22	• Proposal for super enhancing recruitment and attraction scheme and campaign	John Edwards	Dedicated project workers appointed and agreed approach with NHSEI in readiness for 28th April national submission.– date moved to April 22	Amber
Apr 22	• Recruitment plan against 22/23 investment			
Mar 23	• All age MH standard recruitment to working planning capacity	Elaine Curtin		
April 22	• To develop a Trust wide safe staffing policy	Emma Wallis	Policy drafted, under consultation due to be finalised April 22	
	• Recruit additional 44 international nurses	Asha Day	Funding to support accelerated recruitment	
	• Recruit new to healthcare HCSWs	Emma Wallis		

Risk No: 61	Date included	29 November 2021	Date revised	10/03/2022
Objective: S	High Standards and Equality, Leadership, Culture			
Risk Title:	A lack of staff with appropriate skills will not be able to safely meet patient care needs, which may lead to poor patient outcomes and experience.			
Risk owner:	Exec: Director of Nursing, AHPs and Quality and Director of HR & OD	Local: Head of Education, Training and Development		
Governance:	SWC, QAC / Board - Monthly Review			

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

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

Controls	Description:	• Mandatory and Role Essential Training Policy, Study Leave Policy • National and local People Plan • Safer staffing policies and guidance • MHOST tool for review of patient acuity and dependency measurement • E rostering in place across inpatient services and community • Auto planner within CHS / E rostering in place across inpatient services and community • On-going recruitment programme • Recovery of Mandatory Training compliance action log reported to Training Education and Development Group monthly
	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 **KPIs** • Core Mandatory Training Compliance for substantive staff - Target is >=85% (Feb 22 = 90%)	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. • Month 11 performance report (February 2022)	Assurance Rating Green
	External:	• NHS retention support and benchmarking data		Assurance Rating Green
	Gaps:			

Actions	Date:	Actions:	Owner:	Progress	Status
	Apr 22	1. New process for amending compliance requirements to position numbers	Head of Ed/ Train/Dev	Ongoing – date delayed to April 22	Amber
	Mar 22	2. Manager compliance and DNA reports live on ulearn 3. Pilot safe care and review establishment	Amrik Singh		
	Mar 22	4. Implementation of bespoke training days for Bank staff to complete 5. Work stream as part of Deteriorating Workforce and Sepsis Group to progress and review training and compliance for ILS and BLS 6. Consideration of staff redeployment from low priority areas to support safe staffing	Emma Wallis / A Scott “ “ “ “	The pilot for Safe Care is underway with four services.	

Risk No: 62	Date included	29 November 2021	Date revised	10/03/2022
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 • Mental Health Act inspection action plans	Assurance Rating Amber
	External:	Source: • CQC Inspection 2021 • Mental Health Act inspections • External Audit value for money conclusion 2020/21	Evidence: CQC overall rating Requires Improvement	Assurance Rating Amber
	Gaps:	16/03/22 The Trust continues to respond to the Covid-19 pandemic impacting on staff absence and reset of services and governance arrangements, . This may impact on: Attendance at required meetings Achieving training compliance Process of auditing against compliance Safe staffing of inpatient areas with increased staff incidence.		

Actions	Date:	Actions:	Action Owner:	Progress:	Status
	31 Mar	• Delivery of the remaining must do CQC action.	Deanne Rennie/Jane Howden	There is one remaining must do action due 31/03/31. All other 'must do' actions are closed.	Green
	Mar 22	• Redesign Foundation for Great Patient Care to ensure cross Trust learning of actions arising from the CQC action plan.		Programme planned for Foundation for Great Patient Care to ensure cross Trust learning.	

Risk No: 63	Date included	29 November 2021	Date revised	10/03/2022
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 • Monthly detailed training reports including DNA		
	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	14/03/2022
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 • SUTG delivery plans
	Gaps:	

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: Ongoing	Actions: Regular attendance at ICS Board meetings, transition and steering groups	Owner: Chair & CEO	Progress: Achieving (this action will be on-going)	Status Green

Risk No: 65	Date included	29 November 2021	Date revised	10/03/2022
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: Mar 22	Actions: • Exit agreement to be agreed and staff engagement/ TUPE sessions jointly planned.	Action Owner: CFO	Progress: In progress	Status: Amber

Risk No: 66	Date included	29 November 2021	Date revised	10/03/2022
Objective: E	Environments			
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.			
Risk owner:	Exec: Chief Finance Officer		Local: Associate Director Estates & Facilities	
Governance:	Estates Committee, FPC / 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:	• 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 Mar 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	17/03/22
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 Red
	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 Amber
	Gaps:			

	Date:	Actions:	Owner:	Progress:	Status
Actions	Mar 22	Funding approval for sustainability posts	PS	Currently with banding panel which was paused. Revised date estimated March 2022	Amber
	Mar 22	Outline chapters drafted and shared with provisional chapter leads	PS	CFO taking the lead on research to support draft chapters	
	May22	Finalised Green Plan	PS	Drafted	

Risk No: 68	Date included	29 November 2021	Date revised	16/03/22
Objective: G	Well Governed			
Risk Title:	A lack of accessibility and reliability of data reporting and analysis will impact on the Trust's ability to use information for decision making, which may impact on the quality of care provided.			
Risk owner:	Exec: Director of Finance & Performance		Local: Head of Information	
Governance:	FPC / Board - Monthly Review			

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

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

Controls

Description:	• Executive senior information risk officer (SIRO) sponsorship • Information asset owners in place • Clinical system training in place • Performance management framework (which includes the 6 dimensions of data quality) • Data quality policy and procedure
Gaps:	• Incomplete data quality reports for local and national data sets; data quality framework being developed through Data Quality Committee • Insufficient monitoring of data quality incidents does not allow for learning opportunities • Configuration of systems to support requirements of information standards and NHS data models • Robust technical infrastructure to support timely and accessible use of data • Ownership of data quality across the Trust – being picked up with support of Change Champion attendance at Data Quality Committee • Capacity of the information team due to demands from national sitrep reporting, changes to information team members

Assurances

Internal:	Source: • Performance review meetings include Directorate level metrics • FPC / Trust Board • Clinical audit • Annual record keeping audit • Data security and protection toolkit self assessment • Regular oversight reports from the IM&T Committee • Data quality committee • Local Risk register	Evidence: • DSPT 'standards met' annual submission made in June 2021 • Data quality actions reported to FPC via Data Privacy Committee highlight report – assurance rating Green (March) • 21/22 DSPT baseline submission (March) showed no gaps - 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 , 20/21 or 21/22, following national guidance.		

Actions

Date:	Actions:	Action Owner:	Progress:	Status
Mar 22	• Delivery of 21/22 data quality work plan, including trust wide ownership of data quality	SM	Phase 1 on track	Green
Mar 22	• New data quality kite mark implementation	SM	On track – Data Quality Framework approved by DQC, will be implemented for 22/23 reporting.	
ongoing	• Review of system 1 data quality live issues in Data Quality Committee	SM	On going, as issues are raised	
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	03/03/22
Objective: G	Well Governed			
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.			
Risk owner:	Exec: Director of Finance & Performance		Local: Director of Finance & Performance	
Governance:	FPC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	2	8
Residual Risk	4	1	4

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

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 (February 2022) • 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	Apr 22	• Revised Board performance report implementation	SM	Report delayed due to technical issue with SPC chart reporting	Amber
	May 22	• Consider ORR links to performance report	SM/KD	Initial set of KPIs populated onto ORR March 22 – ongoing	
	Mar 22	• Review of Information Team capacity & delivery model	SM	Options paper to OEB 18/03/22	
	Apr 22	• Quality accounts reporting & management of actions	SM	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	03/03/22
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	1	5
Residual Risk	5	1	5

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 (February 2022)	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 issued – Significant assurance • 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 – capital plan delivery remains an area of risk	

Risk No: 71	Date included	29 November 2021	Date revised	03/03/22
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	2	10
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	SM	On track	Green
	Apr 22	Trust Board approval of 2022/23 plans	SM	On track	
	Apr 22	Submit LPT finance, activity, workforce & performance plans to ICS/NHSI	CP	On track	

Risk No: 72	Date included	29 November 2021	Date revised	14/03/2022
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.		

Actions	Date:	Actions:	Owner:	Progress:	Status
	Mar 22	Reaching out delivery plan as part of the Step Up to Great (SUTG) strategy and plan	David Williams	Revied timescales – end March 2022	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	14/03/2022
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	14/03/2022		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 • Action plan reporting through SG AND ICC	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	27/01/22
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 / EQIA 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:

- 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: • Internal Audit – Remote Consultations due Q1 2022/23 • Internal Audit – Patient Experience due Q1 2022/23 • 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
Mar 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 Mar 22	Amber
Mar 22	Consideration of avoidable harm measures including impact of partial or full COVID related closures		Agreed joint working approach between LLR and Northants system to undertake demand and capacity modelling Actively considered and covered in regular reports – to review for closure in Mar 22	

Risk No: 76	Date included	December 2021	Date revised	14/03/2022		Consequence	Likelihood	Combined
Objective: S	High Standards				Current Risk			
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.				Residual Risk			
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		Tolerance Level Significant 16-20 (Appetite Quality - Seek)			
Governance:	SWC / QAC / Board - Monthly Review							

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:			
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
	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
	Gaps:			

Actions	Date:	Actions	Progress:	Status

Risk No: 77	Date included	1 December 2021	Date revised	14/03/2022
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:	• National Public Inquiry Chair and Terms of Reference • 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 • Local strategy for the National Public Inquiry drafted
	Gaps:	• Public Inquiry Programme and Project Board paused under the interim governance arrangements – subject to review in April 22 • Local strategy for the National Public Inquiry drafted – to be approved (when work recommences)

Assurances	Internal:	Source • SEB • Joint Public Inquiry Programme Board • LPT Project Board	Evidence: Highlight reports from the LPT Project board to SEB (last dated 3 December 2021) Amber Assurance	Assurance Rating Amber
	External:	Source	Evidence:	Assurance Rating
	Gaps:			

Actions	Date:	Actions:	Action Owner:	Progress: Remains paused	Status
	Apr 22	Approval of local strategy.	Sandra Mellors /Kate Dyer SM/KD	To be presented to SEB when work recommences	Amber
	Apr 22	Implementation of the Public Inquiry IM&T strategy		To be reviewed within LPT when work recommences	

Risk No: 78	Environment / High Standards	Date reviewed:	10/03/2022		Consequence	Likelihood	Combined
Risk Title:	Inability to sustain the level of cleanliness required within the National Cleanliness Standards and Hygiene Code			Current Risk	4	3	12
Director risk owner:	Director of Nursing, AHP's and Quality and Chief Finance Officer	Date Last Reviewed:	11.02.22	Residual Risk	4	2	8
Governance / Review:	IPCC, QAC and FPC / Board - Monthly Review			**Tolerance** level Moderate 9-11 (Appetite Reputational–Cautious)			

Controls	Description:	• Contract management with NHSPS for provision of soft facilities management (including cleaning standards) • Collaborative agreement in place with UHL for provision of soft facilities management (including cleaning standards) • Use of the Hygiene standards • LPT estates rep sits on/reports into IPC Group (cleaning/water/waste/decontamination) • Infection control team / IPC quarterly report and annual report / • SOPs in place to describe key responsibilities • Audit programme includes Cleaners rooms and trolleys / Clear and agreed reporting mechanism against the Hygiene code • 21/22 FM SLA and performance KPIs • Revised cleaning spec/scope (zoned wards) and allocation of cleaning responsibilities (FM staff/Ward staff) • On outbreak wards staff aligned to task for whole shift. System in operation and working. • Additional rapid response staff • LPT participation in NHSEI cleaning with confidence (CwC) campaign – training programme added to Ulearn • Service spec updated to introduce a third daily clean to IP areas • Inpatient ward matron cleaning roles and responsibility meetings with the Director for Infection, Prevention and Control
	Gaps:	• Progress with the FM transformation • Progress with sustained implementation of the turnaround plan • Appropriately trained estates team in place • UHL / NHSPS representation at LPT IPC Group and Cleaning Forum • Inconsistent reporting with cleaning scores • Number of audits completed KPI not being met

Assurances	Internal:	Source: • Cleaning report to the Estates Committee • Finance and Performance Committee • IPC Group to QAC • Bi-monthly contractual cleaning forum (estates/IPC/NHS PS/UHL) - this goes to estates committee and FPC. • Regular cleaning audits and KPI score monitoring • IPC Bi-Annual report to Trust Board	• DMTs • Monthly reports to FPC (Estates) and QAC - (IPC) • Environmental audit • Contractual cleaning audit findings • Regular performance reports against hygiene standards and regular review at IPC	Assurance Rating Amber
	External:	Source: • NHSI IPC audit • CQC inspections	Evidence: • National Guidance on cleaning for COVID-19 • CQC IPC summary inspection report	Assurance Rating Green
	Gaps:	UHL Facilities Cleaning Turnaround plan - plan received 4.10.21 - nothing further to IPC Group.		

Actions	Date: Mar 22 Mar 22	Actions: Implementation of the cleaning turnaround plan with evidence Implement the National Standards of Healthcare Cleanliness 2021 – statement required at 31 March 2022	Action Owner: UHL – oversight R. Brown UHL and NHSPS – oversight H. Walton and A. Hemsley	Progress All actions are on-going	Status: Amber

G

Leicestershire Partnership NHS Trust

Trust Board Public Meeting – 29th March 2022

Documents Signed Under Seal – Quarter 3 Report

Standing order 8.3 requires that the Trust Board receives reports on the use of the Trust Seal on a quarterly basis.

Purpose of the report

An entry of every sealing is made and numbered consecutively in a book provided for that purpose, and is signed by the person who has approved and authorised the document.

Use of Seal – General guide

(i) All contracts for the purchase/lease of land and/or building
(ii) All contracts for capital works exceeding £100,000
(iii) All lease agreements where the annual lease charge exceeds £10,000 per annum and the period of the lease exceeds beyond five years
(iv) Any other lease agreement where the total payable under the lease exceeds £100,000
(v) Any contract or agreement with organisations other than NHS or other government bodies including local authorities where the annual costs exceed or are expected to exceed £100,000

The SOs & SFIs will undergo an annual review at the end of March 2022 and the team are proposing amendments to the use of the seal to both streamline and strengthen the process. These changes have been proposed in collaboration with the Trust Surveyor and The Director of Finance and legal advice has been sought on the proposed changes. The changes will mean that only transactions that are required by law (or requested by a third party) to become deeds will be therefore sealed using the Trust Seal.

Analysis

The documents shown below have been signed under seal during quarter 3 2021/22 from 1st October to 31st December 2021.

Seal Register Number	Type	Description	Date Recorded
323	Contract for Services exceeding £100,000	Provision of Locum Doctors	29th October 2021
324	Contract for Services exceeding £100,000	Fleet Management (Lease Cars) Tender	21st December 2021
325	Contract for Services exceeding £100,000	MEVPN Non MEPVN	21st December 2021
326	Contract for Services exceeding £100,000	Archiving Records Management	21st December 2021

Decision required

The Board is asked to note the content of this report.

Governance table

For Board and Board Committees:	Public Trust Board 29th March 2022	
Paper sponsored by:	Chris Oakes, Director of Corporate Governance and Risk	
Paper authored by:	Kay Rippin Corporate Affairs Manager	
Date submitted:	14.03.22	
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):	SEB 7th 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:	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	Quarterly report at 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	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	NA	
Equality considerations:	NA	

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Leicestershire Partnership NHS Trust

LPT Trust Board – 29th March 2022

Non-Executive Director Champion Roles and Responsibilities with effect from 1st April 2022

Purpose of the report

- To update the Board on the proposed allocation of Non-Executive Director (NED) champion roles following the development of new guidance by NHSIE.
- To appoint the Senior Independent Director (SID)
- To update the Board on the NED team responsibilities

The Board is asked to approve the proposals made in the report

Analysis of the issue

In December 2021 NHSIE issued guidance to all Trusts regarding Non-Executive Director Champion roles – '*Enhancing Board oversight, A new approach to Non-Executive director champion roles'*.

To ensure Board oversight of important issues, the guidance sets out some recommended NED Champion roles and a new approach for responsibilities that can be discharged through the Trust's committee structure.

The new approach has been developed with a working group of trust chairs and the CQC have also been consulted. CQC inspectors will be looking for evidence of strong leadership and governance, with effective oversight of specified issues. The Trust will be expected to demonstrate how this is provided including reference to the new guidance where appropriate.

Although the guidance is recommended it is not mandatory, LPT will be adopting this guidance as best practice.

Proposal 1) – NED Champion Roles

The NED Champion roles proposed by NHSIE are shown in the table below along with the named LPT NED and alignment to the LPT committee governance.

	Maternity board Safety Champion	**Wellbeing guardian**	**Freedom to Speak up**	**Doctors disciplinary**	**Security management (counter fraud)**	**Security management (violence & aggression)**
NED	Moira Ingham	Cathy Ellis	Ruth Marchington	Ruth Marchington	Darren Hickman	Moira Ingham
Committee	Quality Assurance Committee	Quality Assurance Committee	Quality Assurance Committee	Remuneration Committee	Audit & Assurance committee	Quality Assurance Committee

In addition, the guidance recommended that a further 11 key themes should be overseen through committee structures as follows:

LPT Committee	**Themes from guidance**
Quality Assurance Committee (QAC)	• Hip fractures, falls & dementia • Learning from deaths • Safety & risk • Palliative and end of life care • Health & safety • Children & young people • Resuscitation • Safeguarding
Finance and Performance Committee (FPC)	• Cyber security • Procurement
Audit & Assurance Committee (AAC)	• Emergency Preparedness

A review of the LPT Board committee Terms of Reference and Workplans will be actioned as part of the LPT committee annual reviews to ensure that these responsibilities are fully reflected.

Proposal 2 – Appointment of Senior Independent Director

The role of the Senior Independent Director (SID) will become vacant when Darren Hickman moves across to his newly appointed ICS Audit Chair role in June 2022. It is proposed to appoint a new SID from 1st April 2022 to ensure a smooth handover. The responsibilities of the role will include:

- Conducting the Chairs appraisal by meeting with the Non-Executives and securing 360 feedback from stakeholders
- The Freedom to Speak Up NED champion
- The Doctors Disciplinary NED champion
- Being the independent NED available to the Board of Directors to raise concerns about the Chair or Chief Executive
- In Foundation Trusts, the SID will also liaise with the Council of Governors. In LPT this role could include at a future date, liaison with the People's Council & Youth Advisory Board.

It is recommended that Ruth Marchington be appointed as the SID. Ruth is an experienced NED, is a well-respected member of the team and has a relevant HR skillset to support the NED champion roles.

Proposal 3) Summary of NED responsibilities and Committee membership

Committee / Role	**NED(s)**
Senior Independent Director	Ruth Marchington
Deputy Chair	Faisal Hussain
Audit & Assurance Committee	Darren Hickman (Audit Chair) Faisal Hussain (interim FPC Chair) Moira Ingham (QAC Chair)
Remuneration Committee	Cathy Ellis (Chair) Darren Hickman Faisal Hussain Moira Ingham Ruth Marchington Kevin Paterson Vacancy (*)
Charitable Funds Committee	Cathy Ellis (Chair) Ruth Marchington (until 31 August 2022) Faisal Hussain (from 1 September 2022)
Quality Assurance Committee	Moira Ingham (QAC Chair) Ruth Marchington Kevin Paterson
Finance & Performance Committee	Faisal Hussain (interim FPC Chair) Ruth Marchington / Moira Ingham (QAC link) Vacancy (*)
Board walks to frontline services	All NEDs
LLR ICS Finance Committee	Cathy Ellis (Chair) Darren Hickman
LLR ICS Quality & Performance Committee	Moira Ingham
LLR ICS Transition Committee until 1st July 2022	Faisal Hussain
LPT / NHFT Joint Working Group	Cathy Ellis (Chairing by rotation with Crishni Waring) Ruth Marchington

(*) there is currently a vacancy for the Finance & Performance Committee chair, this is out to recruitment along with the new Audit Chair to replace Darren Hickman when he moves to the ICS.

Decision required

- To approve the proposed allocation of NED champion roles.
- To appoint Ruth Marchington as the Senior Independent Director (SID)
- To approve the NED team roles and committee responsibilities

Governance table

For Board and Board Committees:	Trust Board 29 March 2022	
Paper sponsored by:	Cathy Ellis & Chris Oakes	
Paper authored by:	Cathy Ellis, Chris Oakes & Kate Dyer	
Date submitted:	16 March 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	Annual review	
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	
	Trustwide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	62 oversight of regulatory standards 69 managing performance
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed	
Equality considerations:	None	

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Leicestershire Partnership NHS Trust

Trust Board – 29 March 2022

Step Up to Great Mental Health

Programme update

Purpose of the report

The report provides an update to the LPT Board on the progress in implementing the decisions made by the CCG Boards following public consultation on the Step Up to Great Mental Health investment and improvement programme.

Analysis of the issue

The LLR system ran a broad public consultation on the plans for investment and improvement of Urgent and Emergency Mental Health and Integrated Community Mental Health services.

In mid-December 2021, the CCG Boards agreed to a set of recommendations relating to the specific investment and service change proposals, alongside some overarching recommendations in relation to working with carers and the VCS. The CCG Boards also agreed to the recommendations in the Equality Impact Assessment report on the consultation process.

The system, including LPT, now has a mandate to make the changes set out in the consultation. The CCG Boards have made a commitment to make the investments and changes which has been confirmed to NHS England and the joint Health Overview and Scrutiny Committees in Leicester, Leicestershire and Rutland.

Progress

Significant progress has been made in implementing the agreed service changes and utilising the confirmed investments. In particular, there has been a focus on increasing the staffing resources available to the services through recruitment. The text below draws out some of the key elements of progress by service. The appended table provides some further detail and a reminder of the CCG Boards' decisions.

Local communities and the VCS

A further joint VCS planning session took place on 28 February and work is underway with the VCS networks to formalise and make permanent a new collaborative way of working. Applications for VCS grant support for new Crisis Cafes have been issued through Voluntary Action Leicestershire.

Working with carers

A carers meeting was held on 4 February. Alison Kirk has developed service user partner and carer partner roles in LPT. The UEC Steering Group will be expanded to include more families and carers by the end of March.

Self-care information

Most of the self-care information is now written and has been tested with service users. The work on the QR code is complete. The CAP support has been agreed and will be in the new CAP specification. The launch of the self-help material is expected to take place in April 2022. The public access to digital terminals to be developed through the ICS digital programme.

Central Access Point

Work has progressed on the service specification for the permanent enhanced service and the KPIs. This is due to be completed with the sign off of the enhanced service specification and KPIs by the end of March.

The strand to promote the service to vulnerable groups was progressed with VCS partners at the joint planning event on 28 February. This is a key area for joint work with the VCS.

The Steering Group will be expanded to include more families and carers by the end of March.

Additional phone lines and access to BSL support to be in place in Q1. Work to move the service to a cloud-based solution rather than an estate-based solution to be undertaken in Q1 once the final enhanced specification is agreed.

Crisis cafes

Applications for VCS grant support for new Crisis Cafes have been issued through Voluntary Action Leicestershire. A review of the applications and decisions on grant funding will be made by the end of March 2022.

We expect to launch at least four new Crisis Cafes in Q1.

Promotion of the existing and new cafes was progressed at the joint VCS planning meeting on 28 February.

Crisis service

Additional Psychologists have been recruited and one started in late January. The recruitment of Care Navigators and Peer Support workers is also underway and will be completed by the end of Q1.

The UEC Steering Group will be expanded to include carers and service users for Q1.

Work on service promotion with the VCS was part of the VCS planning event on 28 February.

Introduce an Acute Mental Health Liaison Service

The join up of the teams at the LRI has been completed. The team office has been refurbished to create a better common space.

The Liaison Group will be re-established in Q1. This will support the promotion of the service within UHL. A training and development plan for hospital colleagues will also be signed off in Q1.

Establish a Mental Health Urgent Care Hub

Significant work has taken place to make the Urgent Care Hub permanent under a new service specification that will be approved by the end of March.

The options and criteria for an options appraisal will be confirmed in Q1 linked to the Strategic Outline Business Case for the site.

The scope of a customer care training programme and a provider will be completed in Q1 for roll out.

Expand the hours that the Triage car is provided

Work has taken place to confirm the enhanced service specification for sign off by the end of March.

We will recruit additional staff in Q1 based on the enhanced specification. The work programme in Q1 will also focus on the pathways of care and conveyancing practice via a UCH mini assessment.

An audit of existing mental health first aid training (currently provided), any additional needs and how they might be provided will also be completed in Q1.

Intensive support to vulnerable groups

The new posts in the Homelessness team have been advertised. The Vulnerable Persons Group has been restarted.

In Q1 we plan an expansion of the service across the County. The implementation plans on effective collaboration will be completed in Q1. This will focus on specific support needs for more effective collaborative working.

Create eight Community Treatment and Recovery Teams focused on adults and eight Community Treatment and Recovery Teams focused on older people

A Project Manager has been appointed to take this work forward.

A paper proposing the eight footprints for adult and eight footprints for Older People is due for review and approval by the end of March. The focus of the work is on alignment with the eight neighbourhoods in LLR.

Consideration of the opportunities for colocation will be completed in April. Locality based work on the best opening hours to meet local population needs to take place in April and May following agreement of the footprints. Quality and safety transition triggers will also be approved in April for implementation from May onwards.

Dramatically cut waiting times to access Personality Disorder Services

A substantive PD Pathway lead has been appointed.

There has been extensive recruitment to Band 6 and Band 7 roles and Assistant Psychologist roles.

These additional roles will support the roll out of the Structured Clinical Management (incorporating Decider Skills) programme, which aims to increase the capacity, responsiveness and flow in the delivery of psychologically informed therapies for service users diagnosable with Personality Disorder. The new groups will start in April.

The groups will be rolled out in each new Community Treatment and Recovery team during 2022/23 until there are two or three running in each of the eight new patches.

The roll out of these groups will dramatically reduce waiting times.

Perinatal - Expand the service available for perinatal women from pre-conception to 24 months after birth and improve the support for women who are experiencing trauma and loss in relation to maternity experience

Recruitment to the additional Perinatal roles has been completed. Recruitment has now begun to the new health visiting roles. Recruitment to the Psychology posts and medical posts will take place in Q1.

Work on the father and partner plan with UHL was paused in December and January due to Omicron but this has been restarted. The work with UHL and service users on the development of support services for fathers and partners, will result in a proposal to the March Programme Board for the service enhancement to begin in May 2022.

The joint co-design of the multi-cultural practices and training will be agreed with the VCS in Q1.

Improve psychosis intervention and early recovery service

A substantive Psychosis pathway lead has been recruited and is in post. The pathway lead has begun work on the frameworks across the pathway including in PIER for psychological assessment and intervention, at individual, group and family level, and also for staff training and supervision.

Recruitment using the additional investment has been progressed. Two Band 7 CBT Therapists and three Band 6 Care Coordinators have been appointed. The recruitment process will be completed with the appointment of Assistant Psychologist posts in Q1.

The service will develop an implementation plan for the final elements of service change in Q1.

Enhance the memory service introducing different ways of providing the service

A pilot is underway using Occupational Therapists in the memory service. Demand and capacity work has been progressed alongside a review of NICE guidance.The review of the service model pathway will be completed in Q1.

A plan to clear the backlog and maintain a sustainable model will also be completed in Q1.

Recruitment to existing vacant posts will be completed in Q1 with the recruitment against the new model beginning in Q2.

Establish an Enhanced Recovery Hub team

The team is in place and the Hub has been established. Two Band 6 nurses have recently been appointed to the CERT team.

Four quality Improvement projects are underway:

1. Establishment of the new Community Enhanced Rehabilitation Team - Reducing anxiety and readmissions in the early week following discharge from inpatient rehabilitation service.
2. Increasing relative and carer involvement in a new community rehabilitation and recovery team.
3. Understanding how service users experience recovery interventions in a community setting.
4. Remote working in the context of designing and implementing a new community rehabilitation team. Review the evaluation of the new Hub arrangement to inform the longer-term development plan.

In 2022, we plan to expand the community enhanced rehabilitation team by recruiting a Band 6 Occupational Therapist, two Peer Support workers and a social worker to work across the enhanced rehab and recovery pathway. The team caseload should expand in line with our workforce, and we anticipate another 30-40 people receiving interventions from CERT.

Telephone and video-based services

There is agreement that telephone and video service offerings will be one of a number of options rather than the only option and determined by the service user.

Access to public IT terminals will be taken forward via the ICS digital programme.

Decision required

The LPT Trust Board is asked to:

- note the significant progress made since the last Board update
- receive a further update at the June Board meeting.

Graeme Jones

17 March 2022

Governance table

For Board and Board Committees:	Trust Board meeting 29.3.22	
Paper sponsored by:	Fiona Myers	
Paper authored by:	Graeme Jones	
Date submitted:	17 March 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):	The LPT Board has received a number of previous updates on the elements of this service investment and improvement programme.	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Update at the June LPT Board.	
STEP up to GREAT strategic alignment*:	High **S**tandards	
	Transformation	X
	Environments	
	Patient Involvement	X
	Well **G**overned	X
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	X
	Trust wide Quality Improvement	X
Organisational Risk Register considerations:	List risk number and title of risk	
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:		
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:	EIA completed in December 2020 and in December 2021.	

Progress and next steps in implementing the SUTG Decision-making Business Case

Cross cutting recommendations to the CCG Board

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

Local communities and the VCS

- A further joint VCS planning session took place on 28 February
- Formulate the VCS networks in March and April following the 28 February session
- Applications for VCS grant support for new Crisis Cafes have been issued through Voluntary Action Leicestershire.

Working with carers

- A carers meeting was held on 4 February.
- Alison Kirk has developed service user partner and carer partner roles in LPT.
- The UEC Steering Group will be expanded to include more families and carers by the end of March.

Decision and progress by service

Service we consulted on	Recommended decision	Implementation progress 17 March 2022	Next steps and Q1 deliverables
Provide an additional comprehensive suite of self-help guidance and tools	a) Agree to provide a comprehensive suite of self-help guidance and tools in one place online, while making the material available in printable format. b) Agree to address the feedback on the type and simplicity of the information, and access routes to the information with the support of a service user advisory group and wider engagement as we develop and implement our plans. c) Agree to provide support to find and understand the information via the Mental Health Central Access Point for people unable to navigate or understand the information on the website. d) Agree to share a QR code on posters and business cards in a wide range of settings including GP practices. e) Agree to pilot the use of publicly accessible IT terminals to access the self-care guidance.	Most of the information is now written and has been tested with service users. The work on the QR code is complete. The CAP support has been agreed and will be in the new CAP specification.	Launch of the self-help material in April 2022. Access to digital terminals to be developed through the ICS digital programme.
Introduction of a Central Access Point	a) Agree to make the Central Access Point permanent. b) Agree to address the consultation feedback on promotion and awareness of the CAP, access routes for vulnerable groups, interpreter and BSL support, improving responsiveness and	Work has progressed on the service specification for the permanent enhanced service and the KPIs.	Complete and sign off enhanced service specification and KPIs by the end of March.

	performance standards as part of the implementation and further development phase. c) Agree to develop the service to provide support to families and carers. To support this, the CAP and the Urgent and Emergency Care Steering Group will be expanded to include family and carer representatives to develop and test material. d) Agree to undertake a review of demand, capacity and workforce models alongside the potential use of technology to improve the support offer. The review of capacity will include modelling the workforce required to introduce a call-back service and a text access route.		Promotion to vulnerable groups to be progressed with VCS partners at the joint planning event on 28 February. The Steering Group will be expanded to include more families and carers by the end of March. Additional phone lines and access to BSL support to be in place in Q1. Work to move the service to a cloud-based solution rather than an estate-based solution to be undertaken in Q1 once the final enhanced specification is agreed.
Expand the number of Crisis Cafés	a) Agree to open a further 22 crisis cafés in community locations in Leicester, Leicestershire and Rutland.	Applications for VCS grant support for new Crisis Cafes have been issued	Review and decisions on grant applications by the end of March 2022.

	b) Agree to work with local communities and voluntary and community groups to identify suitable locations, to co-design appropriate support offers considering diversity and ethnicity, co-location of other services and to link with wider community assets. Developing an appropriate local offer in each neighbourhood. c) Agree to work with local communities and service user groups to inform the names of the Cafés to identify a different term or terms for the cafés.	through Voluntary Action Leicestershire.	At least four new Crisis Cafes to be launched in Q1. Promotion of the existing and new cafes was progressed at the joint VCS planning meeting on 28 February.
Improve and expand the Crisis Service	a) Agree to improve and expand the Crisis Service in Leicester, Leicestershire and Rutland as set out in the Pre Consultation Business Case. b) Agree to promote the range of Urgent and Emergency Care (UEC) services and build awareness of the support available across the pathway. c) Agree to work with the UEC service user group to consider options to improve communication with service users and their families as part of our implementation and on-going review processes.	Additional Psychologists have been recruited and one started in late January. The recruitment of Care Navigators and Peer Support workers is underway.	Complete the recruitment of Care Navigators and Peer Support workers by the end of Q1. The UEC Steering Group will be expanded to include carers and service users for Q1. Work on service promotion with the VCS was part of the VCS planning event on 28 February.
Introduce an Acute Mental Health Liaison Service	a) Agree to create an Acute Mental Health Liaison Service by joining together the existing teams and basing them at Leicester Royal Infirmary close to the emergency department.	The join up of the teams at the LRI has been completed.	The Liaison Group will be re-established in Q1. This will support the

	b) Agree to address the feedback on promoting the service to UHL staff and building awareness of all wards and departments through implementation. c) Agree to provide support and development training to acute hospital colleagues including to A&E staff in mental health awareness.	Team office space has been refurbished to create a better common space.	promotion of the service within UHL. A training and development plan for hospital colleagues will be signed off in Q1.
Establish a Mental Health Urgent Care Hub	a) Agree to make the Urgent Care Hub permanent and to undertake an options appraisal on whether to maintain the Hub at the Bradgate Unit in the longer term. b) Agree to include staff training in customer care to strengthen the nature of the welcome at the Urgent Care Hub.	Significant work to make the Urgent Care Hub permanent under a new service specification that will be approved by the end of March.	The options and criteria for an options appraisal will be confirmed in Q1 linked to the Strategic Outline Business Case for the site. The scope of a customer care training programme and a provider will be completed in Q1 for roll out.
Expand the hours that the Triage car is provided	a) Agree to expand the hours of the Triage car service and to expand the joint working with East Midlands Ambulance Service. b) Agree to develop further mental health awareness training alongside the police and ambulance services.	Work is on-going to confirm the enhanced service specification for sign off by the end of March.	We will recruit additional staff in Q1 based on the enhanced specification. The work programme in Q1 is focused on the pathways of care and conveyancing practice via a UCH mini assessment.

			An audit of existing mental health first aid training (currently provided), any additional needs and how they might be provided will be completed in Q1.
Intensive support to vulnerable groups	a) Agree to implement the investment and recruitment plans set out in the consultation, focusing our implementation plans on effective collaboration between the teams coming together.	The new posts in the Homelessness team have been advertised. The Vulnerable Persons Group has been restarted.	In Q1 we plan an expansion of the service across the County. The implementation plans on effective collaboration will be completed in Q1. This will focus on specific support needs for more effective collaborative working.
Create eight Community Treatment and Recovery Teams focused on adults and eight Community Treatment and Recovery Teams focused on older people	a) Agree to move eight Community Treatment and Recovery Teams for adult mental health with eight dedicated teams for Older People's mental health operating on the same geographic footprints. b) Agree to undertake dedicated engagement in each locality to agree the working hours that best meet the need of the local population.	A paper proposing the eight footprints for adult and eight footprints for Olde People is being developed for review and approval by the end of March. The focus of the work is on alignment with	Approval of the footprints in March 2022. Consideration of opportunities for colocation to be completed in April. Locality based work on the best opening hours to

	c) Agree to focus implementation plans on existing service users and managing their care during the period of transition. These plans will be linked to specific quality and safety triggers to be applied during the implementation phase.	the eight neighbourhoods in LLR. A Project Manager has been appointed to take this work forward.	meet local population needs to take place in April and May following agreement of the footprints. Quality and safety transition triggers to be approved in April. Implementation from May onwards.
Dramatically cut waiting times to access Personality Disorder Services	a) Agree to the investment and expansion to the Personality Disorder service set out in the Pre-Consultation Business Case focusing on integration with other services.	A substantive PD Pathway lead has been appointed. There has been extensive recruitment to Band 6 and Band 7 roles and Assistant Psychologist roles. These additional roles will support the roll out of the Structured Clinical Management (incorporating Decider Skills) programme, which aims to increase the capacity, responsiveness and flow in the delivery of psychologically informed	The new groups will start in April. The groups will be rolled out in each new Community Treatment and Recovery team during 2022/23 until there are two or three running in each of the eight new patches. The roll out of these groups will dramatically reduce waiting times.

		therapies for service users diagnosable with Personality Disorder.	
Perinatal Expand the service available for perinatal women from pre-conception to 24 months after birth Improve the support for women who are experiencing trauma and loss in relation to maternity experience	a) Agree to the investment and expansion of the perinatal service including doubling the period of support from 12 months to 24 months after birth. b) Agree to develop specific implementation plans to reflect the diverse community and work with relevant community groups to build awareness and access to the support on offer. c) Agree to the investment and expansion of the maternal outreach service including the development of support services for fathers and partners. d) Agree to address the suggestions of training on cultural diversity and incorporating multicultural practices through the implementation plans.	Recruitment to the additional Perinatal roles has now been completed. Recruitment has begun to the new health visiting roles. Work on the father and partner plan with UHL was paused in December and January due to Omicron but this has been restarted.	Recruitment to the Psychology posts and medical posts will take place in Q1. The joint co-design of the multi-cultural practices and training will be agreed with the VCS in Q1. Re-engage with UHL and service users on the development of support services for fathers and partners, to take a proposal to the March Programme Board for the service enhancement to begin in May 2022.
Improve psychosis intervention and early recovery service	a) Agree to support the investment and service change plans to improve psychosis intervention and early recovery, set out in the Pre-Consultation Business Case.	A substantive Psychosis pathway lead has been recruited and in post since November.	Complete the additional recruitment in Q1 – Assistant Psychologist posts.

		The pathway lead has begun work on the frameworks across the pathway including in PIER for psychological assessment and intervention, at individual, group and family level, and also for staff training and supervision. Two Band 7 CBT Therapists have been appointed. Three Band 6 Care Coordinators have been appointed.	Develop an implementation plan for the final elements of service change in Q1.
Enhance the memory service introducing different ways of providing the service	a) Agree to the investment and improvement proposals relating to the Memory Service, set out in the Pre-Consultation Business Case. b) Agree that provision via digital means will be an option rather than the only route to Memory Services and that service users will be able to choose the vehicle that suits them best.	A pilot is underway using Occupational Therapists in the memory service. Demand and capacity work has been progressed alongside a review of NICE guidance.	The review of the service model pathway will be completed in Q1. A plan to clear the backlog and maintain a sustainable model will also be completed ion Q1.

			Recruitment to existing vacant posts will be completed in Q1. The recruitment against the new model will begin in Q2.
Establish an Enhanced Recovery Hub team	a) Agree to establish an Enhanced Recovery Hub team and to develop the services, as set out in the Pre-Consultation Business Case.	The team is in place and the Hub has been established. Two Band 6 nurses have recently been appointed to the CERT team. Four quality Improvement projects are underway: 1. Establishment of the new Community Enhanced Rehabilitation Team - Reducing anxiety and readmissions in the early week following discharge from inpatient rehabilitation service	Review the evaluation of the new Hub arrangement to inform the longer-term development plan. In 2022, we plan to expand the community enhanced rehabilitation team by recruiting a Band 6 Occupational Therapist, two Peer Support workers and a social worker to work across the enhanced rehab and recovery pathway. Caseload should expand in line with our workforce, and we anticipate another 30-40 people receiving

		2. Increasing relative and carer involvement in a new community rehabilitation and recovery team 3. Understanding how service users experience recovery interventions in a community setting 4. Remote working in the context of designing and implementing a new community rehabilitation team	interventions from CERT (current caseload 52).
Telephone and video-based services	a) Agree to continue to offer and develop telephone and video-based services as an option for service delivery. b) Agree that the use of telephone and video as a vehicle to interact with service users will be offered a choice determined by the service user. c) Agree to pilot the use of publicly accessible IT terminals to access the self-care guidance.	Agreement that telephone and video service offerings will be one of a number of options rather than the only option and determined by the service user	Part c will be taken forward via the ICS digital programme.

Leicestershire Partnership and
Northamptonshire Healthcare Group

J

Trust Board March 2022
Leicestershire Partnership & Northamptonshire Healthcare Group
Chairs' Joint Highlight Report

Purpose of the report

- This joint report from the LPT Committee in Common and NHFT Committee in Common Chairs provides assurance on the progress of the Group model, strategic priorities, governance framework and other work streams for LPT Trust Board and NHFT Trust Boards in March 2022.

Analysis of the issue

- Work to align The CiC JWG meetings and work flow with Trust Boards is nearing completion.
- The first annual review of strategic priorities and other group work delivery and benefits has been set for May 2022
- Task and finish work to mobilise more joint roles and support Talent Management across the group is underway
- The Group Governance leads have been invited to showcase the LPT-NHFT Group model at this year's NHS Providers conference on governance in May 2022.
- The CiCs considered similarities and areas of alignment between each Trust's organisational strategy, Group strategic priorities and themes within each ICS. Some further exploratory work on potential business case for an over-arching Group strategic framework was supported.

Proposal

- The Highlight report, Appendix A is proposed as a summary of the Group model developments, strategic priorities programme and enabler work-streams.

Decision required

- The Board is asked to approve the Highlight report summary from the LPT Committee in Common and NHFT Committee in Common Chairs as an accurate account of status.

Leicestershire Partnership and Northamptonshire Healthcare Group

Appendix A - LPT-NHFT Committees in Common (CiC) Joint Working Group (JWG) HIGHLIGHT REPORT 10th Jan 2022 and 21st March 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 2. Talent Management 3. Together Against Racism 4. Joint Governance	5. Strategic Financial Leadership 6. Strategic Estates 7. Quality Improvement 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 21st March 2022 meeting of the CiCs discussed open actions as follows: **28 - Group benefits** capture and agreed an end of year review of the Strategic Priorities and other Group work for the May meeting that consolidates benefits and learning. **32 - Reset and synchronisation of CiC JWG meetings with Trust Boards,** and confirmed the new schedule developed should support Executive team wellbeing charter **33 - Creation of Group joint roles register,** and agreed this will be created in parallel to the task and finish work with Hempsons on the Memorandum of Understanding (MoU) and additional clauses in employment collateral. The risk register was reviewed and the overall level of risk considered low, with registered risks being more of	N/A

Report	Assurance level	Committee escalation	ORR Risk Reference
		a missed opportunity basis and not operational risk in nature.	
3.			
4. Group Model a. Governance Assurance Framework	High	The Group Governance leads have been invited to showcase the LPT-NHFT Group model at this year's NHS Providers conference on governance in May 2022. The conference will bring focus to good principles of partnership working between trusts, partnerships and systems. The Strategy and Governance sub group is meeting regularly to future proof and strengthen the Group model. Early benefits of this focused approach have been the refreshed Terms of Reference agreed by each Trust Board in January. Some exploratory work has started on how other Group models interface with their ICS in terms of governance architecture.	N/A
4b.Group Employment model development	Medium	Following the approval of the proposal on joint roles by LPT and NHFT Trust Boards in January 2022, work with HEMPSONs to finalise the MoU agreement in parallel with the updated clauses for Trust recruitment and employment collateral is progressing and CiCs will receive further assurance on this before the next meeting in May 2022. Some minor delay has occurred due to workload / capacity but measures in place to regain pace – hence amber rating	
5. Group Strategic Priorities Programme a. Plans supported for delivery	High	The CiCs received updates, assurance and discussed benefit delivery and learning on the following Strategic Priority plans: Talent Management Leadership and OD Together Against Racism Strategic Financial Leadership Quality Improvement The first annual review of the whole programme of strategic priorities has been agreed and scheduled for the May 2022 CiC meeting.	
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)	High	The Group Strategic Priority Plans are currently RAG rated by the CiCs at the JWG meeting as follows and ratings will be updated following the programme annual review taking place in May 2022: **KPI Target = 100% of plans Green** There are eight strategic priority plans in 2021/22 0% In Development 0	N/A

Report	Assurance level	Committee escalation	ORR Risk Reference
in development (grey)		100% Green 8 0% Amber 0 0% Red 0	
6. Our Other Joint Work	High	The CiC's agreed to incorporate benefit delivery and opportunity analysis on other joint work streams in the Strategic Priorities programme annual review work in Item 5 above.	
7. Strategic Alignment	High	The CiCs received and supported a paper that explored similarities and areas of alignment between each Trust's organisational strategy, Group strategic priorities and themes within each ICS. Some further exploratory work on a business case for an over-arching Group strategic framework was agreed.	N/A

Leicestershire Partnership and Northamptonshire Healthcare Group

LPT Trust Governance Table

For Board and Board Committees:	Trust Board 29.3.22	
Paper sponsored by:	LPT Trust Chair, Cathy Ellis, NHF Trust Chair, Crishni Waring	
Paper authored by:	Amanda Johnston, Strategy and Partnerships Manager	
Date submitted:	21st March 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):	LPT-NHFT CiC JWG 21st March 2022	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Assured	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Next update to Trust Board May 2022	
STEP up to GREAT strategic alignment*:	High **S**tandards	x
	Transformation	x
	Environments	x
	Patient Involvement	
	Well **G**overned	X
	Reaching Out	
	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:	yes	
False and misleading information (FOMI) considerations:	None identified	
Positive confirmation that the content does not risk the safety of patients or the public	None identified	
Equality considerations:	Outcome will apply equally to all staff in LPT	

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Leicestershire Partnership NHS Trust

Trust Board – 29th March 2022

East Midlands Alliance for Mental Health and Learning Difficulties Partnership Agreement

Purpose of the report

- The purpose of this paper is to facilitate the approval of the updated version of the East Midlands Alliance for Mental Health and Learning Disabilities partnership agreement and update the Board on NHS/I developments in respect of NHSE/I Phase 2 of the Collaborative work regarding Perinatal Mental Health Services;

Updated Alliance Partnership Agreement

- The East Midlands Alliance for Mental Health and Learning Disabilities was formed in summer 2019 based on a Memorandum of Understanding agreed by the providers boards.
- There is not currently an approved vision statement for the Alliance, however, members agreed to develop one once the updated Collaborative Agreement has been approved.
- The Alliance members have agreed a set of shared aims, which are to:
    - Establish a more formal collective arrangement to strengthen joint working and support delivery of the NHS Long Term Plan,
    - Share learning across the East Midlands,
    - Undertake the strategic oversight of the Provider Collaboratives
    - To develop a stronger collective East Midlands voice for mental health, learning disability and autism.
- Further to the Common Private Board paper circulated to all participating trust Boards in March 2021 updating on the work of the East Midlands Mental Health and Learning Disabilities Provider Alliance (the Alliance) during 2020/21, NHSE/I announced in autumn 2021 that Phase 2 of the Provider Collaborative work, which includes Perinatal Mental Health Services, should be taken forwards. This is a further opportunity to work towards the Alliance's strategic ambition to improve the health and wellbeing of the local population by working in collaboration. As outlined in the March 2021 paper, it is proposed that Derbyshire Healthcare FT (DHCFT) will be the Lead Provider for the Perinatal Mental Health Services Provider Collaborative and that the Alliance will be the overarching governance mechanism for this collaborative in addition to current provider collaboratives

Proposal

- The Board is asked to consider the draft agreement and to note the NHSE/I developments in relation to Perinatal Mental Health Services

Decision required

- All Provider Boards within the Alliance are asked to approve this agreement for implementation.

Governance table

For Board and Board Committees:	Trust Board 29.3.22	
Paper sponsored by:	David Williams	
Paper authored by:	Amanda Johnston	
Date submitted:	14th March 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 21st December 2021	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Partially	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	One off	
STEP up to GREAT strategic alignment*:	High **S**tandards	x
	Transformation	x
	Environments	x
	Patient Involvement	
	Well **G**overned	x
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	x
	Trust wide Quality Improvement	x
Organisational Risk Register considerations:	List risk number and title of risk	all
Is the decision required consistent with LPT's risk appetite:	Y	
False and misleading information (FOMI) considerations:	NA	
Positive confirmation that the content does not risk the safety of patients or the public	Y	
Equality considerations:	NA	

East Midlands Alliance for Mental Health and Learning Disabilities

Common Board paper

February 2022

Introduction

This common Board paper provides an update to Boards on the work of the East Midlands Alliance for the period October 2021 to February 2022.

CEO meetings

The CEO group has continued to meet on a fortnightly basis sharing current issues and challenges. Giles Tindsley, the NHS England regional Head of Mental Health, will join the CEO meeting on 11 February.

Health Education England funding to support the retention of Clinical Support Workers

The Alliance agreed to receive £752,000 of funding from Health Education England to support the retention of Clinical Support Workers. The Alliance Board agreed to a proposal from the Chief Operating Officer group to focus on four strands of work:

1. Develop a common programme to wrap round training, induction and support to increase retention and establish the Clinical Support Worker role as the first step on a supported career pathway. Engage a partner to develop and deliver a structured induction programme, wrap round support, on-going training, development packages and a support network. The idea is to develop a leading edge programme to be delivered across the Alliance.
2. Develop a competency framework linked to values based recruitment. This initiative is also aimed at improving retention, reducing turnover and increasing effectiveness. The aim is to develop a competency framework that identifies new Clinical Support Workers that will see the role as the starting point on a healthcare career.
3. Some of the funding will be used to support a values based recruitment process for CSWs developed at an East Midlands Alliance level and rolled out across providers.
4. Targeting more men into the Clinical Support Worker roles in mental health settings. Men are significantly under-represented in these roles in some providers in the East Midlands.

The first element of this programme is the lunch of two cohorts of 20 Clinical Support Workers within an externally funded development programme run by Talent for Care and supported by Health Education England.

Northamptonshire Healthcare has agreed to receive and hold this funding for the Alliance.

NHS England funding for the expansion of supervision capacity for psychological therapies

The Alliance agreed to receive £153,000 of funding from NHS England to support innovation in supervision. The Alliance Board agreed to support a proposal from the Chief Operating Officer group to focus the funding on a hub to provide specialist support across the Alliance with a focus on increasing capacity through the part-time return of recently retired clinical staff. St Andrew's Healthcare has developed a proposal to host the Hub. Lincolnshire Partnership agreed to receive and hold the funding for the Alliance.

CAMHS workforce challenges

There have been a series of meetings between Alliance partners to share approaches and agree joint actions to improve the position on CAMHS workforce across the East Midlands. A large action plan has been developed and progressed. The highest priorities in that plan are:

1. Request age profile data from HRDs relating to CAMHS inpatient units to scale the problem.
2. Holding a CAMHS clinical summit led by the Medical Directors on 4 February.
3. Joint review of the Derbyshire CAMHS risk mitigation plans relating to their loss of CAMHS capacity.
4. Developing a proposal to block purchase the commissioning of Higher Education training places for key CAMHS roles.
5. Receive and review a proposal from Lincolnshire Partnership to establish an OSCE Hub for the East Midlands.
6. Meet with HEE to discuss options to bid for their available funding to support CAMHS work.
7. Receive and review a proposal from Derbyshire on rotational roles across the Alliance

An update and review of the joint CAMHS action plan took place at the 25 January Alliance Board.

The Alliance CEO group held a joint session with Alliance Medical Directors to review and address concerns over the use of recruitment premia to move CAMHS consultants between Alliance member providers.

The meeting heard about the risks and challenges in Derbyshire caused by the loss of three of their four CAMHS consultants to Nottinghamshire. It also discussed the broader impact of using recruitment and retention premiums on pay inflation, gazumping between Alliance members and the risks that an unplanned movement in staffing can cause.

The group discussed opportunities to develop shared posts, sharing expertise and region wide rotas. There was also discussion about longer term service redesign to reduce the need for beds. The meeting heard about an example of a new joint CAMHS post which is split between two providers and focuses on both community and inpatient services.

The group discussed the reliance on agency doctors, the opportunity to grow your own doctors and international recruitment. The group also discussed the nature of the CAMHS work and work environments alongside potential actions to make environments safer.

The meeting shared concerns that moving community staff to cover inpatient settings will ultimately drive up demand for inpatient support. The group discussed capping locum rates and agreed to stop the use of RRP.

The following actions were agreed:

- There was agreement to take a common Alliance wide approach.
- The Medical Directors would write to CAMHS consultants acknowledging the challenges and setting out the intent to work together in this space.
- The Alliance CEOs were agreeing not to use RRP.
- The Medical Directors will develop a short, medium and long term plan.
- There would be an immediate focus on mitigating the issues in Derbyshire.
- A summit will co-produce a medium and long term plan.
- The HR Directors will be drawn in.
- Wider engagement with the CQC, Royal Colleges and HEE would form part of the plan.
- Itai will coordinate.
- The Alliance will develop an MOU in relation to CAMHS.
- This group will come back together to review progress.

The summit with CAMHS consultants from across the East Midlands to agree what will change and how the available investment resource to transform CAMHS services might be used took place on 4 February and the CEOs will invite the Medical Directors to meet with them again to review the agreed plan and next steps.

A review of the risk mitigation in Derbyshire took place on 7 February with senior representation from across the Alliance. The meeting heard that Derbyshire have mitigated their immediate clinical staff risks but set out a set of supportive next steps for Alliance partners to support the Trust. The CAMHS Collaborative agreed to further develop a single plan of action on CAMHS workforce.

Eating Disorders workshop

The CEO group agreed to hold a joint eating disorder workshop to hear from the leads of CAMHS and Adult Eating Disorder services on the challenges that they face, to share innovation and consider joint actions. A workshop on 10 December was well attended and opened by Angela Hillery.

The issues and challenges included:

a) Significant increases in referrals, acuity and caseloads
b) Waiting lists for review and treatment
c) Keeping people safe while they wait for treatment – focus of the teams
d) Access to beds outside of the East Midlands collaborative area
e) Workforce supply
f) The transition from CAMHS to Adult services
g) Clarifying ownership of physical health monitoring with Primary Care and commissioners
h) Potential for new targets – RTT
i) Modelling likely demand and capacity as the service expands in Derbyshire to create a comprehensive service

The innovation shared included:

a) New roles – e.g. Advanced Nurse Practitioners
b) Work with Gastro colleagues in acute trusts

c) Peer Mentors, diabetes offer and Gastro clinics (Derbyshire)
d) Close work with Community Mental Health and the PD Hub (Northants)
e) FREED services
f) Group work to meet some of the increased demand
g) Guided self-help guidance
h) Buying in support from Beat to help with service waits
i) Support, training and advice to Primary Care to address anxiety relating to being responsible for people with eating disorders
j) Use of OPEL levels for ED services
k) Closer joint work between Leicestershire and Northamptonshire
l) Intensive Home Treatment model
m) Direct consultation models working with GPs and VCSE (Lincolnshire)

The workshop also considered very significant differences in the services provided in each ICS, the AED Collaborative inpatient bed review and funding offers from NHS England to develop a medical monitoring models for children in crisis and to undertake training to be better able to manage disordered eating referrals.

National visit to the East Midlands Academic Health Science Network

The national NHS England Transformation team are undertaking a series of visits to each Academic Health Science Network. The East Midlands Network invited the Alliance to take a prominent role in their review in November, focusing on mental health and the successful partnership between the AHSN and Alliance. David Williams and Graeme Jones presented alongside Eddie Alder from the AHSN on the development of the Patient Safety network and broader support from the AHSN to the Alliance.

East Midlands Mental Health Patient Safety programme

The development of the joint Alliance and AHSN Mental Health Patient Safety programme was the main topic for the Alliance Board development sessions in October. The plans for the three main strands of the programme have been developed and learning and best practice is being shared across the region and from beyond.

The overall aim of the programme is to improve the safety and outcomes of mental health care by reducing unwarranted variation and providing a high quality healthcare experience for all people across the system by March 2024. The three strands of the programme are:

1. Reducing Self harm and Suicide
2. Reducing Restrictive Practices
3. Improve Sexual Safety in inpatient services

Participation from the six providers has been good and the AHSN are arranging a learning day with regional awards on 14 June 2022 at St Andrew's in Northampton.

An Understanding Safety Culture webinar was held on 31 January to discuss how to introduce a safety culture, to understand an example and how to use Quality Improvement and Human Factor Ergonomics to Improve Safety.

Alliance buddy support to St Andrew's

The Alliance is providing buddy support to St Andrew's as part of their improvement programme. Northamptonshire Healthcare are leading the support programme. The CEOs of St Andrew's and Northamptonshire Health care have met with the national Director for Mental Health, Claire Murdoch, to brief her. An update on the progress of the support programme is presented to each Alliance Board. All Alliance partners have nominated lead Directors and taken the lead role with one of the workstreams.

Provider Collaboratives

Each Alliance Board receives written updates from each Provider Collaborative including successes, progress, risks and issues for escalation. In recent months the Board has noted the strong progress made by the Veteran's collaborative, the workforce challenges in CAMHS and Adult Eating Disorders and the quality and financial challenges being addressed by the Impact Forensic collaborative.

The Alliance Board agreed a letter of support from the CEOs to NHS England supporting the establishment of a Perinatal Provider Collaborative under the leadership of Derbyshire Healthcare. The CEOs also expressed their preference for two collaboratives in the Midlands, to focus on mother and baby units in the first instance and the importance of ICSs and local providers developing and delivering community models that best meet the needs of their local populations.

Alliance Strategy Director forum

The Alliance Strategy Director forum has continued to meet with a focus on the planning, strategic developments, innovation and the links with the NHS England Provider Collaborative programme and the new East Midlands Integrated Commissioning Board. In recent months the Strategy Directors commissioned a CAMHS innovation horizon scan from the AHSN and met with the regional Head of Mental Health to agree the focus and scope for the planning process for 2022/23.

East Midlands Integrated Commissioning Board

Sarah Connery and Ifti Majid have represented the Alliance on the Integrated Commissioning Board. The Integrated Commissioning Board has discussed Perinatal services and had discussed whether future collaboration should have a Midlands wide or a West Midlands/East Midlands footprint.

There had also been some discussions on who will hold contracts in the future and the link to ICSs and local LHLDA alliances. The CEOs asked that the Strategy Director group consider this at their next meeting and produce a proposal for CEO review.

Proposed revised governance arrangements for the Alliance

The Board development sessions in October included a presentation by Kevin Lockyer, Chair at Lincolnshire Partnership and Graeme Jones on the revised and streamlined Collaborative Agreement for the Alliance. The revised version has been to all six Boards for consideration and comment. All six Boards were supportive of the revised document. The main comments were on the need to

ensure that the final version includes specific reference to autism and the need to define the exit notice period. A final version is appended to this Board paper for approval.

Recommendations

Provider Board are asked to:

a) note the updates in the common Board paper including the range of joint work on quality and the success in attracting additional external funding to the East Midlands through the Alliance.

b) approve the updated Collaborative Agreement which has been amended following feedback from all six Boards and is supported by the CEO group.

c) review the appended common Board paper on the Perinatal Provider Collaborative.

Appendices

1. Perinatal Provider Collaborative common Board paper
2. East Midlands Alliance Collaborative Agreement

Common Board Paper

East Midlands Perinatal Mental Health (PMH) Services Provider Collaborative Update

Purpose of Report

The purpose of the report is to update all Boards/Governing Bodies of organisations participating in the perinatal mental health provider collaborative. The paper updates on the current position and reflects discussions held at dedicated sessions of the Midlands Perinatal Mental Health Clinical Network in November and December 2021 and January 2022.

Introduction

Further to the Common Private Board paper circulated to all participating trust Boards in March 2021 updating on the work of the East Midlands Mental Health and Learning Disabilities Provider Alliance (the Alliance) during 2020/21, NHSE/I announced in Autumn 2021 that Phase 2 of the Provider Collaborative work, which includes Perinatal Mental Health Services, should be taken forwards. This is a further opportunity to work towards the Alliance's strategic ambition to improve the health and wellbeing of the local population by working in collaboration.

As outlined in the March 2021 paper, it is proposed that Derbyshire Healthcare FT (DHCFT) will be the Lead Provider for the Perinatal Mental Health Services Provider Collaborative and that the Alliance will be the overarching governance mechanism for this collaborative in addition to current provider collaboratives.

The partners in the Provider Collaborative are:

- Derbyshire Healthcare NHS Foundation Trust (Lead Provider)
- Leicestershire Partnership NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- Northamptonshire Healthcare NHS Foundation Trust
- Nottinghamshire Healthcare NHS Foundation Trust

This partnership, including community perinatal services providers, provides an opportunity to bring together decision making on inpatient services from providers across the whole pathway, and work closely with community teams to connect services and improve quality.

Key principles of the provider collaborative are that it is clinically driven and that input from Experts by Experience are integral to both the planning, development and oversight of delivery of the model.

Developments to date

- DHCFT has been in ongoing dialogue with NHSE/I and a letter of support (23 November 2021) has been written from the Alliance to NHSE/I to reiterate their support for DHCFT to take this role, that the provider collaborative take an East Midlands footprint and the remit be specialist inpatient services.

- DHCFT has undertaken Trust Board level discussion to review Lead Provider risks and confirm commitment to taking on the role. This includes a proposal to use the

Northamptonshire Healthcare Commissioning Hub for commissioning support (as for the provider collaboratives for Adult Eating Disorders Services and CAMHS).

- A national Task and Finish Group on Perinatal Provider Collaboratives presented their findings in November 2021 recommending that provider collaboratives should take a whole pathway approach to perinatal mental health.

- The Midlands Perinatal Mental Health Clinical Network has had three sessions to discuss the development of the provider collaborative – including presentation from the national lead, Becky Gill. This well-established forum has broad clinical and operational involvement from all proposed providers in the collaborative.

- A project group has been established by NHSE/I to oversee the development of the PMH provider collaborative and carry out the Gateway assessment process.

- A proposed timeline for 'go live' has been outlined as July-October 2022. In order to ensure that clinical input and engagement with Experts by Experience is meaningfully driving the clinical model and business case, NHSE/I have been asked to review this timeline and confirm an October 2022 date.

Midlands Perinatal Mental Health Clinical Network

The clinical network met on 11 January and confirmed their support for the following:

- That the provider collaborative should have an East Midlands footprint (ie including two Mother and Baby Units, at Derby and Nottingham)

- The clinical network supported the view that the East Midlands Provider Collaborative should include the responsibility for in-patient services at Mother and Baby Units only, but work closely with community teams in order to connect services and therefore enhance the quality of service user experience.

The network also discussed **clinical ambitions** to drive the collaborative to enhance the experience and outcomes for patients and families. Several initial principles were identified.

That the East Midlands perinatal mental health provider collaborative:

- will not disrupt natural patient flows
- will seek to maximise continuity of care between MBUs and community services (including admissions and discharge processes)
- will ensure equity of service provision across both MBUs
- will work to ensure equity of access (link with epidemiology and demographics to ensure that services are available to those with greatest need)
- will work to reduce unwarranted variations of care
- will develop embedded Expert by Experience engagement in ongoing operation and development of the collaborative

Next Steps

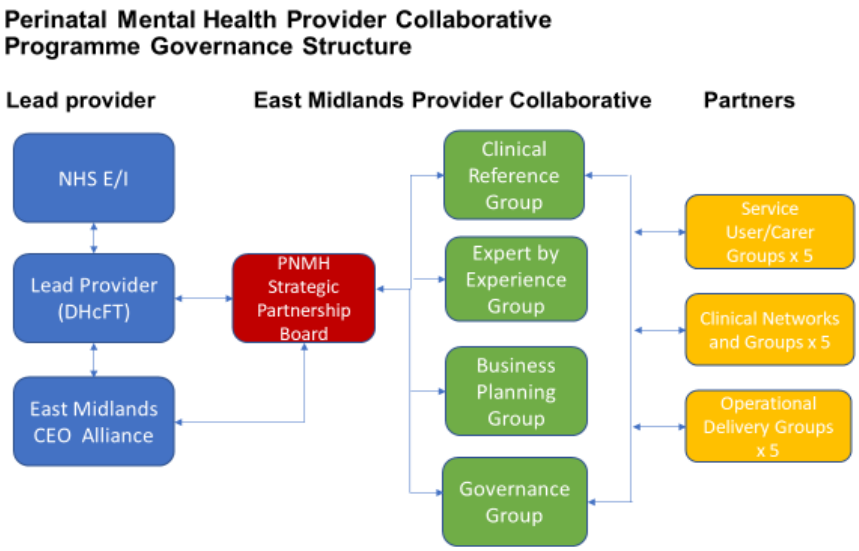
- Initial perinatal mental health provider collaborative planning meeting on 19 January involving Executive Leads from provider trusts and representatives from ICSs to discuss taking forward the governance (see Annex A) and leadership of the collaborative, and to establish meaningful ongoing partnership with commissioner colleagues
- Appointment of Clinical Lead
- Liaison with Clinical Network to establish Clinical Reference Group and Expert by Experience Group to input to the collaborative clinical model and business case and take an ongoing role in the collaborative once operational.

Recommendations

Boards/Governing Bodies are asked to note the update and support appropriate engagement and representation to the proposed provider collaborative governance arrangements.

Annex A

The proposed wider Provider Collaborative governance to support development, planning and engagement to develop an effective business case is as below:



East Midlands Alliance for Mental Health and Learning Disabilities

Collaborative agreement

Version 10

7 February 2022

For approval

1. Background

1.1 The East Midlands Alliance for Mental Health and Learning Disabilities was formed in summer 2019 bringing together the six largest providers of mental health, learning disability and autism services in the East Midlands. The establishment of the Alliance was based on a Memorandum of Understanding agreed by the providers boards.

1.2 The Alliance has made strong progress in areas of joint work including the establishment of four Provider Collaboratives to take on the organisation and commissioning of specialised veterans, forensic, child and adolescent mental health and adult eating disorder services from NHS England.

1.3 As the work programme has expanded and the formal responsibility for specialised services moves across from NHS England to the Alliance, the provider Boards have agreed to establish an Alliance Executive Board based on a new Collaborative Agreement.

2. The Alliance partners

- Derbyshire Healthcare NHS Foundation Trust
- Leicestershire Partnership NHS Trust
- Lincolnshire Partnership NHS Foundation Trust
- Northamptonshire Healthcare NHS Foundation Trust
- Nottinghamshire Healthcare NHS Foundation Trust
- St Andrew's Healthcare

3. Aims and objectives of the East Midlands Alliance

3.1 The Alliance was established in 2019 based on a Memorandum of Understanding approved by the six provider members. The aims in setting up the Alliance were to:

- establish a more formal collective arrangement to strengthen joint working and support delivery of the NHS Long Term Plan,
- to share learning across the East Midlands,
- undertake the strategic oversight of the Provider Collaboratives
- to develop a stronger collective East Midlands voice for mental health, learning disability and autism.

3.2 The establishment of the regional alliance is consistent with the national mental health leadership view that each NHS Trust will be part of a local system provider alliance and a wider regional provider alliance.

3.3 The agreed initial objectives in setting up the Alliance included:

- Working together to improve the quality and effectiveness of mental health, learning disability and autism services in the East Midlands
- Working more collectively to deliver the NHS Long Term Plan across the East Midlands region
- Establishing a more effective voice for mental health, learning disability and autism via an Alliance
- Sharing best practice and effective solutions to common issues
- Thinking and acting more strategically across the East Midlands
- Being consistent with the national policy direction
- Establishing a vehicle through which to take strategic decisions relating to the East Midlands Provider Collaboratives

4. Governance

4.1 The Alliance Board does not seek to establish a new organisation or legal entity. The Alliance Board is established by the Providers, each of which remains a sovereign organisation, to provide a governance framework for the further development of collaborative working between the Providers.

4.2 The Alliance Board will function through engagement and discussion between its members so that each of the Providers makes a decision in respect of each matter considered by the Alliance Board. The decisions of the Alliance Board will, therefore, be the decisions of the individual Providers, the mechanism for which shall be authority delegated by the individual Providers to their representatives (normally their CEO) on the Alliance Board. The Providers will ensure that the Alliance Board members understand the status of the Alliance Board and the limits of the authority delegated to them.

4.3 The Alliance is made up of willing partners and as such, any of the six member organisations can withdraw from the Alliance. This should be done in writing from the CEO and Chair of the organisation to the other Alliance members giving three months' notice. Withdrawal from the East Midlands Provider Collaboratives will be managed in line with the withdrawal procedures, including notice periods and surviving terms, set out in the respective Partnership Agreements.

5. Executive Board

5.1 The Alliance will be overseen by an Executive Board which will be made up of the Chief Executives of the six provider partners. The Board will meet every two months.

5.2 The Alliance Board will oversee the development and implementation of an annual work programme, respond to opportunities and shared challenges through collaborative work, allocate specific tasks to the professional groups and act as the Part B Board for the East Midlands Provider Collaboratives.

5.3 The Alliance Board will receive updates from each of the East Midlands Provider Collaboratives including key risks, issues and strategic decisions. The Alliance Board will act in line with the respective Provider Collaborative agreements which have been approved by the Boards of the Alliance members.

5.4 The Board will be chaired by one of the provider Chairs for a one year term before rotating to another provider Chair.

5.5 Conflicts of interest will be declared at the start of each Alliance Board meeting. Conflicts of interest relating to the pathway specific East Midlands Provider Collaboratives will be managed in line with the relevant approved Partnership Agreement.

5.6 The Alliance Board will agree an annual work programme informed by the Boards of the member organisations.

5.7 The Alliance will hold regular joint Board development sessions to share progress and review issues of common interest to member Boards.

5.8 A common Board paper will be circulated following each Alliance Board to keep provider Boards updated and to set out any decisions for the member Boards.

5.9 The Alliance Board will undertake an annual review of the effectiveness of the governance arrangements and the impact of the Alliance. This review will be carried out with the Chairs of the member organisations.

Signed by

for and on behalf of .....

Derbyshire Healthcare NHS Foundation Trust

Signed by

for and on behalf of .....

Leicestershire Partnership NHS Trust

Signed by

for and on behalf of .....

Lincolnshire Partnership NHS Foundation Trust

Signed by

for and on behalf of .....

Northamptonshire Healthcare NHS Foundation Trust

Signed by

for and on behalf of

.....

Nottinghamshire Healthcare NHS Foundation Trust

Signed by

.....

for and on behalf of

St Andrew's Healthcare

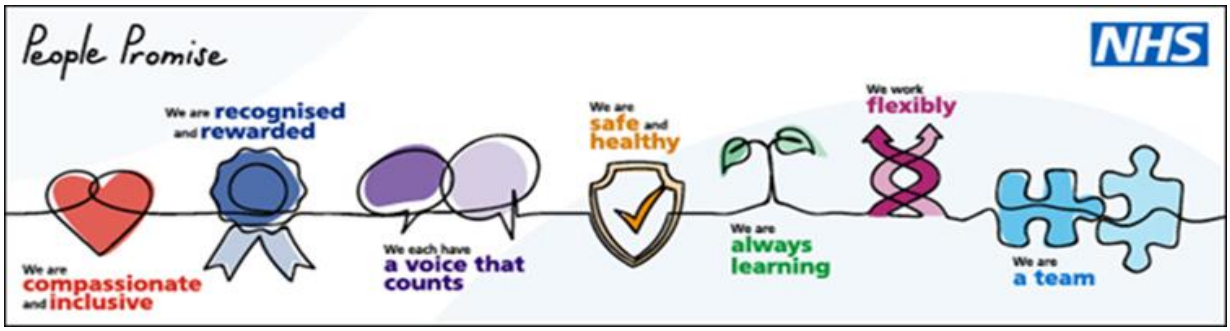
L

Leicestershire Partnership NHS Trust

Trust Board 29th March 2022

People Plan – March 2022 update

This report is being presented to Trust Board members on the progress made against our People Plan to March 2022.



Purpose of the Report

The purpose of this report is to raise awareness of the progress that has been made against the planned actions in our People Plan, under the 4 domains of:

- Looking after our people
- Belonging in the NHS
- New ways of working
- Growing for the future

In addition to the updates on the people plan we are pleased to share that LPT have become a People Promise Exemplar site and we are working with NHS England to bring to life the People Promise with a significant focus being on staff retention. We will shortly be interviewing for 2 x People Promise Managers in the LLR ICS and one of those will be sited within LPT. From April, for a 90-day period, we will commence a review of our data and a retention plan will then be developed, outlining the interventions upon which our organisation will focus over the next 12 months. During the subsequent nine months, focus will be on delivery of this plan with support provided to embed this plan within system governance whilst reporting regularly on progress at agreed timescales to NHS England

This report also provides the Health and Wellbeing Guardian Principles update as an attachment.

March 2022 update

Priority	Milestones Achieved	Future Milestones and plans	Lead person
Looking after our people			
Ensuring diversity across recruitment panels	Diverse panels and numbers monitored through EDI group. Monitoring of diverse panel data reported to EDI Workforce Group 24th November 2021 and every two months thereafter. 65% average of panels currently diverse.	Ongoing communication of the need to improve diversity on interview panels via staff newsletter and team briefings. Data presented through directorate workforce strategy groups. Plans to recruit more BAME colleagues to centralised pool of panel members in place and will be communicated through newsletter, BAME staff network and WhatsApp Group.	HA
Staff Engagement	Record uptake for People Pulse Survey – over 1000 responses Big conversations continue as part of our Road to recovery, reset and rebuild with trust wide engagement. Directorate specific staff surgeries in FYPC.LD and DMH. Staff Q&A sessions regarding VCOD Listening event for BAME staff network NHS Staff survey 52% response rate, in line with national average.	Staff engagement plan drafted following NHS staff survey results. To be presented at Trust Board. Sustainable staff engagement framework being developed. Communications champions are being recruited to improve local staff engagement, and training sessions have begun. Monthly Team Briefs with Angela and Exec Team, plus local directorate specific ongoing staff engagement sessions planned. Road to Reset engagement plan to support staff over the next few months as Government restrictions decrease.	KBa
Staff Recovery & Reset	Blended working principles agreed. Blended working pilot paused due to COVID. Road to Reset and Rebuild project team of reps across LPT set up to identify immediate actions in response to staff feedback.	Pilot restarted for blended working for those previously based in County Hall plus exec team. The postponed Staff Reflection Day scheduled in December for staff to pause, reflect and remember takes place in March 2022 with the support of chaplaincy service. Key areas identified for action by Road to Reset following staff feedback are: • Workload pressures • Estates provision	KBa

		• Connectivity (individual and team) • New ways of working • Health and wellbeing • Transformation and quality improvement	
Health & Wellbeing Offer	Delivery of specific health and wellbeing action plan linked to surge and supporting staff including development of golden ticket. Monitored through ICC. Regular updates of HWB pages on Staffnet to ensure that all national and local offers are shared with staff	New HWB lead to take up role on 1 April 2022. Self assessment to be undertaken against HWB Framework to identify areas for additional focus – links in to People Promise Exemplar Programme. Be Well Midlands Programme to be launched. LPT staff to be encouraged to participate.	
Flexible Working	Flexible working policy in place and requests monitored.	Participating in national People Promise Exemplar programme, part of which will involve a review of flexible working practices. Flexible Working Policy being reviewed in light of NHSE/I best practice guidance.	KBu
Listening Conversations	Compassionate Conversations: Understanding BAME communities run monthly. Senior leadership forums. Staff networks. Big conversations. Exec sponsors in place. DON recently compassionate conversations. BAME staff listening event re VCOD Step up to Great refreshed strategy Big Conversation	Road to Reset check ins and specific sessions on focus areas Staff networks SLF Further planned events to take place and also upon request in Directorates. Inclusive leadership masterclasses with NHFT	HA/ KBu/ KBa
Together Against Racism TAR	Group communications and intentions distributed. Board and Executive pledges confirmed (shared with BAME Support Network for feedback). First group masterclass taken place and well received – John Amaechi. Follow up session also delivered in January 2022. More masterclasses planned, including Cultural Intelligence 12th July.	Executive pledges utilised through conversations and ongoing dialogue with BAME staff support network. TAR meetings. Pledges linked to appraisal Proposal for EDI appraisal objectives for all staff approved at 4th March SEB meeting that will support TAR priorities Review of Zero Tolerance campaign being planned with a specific focus on approach to addressing racism by patients and service users. Exploration of the language of Race and how to raise awareness amongst colleagues on	HA

		the correct use of language underway. Further masterclasses planned for 2022.	
Landmark Scheme	Participating in national retention scheme to support return of NHS leavers who have stepped forward during Covid to the general workforce.	National retention scheme workshops to be scheduled. The retention scheme has morphed in to the People Promise Exemplar Programme that will kick off during Q4.	DN/K Bu
Belonging in the NHS			
Staff Support Groups	Black History Month sessions delivered BAME staff support network working with Executive Directors on TAR pledges. Three Disability History Month sessions delivered. LGBTQ+ History Month joint LPT and NHFT session run in February International Women's Day sessions successfully delivered during week commencing 7th March Review of staff networks underway . Reviewed Gender Pay Gap findings	BAME staff support network to continue working with Executive Directors to develop TAR pledges and establish process for setting up one to one support on the latter (buddy/ ambassador support). MAPLE staff support network to continue working with EDI Team to develop disability equality training with lived experience. Women's network to identify plans following International Women's Day discussions EDI Coordinator in post from 2nd February who is reviewing parity of support currently afforded to each support network and provide recommendations for any further support/ resource required across support networks.	HA
WRES/WDES Action plans	WRES and WDES action plans were reviewed following analysis of 2021 data. 2nd cohort Reverse Mentoring programme is completed and third cohort launched. Diverse panel requirements are actively promoted and proportion of panels that are diverse are going up on a monthly basis. Race Equality and Cultural Intelligence Sets training are ongoing, however attendance numbers have been low throughout 2021, as a result of ongoing pressures. A resource to support talent management and succession planning for BAME staff specifically is being explored. Targeted We Nurture Programme underway with 2nd cohort completed.	3rd cohort of reverse mentoring programme has been launched. Application deadline 15th April 2022. Diverse panel requirement will continue to be communicated and steps taken to increase the number of central pool of BAME recruiters is ongoing. Race Equality and Cultural Intelligence Learning Set will be reviewed and sessions to be organised for post April 2022. Two sessions remain to be delivered in quarter four. System Wide Cultural competency initiative currently being developed that will support delivery of leadership level learning and development in this area. WDES a number of objectives have been developed to drive up declaration rates, access to career opportunities, access audits of estates and facilities and	HA

		awareness raising . Action plans to be aligned to system wide priorities.	
Increase BAME Representation at band 8a+	Career conversations, in addition to those that take place during appraisals (for example career development sessions being held for Nursing and AHP staff, led by Chief Nurse). LPT has a delegate on the Regional Aspiring BAME Nursing and Midwifery Programme (2021 intake). Interview skills training Model employer Target for 2025 is 23.9% band 8a and above in senior positions.	At March 31 the number of BAME staff at bands 8a and above was 13.4% (50). At the end of February 2022 the figure was 14.7%.	HA
Continuing the Our Future Our Way culture, inclusion and leadership programme	Change champions meetings continue to take place on a monthly basis. The first 90-day onboarding toolkit for new starters and managers has been rolled out and also shared with NHFT colleagues. Change champions supporting the embedding of our Leadership Behaviours for all staff.	Review of OFOW taking place along with Change Champions role and that of other champions across the Trust – all to align with SUTG Culture objective. Inclusive Leadership Masterclasses for our Group model taking place and being plan for the next 12 months – 7th April with Michael West on Compassionate Leadership.	FM
Leadership behaviours	You Said We Did comms campaign to promoted leadership behaviours and improvement made. Training compliance reports being shared across Directorates and action plans requested.	OD plan in place to support further staff to complete behaviours training – Divisional approach with support from change champions to gain 85% compliance across the Trust by Summer 2022.	FM
Together against racism	Please refer above to previous Together Against Racism section	Please refer above to previous Together Against Racism section	HA
New ways of working			
Transforming working lives	Meetings have been paused due to COVID. Implementation of blended working pilot paused.	Implementation of blended working County Hall pilot has begun to inform roll out at future sites.	SM
Workforce planning	Agreed a joint approach to planning across activity, finance and workforce ensuring alignment. Quarterly planning review meetings with services to review progress against current plan and upcoming developments for future plan. Continuous cycle of planning. Set of wellbeing early warning indicators and an approach to monitoring recruitment/workforce	First set of planning review meetings held with directorates more to follow. Consider the remit of Strategic workforce committee to become more future and planning focused.	NW

	growth agreed by system workforce planning team.		
New roles development	Appointment of a Practice Development Practitioner for MH Transformation Programme to support the development and embedding of new roles within the programme. Grow our own is the programme of support for the development of our existing workforce. to meet our future knowledge and skills requirements, particularly focusing on two categories: • Roles that impact on the establishment. • Roles that need specific (predetermined) education.	Progress the roles identified in the 6 months staffing review that went to board.	NW/DN/AOD/EW
Grow our own	Exec talent development session taken place in November – learning lessons and next steps discussed. Talent conversations and succession plans undertaken for all those who report into an Exec Director.	Talent mapping for all exec director direct reports to have been completed by Spring 2022, along with succession pipelines to be established.	FM/AOD
Nurse associate centralisation	36 appointed 2 Cohorts due to complete March & June 2022. 2 Cohorts due to complete March & June 2023.	Continue with cohorts.	AOD
Growing for the future			
Enhancing recruitment project	Recruitment deep dive on activity through SWC Programme of recruitment in place.	Review progress through SWC.	DN
Growing our own	Funding to accelerate recruitment, on-boarding and ongoing support for new. HCSWs without prior health or social care experience, in order to significantly reduce established vacancies as close to zero as operationally possible by March 2021. Intense 5 day core Health Care Assistant (HCA) clinical skills training programme. Six courses delivered to date with a total of 60 places available. 28 delegates have attended: 8 delegates new to health care, 14 joining with some prior care experience, 4 existing LPT HCAs and 2 Bank staff. Of those numbers; 24 HCAs have been appointed to community hospital wards,	Continue to recruit and train.	AOD

	one to FYPC&LD Services and one to Mental Health Services.		
Talent management and succession planning	Exec talent development session taken place in November – learning lessons and next steps discussed. Talent conversations and succession plans undertaken for all those who report into an Exec Director. Career progression tools put onto Staffnet for all staff to use.	My Career Talk to be planned with existing staff to share their career journey to support talent and retention. Jobs from NHFT+LPT to be advertised across the group.	FM
International recruitment	Recruitment in progress and 30 candidates appointed and doing well. Long term strategy agreed,	Progress with 5 years strategy for international nursing recruitment.	DN/AD
HCA Vacancy Reduction	Introduced new to health / care training course for staff who were new to the sector to widen recruitment pool	Trust wide programme to in development moving to zero vacancies and over recruitment. Programme managed through transformation committee.	DN/AOD

Assurance approval

Trust board members asked to note progress against actions outlined in the people plan.

Governance table

For Board and Board Committees:	Trust Board 29.3.22	
Paper sponsored by:	Sarah Willis, Director of HR & OD	
Paper authored by:	Fiona McNamee, Head of Organisational Development	
Date submitted:	21/03/22	
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	
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	Progress reports will be provided 6 monthly.	
STEP up to GREAT strategic alignment*:	High **S**tandards	
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	
	Reaching Out	
	Equality, Leadership, Culture	X
	Access to Services	
	Trust Wide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	60 61 73 74
Is the decision required consistent with LPT's risk appetite:	n/a	
False and misleading information (FOMI) considerations:	no	
Positive confirmation that the content does not risk the safety of patients or the public	No Risk	
Equality considerations:	Included	

The NHS workforce Health & Wellbeing Guardian 9 principles – March 2022

The 9 Principles	LPT current actions	Actions in development
1. The health and wellbeing of NHS people will not be compromised by the work they do	• Appraisals currently have a section on HWB within it and health and wellbeing conversations are promoted as integral to the appraisal process. • Staffnet includes HWB resources and signposting to support managers to facilitate a wellbeing conversation and staff to prepare for one. Half hour sessions available for leaders and managers on MS teams to provide additional support.	The Road to Recovery project is reviewing actions for office based and home working staff.
2. The board and guardian will check the wellbeing of any staff member exposed to distressing clinical events	• Immediate support is offered locally and psychological support offered as a follow up. • Following an SI there is a learning event held (Learning lessons exchange group) • Covid Reflection event on 22 March, reflection gardens and rainbow benches now in place	Policy development for debrief of staff to support local arrangements
3. All new NHS staff will receive a wellbeing induction.	• HWB is included in our current induction. • HWB lead delivers HWB presentation to all new staff recruited.	
4. The NHS people will have ready access to self-referral & confidential occupational health	• Occupational health services, Amica, the LLR Mental Health Wellbeing Hub and our self-referral to MSK services are all regularly promoted in both our weekly and monthly HWB communications and in the Trust newsletter. • The LLR Mental Health Wellbeing Hub is available to all NHS and social care staff	

The 9 Principles	LPT current actions	Actions in development
5. Death by suicide of any NHS people will be independently examined	• The Suicide prevention lead for the Trust has shared resources which are now included and discussed in the HWB presentation. These are also shared through the monthly newsletter and on social media. • Suicide prevention section within HWB page on staffnet. • Commitment that suicide of any NHS staff member whilst in employment would be independently reviewed.	
6. The NHS will ensure a supportive, safe environment to promote psychological and physical wellbeing	• LPT has a HWB calendar with a HWB topic each month to support psychological and physical wellbeing. This is also shared though our HWB Champions and HWB communications. • The HWB Guardian writes a message to all LPT staff which is shared via our weekly “Wellbeing Wednesday” email, often features staff stories. • Wellbeing Wednesday lunchtime activity sessions online and recorded for viewing anytime include: Yoga, Pilates and Tai Chi. • HWB has a dedicated, regularly updated page on staffnet. • Regular posts are made to support HWB on social media. • Infection Prevention Control practices embedded and audited across LPT • Input from Health and Safety Team to ensure safe environments. • The programme of upgrading staff rooms to a consistent standard across the trust is almost complete. This gives our staff the opportunity to take a break and relax in a comfortable space.	Use the results of the 2021 staff survey to enhance our HWB offer based on staff feedback. Specifically for staff based in wards, the community and office/home working. Connect LPT staff with the regional “Be Well to Care Well” programme

The 9 Principles	**LPT current actions**	**Actions in development**
7. The NHS will protect the cultural and spiritual needs of its people, ensuring appropriate support is in place for overseas NHS people	• Promotion and celebration of religious festivals takes place with staff. • Signposts to culturally diverse resources eg- Liberate Meditation app, multi-faith prayer rooms • BAME coaching available through NHSE/I and promoted via HWB comms • Overseas nurses recruited and given pastoral care as part of their induction and settling in period • Chaplaincy services are available and visible to staff	
8. Necessary adjustments for the nine groups under the Equality Act 2010 will be made	• Regular promotion and signposting of HWB to our staff support networks for BAME, LGBTQ+, Carers, Young voices, MAPLE (Mental & Physical Life Experience), Womens • Exec sponsorship of each group and HWB Guardian has joined in some of the network sessions and special events. • Reasonable adjustments made to retain staff in employment	
9. The wellbeing guardian will suitably challenge the board	• The HWB Guardian will use the People Plan and 9 principles to hold the Board to account on delivery of agreed actions and provide assurance at the public Board.	

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Leicestershire Partnership NHS Trust

QAC 22nd February 2022

Highlight Report

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

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
Director of Nursing, AHPs & Quality Report – Paper C	NA	IPC guidelines continue to be followed and the flu and covid vaccination programme remains in operation and uptake figures have levelled out. Patient involvement has seen an increase in concerns related to accessing services. The Safeguarding LeadershipTeam are continuing to work on their QI plan. The SI investigators have begun work although timely management of SI investigations remains challenging. A series of Quality Summits have been making good progress in areas of concern. Work has begun on the draft Quality Account and 2022-23 CQUINS have been announced with targets under consideration.	
Medical Director Update – Paper D –	NA	In respect to medical recruitment, locum consultants continue to be needed. Although some are long term, this is not sustainable and does not support a good trainee experience. This has clinical director oversight and escalation routes for concerns are in place. In respect to consultant caseload variation and acuity is having an impact on RCPsych guidelines.	
Director of HR Update – Paper E	NA	The National Staff Survey results are due on 24th February. Training compliance remains a challenge and STAR days are planned to support this. Bank worker training linked to incremental progression has also been introduced. A recruitment and attraction cell has been set up. The VCOD consultation period has now closed, and regulations will be removed following confirmation.	

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
CQC Action Plan Assurance Report – Paper F	High	All actions in the plan are on track with some being completed this week. MHA visits are ongoing, and the immediate learning is being shared daily. The peer review by NHFT has offered both positive feedback and learning and is now incorporated as part of the quality surveillance work. QAC confirmed that good grip on actions remains.	57, 62, 63
Performance Report - Quality and Workforce Measures – Paper G	Medium	The SI process is on an improvement journey but remains a challenge. There is a Quality Summit planned for 11.3.22. Appraisals & supervision improvement plans are in place. The Positive and Safe work continues to monitor and reports on seclusion and restraint. The Pressure ulcer work continues including quality summits and there are 4 workstreams supporting improvement and embedding processes. Workforce capacity is key to sustaining a reduction in incidence.	59, 60, 61, 63, 75
Provider Collaborative Performance – Paper H	High	Quality oversight and assurance functions continue to positively progress across the collaborative. No escalations raised.	57
Safeguarding Quarter 3 Report – Paper I	Medium	Independent support for this team is ongoing including a RAG rating of the work programme detailed in the report. The team now has 4 priority areas – team development and upskilling, effective training, processes and systems supporting specialist and skilled advice for front line staff. There will be a focus on training with an update in the Q4 report.	58, 59, 61
Equality & Quality Impact Assessment Update – Paper J	High	Actions from the internal audit on EQIA process are on track. Policy has been updated and builds in QAC scrutiny. No escalations raised.	57, 61, 75
IPC BAF sign off – Paper K	High	This updated version contains a further 82 KLOEs. The benchmarking is now complete, and an IPC dashboard is being developed. No escalations raised.	78
Census Data Report – Paper L	Low	Challenges with completion of MHA census data continues, with delays in returns due to operational pressures and SystmOne access issues. Mitigating actions are being considered at LEC. QAC received low assurance from the paper due to reporting processes not being satisfactory and required amendments to the presentation of data.	57, 62

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
Ligature Risks Quarter 3 Report – Paper M	High	Policy update and CQC actions in progress. Focus of the work is now on community teams. A task and finish group is looking at non-fixed ligature risks awaiting further guidance from NICE which will inform Self-Harm Reduction Policy.	59, 60, 63
Information Accessibility Standards & Annual EDI Report – Paper N	High	The report provided assurance that LPT remains compliant with its statutory and regulatory equality duties. The paper highlighted key achievements and identified areas for improvement, with work ongoing internally, with NHFT and LLR system wide.	73
Guardian for Safer Working Quarter 3 Report – Paper O	High	The paper detailed exception reports also discussed at the Junior Doctors Forum. No financial penalties and no escalations raised.	60, 61, 74
Safe and Effective Staffing 6 Monthly Review – Paper P	High	Report covers July-December 2021. Collective actions are underway to support nurse to patient ratios. Business continuity and surge escalation plans were enacted in directorates and continue to run. Annual establishment reviews had been paused until August, but data collection is now complete across LPT, and triangulation/validation is in progress by DMTs.	60, 63, 74, 75
ORR – Paper Q	High	There are 11 QAC risks, 6 which are high rated. Discussion around increasing maturity of ORR with tolerance levels acting as trigger for escalation. Agreed risk 62 narrative to be refined to more accurately reflect the issue.	57, 62
Research and Development Quarter 3 Report – Paper R	NA	Deferred due to presenter technical difficulties joining meeting– on next QAC agenda.	
Strategic Workforce Committee Highlight Report – 19th January 2022 – Paper S	High	Mandatory training compliance remains static. Bespoke training for bank staff to enable attendance. QAC asked for more detail around outcomes in future highlight reports.	60, 61, 63, 73, 74, 76
Health and Safety Highlight Report – 13th January 2022 – Paper T	High	All amber areas have actions in place and it was reported from directorates that the operational use and management of alarm devices had improved.	57, 59, 61, 63
Legislative Committee Highlight Report – 24th November	Medium	All agenda items are rated as amber due to assurance gaps and actions on MHA governance. The annual effectiveness committee review planned for March 2022	57, 61, 62

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
2022 – Paper U		will consider this further. LEC escalated the issue of SystmOne as a factor in compliance with MHA census data collection. QAC requested detailed census data to be appended to all future highlight reports.	
Safeguarding Committee Highlight Report – 8th December 2021 – Paper V	Medium	The committee acknowledged improvements in training compliance. Further progress still required in relation to Prevent and other policy developments. A review of the Clawston Park report included a deep dive on 8 LPT patients to consider learning from themes.	57, 58, 59
Quality Forum Highlight Reports – 13th January 2022 & 10th February 2022 – Paper W	Medium	SIs & Pressure ulcers remain at low assurance, discussed in relation to other papers and updated risk on ORR.	58, 59, 60, 63, 75

Chair of Committee:	Moira Ingham

Leicestershire Partnership NHS Trust

N

Trust Board – 29th March 2022

Care Quality Commission Update and Registration

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. An overview of current inspection activities is provided. 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

The continued governance and reporting arrangements for the CQC assurance action plan are detailed below:

- 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.
- The Quality Compliance and Regulation team have built a repository of evidence for each action.
- Progress is 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.
- Once achieved the action moves into the sustainability phase where evidence is provided on a monthly basis to ensure that compliance has been maintained.

Action Plan Summary

1. All actions are progressing with only one remaining must do action to be achieved by the 31st of March 2022.
2. Estates and Facilities work in relation to dormitories remains on track.

CQC Inspection Activity

On the 27th of January 2022 the CQC published its intention to re-start inspection activity from the 1st of February 2022 following the lifting a national covid-19 restrictions.

They will continue to prioritise inspections based on services where there is evidence of risk or harm to patients, and in urgent and emergency care pathways how services across a system are working together throughout the winter and covid-19 pandemic pressures.

Alongside the inspections carried out on risk-based activity, they will also undertake ongoing monitoring of services offering support to providers to ensure that patients receive safe care.

Since this time, Mental Health Act inspections on wards within the Directorate of Mental Health have re-commenced.

CQC Re-inspection

On Monday 28th February 2022 the CQC carried out a re-inspection at the Bradgate Mental Health Unit of 'must do' actions 1 and 11 – dormitories and actions 2 and 14 – call bells. At the time of writing, the re-inspection report is still awaited.

Urgent and Emergency Care Inspection

The trust is participating in a system wide CQC urgent and emergency care inspection which will encompass all services across Leicester, Leicestershire, and Rutland, including primary care. The inspection is expected to take place before mid-April 2022. The CQC findings will provide a system pathway picture and the trust can expect to receive feedback.

Registration

There are no changes to the CQC registration status for services within LPT this month.

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 required actions.

Decision required

Trust Board is asked to note the oversight of the progress against the action plan.

Governance table

For Board and Board Committees:	Public Trust Board 29th March, 2022	
Paper sponsored by:	Anne Scott, Director of Nursing, AHP's and Quality	
Paper authored by:	Jane Gourley Head of Quality, Compliance and Regulation	
Date submitted:	11/03/22	
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 4th March 2022 Operational Executive Board 18th March 2022	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Assured	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Twice monthly reports to Board	
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	Action Closed
MD1 - Page 8, 51 MD 11- Page 9	The trust must ensure it immediately reviews arrangements of dormitory accommodation with a view to eliminating this in line with national guidance. (Regulation 10(1)	Dormitories - Estates	Trust wide (Well Led)	The Trust will eliminate all dormitory accommodation in line with National guidance	Update: -The Trust reviewed its dormitory accommodation reprovision plan immediately post inspection. There is no potential for acceleration of the existing planned timescale. Agreed timeline for the programme of works is to be concluded by 2023. There is a clear governance process in place to ensure the progress of the plan is kept under review at the Estates and Medical Equipment Committee (EMEC) and any risks are escalated through to the Finance and Performance Committee (FPC). Post inspection an action plan was developed and shared with the CQC with further updates sent on the 25/11/21. This plan detailed actions taken to improve the dignity and privacy of patients, improve storage and laundry facilities. The two remaining actions from the Dormitory action plan on implementation of laundry facilities for Aston and Ashby Ward and permanent storage for the Bradgate Mental Health Unit and Willows are aligned to the delivery of the dormitory reprovision accommodation plan.	1. Review of dormitory accommodation reprovision plan to establish if timescales can be brought forward.	Richard Wheeler/Richard Brown	12/08/2021		Estates and Medical Equipment Committee, DMH DMT and Executive Boards.	Closed
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 Wheeler/ Richard Brown	31/01/2022	Closed	Estates and Medical Equipment Committee, Directorate Management Team Meetings and Executive Boards.	Closed
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 carried out by the Ward Sister / Charge Nurse. - Work 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	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards	Closed
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	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards	Closed
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	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards	Closed
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~~ revised date 28/2/22 due to the impact of Omicron Covid	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards	Closed

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	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards	Closed
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	Open
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	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards Quality Forum	Closed
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~~ revised date 28/2/22 due to impact of Omicron Covid	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards	Closed
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	Closed	Acute and PICU Quality and Safety meeting, DMT, Executive Boards	Closed

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	Closed	Acute and PICU Quality and Safety meeting, DMT, Executive Boards	Closed
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 all 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	Closed	Acute and PICU Quality and Safety meeting, DMT, Executive Boards	Closed
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~~ revised date 28/2/22 due to impact of Omicron Covid	Closed	Acute and PICU Quality and Safety meeting, DMT, Executive Boards	Closed
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	Closed	Acute and PICU Quality and Safety meeting, DMT, Executive Boards	Closed
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	Closed	Acute and PICU Operational Management meeting, mental health Directorate Workforce group, DMT, Executive Boards	Closed
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	~~31/01/2022~~ revised deadline 28/2/22 due to impact of Omicron Covid	Closed	Acute and PICU Operational Management meeting, mental health Directorate Workforce group, DMT, Executive Boards	Closed

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	~~31/01/2022~~ revised deadline 28/2/22 due to impact of Omicron Covid	Closed	Acute and PICU Operational Management meeting, mental health Directorate Workforce group, DMT, Executive Boards	Closed
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	~~31/01/2022~~ revised deadline 28/2/22 due to impact of Omicron Covid	Closed	Acute and PICU Operational Management meeting, mental health Directorate Workforce group, DMT, Executive Boards	Closed

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	Closed	Service line weekly meetings, monthly DMT and reporting to Executive Boards	Closed
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	Closed	Service line weekly meetings, monthly DMT and reporting to Executive Boards	Closed
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	Closed		Closed

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Leicestershire Partnership NHS Trust

Public Trust Board – 29 March 2022

Infection Prevention and Control Board Assurance Framework v 1.8, 24 December 2021 – Trust Self-Assessment and Action Plan

Purpose of the report

NHS England and NHS Improvement (NHSE/I) issued an Infection Prevention and Control (IPC) Board Assurance Framework (BAF) to support all healthcare providers to effectively self-assess their compliance with UK Health Security Agency (formally Public Health England, PHE) COVID-19 related IPC guidance and to identify risks as a source of internal assurance to support and maintain quality standards.

The purpose of this report is to provide a summary of the Trust's self-assessment against the updated IPC BAF version 1.8 and Key Lines of Enquiry (KLOE) issued on 24 December 2021 and actions to further strengthen assurance.

Background

The Infection Prevention and Control Board Assurance Framework (BAF) was issued in May 2020 and further updated throughout 2020-2021. The Trust has completed self-assessments against all BAF versions and subsequent updates have been shared through the Trust Board six-monthly IPC reports and with NHS England & Improvement IPC leads and the Care Quality Commission (CQC).

The updated IPC BAF version 1.8 (December 2021) includes an additional eighty-two Key Lines of Enquiry (KLOE), the framework is linked to the IPC Code of Practice.

UKHSA issued Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022 on 24 November 21. This guidance is intended to prevent transmission of seasonal respiratory viral infections focusing on influenza, Covid-19, and respiratory syncytial virus (RSV) in health and care settings while continuing to support the recovery of services.

Letter to all providers received on 30 November 21 from Ruth May and Stephen Powis outlining the main changes to the guidance (applicable to all healthcare settings in England) asking providers to implement the revised measures, subject to local risk assessment as advised in the guidance.

On 30 November 2021, UKHSA issue a technical briefing outlining the new Variant of Concern (VOC) Omicron.

Following benchmarking with UHL, NHFT and through the national IPC shared council network regarding implementation of new guidance it was agreed to pause implementation of the new guidance whilst we awaited further information and guidance regarding the new variant of concern and to continue with the current safe systems of working.

Analysis of the issue

In total there were 102 points for self-assessment. A multi-disciplinary group including, clinicians, IPC team, Health & Safety and Facilities completed a self-assessment (Appendix 1) on 21 February 2022. Of the 82 KLOE there are 12 areas for further action to improve assurance as detailed in the action plan (Appendix 2), in summary;

- Moving from three Covid-19 risk managed pathways to a respiratory seasonal pathway including Covid-19
- Update the employee risk assessment to include other high consequence respiratory illnesses
- IPC dashboard evidencing compliance of all IPC audits at Trust and local level
- Regular and consistent cleaning scores in non-clinical areas
- Evidence of twice daily cleans and deep cleans
- Entrance signage that includes respiratory illness including Covid-19
- Season winter IPC plan
- Patient information

The action plan is to be monitored through the Trust IPC group, updated monthly, and progress shared through IPC reporting to the Trust Quality Forum and regular updates to the CQC.

Proposal

It is proposed that the IPC BAF action plan continues to be monitored through the Trust IPC group, progress against the actions included in the bi-monthly IPC updates to the Quality Forum and six-monthly IPC update to Trust Board.

Decision required

For the Trust board to confirm a level of assurance and agree proposed oversight and governance going forward as detailed above.

(all embedded documents available on request)

Governance table

For Board and Board Committees:	Trust Board 29.3.22	
Paper sponsored by:	Anne Scott, Executive Director of Nursing, AHPs and Quality	
Paper authored by:	Emma Wallis, Interim Deputy Director of Nursing and Quality & Amanda Hemsley, Lead Infection Prevention Control Lead	
Date submitted:	18.03.2022	
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):	Quality Assurance Committee – 22.2.22	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Assured	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Further updates will be provided in the Trust IPC 6 monthly reports	
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	1: High standards The Trust's clinical systems & processes may not consistently deliver harm free care
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:	Access to training Hearing difficulties Learning difficulties	

IPC COVID-19 Board Assurance Framework Version 1.8 – Self-assessment Action Plan V2 15/03/2022

KLOE identified gap in assurance	Action to improve assurance	Action owner	Date	Evidence	Progress	Status
A risk assessment for health and social care staff who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19.	Update the existing risk assessment to include respiratory infections i.e. influenza and RSV	KB & EW	31/03/2022	An updated tool	Task and finish group to be established	
Seasonal infection reporting other than COVID-19	Review national requirement as a Community Mental Health Trust	AH	1/03/2022	Confirmation from UK HSA	Currently waiting for feedback from the consultant lead regarding flu testing for patients	
Dashboard evidencing all IPC audits	Benchmark with other organisations and identify which audits need to go onto the dashboard	AH	31/03/2022	Options appraisal	Currently benchmarking with other Trusts	
Regular and consistent audit scores for cleaning in non-clinical areas	System and process confirmed for auditing and reporting to IPC group	AH, HW, SS & TC	31/03/2022	Non-clinical cleaning audits reported monthly at IPC group meeting	To work through with HW, TC & SS	
Evidence of twice daily cleans	System and process confirmed for auditing and reporting to IPC group	AH, HW, SS & TC	31/03/2022	Assurance reports at IPC group	To work through with HW, TC & SS	

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KLOE identified gap in assurance	Action to improve assurance	Action owner	Date	Evidence	Progress	Status
Evidence of deep cleans	System and process confirmed for auditing and reporting to IPC group	AH, HW, SS & TC	31/03/2022	Assurance reports at IPC group	To work through with HW, TC & SS	
Compliance with regular cleaning regimes is monitored including that of the reusable patient care equipment	System and process confirmed for auditing and reporting to IPC group	AH, HW, SS & TC	31/03/2022	Assurance reports at IPC group	To work through with HW, TC & SS and directorate IPC leads	
Poster for entrances to buildings regarding respiratory symptoms	Production of a poster	VP/AH/EM	~~1/03/2022~~ 4.4.2022	PDF Are you suffering from any respiratory s	Roll out plan to coincide with move to winter plan and pathways	
Triage area at reception for people who attend with respiratory symptoms	Premises assessment	MR/HW/BK/AH	07/03/2022	Meeting held to discuss outpatient facilities. Current triaging in place and letters to ask patients not to attend if they have any respiratory symptoms separate areas not viable		
Respiratory season/winter plan	Develop a plan to move from red/amber/green pathways to a respiratory plan Develop a policy	EW & AH	~~22/02/2022~~ 28/03/2022	Draft proposal/plan	Plan drafted for consultation through CRG, final draft to be submitted on 28/03/22	
Patient information regarding IPC	Review patient information leaflets – review gaps Adapt visitor IPC guide for patients	AK/CK/DG	07/03/2022	Availability of patient leaflet information	Patient leaflets undergoing review in line with trust format	

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KLOE identified gap in assurance	Action to improve assurance	Action owner	Date	Evidence	Progress	Status
Where fit testing for FFP3 masks have failed suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions.	Flowchart for the process of fit testing and what to do in the event of failure Identification of all staff within the directorates who require FFP3 and gaps in fit test	MW/AO'D/CS/AH	April 22	Flowchart Definitive list of staff who require fit test, mask type and alternative options		

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Classification: Official

Publication approval reference: C1501

Infection prevention and control board assurance framework

24 December 2021 Version 1.8

Updates from version 1.6 are highlighted in yellow.

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have further developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with UKHSA Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022 and other related infection prevention and control guidance to identify risks associated with COVID-19 and other seasonal respiratory viral infections The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors, and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, guidance on the required infection prevention and control measures has been published, this has now been updated and refined to reflect the learning from the SARS-CoV-2 and to acknowledge the threat from other respiratory viruses. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users, and staff.

This framework has been developed and updated following updates in the guidance to help providers assess themselves as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors, and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self -employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. Local risk assessments should be based on the measures as prioritised in the hierarchy of controls. In the context of SARs-CoV-2 and other seasonal respiratory viruses, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed, and mitigated effectively.

Infection prevention and control board assurance framework – LPT self-assessment V1 14.1.21

1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility service users and any risks their environment and other users may pose to them				
Key lines of enquiry	**Evidence**	**Documents**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • a respiratory season/winter plan is in place: o that includes point of care testing (POCT) methods for seasonalrespiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services o to enable appropriate segregation of cases depending on thepathogen. o plan for and manage increasing case numbers where they occur. o a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units aspart of the Trusts winter plan. • health and care settings continue to apply COVID-19 secure workplacerequirements as far as practicable, and that any workplace risk(s) are mitigated for everyone. • Organisational /employers risk assessments in the context of managingseasonal respiratory infectious agents are:	Paper/verbal update at OEB on 5.12.21 to outline decision to maintain current IPC pathways, testing and patient placement Clinical Reference Group oversees all clinical decision making processes which then escalates to the ICC Covid secure risk assessments completed for every area. Reviewed and updated with any change to service or after an outbreak. 401 COVID secure risk assessments completed. A spreadsheet includes data sign off and review dates. Every action count risk assessment adopted to risk assess admissions to a Covid-19 outbreak	Revised UKHSA IPC guidance November 2 CRG TOR updated 28012022 (002).docx Local LPT Covid Secure RA - July 2021 A Template - Covid Secure Certificate - M Admission to an area where there is a Covic		Safe systems of working, Red, Amber & Green, POCT for all in-patients, segregation of cases

o based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in thelocal area. o applied in order and include elimination; substitution, engineering,administration and PPE/RPE. o communicated to staff. • safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have beenapproved through local governance procedures, for example Integrated Care Systems.	Clinical Reference Group oversees all clinical and decision-making processes which then escalates to the ICC. Add in system quality meeting Action to review pathways and plans longer term and process for risk assessing			

• if the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems.	LPT follows national guidance. Action cards developed in line with the guidance Every action count risk assessment adopted to risk assess admissions to a Covid-19 outbreak		
• risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents.	Risk assessment sign off includes Lead IPC nurse and DIPaC. Access to specialist Authorised Engineer (AE) or advisors e.g Health & Safety, Ventilation.  C1490_i_EAC risk assessment tools - pri		
• if an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	Risk assessment and sign off through CRG		
• ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.	Admission/Transfer risk assessment and Outbreak Management Policy. Identified Red areas for patients with covid19. Single rooms first option for patient with any infection.  COVID-19 outbreak agenda.docx		
• the Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases	Currently Covid-19 is the only respiratory infection		

	reported to Trust Board		
• there are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.	DoN/Deputy clinical visits undertaken regularly. NED visits currently paused		
• resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	Covid-19 observational tool completed weekly currently on paper includes all staff completed weekly and daily in an outbreak meeting Hand hygiene audits inputted to a Trust App. Monthly reports produced and submitted to IPC group Programme of IPC environmental audits for all inpatient areas  Full IPC Audit - FINAL.docx	Do not have a full IPC dashboard for Trust oversight	Hand hygiene app and monthly reporting Mattress checking audit – AMAT Covid-19 observational audit including, PPE on paper
• the application of IPC practices within this guidance is monitored, e.g.: o hand hygiene. o PPE donning and doffing training. o cleaning and decontamination.	Touch point cleaning As above for audits. Training compliance through uLearn  2 hourly touch point cleaning.xlsx		
• the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.	Updates included in six monthly IPC Board updates		Weekly outbreak meetings Trust oversight and scrutiny of actions, lessons to be learned chaired by

• the Trust Board has oversight of ongoing outbreaks and action plans. • the Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	Daily outbreak summary M-F and nosocomial data reported weekly to the ICC and in the IQPR  Nosocomial Data - 25.01.2022.msg  Outbreak Summary - 25.01.22.pdf Aggregated review to Trust Board  Aggregated COVID-19 Outbreak R		exec DoN/DIPaC

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Key lines of enquiry	Evidence	Gaps in assurance	Mitigating actions
Systems and processes are in place to ensure that: • the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.	Plan identified as part of the 6 monthly IPC trust board update. Revised plan  NSoHC board paper HW update 2022 01 2 Working group to identify	Changes to functional use of space are requested via the Strategic Property Group or via capital bids. There is a process to agree any changes needed to ensure the space is compliant with IPC and H&S via the capital design procedures/sign off. LPT property manager attends both meetings and can capture any requests that have not	Revised programme submitted – confident that the plan can be brought back on track as the plan had 4 weeks contingency built in to meet the NSoHC start date of May 2022. Cleaning standards are audited in line with existing NCS 2007 frequencies. 12 month rolling programme of audits attached.

• the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms • cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a cleanenvironment. • increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas. • Where patients with respiratory infections are cared for : cleaning and decontamination are carried out with neutral detergent or a combined	any changes to functionality of areas/ rooms.  Agreed SPG TOR Oct 2020 v2.docx  Accommodation-and -Space-Policy-exp-De Cleaning increased to two full cleans and a third check clean with increased incidents/outbreaks.  UHL 2022 audit schedule.xlsx  NHS PS cleaning audit scores.xlsx Touch point cleaning in place 2 hourly  2 hourly touch point cleaning.xlsx The action for an alternative to chlorine-based solutions has not been undertaken. UHL facilities team are now looking this urgently, will agree with IPC any options, obtain the COSHH sheets and update the	been through an approval process from IPC.	Cleaning in all inpatient facilities increased to x2 cleans per day and a third clean in outbreak areas. Two hourly high touchpoint cleaning is undertaken daily in all in-patient facilities (recorded via clinical teams) and additional high touchpoint cleaning is undertaken in circulation spaces via the facilities team (not recorded) and SOPs exist within admin areas for desk and high touch point cleaning by the users (not recorded).

solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. • if an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses. • manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products. • a minimum of twice daily cleaning of: o patient isolation rooms. o cohort areas. o Donning & doffing areas o 'Frequently touched' surfaces eg, door/toilet handles, patient call bells, over bed tables and bed rails. o where there may be higher environmental contamination rates, including: ▪ toilets/commodes particularly if patients have diarrhoea	cleaning manuals with processes. Cleaning in all inpatient facilities increased to x2 cleans per day and a third clean in outbreak areas. Two hourly high touchpoint cleaning is undertaken daily in all in-patient facilities and recorded by the clinical team and additional high touchpoint cleaning is undertaken in circulation spaces via the facilities team (not recorded) and SOPs exist within admin areas for desk and high touch point cleaning by the users (not recorded).	Part of the SOP/cleaning manual – Facilities Manager for UHL to provide the evidence for UHL – Facilities Coordinator NHS PS to provide the evidence for NHS PS. COSHH data sheets are kept in all cleaners' cupboards. Copy of cleaning manual and SOPs are held locally in cleaners' cupboards.	

A terminal/deep clean of inpatient rooms is carried out: o following resolutions of symptoms and removal of precautions. o when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens); o following an AGP **if room vacated** (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room). • reusable non-invasive care equipment is decontaminated: o between each use. o after blood and/or body fluid contamination o at regular predefined intervals as part of an equipment cleaning protocol o before inspection, servicing, or repair equipment. • Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment. • As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities. • the assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the	The implementation of the Rapid Response team allows for responding to deep cleans following isolated outbreak areas. Curtain changes form part of the SOP for deep clean of infected areas. Cleaning-and-Decontamination-Policy.pdf Cleaning-and-decontamination-of-the-env Cleaning-of-workstation-May-2021-Final1. (The above policy and action cards are being updated) Environmental audit? Cleaning audits – 12-month scores attached UHL rolling 12 month audit scores.xls At installation stage, mechanical systems perform at a rate to meet compliance with guidance of that time.		

organisations, authorised engineer. • a systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways • where possible air is diluted by natural ventilation by opening windows and doors where appropriate • where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group. • when considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place.	In recognition of new guidance the Ventilation Safety Group has requested the AE (V) to reinspect existing mechanical systems for the purposes of auditing performance. COVID risk assessments identify ventilation means including mechanical and natural (opening windows) and activity. Outbreak actions/environmental actions – wards/clinical activity SOPs implemented for the use of fans. Review other alternatives with AE(V) – action for VSG All screens installed are designed to have air flow above and at desk height. Cleaning is undertaken as BAU		

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and process are in place to ensure that: • arrangements for antimicrobial stewardship are maintained • previous antimicrobial history is considered • the use of antimicrobials is managed and monitored: o to reduce inappropriate prescribing. o to ensure patients with infections are treated promptly with correct antibiotic. • mandatory reporting requirements are adhered to, and boards continue to maintain oversight. • risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	Lead pharmacist for antimicrobial stewardship. Trust Policy to detail strategy and KPIs Prescribing protocols to make formulary adherence easier to achieve. Antimicrobial stock lists reviewed based on needs of each ward. Pharmacy check for each inpatient prescription Annual inpatient audit taking place around November. This has recently moved to bi-annual (November and April). This checks that rationale and choice is appropriate. Inpatient consumption data collated and analysed quarterly to pick up anomalies Adherence to formulary/guidelines checked by way of all the above interventions ensures antibiotics which are restricted or have tendency to cause other		

	complications are used very carefully (e.g. cephalosporin and macrolides). 6 monthly updates to IPC group and included in the 6 monthly IPC update to Trust Board 6 monthly updates to IPC group and included in the 6 monthly IPC update to Trust Board		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors • national guidance on visiting patients in a care setting is implemented . • restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment. • there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing.	 604-Guide-to-safer-visiting-2.pdf  Standard-Operating-Guidance Inpatier Included on outbreak meetings on agenda and decisions recorded in outbreak meetings  COVID-19 outbreak agenda.docx  23 December 2021 inpatient face mask pc		

• if visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.	Risk included in the screening within the SOP		

• visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible. • visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment eg, carer/parent/guardian. • Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been adopted C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Included in the SOP Included in the SOP Elements that have been incorporated Creating-covid-secure-environments-acros BBE-poster-including-admin-staff-every-ac Back-to-Basic-Update-29.11.21.pdf IPC-donning-and-doffing.pdf IPC-Testing.pdf IPC-safe-breaks.pdf IPC-car-sharing.pdf		

	IPC-facemasks-2.pdf 50183_NHS_IPC_Staff_A4_Poster_Simi.pdf		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival. • infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred. • staff are aware of agreed template for screening questions to ask. • screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment.	NEW-PPE-Door-sign.pdf Communicated for Covid-19 further work around other high consequence respiratory infections Are you suffering from any respiratory s Signed off Covid 19 Questionnaire_17.12.2 Screening on admission and thereafter Triage and screening on SystmOne – as above		

• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance. • triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible. • there is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved.	Routine testing in place for patients no process or system for collating evidence of compliance  LPT Inpatient Wards swabbing following le	Increased cases are being identified through routine testing	

• patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated. • patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result. • patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing. • patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare eg, priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered.	 Action-card-Surgical-Masks-for-Patient-Us Admission pathways, IPC policies and source isolation This has been impacted by number of single rooms for source isolating within LPT  Management-of-a-Patient-Requiring-Sourc  MRSA Policy.docx This has been impacted by number of single rooms for source isolating within LPT		Patients are assessed on admission and as part of the screening process for an inpatient for wearing of face masks. Documented in patient electronic notes

• where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes. • face masks/coverings are worn by staff and patients in all health and care facilities. • where infectious respiratory patients are cared for physical distancing remains at 2 metres distance. • patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff. • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly. • isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative. • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	Mandatory for staff. Patients – see action above. Spot check audits will be carried out. Standard practice All areas have had a COVID secure risk assessment Current pathways in place to support		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
• appropriate infection prevention education is provided for staff, patients, and visitors. • training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely.	Level 1 and level 2 IPC mandatory training. Donning and Doffing training mandatory, refreshers during outbreaks. FFP3 training system in place.  604-Guide-to-safer-visiting.pdf		

• all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it; • • adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk. • gloves are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's. • the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance. • staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace • staff understand the requirements for uniform laundering where this is not provided for onsite. • all staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance. • to monitor compliance and reporting for asymptomatic staff testing • there is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).	 Final-Action-card-for -External-Professional Trust Donning and Doffing e-Learning module  Covid-19 observational audit to  Management-of-Shar ps-and-Exposure-to-B To review 1 metre HR advisory reporting  Return-from-isolatio n-SOP-v4-Jan-2022-f Nosocomial review weekly, surveillance testing and outbreak management  Management-and-Re porting-of-Covid-19-i  Scoping template for reporting hospital out		

• positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	 Outbreak form.xlsx  Increased incidence pack V4.odt Outbreak policy and triggers working as evidenced through outbreak reporting and management		
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**

Systems and processes are in place to ensure: • that clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs. • separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients. • patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals. • patients are appropriately placed ie, infectious patients in isolation or cohorts. • ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements). • standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result • the principles of SICPs and TBPs continued to be applied when caring for the deceased	Patient mask use spot check audits completed – gaps identified (see action plan)  IPC spot check report - v1 210122.docx Included in the COVID secure risk assessment Review of respiratory pathway and move away from RAG pathways Currently source isolated in single rooms, Red Wards are cohorted. Health & Safety review of bed spacing  3 Bed Ward - 2 metre distance April  5 Bed Ward space layout.pdf  4 Bed Ward - 2 metre distance April Patient pathways and placement Care of the deceased policy and action card		

	LPT-Inpatient-Care-of -the-Deceased-Suspe Care-of-the-Decease d-Policy-exp-Oct-22.p		
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals. • patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance;	LPT Inpatient Wards swabbing following le LPT-Inpatient-Wards-Units-swabbing-on-ac All admissions, 3. 5. 7. 13 and weekly	Service level agreement with microbiology	

• staff testing protocols are in place	Twice weekly asymptomatic screening	
• there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available.	N/A	
• there is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data).	N/A	
• screening for other potential infections takes place.	Screening in place with associated policies	
• that all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission.	 Action-Card-swabbing-V6-09.06.20.docx	
• that those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise.	(Action card being updated)	
• that all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission.		
• that sites with high nosocomial rates should consider testing COVID-19 negative patients daily.	Yes routine swabbing	
• that those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge.	Part of outbreak management	
• those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance	 Access-to-Nursing-Homes-and-other-com	
• there is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patients whoare fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.	See action card above Every patient undergoing ECT is required to have a weekly negative PCR test and this is in place immediately prior to commencing ECT so that it ensures one weeks cover.	

	Any positive results are asked to put on hold ECT until current self-isolation period is complete and then they return to weekly PCR tests.		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that • the application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors). • staff are supported in adhering to all IPC policies, including those for other alert organisms. • safe spaces for staff break areas/changing facilities are provided. • robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak. • all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance. • PPE stock is appropriately stored and accessible to staff who require it.	GAP in terms of an IPC dashboard Hand hygiene audits – app Mattress – AMAT Covid-19 observational – paper audit This is included in the COVID secure risk assessment and consideration given to COVID outbreak areas for a changing and welfare facility on the ward	Hand hygiene APP and data Paper audit of Covid-19 observational tool – goes live on AMAT 1 March 2022 Mattress checking audit on AMAT	
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating actions**
Systems and processes are in place to ensure that: • staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy. • bank, agency, and locum staff follow the same deployment advice as permanent staff. • staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-	UHL service level agreement Local induction and training		

isolate (see Staff isolation: approach following updated government guidance) • staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE. • a fit testing programme is in place for those who may need to wear respiratory protection. • where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: o lead on the implementation of systems to monitor for illness andabsence. • facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce • lead on the implementation of systems to monitor staff illness, absenceand vaccination against seasonal influenza and COVID-19 • encourage staff vaccine uptake. • staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance. • a risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19. o A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups; o that advice is available to all health and social care staff, including specific advice to those at risk from complications. o Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. o A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff. • vaccination and testing policies are in place as advised by occupational health/public health. • staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained and held centrally/ESR records. • staff who carry out fit test training are trained and competent to do so. • all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is	Return-from-isolation-risk-assessment-sta Level 1, 2 and Donning & Doffing L & D programme Staff referral to OH Employee Risk assessment to be updated to include respiratory infections Yes		

used. • all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks • a record of the fit test and result is given to and kept by the trainee and centrally within the organisation. • those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respiratorsand hoods. • that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions. • members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. • a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health. • boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board. • consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance. • health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone. • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing. • staff who test positive have adequate information and support to aid their recovery and return to work.	Need to strengthen process for suitable alternatives, sign off and governance		Currently staff are referred to IPC and discussion with line manager to order alternative equipment for example hoods for staff in ECT

P

Leicestershire Partnership NHS Trust

Trust Board – 29th March 2022

Patient and Carer Experience and Involvement (PCEI) Quarterly Report (including Complaints) Quarter 3, 2021/22

Purpose of the report

- To provide an overview and update of the various aspects of the Patient Experience and Involvement team's work.
- To provide an overview and update on the complaint's activity for quarter 3.
- To provide assurance to the Trust Board.

Analysis of the issue

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

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

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

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

Complaints and Patient Advice and Liaison Service [PALS]

Overview

During discussions at the July 2021 Complaints Review Group, it was proposed that the Trust move towards a reduction in the timeframe for investigation of formal complaints from 45 working days to 25 working days, the timeframe pre-Covid-19, by the end of quarter 4 2021/2022. A trajectory of reducing complaint investigation timescales with a quarterly reduction back to 25 working days by the end of quarter 4. At Q3 the investigation timeframe was reduced to 35 working days however, due to the discovery of the Omicron variant and the increased pressures on the services pre-Christmas with staffing levels and sickness, the investigation timeframe was again increased to 45 working days from 22 December 2021. It was subsequently identified that there is no regulation

which requires the Trust to have a 25-working day investigation timeframe and most other local agencies have a similar, if not longer timeframe for investigation. The timeframe for a complaint investigation will be discussed once again when the Trust returns to a pre-Covid-19 status.

In Q3, the Trust formally registered 66 complaints, which is an increase of 3 from the previous quarter and further increase on the 54 registered in Q1. Although the number of complaints received has increased, no complainants got back in touch following the final response on their concerns, to raise outstanding concerns. This has resulted in no complaints being re-opened in Q3 which is the first time this year that this has been achieved. This reduction can be explained by the continuous collaborative work between services and the Corporate Complaints Team. Regular reviews on each case, considering and determining whether a further formal investigation will change the outcome. Furthermore, several meetings between complainants and the services have been organised to ensure that the investigation and outcome could be explained and discussed in a less formal environment.

Q3 again saw a significant increase in District Nursing complaints, however, as was the case in Q2, the team have worked closely with the directorate, bringing back the weekly governance meetings, which provide a place where information can be shared, and any future trends or concerns can be discussed, and a plan put in place before it has time to escalate. The Complaints Manager has also linked in with the Patient Safety Team, where a District Nursing case is being discussed to ensure all parties are present for the decision to be made regarding the route of investigation.

November and December 2021 saw the introduction of the Omicron variant and resulted in a call from the government to attempt to vaccinate as many people as possible before Christmas. In direct correlation to this, the Trust saw an upsurge in contacts made regarding the School Immunisation Service and the cancellation or rescheduling of flu vaccinations in Primary and Secondary schools around Leicester, Leicestershire, and Rutland. As had been the case in Q2, the issue was identified early and based on the established relationships between the service and the team, a plan of action was swiftly agreed. This allowed the issues to be raised, investigated, and responded to in an efficient and effective manner, with only two cases being escalated through to the formal process.

As we moved into Q4 the team continue to work closely with the directorates, having open, honest, and productive conversations with members of staff. We have seen a shift towards a more collaborative way of working between the services and the corporate teams, which has enabled us to react more quickly to increases in contact and resolve matters informally, where possible in the first instance. Whilst there was a slight increase in the registration of formal complaints in Q3 in comparison to Q2, it will remain to be seen, whether the continuing changing attitudes of the public towards the NHS, as the outside world moves back to “normality”, has a continued impact on the number of complaints logged.

Complaints Activity Data – October 2021 – December 2021

Key Performance Indicator	Q3 21/22	Q2 21/22
% Of complaints acknowledged within three working days	97%	92%
% Of complaints responded to within the date agreed with the complainant	97%	97%
Number of complaints upheld or partly upheld in quarter	29	21
Number of reopened complaints	0	7

Number of complaints formally investigated by the PHSO	0	0
Number of complaints upheld or partly upheld by the PHSO	0	0

The number of PALS contacts received in Q3 totalled 443 (including signposting), this is a 9% increase on the numbers received in Q2 and 45% increase to those received in Q1. There was an increase of 8% (n=45) in the number of concerns and enquiries received compared to Q2, including 6 enquiries received by the CQC on behalf of patients. There was again a high number of contacts received by the Service that related to either UHL or NHS England (GP contacts) amounting to 4% of all contacts received. Despite corrections being made on NHS Choices in Q2, the ongoing number of contacts has necessitated an approach to colleagues within UHL to try to address, this will be progressed in Q4.

Themes from complaints, concerns, and compliments

Q3 shows a clear trend in terms of the number of concerns and enquiries received by the Trust in relation to accessing services (including appointments and delays in treatment) which constitutes 35% of all contacts received. Communication between professionals and patients, carers and families remain a key theme with 22% of all contacts relating to communications followed by 21% in relation to care needs not being adequately met. The deep dive into complaints relating to communications has been delayed in Q3 due to staff capacity and this will be undertaken in Q4 with the results being reported to the Complaints Review Group for further consideration. It will be proposed that a review of all complaints and concerns categories be reviewed in 2022-23 to allow for more accurate reporting.

The Directorate of Mental Health received a total of 119 complaints, concerns, comments and which is like the number received in Q2. The key themes of concerns and complaints for the directorate are in line with those across the Trust with access to services (including appointments and delays in treatment) making up 20% of all contacts received, 22% relating to communication with patients, carers, or families and 16% relating to patient care. Adult Community Mental Health Teams continued to see the highest number of issues with 51 contacts which is in line with the last two quarters. This data has been triangulated with the results from the 2021 Community Mental Health Survey and has been shared with service leads to help them identify any areas for action. The Community Mental Health Survey Report for 2021 will be going to the Directorate Management in February, delayed due to the recent wave of the Omicron variant, where improvements and actions will be discussed.

Community Health Services Directorate received 74 concerns and complaints which is an increase of 33% compared from Q2. As set out earlier in this report District Nursing continues to receive a high number of concerns, 36% of all concerns and complaints received by the service are in relation to access (including appointments and delays in treatment) and patient care with 19% of concerns and complaints sighting areas for concern in relation to failing to provide adequate care. This patient experience information has been included in the recent Quality Summit held in early November by the Directorate to look at the concerns within the District Nursing Service. A follow up summit is taking place in February 2022. For the directorate the trends for concerns and complaints are in line with those of the Trust and the Directorate of Mental Health with 34% relating to access (including appointments and delays in treatment); communication with patients, carers, and families 18% and patient care 24%.

For Families, Children, Young People and Learning Disabilities the total number of concerns received was 83 which is a 22% increase to those received in Q2 (65). CAMHS Services, including the Eating

Disorder Team have seen most of the concerns for the directorate with 26 concerns and complaints equating to 31% of all contacts for the directorate. As with the Trust and other two service directorates, key themes for both CAMHS and wider services within the directorate relate to access (including appointments and delays in treatment) 47%, communications 13% and patient care 16%. However, it should be noted that concern and complaints relating to access to services (including appointments and delays in treatment) was higher for Families, Young People and Children and Learning Disabilities than other directorates. Drilling down the data shows that School Aged Immunisations Team, having also received a high number of concerns, can be attributed to the reduction in services offered by the Team as they support the ongoing vaccination programme in response to the Covid 19 pandemic. As set out previously in this report the issue was identified early, and a plan of action was swiftly agreed. This allowed the issues to be raised, investigated, and responded to in an efficient and effective manner, with only two cases being escalated through to the formal process.

13 concerns were received were in relation to Quality and Professional Practice and Corporate Services. Of these 13contacts, 4 related to access; 4 communications; and the remaining 5 in relation to Trust policies and administrative processes.

4 MP enquiries were received in the quarter.
6 CQC enquiries were received in the quarter.

Activity data – 1 October 2021 to 31 December 2021

	PALS concerns (excld signposting)	Complaints	Compliments
Number	223	66	138
Top 3 Themes	• Communications • Access to services • Patient Care	• Patient Care • Communications • Access to services	• Staff Attitude • Care & Treatment • End of Life Care

Good news story

No reopened complaints were received in the quarter. This reduction demonstrates the continuous collaborative work between the service and the Corporate Complaints Team to review each case on their own merits and determine whether a further formal investigation will change the outcome. Furthermore, several meetings between complainants and the services have been organised to ensure that the investigation and outcome could be explained and discussed in a less formal environment.

Keys areas of concern

Risks	Mitigations
Numbers of in appropriate contacts into both PALS and Complaints Service that are not related to LPT Services. Impact on patient experience in being passed around services.	• Request to meet with lead for Complaints and PALS within the Trust to agree how to mitigate

Assurance

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

Friends and Family Test

Overview

In Q3 the Trust received 5846 individual responses to the FFT question which equated to a response rate of 7% which is an increase of 1% from Q2. Of these responses 82% (Q1 78%) reported a positive experience of care and a 10% (Q2 12%) response rate recording negative or poor experience of care. The full breakdown of date received in Q3 is available in Appendix 1.

Breakdown of responses received:

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

Method of collection	Rating Received	Response Rate
Electronic tablet / kiosk at point of discharge	252	0.029%
Individual Voice Message	667	00.76%
Online Survey Once Patient is home	266	00.30%
Paper Survey	19	00.02%
SMS/Text	4642	05.27%
Total	5846	06.63%

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

Method of collection	Rating Received	Response Rate
Electronic tablet / kiosk at point of Discharge	206	00.23%
Individual Voice Message	396	00.45%
Online Survey Once Patient is home	39	00.04%
Paper Survey	201	00.23%
SMS/Text	3726	0.4.23%
Total	4568	0.5.18%

During the Quarter the Team ran a drop-in masterclass sessions focusing on 'working with patients and carers for improvement'. Due to the ongoing challenges on staff capacity in response to the ongoing pandemic the session was recorded to enable those who could not attend to listen when they had capacity to do so. The recording of the session can be found here: https://youtu.be/egd3PLwdTws. There are some useful tips and hints on how to involve patients and carers in any quality improvements.

Due to the ongoing capacity demands on staff responding to the pandemic, planned developments for Q3 were not achieved. These are currently being reviewed and will be discussed with directorates through the Patient and Carer Experience Group.

Key Areas of concern

Risks	Mitigations
Ongoing connection issues on wards are preventing some services from using iPads to collect their FFT data	• Working with LHIS on options for connectivity. Working closely with those services and wards affected to adopt different collection approaches in the interim

Good news story

On 7 December the presentation for the competition winner of the Friends and Family Test board took place. Sim Chopra, ward clerk at Mill Lodge, created the display board. Grant, one of our service users on the judging panel, presented the Unit with £100 of vouchers and a certificate signed by Anne Scott, executive director of nursing, AHP's and quality.

The vouchers will go towards activities planned for Christmas. Well done again Mill Lodge and many thanks to Grant for taking time to present the voucher and certificate.

Assurance

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

Patient and Carer Involvement

Patient and Carer Involvement in Quality Improvement
The Patient Experience and Involvement team have been working with the Lived Experience Quality Improvement volunteer to co-create an introduction to quality improvement session, which includes:

- Understanding what quality improvement is
- We Improve Q; LPT's QI strategy
- QI approach - Plan, Do, Study, Act (PDSA)
- LPT's involvement approach
- How service users and carers are matched to projects
- Roles in projects

A group of 8 service users and carers with lived experience have now come together as a community of practice to start looking at developing skills around quality improvement and to work more collaboratively with QI projects across the trust from a lived perspective.

Complaint's satisfaction survey review
A person with lived experience of the complaints process is working collaboratively with the Patient Experience and Involvement team to review the current complaints satisfaction survey and to develop a new one. Work has commenced reviewing the survey along with current processes. We are also inviting people with experience of accessing PALS and/or complaints to get further involved with creating a new survey which aims to capture experience of those accessing the complaints

process and to share the experiences with a view for further Quality Improvements across PALS and Complaints.

Involvement those with Lived Experience in Trust recruitment
Over 20 patients, service users and carers, including members from Youth Advisory Board, have now received training in recruitment to enable them to get involved in staff recruitment. This includes the development of values- based questions which can be used in interviews where we have not been able to involve patients, service users and/or carers directly. During Q3 several recruitments have taken place with patients, service users and carers taking part in panels, these include Mental Health Practitioner roles, Quality Improvement Clinical Lead, Complex Trauma Pathway Lead and Peer Support Workers.

Recovery and Collaborative Care Planning Cafes
Cafes continue to take place via MS teams with a regular group of around 15 service users, carers, and staff, we are also starting to see new staff members attend the cafes. We have worked with café attendees to plan for the 2022 programme of cafes, theming them around topic areas and inviting guest speakers. These sessions are being created with patient, service users and carer leaders and they are also leading on these sessions. Some of the upcoming cafes include a focus on collaborative care planning, the care coordination policy, and LGBTQ+ with guest speakers from Trade Sexual health and Victim first.

A member of staff from the café planning team and a patient leader presented at two national Patient Experience Network (PEN) events to share learning from the collaborative approach to the cafes as a result of being runner up for the category of 'Strengthening the Foundations' at the PEN Awards 2021.

Developing a Lived Experience Framework
A small group of people with lived experience and working alongside an external ex Patient Director to develop a Lived Experience Framework. The framework will bring together three key components of lived experience including the People's Council: developing Patient Partners and scoping the role of a Patient Director. Work will include the creation of a discussion paper which will be shared with directorate leads during quarter 4 to facilitate further discussions on the roles of lived experience within directorates at both the strategic and operational level through roles such as patient partners. Feedback from these discussions will then be pulled together in a draft framework for further discussion and agreement with senior leaders on aspects of the framework for implementation in 2022/23.

Involvement in Community Health Services

Community Health Services (CHS) patient leader
CHS has recruited its first patient leader who has been working collaboratively with the Cardi-Respiratory team on the award-winning quality improvement project improving access and uptake of digital technology to support the care of adults with long term conditions in the Cardi-Respiratory services.

The patient leader is now working on a collaborative project with LPT and UHL developing a new integrated asthma pathway. They are also attending various training and development and would like to offer peer support to other service users, as well as offer peer led education session

Involvement in Adult Mental Health

Mental Health Central Access Point Service user/carer group
This group has reconnected after a few months of no meetings and discussed next steps. The group intends to extend the area of focus to also cover mental health urgent care services, with a view to

also expand the members of the group and to meet on a bi-monthly basis moving forward. The team are aligning workplans with those of the mental health step up to great transformation plans to firm up an offer to those expressed a wish to get further involved as a result of attending consultation events.

Developing mental health patient, family, and carer facilitators
A small group of people with lived experience of inpatient mental health services came together with the Patient Experience and Involvement Team to input into the creation a role description for a Patient, Family and Carer Facilitator. The role who be placed within a ward team. The proposed role would be a point of contact for service users, families, and carers whilst on the ward, facilitating communications, supporting both service users, their families, and carers through provision of advice, signposting to support and capturing experience and feedback. The draft role description, which has been based on the current Patient and Care Facilitator role within the Agnes Unit, which was identified as outstanding practice by the CQC, will be shared with the Head of Nursing for Mental Health Services for consideration.

Personal safety planning
This group of service users and carers continue to work on the personal safety planning work with the Trust lead, Ann Jackson. Work has now began creating a draft of personal safety planning principles and guidance, along with a letter of hope. The group are also working alongside the communications team to help create content and ensure patient/carer voice is included in a new staff webpage focusing on support and resources to enable staff.

Involvement in Families, Children and Young People and Learning Disabilities

CAMHS

The LGBT centre led training sessions for staff has been completed all those that attended have received relevant resources and information shared during the sessions. CAMHS staff have received a report sharing the survey feedback gained from participants attending the sessions. The training was positively received from most staff, with 31/34 who completed the survey saying they would recommend the training to colleagues.

The Governance team have supported CAMHS staff cultural awareness surveys for clinical and non-clinical staff, these were developed by psychologists Andy Bracket and Alison Smith as part of the CAMHS BAME steering group. The survey has been extended into January 2022 to ensure further staff engagement and increase uptake. Training has been offered to staff based on YP feedback and experiences with their gender and identify when accessing CAMHS services. To improve the experience of YP across the LGBTQ community when accessing services

A programme of 8 sessions with Rob Gee have been undertaken at the Beacon on Tuesday evenings. The interactive creative sessions have involved both staff and young people taking part in group poems, short story telling and other group work word games. Feedback is being received via a short 4 question paper survey and collected at each session to form the evaluation of the 8-week intervention. Feedback from staff and YP so far is 100% positive, YP have engaged well with the sessions and are reluctant for the sessions to finish in January.

0-19 Healthy Together

Information gathering for Rutland Healthwatch is underway as they propose to be focusing on project to understand family's experiences of maternity and health visiting (6 months post birth) for a project starting in 2022.

Impact and engagement below shared from the Move it Boom campaign this year, which saw the biggest rise in the engagement of this programme since starting.

Learning Disabilities - Agnes Unit

The Phoenix Charity visited the Agnes with George the Reindeer and Chester the Dog over the festive period and patients enjoyed the visit along with turkey and stuffing cobs, hot chocolates, non-alcoholic mulled wine, and mince pies.

The Unit now have new user-friendly signage up, which supports patients and families to navigate the building.

Every patient is having a review of their timetables which includes evening and weekend activities for them to support their needs and preferences in engaging with meaningful activities

Learning Disabilities - Community Update

One of the nursing team is undertaking research into discharge from the service. Easy read information has been developed to gather feedback directly from people with learning disabilities about how they feel about discharge and leaving services.

Adult Eating Disorders Service

- Inpatients have been actively involved in the training for staff on Langley Ward
- Inpatients have been on the interview panels for new Langley Ward staff during November & December 2021
- Outpatients were involved in the development of a 'virtual' group which will offer psychoeducation on eating disorders for patients on the waiting list for therapy
- A clinical psychology student is conducting a qualitative research study within LAEDS: 'A service evaluation exploring the experience of adults from a South Asian background within an eating disorders service'

Good news story

The Learning Disability Service were able to secure Charitable funds to buy Christmas boxes for the Talk and listen group members to thank them for being involved and codesigning virtually all this year. The service recognise that it has been extremely difficult all year to involve and engage on-line but are grateful for the support and patience.

Key areas of concern

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

Assurance

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

The People's Council

During the quarter the People's Council have been undertaking a review as they come to their first year of establishment.

The independent review, included a review of the activity of the Council over the last year, interviews with members of the Council and a review of the Terms of Reference. The review recommended that:

- Expending the membership of The People's Council to provide a wider viewpoint of LPT services
- Consider moving to face to face meetings to ensure better interaction with members
- Improve the impact of the Council
- Reform the Council to:
    - Speed up decision making
    - Provide more welfare support to members of the Council

These recommendations are now being considered by the Council and will be discussed in February 2022.

LPT Youth Advisory Board (YAB)

YAB continue to meet virtually, each week on MS TEAMS. The group celebrated Christmas with a virtual quiz hosted by Peer support worker Leanne during the last meeting of the year.

YAB members, their families, LPT staff and the local community including LCFC successfully supported the 2021 YAB Christmas Campaign.

Over 60 shoe box parcels were put together for Children and Young People (CYP) aged 13+ which included self-care items, sensory gifts, Christmas treats, and scarfs donated by LCFC. These were given out at clinicians/staff discretion to young people accessing CAMHS services across LLR. All young people at the Beacon, and those supported by YPT CAMHS were the majority of those to receive boxes.

During December the YAB met with colleagues from the CCG to discuss their ideas and suggestions for promoting the help and support available for young people across schools and colleges, the group met the new CCG commissioner and shared discussions around future involvement for the group next year.

The YAB met with the 0-19 Healthy Together service group manager and school nursing lead to help support the service understand how young people feel the school nursing service should be promoted and communicated to them. The group supported helpful discussion and gave ideas to the service, the team have agreed to meet with YAB on a rolling 3 monthly basis to ensure that feedback, actions and improvements are being achieved based on feedback and to create a partnership relationship to all improvement work.

Bez Martin who has been supporting the YAB from the LA has left her role and working for the Local Authority during the quarter. Two Youth Workers from the City Council will be supporting meetings until further notice.

The group supported a session with the CAMHS Eating Disorder team to shape service evaluation and feedback forms that young people who access the service are asked to complete following treatment. The group offered an insightful young peopl view to this and have created the survey to become more user friendly. The group will be reviewing the feedback in 3-4 months time with the service to understand what YP are sharing around their experiences.

The group have started to plan a mystery shop of online MH support, this will begin with scoping the accessibility of "online offers" and feature specific mystery shopping of the "Kooth" service available to young people.

Good News Story

YAB were pleased to be shared and see the below covid vaccination video that they supported co-designing with the digital engagement team at the end of last year. An example of their co-production in action!
https://www.healthforteens.co.uk/health/coronavirus/covid-19-vaccination-information/

Assurance

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

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

The Group met in October and December during Q3.

Following the concerns raised by Mark Burleigh, Chaplain in respect of the Gideon Bibles, it was agreed by the group that a targeted piece of work needs to be undertaken in the form of an audit/review around religious and faith materials and spaces available through the Trust estate. Further work will include agreement of questions for the audit, identification on who can support doing this work e.g., volunteers and timescales. This will be picked up in Q4

EDI Groups have now been established in the Directorate of Mental Health and Community Health Services.

Work has commenced within Community Health Services with the creation of a dashboard, which outlines protected characteristics, against services and localities. The directorate are looking at establishing EDI ambassadors within services. There is also research being undertaken in relation to End of Life which will be reported backed to the group once completed.

In the Directorate of Mental Health working groups have been established to focus on:

1. Supporting staff, including career progression
2. Equality data, EIAs
3. Coproduction and codesign of services to meet diverse patient needs
4. Maximising access to service and sharing good practice

Key areas of focus for the directorate groups will be to align to organisational priorities. These will be set out in the new EDI Strategy.

In December the group received a presentation by CAMHS staff, Dr Andrew Brackett, Clinical Psychologist and CPN Nyasha Mupfukudzwa on the work of the CAMHS BAME Strategy Group. The group is a group led by 14 CAMHS clinicians and admin staff with support from FYPC LD Governance lead. The group was pulled together by Parvinder Baines who works within the Primary Mental Health Team in June 2020 following the tragic killing of George Floyd. The group meet monthly and feed in to the CAMHS Improvement meeting, which is led by Jeanette Bowlay-Williams.

The overall goal is to support and implement the anti-racism strategy within CAMHS and to make it an equitable and meaningful service for the diverse population of Leicestershire. The structure of racism, the systems, social forces, institution, ideology, and processes that interact with one another to generate and reinforce inequalities among racial ethnic groups. Ongoing challenges of the group are changing membership, dynamics of new people coming in, time between meetings to get the work done, time to process if talking about emotive topics.

Data for the group is set up and led by Allison Smith who is working with data analysts, to make it meaningful and used to inform service provision. Allison is also leading on the staff experience side, upskilling, training and engagement, shared folders for teams, and pooling resources.

The project is based on the IAPT BAME Positive Practice Guide. The project is trying to understand the cultural responsiveness of CAMHS. To design systems to reflect and accommodate differences and then engage in an ongoing process of reflection. Three overarching aims are:

- Highlight areas for improvement.
- Provide recommendations to the CAMHS service.
- Have a baseline of how we're doing to be able to measure against in future years about progress, and whether we're heading in the right direction.

The strands around the project are:

- Understanding our existing data and gaps in data.
- 2.Understanding staff experience, there's a staff survey asking about experiences of and confidence with talking about racial, ethnic, and cultural difference.
- Conducting team lead interviews within CAMHS to understand their perceptions of experiences with and confidence around issues of racial, ethnic, cultural diversity.

The group will report back on its work in early 2022 so this can be shared across each directorate.

Proposal

- The Trust Board is asked to be assured of the work of the Patient Experience and Involvement Team.

- All risks and mitigations have been set out within **key concerns.**

Decision required

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

Governance table

For Board and Board Committees:	Trust Board 29.3.22	
Paper sponsored by:	Anne Scott, Director of Nursing, AHPs and Quality	
Paper authored by:	Alison Kirk, Head of Patient Experience, and Involvement	
Date submitted:	8 February 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):	Quality Forum, 10th February 2022	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	Assured	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning		
STEP up to GREAT strategic alignment*:	High **S**tandards	X
	Transformation	X
	Environments	
	Patient Involvement	X
	Well **G**overned	X
	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:		
False and misleading information (FOMI) considerations:		
Positive confirmation that the content does not risk the safety of patients or the public		
Equality considerations:		

Appendix 1 – Quarter 3 Complaints Breakdown

Complaints Activity for Q3 – 1 October – 31 December 2021

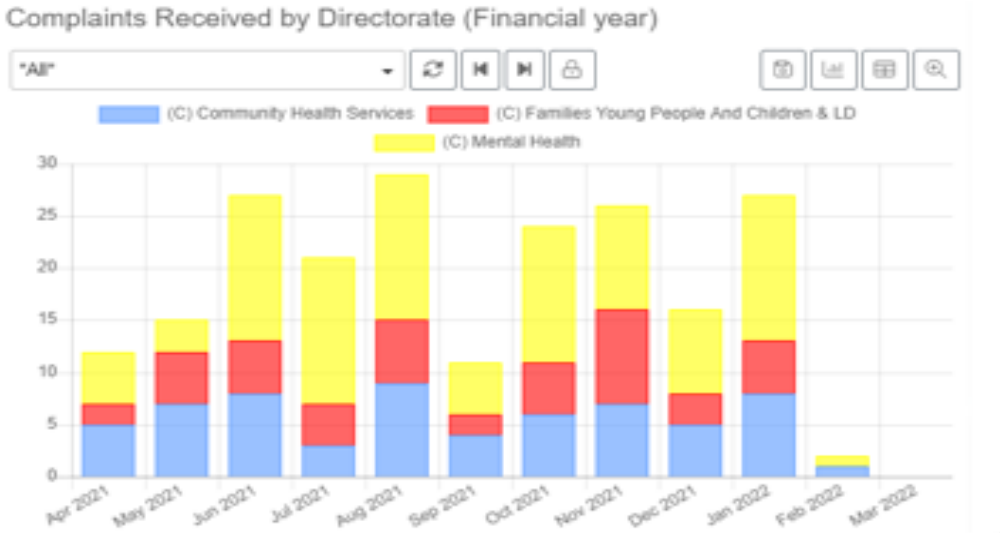
	Q1	Q2	Oct 2021	Nov 2021	Dec 2021	Total Q3	Total 21/22
Mental Health Service	22	34	13	10	7	30	86
Community Health Services	20	16	6	7	5	18	54
Families, Young People and Children & LD	12	13	5	9	4	18	43
Total Received	**54**	**63**	**24**	**26**	**16**	**66**	**183**
Complaints vs Patient Activity (Complaints Rate as a %)*	0.05	0.05	0.03	0.04	0.02	0.04	0.04
% of complaints acknowledged within three working days	94	92	100	81	94	97	94
Number of complaints responded to within the date agreed with the complainant****	13	31	12	15	3	30	74
Number of complaints responded to in 45 working days	13	31	11	10	2	23	67
Number of complaints responded to in a date agreed with the complainant	3	0	0	0	0	3	3
Number under investigation at the end of the Quarter	38	30	1	1	11	13	81
% of complaints responded to within the date agreed with the complainant ****	100	97	96	96	100	97	96
Number of complaints upheld or partly upheld in quarter	7	28	12	16	1	29	64
Number of complaints ongoing after 3 months**	3	2	0	0	0	0	5
Number of complaints ongoing after 6 months***	0	0	0	0	0	0	0
Number of reopened complaints	12	7	0	0	0	0	19
Number of complaints formally investigated by the PHSO	0	0	0	0	0	0	0
Number of complaints upheld or partly upheld by the PHSO	0	0	0	0	0	0	0

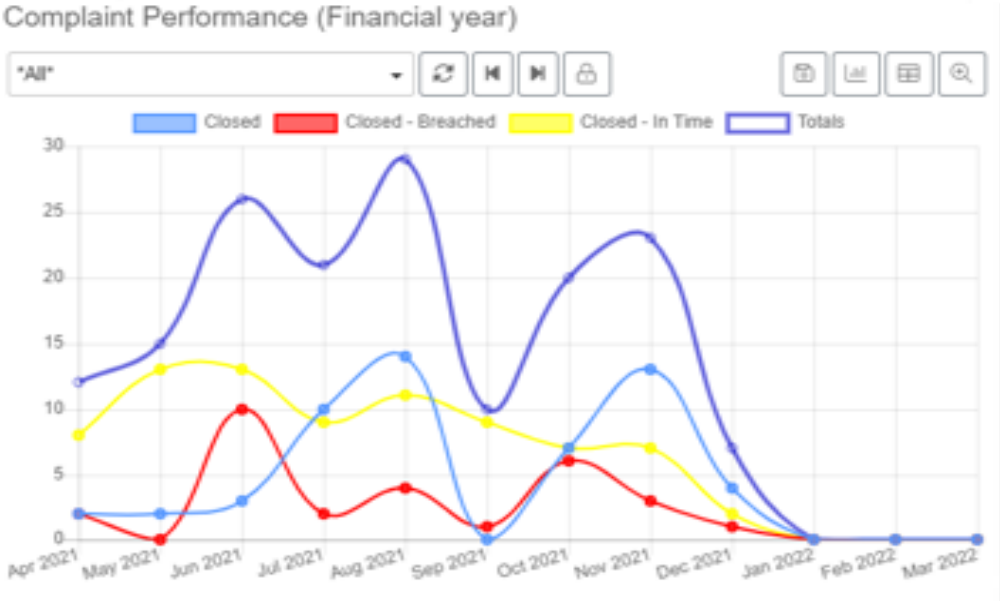
Patients attended and seen

*Complaints ongoing after 3 months at the end of Q3.

**Complaints ongoing after 6 months at the end of Q3. These do not include those complaints included in the ongoing after 3 months section.

***Position statement as responses still under investigation.

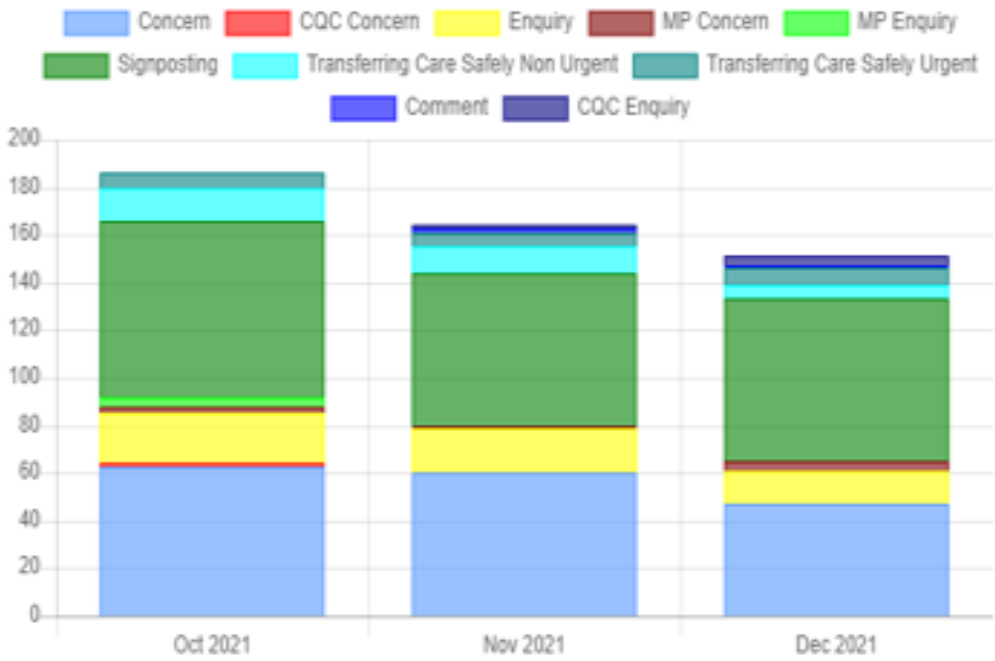




Complaints and PALS received by Service area:

		Complaints	Concerns
Directorate of Adult Mental Health	ADHD Service		3
	CMHT's City	8	13
	CMHT's County	9	18
	Crisis Resolution Team	1	4
	Central Access Point		9
	Arts in Health		1
	Inpatient Wards	7	27
	Neuro Psychology		1
	Medical Psychology		1
	Francis Dixon Lodge		2
	Perinatal Mental Health		3
	Memory Service West	1	1
	Recovery College		1
	Peer		3
	MH Liaison Team	1	
	MH Practitioner	1	
	Urgent Care	1	
	MHSOP CMHT County	1	2
Community Health Services	District Nursing – City	2	24
	District Nursing – County	2	7
	District Nursing – Wards	5	2
	Community Therapies		4
	Integrated Specialist Palliative Care	2	
	SPA	2	
	Advanced Nurse Practitioner		1
	MSK Physiotherapy	1	4
	Continence		2
	Podiatry		3
	SALT		1
	Inpatient Wards	4	8
Families, Children and Young People and Learning Disabilities	CAMHS – City	2	4
	CAMHS Crisis		1
	CAMHS – Eating Disorders		4
	CAMHS – County	4	11
	Children's Health		1
	Diana Service		1
	FYPC Area 1		1
	FYPC Area 3		2
	FYPC Area 6		1
	Healthy Together Administration		1
	Health Improvement Service	1	
	Nutrition and Dietetics		5
	FYPC Blaby		2
	FYPC Paediatrics		1
	FYPC Hinckley and Bosworth		1
	LD Administration		1
	LD Access Team	1	
	LD Forensics		1
	LD Physiotherapy		1
	Mental Health Support Team		1
	Eating Disorders Outpatients	1	2
	Specialist Autism Services	1	2
	School Immunisations	8	10
	Paediatric Medical Services	2	6
	Neurodevelopmental Team		2
	SALT – Children's	2	3
Corporate Services	Covid Vaccination Loughborough		4
	Estates Facilities Management		3
	PALS		4
	Patient Safety		2

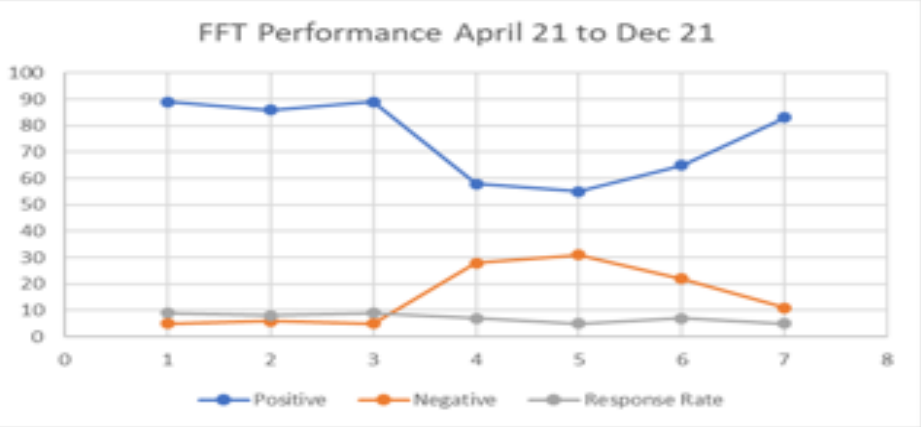
Breakdown of PALS Contacts by Contact Type



FFT Responses – October to December 2021

7%
Response Rate

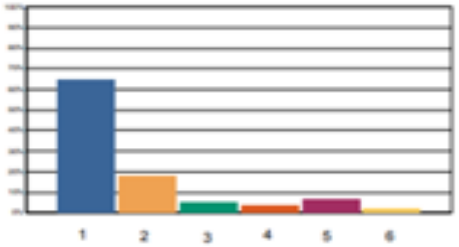
Positive: 82.07%
Negative: 10.21%
Ratings



All Departments

Star Rating	Positive	Negative
★★★★☆	82.07%	10.21%

Overall Scores



Response Option	Responses	Percentage
1 - Very good	3,756	64.25%
2 - Good	1,042	17.82%
3 - Neither good nor poor	322	5.51%
4 - Poor	211	3.61%
5 - Very poor	386	6.60%
6 - Don't know	129	2.21%

Top 10 Words

Positive		Negative	
1. Good	756	1. Time	115
2. Service	439	2. Help	108
3. Helpful	373	3. Appointment	104
4. Staff	338	4. Call	88
5. Time	255	5. Waiting	86
6. Friendly	236	6. Phone	85
7. Care	232	7. Service	72
8. Excellent	215	8. Feel	66
9. Professional	200	9. Poor	59
10. Received	185	10. Care	58

Top 10 Themes

Positive		Negative	
1. Staff attitude	1791	1. Staff attitude	330
2. Implementation of care	1194	2. Implementation of care	287
3. Environment	802	3. Environment	273
4. Communication	650	4. Communication	260
5. Patient Mood/Feeling	548	5. Patient Mood/Feeling	188
6. Clinical Treatment	392	6. Waiting time	165
7. Waiting time	246	7. Clinical Treatment	157
8. Admission	218	8. Admission	102
9. Staffing levels	78	9. Staffing levels	37
10. Catering	33	10. Catering	19

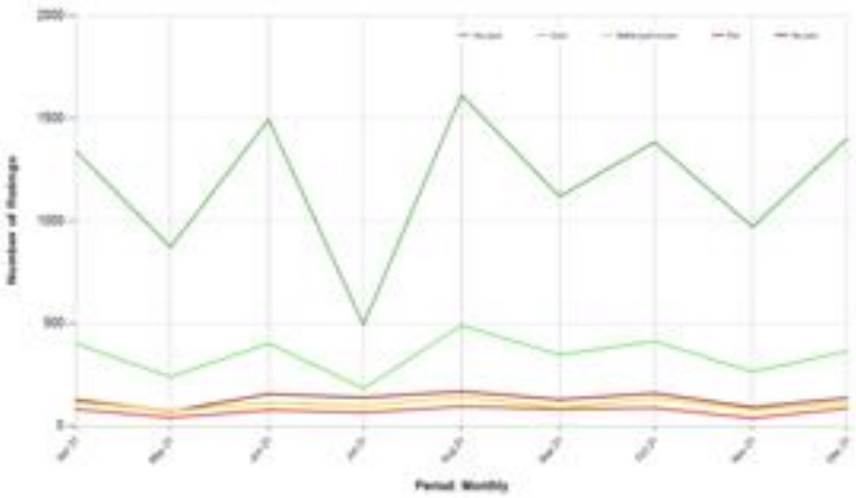
Breakdown

No Gender Breakdown Available

Eligible Patients	Response Rate
88143	6.6%

Total Responses
5846

Rating Trend – Year to date



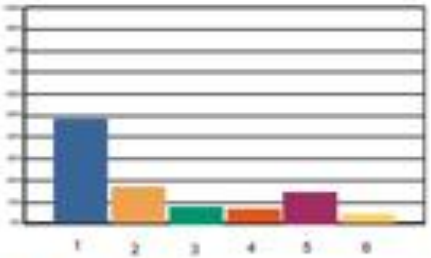
Very good
Good
Neither good nor poor
Poor
Very poor

Directorate of Mental Health Service Report

Adult Mental Health and Learning Disability

Positive	Negative
65.36%	22.31%

Overall Scores



Breakdown

No Gender Breakdown Available

Eligible Patients	Response Rate
24204	5.0%

Total Responses
1201

Community Health Services Service Report

Service

Community Health Services(8877)

Star Rating

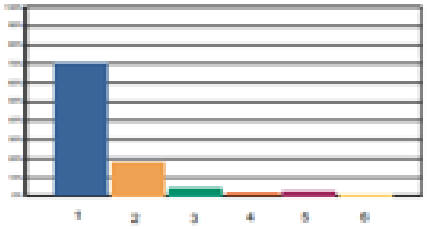
Positive

88.74%

Negative

5.34%

Overall Scores



Response Option	Responses	Percentage
1 - Very good	2,711	70.32%
2 - Good	710	18.42%
3 - Neither good nor poor	175	4.54%
4 - Poor	85	2.20%
5 - Very poor	121	3.14%
6 - Don't know	53	1.37%

Breakdown

No Gender Breakdown Available

Eligible Patients

43657

Response Rate

8.8%

Total Responses

3855

Families, Children and Young People and Learning Disability Service Report

Service

Families, Young Peoples and Childrens Services

Star Rating

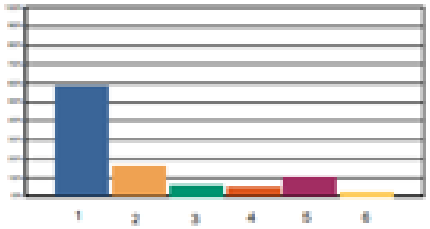
Positive

74.55%

Negative

15.81%

Overall Scores



Response Option	Responses	Percentage
1 - Very good	454	58.35%
2 - Good	126	16.20%
3 - Neither good nor poor	50	6.43%
4 - Poor	40	5.14%
5 - Very poor	83	10.67%
6 - Don't know	25	3.21%

Breakdown

No Gender Breakdown Available

Eligible Patients

20277

Response Rate

3.8%

Total Responses

778

Compliments Received October – December 2021

Compliments by Directorate	
Directorate of Mental Health	24
Community Health Services	85
Families, Young People, Children's & Learning Disabilities	28

Compliment by theme	
Staff Attitude	30
Care and Treatment	36
Customer Service	4
End of Life Care	23
Communications	7
Access to Services	10
Other	28

Compliments received during the quarter

""I cannot fault the therapy I have received and I am so grateful to L for guiding me. She really made me feel empowered to make change and each session we had made me feel that we were exploring options together, rather than being told what to do. Staff member listened and tailored my therapy perfectly and I have her to thank for being so much better so quickly and without having to put life on hold."

"They seemed like they really wanted to help. It made me feel good. Like there are some people out there who really do care."

"Our experience with the Agnes Unit was very good. The communication was brilliant and everything that was said would be done, was. All of the team members worked together so well. I always felt comfortable to call or visit the unit, everyone made time for us as a family. It was absolutely brilliant, I couldn't fault it, we are so grateful for all that everyone has done."

Q

Leicestershire Partnership NHS Trust

Trust Board 29th March 2022

Report title

Patient Safety Incident and Serious Incident Learning Assurance Report for Trust Board March 2022

Purpose of the report

This document is presented to the Trust Board bi-monthly for January and February 2022 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

We continue 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 staff within 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 continues to be significant challenges in relation to allocation of investigations and completion of both serious incident and internal investigation; this is reflected in our compliance with NHS framework timescales of Serious Incident (SI) investigations which continues to be really challenging with almost all reports not compliant with the 60 working day deadline for submission to the CCG/other commissioners to a varying degree.

We continue to see reallocations of investigations due significant staffing challenges; such as unplanned sickness/absence, increasing workloads. This is resulting in an increasing requirement to support and further train staff in order that operational teams can juggling all necessary investigations e.g complaints and human resources. Delays are occurring within directorates around agreement with 'recommendations into actions' causing significant further delays in the completion of draft report for sharing with commissioners and patients/families.

The national picture around patient safety incident investigation progress in conjunction with the patient safety strategy is unchanged due to the continuing impact of Covid19 with planned changes through the patient safety investigation framework. The CPST key message has been 'keep families and patients informed throughout investigations and any delays in investigations and include them meaningfully in the investigation'; this is recognised as needing 'sustained improvement' in all directorates. We are actively promoting sharing of the report at point of sharing with CCG as a 'final draft' to ensure they have right to reply earlier on. The Directorates are continuing to work hard to

improve this. Additional scrutiny from the Executive 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.

The 8 Corporate investigators are all now in post and undertaking investigations, some very complex and this is starting to have a positive impact on Directorates requirement to investigate.

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

As previously reported the CPST continue to describe incident reporting should 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.

Work related to 'open incident backlogs' linked to CQC request for improvement and request for daily data, has impacted on incident reporting to the national reporting and learning system (NRLS), although plans are in place to rectify. Unfortunately, the transition to a new improved national 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 continues to be interrupted by the Covid19 pandemic.

We have a robust 'safety net' system in place to regularly review 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. Where possible, weekly review of all incidents via a triage report however the directorates need to be managing their incidents from review to closure within the allocate 15 days; training of key staff has been delivered over eight separate sessions as part of CQC request to action along with updating senior frontline clinical staff in relation to culture of candour.

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 March 2022 to consider further actions required to manage incidents, investigations and the actions/learning from them.

Review of Patient Safety Related Incidents

The overall numbers of reported of all incidents continued to be above the expected range based on previous reporting patterns and can be seen in our accompanying appendices in January 2022 with Covid19 influencing incidents. This has also had the incidental effect of there being > in January 2022 still not returning to our baseline for our trust in February. The reporting for infection control continues in the majority of services 'Top 5 incident' category which corroborates to individual and outbreak reporting.

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 February 2021. December 2021 identified the highest ever reported numbers of category 2 pressure ulcers that have affected patients and have developed whilst in LPT care his has reduced for January and February 2022 however, still remains well above the trajectory.

Category 3 pressure ulcers that have developed in LPT care have unfortunately shown an increasing trend in January and February 2022 with the continued focus on the prevention to deteriorate to category 4 for our patients in our care leading to significant harm, distress and an increase in healthcare resources.

Concern with regards to the distressing development of category 4 pressure ulcers remain of concern with an increase in February 2022 with several 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 the continued significant challenges affecting 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.

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 January/February 2022. One investigation report related to the care of a patient whose exiting pressure ulcer on transfer further deteriorated to a category 4 pressure ulcer and acquired Covid19 as an inpatient in LPT was completed in February 2022 and has resulted in a significant sharing/learning exercise with staff involved in the lady's care. We have used 'Gloria's' story with the 'brave & continued' involvement of her family during the investigation and development of the training/feedback sessions **– Appendix A**

Falls

Our falls across the organisation in patient areas have continued to show an increase in the month of February 2022 with increasing incidents in MHSOP approaching that seen back in April/May 2020. We continue to consider that the impact reduced staffing, patient acuity and the increased reliance on temporary staffing due to the challenges of managing the current Covid19 response. Inpatient Falls with harm Incident Investigations continue to be reviewed at incident review meeting (IRM), a 72hr report developed and shared with commissioners with completed report reviewed by the Executive Nurse before sharing with CCG. However, we do continue to see the lack of adherence to practice of 'specialling' for falls prevention being an influence in many patient falls in conjunction with risk assessment review and regular review/stop and pause.

We continue to see the use of the 'flat lifting' equipment that has been successfully rolled out in many inpatient areas enabling staff to safely raise people, who have fallen, off the floor and thus reducing the risk of exacerbating any injury and minimising moving and handling risks to staff. These have been described as being used appropriately in falls incidents and feedback is positive from the clinical staff. The publication of the national inpatient falls data demonstrates a good link with sharing the introduction of this useful piece of equipment across the NHS in England.

All Self-Harm including Patient Suicide & Progress

We continue to report as before and see a high numbers of self-harm incidents resulting in moderate harm and above. The picture continues within the community mental health access services who report increasing numbers of patients in crisis who have allegedly self-harmed or are planning to. This continues to be 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 remains unchanged with the influence of individual patients and their risk profile affecting incidents. Self-harm behaviours

continue to range from very low harm to multiple attempts by inpatients during individual shifts of head-banging, ingestion of foreign objects, cutting with any implement and ligature attempts being common themes. We have seen many patients escalated for review by our acute care colleagues and the request of the support of EMAS colleagues as first line assistance.

Violence, Assault and Aggression (VAA)

The worrying trend of high numbers of VAA across the Trust continues with significant increase in February incidents of moderate harm to the highest ever reported.

Violence, Assault and Aggression continues to feature in all mental health, CAMHS inpatient and all learning disabilities top 5 incidents. Our position is sadly not unique with VAA featuring nationally across all aspects of the NHS in particular access services. LPT's challenge is to understand the patient's impact of mental health wellbeing and risk mitigations in place.

Promotion of using lone worker devices continues following learning from a serious incident in community mental health with direct feedback with/from the colleagues involved with the investigator and CPST Lead Nurse. CPST looks forward to the outcome of the body worn camera trial in LPT. Other NHS Trusts, Emergency departments and emergency workers have had success and reported them working as a deterrent and also to positively improve staff safety and training.

Medication incidents

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 915 (846 in community setting) 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 CQC have not raised any concerns

Our compliance with timely submission of 72hr reports from CHS & FYPCLD to commissioners has reduced over January and February 2022 with lack of staffing being the main influence and return by CPST for incomplete information. The provider collaboratives have raised concern around compliance with timescales.

Learning Lessons and Action Plan Themes

Learning Lessons Exchange

The Learning Lessons exchange group has not met due to the ongoing staffing pressures

Key learning themes from SI's:-

Emerging and Recurring themes (some remain unchanged):

- Record keeping consistently highlighted across all directorates due to timing of entries (i.e. not contemporaneous), standard of record to provide a flow of knowledge this is corroborated with shared analyses with LLR CCG
- Lack of updated risk assessments, personal safety plans and their application to clinical practice and from an MDT approach
- Mental Capacity and safeguarding knowledge with Mental Capacity Assessments and overall care plans and risk assessments not considered or completed
- 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 makes assessment more difficult especially when these reviews take place without the 'seeing' of the patient
- The inconsistent use of data to monitor quality and performance
- Not listening to patients/families
- Action Plans tend to be ward or person specific rather than taking a wider approach corroborated with shared analyses with LLR CCG

Focused themes and learning themes from Pressure Ulcer category 4 (again remain unchanged)

- 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
- Inconsistent approach to photography/documentation of wounds and to use the photography to inform care/escalation
- 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. **Nursing observation intervention** – not being adhered to or not assessed correctly/timely when there are patient changes and adhering to 'specialling' to prevent falls
2. **Monitoring of physical health status** – i.e., lying and standing blood pressure and recognition that change in wellbeing/medication matters
3. **Use of low beds** -staff are using low beds inappropriately as a falls reduction strategy when actually a bed at standard height may be safer depending on the patients mobility and cognitive status.

Culture of Candour

There have been no Statutory breaches of Duty of Candour.

We 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. There are some challenges in the 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 weekly incident review meeting process continues and 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. Other provider collaboratives attend for incidents in services that they commission. 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 and as part of induction. As part of supporting an open learning culture and responding to feedback, we have developed a guide to attending the IRM for staff that is embedded in the agenda at the point of sharing.

We continue 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.

We also continue 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 and staff have cancelled at short notice. Our training programme is continuously evolving based on feedback and also increasing the use of real-time patient experience with investigations utilising the training tools available via NHSE/I.

Incident Oversight and action plans post investigation

The incident oversight group continues to monitor the completion of PSSI investigation reports, action plans, monitoring on the timeliness and quality of initial service managers reports and management of incidents; there continues to be challenges faced by all directorates in relation to compliance and timely completion.

Learning from Deaths (LfD)

The LfD process is well supported by a Trust coordinator. 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.

Suicide Prevention – key sharing

NHSE has commissioned the Samaritans to develop NHS Postvention Guidance – due to be published in Spring 2022 which supports the 'Staff Well-Being and Suicide Prevention (Workforce)' we have ongoing work to identify support needed for our staff following incidents of significant self-harm by patients known to them this will include specific postvention and will be linked into the work being undertaken by the De-Briefing Working Group; there is a key link in DMH; however this work extends for staff support across the trust.

The 'East Midlands Patient Safety Collaborative' has identified a key ambition with the aim of 'Reducing suicide and self-harm in inpatient mental health services, the healthcare workforce and non-mental health acute settings' and is rolling out a programme that aims to reduce unwarranted variation and providing a high-quality healthcare experience for all the people across the system by March 2024. Key individuals have been identified in DMH to facilitate this programme in LPT.

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, concerns through incident reporting and management and patient safety improvements

Governance table

For Board and Board Committees:	Trust Board 29.3.22	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Sue Arnold, Tracy Ward (Corporate Patient Safety Team)	
Date submitted:	14/03/2022	
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		
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 A
Patient Safety - Learning from incidents

About Gloria:

Gloria is a 79 year old lady who lived alone with daily family support since her husband died four years ago. She took great pride in her house being kept clean, tidy and used to love watching the birds in her garden.

She underwent abdominal surgery in July 2021 which resulted in a week in intensive care. She was almost fully recovered although had background physical health conditions and medications to support these.

In Sept 2021 Gloria fell at home & broke her hip requiring admission to acute hospital & transferred for ongoing recovery to LPT in early October with the aim of returning home. The day before her fall she appeared in a 'Tik Tok' video dancing in her kitchen.

What happened to Gloria:

Gloria developed a category 2 sacral pressure ulcer in the acute hospital. Following transfer this was reassessed and considered to be category 3. Five days later she had developed a category 2 pressure ulcer on her left heel.

Five days later her sacral pressure ulcer was deteriorating, she was unwell, not eating/drinking well and four days later, although showing few symptoms, she was Covid19+ve and was transferred to a 'red ward'.

Six days later her sacral pressure ulcer was reviewed (five days after the last review) & identified as category 4 along with likely infection & bone involvement, symptomatic of infection she was transferred to acute hospital for treatment for acute wound infection.

NHS
Leicestershire Partnership
NHS Trust

Patient Safety - Learning from incidents

Effect on Gloria:

She was already weak from her fall, surgery & recovery. It was her 2nd acute health episode in less than six months. She was struggling to mobilise/move/work with therapy teams often due to pain and exhaustion. Standing was difficult due to deconditioning/muscle strength and she was requiring significant nursing intervention for ADL's.

Gloria's sacral pressure ulcer deteriorated to category 4. She acquired Covid19 in our care and moved wards as a result. Her pressure ulcer became infected further debilitating her, necessitating transfer to acute hospital.

Gloria returned to LPT on Christmas Day, unable to stand due to pain, lack of strength, frailty and bedbound, unable to progress in rehabilitation following her hemiarthroplasty due to nerve impingement in her left leg causing pain.

Gloria has not been able to improve her sitting tolerance due to the fact that she is unable to sit out in her chair due to the pain from her pressure ulcer. She was also confirmed as Covid19 +ve again four days later.

Gloria was transferred to a local nursing home late January 2022 and is not likely to return home.

Effect on Gloria's daughter:

She felt she had to raise her concerns with CQC to get her mother's voice & hers heard. She was unhappy about transfers, different ward moves and not being informed of deterioration of pressure ulcer to Cat 4.

Her mum had caught Covid and as result due to Covid rules she was not able to visit her mum. She had a loss of trust in NHS care, both LPT & acute provider.

Leicestershire Partnership NHS Trust

Patient Safety - Learning from incidents

Learning:

LPT only became aware of the care concerns when Gloria's daughter raised it directly with the CQC. The key points were :

- Pressure ulcer plan lacked detail for dressings & management.
- No contact with TVN
- Lack of detailed records
- PU was not seen/evaluated daily, plan not followed, not photographed weekly
- Waterlow score not assessed weekly
- Staff training not in date with pressure ulcer care
- Food, fluid & FIR charts not consistent
- Lacked leadership oversight

Actions & Transferable Learning:

- Strong Leadership & oversight of the quality of care & appropriate delegation, develop a robust & open culture of incident reporting & management
- Promoting training compliance as a measure of strong safety culture, promoting a strong culture of communication with families and local reporting of all incidents
- Foster a strong open culture for multidisciplinary working & promoting a culture of positive and timely record keeping
- Recognising the positive impact of effective pain management for patients.
- Recognition & escalation of the deteriorating patient by adherence to NEWS2.
- Processes for measuring for the success of the above.

March 2022

For further information please contact the patient safety team at lpt-patientsafety@leicspart.nhs.uk

Appendix 1

The following slides show Statistical Process Charts of incidents that have been reported by our staff during January & February 2022

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

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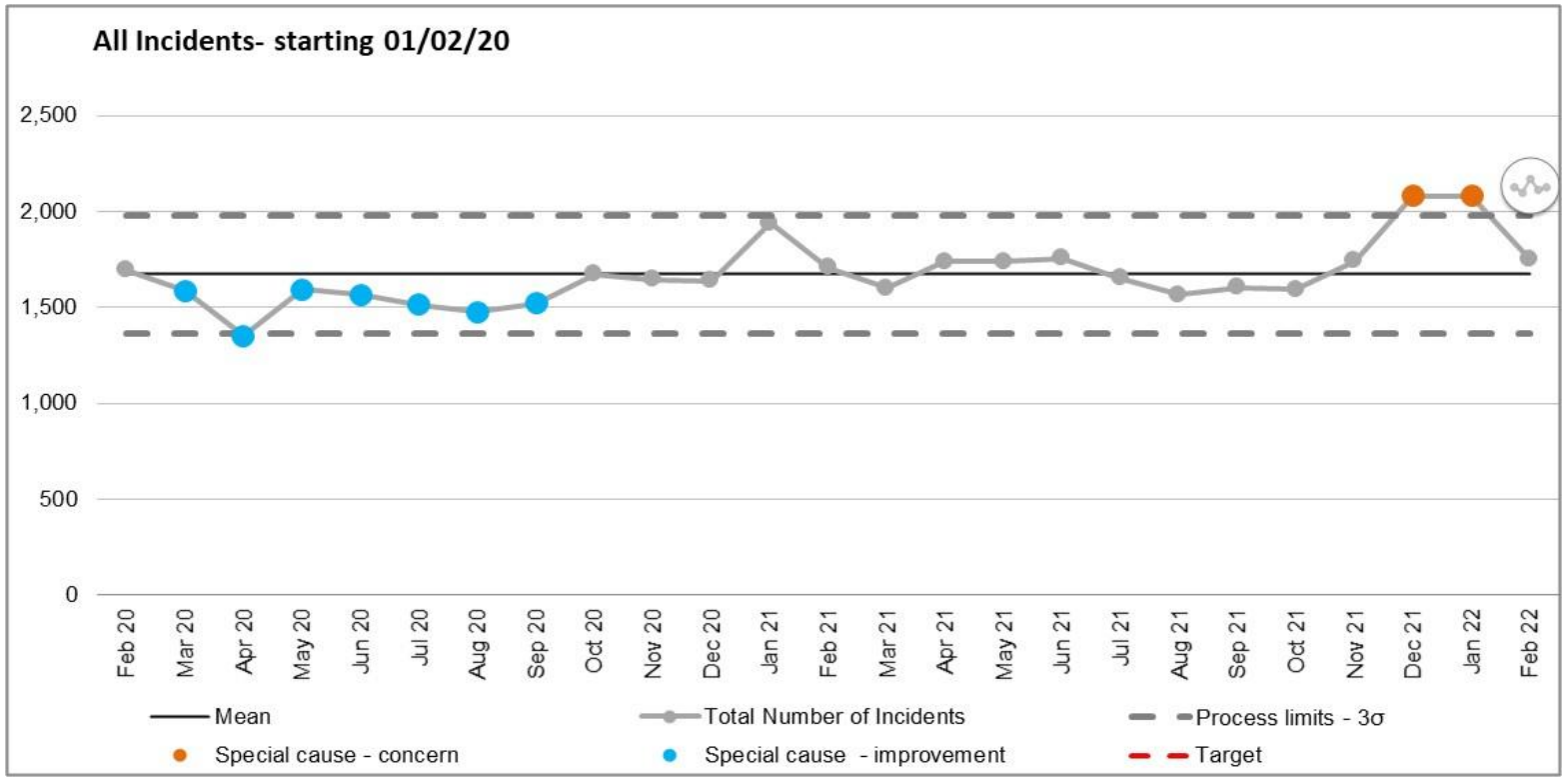
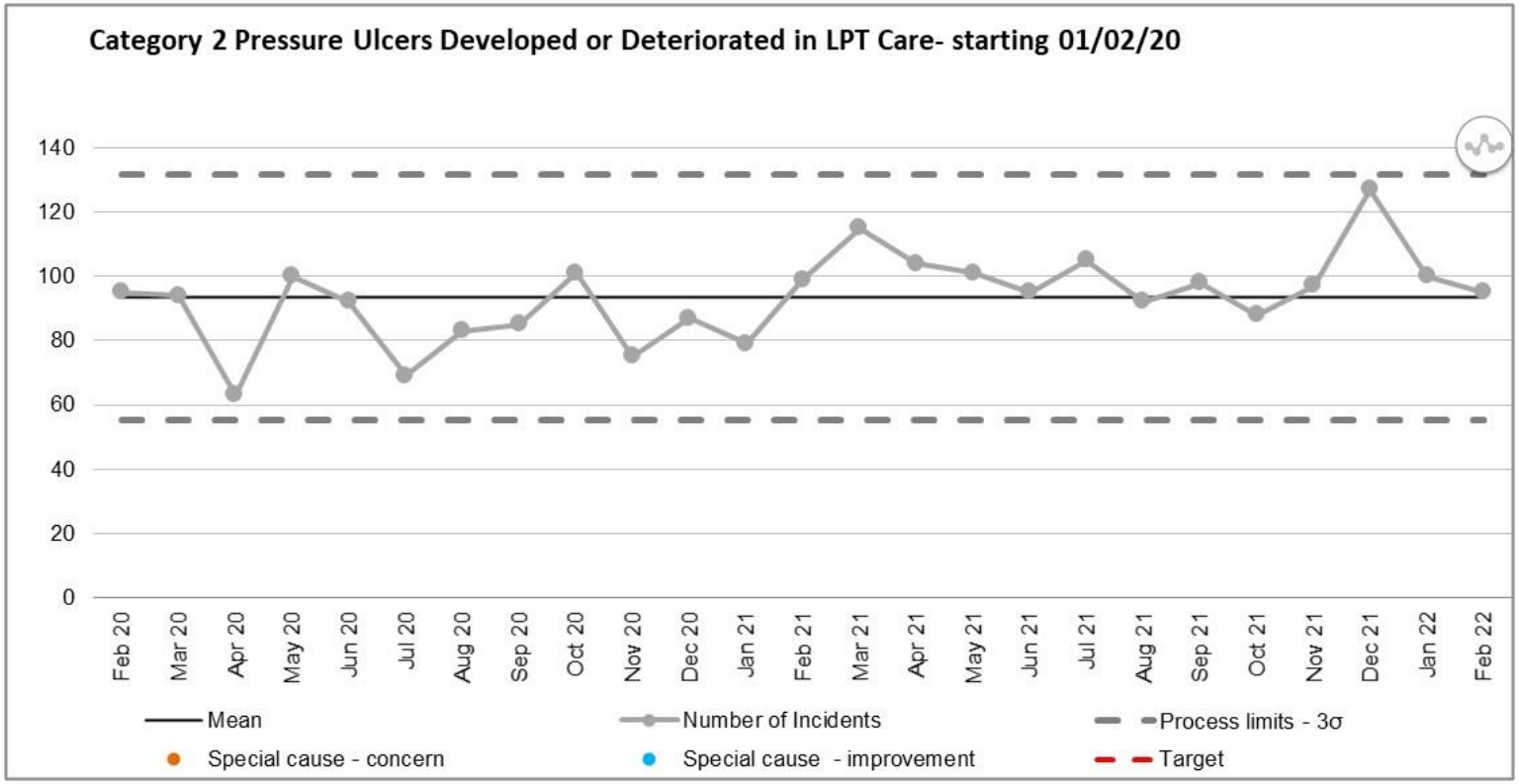
1. All incidents



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



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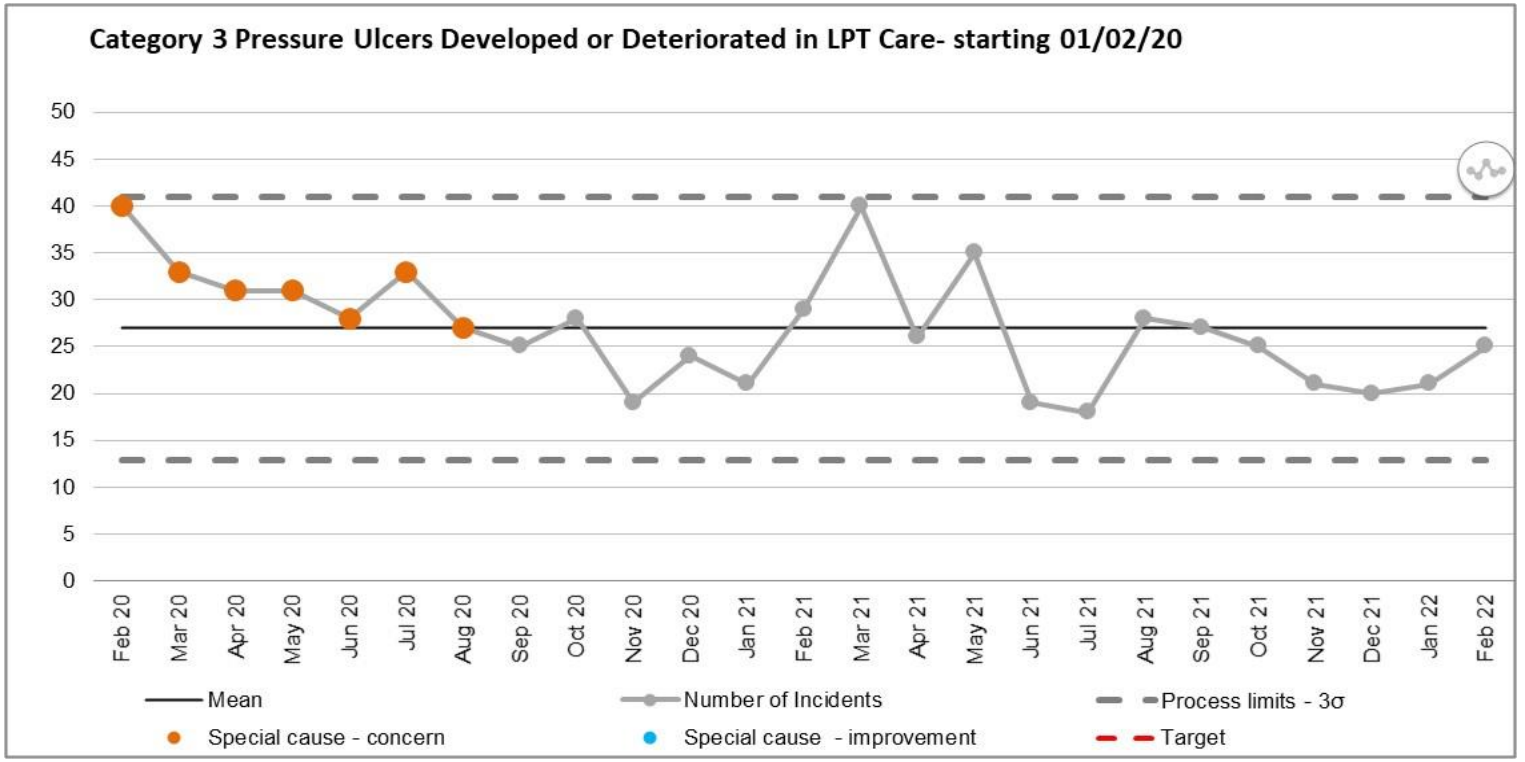
3. Category 3 Pressure Ulcers developed or deteriorated in LPT Care



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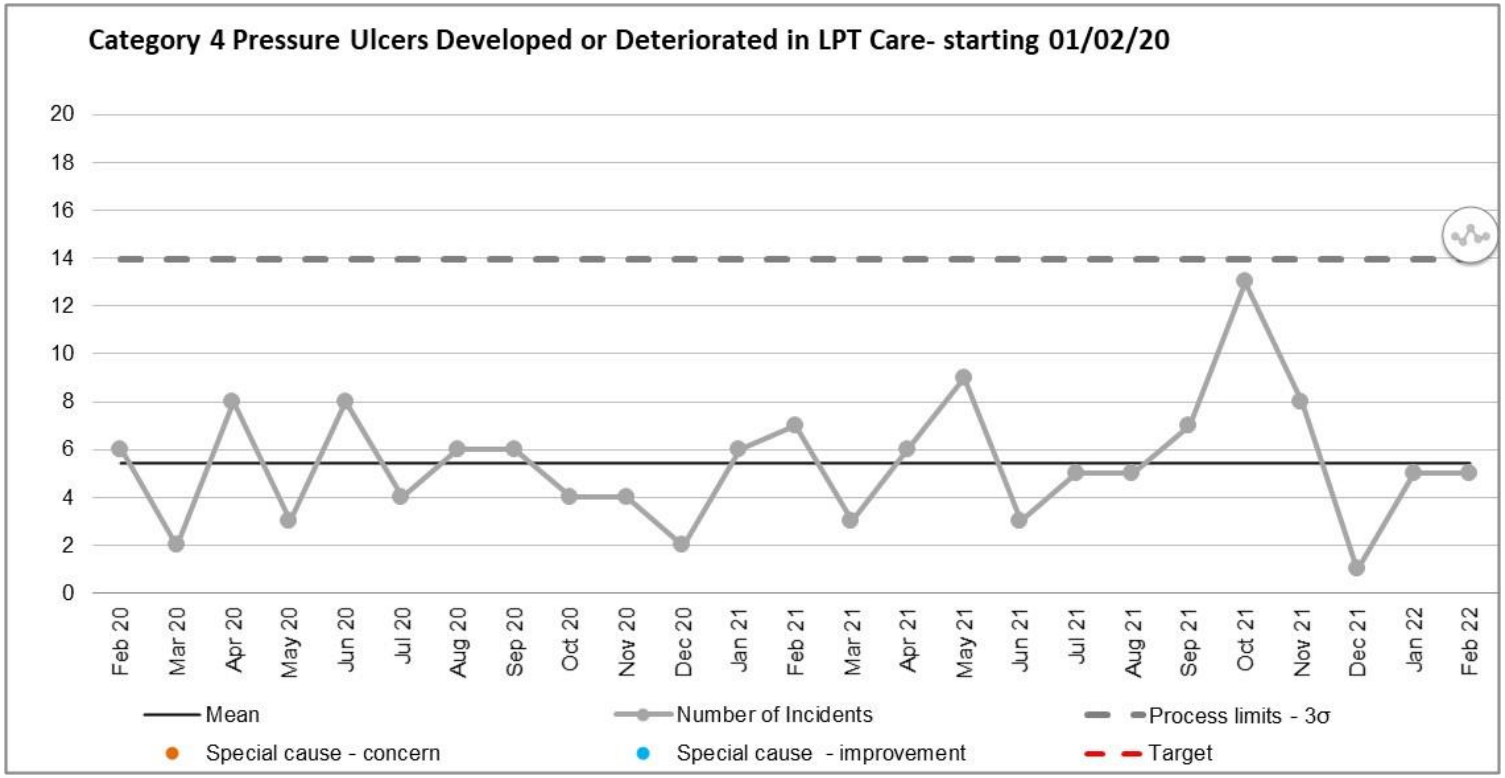
4. Category 4 Pressure Ulcers Developed or deteriorated in LPT Care



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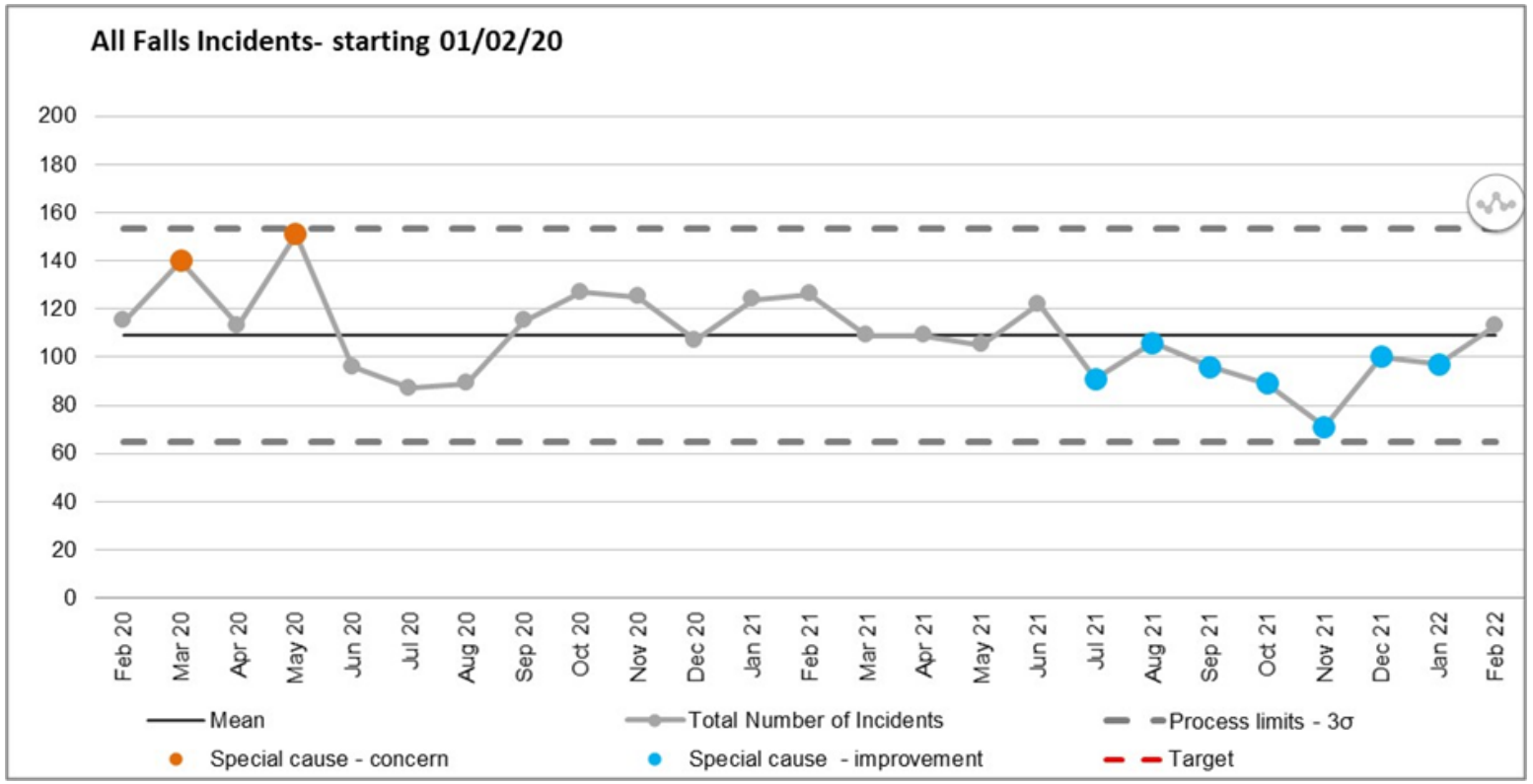
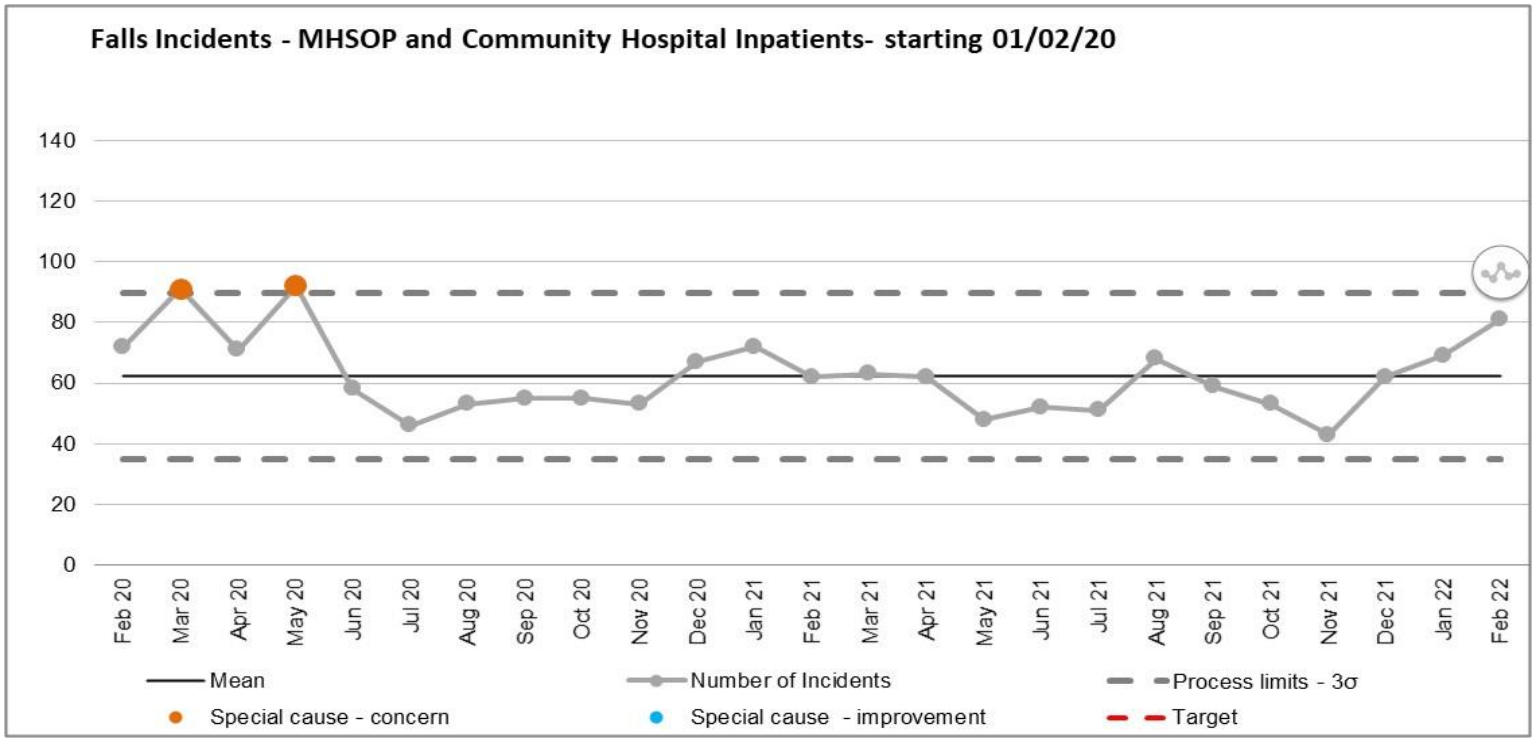
5. All falls incidents reported



6. Falls incidents reported – MHSOP and Community Inpatients



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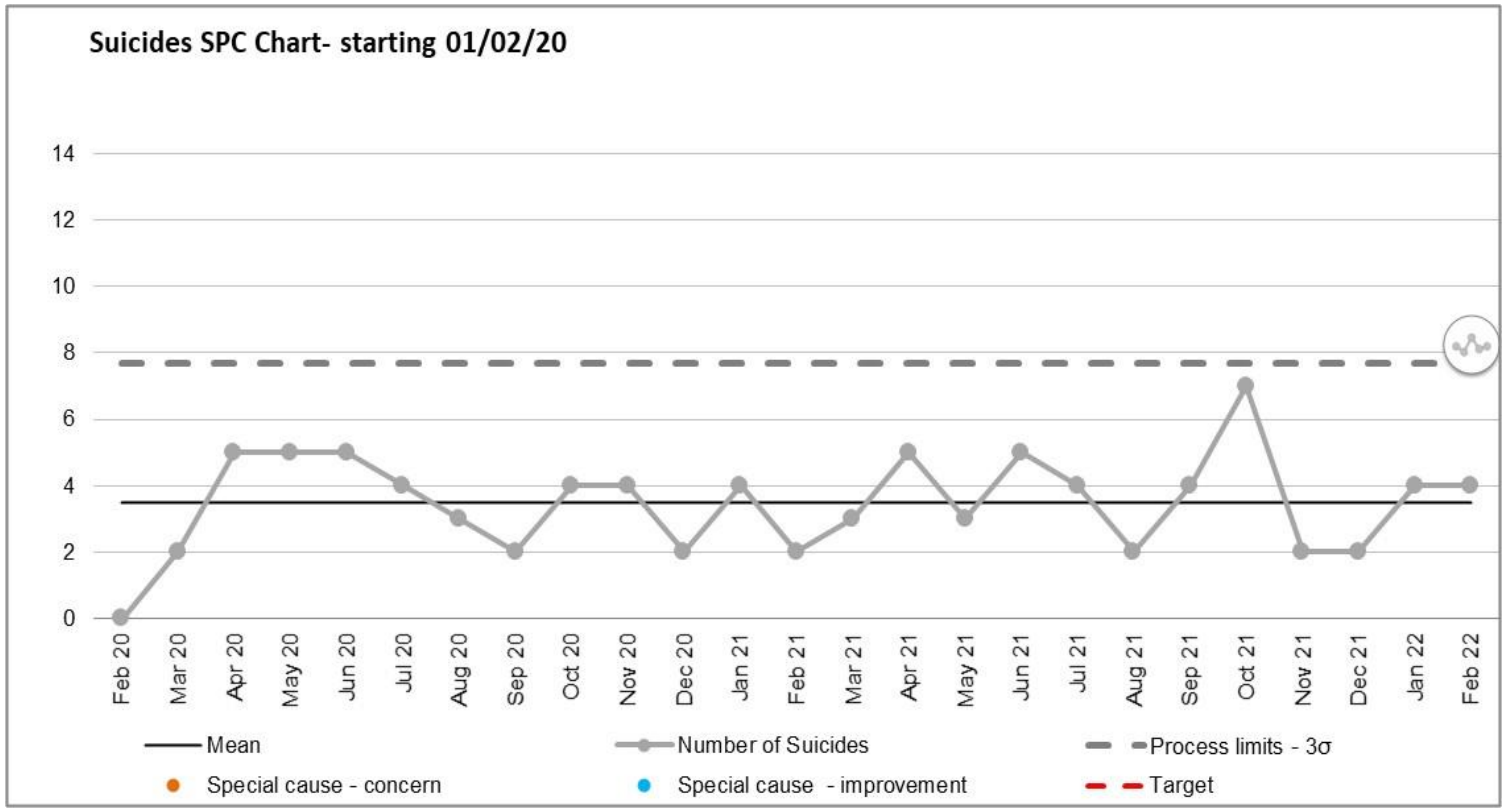
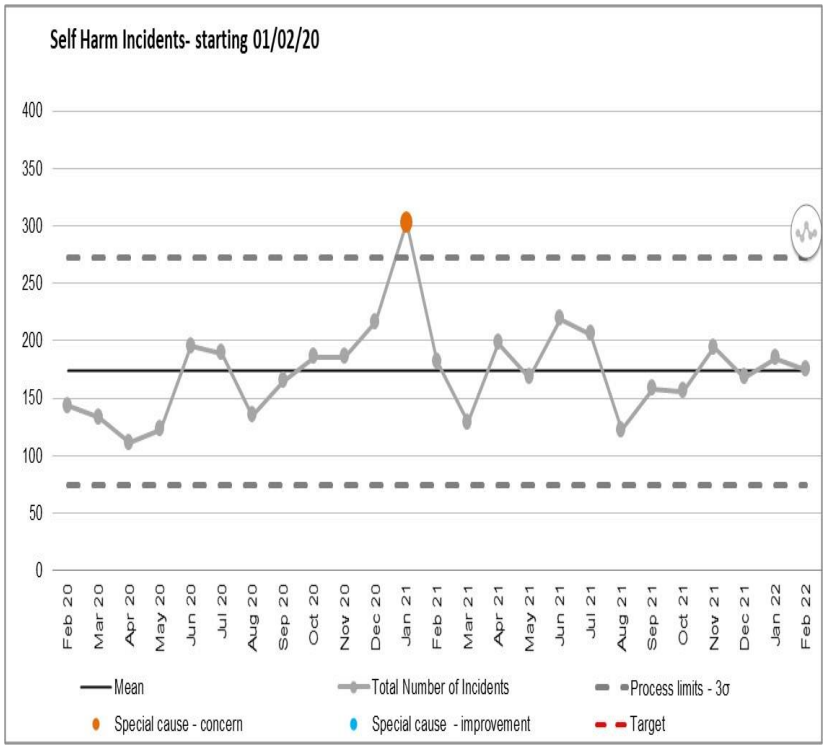
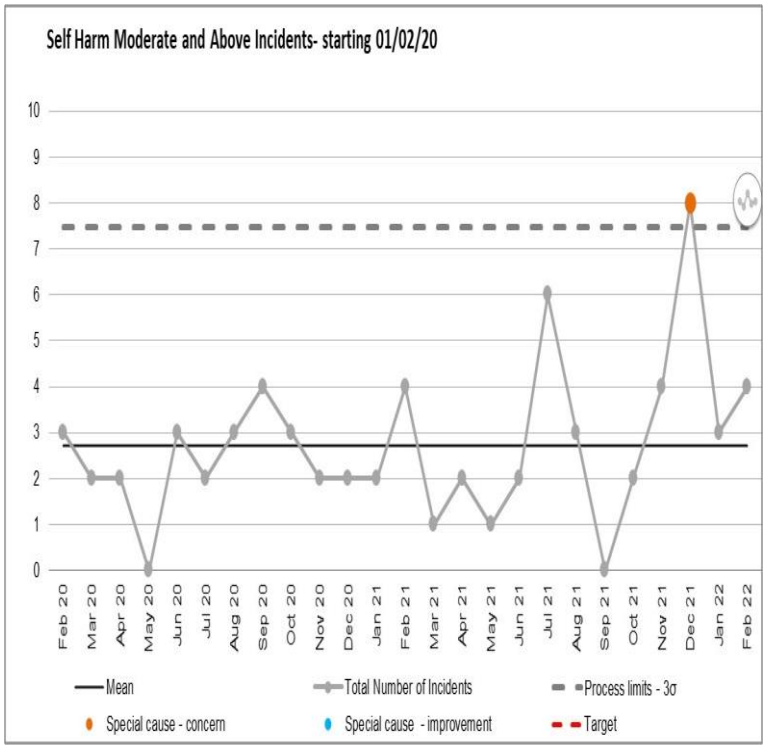
7. All reported Suicides



8. Self Harm reported Incidents





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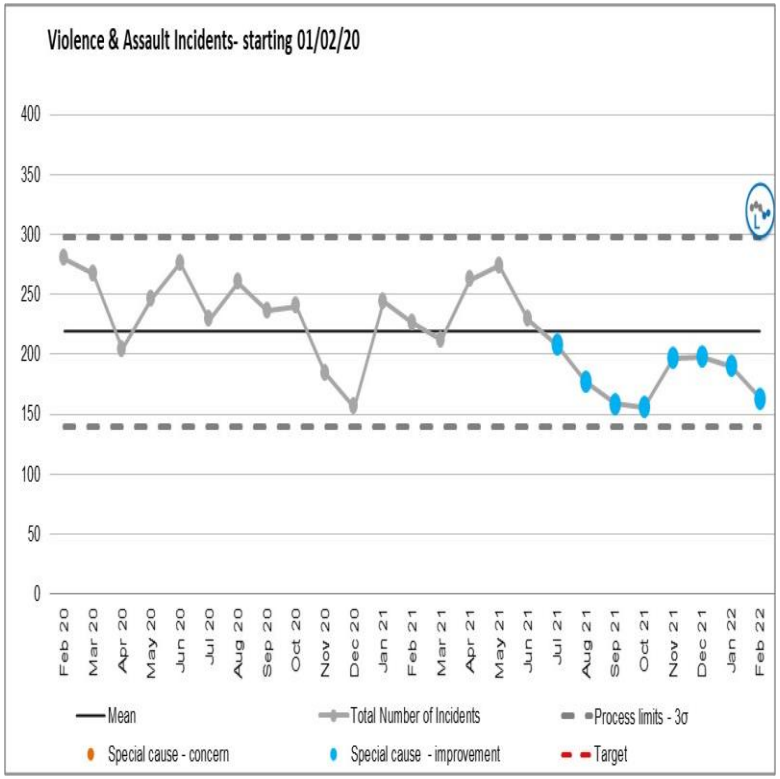
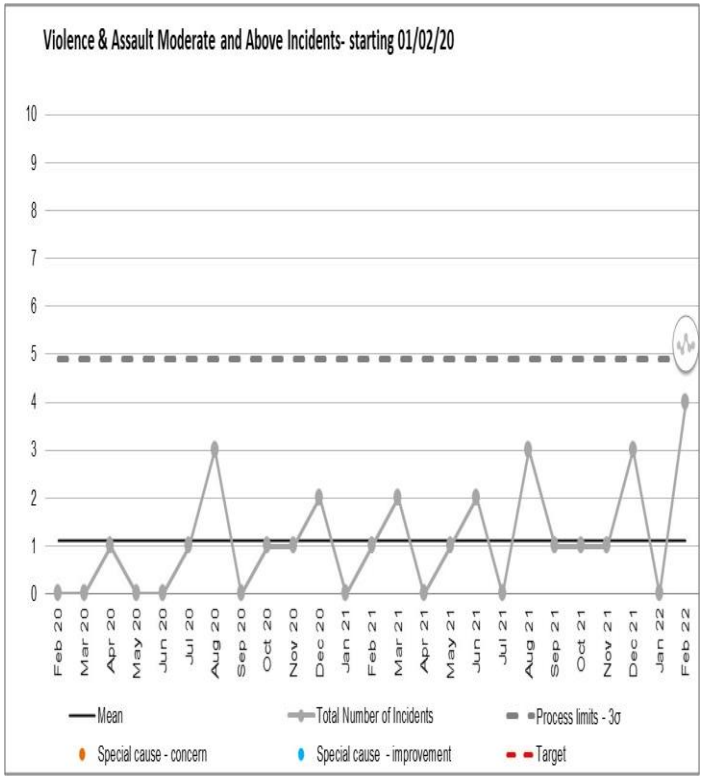
9. All Violence & Assaults reported Incidents





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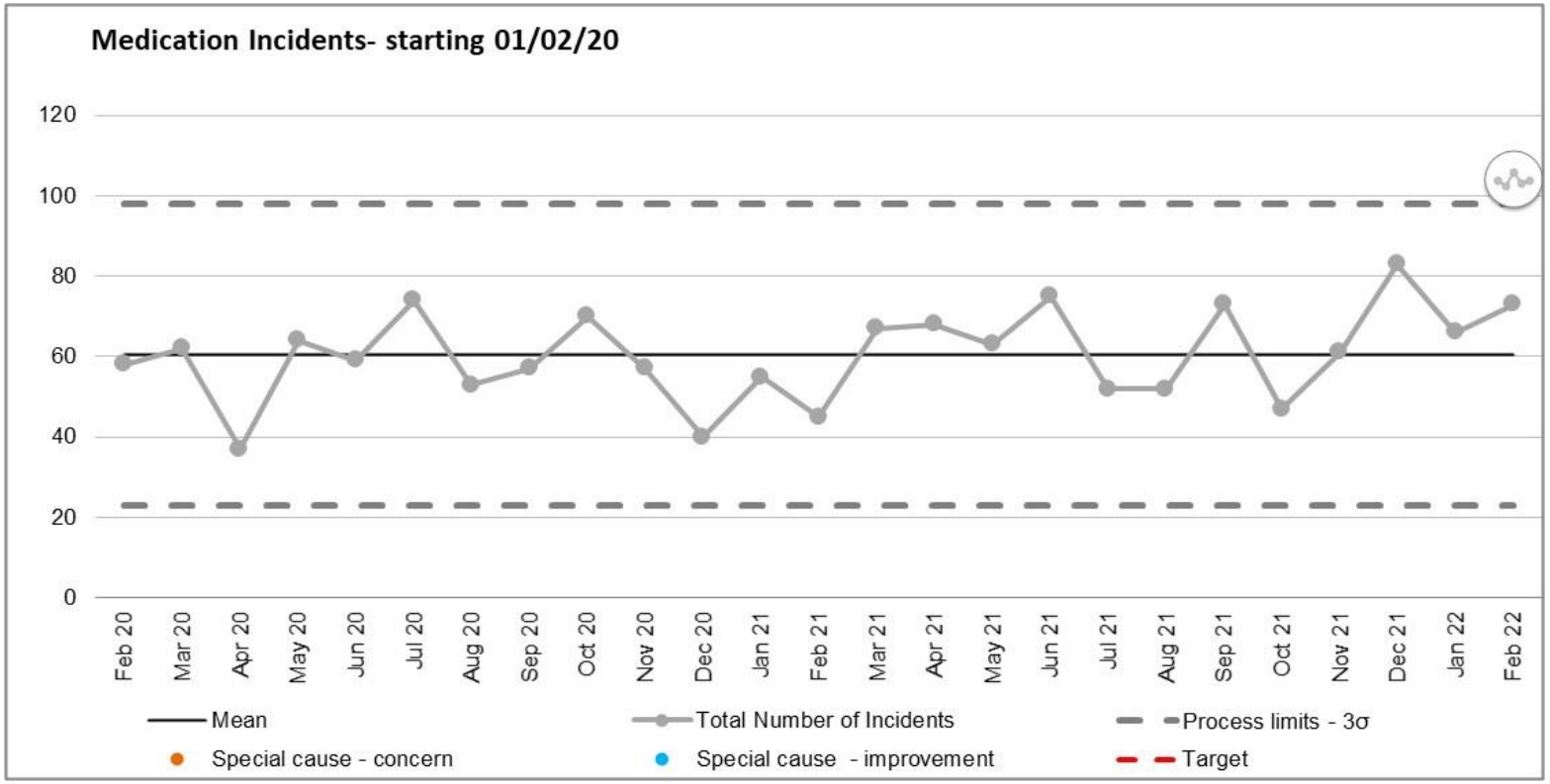
10. All Medication Incidents reported



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11. Directorate Specialities describing Top 5 Incidents

Table 1: Mental Health: Community

Mental Health Non MHSOP Community - January	
Cause Group	**Total**
Infection Control	76
Self Harm	44
Violence/Assault	29
Staffing	26
Safeguarding (Children)	15

Mental Health Non MHSOP Community - February	
Cause Group	**Total**
Self Harm	44
Violence/Assault	44
Infection Control	39
Safeguarding (Adults)	18
Patient Falls, Slips, And Trips	14

Table 2: Mental Health: Inpatients

Mental Health Non MHSOP Inpatient - January	
Cause Group	**Total**
Violence/Assault	71
Self Harm	31
Clinical Condition	20
Security	19
Infection Control	18

Mental Health Non MHSOP Inpatient - February	
Cause Group	**Total**
Violence/Assault	74
Self Harm	43
Infection Control	25
Clinical Condition	24
Security	15

Directorate Specialities describing Top 5 Incidents

Table 3: MHSOP – Inpatients

MHSOP Inpatient - January	
Cause Group	**Total**
Patient Falls, Slips, And Trips	33
Infection Control	23
Violence/Assault	12
Clinical Condition	9
Accident	4

MHSOP Inpatient - February	
Cause Group	**Total**
Patient Falls, Slips, And Trips	35
Violence/Assault	23
Clinical Condition	13
Medication	4
Accident	3
Missing Patient	3
Tissue Viability	3

Table 4: MHSOP – Community

MHSOP Community - January	
Cause Group	**Total**
Patient Death	13
Infection Control	12
Self Harm	3
Case Notes & Records	2
Communication	2

MHSOP Community - February	
Cause Group	**Total**
Patient Death	12
Infection Control	9
Case Notes & Records	3
Medication	3
Self Harm	3

Directorate Specialities describing Top 5 Incidents

Table 5: Learning Disability – In-Patient

LD Agnes Unit - January	
Cause Group	**Total**
Violence/Assault	34
Self Harm	11
Infection Control	6
Patient Falls, Slips, And Trips	3
Staffing	2

LD Agnes Unit - February	
Cause Group	**Total**
Violence/Assault	24
IT Equipment / Systems	8
Missing Patient	4
Clinical Condition	3
Clinical Assess. (Diag, Scans, Tests)	2

Table 6: Learning Disability - Community

LD Community - January	
Cause Group	**Total**
Infection Control	18
Self Harm	9
Communication	6
Violence/Assault	6
Safeguarding (Adults)	5

LD Community - February	
Cause Group	**Total**
Safeguarding (Adults)	11
Self Harm	9
Violence/Assault	8
Infection Control	4
Clinical Assess. (Diag, Scans, Tests)	2

Directorate Specialities describing Top 5 Incidents

Table 7: FYPC Inpatient CAMHS

FYPC CAMHS Inpatient - January	
Cause Group	**Total**
Self Harm	74
Violence/Assault	40
Mental Health Act	22
Infection Control	5
Clinical Condition	4

FYPC CAMHS Inpatient - February	
Cause Group	**Total**
Self Harm	63
Violence/Assault	14
Clinical Condition	7
Access, Admission, Appts, Xfer, Discharge	6
Mental Health Act	4

Table 8: FYPC non LD Non CAMHS

FYPC Non LD Non CAMHS - January	
Cause Group	**Total**
Infection Control	86
Mental Health Act	34
Communication	24
Medication	19
Case Notes & Records	12

FYPC Non LD Non CAMHS - February	
Cause Group	**Total**
Mental Health Act	51
Infection Control	36
Case Notes & Records	9
Medication	9
Communication	8

Directorate Specialities describing Top 5 Incidents

Table 10: CHS In-Patient

CHS Inpatient - January	
Cause Group	**Total**
Infection Control	58
Patient Falls, Slips, And Trips	36
Tissue Viability	28
Patient Death	16
Staffing	13

CHS Inpatient - February	
Cause Group	**Total**
Patient Falls, Slips, And Trips	46
Tissue Viability	41
Infection Control	26
Patient Death	14
Medication	13
Staffing	13

Table 11: CHS Community

CHS Community - January	
Cause Group	**Total**
Tissue Viability	426
Infection Control	83
Medication	17
Safeguarding (Adults)	12
Confidentiality	7

CHS Community - February	
Cause Group	**Total**
Tissue Viability	420
Infection Control	31
Medication	24
Communication	9
Safeguarding (Adults)	6

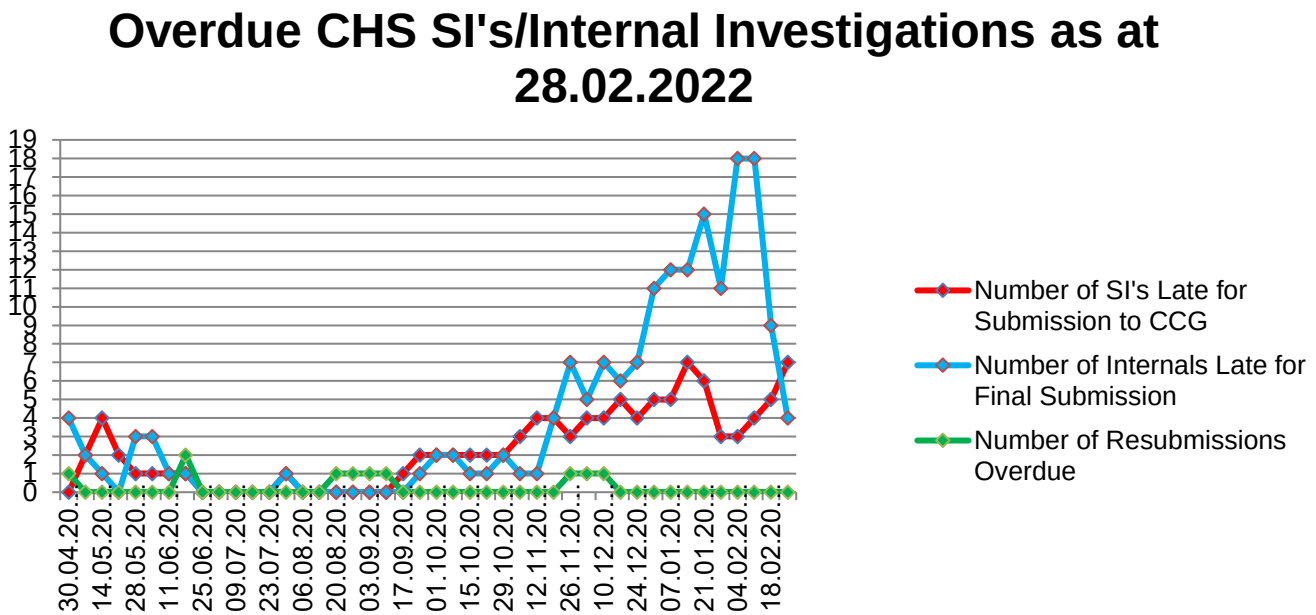
12. Ongoing - StEIS Notifications for Serious Incidents

2021/2022 - STEIS Notifications and Internal Investigations

		StEIS Notifications	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	*0*	*10*	*2*	*2*	*8*	*4*	*3*	*9*
	February	0	3	2	4	16	9	2	3
	March								
YTD			78	19	28	99	54	21	54

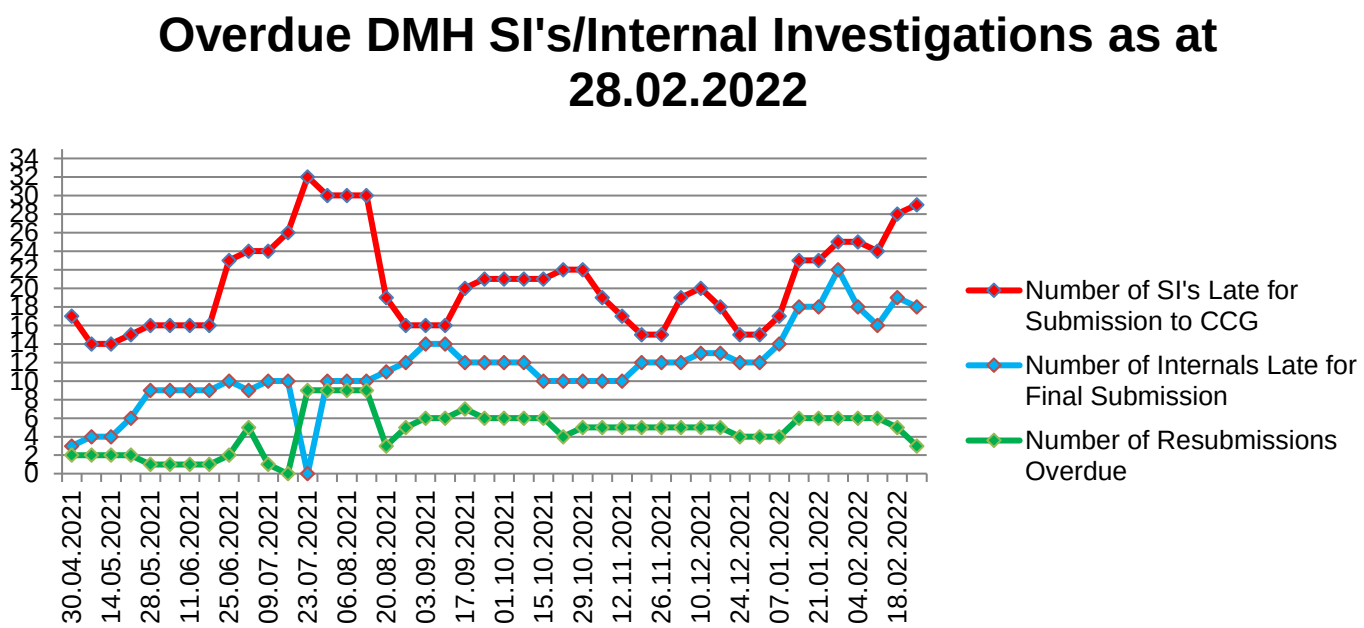
WeAreLPT
compassion respect
integrity trust

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



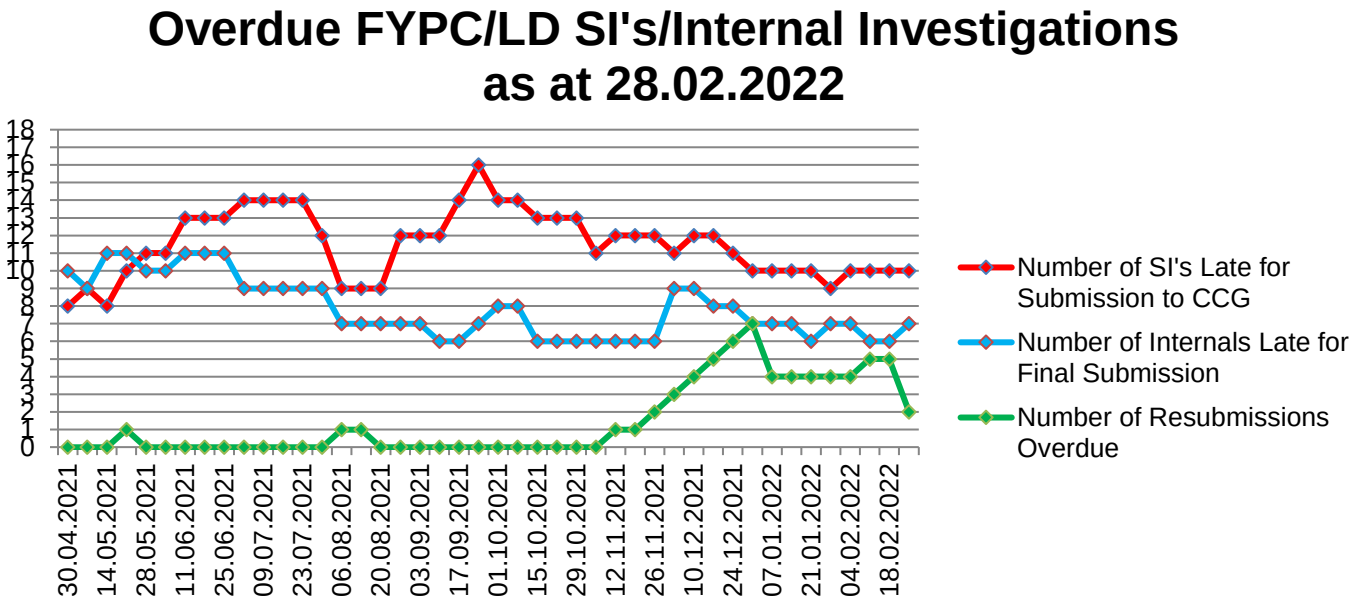
WeAreLPT
compassion respect
integrity trust

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



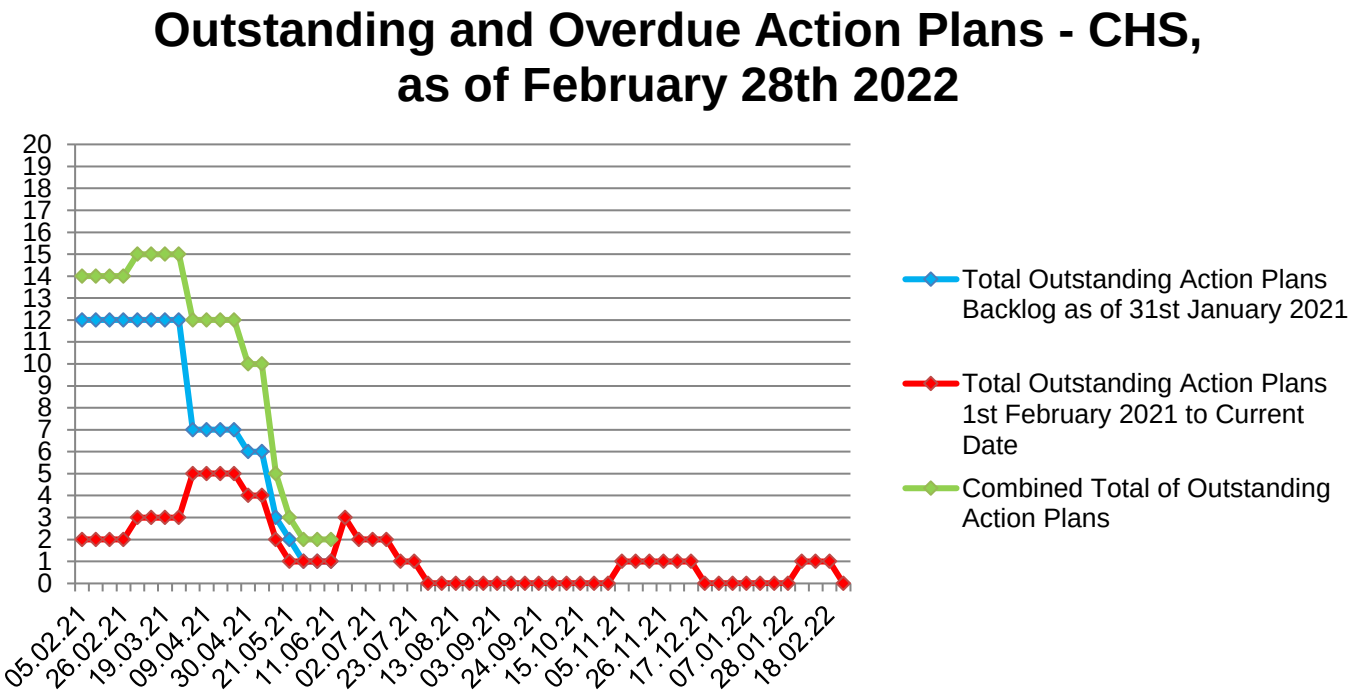
WeAreLPT
compassion respect
integrity trust

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



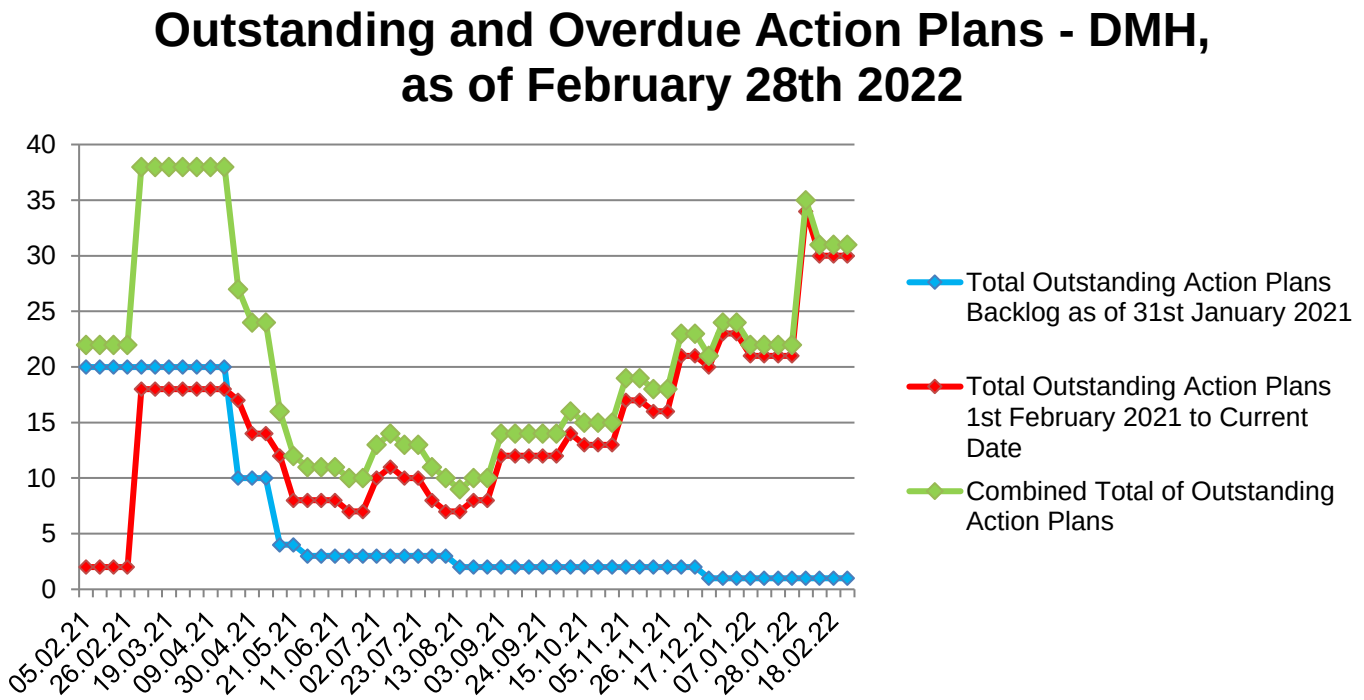
WeAreLPT
compassion respect
integrity trust

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



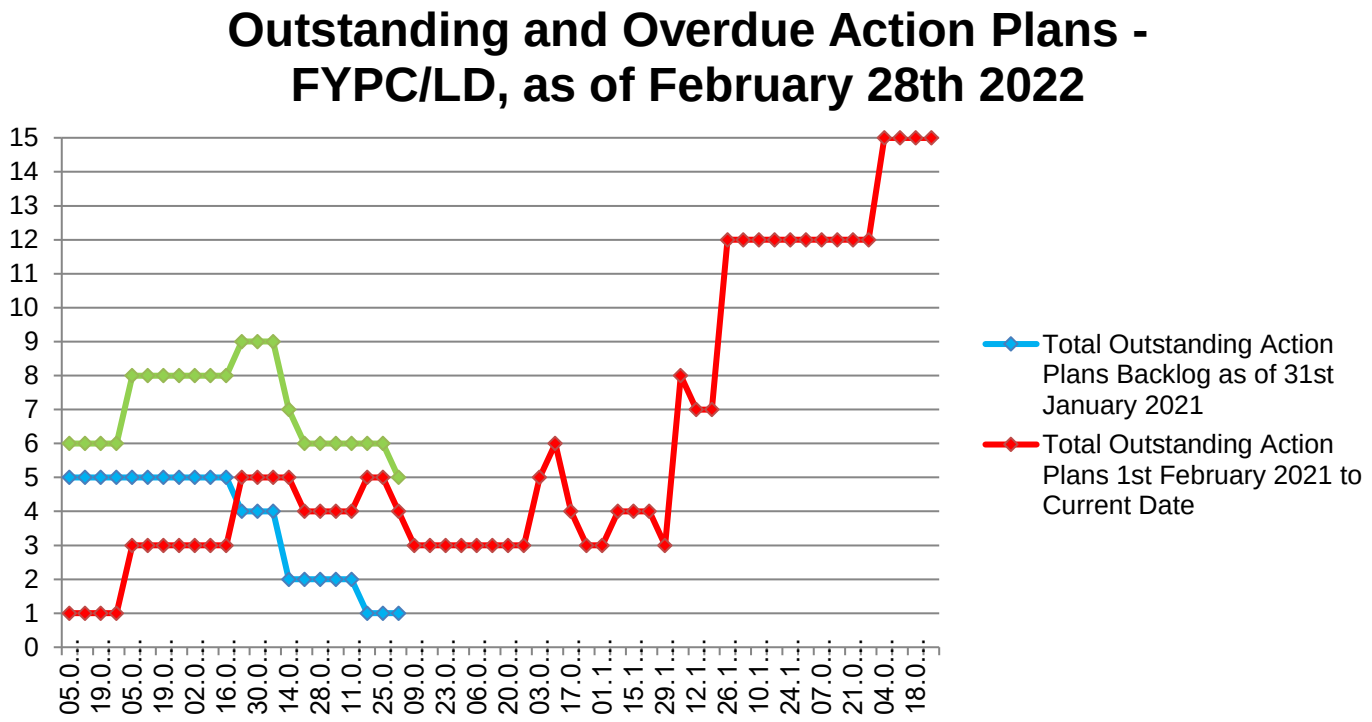
WeAreLPT
compassion respect
integrity trust

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



WeAreLPT
compassion respect
integrity trust

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



12. Learning

Serious & Internal Incidents Emerging & Recurring Themes – joint analysis with LLR CCG & CPST

- Personal Safety plans inconsistent, not completed or considered
- Lack of communication or joined up approach between teams or sharing of information with other agencies
- Mental Capacity Assessments & overall care plans and risk assessments not considered or completed
- Documentation – identified as poor quality, lacking detail
- Staff not following/adhering to policy/practice
- Non-compliance with mandatory training (MAPA, BLS); unintentional findings with no plan offered to promote compliance
- SI Action Plans tend to be ward or person specific rather than taking a wider approach

12. Lessons Learned – Trust-wide process

- Increasing & continuing concerns with reports being ‘late’ & challenges in allocations
- CPST having to raise profile with directorates importance of keeping families/patients up to date with delays/maintaining contact
- Continued promotion of sharing of final draft serious incident reports with families/staff at point of sharing with commissioners
- Corporate investigators taking caseload of investigations bringing objectivity & supporting delayed/reallocated starting of investigations by undertaken timelines/initial review of information and sharing with directorate allocated investigators
- CPST continue to promote recognising early actions especially with delay in timescale/completion to offer commissioners assurance
- SystmOne challenging to navigate modules/journals, inconsistent places/approach to recording patient contact

R

Leicestershire Partnership NHS Trust

Trust Board – 29th March 2022

LPT's Response to the Ockenden review of maternity care (1 year on)

Purpose of the report

To update Trust Board on LPT's response to the Ockenden review of maternity care one year on.

Background

In December 2020, the Ockenden Report was published, which set out immediate and essential actions for maternity services across England under seven key themes. The Ockenden report was written following a review at another NHS Trust in response to letters from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm while receiving maternity care at the hospital. Recommendations were issued for all acute Trusts offering maternity care and the wider maternity community across England to be addressed as soon as possible.

There was no formal requirement for LPT to provide a formal response to these actions. The corporate patient safety team did however use a Learning Lessons Exchange (LLE) meeting to consider the transferrable learning from the enhanced safety areas identified in this report.

In addition to this, the aim was to further develop our culture as a Learning organisation to encourage and reach a level where all staff are thinking 'learning all the time' and moving from a safety 1 position (reacting to incidents) to a safety 2 position (focusing on what goes right and doing more).

In January 2022 all Chief Executives received a letter from NHSE/I, requesting that one year on from the Ockenden report publication, all Trusts reviewed and discussed any progress with learning before the end of March 2022. The following report presents five key areas from the Ockenden that were considered to be transferrable within LPT and details actions and progress and alignment to LPT's leadership behaviors.

Analysis of the issue

1 Enhanced safety – This was about visibility/transparency and oversight of incidents

We have robust processes to ensure that any potential serious incidents are discussed at Incident Review Meeting (IRM) to strengthen the governance of decision making and transparency. Commissioners are invited to attend. These are reported to Board via Exec bulletins and learning via Bi -monthly report. Our commissioners and CQC are informed via 72-hour reports, meeting the requirements for external input and oversight.

We also report performance against a range of safety measures to the Trust Board on a regular basis using Statistical Process Control (SPC) to support appropriate analysis. We have employed eight designated patient safety investigators to strengthen the quality of Serious Incident investigations and more system focused actions using a 'just culture' approach.

Actions to be taken

- Trial of learning patient stories from SI's to share across the organisation.
- Improve the quality of Executive summaries for SI's so they can be shared and more readily accessible (to Board and the wider organisation).

'Always learning and improving'.

2. Listening to women and their families - this is a key theme and very transferrable to listen to our patients and their families

- The CPST have begun a piece of work 'caring confidentiality' this is around working with patients who may be demonstrating suicidal behaviour to support staff to involve their family without fear of breaching confidentiality; this is being taken forward in DMH with Psychology and other expert input.
- The CPST work closely with the complaints team to ensure that where patient safety concerns are identified through complaints they are shared, heard and responded to and triangulated for learning.

Actions

- Identify a Patient Safety champion on the Board.
- DMH to strengthen the identification of a Next of Kin/Significant person and ensure this is recorded and conversations are had with patients around involving them in their care as appropriate.

'Working together'

3. Staff training and working together - this is about bringing the MDT together and not training staff separately. This is also relevant to temporary staffing and links to the research around safety benefits of cohesive teams.

The Medical Director has identified a team of senior medical staff to attend IRM to bring together the MDT at this point as part of learning from incidents form a transparent approach.

The CPST are working with the Medical Directors deputies in DMH to strengthen the input to investigations from medical staff.

LPT still could improve this opportunity of promoting shared learning amongst medical staff.

Actions

- Medical representative for PSIG
- Review all training and consider where this can be delivered to teams

'Valuing one another & recognising and valuing people's difference'.

4. Informed consent and shared decision making-This is not new **'nothing about me without me' (DH 2012)** and more recently **Cumbeledge 'first do no harm' 2020**

- Our record keeping and care planning policy (2019) describes that care plans are 'developed with the patient, and their carers where appropriate' and the 'care plan where possible should be left with the patient and their carers where appropriate'. Along with the current Consent to examination or treatment policy (2020) which outlines the process in conjunction with the legal and best interests' approach does consider the importance and inclusion by 'the health professional must consult with those close to the patient (e.g., spouse/partner, family and friends, carer, supporter, or advocate) as far as is practicable and as appropriate'.

The importance of clear documentation in patient records around these aspects of shared decision making is key for good governance and continuing communication between the healthcare professionals

Actions

- DMH to strengthen personal safety planning (identified in SI's)
- CHS to further embed motivational interviewing and the training of DN's in assessing mental capacity to support good quality decision making (identified in SI's)
- Medical staff to strengthen the documentation of shared decision making and information used to make decisions including risks as well as uncertainties.

'Recognising and valuing people's differences' & 'Working together'.

5. **Leadership and poor workplace culture-** this is key across the whole of the NHS.

Safety culture is a key fundamental of the Patient Safety Strategy (2020).

- The CPST are encouraging leadership for safety - promoting a culture that safety actions are for our patients and not for our regulators
- Presentation at Leadership forum
- Presentation at foundations for great patient care
- CPST are working with HR and our change champions to support psychological safety

Actions

- Directorate leadership teams to support and promote this
- High visibility in the clinical workplace promoting high standards
- Using all available data
- Learning from incidents, embedding change
- Consider all anonymous reporting as a red flag and not only respond to the content of the report but what led up to it

Decision required

- Board to be assured that the findings of the Ockenden review have been considered for transferrable learning and actions taken.
- To support Patient Safety Champion at Board level.

Governance table

For Board and Board Committees:	Trust Board 29TH March 2022	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Tracy Ward- (Patient Safety Specialist) Sue Arnold (Lead Nurse patient safety) CPST	
Date submitted:	2nd March 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):	SEB 4th March 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	This is a 1 year on report – the work from this and the previous report should become BAU in Directorates	
STEP up to GREAT strategic alignment*:	High **S**tandards	yes
	Transformation	
	Environments	
	Patient Involvement	yes
	Well **G**overned	yes
	Reaching Out	
	Equality, Leadership, Culture	yes
	Access to Services	
	Trustwide Quality Improvement	yes
Organisational Risk Register considerations:	List risk number and title of risk	
Is the decision required consistent with LPT's risk appetite:		
False and misleading information (FOMI) considerations:		
Positive confirmation that the content does not risk the safety of patients or the public	This supports the safety of the public	
Equality considerations:	This is promoting equality	

S

Public Trust Board of Directors

Leicestershire Partnership NHS Trust

Safety and Quality in Learning from Deaths Assurance (Quarter 3)

1. Purpose of the report

This report is presented to the Trust Board as assurance of the efficacy of the Learning from Deaths (LfD), Child Death Overview Panel (CDOP), Learning Disabilities Mortality Review (LeDeR), and Serious Incident (SI) processes in adherence to the National Quality Board (NQB) guidance on Learning from Deaths (2017). This Report presents data from October to December 2021 inclusive (Quarter 3: Q3) as well as data reviewed and learning from Q3 and previous quarters not already reported, at Leicestershire Partnership Trust (LPT).

2. Analysis of the issue

- The information presented in this report is collated by the patient safety team and allocated to each Directorate; LfD meetings are carried out within each Directorate.
- There remains a theme around the full and accurate gathering of demographic information. This is not being consistently completed at a service level (particularly Disability, sexual orientation and Religion). We are however emphasising the importance of this data as a means of better understanding and overcoming potential health inequalities.
- The Band 5 Governance and Quality Assurance co-ordinator LfD commenced in post on 25th October 2021 and has been assisting Directorates with LfD process.
- CHS Community Hospitals review deaths recorded via eIRF to identify and facilitate learning and improve practice and patient care. This is achieved in two ways. Documentation is reviewed by members of a clinical team on a monthly basis via a pro forma to identify good practice and to identify areas where improvement or actions may be required. There is then a recommendation for a proportion of these to be discussed at a quarterly forum. These presentations allow discussion in greater detail and reflection with actions from the learning being implemented. Individuals that were caring for the patient are also involved allowing for real time learning and reflection.
- CHS's greatest reflection and learning is from the forum meeting however there is discussion and actions from the screening meetings. From December 2021, the screening meetings have a formal agenda and minutes taken as well as any actions arising from screening meeting being added to the action log.
- CHS There will be a mandated requirement to report all deaths to the medical examiner from April 2022. A process for this has commenced in CHS. All patients' relatives will be contacted via this process with the opportunity to give feedback positive or for improvement to CHS.
- DMH have been challenged in being able to convene meetings and have a recovery plan in place.
- FYPC/LD have worked to refresh their process.

3. Proposal

The Board is asked to consider the content of this paper in alignment with Learning from Deaths guidance. The board is also asked to recognise the action and progress being in the LfD process at LPT.

4. Demographics

Demographic information is provided in Tables 1-5. After working with our Information Team it is clear that demographic information is not being captured at a service level. In order to overcome gaps in demographic information, an in-depth discussion took place during the Trust wide LfD meeting, where it was agreed that we needed Directorate and Board Level Support to mandate the completion of demographic information at the service level, potentially as soon as a referral to LPT was initiated. An initial meeting has been held and further investigation is required. A further meeting will take place in a months time.

Table 1: Q3 Gender & Age

Gender	Age Bands									
	1-28 (D)	Up to 12 (M)	1-10 (Y)	11-18	19-24	25-44	45-64	65-79	80+	Total
Female	5	2	0	3	0	4	9	15	25	63
Male	2	5	3	2	3	9	24	16	26	90
Total	**7**	**7**	**3**	**5**	**3**	**13**	**33**	**31**	**51**	**153**

Key: D: Day; **M:** Months; **Y:** Years

Table 2: Q3 Disability

Disability	
Disability	0
No Disability	0
Disability not recorded / not known	153
Total	**153**

Table 3: Q3 Religion

Religion	
Buddhist	0
Christian	2
Hindu	0
Jewish	0
Muslim	0
Sikh	0
Other	0
Not recorded / not known	151
No religion	0
Total	**153**

Table 4: Q3 Sexual Orientation

Sexual orientation	
Bisexual	0
Heterosexual	0
Homosexual	0
None recorded	153
Not Disclosed	0
Not applicable	0
Total	**153**

Table 2: Q3 Ethnicity

Ethnicity	
White	
English / Welsh / Scottish / Northern Irish / British / Irish	110
Any other White background	1
Mixed / Multiple ethnic groups	
White and Black African	1
White and Asian	1
Asian / Asian British	
Indian	8
Pakistani	1
Any other Asian background	6
Black / African / Caribbean / Black British	
African	4
Any other Black / African / Caribbean background	1
Other ethnic group	
Not recorded / Not known	20
Total	153

5. Number of Deaths reported and reviewed in Q3

In adherence with NHS/I (2017) recommendations, the number and percentages of deaths reviewed through mSJR case record review and the Serious Incident (SI) process across LPT in Q3 are shown in Table 6:

Table 3: Annual backlog of deaths

Breakdown by Directorate									
	CHS			**DMH/MHSOP**			**FYPC/LD**		
	Q1 (Apr-Jun)	**Q2 (Jul-Sep)**	**Q3 (Oct-Nov)**	**Q1 (Apr-Jun)**	**Q2 (Jul-Sep)**	**Q3 (Oct-Nov)**	**Q1 (Apr-Jun)**	**Q2 (Jul-Sep)**	**Q3 (Oct-Nov)**
Number of deaths reviewed	39	34	45	57	39	32	6	30	16***
Percentage of deaths reviewed	90%	65%	16%	80%	52%	42%	43%	83%	58%
Number of deaths outstanding for Directorate review	4	12	38*	14	36**	45**	8	6	15
Percentage outstanding for directorate review	10%	35%	84%	20%	48%	58%	57%	17%	52%

KEY

CHS: Community Health Services; **DMH/MHSOP:** Directorate of Mental Health/Mental Health Services for Older people; **FYPC/LD:** Families Young Persons and Children/Learning Disabilities

*CHS Allocation of December's reviews deferred to February 22.
**DMH September, October, November and December reviews for DMH are awaiting allocation.
*** FYPC this figure includes 13 Neonatal Out of Scope deaths which do not require discussion at LfD meetings

CHS

- The LFD forum meeting due to be held on 21st January 2022 was postponed due to the step down of Level 2 meetings and clinical commitments of staff engaged with Surge which has resulted in a backlog of reviews.
- The plan to recover the backlog of reviews of deaths;
    - Deaths that occurred in December 2021 were circulated for review w/c 31st January 2021 and discussed at the Screening meeting held on 22nd February 2022.

DMH(MHSOP)

- The DMH meeting due to be held on 21st December 2021 was postponed due to the step down of Level 2 meetings which has resulted in an increased backlog of reviews.
- DMH meetings were restarted in March 2022 and dates have been agreed for the next financial year 1st April 2022 to 31st March 2023. DMH will meet monthly on 1st Tuesday of the month.
- The plan to recover DMH's backlog of reviews of deaths is to meet twice monthly in March, April and May on the 2nd Tuesday of the month until caught up. This will be reviewed again in May's meeting and further additional meetings arranged if necessary.
- MHSOP have 4 outstanding reviews, 2 from Quarter 2 and 2 from Quarter 3.

FYPC/LD

- Report disseminated through the FYPC LD Clinical Leadership Forum.
- There is a new process for learning and reviewing deaths for people with a learning disability. The clinician who reported the death with complete an Adult Learning Disability Deaths Review form which is based on the IRM but also includes the learning elements from the Learning form Deaths Quality & Safety Review form.
- Not all adult deaths in December have been added to Ulysses (this is being addressed)

5.1 Learning themes identified

Learning and discussions associated with deaths in Q3 within the CHS directorate identified the importance of timely reviews as learning can be less effective if too much time has elapsed. A resulting learning action was to take the learning from the reviews back into Directorate more frequently. The use of NEWS2 and it's associated escalation remains a theme and there is a programme of work to support this. There has been an additional risk associated with the switch to BRIGID which is also being addressed. Within DMH/MHSOP, Learning from Death discussions focused on the need for increased support for patients to access services outside of DMH/MHSOP, which include the GP and the wider voluntary sector, acknowledging patients may be too unwell to initiate this contact (C718: Clinical Care, multi-disciplinary, and inter-speciality liaison) – which will be fed back into services, as a means of increasing support. In FYPC/LD it was emphasised that there was a need for timely and robust information sharing across multiple agencies (C718: Clinical Care, multi-disciplinary team working continuity of care) and a need to develop a process to identify complex patients needing care coordination. Additional learning from all directorates is provided in **Appendix 1.**

5.2 Examples of good practice

Examples of good practice in the current Quarter Q3 and previous quarters not already reported consisted of:

- **CHS:** Some examples of good communication with families

- **DMH/MHSOP:** Evidence of CPN's building really good supportive relationships for patient and families
- **FYPC/LD:** have developed a process for weighing of patients in the community to support their care

6. Number of deaths reported during Q3

In adherence with NHS/I (2017) recommendations Table 7 also shows the number of deaths reported by each Directorate for Q3. Formal investigations consist of Serious Incident (SI) investigations and modified Structured Judgement Reviews (mSJR) case record reviews:

- There were 153 deaths considered in Q3.
- There were a total of 11 deaths which are for Serious Incident Investigation.
- There were 11 adult deaths of individuals with Learning Disabilities which are undergoing LeDer review, and are to be reviewed using the mSJR case record review within FYPC.

Table 7: Number of deaths (Q3)

Q3 Mortality Data 2021										
Q3	**Oct**			**Nov**			**Dec**			**Total**
	C	**D**	**F**	**C**	**D**	**F**	**C**	**D**	**F**	**153**
Number of Deaths	11	21	10	17	30	10	17	26	11	
Consideration for formal investigation										
	C	**D**	**F**	**C**	**D**	**F**	**C**	**D**	**F**	**Total**
Serious Incident	0	6	0	0	4	0	0	1	0	**11**
mSJR* Case record review	11	21	10	17	30	10	17	26	11	**153**
Learning Disabilities deaths			2			2		7		**11**
Number of deaths reviewed/investigated and as a result considered more likely than not to be due to problems in care	0	0	0	0	0	0	0	0	0	**0**

KEY

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

7. Decision required

The Trust Board is required to confirm assurance on the implementation of the National Quality Boards Learning from Deaths guidance within the Trust.

8. Governance table

For Board and Board Committees:	Trust Board 29.3.22	
Paper presented by:	Dr Avinash Hiremath	
Paper sponsored by:	Professor Al-Uzri	
Paper authored by:	Tracy Ward/Evelyn Finnigan	
Date submitted:		
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	N/A due to no meeting	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Report provided to the Trust Board quarterly	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Report provided to the Trust Board quarterly	
STEP up to GREAT strategic alignment*:	High **S**tandards	✓
	Transformation	
	Environments	
	Patient Involvement	✓
	Well **G**overned	
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trust wide Quality Improvement	✓
Organisational Risk Register considerations:	List risk number and title of risk	1, 3
Is the decision required consistent with LPT's risk appetite:		
False and misleading information (FOMI) considerations:		
Positive confirmation that the content does not risk the safety of patients or the public		
Equality considerations:		

Appendix 1. Examples of Learning identified, both good practice and areas for improvement

Learning Code	Theme	Learning impact & Action
CHS		
E5 Documentation - Paper & Electronic	15 Completion of clinical forms i.e. DNACPR, Consent, Nursing Assessments	Nursing and ANP documentation clear and easy to follow. Due to rapid deterioration – End-of-life paperwork not completed. Outpatient needs to communicate with the ward if possible. Observation and escalation of screening for Sepsis. Trust wide programme in training and escalation in NEWS2 and Sepsis screening.
8 Medication	23 Administration (meds)	Staff to escalate refusal of medication to allow remedial action to be taken.
1 Assessment, Diagnosis & Plan	3 Management plan	Ensure all plans are scanned and kept in a consistent location for ease of staff reference and to be available and seen by staff.
E5 Documentation - Paper & Electronic	13 Correspondence – with patients, other clinical teams	Good communication with family & patient's partner.
DMH/MHSOP		
2 Communication	5 Imminence of Death/DNACPR/Prognosis	Patient had RESPECT form completed at UHL, not LPT. He reported that this had not been discussed with him first. A reminder to discuss RESPECT forms with NOK in advance when possible.
9 Ceiling of care	27 Escalation / Ceiling of care	Physical health deterioration since the admission leading to dehydration and electrolyte imbalance should have been escalated sooner. Patient was admitted to UHL and died of cardiac arrest. Signs of dehydration to be monitored and recognised and escalated promptly. Trust Task & Finish Group (Sub group of deteriorating patient and resus group) to develop and produce guidance and training.
2 Communications	4 Results/Management / Discharge Plan	Daughter was very thankful to the CPN for the support she provided from a mental health perspective and liaising with social care.
1 Assessment	1.1 Assessment	Good core assessment. Clinician had clearly identified risk and protective factors.
2 Communications	2.5 Imminence of Death/DNACPR/Prognosis	The CMHT- CPN and HCSW- kept in contact with the patient's husband when she was admitted to UHL. They made a plan to discharge her when it was clear that she was receiving end of life care.
2 Communications	4 Results/Management / Discharge Plan	Patient and care home supported by Care Home In reach team.

7 Multi-disciplinary Team Working	18 Inter-speciality liaison/continuity of care/ownership	Good working between the CMHT and Unscheduled care Service. Breach process in place and working appropriately.
7 Multi-disciplinary Team Working	19 Inter-speciality referrals/review	Standard MDT practice including joint working with Safeguarding.
1 Assessment, Diagnosis & Plan	3 Management Plan	Remained under care of DMH services.
2 Communications	4 Results/Management / Discharge Plan	CMHT were very supportive and responsive.
2 Communications	4 Results/Management / Discharge Plan	Good communication with MDT and with the family.
7 Multi-disciplinary Team Working	18 Inter-speciality liaison/continuity of care/ownership	Thorough assessment of need. Multi-disciplinary working.
2 Communications	4 Results/Management / Discharge Plan	CPN updated the notes regularly and liaised with others- including family and Admiral nurse.
5 Documentation – Paper & Electronic	14 Clinician documentation within the clinical record	
2 Communications	4 Results/Management / Discharge Plan	Good communication between LPT, family and GP.
7 Multi-disciplinary Team Working	18 Inter-speciality liaison/continuity of care/ownership	
FYPC/LD		
C10 Transfer & Handover	30 Omissions/Errors in Handover communication.	Service to ensure Safeguarding referral had been done. Investigation identified that the Ambulance Service had completed the Safeguarding referral.
7 Multi-Disciplinary Team Working	18 Inter-speciality liaison/continuity of care/ownership	Need to identify a Lead Practitioner to co-ordinate care across LD community services where multi services involved
3 Dignity & Compassion	7 ADL Assistance/Reasonable Adjustments	Weighing patients with learning disabilities, especially weighing patients in wheelchairs.
9 Monitoring, Recognition & Escalation/Ceiling of Care	25 Monitoring	Continuation of care for patients with complex needs and nurse oversight (i.e., patients under diffident specialities for example physio and speech and language who become unwell but haven't had any nurse oversight).
C&E7 Multi-Disciplinary Team Working	18 Inter-speciality liaison/continuity of care/ownership 19 Inter-speciality referrals/review	Placed on end of life. Happened over weekend so acute liaison nurses did not have input. Sister said main issue is did they know brother had an LD and was in pain. Was his pain relief handled properly? She has raised this with LRI issues related to people with LD. If a weekday may have been better liaison/care. staff at hospital needed training to communicate better with patients with Learning disability

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Leicestershire Partnership NHS Trust

Public Trust Board – 29th March 2022

Safe Staffing - December 2021 Review

Purpose of the report

This report provides a full overview of nursing safe staffing during the month of December 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 highlight report for safe staffing December 2021 was submitted to trust Board on the 25 January 2022 with an overview of key areas to note and actions to mitigate risks based on the weekly safe staffing situational and forecasting reviews.

On 20 December 2021 safe staffing and patient safety meetings were stepped up to daily in response to significant staffing challenges and to ensure safe nurse staffing levels were reviewed and any actions and risks escalated to the ICC throughout the Christmas and New Year period. Daily meetings continued into January 2022.

This report triangulates workforce metrics; fill rates, Care Hours Per Patient Day (CHPPD), quality and outcomes linked to Nurse Sensitive Indicators (NSI's) 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.

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

Right Staff

- Temporary worker utilisation rate slightly increased this month; 0.59% reported at 39.89% overall and Trust wide agency usage slightly increased this month by 1.48% to 18.43% overall
- In December 2021, 28 inpatient wards/units utilised above 6% agency staff to meet safe staffing levels, this equates to 87.5% of our inpatient wards and units.
- Areas to note are identified either by the Head/Deputy Head of Nursing due to; high percentage of temporary workforce/agency utilisation or concerns relating to ; increased acuity, high risk patients, staff sickness, ability to fill additional shifts and 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 unit, Agnes unit, Mill Lodge, Watermead, Heather, Coleman, North and East wards, Beechwood, Rutland and St Luke's ward 1.
- There are thirteen community team 'areas to note', City Community Hub, City East and West and East central, Healthy Together city and county (notably Blaby team) Looked After Children, Phlebotomy, Diana, CAMHS Crisis , Crisis resolution and Home Treatment team, Central Access Point (CAP) , South Leicestershire/Charnwood, Assertive Outreach, Attention Deficit Hyperactivity Disorder (ADHD) and memory service

- 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 confirming MDT reserve lists to deploy to support safe staffing.
- Following an escalation of a risk, a quality and equalities impact assessment was completed on 24 December 2021 and 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.
- 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 fell below national quality board/professional standards. The visiting risk assessment has been added to the ICC risk log and staffing system controls and actions were reflected in the organisational risk for staffing.
- 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).

Right Skills

During Covid-19 the compliance renewal date for each mandatory and role essential topic was extended by 6 months. Correct to 1 December 2021 Trust wide substantive staff.

  - Appraisal at 75.1%% compliance AMBER
  - Clinical supervision at 72.7 % compliance RED
  - All core mandatory training compliance GREEN except for Information Governance AMBER at 91.5%

- Clinical mandatory training compliance for substantive staff, to note.

- BLS increased compliance by 1.6 % to 85.4% compliance GREEN
- ILS increased compliance by 0.9 % to 80.9% compliance AMBER

- Clinical mandatory training compliance for bank only workforce remains low.
  - BLS 54.1% % at RED compliance
  - ILS 43.0 % 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, Beacon, and Watermead ward. Risk managed is to mean that the ward is caring for patients on the emergency admission Covid-19 high and medium risk pathways, as per the national safe staffing descriptors and IPC care pathways, maintaining separation between possible and confirmed COVID-19 patients and supporting staff cohorting.
- There was a significant number of Covid-19 outbreaks during the month of December on the Beacon unit, Rutland, Beechwood, East and St Luke's ward 1, Watermead, Coleman, Heather, Welford and Kirby wards and Central Access Point community team
- Fill rates above and below 100% for actual HCSWs predominantly on days reflect adjusted staffing levels and skill mix to meet patient care needs.
- The total Trust CHPPD average (including ward based AHPs) is reported at 17.03 CHPPD in December 2021, with a range between 4.8 (Stewart House) and 70.1 (Agnes Unit) CHPPD. General variation reflects the diversity of services, complex and specialist care provided across the Trust. Analysis has not identified significant variation at service level; indicating that staff are being deployed productively across services.

Staff Absence Data

The table below 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% this increase was attributed largely to Covid-19

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%**

In-Patient Staffing

Summary of inpatient staffing areas to note.

Wards	October 2021	November 21	December 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
St Luke's Ward 3	X	x	x
Beechwood	X	x	x
Clarendon	X	x	x
Coalville Ward 1	X	x	x
Coalville Ward 2	x		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, Beacon and Watermead. Risk managed is to mean that the ward is caring for patients on the emergency admission COVID pathway as per the national safe staffing descriptors and IPC care pathways medium and high.

The 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, increasing staff absence due to Covid related staff isolation and sickness exacerbated by omicron variant and significant vacancies. Due to decreased substantive staff numbers, the unit currently has capacity to safely staff 7 beds; this has been agreed until December 2021. Daily directorate prioritisation of services and business continuity plans enacted in addition to existing actions currently in place; for example, single ward sites to have additional RN and HCSW staff to support. All staff in non -patient facing roles with a clinical qualification are currently working within the staffing establishment to support continuity of care. The unit continues to progress with the quality improvement plan with oversight to Quality Assurance Committee (QAC). Block booking of bank and agency and successful recruitment to staff in bands 5,6 and 7 is in progress. An evidence based establishment review has been completed and presented to the Directorate Management Team (DMT) for sign off.

CHS

All in-patient wards in Community Hospitals reported operating at an amber risk overall, due to increased patient acuity and dependency, high vacancies, maternity leave, and increasing staff absence due to covid related staff isolation and sickness exacerbated by the omicron variant. All wards operating at 50% substantive Registered Nurse (RN) and 50%

bank/agency 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. Key areas to note, North and East ward, Beechwood, Rutland and St Luke's ward 1. Covid outbreaks on Rutland, Beechwood, East and St Luke's ward 1. Rutland and Beechwood were temporarily closed to admissions due to outbreaks and staffing impact. 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. Sixteen international nurses recruited to a number of wards and in supernumerary phase.

DMH

Mill Lodge continues as a key area to note 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. Daily directorate review continues with a number of actions 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.

In patient wards across DMH reported increased patient acuity and dependency, complexity, vacancies, sickness and increasing staff absence due to covid related staff isolation exacerbated by omicron variant and additional increased staff movement and promotions to urgent care pathway roles and step up to great mental health transformation impacting safer staffing. Key areas to note; Watermead, Heather and Coleman wards. With Covid outbreaks on Watermead, Coleman, Heather, Welford and Kirby wards. Staff movement across the wards to ensure substantive RN cover and flexible workers (booked in addition to block booking of temporary workforce) to cover last minute sickness/shortfalls.

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	October2021	November 2021	December 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
Children's Phlebotomy team			x
CAMHS Crisis team (on call rota)			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
Crisis team	x	x	x
Central Access Point (CAP)	x	x	x

Table 3 – Community areas to note

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

FYPC/LD Community

Healthy Together City, County, Diana service and Looked After Children (LAC) teams continue to be rated to be at moderate to high risk due to vacancies, absence 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 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 December 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 leads and a plan has been implemented which includes an assurance framework to be reviewed by Designated Lead Nurse for LAC.

CHS Community

Throughout December 2021, Community Nursing has been reporting operating at OPEL level 3 working to level 3actions. 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. Increasing staff absence due to covid related staff isolation and sickness exacerbated by omicron variant continues to impact on service provision with the highest risk being in the City community nursing hub, with key areas to note; City East, City West and East Central.

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:

- 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).
- Following the quality summit held on the 2nd November 2021, a quality improvement plan is in place focusing on workforce, learning from serious incident investigation, a pressure ulcer Quality Improvement (QI) programme and staff engagement and communication with oversight to QAC.

MH Community

The Central Access Point (CAP) and 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 numbers (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 Melton CMHT, Charnwood CMHT, South Leicestershire CMHT, the ADHD Service, Assertive Outreach and Memory service.

Proposal

Considering the triangulated review of workforce metrics, nurse sensitive indicators, patient feedback and outcomes in December 2021 and high levels of staff sickness absence, it is recognised that significant staffing challenges continue and there is emerging evidence that current controls and implemented business continuity plans are not fully mitigating the risk, impacting the quality and safety of patient care across services.

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.

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 actions in place to try to mitigate the risk of impact 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 (Early & Late Shift) – 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	% Temporary Workers (NURSING ONLY) – Bank	% Temporary Workers (NURSING ONLY) – Agency	Overall CHPPD (Nursing And AHP)	Medication Errors	Falls	Complaints	PU Category 2 (in month)	PU Category 4 (in month)
				>=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	1	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	0	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	3	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	3	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	1	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	4	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	2	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	1	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		

Annexe 2: Inpatient Ward triangulation staffing and NSIs.

Pressure ulcer data is accurate for the month of December 2021

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	83.4%	180.3%	98.1%	110.7%	40.7%	25.5%	15.3%	8.3	0→	2↑	→0
Aston	19	97.5%	186.6%	112.3%	161.9%	58.0%	26.9%	31.1%	7.1	↑1	2↑	→0
Beaumont	20	91.4%	131.2%	103.0%	129.5%	49.8%	35.4%	14.4%	11.4	↑4	↓1	2↑
Belvoir Unit	10	108.7%	188.0%	101.5%	215.9%	53.7%	32.4%	21.3%	20.8	→1	↑1	→0
Heather	18	75.3%	211.5%	99.7%	148.0%	57.5%	34.1%	23.4%	6.9	→1	2↑	0↓
Thornton	12	76.4%	194.1%	102.9%	123.2%	38.4%	31.2%	7.2%	9.5	→0	→0	→0
Watermead	19	82.6%	228.2%	109.8%	212.3%	47.1%	15.6%	31.5%	8.0	↑3	↓3	→1
Griffin - Herschel Prins	6	105.8%	202.2%	103.8%	486.6%	55.5%	32.8%	22.7%	28.7	↑1	→0	→0
Totals										↑11	↓11	↑3

Table 4 - Acute inpatient ward safe staffing

The majority of wards have utilised a high percentage of temporary workforce in December 2021, due to high/complex patient acuity and to meet planned safe staffing levels due to vacancies and COVID-19 related sickness

Analysis of the falls in December has shown 11 falls reported, which is a slight decrease from 13 in November 2021. The main areas where falls were experienced were in bedrooms and corridors and 4 were first falls.

All medication errors have been reviewed in line with Trust policy; there were eleven medication errors in December 2021 that occurred on five wards an increase compared to November 2021. Of the eleven incidents five were E-CD register recording errors; one incident involved the

incorrect return of medication to pharmacy, another incident was in relation to a relative giving medication whilst the patient was on leave, one prescribing error, one additional dose was given in another hospital (so the error did not occur on our site) and an additional dose given over the 24 hour period. Of the eleven medication errors, only one actual drug error was within Acute and PICU with the additional dose being administered over a 24-hour period. This was given by an Agency Nurse who has been supported and reviewed in line with the medication error policy and has completed a reflection.

Due to the increase in medication incidents related to E-CD recording errors, liaison will take place with pharmacy and Medication Risk Reduction Group to establish if this is identified as a theme across the Trust and support that can be put in place.

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	104.6%	169.1%	105.3%	162.8%	43.5%	24.9%	18.6%	12.7	→0	→0	→0
Totals										→0	→0	→0

Table 5- Low secure safe staffing

There were no complaints, medication errors or falls reported in December 2021 at Phoenix, Hershel Prins. Phoenix continued to use a higher proportion of agency staff in December 2021 to support planned staffing due to staff vacancies and sickness.

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 errors	Falls	Complaints
Skye Wing	29	106.6%	99.2%	127.7%	140.0%	30.6%	26.7%	4.0%	4.8	↑1	↓0	→0
Willows	8	140.5%	126.5%	102.3%	147.8%	42.9%	36.5%	6.3%	15.5	↓0	↑1	↑1
Mill Lodge	10	83.0%	92.0%	131.4%	134.4%	65.5%	42.5%	23.0%	16.0	→0	→7	→0
TOTALS										→1	↓8	↑1

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 some staff still awaiting to start. One international nurse has registered with the NMC and recruitment is ongoing for RN vacancies

Willows use of temporary staff is higher due to the acuity of one of the wards, a step down from acute wards requiring adjusted skill mix and staffing. The opening of one of the Wards at Willows as the Red Ward for COVID-19 for DMH has seen fluctuations in use of bank and agency depending on its occupancy.

There has been one medication incident in December 2021 which is consistent with November 2021. This was a charting error (not charted) staff were unaware if the medication had been administered. Therefore, if the medication was previously administered it could not be given.

There were eight patient falls in December 2021: a decrease from eleven in November 2021.

Of the falls reported for the rehabilitation service, these occurred in bedrooms and the communal lounge. One was a first fall and seven were repeat falls, seven were patients with repeat falls and three patients with first falls.

Seven of the eight falls were reported at Mill lodge, which is consistent with November 2021; all incidents were repeat falls. The seven falls were all located in the bedroom and were in relation to three patients, linked to deterioration in their Huntington's Disease symptoms.

One fall reported at the Willows, involved a patient who received an injury and was transferred to A&E, an incident investigation review was completed.

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	Complaints	Complaints	PU Category 2	PU Category 4
Kirby	20	50.6%	110.1%	122.6%	153.1%	40.4%	33.1%	7.4%	7.5	↓0	→5	→0	→0	→0
Welford	20	62.1%	102.3%	126.9%	137.6%	14.6%	11.6%	3.0%	6.1	↑2	↓1	→0	→0	→0
Coleman	14	69.3%	139.2%	133.3%	238.7%	39.0%	24.4%	14.5%	14.1	↑1	↑7	→0	→0	→0
Wakerley	16	104.6%	118.5%	152.6%	185.0%	47.3%	28.0%	19.3%	14.0	↑2	↑8	→0	→0	→0
TOTALS										↑5	↑21	→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, Welford and Coleman Wards. The staffing establishment on these wards consist of a Medication Administration Technician (MAT) and nursing associates. Kirby Ward has a Mental Health Practitioner (MHP), which does not fall within the registered nurse numbers.

The service continues to use temporary staff to support unfilled shifts due to vacancies, sickness and to support increased patient acuity and levels of observation. All the wards have vacancies for registered nurses, an advert is currently out for Registered Nurse recruitment. In addition, each ward has two international recruitment nurses who commenced in post 20th December 2021. They are currently supernumerary whilst awaiting completion of the OSCE programme in preparation for NMC registration.
Staffing continues to be risk assessed and managed across all MHSOP wards and staff moved to support safe staffing levels and skill mix whilst considering patient care needs/acuity and dependency.

There were no pressure ulcer incidences reported in December 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 were five medication errors reported in December 2021, one for Coleman, two for Wakerley ward and two for Welford. None of the incidents were related to staffing of the ward and there was no harm to patients. Of the five medication errors reported; one related to covert medication administration, two related to discrepancy in recording on controlled medication on the CD register, another related to liquid medication measurement and query wastage/spillage and one related to a prescription whereby the patient was prescribed a higher dose of a medication on admission than in the community. The higher dose was not administered.

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	Complaints	Complaints	PU Category 2	PU Category 4
MM Dalgliesh	15	104.1%	85.0%	105.1%	107.1%	21.2%	9.2%	11.9%	8.3	→1	↓0	→0	↓0	→0
Rutland	12	54.7%	86.3%	67.7%	72.2%	31.5%	19.0%	12.5%	10.4	→0	↓0	↑1	↑3	→0
SL Ward 1	14	72.2%	104.9%	96.6%	145.1%	22.3%	13.2%	9.0%	11.5	→1	↑3	→0	→0	→0
SL Ward 3	11	107.3%	109.0%	94.8%	177.7%	21.2%	9.2%	11.9%	8.3	→1	→3	→0	↑3	→0
CV Ellistown 2	13	95.2%	110.2%	93.5%	123.2%	13.8%	7.7%	6.2%	10.9	↑3	↓2	→0	→1	→0
CV Snibston 1	15	80.1%	126.2%	101.6%	116.4%	18.1%	6.4%	11.8%	11.3	→0	↓1	→0	↑1	→0
HB East Ward	19	93.2%	108.6%	124.0%	147.7%	29.4%	4.3%	25.1%	10.0	→2	↑11	↑1	↑4	→0
HB North Ward	14	101.1%	97.6%	103.3%	106.2%	30.1%	9.1%	21.0%	11.5	↓1	↑6	→0	↑2	→0
Swithland	16	98.3%	95.1%	87.4%	142.8%	14.3%	5.3%	9.0%	9.7	↑1	↑5	→0	↑1	→0
CB Beechwood	19	88.2%	107.4%	101.0%	123.6%	37.3%	13.5%	23.8%	9.6	↑6	↑3	↓0	→1	→0
CB Clarendon	19	81.4%	110.9%	99.5%	119.8%	33.1%	10.3%	22.8%	9.5	↓0	↑6	→0	↓1	→0
TOTALS										↑16	↑40	↑2	↑17	→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.

Rutland Ward's data is reduced as it was closed on Christmas Eve due to the impact of a COVID 19 outbreak which impacted on patients and staff. The decision to close the ward temporarily was made with the clinical team supported by the Trust executive Team. The Ward reopened on Tuesday 4th Jan 2022.

St Lukes Ward 1 fill rate for registered nurses has reduced, this was due to the ward having

a COVID 19 outbreak towards the end of December and reduced RN requirement due to the closed beds for infection prevention and control reasons (up to 12 beds out of 17 were closed).

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 continues to rise compared to November 21 with areas to note of North, East, Beechwood and Clarendon 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, sickness and impact of COVID 19 related isolation requirements.

A review of the Nurse Sensitive Indicators (NSIs) for the community hospital wards has identified an increase in the number of falls incidents from 26 in November 2021 to 40 in December 2021 comprising of thirty one first falls, eight repeat falls and one patient placed on the floor. Ward areas to note are East Ward, North, Clarendon 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 fifteen in November 2021 to sixteen in December 2021. 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 increased from seven in November 2021 to seventeen in December 2021. Areas to note are Rutland, East Ward and Ward 3 St Luke's. A particular focus for the ward teams during quarter 4 reviewing training for both registered and non-registered staff, focusing on prevention, repositioning and management plans.

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	Complaints	Complaints
Langley	14	143.6%	87.5%	146.2%	126.2%	43.0%	33.1%	9.9%	10.8	→1	↓0	→0
CAMHS	7	135.0%	159.0%	156.1%	316.6%	72.3%	21.7%	50.6%	33.2	↓0	→0	→0
TOTALS										↓1	↓0	→0

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

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

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. Recruitment to Band 5 positions remains a challenge and reflects the national picture.

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

There was no medication error on the CAMHS Beacon Unit in December 2021.

Langley had one medication error, and this was an increase from the previous month and a full review of the incident confirmed this 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	Complaints	Complaints
Agnes Unit	2	117.6%	96.1%	141.1%	137.3%	58.2%	24.4%	33.8%	70.1	↑1	→0	→0
Gillivers	1	95.5%	72.3%	107.5%	90.3%	6.6%	6.6%	0.0%	68.6	→0	↑1	→0
1 The Grange	1	86.7%	83.3%	-	102.7%	12.9%	11.7%	1.2%	57.3	↑1	↑5	0→
TOTALS										↑2	↑6	→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. There was one medication error in December 2021 and a full review of the incident has not identified any staffing impact on the quality and safety of patient care/outcomes.

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 was one medication error on The Grange and the incident has been fully reviewed to explore learning and implement actions. 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 29.3.22	
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:	29.03.2022	
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:		

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Leicestershire Partnership NHS Trust

Public Trust Board – 29 March 2022

Safe Staffing- January 2022 Review

Purpose of the report

This report provides a full overview of nursing safe staffing during the month of January 2022, 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.

This report triangulates workforce metrics; fill rates, Care Hours Per Patient Day (CHPPD), quality and outcomes linked to Nurse Sensitive Indicators (NSI's) 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 increased this month; 3.19 % reported at 43.08% overall and Trust wide agency usage slightly increased this month by 3.59% to 20.54% overall.
- In January 2022; 30 inpatient wards/units utilised above 6% agency staff to meet safe staffing levels, this equates to 93.75% of our inpatient Wards and Units, changes from last month include Stewart House and Welford ward.
- Areas to note are identified either by the Head/Deputy Head of Nursing due to; high percentage of temporary worker/agency utilisation or concerns relating to; increased acuity, high risk patients, staff sickness, ability to fill additional shifts and the impact to safe and effective care.
- The key in-patient areas to note regarding current staffing challenges with high risk and potential impact to quality and safety; Beacon unit, Agnes unit, Mill Lodge, Watermead, Coleman, Wakerley, North and East wards, Beechwood and Clarendon.
- 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, Melton, Charnwood, Assertive outreach, ADHD Community Mental Health Teams, and the memory service.

Right Skills

- During Covid-19 the compliance renewal date for each mandatory and role essential topic was extended by 6 months. Correct to 1 February 2022 Trust wide substantive staff;
    - Appraisal at 73.7% compliance AMBER
    - Clinical supervision at 71.3% compliance RED
    - All core mandatory training compliance GREEN except for Information Governance AMBER at 91.6%
- Clinical mandatory training compliance for substantive staff, to note.
    - BLS increased compliance by 2.4 % to 87.8% compliance GREEN
    - ILS increased compliance by 0.4 % to 81.3% compliance AMBER
- Clinical mandatory training compliance for bank only workforce remains low.
    - BLS 58.9% at RED compliance
    - ILS 45.5% 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 - updated

- 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.
- There was a significant number of Covid-19 outbreaks during the month of January 2022 on Agnes unit, Beacon, Welford, Beaumont, Thornton, Coalville (ward 4), Coleman, Wakerley, East ward, Swithland, St Luke's ward 3 and Maple ward.

- Fill rates above and below 100% for actual HCSWs predominantly on days reflect adjusted staffing levels and skill mix to meet patient care needs.

- The total Trust CHPPD average (including ward based AHPs) is reported at 17.47 CHPPD in January 2022, with a range between 5.3 (Stewart House) and 70.4 (Agnes Unit) CHPPD. General variation reflects the diversity of services, complex and specialist care provided across the Trust. Analysis has not identified significant variation at service level; indicating that staff are being deployed productively across services.

Staff absence data

Absence by directorate	Sickness absence	Self-Isolation - Working from home	Self-Isolation - Unable to work from home	Total
Community Health Services	4.9%	0.9%	1.8%	7.6%
Enabling Services	2.0%	0.2%	0.8%	2.9%
FYPC	4.2%	1.6%	3.6%	9.4%
Hosted Service	1.4%	0.5%	1.3%	3.3%
Mental Health Services	4.9%	0.9%	2.5%	8.4%
LPT Total	**4.3%**	**1.0%**	**2.4%**	**7.6%**

Table 1 – COVID-19 and general absence – 31 January 2022

In comparison to the previous month total absence has decreased by 3.5% associated with an increase in general absence overall.

In-patient Staffing

Summary of inpatient staffing areas to note.

Wards	November 21	December 21	January 22
Hinckley and Bosworth East Ward	x	x	x
Hinckley and Bosworth North Ward	x	x	x
St Luke's Ward 1	x	x	x
St Luke's Ward 3	x	x	x
Beechwood	x	x	x
Clarendon	x	x	x
Coalville Ward 1	x	x	x
Coalville Ward 2		x	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
Stewart House		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, 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.

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, increasing staff absence due to Covid related staff isolation and sickness exacerbated by omicron variant and significant vacancies. Due to decreased substantive staff numbers, the Beacon unit has capacity to safely staff 7 beds, this is under daily review and has been agreed with commissioners. Daily directorate prioritisation of services and business continuity plans enacted in addition to existing actions currently in place; for example, single ward sites to have additional RN and HCSW staff to support. All staff in non -patient facing roles with a clinical qualification are currently working within the staffing establishment to support continuity of care. 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, presented to FYPC.LD DMT and in discussion with commissioners.

CHS

All in-patient wards in Community Hospitals reported operating at an amber risk overall, due to increased patient acuity and dependency, high vacancies, maternity leave, and increasing staff absence due to covid related staff isolation and sickness exacerbated by the omicron variant. All wards operating at 50% substantive RN and 50% bank/agency 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. Key areas to note North, East, Beechwood, and Clarendon wards. Covid outbreaks on Coalville (ward 4), East ward, Swithland, St Luke's ward 3. 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. Sixteen international nurses recruited to a number of wards and in supernumerary phase.

DMH

Mill Lodge continues as a key area to note 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. Daily directorate review continues with a number of actions 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 quality improvement plan implementation continues focusing on leadership, culture, and staffing with oversight to QAC.

In patient wards across DMH reported increased acuity and dependency, complexity, vacancies, sickness and increasing staff absence due to covid related staff isolation exacerbated by omicron variant and additional increased staff movement and promotions to urgent care pathway roles and step up to great mental health transformation. Key areas to note; Watermead, Coleman and Wakerley wards. With Covid outbreaks on Welford, Beaumont, Thornton, Coleman, Wakerley, and Maple ward. Staff Movement across the wards to ensure substantive RN cover and flexible workers (booked in addition to block booking of temporary workforce) to cover last minute sickness/shortfalls. 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	November 2021	December 2021	January 2022
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
Children's Phlebotomy team		x	x
CAMHS Crisis team (on call rota)		x	x

South Leicestershire CMHT	x	x	
Melton CMHT			x
Charnwood CMHT	x	x	x
Memory service	x	x	x
Assertive outreach	x	x	x
ADHD service	x	x	x
Crisis team	x	x	x
Central Access Point (CAP)	x	x	x

Table 3 – Community areas to note

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

FYPC/LD Community

Healthy Together City, County, Diana service and Looked After Children (LAC) teams continue to be rated to be at moderate to high risk due to vacancies, absence 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 continue and 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 January 2022. 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 recruiting to Band 4 posts.

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 leads and a plan has been implemented and continues including an assurance framework to be reviewed by Designated Lead Nurse for LAC.

CHS Community

Throughout January 2022, Community Nursing has been reporting operating at OPEL level 3 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. Increasing staff absence due to covid related staff isolation and sickness exacerbated by omicron variant continues to impact on service provision with the highest risk being in the City community nursing hub, with key areas to note, City, East Central and Hinckley.

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, Podiatry 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.

Several actions remain in place and continue to mitigate the staffing risks including:

- 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 and to ensure the process to regulate deferred visits is fully understood.
- 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
- Piloting new service line situational rep and weekend safe staffing risk assessment
- Ongoing targeted recruitment campaign to band 5 RNs, Health Care Support Workers, assistant practitioner, and nursing associates continues. This month the focus is upon advertising on petrol station nozzles and via YouTube. A Registered Nurse advert is open until June 2022. Recruitment process continues with Interviews taking place this month for Registered Nurses (RN's) and Health care Support Workers (HCSWs).

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 Crisis Team continue to experience high levels of routine referrals. The Crisis Resolution and Home Treatment team continues as 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 Melton, Charnwood CMHT, the ADHD Service, Assertive Outreach and Memory service.

Proposal

Considering the triangulated review of workforce metrics, nurse sensitive indicators, patient feedback and outcomes in January 2022 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.

January 2022

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 (Early & Late Shift) – 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	14	14	93.8%	209.7%	119.1%	151.6%			47.3%	26.5%	20.9%	9.6	→0	↑5	→0		
	Aston	19	20	92.5%	231.9%	125.8%	211.0%			63.2%	24.8%	38.4%	7.9	↓0	↑3	→0		
	Beaumont	22	20	86.3%	122.9%	101.6%	123.0%			53.7%	39.8%	14.0%	11.2	↓1	→1	↓1		
	Belvoir Unit	10	10	104.3%	180.9%	110.3%	194.8%			50.5%	31.8%	18.6%	20.0	↓0	↓0	→0		
	Heather	18	18	92.5%	208.1%	110.9%	157.0%			58.2%	30.8%	27.4%	7.5	↑2	↓0	↑1		
	Thornton	17	14	90.3%	146.6%	96.4%	111.2%			40.3%	33.0%	7.3%	8.0	→0	→0	→0		
	Watermead	20	16	120.1%	240.9%	129.0%	245.4%		100.0%	44.7%	14.1%	30.6%	11.4	↓2	↓1	↓0		
	Griffin - Herschel Prins	6	5	141.0%	183.7%	126.5%	432.0%			54.1%	21.3%	32.8%	31.4	↓0	→0	→0		
AMH Other	Phoenix - Herschel Prins	12	11	108.9%	148.7%	105.3%	143.8%		100.0%	37.3%	19.2%	18.0%	12.1	→0	→0	→0		
	Skye Wing - Stewart House	30	28	100.0%	109.8%	146.2%	157.2%			41.0%	33.2%	7.8%	5.3	→1	↑2	→0		
	Willows	9	7	145.5%	159.1%	124.2%	182.6%			56.6%	39.7%	16.9%	16.5	1↑	→1	↓0		
	Mill Lodge	14	10	76.8%	87.0%	129.6%	114.2%			58.4%	43.5%	15.0%	15.5	↑3	↓3	→0		
CHS City	Kirby	23	18	51.5%	101.1%	122.3%	159.1%	100.0%	100.0%	36.1%	28.6%	7.5%	8.6	→0	→5	→0	→0	→0
	Welford	24	16	63.2%	99.0%	124.6%	152.7%			26.5%	17.6%	8.9%	7.6	↓0	↑6	→0	→0	→0
	Beechwood Ward - BC03	23	18	81.8%	75.4%	95.2%	109.5%	100.0%	100.0%	29.6%	13.8%	15.8%	8.4	↓4	↑6	↑1	↓0	→0
	Clarendon Ward - CW01	21	19	84.1%	106.1%	101.6%	107.4%	100.0%	100.0%	33.5%	12.0%	21.5%	9.1	↑1	↓4	→0	→0	→0
	Coleman	21	11	58.5%	120.2%	135.5%	262.3%	100.0%	100.0%	40.8%	23.2%	17.5%	17.0	↓0	→7	→0	→0	→0
	Wakerley (MHSOP)	21	18	110.3%	105.3%	133.1%	177.9%			53.8%	28.1%	25.7%	11.7	↓0	↑15	→0	→0	→0
CHS East	Dalgleish Ward – MMDW	17	15	101.9%	79.1%	93.3%	91.9%	100.0%	100.0%	25.9%	11.5%	14.4%	7.5	↓0	↑1	→0	↑2	→0
	Rutland Ward – RURW	19	13	78.8%	95.7%	71.0%	107.8%	100.0%	100.0%	29.3%	20.8%	8.5%	9.0	↑1	↑2	↓0	↓0	→0
	Ward 1 - SL1	17	13	74.9%	104.9%	99.8%	127.8%	100.0%	100.0%	22.8%	14.7%	8.1%	11.8	↓0	↓0	→0	→0	→0
	Ward 3 - SL3	11	9	101.4%	99.9%	100.0%	186.3%	100.0%	100.0%	26.1%	18.6%	7.5%	12.7	↓0	↓0	→0	↓0	→0
CHS West	Ellistown Ward – CVEL	16	12	97.6%	100.0%	106.9%	129.1%	100.0%	100.0%	15.7%	4.0%	11.7%	12.7	→3	↑5	→0	↓0	→0
	Snibston Ward – CVSN	18	15	82.8%	127.9%	103.1%	112.0%	100.0%	100.0%	15.4%	7.1%	8.2%	10.9	→0	↑8	↑1	→1	→0
	East Ward – HSEW	21	18	95.0%	105.5%	112.4%	125.4%	100.0%	100.0%	35.7%	10.1%	25.6%	9.9	↓1	↓3	↓0	↑3	→0
	North Ward – HSNW	18	14	114.7%	100.2%	96.7%	113.8%	100.0%	100.0%	39.1%	9.1%	30.1%	11.1	→1	↑0	→0	↓1	→0
	Swithland Ward – LBSW	18	16	100.3%	95.1%	94.8%	143.5%	100.0%	100.0%	17.2%	7.4%	9.8%	9.9	→1	↑7	→0	↓0	→0
FYPC	Langley	15	13	88.9%	97.6%	133.3%	127.9%	100.0%		50.4%	38.4%	12.0%	13.1	↓0	→0	→0		
	CAMHS Beacon Ward - Inpatient Adolescent	16	7	119.7%	214.6%	180.7%	416.1%			76.3%	21.6%	54.7%	39.5	→0	↑1	→0		
LD	Agnes Unit	4	2	113.0%	98.5%	129.8%	147.1%			59.6%	25.0%	34.6%	70.4	↓0	↑3	→0		
	Gillivers	4	1	89.0%	68.5%	98.9%	98.9%			6.0%	6.0%	0.0%	65.7	↑1	↓0	→0		
	1 The Grange	2	1	56.3%	87.8%	-	106.1%			14.5%	13.9%	0.6%	56.2	↓0	↓1	→0		

Annexe 2: Inpatient Ward triangulation staffing and NSIs.

Trust thresholds are indicated below.

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

Mental Health (MH)

Acute Inpatient Wards

Ward	Average no. of Occupied Beds	Average % fill rate registered nurses	Average % fill rate care staff	Average % fill rate registered nurses	Average % fill rate care staff	Total	Bank	Agency	CHPPD	Medication Errors	Falls	Complaints
		>=80%	>=80%	>=80%	>=80%	<20%						
Ashby	14	93.8%	209.7%	119.1%	151.6%	47.3%	26.5%	20.9%	9.6	→0	↑5	→0
Aston	20	92.5%	231.9%	125.8%	211.0%	63.2%	24.8%	38.4%	7.9	↓0	↑3	→0
Beaumont	20	86.3%	122.9%	101.6%	123.0%	53.7%	39.8%	14.0%	11.2	↓1	→1	↓1
Belvoir Unit	10	104.3%	180.9%	110.3%	194.8%	50.5%	31.8%	18.6%	20.0	↓0	↓0	→0
Heather	18	92.5%	208.1%	110.9%	157.0%	58.2%	30.8%	27.4%	7.5	↑2	↓0	↑1
Thornton	14	90.3%	146.6%	96.4%	111.2%	40.3%	33.0%	7.3%	8.0	→0	→0	→0
Watermead	16	120.1%	240.9%	129.0%	245.4%	44.7%	14.1%	30.6%	11.4	↓2	↓1	↓0
Griffin - Herschel Prins	5	141.0%	183.7%	126.5%	432.0%	54.1%	21.3%	32.8%	31.4	↓0	→0	→0
Totals										↓5	↓10	↓2

Table 4 - Acute inpatient ward safe staffing

All the wards have used a high percentage of temporary workforce throughout January 2022.This is due to high acuity /patient complexity and to meet planned staffing levels with the added pressure of Covid related sickness and staff vacancies.

There were ten falls reported during January 2022. This is a slight decrease in falls from eleven reported in December 2021. The ten falls comprised of first falls and repeat falls, for three patients relating to their clinical condition and medication. The falls occurred in bathrooms, bedrooms, and communal areas. Analysis has shown that staffing was not a contributory factor.

There were five medication errors reported which is a decrease compared to December 2021. One incident involved a patient being given the incorrect medication prior to leave. The medication had been reviewed and amended and there were two packs of leave medication. The patient was given the medication that was dispensed prior to the medication review.

Three incidents related to the Electronic Controlled Drug (CD) register; an incorrect recording of a patient's own CD medication not being logged or stored correctly, another was incorrect storage and recording on to the CD register and the third related to incorrect calculation of a patient's own CD medication with the ward stock and incorrect recording on to the CD register. The fifth incident related to a prescribing error. Every ward Clinic room has now been updated with copies of the medication policy for all staff including temporary staffing. Analysis has shown there was no direct correlation with staffing.

Low Secure Services – Herschel Prins

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints
HP Phoenix	11	108.9%	148.7%	105.3%	143.8%	37.3%	19.2%	18.0%	12.1	→0	→0	→0
Totals										→0	→0	→0

Table 5- Low secure safe staffing

Phoenix continues to use high proportion of bank and agency Staff to support planned staffing levels and to cover vacancies and sickness. There were no medication errors or falls reported for Phoenix Ward for January 2022.

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	28	100.0%	109.8 %	146.2%	157.2%	41.0%	33.2%	7.8%	5.3	→1	↑2	→0
Willows	7	145.5%	159.1 %	124.2%	182.6%	56.6%	39.7%	16.9%	16.5	1↑	→1	↓0
Mill Lodge	10	76.8%	87.0%	129.6%	114.2%	58.4%	43.5%	15.0%	15.5	↑3	↓3	→0
TOTALS										↑5	↓6	↓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. Mill lodge has had some staff leave and additional sickness which has resulted in an increase in temporary staffing utilisation. One international nurse has registered with the Nursing Midwifery Council (NMC) and another is awaiting completion of their OSCE, registration planned for March 2022. A new Registered Nurse band 5 is starting in April 2022 with rolling adverts out for nursing vacancies and on -going recruitment. The DMT is considering a premia payment for all substantive nursing staff on the ward in bands 2- 7 to assist with retention.

Willows use of temporary staffing remains higher due to the opening of the additional ward as the red ward for COVID- 19 for DMH with fluctuations in use of the bank and agency depending on its occupancy.

There have been five medication errors in January 2022 which is an increase from December 2021. One incident occurred on Skye ward relating to medication procedure, another incident occurred at Mill Lodge relating to the Electronic CD register not allowing the recording of a second checker and omission of an anti-biotic medication. There was also an incident relating to a faulty vial of medication and a medication being unavailable to administer as prescribed pharmacy contacted with new medicines re-ordered and medication administered correctly

There were six falls reported in January 2022 a decrease from December 2021. Two of the falls were repeat falls occurring in the patient's bedroom at Mill lodge; whereby a patient slipped from their bed onto a safety mat, another patient slipped down an adapted chair. There was no patient harm or injuries both patients were hoisted back and made comfortable. A further two incidents occurred at Stewart house involving a patient tripping over another patients walking aid and another patient who attempted to stand out of their chair. One patient sustained a bruised knee, patients were medically reviewed and made comfortable. Another patient slid out of bed onto the floor at the Willows, with no injuries as a result of the slip.

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
Kirby	18	51.5%	101.1%	122.3%	159.1%	36.1%	28.6%	7.5%	8.6	→0	→5	→0	→0	→0
Welford	16	63.2%	99.0%	124.6%	152.7%	26.5%	17.6%	8.9%	7.6	↓0	↑6	→0	→0	→0
Coleman	11	58.5%	120.2%	135.5%	262.3%	40.8%	23.2%	17.5%	17.0	↓0	→7	→0	→0	→0
Wakerley	18	110.3%	105.3%	133.1%	177.9%	53.8%	28.1%	25.7%	11.7	↓0	↑15	→0	→0	→0
TOTALS										↓0	↑33	→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, Welford and Coleman Wards. The staffing establishment on these wards consist of a Medication Administration Technician (MAT) and nursing associates. Kirby Ward has a Mental Health Practitioner (MHP), which does not fall within the registered nurse numbers.

The service continues to use temporary staff to support unfilled shifts due to vacancies, sickness and to support increased patient acuity and levels of observation. All the wards have vacancies for registered nurses, advert is currently out Registered Nurse recruitment. In addition, each ward has two international recruitment nurses who commenced in post 20th December 2021. They are currently completing OSCE training and transitioning into substantive roles once successful completion of OSCE.

Staffing continues to be risk assessed and managed across all MHSOP wards and staff moved to support safe staffing levels and skill mix whilst considering patient care needs/acuity and dependency. Acuity across all wards increased significantly during January 2022 which increased the need for additional temporary staffing. Staffing was further compounded by all MHSOP wards having Covid 19 outbreaks resulting in increased staffing absence.

There were no pressure ulcer incidents reported in January 2022 and no complaints received.

A review of falls for MHSOP wards identified; Wakerley where one patient with eight recorded falls during the period, and two patients with three recorded falls each – thirteen of the falls were reported during the night shift in patient bedrooms. Coleman reported five of the falls during the night shift with one patient recording four falls during the period. Kirby ward also reported higher number of falls during the night shift with two patients repeat falling (on recorded three falls, other two falls). Welford had two patients with repeated falls.

Falls huddles were implemented to minimise risk of further falling. The falls process was followed in each case and physiotherapy involvement established prior to falls occurring in most cases. 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.

There were no medication errors reported in January 2022.

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 Dalgleish	15	101.9%	79.1%	93.3%	91.9%	25.9%	11.5%	14.4%	7.5	↓0	↑1	→0	↑2	→0
Rutland	13	78.8%	95.7%	71.0%	107.8%	29.3%	20.8%	8.5%	9.0	↑1	↑2	↓0	↓0	→0
SL Ward 1	13	74.9%	104.9%	99.8%	127.8%	22.8%	14.7%	8.1%	11.8	↓0	↓0	→0	→0	→0
SL Ward 3	9	101.4%	99.9%	100.0%	186.3%	26.1%	18.6%	7.5%	12.7	↓0	↓0	→0	↓0	→0
CV Elliston 2	12	97.6%	100.0%	106.9%	129.1%	15.7%	4.0%	11.7%	12.7	→3	↑5	→0	↓0	→0
CV Snibston 1	15	82.8%	127.9%	103.1%	112.0%	15.4%	7.1%	8.2%	10.9	→0	↑8	↑1	→1	→0
HB East Ward	18	95.0%	105.5%	112.4%	125.4%	35.7%	10.1%	25.6%	9.9	↓1	↓3	↓0	↑3	→0
HB North Ward	14	114.7%	100.2%	96.7%	113.8%	39.1%	9.1%	30.1%	11.1	→1	↑0	→0	↓1	→0
Swithland	16	100.3%	95.1%	94.8%	143.5%	17.2%	7.4%	9.8%	9.9	→1	↑7	→0	↓0	→0
CB Beechwood	18	81.8%	75.4%	95.2%	109.5%	29.6%	13.8%	15.8%	8.4	↓4	↑6	↑1	↓0	→0
CB Clarendon	19	84.1%	106.1%	101.6%	107.4%	33.5%	12.0%	21.5%	9.1	↑1	↓4	→0	→0	→0
TOTALS										↓12	↓36	→2	↓7	→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.

There has been a reduced fill rate for registered nurses on Rutland Ward for day and night shifts and St Luke's Ward 1 (day shifts) and for HCA shifts on Beechwood Ward and Dalgleish Ward night shifts, this is due to the impact of sickness, maternity leave and vacancies. A review of the episodes has identified that temporary staff (agency) did not attend for shifts or cancelled the shift at the last minute prior to the shift time starting. The Trusts Centralised Staffing Solutions department are monitoring last minute cancellations and escalate through contracting meetings with agency providers.

The increased fill rate for HCA on night shifts for Snibston Stroke Ward, Ward 3 St Luke's, Ward 2 Coalville, Swithland Ward, East Ward is due to increased acuity and dependency and patients requiring enhanced observations, one to one supervision.

Temporary workforce usage continues to remain high across North, East, Beechwood and Clarendon 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, sickness and impact of COVID 19 related isolation requirements.

A review of the Nurse Sensitive Indicators (NSIs) for the community hospital wards has identified a decrease in the number of falls incidents from 40 in December to 36 in January 2022 comprising of 26 first falls, 9 repeat falls and 1 patient placed on the floor. Ward areas to note are Snibston Ward, Clarendon, Beechwood, Elliston 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 decreased from 16 in December 21 to 12 in January 2022. 12 medication incidents reported in month. The incidents reported were across 7 of the wards with Beechwood Ward being the highest reporting area with 4 medication incidents. The main cause group of medication incidents related to failure of staff to following medication procedure/policy/guidance, discrepancy in counted medicine, electronic controlled drug register issues, prescribing error, lost/misplaced medication, medication unavailable. No themes have been identified and there was no direct correlation with staffing.

The number of category 2 pressure ulcers developed in our care has reduced to 7 in January 2022. Areas to note are Rutland, East Ward, and Ward 3 St Luke's. The focus continues with

the ward teams during quarter 4 reviewing training for both registered and non-registered staff, targeting prevention, repositioning and management plans.

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

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints
Langley	13	88.9%	97.6%	133.3%	127.9%	50.4%	38.4%	12.0%	13.1	↓0	→0	→0
CAMHS	7	119.7%	214.6%	180.7%	416.1%	76.3%	21.6%	54.7%	39.5	→0	↑1	→0
TOTALS										↓0	↑1	→0

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

The Beacon Unit is facing challenges to recruit to a variety of positions and the trajectory to increase bed capacity and reduce temporary workforce utilisation over the next 3 months is based on the proviso that vacancies are filled. Recruitment to Band 5 positions remains a challenge and reflects the national picture.

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

The fall on Beacon was related to a staff member who slipped wile entering the building.

There were no medication errors on the CAMHS Beacon Unit or Langley in January 2022.

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	113.0%	98.5%	129.8%	147.1%	59.6%	25.0%	34.6%	70.4	↓0	↑3	→0
Gillivers	1	89.0%	68.5%	98.9%	98.9%	6.0%	6.0%	0.0%	65.7	↑1	↓0	→0
1 The Grange	1	56.3%	87.8%	-	106.1%	14.5%	13.9%	0.6%	56.2	↓0	↓1	→0
TOTALS										↓1	↓4	→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.

There were 3 falls on the Agnes Unit and one of the falls was related to a patient who had an epileptic seizure. The two other falls were directly related to a patient tripping whilst on community leave and patient falling having stood on a chair. Review of the incidents has not identified any staffing impact on the quality and safety of the patient.

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 was one medication error on The Grange and the incident has been fully reviewed to explore learning and implement actions. Review of the Nurse sensitive indicators (NSI) has not identified any staffing impact on the quality and safety of patient care/outcomes.

Governance table

For Board and Board Committees: **Paper sponsored by:**	Trust Board 29.3.22 Anne Scott, Interim Executive Director of Nursing, AHPs and Quality	
Paper authored by: **Date submitted:**	Emma Wallis, Interim Deputy Director of Nursing and Quality and Elaine Curtin Workforce and Safe staffing Matron 29.03.2022	
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: **Is the decision required consistent with LPT's risk appetite:**	List risk number and title of risk Yes	1: Deliver Harm Free Care 4: Services unable to meet safe staffing requirements
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:		

U

Leicestershire Partnership NHS Trust

Public Trust Board Committee–

Six month Safe and Effective Staffing review- July 2021-December 2021

Purpose of the report

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

Background

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

The last six month safe and effective report was presented to the Quality Assurance Committee (QAC) on 27 July 2021 and to Trust Board on 31 August 2021. Annual establishment reviews recommenced in August 2021 following a pause due to the pandemic response.

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

In responding to Covid-19 staffing surge and escalation plans, decisions regarding skill mix and nurse ratios were taken in conjunction with a review of patient acuity and dependency, professional judgement and the environment of care. Proposals for redeployment and surge/escalation plans were revisited and connected to the wider system, with proposal papers and quality impact assessments reviewed, updated and

submitted to the Trust Clinical Reference Group, then Incident Control Centre for robust governance and assurance.

Analysis of the issue

Attention has been focused on the NHS Winter 2021 guidance on preparedness, decision making and escalation processes to support safer nursing staffing, building on the previous guidance issued in relation to COVID-19 workforce models and the fundamental principles for the nursing workforce as set out in the National Quality Board (NQB) Safe Sustainable and Productive staffing guidance.

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). Review and progress will be monitored at the Strategic Workforce Committee (SWC).

In November 2021 NHS England & Improvement (NHSE & I) in conjunction with Health Education England (HEE) outlined key priorities for organisations to meet the workforce requirements for winter 2021 Covid-19 response:

- Maintain the health and wellbeing of the whole workforce
- Secure additional workforce supply from across the system and reintroduction of the temporary register
- Assess, review and embed ongoing risk assessments as part of all workforce planning and ongoing discussions with staff
- Assess the clinical workforce resource, readiness and surge capacity

The Royal College of Nursing (RCN) wrote to all Chief Executives on 11 January 2022 in response to 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.

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.

Both letters were received and logged at the Trust ICC for consideration and response. A system response was sent out to all staff on the 14 January 2022 from senior leads across LPT, CCG and UHL collectively thanking staff for the response to the extraordinary challenges faced and an explanation of how support will be offered from a professional and regulatory standpoint.

Workforce planning

- Learning from previous waves, impact on staffing availability
- Planning for staff unavailability- forecasting, planning, risk escalation and Quality Impact Assessment (QIA), Gold level decision making support
- Early conversation with workforce leads and staff about redeployment
- Supporting workforce is paramount; assurance that there are well publicised and accessible resources in place for staff
- Professional nurse/ midwife Advocates

In response, each directorate has business continuity and surge escalation plans that set out how they will manage staff and services in the event of a surge in Covid-19. These plans are under continuous review, a united Trust-wide approach is being taken to ensure safety and appropriate governance through the Trust Incident Co-ordination Centre (ICC), which includes oversight and support from the Clinical Reference Group (CRG) and the Workforce Cell, to ensure safe basic nursing staffing levels can be achieved throughout the winter period.

In addition the Trust have delivered four Surge Preparedness Exercises, each in preparation for seasonal change or forecasted escalation in Covid-19 or any other seasonal viruses such as Flu.

The redeployment process established in the first wave continues to be co-ordinated through the ICC and reviewed at both gold and silver meetings. Service prioritisation for clinical and enabling services completed with QIAs signed off at CRG. This is on review and reflection has identified limited available skilled workforce for redeployment.

A briefing paper was submitted to the ICC on the 24 December 2021 outlining 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.

A daily 4.30pm Trust safe staffing cell huddle has been set up led by the Assistant Director of Nursing, senior oversight by the Director of Nursing, AHPs and Quality with a direct link to the ICC and redeployment cell. Including the agility to step up an additional midday safe staffing meeting (if required) for any unmitigated risk areas.

Temporary registrants

The NMC reopened the Covid-19 temporary register until the end of February 2022 to support newly internationally recruited nurses joining. The Trust recruited 30 international nurses in November 2021, ten of the nurses joined the temporary register, a decision was made not to add all thirty due to timing of their final examination and joining the register substantively.

International nurse recruitment

The Trust plan to recruit thirty international registered general nurses by December 2021 has been achieved with thirty nurses who arrived in Leicester in November 2021. The International Recruitment Matron and team have provided a robust education and pastoral support programme including welcome packs, out of hours support and all nurses have received a warm welcome across all areas of the Trust. The November 2021 cohort have completed their 6-week Objective Structured Clinical Exam (OSCE) preparation training programme at UHL, supported by the LPT team, the nurses are currently in their third week of practice in their designated clinical areas. To date seven nurses have undertaken their OSCE on 24 December 21. It is planned that all the remaining nurses will have undertaken the OSCE by 4 February .22. The nurses will then join the NMC register and commence their local transition support programme.

The Trust has been successful in collaboration with UHL to bid for international nurse recruitment funding for 2022 and the team continue to work with system partners to support training and future recruitment through the procured agency.

Healthcare support workers

Healthcare support workers (HCSWs) play a vital role supporting our clinical teams to deliver the best outcomes for our patients. Throughout the pandemic the Trust has focused efforts and actions to accelerate recruitment, onboarding, and support for HCSW's new to health care in response to reducing the established vacancies.

In response an intense five-day core Health Care Assistant (HCA) clinical skills training programme was devised and implemented to facilitate accessibility to Band 2 substantive posts, previously only opened for people with previous experience.

Building on the success of the 2020-21 programme to further reduce and maintain HCSW vacancies at minimal levels NHS England and Improvement allocated additional funding to;

- Support recruitment into new vacancies due to changes in establishment from April 2021.
- Respond to elective demands and ensure adequate provision for winter 2021/22.
- Ensure focused career conversations with all newly recruited HCSWs.
- Provide pastoral care and support and mitigate potential for early attrition.

The Trust submitted a bid and have received additional funding to explore any new technology and funding for promoting engagement events in local communities to help recruit HCSWs and to fund the ongoing training resource to keep the new to health care bespoke induction course running.

Professional Nurse Advocates

The Professional Nurse Advocate (PNA) programme delivers training and restorative supervision for colleagues right across England. The programme was launched in March 2021, towards the end of the third wave of COVID-19. This was the start of a critical point of recovery: for patients, for services and for our workforce. The table below shows a breakdown of the three cohorts:

	Applicant Numbers	By Directorate	Undertaking the PNA course
Cohort 1	11	CHS-7 FYPC/LD-4	5
Cohort 2	7	CHS-3 FYPC/LD-4	5
Cohort 3	4	CHS-1 MHSOP-1 DMH-2	1
Applicants for next cohort	2	FYPC/LD	TBC

Applicants who were not accepted onto the Cohort 3 programme as this was full will be supported to apply for the next cohort once dates have been confirmed.

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

Right Staff

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

	DAY		NIGHT	
Trust wide	% of actual vs total planned shifts RN	% of actual vs total planned shifts care HCSW	% of actual vs total planned shifts RN	% of actual vs total planned shifts care HCSW
Jul-21	104.4%	115.6%	126.1%	175.6%
Aug-21	105.8%	117.9%	128.4%	187.0%
Sep-21	106.2%	120.4%	129.5%	186.5%
Oct-21	107.3%	136.8%	112.6%	155.2%
Nov-21	108.8%	135.5%	111.9%	163.3%
Dec-21	92.9%	118.4%	108.9%	150.1%
Average	**104.1%**	**123.7%**	**118.8%**	**168.0%**

The planned staffing levels over the last six months were achieved overall across the Trust with December 2021 proving to be a challenging period due to increase in staff absence linked to Covid-19. Exception reporting is provided monthly within the Trust safe staffing report per service.

Over the last six months the Mental Health Older people (MHSOP) wards and Community Health Services (CHS) consistently did not meet the planned registered

nurse (RN) and Health Care Support Worker (HCSW) fill rate across several days. 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 onwards.

MHSOP Wards

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

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

Mill Lodge

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) due to a Covid-19 outbreak and has had daily Directorate review. A number of actions are in place terms of recruitment to support continuity of staffing across the unit with consideration to new/alternative roles. The Ward has supported 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.

Community Hospitals

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.

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.

Community Nursing CHS

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. There were four workstreams identified: workforce, Serious Incident investigation, pressure ulcer Quality Improvement project programme and staff engagement and communication. Staff are being kept up to date about progress on the workstreams and this will be monitored through the CHS Directorate with reports to Quality Assurance Committee.

Beacon

Beacon continues with high utilisation of temporary workforce impacting on continuity of care. The ward has managed to staff the majority of night shifts with two RN's for 7-9 patients, a mix of substantive and temporary qualified staff. There have been shifts where double agency RN's have staffed the ward at however this has been infrequent. The unit had an outbreak in December 2021 and this further impacted bed closures and staff absence. Work continues to progress a quality improvement plan with oversight from Head of Nursing, Head of Service and Director. Recruitment to vacant posts at band 5 and band 2 has been challenging and is reflective of the national picture. Review of acuity and staffing continues Monday to Friday with involvement of Service Manager, Deputy Head of Nursing and Multi- Disciplinary Team.

Increased utilisation and fill rates of HCSWs

Increased utilisation of additional HCSWs remains high in MHSOP wards, DMH, CAMHS FYPC/LD. Increased patient acuity and dependency levels have necessitated additional HCSW's to undertake observation levels and support safe patient care. Fill rates above and below 100% for actual HCSWs predominantly on days reflect adjusted staffing levels and skill mix to meet patient care needs.

Temporary staffing utilisation

The Trust six-month average overall percentage use of temporary workers between July 2021 to December 2021 was 38.52%, this is an increase from 35.92% from the previous six months. The average monthly percentage of agency utilisation is 16.31%, this is a significant increase from the last six-month period (@11.55%) with a peak at 18.34% in December 2021. Contributory factors linked to increased demand due to high patient acuity and dependency, surge wards, increased staff Covid-19 absence, increased incidences and Covid-19 outbreaks, and staff movement due to individual risk and care pathways.

Business continuity plans and escalation processes were updated, and staffing continues to be reviewed daily at service and Trust Wide level during the current unprecedented period of high sickness rates for staff.

Scoping work has been undertaken to identify the best model for supply of agency staff for LPT. This has included discussions with our agency framework experts North of England Commercial Procurement Collaborative (NOE CPC), demonstrating there is no single preferred model used by NHS Trusts. There is a wide variation in models of supply with geographical location, professional group and collaborative approaches between providers also influencing the success or otherwise of those contracts. As a result, we cannot be confident which model will work best for LPT and therefore unable to enter a procurement exercise which carries a risk of disrupting our supply of agency staff.

It is proposed that we directly award a 1+1-year contract to HCL (also known as HCRG) for a new model of supply for both nursing and AHP's. The model will be a managed service which differs from our current model in the following ways:

- It will provide a fully managed service at no extra cost to the Trust and include a dedicated team of experts and specialists who will manage the entire recruitment process through technology that will empower the service.
- They will aid with strategy by implementing processes and systems that are tailored to LPT and our issues (such as the requirement for agency staff to have access to and be trained on SystmOne).
- They will become a partner, rather than an operational supplier and take a more leading role in agency staffing strategy.

Right Skills

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

- All face-to-face training was reintroduced in September 2021 with staff being invited to attend mandatory training. A further review was undertaken following the impact of Omicron variant on staffing absence levels in the last week of December 2021. All non-essential mandatory training was put on hold during this period.
- The 11 mandatory training topics were updated in November 2021, primarily to advise on changes to delivery methods to comply with Covid secure regulations.
- Course capacity has since been reviewed and for the induction course has been extended to five days from two to ensure all new starters are secured a place.
- Compliance renewal date for each topic was initially extended by six months throughout 2021 and this will revert to twelve months for clinical skills training (MAPA, Manual Handling and Resus) from the beginning of February 2022. From 1st April the six-month extension will be removed for all eLearning modules. Staff will need to demonstrate compliance as per pre-covid timeframes.
- There has been a high level of DNA's throughout October to December 2021 as a result of sickness absence and staff prioritising frontline clinical care delivery. Going forward the monthly workforce training compliance reports will report on DNA's from 1st March 2022.

Correct to 1 December 2021 Trust wide substantive staff;

- Appraisal at 76.1 % compliance Amber
- Clinical supervision at 78.7% compliance Amber
- PPE donning and Doffing at 94.5% GREEN

Directorates have reported high levels of staff absence due to the impact of covid-19 and prioritising clinical delivery which has impacted compliance moving from green to amber.

Area to note;

Resuscitation training is a mandatory training requirement for all clinical (registered and non-registered) staff. The determination of which resuscitation training each staff requires is identified in the national core skills training framework. All training in the Trust is accredited with the UK Resus Council. There are two forms of resus delivered: Basic Life Support; and Immediate Life Support.

Basic Life Support (BLS):

3553 substantive staff and 719 bank staff, require this on an annual basis (Covid-19 refresher 18 monthly)

Compliance substantive staff as 1 December 2021- 83.8% (Amber, trending up)

Compliance for bank staff as 1 December 2021- 52.4% (Red, trending up)

Immediate Life Support (ILS):

516 substantive staff and 138 bank staff require this on an annual basis (Covid-19 refresher 18monthly)

Compliance substantive staff as 1 December 2021- 80% (Amber, trending up)

Compliance for bank staff as 1 December 2021- 37.7% (Red, trending down)

The Covid-19 impact:

- Introduction of face-to-face training from July for substantive and bank staff- this has now be revised following the increase in staff absence due to Omicron variant and need to deliver essential mandated training

- 6-month refresher extension to be reviewed for staff to undertake mandatory training topics for all staff
- Introduction of bespoke mandatory training for staff being redeployed to inpatient areas where staffing has been significantly impacted due to increasing absence
- ILS and BLS training days allocated for bank staff in January 2022
- Non-attendance on booked places (DNAs) without cancellation demonstrates increase from pre-covid 19 rates
- Reduced trainer capacity due to vacancies and sickness levels identified throughout October to December

A number of actions and steps taken to support improved attendance and compliance, summary below;

- Issue of non-attendance at training (DNA) continue to be raised at both Training, Education and Development Group (TED) and Deteriorating Patient and Resus Group (DPARG). Actions were taken from these groups by service lead members to respond within their clinical services and through to Directorate Management Teams.
- Available places at BLS are shared on closed Facebook, through TED and the Education and Training ICC cell and managers can book staff on directly
- ILS recertification has been reduced from a full day's training to ½ day training. This has enabled more courses to be delivered
- All new starters booked onto ILS includes FFP3 mask fit testing
- New Resus Officers have commenced in post and enhancing ILS and BLS delivery

Managing the risk of potential untrained/out of date staff in practice

- Managers have a local risk assessment and process to ensure appropriately skilled staff are on shift e.g. moving an ILS trained staff member to cover
- Resus training team have carried out many clinical drills on site over the last six months and offered additional sessions to support services/staff who have been unable to attend ILS/BLS training.
- Resus training remains high priority and has a dedicated working group to drive improvement in compliance and quality

Bank staff training compliance

The Trust has a large bank only workforce with individuals working across a wide range of professions, roles, and services. Compliance with mandatory training for bank staff remains historically lower than that of substantive staff. This raises challenges particularly in areas where bank use is high, and assurance is required that bank workers who are actively working in our services have the right skills.

From June 2021, the Trust introduced pay progression for bank staff to recognise their contribution in creating high quality, compassionate care and wellbeing for all. One of the eligibility criteria for pay progression is that all mandatory training is in date (core and clinical mandatory) and clinical supervision is in date (at least one every three months). This has been escalated with the centralised staffing team and will continue to be used as an incentive to improve attendance and compliance.

In addition, two bespoke days in January 2022 have been added to support Bank staff to complete mandatory training and include BLS over a set day where they will be paid for the whole day rather than part of a day.

Right Place

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

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

CHPPD includes total staff time spent on direct patient care but also on activities such as updating patient records and sharing care information with other staff and departments. It covers both temporary and permanent care staff but excludes student nurses and staff working across more than one ward. CHPPD relates only to hospital wards where patients stay overnight.

NHS England and Improvement national nursing CHPPD data is reported from the organisational monthly staffing returns from 195 Trusts including LPT.

The national nursing CHPPD average is reported at 9.51 in October 2021. LPT nursing CHPPD was reported at 12.34 CHPPD in October 2021, comparative Trust averages; Lincolnshire 8.74 CHPPD, Derbyshire 13.43 CHPPD and Midlands Partnership 10.33 CHPPD. As a Trust we are reporting above average nursing CHPPD.

The Trust CHPPD average (including ward based AHPs) is reported at 17.24 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. It should be noted that the Trust monthly CHPPD reporting includes ward based AHPs and nurses.

Establishment reviews- Inpatient Wards

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

Due to the pandemic response, the annual establishment reviews and bi-annual acuity and dependency evidence-based data collection was paused and reintroduced in August 2021. There has been a delay in presenting the completed reports to DMT for discussion and sign off due to the increasing staffing pressures experienced throughout late December 2021.

To support and facilitate a triangulated and evidence-based review of all in-patient nursing establishments a new post Workforce and Safe Staffing matron commenced on 7 June 2021. Plans have been progressed and a staged approach to acuity and dependency data collection from August 2021 onwards using the Shelford Mental Health Optimal Staffing tool (MHOST), Learning Disabilities Optimal Staffing Tool (LDOST) in DMH and FYPC and Activities of Daily Living tool (Hurst) in CHS was implemented.

All in patient areas across the trust have now completed acuity and dependency data collection utilising evidence-based tools. This data is in process of being 'sense checked' with all ward sisters/charge nurse's and triangulated with professional judgement and nurse sensitive outcomes.

All community hospital in patient areas have completed their triangulation and annual establishment review templates, progressing to a tabletop service line meeting in January 2022, with reporting to divisional management team meeting.

ALL FYPC & LD in patient areas including the Beacon Unit, Agnes unit and Langley ward have also completed their triangulation and annual establishment review templates, for consideration at divisional management meeting in February 2022.

DMH is also progressing with 'sense checking' of data collection with all ward sisters/charge nurses. Mill Lodge have completed their triangulation and annual establishment review template for specific consideration in February 2022. It is important to note that in DMH and FYPC/LD all previous ward establishments were set according to their budget. This is the first opportunity to fully utilise the MHOST tool in DMH and LDOST tool in FYPC & LD to systematically assess acuity and dependency measurements of patients' needs to inform triangulated establishment reviews. Significant progress has been made to systematically review nursing staffing levels.

An up-to-date position on the annual establishment reviews completed using the Annual Establishment Framework is included for information (see appendix 1). A summary of the findings and recommendations will be shared through subsequent safer staffing reports following review within Directorates.

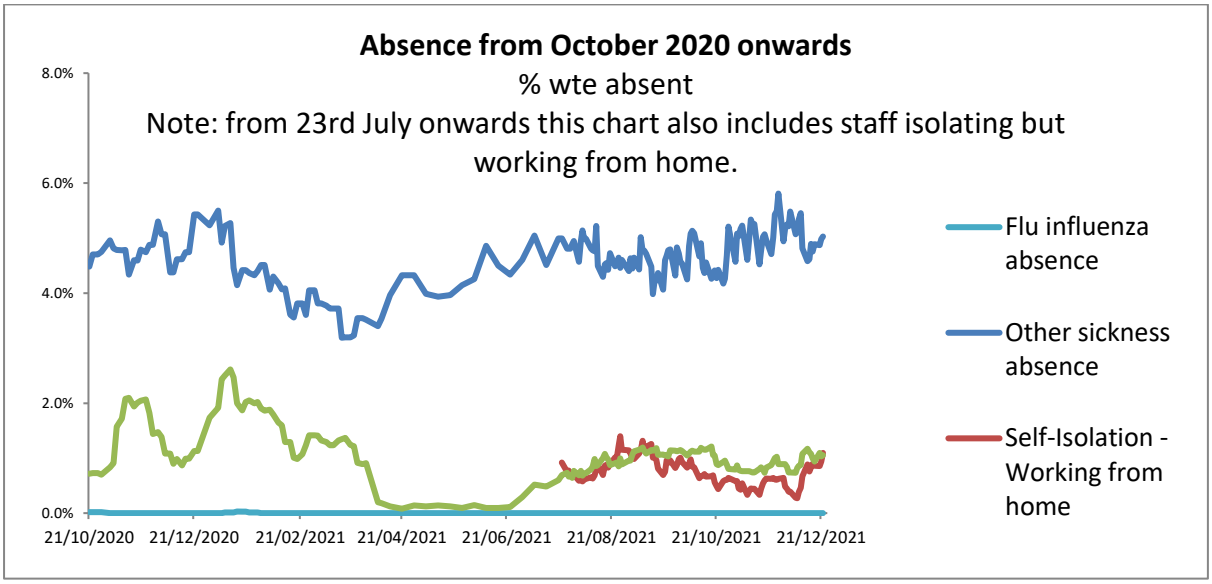
Community Nursing Service Workload, Staffing and Quality Project

CHS Community Nursing have been selected to join the NHS England and Improvement Community Nursing Service workload, staffing and quality project as part of phase 3 development of the tool. Data has been submitted for development of a community safer nursing care tool.

Workforce Planning

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

Sickness and absence



This table gives an indication of staffing pressures within each directorate. It shows the proportion of staff absent due to sickness absence, covid-19 isolation and those who are working from home so may not be undertaking their usual duties.

Absence by directorate	Sickness absence	Self-Isolation - Working from home	Self-Isolation - Unable to work from home	Total
Community Health Services	6.4%	0.9%	0.9%	8.2%
Enabling Services	2.7%	1.4%	1.1%	5.2%
FYPC	4.4%	1.3%	1.4%	7.2%
Hosted Service	1.9%	0.5%	0.9%	3.3%
Mental Health Services	5.5%	1.0%	0.9%	7.4%
LPT Total	**5.0%**	**1.1%**	**1.1%**	**7.2%**

In comparison to October 2021 and November 2021, December's 2021 total absence has increased by 0.7% associated with an increase in general absence overall linked to staff self isolation.

Vacancies

Across the Trust, we currently have 417.8 FTE nursing vacancies, according to our vacancy data reports. This is at Band 5 and Band 6 level and demonstrates an increase of 89.8 FTE from the position reported in June 2021.

This is broken down as below, to note there are certain caveats with the data:

- The numbers above may not be a true reflective picture as some services may be over-recruited on some wards and under-recruited on others against their financial establishment.
- There may be vacancies that are covered by other staff and this is not reflected in the establishment fully.

Directorate	Number of Vacancies (FTE)	Number ofLive Nurse Adverts in Dec 2021	Number of Live Band 5 Adverts in Dec 2021	Number of Live Band 6 Adverts in Dec 2021	Number of candidates with interviews Booked in Dec 2021	Number of candidates at recruitment check stage in Dec 2021
DMH	175.7	20	4	16	16	11
FYPC/LD	79.7	6	1	5	4	7
CHS	162.4	9	5	4	13	10
TOTALS	417.8	**35**	**10**	**25**	**33**	**28**

Vacancy by directorate	Vacancy %
Community Health Services	9.7%
Enabling Services	7.4%
FYPC	9.5%
Hosted Service	0.0%
Mental Health Services	18.6%
LPT Total	**10.5%**

Recruitment

This is a summary of major activity that has been employed in addition to the 'business as usual' approach taken to promote recruitment opportunities.

CHS

CHS Community

- 12-month recruitment campaign signed off to fill 30 vacancies in 2 specific locations in Leicester City.
- A major focus of the campaign is offering flexible working hours to help attract Nurses.
- Currently delivered the following elements of the campaign: social media, Virtual Event, Google and Facebook Ads. We have currently managed to recruit 10 nursing staff (5 Nurses, 5 Nursing Associates) since the launch of the campaign.

CHS Inpatient Nursing

- 30-day RCNi Job advert signed off and went live in Nov 2021.
- Trying a centralised approach of recruitment with a push on flexibility in terms of working hours to attract further candidates.

FYPC/LD

School Nursing Recruitment Campaign

- Launched a recruitment campaign to attract Nurses who want to work school hours, working with children and young people.
- Created an animation video and utilised this as part of our advertising.
- Video is not time-sensitive and can be used in the future.

DMH

Mental Health Practitioners (MHPs) and Senior MHPs

- As part of additional funding into the Directorate, we had to recruit 25 MHPs and Senior MHPs to work at GP sites. We have currently recruited 12 with more candidates in the pipeline. This campaign will be on-going into 2022.
- Recruitment has been happening consistently for months and we have utilised a number of different attraction methods including social media and specialist publications (i.e. RCNi, CSP, RCSLT to name a few).

Peer Support Workers (PSWs)

- The Directorate have changed the way they are delivering mental health services by making it more accessible and personable. To enable this, we are aiming to recruit 24 Peer Support Workers by the end of March 2022, so far we have a total of 17 Peer Support Workers in the pipeline.
- Recruitment has consisted of different attraction methods including radio and social media. PR activities planned for 2022.

Apprentice Recruitment

- Project underway for Adult Mental Health and Learning Disability Services, aim is to recruit 48 Apprentices (Clinical and non-Clinical) by September 2022.

International Recruitment

As highlighted earlier in the report; a cross directorate initiative with a Trust commitment to recruit 30 nurses across the Trust by December 2021 has been effective and the staff recruited commenced in November 2021. At the time of this report 13 of the 30 nurses had passed their OSCE exam. CHS inpatient areas continue to support 16 of the group, DMH are supporting 10 members of the group and FYPC/LD supporting 4.

Recruitment Events

Due to Covid-19, the recruitment teams virtually attended a careers fair at De Montfort University, the PAVE event, along with the RCN Midlands Nursing event.

Wider Projects that will support us filling Nursing vacancies:

- Employer Brand project to help improve our social presence on social media and sites such as Indeed and Glassdoor was launched in 2021 and will continue into 2022.
- In 2022, our Refer-A-Friend scheme and Recruitment and Retention Premia schemes will be revamped and relaunched.
- In 2021 we started working more closely with our Armed Forces Lead and will continue this into 2022 to help members of the Armed Forces to transition into roles at LPT. Project underway which will link the Trust into a candidate system – enable direct recruitment with Army reserves, cadets and veterans.
- Planning for nursing-specific recruitment events in 2022 including the RCN nursing careers fair in November.

Grow Our Own

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

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

Roles that need specific education	Roles that impact the establishment
Health Visitor	Nursing Associates
School Nurse	Medicine Administration Technicians
District Nurse	Physicians Associate
Physiotherapy	Advanced Clinical/Nurse Practitioner
Occupational Therapy	Medical Assistants
Nursing	Peer Support Worker
Nursing Associate	Assistant Practitioner
Clinical Apprentice	
Non-Medical Prescriber	
Clinical/Medical Psychology	
Advanced Clinical Practitioner	

The table below outlines the current position;

Role	Currently on programmes	Breakdown per directorate / profession	Comments
Trainee Nursing Associates	36	MH- 16 FYPC – 7 CHS – 13	2 Cohorts due to complete March & June 2022 March – 5 Candidates June – 8 Candidates 2 cohorts due to complete Jan &Sept 2023 Jan- 6 Candidates Sept 10 Candidates 1 cohort due to complete Feb 2024 – 6 candidates Feb 2022 cohort – 2 due to commence programme Current number of TNA's across all directorates – 22
Degree Programme top up	11 commenced October 2021	MH-5 FYPC/LD-3 CHS-3	4 due to commence Feb 2022 (2 CHS,2FYPC)
Clinical Apprenticeships	11	**OT** x 3 (1 MH & 2 CHS) **Physio** x 8 (1 FYPC & 7 CHS)	1 due to complete Sept 2023 2 due to complete Sept 2024 5 due to complete Sept 2023 3 due to complete Sept 2024
Degree Apprenticeship nurses	8 currently on programme	MH-4 FYPC/LD-2 CHS-2	9 due to commence programme Feb 2022 (4 MH,3 CHS, 1 LD, 1FYPC) – 3year OU route

eRoster

LPT uses Allocate Healthroster to manage the deployment of substantive, bank and agency staff for around one third of the Trust. All inpatient wards use HealthRoster as well as some community teams. Using recommendation from the Carter Review, the focus is supporting services to make the best use of staff time by:

- Improving timeliness of rosters being published (minimum 6 weeks before they are due to be worked). From April 2022 this lead time has been adjusted to 12 weeks. This means rosters should be made available to staff with 12 weeks' notice.
- Reducing unused hours (hours staff have been paid for but not yet worked)
- Reducing accrued time off in lieu (TOIL) (hours that have been worked but not paid for)
- Effective planning of annual leave to avoid pressure points at certain times of the year

These actions will help services to better plan their workforce and manage staffing levels on a shift-by-shift basis. Detailed reports on rostering effectiveness are provided to services each month to measure the impact of different initiatives and to help identify areas for improvement.

Safe care

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

Safe Care also has a positive impact on improving accuracy of rosters through contemporaneous updating of changes which further informs decision making and visibility. The net result of the above is an improved utilisation of substantive staff and reduction in temporary staff requirement.

LPT have started to pilot the use of Safe Care in four wards; Heather Ward, Aston Ward, East Ward and Coalville Snibston Ward. The first phase of the pilot is to ensure teams are accessing Safe Care to manage staff attendance, this training has been completed and the system has been handed over to the wards. The second phase which will commence at the end of January 2022 and will focus on acuity and dependency.

Decision required

The Trust Board is asked to confirm a level of assurance considering the report.

References

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

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

Appendix 1: Table to demonstrate completed annual safer staffing establishment reviews:

Inpatient area	Evidence Base (MHOST or ADL) data collected Yes /No	Establishment review template sense checked and complete Yes/No If not when by	Directorate sign off Yes/No If not when by
1. DMH (Bradgate Unit) - Ashby	Yes	No Rescheduled to 25.01.2022	No February 2022
2. DMH (Bradgate Unit) - Aston	Yes	No Rescheduled to 26.01.2022	No February 2022
3. DMH (Bradgate Unit) - Beaumont	Yes	No Rescheduled to 3.02.2022	No February 2022
4. DMH (Bradgate Unit) - Belvoir	Yes	No Rescheduled to 25.01.2022	No February 2022
5. DMH (Bradgate Unit) - Heather	Yes	No Rescheduled to 26.01.2022	No February 2022
6. DMH (Bradgate Unit) Thornton	Yes	No Rescheduled to 03.02.2022	No February 2022
7. DMH (Bradgate Unit) Watermead	Yes	No Rescheduled to 26.01.2022	No February 2022
8. DMH (Hershal Prins) - Phoenix	Yes	No Rescheduled to 25.02.2022	No February 2022
9. DMH (Hershal Prins) - Griffin	Yes	No Rescheduled to 26.01.2022	No February 2022
10. DMH (MHSOP) Benion Centre - Kirby	Yes	No Rescheduled February 2022	No February 2022
11. DMH (MHSOP) Benion Centre - Welford	Yes	No Rescheduled February 2022	No February 2022
12. DMH (MHSOP) Evington Centre - Coleman	Yes	Partial completion Rescheduled February 2022	No February 2022

Inpatient area	Evidence Base (MHOST or ADL) data collected Yes /No	Establishment review template sense checked and complete Yes/No If not when by	Directorate sign off Yes/No If not when by
13. DMH (MHSOP) Evington Centre - Gwendolin	Only opened for COVID positive patients as needed		
14. DMH (MHSOP) Evington Centre - Wakerley	Yes	No Rescheduled February 2022	No February 2022
15. DMH (Rehab) Mill Lodge	Yes	Yes	Tabletop review planned 20.01.22
16. DMH (Rehab) Stuart House - Skye Wing	Yes	No Rescheduled February 2022	No February 2022
17. DMH (Rehab) Willows Unit	Yes	No Rescheduled February 2022	No February 2022
18. CHS (Evington Centre) - Beechwood	Yes	No Rescheduled January 2022	No February 2022
19. CHS (Evington Centre) - Clarendon	Yes	Yes	No February 2022
20. CHS (Coalville Hosp) - Ward 1 Snibston	Yes	Yes	No February 2022
21. CHS (Coalville Hosp) - Ward 2 Ellistown	Yes	Yes	No February 2022
22. CHS (Melton Hosp) - Dalgleish	Yes	Yes	No February 2022
23. CHS (Hinckley & Bosworth) - East ward	Yes	Yes	No February 2022
24. CHS (Hinckley & Bosworth) - North ward	Yes	Yes	No February 2022
25. CHS (Rutland Hospital) - Rutland	Yes	Yes	No February 2022

Inpatient area	Evidence Base (MHOST or ADL) data collected Yes /No	Establishment review template sense checked and complete Yes/No If not when by	Directorate sign off Yes/No If not when by
26. CHS (St Lukes MH) - ward 1	Yes	Yes	No February 2022
27. CHS (St Lukes MH) - ward 3	Yes	Yes	No February 2022
28. CHS (Loughborough Hosp) - Swithland	Yes	Yes	No February 2022
29. CHS (Fielding Palmer Hosp) - Fielding Palmer	Vaccination hub		
30. FYPC.LD (Benion Centre) - Langley	Yes	Yes	February 2022
31. FYPC.LD (CAMHS) - Beacon unit	Yes	Yes	Initial review November 2021- scheduled February 2022
32. FYPC.LD (LD) - Agnes Unit	Yes	Yes	February 2022
Total x 32 wards (2 of which NA)	30	X 14 Yes X 16 no	X 3 partial X 27 Planned

Governance table

For Board and Board Committees: **Paper sponsored by:**	Trust Board Anne Scott, Executive Director of Nursing, AHPs and Quality	
Paper authored by: **Date submitted:**	Emma Wallis, Interim Deputy Director of Nursing and Quality and Louise Evans, Interim Assistant Director of Nursing 14.03.2022	
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: **Is the decision required consistent with LPT's risk appetite:**	List risk number and title of risk Yes	1: Deliver Harm Free Care 4: Services unable to meet safe staffing requirements
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:		

V

Leicestershire Partnership NHS Trust

Trust Board 29th March 2022

LPT Safeguarding Declaration 2022/23

Purpose of the Report

The Trust Board are required to produce an annual safeguarding declaration and to publish this on the external public facing website by 1st April 2022.

Analysis of the issue

The key issues of the declaration are:

-Confirmation of the Trust's ongoing commitment to safeguarding in 2022/23.

-Confirmation that Trust staff are trained and that the Trust is resourced to provide the appropriate levels of safeguarding expertise and Board level representation.

-Highlights the completion of the review and implementation of policies and systems and refers to the ongoing quality improvement work being completed across safeguarding within LPT.

Proposal

That the Board of Directors approve and publish the safeguarding declaration 2022/23 at Appendix A.

Decision required

For the Board of Directors to approve the safeguarding declaration 2022/23 and publish it on the Trust's public facing website.

Governance table

Paper sponsored by:	Anne Scott Director of Nursing/AHPs & Quality Executive Lead for Safeguarding	
Paper authored by:	Liz Bainbridge Independent Safeguarding Consultant	
Date submitted:	21/03/2022	
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):	First consideration, to progress to The Board for approval.	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	N/A	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	One off annual declaration.	
STEP up to GREAT strategic alignment*:	High **S**tandards	X
	Transformation	X
	Environments	
	Patient Involvement	X
	Well **G**overned	X
	Reaching Out	
	Equality, Leadership, Culture	X
	Access to Services	X
	Trust Wide Quality Improvement	X
Organisational Risk Register considerations:	List risk number and title of risk	ORR Risk 2
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:	All safeguarding legislation considers equality at source	

Appendix A

NHS
Leicestershire Partnership
NHS Trust

Board of Directors' Safeguarding Declaration 2021/22

Leicestershire Partnership NHS Trust's (LPT) Board of Directors take their responsibility for safeguarding seriously. The Trust is therefore making a declaration of compliance with the following aspects of safeguarding children, adults, domestic abuse and Prevent practice:

- The Trust meets the statutory requirement with regard to the carrying out of Disclosure & Barring Service checks.

- All safeguarding policies and systems have been reviewed and updated, including a process for following up children who miss appointments (was not brought) and a system for flagging children & adults for whom there are safeguarding concerns are in place. All safeguarding policies are reviewed on an annual basis or as guidance or legislation changes.

- Staff & volunteers have completed and are up to date with safeguarding children and adult training to at least level 1. All safeguarding training is reviewed on an annual basis.

- Our Named Nurse, Named Practitioner, Named Doctors and Safeguarding Staff are clear about their roles and the Trust is independently reviewing this specialist resource's capacity, knowledge and skill to ensure that they have time, training and support to undertake their roles.

- There is a Board level Executive Director Lead for safeguarding; namely Anne Scott Director of Nursing, AHPs & Quality and a Non-Executive Director, Moira Ingham, who champions and scrutinises LPT's safeguarding governance. The Board reviews safeguarding across the organisation at least quarterly and has robust internal and external audit programmes to assure it that safeguarding systems and processes are in place and working.

- The Trust is assured that all clinical staff are aware of the Trust's Prevent Duty and Government strategy and have robust processes in place to ensure that any patient who may be at risk of radicalisation is identified and supported through the Channel process.

- The Board receives an annual report and there is a quality improvement work programme across the four safeguarding domains namely safeguarding children, adults, domestic abuse and Prevent. The Board is assured that LPT is working to ensure that it adheres to good practice, and that appropriate arrangements are in place.

If any further information is required, please contact the Director of Nursing, AHPs and Quality at Trust Headquarters. The full safeguarding 2020/21 Annual Report is available via the following link Final-BoD-LPT-safeguarding-annual-report-2020-21.pdf (leicspart.nhs.uk)

W

Leicestershire Partnership NHS Trust

FPC 22nd February 2022

Highlight Report

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

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
Director of Finance Update – Verbal Update	NA	No escalations that were not addressed in the papers on the agenda today.	
CFO – Strategic Estates Update – Verbal Update	NA	FM Transformation project Board has been stood up from March and work continues across the Trust with the fire safety remedial work – 13 areas over 10 sites are complete and Loughborough and Coalville began on 14.2.22. The final – Bennion – will be complete before the end of March and so is on track. This work was a positive piece of collaboration between teams and a good resolution.	
Director of Strategy and Partnerships – Verbal Update	NA	LLR working partnerships have a key focus in connecting the system up. No escalations.	
Finance Report Month – 10 – Paper C	High	Some adverse movement towards an operational overspend due to high agency spend with DMH being a key area of focus. An escalation meeting is planned for next week to discuss this movement from the original H2 plan. The forecast remains at breakeven at the end of the year. Month 10 shows a £2.8m agency spend. Capital shows a £9m recorded spend – with £7m left to spend which we remain confident about delivering. All 4 targets are achieved for the BPPC and cumulatively 3 of the 4 targets at the year-end forecast expected. DMH has a large share of the agency spend and a piece of work is underway around filling empty E-Roster shifts to support in the addressing of this. As part of	60, 70, 71

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
		next year's planning returns on investments will be considered.	
Operational & Financial Plan Update Paper D	Medium	Draft plan included in the paper. The prioritisation of investments is currently being considered with £5m efficiency needing to be delivered next year. Meetings planned to discuss further. Capital planning is ongoing, and the draft plan is detailed in the slides. £59m allocated to LLR next year for operational capital. Operational plans continue to be submitted to the system narrative plan – the timeline is detailed in the pack and the final submission will be to Trust Board on 19.4.22.	70, 71
Business Pipeline – Bids & Tenders Update Paper E	High	FPC received high assurance from the report. No escalations.	64
Performance Report Month – 10 – Paper F	Medium	FYPC audiology performance has dropped back – this was picked up in the performance review. More information regarding referral data will be included moving forward. CAMHS ED has also deteriorated due to increased referrals. The CHS performance review has taken place providing robust assurance around the plans in place. DMH reporting is stable – ADHD is off trajectory – the MH Investment Standard will provide additional support and a new model for delivery. This is being closely monitored. Over 52ww have reduced in all areas apart from dynamic psychotherapy. There are no over 52ww in LD services now. Appraisal and clinical supervision rates remain below target and HR are providing additional reporting to get back on track. FPC received medium assurance from the report as the improvement outcomes are not yet fully visible.	63, 68, 69,
Waiting Times Report – Paper G	Medium	No significant improvement seen but also no significant decline despite increased demand. Significant demand in PIER, Audiology and CAMHS was noted. Services are maintaining a steady pace and trajectories are maintained. Waiting time governance is described in the paper to support keeping people safe whilst waiting. Bi - monthly performance meetings continue to monitor all wait times.	60, 61, 63 72, 74, 75

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
		FPC received medium assurance from the report – the size of the issue is understood, processes are in place, this is recorded and monitored on the ORR and there has been no serious decline in wait times.	
CQC Action Plan Assurance Report – Paper H	High	The report showed good progress and that all actions were on track no escalations.	57, 62, 65, 66,
Provider Collaborative Performance – Paper I	High	The work of the Provider Collaborative is well established and embedded with partners. No escalatons and FPC received high assurance from the paper.	
Income Management & Distribution Policy – Paper J	High	FPC received high assurance from the policy. Conflicts of Interest to be added to the narrative.	70
Cyber Security Report (Log4Shell) – Paper K	High	Paper describing the circumstances around Log4Shell and the programme of activity to protect that is in place. Regular reports go to the Data Privacy Committee and Audit Committee where this is monitored closely.	
Green Plan – Paper L	Medium	Next steps are to build engagement within the organisation which will be critical in order to be able to measure ourselves. It was noted that the ORR needs a narrative update and this was recorded as an action.	67
ORR – Paper M	High	Currently 21 risks, 10 with FPC oversight – 6 of which are high risks. There have been no real changes, the cleanliness risk has been escalated and key work is ongoing around this. The level of risk described in risk 70 will be reduced -following a meeting with the finance team which has taken place this week.	All
Estates and Medical Equipment Committee Highlight Report – 19th January 2022 – Paper N	High	There has been an enormous amount of work completed over the last few weeks making great improvements and it's important to celebrate this. No escalations. .	65, 66, 78
IM&T Committee Highlight Report – 14th January 2022 – Paper O	High	One medium rating around the SystmOne business case – the learning is being extracted. FPC requested a focused SystmOne report including feedback from directorates should be presented to the next FPC meeting.	
Capital	High	The medium assurance listed represent a	

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
Management Committee Highlight Report – 19th January 2022 – Paper P		point in time. No escalations.	
Strategic Waiting Time and Harm Review Committee Highlight Report – 24th November 2021 – Paper Q	Medium	The SWTHR Committee is now called the Improving Access Committee this meeting will resume following a pause next week. Medium assurance received from the report – the size of the issue is understood, processes are in place, this is recorded and monitored on the ORR and there has been no serious decline in wait times.	60, 61, 63 72, 74, 75

Chair of Committee:	Faisal Hussain

Leicestershire Partnership NHS
NHS Trust

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Finance Report for the period ended
28 February 2022

For presentation at the
Trust Board
29 March 2022

Contents

Executive Summary and overall performance against targets

Introduction

1. This report presents the financial position for the period ended 28 February 2022 (Month 11). A small net income and expenditure surplus of £60k is reported for the period, which relates to the gain on disposal of Rubicon Close.

2. Note that the property disposal gain of £60k cannot be counted towards NHS Control Total Performance. Excluding this from the position results in a breakeven for M11 in line with plan.

3. Within this overall position, net operational budgets report a £85k overspend. Directorate overspends include DMH (£991k), LD Services (£445k) and Estates (£24k). Enabling services are underspending by £647k, Hosted by £533k, FYPC by £145k and CHS by £50k

4. Central reserves report a small underspend which offsets the net operational overspends.

5. Closing cash for February stood at £32.4m. This equates to 40.8 days' operating costs.

Performance against key targets and KPIs

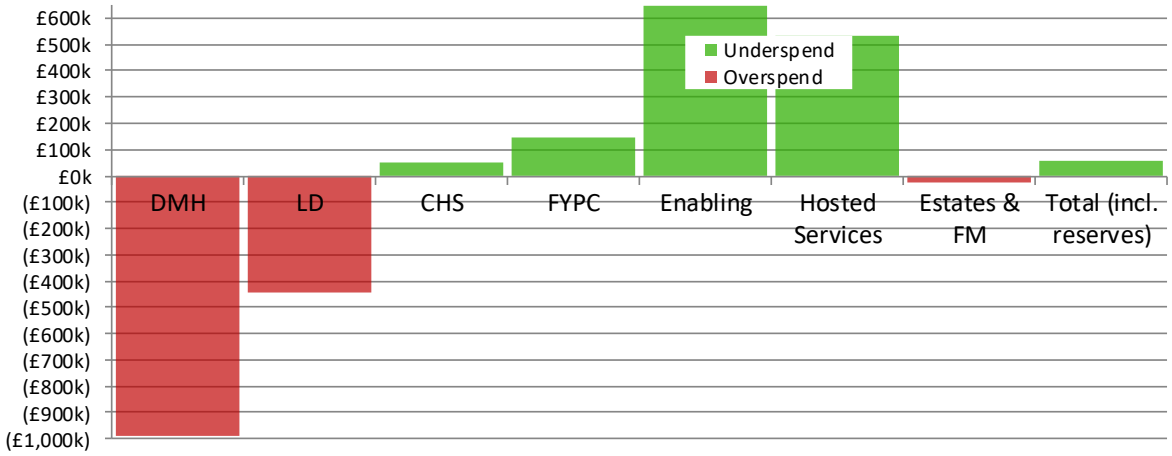
NHS Trust Statutory Duties	Year to date	Year end f'cast	Comments
1. Income and Expenditure break-even.	G	G	Excluding the £60k disposal gain, the Trust is reporting a financial break-even position at the end of February 2022. **[see 'Service I&E position' and *Appendix A*]**.
2. Remain within Capital Resource Limit (CRL).	G	G	The capital spend for February is £10.3m, which is within limits. The likely year end forecast is also within the limits for the year.
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 £32.4m. The year-end forecast is £28m.

Secondary targets	Year to date	Year end f'cast	Comments
5. Comply with Better Payment Practice Code (BPPC).	A	A	The target is to pay 95% of invoices within 30 days. Cumulatively the Trust achieved 3 of the 4 BPPC targets in February.
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 £32.4m was achieved at the end of February 2022. **[See 'cash and working capital']**
10. Deliver capital investment in line with plan (within +/- 15% YTD planned spend levels)	R	G	Capital expenditure totals £10.3m at the end of Month 11; this is £4m (28%) below the YTD planned level of £14.3m. The likely year end forecast shows available capital resource as being fully utilised **[See 'Capital Programme 2021/22'].**

Income and Expenditure position

The month 11 position shows a net operational overspend against year-to-date budgets, offset by an underspend of £85k within reserves.

Month 11 year to date operational income and expenditure budget variances by service



The Mental Health directorate is overspending by £991k at the end of Month 11, which reflects an adverse overall movement of £372k. This is largely due to a continuing increase in the use of agency staff to cover significantly high vacancy levels and wait times. The non-pay overspend is also increasing at a higher than trend rate, including overspends against FP10 budgets. Income continues to report an over recovery relating largely to Specialised Commissioning. As a result of the continued overspend, an escalation meeting was held on 8th March to review specific financial pressures and to highlight potential opportunities to improve financial performance. Several key actions were discussed and will be kept under review. The average monthly expenditure run-rate for DMH was £7.35m during the first half of the year (H1) and this has increased to £7.9m in the second half (H2). Even allowing for the additional costs of funded investments being phased into latter months, there is an (average) £0.3m - £0.35m general increase in costs during H2. This can be seen to correlate with the increase in agency costs during the same period. The key focus for improvement is therefore around efforts to reduce agency and a number of priority options are being explored in order to reduce monthly expenditure as we move into the new financial year.

The FYPC financial position improved in month 11, to now report an underspend of £145k. The Beacon Unit continues to face significant staffing pressures and increased agency costs, along with medical equipment budgets within the Diana service, and mobile phone and VPN costs. Healthy Together budgets report underspends due to staff vacancies, although posts have been recruited to in the County. The income position shows an over achievement against budget mainly related to Out of Area income and additional provider collaborative income. Travel budgets continue to underspend off-setting some of the non-pay pressures.

The LD financial position worsened again in the month as the Agnes Unit continued to incur greater agency costs due to staff sickness, acuity on the ward and through operating over all 5 pods. In contrast, Community services remained underspent, albeit the rate of underspend reduced in the month mainly due to a reduction in vacancies.

The CHS Directorate is reporting an underspend of £51k at month 11, representing an adverse movement of £11k within the month. 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 bank and agency use within the Inpatient wards remains high, 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. The Directorate remains on track to deliver a balanced, or a slight underspend, position by the end of the financial year.

Enabling Services are reporting an underspend of £647k as at M11. This reflects a large positive movement of £431k compared to M10 (£215k underspend). This is the result of additional income received relating to Clinical Psychology Tutors (£261k) and Child Death Review (£96k). There has also been an increase in Income from Health Education England. Furthermore, there have been some costs incurred within HR Services that have been moved to the Vaccination Programme following a review of their expenditure.

Efficiency savings

Nationally, a base efficiency savings target of c. 0.8% has been applied to system financial allocations. Additional savings requirements have been levied dependent on a system's distance to overall financial targets. Within LLR, the inclusion of the additional savings requirement increases the target efficiency rate to c. 1.5% and so the target for LPT is £2.6m. This level of efficiency requirement was anticipated throughout the H2 planning process and savings and other gains have already been fully identified to deliver this target. These include a continuation of travel savings, VAT reclaims, balance sheet gains, underspends against internal investment budgets and other income gains.

Forecast position

The overall forecast position for the year is an I&E break-even, in line with the plan submitted for the second half of the financial year.

The DMH position remains a concern, although further adverse movement is already factored into the forecast for M12. External Trust income remains difficult to predict and there remains the potential for late changes (both up or down) as funding organisations seek to balance their own year end finances. The annual leave provision (a charge to this year's financial position to reflect untaken / 'owed' annual leave) is likely to be much larger than historical norms due to the operational pressures of the last 2 months. The actual value is difficult to determine until after March 31st, so this also has the potential to impact on the final position. To minimise this risk, a significant increase in the provision is already reflected in the forecast.

A further emerging risk relates to Low Secure income via the IMPACT provider collaborative. A significant underlying shortfall has been identified within the overall funding envelope transferred over from NHS England to Nottinghamshire Healthcare NHS Trust, as lead provider. LPT's exposure is relatively minor, being one of the smaller providers in the collaborative, and the lead provider has informally provided assurances that they can absorb the shortfall themselves this financial year. This issue is therefore more likely to come to the fore next financial year.

Additional agency expenditure analysis

For the period April 2021 to February 2022, total expenditure on agency staff was £23m. The forecast for the year is £25.7m (£24.1m excluding Covid), which again reflects an increase on previous forecasts. Agency costs have slightly reduced in February (by £141k) however are still high due to high vacancy levels and staff sickness. ***Appendix C*** provides an overall monthly breakdown of agency costs by directorate.

The table below compares forecast agency costs for the year with those incurred in 2019/20 (being the last full year before Covid began to have an impact). To allow for meaningful comparison, Covid costs are excluded from the 2021/22 figures. The analysis also then allows for the exclusion of the significant agency costs linked to the large amount of investment this year.

The resulting comparable costs are shown as £21.2m in the current year (forecast) versus £10.6m in 2019/20 – a 100% 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. Note that this underlying position will not align with 22/23 planning assumptions as it excludes expected temporary costs such as those related to Covid or new investment (which will be included in plan costings).

Directorate	2019/20	2021/22 including new investm.	2021/22 investments	2021/22 excluding new investm.	Movement 19/20 to 21/22		underlying agency positon 1st April 2022
	£000	£000	£000	£000	**£000**	Comment on movement	£000
DMH	**3,400**	10,105	-2,214	**7,891**	**4,491**	Continued use of locums and agency staff to cover vacancies. High vacancy levels. Bank and Agency usage increased to reduce wait times, winter pressures and high levels of staff absence due to omicron.	6,981
CHS	**4,341**	5,716	-265	**5,451**	**1,110**	Bank and Agency usage continues to increase due to high number of vacancies, high level of specialling and staff sickness within the wards. Bank and Agency required to adequately staff the Wards	5,076
FYPC	**2,059**	4,655	-358	**4,297**	**2,238**	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	3,797
LD	**301**	2,529	0	**2,529**	**2,228**	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.	2,279
Enabling / Hosted	**541**	1,132	-48	**1,084**	**543**	The increase in agency costs relates to HIS (GP IT capital and finish off other projects) and the Vaccination Programme.	575
TOTAL:	**10,642**	**24,136**	**-2,885**	**21,252**	**10,609**		**18,707**

DMH continues to show the highest forecast increase compared to 2019/20. The £4.4m increase in business as usual costs relates to additional medical locum cover and a general increase in cover for nursing vacancies.

The LD agency increase from 19/20 is £2.2m due to increased locum cover and the pressure with the Agnes Unit.

The FYPC increase of £2.2m 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: February 2022	2020/21 31/03/21 Audited £'000's	2021/22 28/02/22 February £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	178,757	180,350
Intangible assets	2,438	2,065
Trade and other receivables	1,129	1,129
Total Non Current Assets	**182,324**	**183,544**
CURRENT ASSETS		
Inventories	574	554
Trade and other receivables	8,304	8,771
Cash and Cash Equivalents	24,139	32,381
Total Current Assets	**33,017**	**41,706**
Non current assets held for sale	**280**	**0**
TOTAL ASSETS	**215,621**	**225,250**
CURRENT LIABILITIES		
Trade and other payables	(21,587)	(30,166)
Borrowings	(296)	(297)
Capital Investment Loan - Current	(189)	(107)
Provisions	(2,851)	(1,985)
Total Current Liabilities	**(24,923)**	**(32,555)**
NET CURRENT ASSETS (LIABILITIES)	**8,374**	**9,151**
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**	**180,731**
TAXPAYERS' EQUITY		
Public Dividend Capital	95,441	97,456
Retained Earnings	37,055	37,116
Revaluation reserve	46,158	46,159
TOTAL TAXPAYERS EQUITY	**178,654**	**180,731**

Non-current assets

Property, plant, and equipment (PPE) amounts to £180.4m. Capital additions of £10.3m more than offset February's depreciation charge.

Current assets

Current assets of £41.7m include cash of £32.4m and receivables of £8.8m.

Non-current assets held for sale

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

Current Liabilities

Current liabilities amount to £32.6m and mainly relate to payables of £30.2m.

Net current assets / (liabilities) show net assets of £9.2m.

Working capital

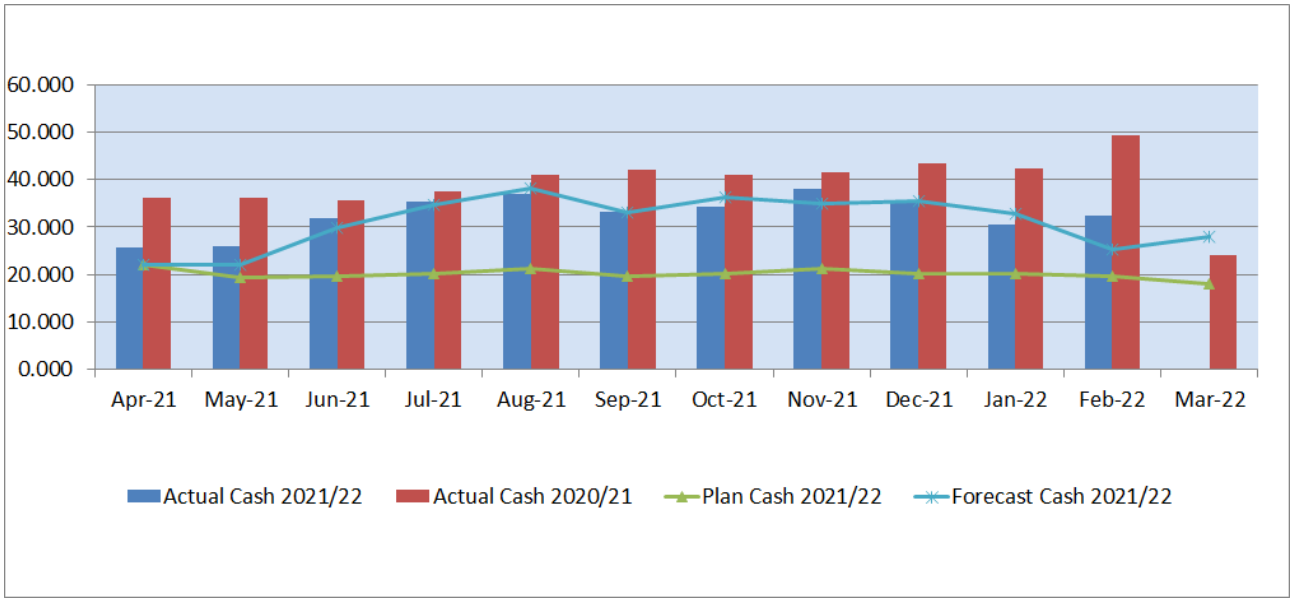
Cash and changes in working capital are reviewed on the following pages.

Taxpayers' Equity

February'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 February was £32.4m, an increase of £1.9m during the month.

Compared to last month, the year-end cashflow forecast has increased by £5m, from £23m to £28m. This increase mainly relates to:

- Increased capital creditors - £6m of capital will be utilised in March, however due to suppliers' 30-day payments terms, invoices to support goods or services delivered by 31st March will not materialise until April/May 2022 and will impact on next year's cashflow.

- Local Authorities have now paid in full their annual recharges for 0-19 years and health visitor contracts. In previous years March's payments were paid in the following financial year.

A cash-flow forecast is included at ***Appendix D.***

Receivables

Current receivables (debtors) total £8.8m; a decrease of £1.5m during the month and an increase of £0.5m since the start of the year.

Receivables	Current Month February 2022					
	NHS	Non NHS	Emp's	Total	% Total	% Sales Ledger
	£'000	£'000	£'000	£'000		
Sales Ledger						
30 days or less	2,134	672	8	**2,814**	**28.4%**	**58.1%**
31 - 60 days	912	98	20	**1,030**	**10.4%**	**21.3%**
61 - 90 days	75	115	24	**214**	**2.2%**	**4.4%**
Over 90 days	216	392	180	**788**	**8.0%**	**16.3%**
	3,337	1,277	232	**4,846**	**48.9%**	**100.0%**
Non sales ledger	2,024	1,901	0	**3,925**	**39.6%**	
Total receivables current	**5,361**	**3,178**	**232**	**8,771**	**88.6%**	
Total receivables non current		1,129		1,129	**11.4%**	
Total	**5,361**	**4,307**	**232**	**9,900**	**100.0%**	**0.0%**

Debt greater than 90 days reduced by £90k since January and now stands at £788k. Receivables over 90 days should not account for more than 5% of the overall total receivables balance. The proportion at Month 11 is 8% (last month: 7.7%). Note – the proportion % has increased due to the overall receivables balance reducing during the month.

£239k of aged debts were cleared in February, however this has been offset by £149k of new debts moving into the 90+ days category. Two invoices with a combined value of £128k account for most of this increase – these relates to recharges to Leicester City and Leicestershire County Council for CAMHS support.

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 now stands at £323k, a reduction of £18k during the month. Following recommendations from our debt recovery agency, due to all appropriate debt chasing activities being exhausted, 22 salary overpayment debts with a combined value of £18k were written off during the month.

Payables

The current payables position in Month 11 is £30.2m. This is an increase of £0.8m since January and an increase of £8.6m 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 anticipated that payables will reduce in the final month of the year.

Provisions

Trust provisions have reduced by £866k since the start of the year and now stand at £3.4m. New provisions will be recognised in this year's accounts, including a provision for the Estates and Facilities Management transfer of services from UHL, to cover expected transitional staffing costs and other known financial implications as a result of the transfer.

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 all 4 BPPC targets. The cumulative non-compliant target continues to relate to the number of NHS invoices not paid within 30 days. It is encouraging to note that the position across all four categories improved in the month of February.

The work recently undertaken to review processes and identify barriers to prompt payment continues to have a successful impact on the monthly position. Due to only having one month of the financial year remaining, unless we have 100% compliance in March, it is unlikely that the cumulative NHS target will reach 95% by the end of the year, however the work undertaken recently to improve the position will help to facilitate a positive position from the beginning of 2022/23. Further details are shown in ***Appendix B***.

Capital Programme 2021/22

Capital expenditure totals £10.3m for the first eleven months of the year.

	Annual Plan	Feb Actual	Year End Forecast	Revision to Plan
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**
Depreciation & technical adjustments	9,500	7,971	9,500	0
Dormitory elimination - Bradgate (PDC)	4,112	2,016	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	43	43
Total Capital funds	**17,552**	**10,267**	**16,313**	**(1,239)**
Application of Funds	**£'000**	**£'000**	**£'000**	**£'000**
Estates & Innovation				
Estates service improvements	(5,019)	(2,287)	(4,369)	650
Estates backlog	(2,395)	(1,033)	(3,190)	(795)
Estates other rolling programmes	(1,950)	(697)	(1,077)	873
Estates staffing	(360)	(511)	(434)	(74)
Estates & FM transformation	(699)	0	(30)	669
Medical devices	(120)	(124)	(129)	(9)
	(10,543)	**(4,652)**	**(9,229)**	**1,314**
IT Programme				
Rolling programmes	(1,865)	(2,930)	(3,040)	(1,175)
Other projects	(595)	(221)	(484)	111
PDC IM&T Shared Care Records	0	(1,245)	(2,192)	(2,192)
	(2,460)	**(4,396)**	**(5,716)**	**(3,256)**
Other				
Directorate capital investment projects	**(1,689)**	**(319)**	**(1,040)**	**649**
System-wide capital	**(2,560)**	**0**	**0**	**2,560**
Revenue to capital transfers	**0**	**(900)**	**(900)**	**(900)**
Contingency	**(300)**	**0**	**572**	**872**
Total Capital Expenditure	**(17,552)**	**(10,267)**	**(16,313)**	**1,239**
(Over)/underspend	**0**	**0**	**0**	**0**

Month 11 capital expenditure of £10.3m represents 63% of total forecast annual spend. This is £4m less than the cumulative planned spend of £14.3m up to February. Spend against several Estates and IM&T 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 month of the financial year.

Compared to planned capital expenditure of £17.6m, the revised annual forecast of £16.3m reflects a £1.3m 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

The capital contingency of £300k set at the start of the year is now over-committed by £572k; this is manageable as there is still £6m left to spend in the last month of the year. It is expected that there will be further slippage on several capital schemes, due to supply chain issues and site access restrictions, which will compensate for the current over-commitment.

The Trust was awarded £2.6m of Targeted Investment Funding (TIF) for 2021/22 digital schemes. Due to the timing of the confirmation of this funding being so late in the financial year, the funding allocation has been transferred to Northamptonshire Healthcare FT for their utilisation. LPT's operational delivery of the scheme will now be in 2022/23; ICS funding allocation arrangements to support both this and enabling works for the Mental Health site reprovision are being discussed with System Capital leads, as part of next year's capital planning.

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. The draft plan was approved by Trust Board approval on 10th March. The Trust must also work within the System capital envelope; work is progressing with ICS partners to agree a finalised capital allocation for next year.

Changes made to individual capital schemes in Month 11 are shown below:

Ref	Scheme type	Scheme	Plan or Previous Forecast	Forecast	Change (Inc) / Dec	Reason
			£000	£000	£000	
Changes to existing schemes - IM&T						
6C93	Existing	Shared care records	(2,278)	(2,192)	86	Slippage to c/f into 2022/23
			(2,278)	**(2,192)**	**86**	
Changes to existing schemes - Medical Devices						
6C07	Existing	Medical Devices	(124)	(129)	(5)	Audiology equipment
			(124)	**(129)**	**(5)**	
Revenue to capital transfers						
2514	Revenue transfer	Revenue to Capital transfers - IT hardware	0	(24)	(24)	IT equipment purchased via revenue
2514	Revenue transfer	Revenue to Capital transfers - Furniture	0	(26)	(26)	Furniture equipment purchased via revenue
			0	**(50)**	**(50)**	
Total changes from contingency - M11					**31**	
Capital Contingency						
M10 contingency					603	
M11 changes impacting on contingency					31	
M11 contingency					**(572)**	

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 28 February 2022	YTD Actual M11 £000	YTD Budget M11 £000	YTD Var. M11 £000
Revenue			
Total income	316,522	311,780	4,742
Operating expenses	(313,126)	(308,384)	(4,742)
Operating surplus (deficit)	**3,396**	**3,396**	**0**
Investment revenue	2,115	2,115	0
Other gains and (losses)	60	0	60
Finance costs	(946)	(946)	0
Surplus/(deficit) for the period	**4,625**	**4,565**	**60**
Public dividend capital dividends payable	(4,565)	(4,565)	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	**12,625**	**12,625**	**0**
Trust EBITDA margin %	**4.0%**	**4.0%**	**-0.1%**

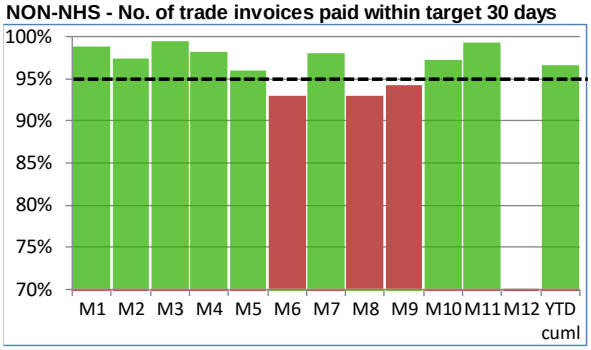
APPENDIX B – BPPC performance

Trust performance – current month (cumulative) v previous

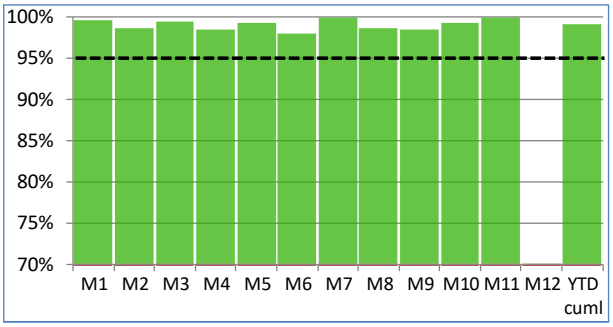
Better Payment Practice Code	February (Cumulative)		January (Cumulative)	
	Number	£000's	Number	£000's
Total Non-NHS trade invoices paid in the year	30,682	115,321	27,562	104,344
Total Non-NHS trade invoices paid within target	29,651	114,354	26,554	103,383
% of Non-NHS trade invoices paid within target	**96.6%**	**99.2%**	**96.3%**	**99.1%**
Total NHS trade invoices paid in the year	959	60,517	833	54,480
Total NHS trade invoices paid within target	905	59,102	781	53,140
% of NHS trade invoices paid within target	**94.4%**	**97.7%**	**93.8%**	**97.5%**
Grand total trade invoices paid in the year	31,641	175,838	28,395	158,824
Grand total trade invoices paid within target	30,556	173,456	27,335	156,523
% of total trade invoices paid within target	**96.6%**	**98.6%**	**96.3%**	**98.6%**

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

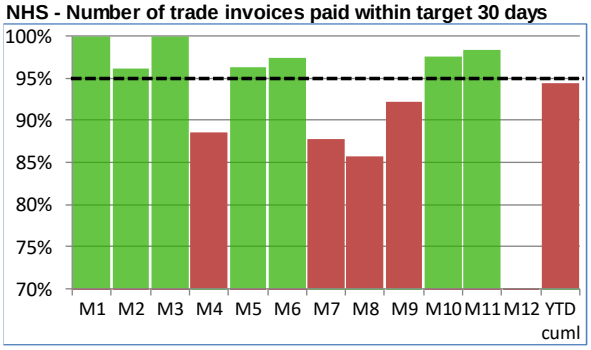
NON-NHS - No. of trade invoices paid within target 30 days



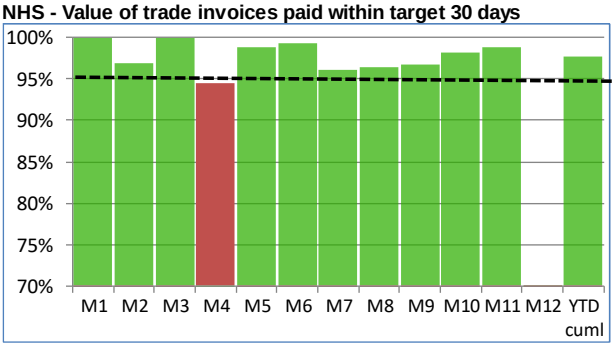
NON-NHS - Value of trade invoices paid within target 30 days



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	2020/2 1 Ave £000s Actual	2021/2 2 M1 £000s Actual	2021/2 2 M2 £000s Actual	2021/2 2 M3 £000s Actual	2021/2 2 M4 £000s Actual	2021/2 2 M5 £000s Actual	2021/2 2 M6 £000s Actual	2021/2 2 M7 £000s Actual	2021/2 2 M8 £000s Actual	2021/2 2 M9 £000s Actual	2021/2 2 M10 £000s Actual	2021/22 M11 £000s Actual	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	-38	-577	-391	-491	-411	-248	-360	-3,316	-3,596
Agency Nursing	-2,642	-220	-344	-265	-301	-422	-432	-548	-552	-486	-656	-754	-824	-524	-5,586	-6,410
Agency Scient, Therap. & Tech	-152	-13	-19	-14	-14	-25	-11	-17	-16	-17	-15	-9	-15	-20	-172	-192
Agency Other clinical staff costs				-11	-16	-11	1	0	0	-11	47	-11	0	-20	-12	-32
Agency Non clinical staff costs	-187	-16	-21	-32	-54	-21	-36	-62	2	-29	-10	-7	-32	-32	-301	-333
Sub-total for Directorate - DMH	**-5,541**	**-462**	**-673**	**-129**	**-905**	**-743**	**-698**	**-725**	**-1,143**	**-935**	**-1,125**	**-1,132**	**-1,120**	**-1,176**	**-9,387**	**-10,563**
Agency Spend relating to Investments			-57	-88	-115	-130	-198	-203	-220	-234	-240	-243	-243	-243	-1,971	-2,214
Agency spend relating to COVID			-53	-37	-150	-40	-6	-15	-5	-14	-15	-24	-28	-5	-453	-458
LEARNING DISABILITIES																
Agency Consultant Costs	-48	-4	-12	-8	-10	-13	-12	0	5	0	-10	-9	-28	-8	-98	-106
Agency Nursing	-761	-63	-123	-135	-156	-165	-156	-183	-295	-183	-260	-210	-267	-255	-2,139	-2,394
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	-1	-3	-2	-9	-11
Sub-total for Directorate - LD	**-894**	**-74**	**-154**	**-151**	**-162**	**-178**	**-168**	**-184**	**-290**	**-186**	**-271**	**-220**	**-298**	**-265**	**-2,264**	**-2,529**
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	-575	-537	-550	-5,005	-5,555
Agency Scient, Therap. & Tech	-375	-31	-36	-36	-50	-42	-22	-38	-67	-65	-56	-49	-80	-75	-540	-615
Agency Non clinical staff costs	-28	-2	-5	-10	-11	0	0	0	0	0	0	0	0	-3	-25	-28
Sub-total for Directorate - CHS	**-4,371**	**-364**	**-279**	**-401**	**-399**	**-453**	**-515**	**-531**	**-518**	**-550**	**-685**	**-624**	**-616**	**-628**	**-5,571**	**-6,199**
Agency Spend relating to Investments			0	0	0	0	0	0	0	0	0	-110	-155	0	-265	-265
Agency spend relating to COVID			-56	-18	-10	-21	-22	-23	-20	-60	-63	-67	-57	-60	-423	-483
FYPC																
Agency Consultant Costs	-816	-68	-70	-17	-48	-63	-44	-110	-83	-67	-29	-36	-63	-68	-691	-759
Agency Nursing	-2,546	-212	-241	-259	-232	-245	-330	-364	-335	-263	-417	-454	-296	-310	-3,435	-3,745
Agency Scient, Therap. & Tech	0	0	0	0	0	-3	-1	-4	-1	-2	-7	-6	-11	-10	-35	-45
Sub-total for clinical costs			**-310**	**-276**	**-280**	**-311**	**-375**	**-477**	**-419**	**-332**	**-454**	**-556**	**-370**	**-388**	-4,161	**-4,549**
Agency Non clinical staff costs	-10	-1	-5	-14	-6	-11	3	-8	-15	-10	-18	-4	-7	-10	-96	-106
Sub-total for Directorate - FYPC	**-3,371**	**-281**	**-315**	**-290**	**-287**	**-322**	**-372**	**-485**	**-435**	**-341**	**-472**	**-560**	**-377**	**-398**	**-4,257**	**-4,655**
Agency Spend relating to Investments			0	0	0	0	-58	-50	-50	-50	**-50**	**-40**	**-20**	**-40**	-318	**-358**
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	-21	-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	-14	-37	-19	-241	-260
Agency Non clinical staff costs	-977	-81	-105	-131	-158	-49	-56	-85	-220	-58	-171	-141	-160	-141	-1,334	-1,475
Sub-total for Directorate - Enab/Host	**-1,069**	**-89**	**-110**	**-141**	**-166**	**-78**	**-99**	**-116**	**-254**	**-76**	**-199**	**-157**	**-199**	**-162**	**-1,596**	**-1,758**
Agency Spend relating to Investments			0	0	-5	0	0	-13	-2	4	**-12**	**-8**	**-10**	**-2**	-46	**-48**
Agency spend relating to COVID			-76	-76	-73	-111	-47	-77	-94	-13	0	0	0	-50	-576	**-626**
TOTAL TRUST																
Agency Consultant Costs	-3,433	-286	-371	168	-578	-341	-276	-221	-657	-454	-537	-518	-341	-358	-4,126	-4,484
Agency Nursing	-9,315	-826	-953	-1,013	-1,028	-1,243	-1,411	-1,588	-1,634	-1,417	-1,362	-1,393	-1,324	-1,339	-16,165	-16,104
Agency Scient, Therap. & Tech	-696	-58	-73	-68	-63	-93	-77	-78	-116	-106	-100	-78	-143	-124	-1,007	-1,131
Agency Other clinical staff costs				-11	-16	-11	1	0	0	-11	47	-11	0	-20	-12	-32
Agency Non clinical staff costs	-1,202	-100	-135	-188	-230	-81	-89	-154	-233	-100	-200	-152	-203	-166	-1,765	-1,953
Total	**-15,246**	**-1,270**	**-1,532**	**-1,113**	**-1,920**	**-1,775**	**-1,852**	**-2,041**	**-2,639**	**-2,087**	**-2,752**	**-2,752**	**-2,611**	**-2,629**	**-23,075**	**-25,704**
Total Trust Agency Spend relating to Investmen	-	-	**-57**	**-88**	**-120**	**-130**	**-256**	**-266**	**-272**	**-280**	**-302**	**-401**	**-428**	**-285**	-2,600	**-2,885**
Total Trust Agency Spend relating to Covid-19	2,578	215	**-193**	**-191**	**-233**	**-172**	**-75**	**-115**	**-119**	**-87**	**-84**	**-91**	**-85**	**-115**	-1,454	**-1,569**
Total excluding Covid-19 and Investm	**-12,668**	**-1,055**	**-1,281**	**-834**	**-1,560**	**-1,473**	**-1,521**	**-1,660**	**-2,248**	**-1,721**	**-2,366**	**-2,260**	**-2,098**	**-2,230**	**-19,021**	**-21,250**

Agency costs for February were £2.7m. Excluding Covid and investment funded posts, costs were £2.2m.

Total forecast agency costs for the year are now £25.7m (£21.3m excluding covid and investments)

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	FEB	FEB	FEB	MAR	YTD	21/22
	FORECAST	ACTUAL	VARIANCE	FORECAST	ACTUAL	FORECAST
	£'000	£'000	£'000	£'000	£'000	£'000
OPENING BALANCE	**30,502**	**30,502**	**0**	**32,381**	**24,139**	**24,139**
INCOME						
Leicester & Leicesteshire CCG block contracts	21,319	22,231	**912**	21,319	252,368	273,687
Other CCG block contracts	471	471	**0**	296	3,252	3,548
East Midlands Provider Collaborative - CAMHS	142	142	**0**	142	1,562	1,704
Local Authorities block contracts	1,484	2,884	**1,400**	1,442	15,862	17,304
NHS England	783	1,949	**1,166**	2,944	13,170	16,114
UHL contract	232	0	**(232)**	464	2,088	2,552
MADEL	1,478	0	**(1,478)**	1,478	9,216	10,694
HIS income	200	521	**321**	200	2,572	2,772
360 Assurance income	100	288	**188**	136	1,665	1,801
UHL rental income	530	242	**(288)**	423	901	1,324
Previous year's income	0	4	**4**	0	4,988	4,988
VAT	455	455	**0**	250	4,886	5,136
Property sales	0	0	**0**	0	341	341
PDC for capital investment	0	0	**0**	4,374	2,016	6,390
Other income	861	1,598	**737**	649	8,078	8,727
Total Receipts	**28,055**	**30,785**	**2,730**	**34,117**	**322,965**	**357,082**
PAYMENTS						
Payroll	20,232	19,787	**(445)**	20,259	211,992	232,251
Capital	2,000	1,074	**(926)**	3,905	8,721	12,626
Non pay general expenditure	5,899	4,207	**(1,692)**	7,394	59,070	66,464
UHL - Estates & FM Services	1,880	940	**(940)**	1,880	9,400	11,280
UHL - Other contracts	288	0	**(288)**	288	1,304	1,592
NHS Property Services rents	1,104	1,178	**74**	226	4,029	4,255
Community Health Partnerships rents	118	118	**0**	118	1,298	1,416
HCL Agency Nursing Costs	1,700	1,460	**(240)**	2,000	14,218	16,218
Out of Area (OOA) costs for patients placed in private hospitals	0	0	**0**	0	195	195
Turning Point	0	142	**142**	142	1,481	1,623
Public dividend capital payment (PDC)	0	0	**0**	2,286	2,785	5,071
Other finance costs (inc loan interest and principal repayments)	0	0	**0**	0	230	230
Total Payments	**33,221**	**28,906**	**(4,315)**	**38,498**	**314,723**	**353,221**
CLOSING CASH BOOK BALANCE	**25,336**	**32,381**	**7,045**	**28,000**	**32,381**	**28,000**

APPENDIX E – Covid-19 expenditure, February 2022

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	3	1	0	0	0	0	0	0	**4**
Bank	194	23	0	0	0	0	0	0	**217**
Agency	-44	57	0	0	0	0	0	0	**13**
Existing workforce additional shifts									
Substantive	0	0	0	0	0	8	0	0	**8**
Bank	0	0	8	1	0	12	0	0	**21**
Agency	0	0	32	0	0	0	0	0	**32**
Backfill for higher sickness absence									
Substantive	0	0	0	0	0	0	0	0	**0**
Bank	0	0	0	0	0	0	0	0	**0**
Agency	0	0	0	0	0	0	0	0	**0**
Sick pay at full pay (all staff types)	0	0	0	0	0	0	0	0	**0**
NON-PAY	£000	£000	£000	£000	£000	£000	£000	£000	£000
NHS Staff Accommodation - if bought outside of national process	0	0	0	0	0	0	0	0	**0**
PPE - locally procured	0	0	0	0	0	1	0	0	**1**
PPE - other associated costs	0	0	0	0	0	0	0	0	**0**
Increase ITU capacity (incl hospital assisted respiratory / mech. ventilation)	0	0	0	0	0	0	0	0	**0**
Remote management of patients	0	0	0	0	0	0	0	0	**0**
Support for patient stay at home models	0	0	0	0	0	0	0	0	**0**
Segregation of patient pathways	0	0	0	0	0	0	0	0	**0**
Plans to release bed capacity	0	0	0	0	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	12	0	0	0	**12**
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	7	0	0	**7**
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 M11 COVID COSTS:	**154**	**82**	**40**	**1**	**12**	**28**	**0**	**0**	**317**
TOTAL M1 to M10 COVID COSTS:	2,444	818	135	97	118	646	24	0	4,282
TOTAL YTD COVID COSTS:	**2,598**	**900**	**175**	**98**	**130**	**674**	**24**	**0**	**4,599**

Covid Vaccination costs

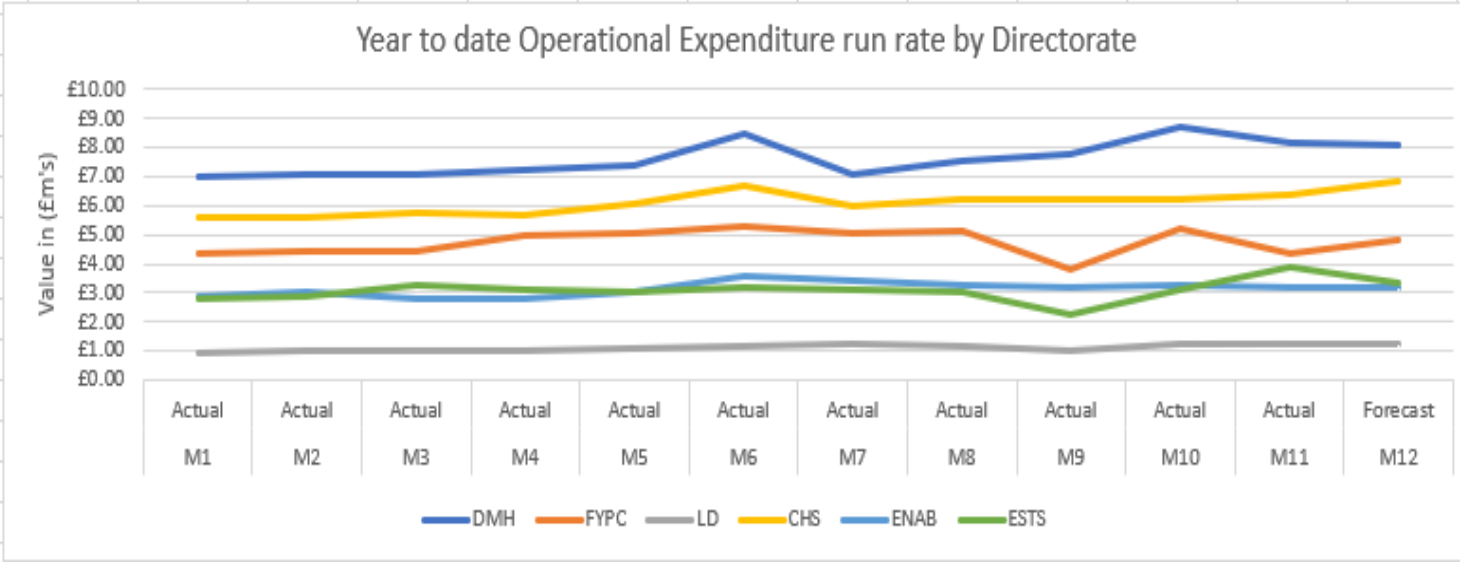
Total Covid vaccination costs incurred to date (April to February 22) are £6.13m. Virtually all the costs relate to staffing - £4.98m, plus another £0.73m on support to the School Age Immunisation Service. The Trust plan assumes total vaccination costs of £7.6m for the financial year, although based on the M11 position, final actual costs may now be less than this. Vaccination costs are currently direct funded based on actual costs incurred, so the programme will have no net impact on the Trust bottom line financial position.

APPENDIX F – Best, Likely and Worse case year end forecast

SUMMARY BY MANAGEMENT AREA / ADDITIONAL PRESSURE OR GAIN	£'000 BEST	£'000 LIKELY	£'000 WORST
DMH	-1,050	-1,175	-1,250
Community Health Service	300	50	-100
HIS	800	600	400
Enabling	1,200	1,000	600
Estates	600	550	480
FYPC	300	200	0
Learning Disabilities	-400	-600	-750
Sub-total operation position:	**1,750**	**625**	**-620**
Reserves underspends (central efficiencies, income over-recoveries)	3,662	3,052	3,052
IT asset write-offs	-1,300	-650	-650
Additional identified year end provisions (including annual leave)	-1,937	-1,677	-1,552
Estates Transformation	-800	-800	-450
Potential additional revenue investment (medical equip etc)	0	0	0
Revenue costs identified within capital programme	0	-200	-350
Additional 'flu vaccination costs not funded	0	-100	-150
Additional year end expenditure accruals	-500	-250	-45
TOTAL TRUST FORECAST YEAR END POSITION:	**875**	**0**	**-765**

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

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	Total
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	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	8.7	8.1	8.1	91.7
FYPC	4.4	4.5	4.4	5.0	5.0	5.3	5.0	5.1	3.8	5.2	4.4	4.8	56.9
LD	1.0	1.0	1.0	1.0	1.1	1.1	1.2	1.1	1.0	1.3	1.2	1.2	13.3
CHS	5.6	5.6	5.8	5.7	6.1	6.7	6.0	6.2	6.2	6.2	6.3	6.9	73.3
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	37.6
ESTS	2.8	2.8	3.3	3.1	3.0	3.2	3.1	3.1	2.3	3.1	3.9	3.3	37.0
TOTAL	**23.7**	**24.0**	**24.4**	**24.8**	**25.7**	**28.3**	**25.8**	**26.4**	**24.3**	**27.8**	**27.1**	**27.5**	**309.9**



The actual expenditure run-rate for operational directorates is shown (left). Average costs can be seen to have increased in month 10 due to high levels of staff sickness / absences and vacancies being covered by Agency. The 'spike' in month 6 reflects the payments relating to the pay award (plus arrears) which were made in that month.

Leicestershire Partnership NHS
NHS Trust

Trust Board 29/03/2022

Month 11 Trust finance report

Purpose of the Report

- To provide an update on the Trust financial position.

Proposal

- The Trust Board is recommended to review the summary financial position and receive assurance that financial performance is in line with the H2 financial plan, and the overall plan for the year.

Decision required: N/A

Governance table

For Board and Board Committees:	Trust Board 29.3.22	
Paper sponsored by:	Sharon Murphy, Director of Finance	
Paper authored by:	Amjad Kadri, Acting Head of Corporate Finance Jackie Moore, Financial Controller	
Date submitted:	21/03/2022	
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, 18/03/2022	
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
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trustwide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	70 - 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).

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

Y

Leicestershire Partnership NHS Trust

Public Trust Board – 29.03.22

Board Performance Report February 2022 (Month 11)

Purpose of the report

To provide the Trust Board with the Trust's performance against KPI's for February 2022 Month 11.

Analysis of the issue

The report is presented to Operational Executive Team each month, prior to it being released to level 1 committees.

Proposal

The Trust Board is asked to approve the performance report.

Decision required

The Trust Board is asked to

- Approve the performance report

Governance table

For Board and Board Committees:	Trust Board 29.3.22	
Paper sponsored by:	Sharon Murphy, Interim Director of Finance and Performance	
Paper authored by:	Sam Kirkland, Head of Data Privacy	
Date submitted:	21.03.22	
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
29 March 2022

Board Performance Report
February 2022 (Month 11)

Highlighted Performance Movements - February 2022

Improved performance:

Metric	Performance	
72 hour Follow Up after discharge Target is 80% (reported a month in arrears)	86.0%	
CAMHS Eating Disorder – one week (complete pathway) Target is 95%	100.0%	

Deteriorating Performance:

Metric	Performance	
LD Community - 8 weeks (complete pathway)	49.3%	Reported 72.1% the previous month
Children and Young People's Access – 13 weeks (incomplete pathway) Target is 92%	90.0%	Reported 100% for past 5 months

Other areas to highlight:

Metric	Performance (No)	
Serious Incidents	7	Increased from 6 reported last month
No. of episodes of seclusions >2hrs *Target decreasing trend*	16	Decreased from19 reported last month
No. of episodes of prone (Supported) restraint	2	Decreased from 3 reported last month
No. of repeat falls *Target decreasing trend*	33	Decreased from 38 reported last month

1. Hospital Acquired COVID Infection Reporting

A nosocomial infection is an infection that is acquired in a hospital or other health care facility. How likely each patient Covid-19 case is to be a nosocomial case is based on the duration of time between admission to a healthcare facility and positive specimen date;.

- **Hospital-Onset Probable Healthcare-Associated** – positive specimen date 8 -14 days after hospital admission.
- **Hospital-Onset Definite Healthcare-Associated** – positive specimen date 15 or more days after hospital admission.

Indicator: Total Admissions

	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	Sparkline
Total Admissions	404	353	389	330	374	366	368	381	377	347	396	377	406	

		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22		Sparkline
Total Admissions		398	437	418	404	412	391	436	403	379	400	359		

Indicator: Covid Positive Prior to Admission

	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	Sparkline
Total Covid +ve Admissions	18	49	31	11	5	4	2	28	41	44	66	31	11	
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%	

		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22		Sparkline
Total Covid +ve Admissions		1	0	3	6	20	12	13	12	17	30	4		
Covid +ve Admission Rate		0.3%	0.0%	0.7%	1.5%	4.9%	3.1%	3.0%	3.0%	4.5%	7.5%	1.1%		

Indicator: Covid Positive Following Swab During Admission

No of Days	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Sparkline
0-2	1	4	2	2	0	0	0	2	5	4	5	4	0	
3-7	2	9	9	1	1	0	1	0	7	12	20	8	1	
8-14	1	8	9	2	0	0	0	0	1	15	9	5	2	
15 and over	11	14	5	2	0	0	0	7	5	29	18	35	9	
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%	

No of Days		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Sparkline
0-2		0	0	0	0	1	1	2	1	3	4	6	
3-7		0	1	0	0	2	1	1	1	8	6	7	
8-14		0	0	0	0	1	0	3	1	7	6	2	
15 and over		1	0	0	0	2	2	11	0	38	43	11	
Hospital Acquired Rate *		0.3%	0.0%	0.0%	0.0%	0.7%	0.5%	3.2%	0.2%	11.9%	12.3%	3.6%	

- *Community-Onset (CO) positive specimen date - <=2 days after hospital admission or hospital attendance.*
- *Hospital-Onset Indeterminate Healthcare Associated (HO.IHA) – positive specimen date 3-7 days after hospital admission.*
- *Hospital-Onset Probable Healthcare-Associated (HO.pHA) – positive specimen date 8 -14 days after hospital admission.*
- *Hospital-Onset Definite Healthcare-Associated (HO.dHA) – positive specimen date 15 or more days after hospital admission.*

** - Includes the Hospital-Onset Probable Healthcare-Associated and Hospital-Onset Definite Healthcare-Associated categories.*

Indicator: Overall Covid Positive Admissions Rate

	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	Sparkline
Total Covid +ve Admissions	33	84	56	18	6	4	3	37	59	104	118	83	23	
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%	

		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22		Sparkline
Total Covid +ve Admissions		2	1	3	6	26	16	30	15	73	89	30		
Average Covid +ve Admissions		0.5%	0.2%	0.7%	1.5%	6.3%	4.1%	6.9%	3.7%	19.3%	22.3%	8.4%		

Current LPT data sources for nosocomial Covid-19

Daily Directorate Covid-19 Sit-rep reports

The template includes; number of confirmed Covid-19 patients diagnosed with Covid-19 between midnight to 23.59:59 on the day before against the date of the positive specimen in line with the above definitions. This information is submitted directly to the ICC and copied to the Trust Infection Prevention and Control team.

IPC team local access database

The IPC team have a local access database for clinical patient reviews that captures all patients with long term infections and more recently Covid-19. The data source is taken from the daily Directorate sit-reps, or through IPC referrals. Data is validated using SystmOne records and ilab to confirm results. The system is backed up daily.

The objective is to move to a utilising System1 functionality when it is available, with reporting through Qliksense. The Information and IPC teams are currently working up this system and process.

Internal reporting

There were thirteen nosocomial cases reported in February 2022. This is broken down into six at 8-14 days and forty at greater than 15 days. These have been managed as patient and staff Covid-19 outbreaks, identified in the following areas:

7-14 days

Swithland Ward - Loughborough Hospital

15+ days

Kirby ward - Bennion centre

Ward 2 - Coalville Hospital

Griffin ward - Herschel Prins

We continue to test, screen and triage all patients and use a risk assessment process. North ward continues to be the primary admissions ward for patients who are positive with Covid19.

Actions to minimise nosocomial Covid-19 infection

The weekly Trust wide outbreak meeting has been reinstated due to an increase in Covid-19 outbreaks to ensure lessons learnt and actions are widely shared.

2. Quality Account

The following standards form the measures for the 2020/21 Quality Account that being reported against in 2021/22 until the new metrics have been agreed.

<table>
<tr><th rowspan="2">Standard</th><th rowspan="2">Trust Performance</th><th rowspan="2">RAG/ Comments on recovery plan position</th><th colspan="2">SPC Flag</th></tr>
<tr><th>Assurance of Meeting Target</th><th>Trend</th></tr>
<tr><td rowspan="3">The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period</td><td><table><tr><td>Sep-21</td><td>Oct-21</td><td>Nov-21</td><td>Dec-21</td><td>Jan-22</td><td>Feb-22</td></tr><tr><td>100.0%</td><td>100.0%</td><td>97.2%</td><td>100.0%</td><td>100.0%</td><td>98.5%</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>Sep-21</td><td>Oct-21</td><td>Nov-21</td><td>Dec-21</td><td>Jan-22</td><td>Feb-22</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>6.9%</td><td>6.2%</td><td>8.0%</td><td>4.5%</td><td>5.8%</td><td>3.7%</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

The following standards form the measures for the 2020/21 Quality Account that being reported against in 2021/22 until the new metrics have been agreed.

<table>
<tr><th rowspan="2">Standard</th><th rowspan="2">Trust Performance</th><th rowspan="2">RAG/ Comments on recovery plan position</th><th colspan="2">SPC Flag</th></tr>
<tr><th>Assurance of Meeting Target</th><th>Trend</th></tr>
<tr><td>The number and, where available rate of patient safety incidents reported within the Trust during the reporting period</td><td>
<table>
<tr><td>Sep-21</td><td>Oct-21</td><td>Nov-21</td><td>Dec-21</td><td>Jan-22</td><td>Feb-22</td></tr>
<tr><td>949</td><td>922</td><td>1061</td><td>1187</td><td>1167</td><td>1098</td></tr>
<tr><td>59.2%</td><td>57.7%</td><td>59.3%</td><td>55.5%</td><td>53.8%</td><td>61.0%</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>Sep-21</td><td>Oct-21</td><td>Nov-21</td><td>Dec-21</td><td>Jan-22</td><td>Feb-22</td></tr>
<tr><td>7</td><td>7</td><td>11</td><td>10</td><td>8</td><td>13</td></tr>
<tr><td>0.7%</td><td>0.8%</td><td>1.0%</td><td>0.8%</td><td>0.7%</td><td>1.2%</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>Aug-21</td><td>Sep-21</td><td>Oct-21</td><td>Nov-21</td><td>Dec-21</td><td>Jan-22</td></tr>
<tr><td>72.4%</td><td>75.0%</td><td>66.7%</td><td>89.5%</td><td>90.9%</td><td>85.7%</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>Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) Inpatient Wards b) EIP Services c) Community Mental Health Services (people on care programme approach)</td><td>Reported Bi-annually
Inpatient Wards
<table>
<tr><td>Mar-20</td><td>Sep-20</td><td>Mar-21</td><td>Sep-21</td></tr>
<tr><td>60.0%</td><td>58.0%</td><td>96.0%</td><td>94.0%</td></tr>
</table>
EIP Services
<table>
<tr><td>Mar-20</td><td>Sep-20</td><td>Mar-21</td><td>Sep-21</td></tr>
<tr><td>93.0%</td><td>-</td><td>97.0%</td><td>-</td></tr>
</table>
Community Mental Health Services on CPA (arrears)
<table>
<tr><td>Mar-20</td><td>Sep-20</td><td>Mar-21</td><td>Sep-21</td></tr>
<tr><td>-</td><td>34.0%</td><td>-</td><td>54.0%</td></tr>
</table>
</td><td>Comments on September 2021 results

To continue the work as has been achieved thus far. Staff should be commended on their excellent work in this area particularly in light of the impacts and implications of COVID.</td><td>n/a</td><td>n/a</td></tr>
<tr><td colspan="3">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>Sep-21</td><td>Oct-21</td><td>Nov-21</td><td>Dec-21</td><td>Jan-22</td><td>Feb-22</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 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>Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22</td><td rowspan="3"></td><td rowspan="2">?</td><td rowspan="2">NO CHANGE</td></tr>
<tr><td>72.4% | 75.0% | 66.7% | 89.5% | 90.9% | 85.7%</td></tr>
<tr><td colspan="2">Over the series of data points being measured, key standards are being delivered inconsistently</td></tr>
<tr><td rowspan="3">6-week wait for diagnostic procedures (Incomplete)

Target is >=99%

(reported a month in arrears)</td><td>Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22</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>49.9% | 58.2% | 64.9% | 72.9% | 57.9% | 67.9%</td></tr>
<tr><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	
		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22		Assurance of Meeting Target	Trend
Adult CMHT Access Six weeks routine Target is 95%	Complete	66.7%	60.9%	68.4%	66.6%	71.7%	62.2%	Noted that there is a shortfall against trajectory. Actions to address this include: •Task and Finish Group which will explore supporting transition into primary care to be established. •Quality summit took place on 7th March, outputs are being developed into a quality improvement plan which will support waiting times improvement work. •Implementation of new assessment model. •Consultant desk top paper caseload review due to commence. •Develop a 'step up' community offer. •Develop training packages. •Workstream in place to review and re- design the workforce. •An estates group is planned to review needs of integrated ways of working and new offers and services. •Community Enhanced Rehab Team (CERT) which offers transitional support to service users leaving rehabilitation inpatient services.	N/A	N/A
	Incomplete	45.3%	56.6%	68.8%	73.5%	72.5%	72.1%		NO	UP
									Key standards are not being delivered but are improving	
Memory Clinic (18 week Local RTT) Target is 95%		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	•Referral rates now back to pre-covid levels. •Continuing to recruit to additional post. •Waiting times have deteriorated as the service suspended during the early stages of the pandemic – this led to a large backlog of cases. •There had been a detrimental impact of long-term sickness in the team. •Advice and guidance service for GPs has been set up using electronic messaging. •The service is working to maximise capacity. •Recommenced satellite clinics in two areas, and seeking to add a third location. •As part of SUTG to review the current memory service pathway with the team and agree what the future model will look like. •QI Work being undertaken including demand and capacity work, review of clinic capacity (estates) and pilot of OT post.		
	Complete	51.6%	49.1%	39.5%	51.4%	49.2%	30.8%		N/A	N/A
	Incomplete	69.7%	70.6%	77.1%	79.5%	79.7%	78.6%		N/A	N/A
ADHD (18 week local RTT) Target is: Complete - 95% Incomplete - 92%		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	•Significant impact due to COVID and increased numbers of referrals which is impacting on waiting times. •An ADHD workstream group has been set up with commissioners chaired by Head of Service. •A robust recovery plan is in place which is monitored via group and reports monthly to DMT. •Work packages include development of a new hub and spoke model with a more integrated approach and engagement work to work through the primary care and the integrated neighbourhood offer with the VCS. •The service specification has been updated to reflect the current service offer. •The post of ADHD Assistant Service Manager has been advertised. •An interim procurement exercise is due to take place with a plan to outsource part of the backlog of people waiting for assessment. •A refresh of the demand and capacity exercise is to be completed.		
	Complete	12.5%	15.4%	21.4%	18.5%	6.3%	14.3%		N/A	N/A
	Incomplete	34.3%	33.9%	31.4%	29.7%	29.8%	28.0%		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%	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Urgent compliance is consistently 100%. Waiting list reduced but not in line with trajectory. Increase in number of 1st assessments. Compliance remains static. Referrals reduced slightly. The longest waiter decreased.	N/A	N/A
	26.2%	20.7%	21.3%	20.9%	32.2%	32.3%			
Continence (Complete Pathway) Target is 95%	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	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
	50.1%	46.0%	39.7%	46.1%	36.6%	41.2%			

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%		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	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	?	NO CHANGE
		100.0%	85.7%	77.8%	83.3%	100.0%	100.0%		Over the series of data points being measured, key standards are being delivered inconsistently	
CAMHS Eating Disorder – four weeks (complete pathway) Target is 95%		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	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. The current recovery trajectory has plateaued due to new posts not being filled. However, if these posts were recruited to we would expect to see a down turn in July/August of the backlog.	NO	DOWN
		30.0%	42.9%	20.0%	30.8%	25.0%	50.0%		Over the series of data points being measured, key standards are not being delivered and are deteriorating	
Children and Young People's Access – four weeks (incomplete pathway) Target is 92%		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	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%		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	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
		100.0%	100.0%	100.0%	100.0%	100.0%	90.0%		Over the series of data points being measured, key standards are being delivered inconsistently	
Aspergers - 18 weeks (complete pathway)	Wait for Treatment	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	The service is receiving an increase in referrals approximately 305 increase on 2019/20 figures this year and this is starting to impact on the target. This month 2 out of 32 patients were seen within 18 weeks. This is being monitored at DMT and Silver meetings.	N/A	N/A
		93.8%	100.0%	95.8%	97.1%	75.0%	6.5%			
	No. of Referrals	45	57	47	88	92	70			
LD Community - 8 weeks (complete pathway)	Wait for Assessment	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22		N/A	N/A
		88.3%	81.0%	79.2%	84.2%	72.1%	49.3%			
	No. of Referrals	97	143	104	93	78	3			

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	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	72 weeks	The CBT improvement plan remains effective in supporting the number of 52 week waiters to fall.	NO	DOWN
	27	23	17	24	23	16			Key standards are not being delivered but are improving	
Dynamic Psychotherapy	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	91 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
	13	14	21	21	24	24			Key standards are not being delivered but are improving	
Therapy Service for People with Personality Disorder - Treatment waiters over 52 weeks	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	235 weeks	The TSPPD Service is achieving against the agreed trajectory to reduce the number of patients waiting for assessment for over 52 weeks. Whilst the service is working towards development and input into pathfinder assessments, they are continuing to review the assessment approaches in the care pathway and at present are still running additional clinics for those service users not open to CMHT/OP.	NO	UP
	380	395	460	473	472	490			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)	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	152 weeks	• Current focus is on providing training to the first cohort of staff across locality teams to begin providing psychological skills groups across locality teams. • Significant programme of recruitment taking place. • Treatment capacity will be increasing over the next 12 months. This will be reviewed against the waiting list to measure impact on reducing waiting list numbers and waiting times. • Assessments to be combined with CMHT assessment to give holistic view on appropriate treatment offers. This is still being developed as part of the post consultation implementation and the development of the Treatment and Recovery Teams. • Implementing a Quality Improvement approach.	N/A	N/A
	486	403	360	341	324	330				
CAMHS	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	104 weeks	As at 31st January 103 waiting over a year, 62 for treatment and 41 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 27 weeks down from a peak of 38 weeks	NO	NO CHANGE
	192	125	141	169	148	150			Key standards are not being delivered and are deteriorating/ not improving	
All LD - No's waiting over 52 weeks	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	77 weeks		N/A	N/A
	25	24	21	18	30	42				

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%	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	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
	78.4%	81.6%	81.3%	85.4%	80.1%	83.8%		Over the series of data points being measured, key standards are being delivered inconsistently	
Occupancy Rate - Community Beds (excluding leave) Target is >=93%	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	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).	?	NO CHANGE
	86.3%	82.2%	85.1%	84.3%	82.7%	90.2%		Over the series of data points being measured, key standards are being delivered inconsistently	
Average Length of stay Community hospitals National benchmark is 25 days.	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	The Trust consistently is below the national benchmark of 25 days.	YES	NO CHANGE
	19.7	17.8	18.3	18.2	19.5	20.3		Key standards are being consistently delivered and are improving/ maintaining performance	
Delayed Transfers of Care Target is <=3.5% across LLR	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	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
	2.5%	3.1%	3.3%	3.8%	3.7%	4.9%		Over the series of data points being measured, key standards are being delivered inconsistently	
Gatekeeping Target is >=95%	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22		?	UP
	100.0%	100.0%	97.2%	100.0%	100.0%	98.5%		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)*	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22		N/A	N/A
	78.0%	82.6%	89.9%	86.1%	83.3%	86.0%			
Perinatal - Number and Percentage of women accessing service Target is 8.6%	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	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
	484	466	495	522	563	594			
	3.9%	3.7%	4.0%	4.2%	4.5%	4.8%		N/A	N/A

7. Quality and Safety

Target	Trust Performance						RAG/ Comments on recovery plan position	SPC Flag	
								Assurance of Meeting Target	Trend
Serious incidents	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22		?	NO CHANGE
	1	5	8	5	6	7		Over the series of data points being measured, key standards are being delivered inconsistently	
STEIS - SI action plans implemented within timescales (in arrears) Target = 100%	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22		?	DOWN
	25.0%	9.0%	0.0%	50.0%	40.0%	0.0%		Over the series of data points being measured, key standards are being delivered inconsistently	
Safe staffing No. of wards not meeting >80% fill rate for RNs Target 0		Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	NO	NO CHANGE
	Day	6	4	3	7	7	4		
	Night	1	2	1	1	1	0	Key standards are not being delivered and are not improving *SPC based on day shift*	
Care Hours per patient day	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22		N/A	N/A
	12.2	12.2	12.4	11.6	12.1	11.9		Key standard has no target; however performance is consistent	
No. of episodes of seclusions >2hrs Target decreasing trend	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22		N/A	NO CHANGE
	24	8	7	9	19	16		Key standard has no target; however performance is consistent	
No. of episodes of prone (Supported) restraint Target decreasing trend	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22		N/A	NO CHANGE
	5	2	2	1	3	2		Key standard has no target; however performance is consistent	
No. of episodes of prone (Unsupported) restraint Target decreasing trend	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22		N/A	NO CHANGE
	0	2	1	0	0	0		Key standard has no target; however performance is consistent	
Total number of Restrictive Practices	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22		N/A	N/A
	226	194	272	204	267	246			

No. of Category 2 and 4 pressure ulcers developed or deteriorated in LPT care Target decreasing trend (RAG based on commissioner trajectory)		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22		N/A	NO CHANGE
	Category 2	93	98	90	97	122	100		N/A	NO CHANGE
	Category 4	5	6	11	6	1	4		*Key standard has no target; however performance is consistent for category 2 and consistent for category 4*	
No. of repeat falls Target decreasing trend		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22		N/A	DOWN
		45	39	32	25	38	33		*Key standard has no target; however performance is consistent*	
LD Annual Health Checks completed - YTD Target is 70%		Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Year To date from 1 April 2021	N/A	N/A
		17.9%	27.5%	30.8%	39.4%	43.9%	62.0%			
LeDeR Reviews completed within timeframe		Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	New LeDeR system is in place – need to redefine.	N/A	N/A
	Allocated	16	13	12	12	28	23		N/A	N/A
	Awaiting Allocation	15	11	19	29	22	10		N/A	N/A
	On Hold	15	6	3	1	2	3			

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
MH Data quality Maturity Index Target >=95%	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21		?	UP
	92.6%	92.9%	93.0%	93.2%	90.2%	90.3%		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%	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	The Trust is below the ceiling set for turnover.	YES	DOWN
	9.3%	9.5%	9.6%	9.4%	9.4%	9.2%		Key standards are being consistently delivered and are improving performance	
Vacancy rate Target is <=7%	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	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
	11.3%	11.1%	10.5%	11.4%	11.1%	10.7%		Key standards are not being delivered and are deteriorating	
Health and Well-being Sickness Absence (1 month in arrears) Target is <=4.5%	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Sickness absence is currently higher than the Trust target, all absence is being appropriately managed within the services with support from HR.	NO	UP
	5.2%	5.1%	5.4%	5.8%	5.4%	5.9%		Key standards are not being delivered and are deteriorating	
Health and Well-being Sickness Absence Costs (1 month in arrears) Target is TBC	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22		n/a	n/a
	£748,440	£709,372	£790,515	£848,444	£816,587	£877,250			
Health and Well-being Sickness Absence YTD (1 month in arrears) Target is <=4.5%	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	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
	5.0%	5.0%	5.1%	5.2%	5.2%	5.3%		Not applicable for SPC as measuring cumulative data	
Agency Costs Target is <=£641,666 (NHSI national target)	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	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
	£2,040,719	£2,639,144	£2,086,944	£2,752,153	£2,751,823	£2,611,046		Key standards are not being delivered and are deteriorating/ not improving	
Core Mandatory Training Compliance for substantive staff Target is >=85%	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	The Trust is meeting the target set for Core Mandatory Training.	YES	NO CHANGE
	92.6%	92.9%	93.4%	93.9%	93.7%	90.0%		Key standards are being consistently delivered and are maintaining performance	
Staff with a Completed Annual Appraisal Target is >=80%	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	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
	83.2%	78.2%	76.0%	75.0%	73.7%	72.5%		Key standards are being delivered but are deteriorating	
% of staff from a BME background Target is >= 22.5%	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	The Trust is meeting the target set.	?	UP
	24.0%	24.0%	24.4%	24.7%	24.7%	24.8%		Over the series of data points being measured, key standards are being delivered inconsistently	
Staff flu vaccination rate (frontline healthcare workers) Target is >= 80%	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22		n/a	n/a
		31.9%	46.3%	57.9%	59.6%	59.8%			
% of staff who have undertaken clinical supervision within the last 3 months Target is >=85%	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	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
	75.7%	77.3%	78.6%	72.7%	71.3%	73.1%		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)	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22		N/A	N/A
	102	130	139	210	301	360			

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 – February 2022

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 – 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
Children and Young People's Access – four weeks (incomplete pathway)

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:	21/03/2022	
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	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:		

Z

Leicestershire Partnership NHS Trust

TRUST BOARD – 29 March 2022

AUDIT AND ASSURANCE COMMITTEE - 4 March 2022

HIGHLIGHT REPORT

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

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

Report	Assurance level*	Committee escalation	ORR Risk Ref
Internal Audit Progress Report 2022/23 Plan 2022/23 Charter	**High**	Four reports had been issued since the last meeting, three with significant assurance opinion and one with split significant / limited assurance. The HoIAO stage 2 work had been issued. The implementation rate in 2021/22 for follow ups was currently 92%. The Committee approved the assurance element of the Violence and Aggression Review being undertaken in Q1 2022/23 due to issues around capacity. The Committee approved the Internal Audit Plan for 2022/23. The charter was presented for information, there had been no changes made from the previous year.	62, 70 71*
External Audit Progress Report 2021/22 Plan	**High**	The Committee received the External Audit Progress Report and technical update. Areas of importance for the Trust related to the 2022/23 priorities and operational planning guidance issued by NHSE/I, in particular the revised contract arrangements, collaborative working and plans to deliver more elective care. Also to note were updates issued by the DoH&SC around changes to fair pay disclosures and IFRS16 implementation. An overview of KPMG's risk assessment and planned audit approach was received. The Committee noted the positive change in materiality which reflected the good work carried out by finance teams over previous years.	62, 70 71*

Report	Assurance level*	Committee escalation	ORR Risk Ref
Counter Fraud Progress Report 2022/23 Plan	**High**	The Committee received the Counter Fraud Progress Report and noted progress made since the previous meeting. LPT was currently in a very good position in terms of the Functional Standard score which had improved to green across the board. The Committee approved the Counter Fraud Plan for the financial year 2022/23 which was based on the same number of days being delivered as the previous year. The only difference was the requirement to provide assurance against the Functional Standard based on broader risks and the work carried out to address them.	62, 70 71*
Clinical Audit Policy	**High**	The Committee received and supported the policy.	62*
Risk Manage-ment Update	**High**	• A number of changes had been made to the ORR with the addition of three new risks since the last meeting in December 21. • A risk assessment functionality had been introduced into the Ulysses system for counter fraud risks. • Risk training was currently facilitated by the Risk Team via a one hour video overview session and three hour risk management session.	62*
Legal and Regulatory Issues	**High**	The implementation of the Liberty Protection Safeguards had been pushed back from April, to July 2022. The Coronavirus Act 2020 was due to expire on 24 March 2022, some elements of it would be confirmed through secondary legislation and some would expire. The Risk Team was closely monitoring this and the implications to the Trust.	62*
Internal and External Audit Follow up of Actions	**High**	The Pentana system was now up and running and had been relatively well received by key users within the Trust. There were no specific concerns to raise.	62*
Financial Waivers	**High**	Thirteen waivers with a total value of c£547k had been raised during quarter 3 of 2021/22, all had been approved. The Committee noted there would be a lot fewer waivers when the Trust moved to new reporting processes.	62, 70 71*
Accounting Policies/Year End Update	**High**	A summary of the 2021/22 annual accounts process was presented including updates since December's progress report. Discussion focused on the proposal for AAC to approve the audited accounts at its meeting in June.	62, 70 71*
Chairs of QAC/FPC - updates on key issues	**High**	The Committee was fully assured by updates provided by QAC and FPC chairs. No specific areas of concern were raised.	62, 70 71*

Chair	**Darren Hickman**

*****principal risk(s) shown but will also cover other risk on ORR

AAA

Leicestershire Partnership NHS Trust

CHARITABLE FUNDS COMMITTEE– DATE 15th MARCH 2022

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 risk 4618 (timely spend of funds) would be closed, as there were no open actions, and no further actions required. The risk assessment 4669 (estates resources available to support projects) would be retained until specific estates dependent projects had been completed.	4618 4669
Review of Fundraising Strategy and Annual Priorities	High	A review was undertaken of delivery against the 2021/22 objectives: • Visibility: Increase the charity brand awareness and profile to all relevant audiences • Income: Increase the level of donations to the charity using the appropriate fundraising mix • Grants: Invest in initiatives that support the vision of the charity • Partnerships: Develop partnerships which increase the reach and impact of the Charity It was agreed that there had been progress in all areas. There is still significant work to be done on all four objectives, so it was agreed that they would be retained for 2022/23, and that new approaches would be implemented	4618 4669

Report	Assurance level*	Committee escalation	Risk Reference
		now that we were operating in a post covid environment.	
Fundraising Manager's report	High	The fundraising manager provided an update on activities to 7th March. Highlights against Raising Health strategic objectives noted were: (Visibility) Signage – The Raising Health Signage is now in place. There are still a few locations outstanding where landlord's permission is being sought. The graphics for the QR code (pointing to the Raising Health Website) will be added to the signs. (Income) - The Free Will Writing Month offer had good uptake (79 new clients), however this had not translated into an increase in donations. The committee agreed we would not undertake this approach to fund raising in future. NHSCT will be releasing funding of £30,000 for the development of the member charities. The committee will consider how best to use this funding. It was noted that there were several appeals not achieving their income target so the Chair requested marketing & media planning work take place to focus on significant fundraising from all sources in 2022/23. (Grants) - Golden Ticket Scheme – This project awards every LPT team Tesco vouchers to spend on Health and wellbeing products or activities. The Coalville Hospital Garden redesign is complete and work is expected to start in the Summer of 2022.	4618 4669
Annual review of performance of Investment Advisors	High	A representative from the external investment advisors, Cazenove Capital, presented their annual committee update. It was noted that there had been a decrease in portfolio performance over the last 3 months which offset the previous 12 months gains. It was agreed that the investment is long term in nature and since inception the portfolio had grown by 15.6%. In light of recent events in Ukraine, the committee asked for, and received, assurance that there were no investments in the portfolio in Russia or Belarus.	4618

Report	Assurance level*	Committee escalation	Risk Reference
Finance report – Q3	High	Total income was £393k at quarter 3, comprising realised income of £203k and an unrealised investment gain of £190k. Expenditure was £378k to quarter 3. Future expenditure commitments total £304k. The cash balance was £525k at the end of December. 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 3, an increase of £15k since the start of the financial year.	4618 4619
Review of CFC Internal Audit Report/associated actions	High	An update on the recommendations in the significant assurance report was received by the committee. The committee was assured with progress.	4618
Updates on Previous Bids	High	Carlton Hayes – feedback from a meeting with Trustees on 3 March 2022 – it was noted that the Carlton Hayes trustees were pleased with progress, but had asked for the bid forms to be simplified. They had not approved a move to the £55k allocation being received at the start of the year, so we would continue to run 2 bidding rounds a year.	4618
New bids received	Amber	Approved bids: • 2022/23 running costs: Raising Health Marketing Budget (£4k) Annual audit fees (£7k) Charity Finance Staffing (£41k) Charity Fundraising Assistant (£19k) Charity Fundraising Manager (£55k) Harlequin Software costs (£4k) Lottery Prizes (£34k) Lottery Staffing Cost (£14k) Lottery Superdraws (£3k) A benchmarking exercise showed historic LPT costs at 24.8% of income against an average benchmark of 25.8%. 2022/23 staffing costs had increased on previous years. The committee expressed concern around the level and increase in running costs and further review work is being undertaken. • Research Proposals: Developing and evaluating a mental imagery-based assessment tool for clinicians and a novel imagery-based intervention for young people who self-harm (£10k) Examining Challenges Encountered in the	4618

Report	Assurance level*	Committee escalation	Risk Reference
		Transition from Child and Adolescent to Adult Mental Health Services for Young People with Complex Needs: Experiences and Views of Young People, Professionals Supporting Them, and Parents and Carers (£10k) • Carlton Hayes Gardening Applications (funded from NHSCT underspends) (£6k) • Carlton Hayes CAMHS bid (£5k)	
New funds created	High	Heather Ward fund created following a regular commitment to donate. .	4618
Raising Health's insert into LPT's Annual Report 2021/2022	High	Extract received for review and approval.	4618
Work plan	High	The work plan was reviewed and agreed for 2022/23.	4618
Review of risk register	High	No new risks were added.	4618
AOB	High	None received.	4618

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