Public Meeting of the Trust Board
31st May 2022
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 – FYPC CAMHS	verbal	Helen Thompson
9.45	3.	Staff Voice – FYPC CAMHS	verbal	Helen Thompson
10.00	4.	Declarations of Interest in Respect of Items on the Agenda	verbal	Chair
	5.	Minutes of the Previous Public Meeting: 29th March 2022	B	Chair
	6.	Matters Arising	C	Chair
	7.	Chair's Report	D	Chair
	8.	Chief Executive's Report	E	Angela Hillery
Governance and Risk				
10.10	9.	Organisational Risk Register	F	Chris Oakes
10.15	10.	Governance Arrangements	G	Chris Oakes
10.20	11.	Documents Signed Under Seal Quarter 4 Report	H	Chris Oakes
10.25	12.	NHS Provider Licence Self Certification (G6 and FT4)	I	Chris Oakes
	13.	AGM Date to be agreed – 5th September 2022	Verbal	Chris Oakes
10.30	14.	NED Responsibilities	J	Chair
Strategy and System Working				
10.35	15.	Service Presentation – FYPC CAMHS	verbal	Helen Thompson
11.00	16.	Break		
11.10	17.	Step Up To Great Strategic Delivery Plan	K	David Williams
11.15	18.	Joint Working Group Highlight Report – 3rd May 2022	L	Chris Oakes
Quality Improvement and Compliance				
11.20	19.	Quality Assurance Committee Highlight Report – 26th April 2022	M	Moira Ingham
11.25	20.	CQC Update	N	Anne Scott
11.30	21.	LPT Urgent & Emergency Care LLR System Inspection feedback (Psychiatric Liaison Service at	O	Angela Hillery

		LRI)		
11.40	22.	Safe Staffing - Monthly Report	P	Anne Scott
11.50	23.	Patient Safety Incident and Serious Incident Learning Assurance Report	Q	Anne Scott
11.55	24.	Patient and Carer Experience and Involvement and Complaints Quarter 4 Report	R	Anne Scott
12.00	25.	Learning From Deaths Quarter 4 Report	S	Avinash Hiremath
12.05	26.	Annual Staff Survey & Action Plan	T	Sarah Willis
12.10	27.	EDI Plan Refresh	U	Sarah Willis
Performance and Assurance				
12.15	28.	Finance and Performance Committee Highlight Report – 26th April 2022	V	Faisal Hussain
12.20	29.	Finance Monthly Report – Month 1	W	Sharon Murphy
12.30	30.	Performance Report – Month 1	X	Sharon Murphy
12.40	31.	Operational and Financial Plan 2022-23	Y	Sharon Murphy
12.50	32.	Review of risk – any further risks as a result of board discussion?	verbal	Chair
	33.	Any other urgent business	verbal	Chair
	34.	Papers/updates not received in line with the work plan - NA	verbal	Chair
	35.	Public questions on agenda items	verbal	Chair
1.00	36.	**Date of next public meeting: 26th July 2022**		Chair

A

Our Trust Board

As of March 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
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
29th March 2022 9:30am - 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 Director of Finance

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
Paul Sheldon Chief Finance Officer
Mark Farmer Healthwatch
Kate Dyer Deputy Director of Governance and Risk
Girish Kunigiri Deputy Medical Director
Emma Wallis Interim Deputy Director of Nursing & Quality
Michelle Churchard - Smith Interim Deputy Director of Nursing
Tracy Ward Head of Patient Safety
Kay Rippin Corporate Affairs Manager (Minutes)

TB/22/024	Apologies for absence: Dr Avinash Hiremath Medical Director Dr Anne Scott Director of Nursing AHPs and Quality David Williams Director of Strategy and Partnerships Welcome: to all board members, additional attendees and observers. The Trust Board Members – Paper A – introduces the Board.
TB/22/025	Patient voice film – Learning Disabilities & Autism A film was shared telling the journeys of Kyle, Claire and Colin and their experience of support from the service. Charlotte Needham Discharge Coordinator at the Agnes Unit spoke about the service and its successes in supporting services users to lead a full and fulfilling life.
TB/22/026	Staff voice - Learning Disabilities & Autism Multi-Agency Team – Transforming Care Collaborative - Laura Smith Service Group Manager, Cheryl Bosworth Senior Programme Manager Transforming Care Leicester CCGs, Michelle Larke Lead Commissioner at Leicester City Council and Jane Richardson Locality Children's Service Manager Barnados presented. Laura Smith explained how the team came together to respond to the system being in escalation with NHS England, sharing a dissatisfaction around silo working and resistance to change that this brought. The team meet every 2 weeks and report in to a management group and then into the Design Group. The team have a shared

	purpose and vision and open and honest conversations supporting innovative initiatives and sharing risks and successes. There is a 3-year plan and 31 projects were undertaken last year aligned to the road map. Cheryl Bosworth detailed how the team hold regular discharge planning meetings in an integrated hub to discuss hospital discharges. There are currently 38 people in hospital – some long stay, some short stay, some complex. All will receive bespoke packages. Michelle Larke led the covid response cell to ensure that the collaborative was efficient and effective. Successes include becoming a team, a risk management system which kept people safe and supported the early dynamic support pathway and the Learning Disabilities Vaccination Clinics which received national media coverage for their success. Jane Richardson commented that the third sector contribution was invaluable for the team supporting the work across Leicester, Leicestershire & Rutland to mobilise the dynamic support register. The third sector provided additional challenge and brought different strengths to the table. The focus was on collaboration, connection, co-production and children, young people and their families. Helen Thompson praised the team commenting that the strength is in their differences, the sum of the whole is greater than the individual parts. Creating a bespoke solution for each patient in our care takes time and the team have really connected well on this collaborative work. Angela Hillery thanked the team and commented that the Integrated Care System (ICS) is all about people coming together to make a difference and this team is leading the way. This learning will be shared across our group. Michelle Churchard-Smith added that the multi-agency approach put patients at the heart of decision-making and the service had come such a long way. Faisal Hussain asked if there were any major challenges or blockages and the team commented that specialist staff are required on the team and the outcome of a bid is awaited. Whilst the Learning Disability physical health check had met the 70% threshold this meant that there were 30% not receiving this annual check and the reach therefore needed to be extended. Angela Hillery commented that the Learning Disability collaborative was discussed at the joint Health Overview and Scrutiny Committee (HOSC) on 28th March, and we are keen to focus on the importance of employment and encourage all partners in the system to do this as it is so important for health and wellbeing.
TB/22/027	Patient Voice – Healthwatch Report - verbal Mark Farmer confirmed that the People's Council review had taken place – recommendations included: expanding the membership, improving the impact and decision making and providing welfare support to council members. The People's council are working with LPT to implement the patient carer leadership triangle which is cited as NICE best practice. Healthwatch are in the process of setting priorities for next year with a focus on engaging with diverse communities and work on the 'Getting the Ball Rolling Campaign' for men's mental health. Healthwatch have concerns around dementia diagnosis services online assessments and long wait times; and with serious mental illness physical health checks. 'Enter and View Visits' will start with the Trust next month. Angela Hillery commented that she welcomed the People's Council opportunity to move forward towards best practice. The balance between face to face and virtual appointments is being considered nationally. Pre covid, face to face appointments made up 75% of all appointments and the effectiveness for all services is being considered. The Chair thanked Mark Farmer for his contribution at the Board meetings as Healthwatch have made the decision to work differently moving forwards and will no longer be attending Trust Board meetings.
TB/22/028	Declarations of interest in respect of items on the agenda

	No declarations were received.
TB/22/029	Minutes of the previous public meeting 25th January 2022 – Paper B **Resolved:** The minutes were approved as an accurate record of the meeting.
TB/22/030	Matters Arising – Paper C **Resolved:** The Board approved the action log – there were no actions outstanding.
TB/22/031	Chair's Report – Paper D The Chair presented the report confirming attendance at several staff network events that had all had good attendance and participation. The covid reflection event took place last week at Loughborough Hospital and the Chair thanked all staff for their work during the pandemic. The Armed Forces Covenant has been signed again this year. Thanks were offered to Darren Hickman who leaves LPT to become the Integrated Care System Audit Chair from 1st June 2022.
TB/22/032	Chief Executive's Report – Paper E Angela Hillery presented the report echoing the thanks already offered across the whole Trust to staff going above and beyond. We remain in a level 4 incident and challenges remain. Moving forward the reset and rebuild work led by Mark Powell Deputy CEO will build on the big conversations that took place across the Trust. Blended working isnow being implemented across the Trust. The CQC have been back to visit the Bradgate Unit to follow up on dormitories and call bells and we await their formal feedback. The urgent and emergency care pressures continue within the Leicester, Leicestershire & Rutland system and we are working collectively to respond to this. Sam Leak is leading work on the community 2 hour response and virtual wards. The CQC will be undertaking a system review including a review of the urgent and emergency care pathway. Thanks were offered to Brendan Daly who has been instrumental and displayed trust values in driving the Armed Forces Covenant work. LPT have been asked to share case studies around our out of area mental health placements as LPT have been very successful in achieving zero out of area placements and this has caught national attention – thanks to all the mental health teams involved. LPT's international nurse recruitment – 30 recruits have now passed and are NMC pin registered – thanks to all involved including Asha Day.
TB/22/033	Organisational Risk Register – Paper F Chris Oakes presented the paper confirming that KPIs are now linking to some risks on the register. The VCOD rule has been revoked by the Secretary of State and the Board is requested to support the closure of risk 76 today. Risks 70 & 71 scores have been reduced as detailed in the paper. Ruth Marchington confirmed that staff workload pressures are evident through papers at Board and Board committees and wondered how these are reflected fully in the ORR. Sarah Willis confirmed that these risks flow through a number of the ORR risks and that the reset and rebuild work will have a key focus on this area as well as health & wellbeing, safe staffing, supply and our equality work with Together Against Racism. Chris Oakes confirmed that this matter will continue to be reviewed as the ORR is reviewed each month to ensure the risk is adequately reflected. **Resolved:** The Trust Board received the report for assurance and approved the closure of risk 76.
TB/22/034	Documents Signed under Seal – Q3 Report – Paper G **Resolved:** The Trust Board received the paper for information.
TB/22/035	Enhancing Board Oversight - NED Responsibilities & Champion Roles – Paper H The paper was presented by the Chair and Chris Oakes detailing the introduction of new NHSEI guidance around the proposal of NED champions. Chris Oakes put forward Ruth Marchington as the SID NED for approval by the Board. It was noted that Darren Hickman was not a member of the Remuneration Committee as detailed in the paper – this would be amended in the document. **Resolved:** The Board approve the SID NED nomination as Ruth Marchington.

TB/22/036	Service Presentation – Learning Disabilities & Autism Rohit Gumbar – Consultant Psychiatrist & Clinical Director for Learning Disabilities & Autism & Mark Roberts Associate Director for Learning Disabilities & Autism presented slides which will be shared after the meeting. The slides covered system working, performance targets, successes and challenges and improvement plans for 2022/23. Angela Hillery commented that the team were leading the way across LLR and really making a difference for people with learning disabilities and autism. Securing the collaborative way of working will ensure that we become accountable to the population's needs. Mark Farmer referred to patients waiting for assessment and treatment and this would be raised at the People's Council. Darren Hickman commented on the great improvements and was supportive of the model. With regards to the annual health checks which met the target of 70% complete but leaves 30% not complete – what will be done differently to address this. Mark Roberts confirmed that this is a GP led process but has a large public health agenda to support, the team had bid for health inequalities funding for nurses to support GPs Ruth Marchington asked about the learning from deaths improvements, Mark Roberts responded that the LeDer reviews highlighted themes of respiratory disease, obesity, exercise and there are very much on the public health agenda. Girish Kunigari advised that there is a robust process with feedback to clinicians and GPs. Ruth Marchington commented that violence & aggression & restrictive practices are not referenced in the slides, and this is a matter that we are monitoring for improvement. Mark Roberts confirmed that there is patient specific monitoring – this can be seen in the context of care plans. The Chair commented in relation to the need for increased sensory environments the Trust's charity Raising Health may be able to support this development.
TB/22/037	Step Up To Great Mental Health Implementation Plan – Paper I Fiona Myers presented the paper which is an update on progress since the conclusion of the consultation. There has been good progress with engagement and co-production and there is a summary of this by service within the paper. The recruitment of an OD practitioner to support and enhance the conversations across the system is in progress. There are plans to open 4 further crisis cafes with the ultimate aim to be 20. Ruth Marchington asked if future reports could begin to show the impact on performance and Fiona Myers confirmed that this would be triangulated to demonstrate improvements and pressure points in future reports. Mark Farmer supported the investment in voluntary and community sector grants. He was keen to ensure that the patient and carer voices are heard and suggested links to the People's Council. Mark raised a concern about the waiting time for personality disorder services. Fiona Myers confirmed that engagement with stakeholders is key and needs to be meaningful – the OD practitioner recruitment will support this work. Girish Kunigiri was keen to engage clinicians more to overcome challenges in access. He commented that this transformation was closely linked to the Clinical Plan supporting NICE guidance and value-based care. Moira Ingham noted the continued recruitment difficulties and plans to expand perinatal care and Fiona Myers confirmed that creative thinking will support recruitment along with aligning and integrating with the voluntary and community sectors. The Chair noted the increase in referrals and demand for services alongside staff workload pressures – the Chair requested that the Board received quarterly updates on progress. **Action:** Implementation plan update to be brought quarterly to Trust Board. **Resolved:** Trust Board received the report for assurance and information.
TB/22/038	Joint Working Group Highlight Report – 21st March 2022 – Paper J Chris Oakes presented the paper for information detailing the ongoing work of the

	committees in common at Leicestershire Partnership NHS Trust and Northamptonshire Healthcare NHS Foundation Trust. The group have a common focus on 8 strategic project and shared learning is embedded. **Resolved:** Trust Board received and approved the highlight report.
TB/22/039	East Midlands Alliance Partnership Agreement – Paper K Mark Powell presented the report on behalf of David Williams describing this common paper with three key items of note. There has been good progress made in services across the alliance with joint working taking place. The Board is recommended to approve the updated collaborative agreement. The Board received an update on perinatal service developments Angela Hillery commented that this is an important stage of the formal governance for the collaborative agreement becoming a formal entity which has helped to secure funding and is an important step moving forwards. **Resolved:** Trust Board approved the new agreement and received the report for information and assurance.
TB/22/040	People Plan 6 monthly Update including assurance from Health & Wellbeing Guardian – Paper L Sarah Willis presented the paper confirming that LPT have signed up to the NHSE NHS People Promise Exemplar Programme which is a 12-month piece of work around workforce retention and this programme of work will inform the People Plan going forward. The 'Be Well to Care Well' initiative was launched yesterday by the NHSE Midlands Region and will run until 19th April – this will support informing our health & well being plans moving forward. The 5-year international nurses' strategy has been signed off with plans to recruit 60 nurses every year for the next 5 years. The Trust wide transformation programme has an ambition of a zero-vacancy rate for health care support workers and grow your own and talent management programmes. The EDI work is progressing with work with NHFT around Together Against Racism. The system reverse mentoring programme is currently open for applications. There are plans underway to refresh and relaunch the zero-tolerance campaign and the Trust is holding an admin and clerical celebration day on 27th April 2022. The new Health & Wellbeing lead starts with the Trust on 1st April 2022, the Health & Wellbeing Guardian report is appended to this paper giving assurance on LPT's wellbeing activities. Faisal Hussain asked if the cost of living rise is being considered, particularly for fuel cost and Sarah Willis confirmed that this is on everyone's agenda and a task and finish group has been set up with a focused piece of work currently ongoing. Moira Ingham asked if any work was ongoing with local universities to attract recently qualified staff and Sarah Willis confirmed that this work takes place with students joining our bank staff and then taking up substantive roles. Sarah Willis described the buddy work around leadership and culture ongoing with St Andrew's that has been very well received, this is similar to LPT's "our future our way" programme with change champions. The Chair commented that the healthcare assistant entry point pathway was a great initiative and asked how we were reaching out to all of our diverse communities in LLR. Sarah Willis confirmed that there was a detailed recruitment campaign as part of the zero vacancies strategy. The next steps include a transformation piece covering all Trust recruitment activities. **Resolved:** Trust Board received the report and note the progress.
TB/22/041	Quality Assurance Committee Highlight Report 22nd February 2022 – Paper M Moira Ingham presented the report confirming that quality measures within the performance report are monitored and the committee are focusing on key work streams including serious incidents and pressure ulcers. The Mental Health Act census data is a low assurance area and the Legislative Committee have been asked to address these points and to append detailed data to their highlight reports to QAC. The Safeguarding Committee have completed deep dive work to extract

	key learning from Clawson Park. **Resolved:** Trust Board received the report for assurance.
TB/22/042	CQC Update Including Registration – Paper N Emma Wallis presented the paper confirming that the final must do action has been signed off since this report was written meaning that all CQC must do actions are now complete. **Resolved:** Trust Board received the report for information and oversight.
TB/22/043	IPC BAF – Update – Paper O Emma Wallis presented the report which is an updated version of the previously presented report including an additional 82 key lines of enquiries (KLOEs). There are now 9 areas for improvement listed. This action plan will be monitored through the Infection Prevention and Control Committee and report up through the quality governance route to Board. Angela Hillery thanked Emma Wallis and the IPC team andasked how the team have supported their own health and wellbeing during this period and Emma Wallis described regular twice weekly catch ups and health and well being check ins; group supervision; restorative supervision and psychological support as we move towards living with covid. **Resolved:** Trust Board received the report and approved the governance route outlined within the report.
TB/22/044	Patient and Carer Experience, Involvement and Complaints Report Quarter 3 Report – Paper P Emma Wallis presented the report confirming that the complaint response timeframe was extended to 45 working days in December 2021 – this is being reviewed in April. During quarter 3 there were no reopened complaints, and this demonstrates the continuous improvement within the area. The People's Council and the lived experience framework are currently undergoing a reflect and rebuild process. The Chair noted an increase in the number of complaints particularly around access to services and waiting times and asked how waiters are being managed. Emma Wallis confirmed that it is an open and transparent process, and a deep dive is planned into face to face access moving forward. The Complaints Group will consider this issue at their April meeting. Sam Leak confirmed that there is a piece of work ongoing reviewing patients on waiting lists – offering phone calls and a point of contact if there is any deterioration in their condition. There is also a clinically led review of wait times on going within Community Health Services. Mark Farmer Healthwatch noted that there were also 138 compliments received. He offered the People's Council and Healthwatch's support in this area. Angela Hillery commented that we need to be agile in feedback to patients and ensure that this can be demonstrated. **Resolved:** Trust Board received the report for assurance.
TB/22/045	Patient Safety Incident and Serious Incident Learning Assurance Report – Paper Q The report was presented by Michelle Churchard Smith and Tracy Ward who described ongoing work to support governance over serious incidents. There have been significant challenges in investigations and 8 new investigators are now in post andmaking an impact. The work to close the list of outstanding serious incident investigations is ongoing and these challenges have been reflected in the risk in the ORR. A recent Quality Summit considered the whole process of incident management. New learning is included in the report – Gloria's Story, category 3 and 4 pressure ulcers have been increasing and a Quality Summit was held in October to examine this There has been an increase in falls which is attributed to patient acuity and temporary staffing levels on some wards. Michelle Churchard Smith advised that for violence and aggression incidents there has been a deep dive with health and safety and the positive and safe approach was supporting staff practice. There have been no statutory breaches of the culture of candour this

	quarter. Darren Hickman referred to staff pressures and triangulation with the number of incidents, he commented that the learning within Gloria's story is difficult to read but an opportunity for learning and asked when we may start to see the impact of the work of the new investigators feeding through. Michelle Churchard Smith confirmed that following the recent Quality Summit new models are being used to support the investigators and additional training is being offered to support the patient safety team. Next quarter report should evidence improvement, 9 incidents had been signed off last week. Moira Ingham asked how lessons learned are shared with the whole Trust – particularly during this period where the Learning Lessons Exchange Group has not met. Tracy Ward confirmed that there are lessons learned – such as Gloria's story – shared from each directorate within the Patient Safety Improvement Group and then this cross-directorate learning is shared. Sam Leak added that there is ongoing work around pressure ulcer themes and that the investigators will release more time back into the clinical settings.**Resolved:** Trust Board received assurance on the processes and learning.
TB/22/046	Ockenden Review – Paper R Michelle Churchard Smith presented the report confirming that there are 7 key themes for learning and whilst these are for maternity services this learning is transferable to LPT and there has been QI and changes to practices as a result of this review. The Board were asked to support a patient safety champion agreed as Moira Ingham. **Resolved:** Trust Board received the report for assurance and agreed Moira Ingham as the patient safety champion.
TB/22/047	Learning from Deaths Quarter 3 Report – Paper S Girish Kunigiri presented the paper confirming the key themes were timeliness of the reviews; patients' support from other stakeholders in the system and how to share this with directorates. There is a robust system in place and the data is broken down into protected characteristics. Angela Hillery commented that there was an opportunity to work across the group on this type of learning. **Resolved:** Trust Board received the report, receiving assurance on the implementation of national quality standards.
TB/22/048	Safe Staffing Monthly Reviews – Paper T Emma Wallis presented the reviews for December 2021 and January 2022 – both containing similar themes and significant challenges. The impact of Omicron was seen in outbreaks, staff sickness and higher absence and difficulty in the ability to fill. Daily staffing and safety huddles and wrap around support have helped support teams and mitigate risk. There was no link between staffing and harm, but re-prioritised visits had led to increased complaints about access. Learning form the recent half-term has led to the introduction of twice weekly forecasting with daily huddles in readiness for the Easter holiday period. The Chair noted that it had been a challenging period and there had been significant agency usage. Ruth Marchington asked if there was any data on staff absence due to work related stress and Sarah Willis confirmed that all levels of sickness are broken down in directorate reports. Clinical supervision supports staff wellbeing and executive meetings currently have a focus around improving supervision compliance rates which have dropped due to reporting issues and are on trajectory to get back on track. Emma Wallis added the recent guide to logging supervision had been helpful. Fiona Myers described an ongoing piece of work around agency staff and using a stable regular agency workforce as much as possible to meet patients' needs and support teams. In mental health the teams have been supported by skillsets form other practitioners - Psychology input has been supporting team dynamics and patient care.

	Resolved: Trust Board received the report for assurance and information.
TB/22/049	Staffing Capacity and Capability 6m Report (NQB) – Paper U Emma Wallis presented the report confirming that 30 international nurses have been recruited, and interviews are taking place for the June 2022 cohort which will include mental health nurses. The direct entry route for trainee nursing associates is currently being considered. Ruth Marchington suggested that there was a gap in assurance for medical staff – as the board do not review caseloads and capacity for this group of staff. Girish Kunigiri confirmed that this was a big challenge and work is ongoing in this area. There is a GMC fellowship scheme of overseas clinicians that is supporting remote working in some part of the UK in Community Mental Health Teams. Sarah Willis added that the Executive Team had held a deep dive on recruitments including time to recruit, campaigns and capacity of HR resources. There was scoping work ongoing considering the campaigns and doing things differently. **Action:** To ensure that assurance around medical staffing capacity is brought to Board. **Resolved:** Trust Board received assurance from the report.
TB/22/050	Safeguarding Annual Declaration – Paper V Michelle Churchard Smith presented the report to request approval to publish on the website. **Resolved:** Trust board approved the declaration for publication.
TB/22/051	Finance and Performance Committee Highlight Report 22nd February 2022 – Paper W Faisal Hussain presented the report confirming that the 2022/23 operational and financial plan received medium assurance due to the level of efficiency targets. The schemes in the planning process represent a point in time view of efficiencies. The performance and waiting times received medium assurance as there is a plan and process in place but the complete picture of improvement was not evident at the last meeting. A joint Quality Assurance Committee and Finance and Performance Committee is planned for 24th May to deep dive into key issues. **Resolved:** Trust Board received the report for assurance.
TB/22/052	Finance Monthly Report – Month 11 – Paper X Sharon Murphy presented the report confirming that all statutory duties are on target to deliver for 2021/22. There was a small overspend in month 11. The directorate of Mental Health had a £1m overspend and key actions have been agreed to address this overspend.. Work is ongoing with the LLR Clinical Commissioning Group to commission the Agnes Unit for its current usage moving forward, for this year some additional income is being used to offset this overspend and reach breakeven. With regards to agency spend, there is Executive oversight on this area- next year there will be a return to price caps and a ceiling monitored by NHSIE. All 4 targets in the Better Payment Practice Code have been achieved in month with 1 non-compliance cumulatively and the target of 95% will hopefully be achieved at year end. There is £6m capital to spend this month, half of which will go towards the dormitory and shared care records, and we remain confident that we will deliver the plan. **Resolved:** Trust Board received the report for assurance and information.
TB/22/053	Performance Report – Month 11 – Paper Y Sharon Murphy presented the report confirming that month 11 showed a mixed picture with some improvements in performance and some declines. The performance review meeting yesterday with the Directorate of Mental Health offered strong assurance around awareness and action plans. The Community Health Services directorate performance review focused on the CINSS and continence services. Further details are contained within the report. The target for the Learning Disability health checks has been met. Asperger's referrals have significantly increased and action is being taken to address the significant decline

	in the pathway target. For workforce targets there is focus on increasing appraisal and supervision rates. Mark Farmer highlighted the personality disorder and dementia service challenges and offered that Healthwatch could support a deep dive. The Chair commented that when we are restoring services, we need to know that we are doing it inclusively and addressing health inequalities. Angela Hillery commented that waiting times is an important piece of work as a system and partnership. Fiona Myers agreed that it will be important to differentiate the impact of covid and where transformation is needed in services. We need to be clear where new investment has been allocated and monitor the impact of that in trajectories. Sharon Murphy confirmed that there is system work ongoing to monitor performance and considering inequalities and solutions. **Resolved:** Trust Board received the report for assurance and approved the position.
TB/22/054	Audit and Assurance Committee Highlight Report 3rd March 2022 – Paper Z Darren Hickman presented the paper confirming that the committee were well assured on all items and will meet again in April to review the accounts. **Resolved:** Trust Board received the report for assurance.
TB/22/055	Charitable Funds Committee Highlight Report 15th March 2022 – Paper AA The Chair presented the report confirming that the committee have reviewed the strategy and have kept the 4 same themes for 2022/23 – visibility, income, grants and partnerships. There are new external and internal signs around the Trust promoting the charity and the existing and new appeals are being considered to boost the income for 2022-23. The running costs versus the income received is also being considered. **Resolved:** Trust Board received the report for assurance.
TB/22/056	Review of risk – any further risks as a result of board discussion? It was agreed that staffing risk is a continuous theme, and this was a golden thread through the organisational risk register and would continued to be reviewed and drawn out. Angela Hillery suggested that the next phase of SystmOne implementation risk should be reviewed and reflected in the ORR. **Action:** Ensure that the staffing risk remains a continuous theme through the ORR and is adequately drawn out in each of the risks in the ORR. **Action:** To review and reflect the SystmOne next phase implementation to ensure that all mitigations are in place and the risk is adequately represented.
TB/22/057	Any other urgent business Congratulations were offered to Sharon Murphy for her substantive appointment to the post of Director of Finance.
TB/22/058	Papers/updates not received in line with the work plan – all papers received.
TB/22/059	Public questions on agenda items **Question One: Stewart William Osgood -** The Carlton Hayes Hospital Chapel. This is a grade 2 listed building and it is in a very bad condition. As a senior member of the Enderby Band Organisation, we are very interested in purchasing the building for a nominal fee and then restoring it so that it can provide a permanent home for the organisation that has been in existence since 1885. Our vision for the building not only involves the six bands in the organisation of which 3 consist of junior and youth members from aged 5 to 18, but to provide a music and drama hub for the local community. Once restored concerts and plays could be performed there and the building would be in use every day and because of its location would not affect the local residents. **Answer: Richard Brown Associate Director Estates & Facilities -** Thank you for your enquiry. The Chapel site is over-grown and the building state is poor. There are no live services connected to the building. This would not be safe or suitable to offer any form tenancy. In a wider context, we are looking into our estate strategy

	and planning across the entire trust estate. The use of our buildings and services locations will be assessed over time in order to ensure we provide the optimum models for delivery of services and have the most efficient portfolio. **Question 2 –** was regarding a confidential employee related matter which is being resolved at a local level.
	Close - Next public meeting 31st May 2022

C

Leicestershire Partnership NHS Trust

TRUST BOARD 31st May 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	TB/22/037 29.3.22	Step Up To Great Mental Health Implementation Plan to be brought to Trust Board for an update quarterly	Fiona Myers	18.7.22	Complete – on future Trust Board work plan & agendas
949	TB/22/049 29.3.22	To bring assurance & information around caseloads and staffing capacity for medical staff to the trust board meeting.	Avinash Hiremath	18.7.22	pending
950	TB/22/056 29.3.22	Ensure that the staffing risk remains a continuous theme through the ORR and is adequately drawn out in each of the risks in the ORR.	Chris Oakes	23.5.22	Reviewed monthly to reflect risk
951	TB/22/056 29.3.22	To review and reflect the SystmOne next phase implementation to ensure	Chris Oakes	23.5.22	Reviewed monthly to reflect risk

Action No	Meeting date and minute ref	Action/issue	Lead	Due date	Outcome/evidence actions are not considered complete without evidence)
		that all mitigations are in place and the risk is adequately represented.			
952					

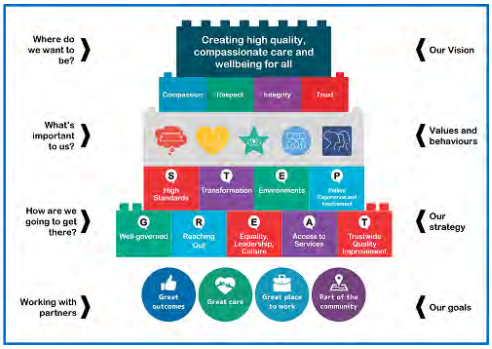
D

Leicestershire Partnership NHS Trust

Trust Board – 31 May 2022 – Chair's report

Purpose of the report

Chairs report for information and accountability, summarising activities and key events
From 29 March 2022 to 31 May 2022



Hearing the patient and staff voice	• The Chair and Non-Executive Directors have been on Boardwalks to meet staff and patients in frontline services. We have visited the following areas: Beechwood ward, Clarendon Ward, St Lukes Hospital wards, Coalville Hospital, Bradgate Unit, Beacon Unit, Tissue Viability Nursing Team, Looked After Children team, Involvement centre, Community Integrated Neurological and Stroke Service.
Connecting for Quality Improvement	• As the UNICEF Baby Friendly Guardian for infant feeding, I participated in the training event and accreditation assessment interviews. The accreditation process included interviews with health visiting staff and mums about the quality of care they received. We are awaiting the results. • Joined the CQC engagement meeting to discuss the recent follow up inspection at the Bradgate Unit and the Urgent and Emergency Care system inspection. The LPT team gave an update on work to ensure safe service delivery, staffing and our cultural and leadership development.
Promoting Equality Leadership & Culture	• Joined the International Nurses Day Celebrations • Attended 2 LPT/NHFT Group "Inclusive Leadership" masterclasses • 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	• Attended LLR Integrated Care Board (ICB) meetings (now held in public) this covered the current operational, financial and quality priorities for the Integrated Care System (ICS)

	• Attended the Health & Wellbeing Partnership Board which included a review of the 3 “place” health and wellbeing strategies. • Attended 2 ICB development sessions which focused on transformation, strategic development of the ICS 3 “places”, health inequalities and collaboratives • Attended the City Health & Wellbeing Board this included presentations on primary care strategy, tobacco control and the first 1001 days of life • Chaired the monthly LLR ICS Finance Committee meetings focusing on 2022/23 plan development, revenue spend, capital programme and key risks. • Attended University of Leicester Council meeting and Finance committee. Congratulations to our partners at University of Leicester for their fantastic Research results – 2nd in the country for Clinical Medicine. • Chaired the Leicestershire Academic Health Partnership Board fr reaesrch projects in LLR • 1:1 stakeholder meetings with John MacDonald Chair of UHL, David Sissling Chair of LLR ICS
Good Governance	• LPT Board development session held 19 April to consider digital transformation in the NHS to harness opportunities for LPT. This included a case study of LPT virtual wards presented by Dr Sudip Ghosh and Dr Girish Kunigiri. The Board also received a presentation from Tracy Ward on the National Patient Safety Specialist and Syllabus. • Extraordinary Board meeting held 26 April to review the final submission of the LPT and LLR ICS financial and operational plan • Chaired the Joint Working Group for LPT & NHFT where we considered strategic finance and risk • Observed LPT Finance & Performance and Quality Assurance committees to review flow and embeddedness of governance • Chaired the Mental Health Act Managers team meeting to review their feedback from patient panels held • Interviewed for Director of Mental Health • Completed CEO, NEDs and Chair appraisals and 2022/23 objectives
Non-Executive Directors (NED)	• Following a successful recruitment campaign we welcome Hetal Parmar and Alex Carpenter who will be joining the LPT Board team as NEDs from 1 June. The updated NED responsibilities are included in the papers. • The NED team had a training session on Quality Improvement with our QI lead Heather Darlow.

Governance table

For Board and Board Committees:	Trust Board 31 May 2022	
Paper sponsored by:	Cathy Ellis	
Paper authored by:	Cathy Ellis	
Date submitted:	19 May 2022	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	N/A	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	N/A	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Reported every public board meeting	
STEP up to GREAT strategic alignment*:	High **S**tandards	X
	Transformation	X
	Environments	
	Patient Involvement	X
	Well **G**overned	X
	Reaching out	X
	Equality, Leadership, Culture	X
	Access to Services	
	Trust Wide Quality Improvement	X
Organisational Risk Register considerations:	List risk number and title of risk	N/A
Is the decision required consistent with LPT's risk appetite:	N/A	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:	Yes reflects the role of our staff networks and personal commitment to inclusion	

E

Trust Board of Directors – 31 May 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

Coronavirus COVID-19

With community cases and hospital inpatient numbers now seeing a sustained decline, thanks in part to the success of winter and now spring booster vaccines, the NHS Chief Executive Amanda Pritchard, following advice from the National Incident Director, has reclassified the Level 4 (National) Incident to a Level 3 (Regional) Incident.

Living with COVID-19

On 29 March 2022, the government set out the next steps for living with COVID-19 by publishing new guidance, confirming that free COVID-19 tests would continue to be available to help protect specific groups once free testing for the general public ended on 1 April 2022. This means that people at risk of serious illness from COVID-19, and eligible for treatments, will continue to get free tests to use if they develop symptoms, along with NHS and adult social care staff and those in other high-risk settings.

Government guidance advised people with symptoms of a respiratory infection, including COVID-19, and a high temperature or who feel unwell, to try to stay at home and avoid contact with other people until they feel well enough to resume normal activities and they no longer have a high temperature. From 1 April 2022, anyone with a positive COVID-19 test result is advised to try to stay at home and avoid contact with other people for five days, which is when they are most infectious.

Regarding lateral flow tests, the guidance notes that asymptomatic testing continues from April in some high-risk settings where infection can spread rapidly while prevalence is high. This includes patient-facing staff in the NHS, staff in hospices and adult social care services, care home visitors who provide personal care and staff in some prisons and places of detention and in high-risk domestic abuse refuges and homelessness settings.

Aside from the changes for the general adult population, guidance confirms that children and young people who are unwell and have a high temperature should stay at home and avoid contact with other people, where they can. They can go back to school, college or childcare when they no longer have a high temperature, and they are well enough to attend.

Although overall testing requirements have been reduced by this updated guidance, the government has retained the ability to enable a rapid testing response should it be needed, such as the emergence of a new variant of concern. It has a stockpile of lateral flow tests and the ability to 'ramp up' testing laboratories and delivery channels.

For more information please visit the government website: https://www.gov.uk/government/news/government-sets-out-next-steps-for-living-with-covid.

IPC guidance for staff continues to be updated and shared with them through weekly communications, including the use of lateral flow testing, self-isolation guidance, and visiting information. Our latest visiting guidance is available on our website here: https://www.leicspart.nhs.uk/latest/covid-19-latest-information/covid-19-visiting/

NHS Providers

After nearly ten years in post Chris Hopson, Chief Executive of NHS Providers, will be leaving on 10th June 2022 to take up the role of Chief Strategy Officer at NHS England. Saffron Cordery, Deputy Chief Executive, will take over as interim Chief Executive whilst the board determines the process for a permanent appointment. You can read more on the NHS Providers website: NHS Providers: from strength to strength - NHS Providers. Congratulations to Chris on his appointment to this key role at NHSE. The insights he brings into the issues and priorities for organisations like LPT from his experience at NHS Providers will I am sure be beneficial both to NHSE and provider organisations themselves. We wish Chris every success in his new role.

Health and Care Act 2022

On 28 April 2022, the Health and Care Bill received Royal Assent to become the Health and Care Act 2022. It builds on the proposals for legislative change set out by NHS England in its Long-Term Plan and places Integrated Care Systems (ICS) onto a statutory footing from 1 July 2022, when Integrated Care Boards (ICBs) replace CCGs. Integrated Care Partnerships (ICPs) will form alongside ICBs, bringing together the NHS and Local Authorities in local areas.

The Act introduces measures to address the COVID-19 backlog and rebuild health and social care services from the pandemic, backed by £36 billion investment over the next 3 years. It also includes provisions for increased transparency on mental health spending with the Secretary of State having to publish government expectations concerning increases in mental health spending by NHS England and ICBs. ICBs will also be required to report on mental health spending.

The CQC has been given new duties, under the Act, to review ICS service provision and Local Authority adult social care responsibilities.

The latest version of the Bill is available on the government website: https://bills.parliament.uk/bills/3022.

The Queen's Speech

On 10 May 2022, His Royal Highness the Prince of Wales set out the government's priorities for the year. From a healthcare perspective, one of the most significant announcements was the draft Mental Health Act Reform Bill, which is intended to ensure that those living with mental health conditions have greater control over their treatment and those with a learning disability and/or autism have a smoother discharge from hospital.

Amongst the things proposed by the Bill are changes to the criteria needed to detain someone to ensure that these powers are only used where the person is a genuine risk to their own safety (or the safety of others) and where there is a clear, therapeutic benefit from detention. It also proposes to deliver improved support through the option of an independent mental health advocate and the ability for patients to choose their own nominated person. A 28-day time limit on prisoner transfers to hospital is proposed along with a new form of supervised community discharge. Increasing the frequency with which patients can appeal their detention at Tribunal and the proposed introduction of a statutory care and treatment plan for all those detained also feature in the proposed changes.

The Speech also confirmed arrangements for the Health and Social Care Levy, which is set to raise c £13bn that the government will invest in health and social care services. A social care cap will be introduced from October 2023, placing a £86k limit on the amount anyone in England will need to spend on their personal care costs over their lifetime.

A women's health strategy will be published in 2022 focussed on priority healthcare issues for women across the life course. A Social Housing Regulation Bill is set to increase social housing tenant's rights to better homes and to enhance their ability to hold their landlords to account. A Renters' Reform Bill is intended to improve housing conditions for renters abolishing no fault evictions, apply legal binding 'decent home' standards in the private sector and introducing a new ombudsman for private landlords to help resolve disputes.

The Bill of Rights will introduce reforms to the Human Rights Act, restoring the balance of power between the legislature and the courts. The Brexit Freedom Bill will ensure that retained EU law can be amended, repealed, or replaced by legislation that meets the needs of the UK. A Data Reform Bill will help create a new UK data protection

framework, whilst the Levelling Up and Regeneration Bill will drive local growth and empower local leaders to regenerate their areas. A Conversion Therapy Bill will ban conversion therapy practices intended to change sexual orientation.

The full text of the Queen's Speech is available on the government's website: https://www.gov.uk/government/speeches/queens-speech-2022

Mental health and wellbeing plan

The government is committed to improving mental health and wellbeing outcomes, particularly for people who experience worse outcomes than the general population. It has committed to develop a new cross-government, 10-year plan for mental health and wellbeing for England to support this objective and has launched a public consultation based on a discussion document. Informed by conversations with stakeholders, people with lived experience and government departments, this discussion document poses the following questions:

- how can we all promote positive mental wellbeing? (chapter 1)
- how can we all prevent the onset of mental ill-health? (chapter 2)
- how can we all intervene earlier when people need support with their mental health? (chapter 3)
- how can we improve the quality and effectiveness of treatment for mental health conditions? (chapter 4)
- how can we all support people living with mental health conditions to live well? (chapter 5)
- how can we all improve support for people in crisis? (chapter 6)

To access a copy of the discussion document and to respond to the consultation, please visit the government website: https://www.gov.uk/government/consultations/mental-health-and-wellbeing-plan-discussion-paper-and-call-for-evidence.

New Deputy Chief Medical Officer for England

On 14 April 2022, the government announced the appointment of Dr Thomas Waite as Deputy Chief Medical Officer for England. Dr Waite will support Chief Medical Officer (CMO) Professor Chris Whitty as the deputy CMO (DCMO) leading on health protection, replacing Professor Jonathan Van-Tam who stepped down on 31 March 2022. His role will cover emergency response and preparedness, infectious diseases, vaccines, and therapeutics.

Restraint, segregation, and seclusion review: Progress report (March 2022)

On 25 March 2022, the Care Quality Commission (CQC) published a progress report following up on its 'Out of Sight' report published two years ago. It centres on the use of restraint, seclusion, and segregation in care services for people with a mental health condition, a learning disability, or autistic people.

The progress report highlights that since the 'Out of Sight' report was published, none of the recommendations have been fully achieved. While the CQC recognises that the pandemic has clearly had an impact on services and the people that use them in a way that could not have been foreseen, it believes that progress on the recommendations it made for change have not been happening quickly enough.

With the publication of its progress report, the CQC is calling on all partners to commit to a renewed effort and to share responsibility for implementing the changes needed. It highlights that these changes must now be co-produced at system level, provider level and at an individual level by collaborating with people and their families. Integrated Care Systems will play a key role in ensuring these changes are delivered. Named leads for learning disabilities and autism on each local integrated care board will support local implementation.

To access a copy of the report, please visit the CQC website: https://www.cqc.org.uk/publications/themes-care/restraint-segregation-seclusion-review-progress-report-march-2022.

Thematic review: people with a learning disability and autistic people's experience of acute care

On 23 March 2022, the CQC announced that it would be carrying out a review to better understand the experiences of people with a learning disability and autistic people when they go to hospital. As part of our review, the CQC planned to visit a sample of hospital trusts and speaking to people who use services, and the people who support them in order to understand:

- whether people have been cared for in a way that meets their needs
- how well people feel they have been supported and involved in their care planning
- if staff understand and are able to meet their needs.

The CQC expects to publish a report on its findings, which we shall review when it becomes available to identify the actions required within Leicester, Leicestershire and Rutland.

Commonwealth Fund's 2021 International Health Policy survey

Results of the Commonwealth Fund's 2021 International Health Policy survey became available in April. Through the survey, just under 19k older adults across 11 countries were about their health and health care between March and June 2021 (almost 2k of which were from the UK). Health Foundation analysis of the results shows that the UK still performs strongly in protecting older people from financial costs related to health care, with the highest proportion of people reporting no 'out-of-pocket' costs (56%).

Older adults in all countries were less likely to have seen a doctor or visited A&E during the pandemic, but the survey suggests that the UK health system experienced more disruption than others in Europe. 25% of UK respondents said that they had appointments either cancelled or postponed. Those in the UK were also most likely to say they had not seen a doctor over the past year, although the UK was among the best in access to same day GP appointments.

The UK was not alone in experiencing disruption to services, but it faces a steep challenge to recover, as the UK has a much leaner health and care system relative to comparable countries. The survey also illustrates the importance of expanding access to social care to reduce unmet need.

To read the Health Foundation's analysis, please visit the organisation's website: https://www.health.org.uk/news-and-comment/charts-and-infographics/health-and-care-for-older-adults-during-the-pandemic.

Spring Statement 2022

On 23 March 2022, the Chancellor delivered his spring statement within which he set out measures aimed at supporting households with the increasing cost of living, including a 5p per litre cut to petrol and diesel duty. The Office of Budgetary Responsibility (OBR) concluded that the measures announced in the Spring Statement will offset just one third of the decline in living standards.

The government retained the planned Health and Care Levy, funded via an increase in national insurance contributions (NICs), and confirmed that the threshold at which people start paying NICs will rise to £12,570 from July 2022.

It also announced that the NHS efficiency target will double from 1.1% to 2.2% a year to free up £4.75 billion to fund NHS priority areas over the next three years and ensure that the extra funding raised by the Levy is well spent.

Please see the government website for full details of the spending announcement: https://www.gov.uk/government/speeches/spring-statement-2022-speech.

Health and prosperity: Introducing the Commission on Health and Prosperity

On 27 April 2022, the Institute for Public Policy Research (IPPR) published "Health and prosperity: Introducing the Commission on Health and Prosperity", which highlights how the COVID-19 pandemic exposed and exacerbated wide and persistent economic and health inequalities. It proposes that government should go beyond simply returning to the pre-pandemic status quo and instead create better health both for the sake of the population and to

address the biggest weaknesses in the UK economy which leave it vulnerable to the impact of poor population health.

The report authors describe a health and an economic 'shock' the country has experienced as a result of the pandemic. It proposes a new approach to strengthen the link between health and wealth, describing how the health and care system has a key role to play in improving UK growth and prosperity. The authors call for the NHS to fulfil its potential by playing a larger role in national and local economies, ensuring access to high quality work, and supporting the transition to a net zero economy. Further information from the Commission is expected over the coming months.

To access the introductory report please visit the IPPR website: https://www.ippr.org/files/2022-04/health-and-prosperity-april22.pdf

Annual WRES data report

On 7 April 2022, NHS England and Improvement (NHSE/I) published its annual report for the NHS Workforce Race Equality Standard (WRES). Summarising the key findings of this report, in a briefing to Trusts, NHS Providers notes:

- Ethnic minority representation at very senior manager (VSM) level has increased in the NHS to its highest recorded point (9.2%), and there has been an increase in the number of Black, Asian and minority ethnic staff working throughout the workforce.
- There has been a fall in the number of executive directors on trusts boards from an ethnic minority background, which is masked by the increase in overall board figure (12.6%, up from 10%), driven by improved non-executive director (NED) representation.
- Only 44.4% of ethnic minority staff believe that their trust provides equal opportunities for career progression or promotion, compared to 58.7% of white staff. Black, Asian and minority ethnic staff also remain less likely to access CPD and non-mandatory training.
- There have been year-on-year improvements in the disciplinary gap, but ethnic minority staff remain more likely to enter a formal disciplinary process than their white peers.
- Improved data collection in 2021 has highlighted the differing experiences of ethnic minority staff from distinct groups and shows that people from Black backgrounds are more likely to experience discrimination and mistreatment from colleagues and managers. Gypsy and Irish Traveller staff are the most likely to experience bullying, harassment or abuse from patients and the public.

Please visit the NHSE/I website for a copy of the report: https://www.england.nhs.uk/wp-content/uploads/2022/04/Workforce-Race-Equality-Standard-report-2021-.pdf

NHS Providers - United Against Health Inequalities briefing

In April 2022, NHS Providers published a report on the results of its race and health equality survey, which was sent to Trust Chairs, Chief Executives and Non-Executive Directors (NEDs) in November 2021. Entitled "United Against Health Inequalities: A Commitment To Lasting Change", the report finds:

- Trust boards have a critical role to play in driving change on race quality and health inequalities;
- There are high levels of board commitment and strategic emphasis on tackling health inequalities but low confidence regarding putting the practical arrangements in place;
- Several barriers to progress, including wider system pressures and operational challenges;
- Embedding action on health inequalities as core business requires robust data analysis and harnessing the insights/skills of frontline staff;
- Health inequalities do not begin or end with individual trusts;
- Boards have an important role in building a culture of equity into services (some people need different access routes); and

- Trusts need an enabling regulatory environment and supportive infrastructure in place.

To read the full report please visit the NHS Providers website: https://nhsproviders.org/united-against-health-inequalities-a-commitment-to-lasting-change.

Final report from the Ockenden Review

The Ockenden Report was published on 30 March 2022, setting out the findings, conclusions, and essential actions from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust. Commissioned by the Secretary of State, the review examined 1,592 clinical incidents between 1973 and 2020 at the hospital. It considered internal investigations where they occurred, external reports, local clinical governance processes, policies and procedures, and reports from the ombudsman and coroner.

The review team found patterns of repeated poor care and failures in governance and leadership. It recommends more than 60 local actions for learning and recognises that many of the issues highlighted in the report are not unique to the hospital. For this reason the review team also identified 15 areas as 'immediate and essential actions' that should be considered by all trusts in England providing maternity services.

To access a copy of the report, please visit the website: https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf

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.

A system-wide planned unannounced CQC inspection into the urgent and emergency care pathway across partner organisations in Leicester, Leicestershire and Rutland has taken place in April. This included inspection of our all-age mental health liaison service in Leicester Hospital's emergency department. Initial informal feedback has been positive. We await a more formal report from the CQC for the LLR system.

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.

Using Artificial Intelligence to improve the health and wellbeing of people with learning disabilities

A new study led by Loughborough University and the Leicestershire Partnership NHS Trust will use Artificial Intelligence to improve the health and wellbeing of people with learning disabilities.

About 1 in 100 people are identified as having a learning disability. Of this population, over 65% have two or more long-term health problems, known as multiple long-term conditions (MLTCs), and a life expectancy that is 20 years lower than the UK average. Often the physical ill-health symptoms experienced by those with a learning disability are mistakenly attributed to a mental health/behavioural problem, or as being inherent to their disability. This means they do not always receive the same level of care as those without a learning disability. And as there is no easy way to understand and predict the complex interactions between MLTCs and the care needs of individuals, it is difficult to provide effective joined-up care between health and social services.

For the DECODE (Data-driven machinE-learning aided stratification and management of multiple long-term COnditions in adults with intellectual disabilitiEs) project, the team will use machine learning to better understand MLTCs in people with learning disabilities. Read more here: https://www.leicspart.nhs.uk/news/using-artificial-intelligence-to-improve-the-health-and-wellbeing-of-people-with-learning-disabilities/

New grant scheme to transform mental health across Leicester, Leicestershire and Rutland awards its first grants

Getting Help in Neighbourhoods, the innovative scheme to that will eventually see around £3M being spent in local areas by charitable, voluntary and community groups to increase the support available for mental health and wellbeing, was announced this month to the recipients of it first round of grants.

Just under £800,000 has been awarded in round one to 28 local groups across Leicester, Leicester and Rutland to spend on their own projects, new or existing, to support people with their mental health and wellbeing.

This NHS funded grant scheme, has been organised in a partnership between the CCG, LPT, Leicestershire County Council, Leicester City Council and Rutland County Council and has been administered by Leicestershire & Rutland Community Foundation (LRCF), an organisation that strengthens local communities by giving thoughtful grants to local charities and voluntary groups, for all kinds of local needs. Read more: https://www.leicspart.nhs.uk/news/new-grant-scheme-to-transform-mental-health-across-leicester-leicestershire-and-rutland-awards-its-first-grants/

CQC report published for acute mental health inpatient wards for adults of working age and psychiatric intensive care units

In May 2022, the Care Quality Commission (CQC) published a report following a focused unannounced inspection of the acute wards for adults of working age and psychiatric intensive care units in February 2022. The unannounced inspection took place to check whether specific improvements had been made following the previous inspections in May to July 2021.

It has been a consistent part of our Step up to Great improvement journey to put improved patient experiences and safety as our highest priority, and we are pleased that the CQC has recognised that significant progress continues to be made by our staff and leaders.

The CQC have moved up our ratings in this core service in recognition of these improvements in the two key domains they inspected – Safety and Responsiveness. The Safety domain of the service has moved up from Inadequate to Requires Improvement. The Responsive domain has moved up from Requires Improvement to Good for this service.

The CQC did not inspect the other domains of Effective, Caring and Well-led hence our overall rating for these domains remains the same and the overall core service rating remains Requires Improvement.

The CQC report concludes that we have met all actions required in the enforcement action issued at the last inspection.

More information: https://www.leicspart.nhs.uk/news/cqc-recognises-further-improvements-in-acute-wards-for-adults-of-working-age-and-psychiatric-intensive-care-units-at-leicestershire-partnership-nhs-trust/

CAHMS recruitment event

LPT's child and adolescent mental health services came together to host a very successful recruitment event for all their roles and services on 28 April at Leicester's Morningside Arena. Over 380 people attended the event and were able to hear about the various services and teams in CAMHS and apply for jobs. Feedback was extremely positive, thank you to everyone involved. The event evaluation is being used to undertaken quarterly recruitment events to showcase LPT jobs, starting with a joint event over the summer for CHS and DMH services.

Leicester Clinical Academic Practitioner Network (LCAPN) Celebration Event

On Monday 9 May, clinical academic nurses, midwives, allied health professionals and pharmacists in the Leicestershire, Northamptonshire and Rutland (LNR) regions came together to mark 3 years of the LCAPN, and celebrate achievements in research and clinical academic careers.

We heard from national keynote speakers, Dr Jo Cooper from NHS England and Improvement and Dr Hazel Roddam from Health Education England, who spoke about the nursing research and AHP research strategic focus and future for clinical academic careers.

Colleagues from LPT also got involved with presentations, such as Dr Sarah Baillon, who presented the LPT clinical academic pathway and clinical academic development opportunities which are available within LPT. Lois Dugmore presented her PhD research project about mental health within the Polish community, and Dr Dolly Sud gave an update about the CardioPhitness study that investigated experiences of physical health care by those with severe mental illness.

The event ended with a Q&A session with system senior leaders including our executive director of nursing, AHPs and quality Dr Anne Scott, and Associate director of AHPs Deanne Rennie.

International Nurses Day

Events were held across the week of International Nurses Day to mark the birth of Florence Nightingale and thank all of LPT's nursing colleagues. Staff shared their nursing stories through virtual events and social media, and local celebrations took place across the Trust.

Admin and clerical professionals' day

Our admin and clerical workforce was celebrated during the April, through virtual events, local celebrations and the sharing of stories through internal and external channels. Dedicated screensavers were created and talks were given on career pathways and support.

Mental Health awareness week

As part of Mental health awareness week the Youth Advisory Board created a series of tips that could be shared with other young people around the theme of loneliness. Signposting to mental health support for all ages was profiled throughout the week including the central access point and a traffic lights poster of where to get help. A new mental health support area has been launched on the LPT website which includes an innovative diagnostic tool to help you work through how you're feeling and relevant signposting support at the end of it.

Equality and Human Rights Week

A round up of all our very important work around equality, diversity and inclusion was shared and celebrated during the week, through events, emails, films and a Staff Networks information event. We re-shared our commitment to Together Against Racism and what this means to us. Further work continues on updating our zero-tolerance campaign which is being co-designed with staff representatives across the Trust.

Reset and Rebuild

We know that the last two years have been the longest marathon; we are extremely proud and grateful for the way staff have stepped up to great throughout this period. We are moving forward with the actions we need to take to support our LPT family to Reset and Rebuild, living with Covid.
In response to all the feedback staff and patients have given through previous BIG conversations, we are focusing on actions to move forward in the following areas.

- Workload pressures/health and wellbeing – with an increased focus on financial wellbeing and mental health.
- New ways of working – updated IPC guidelines have been issued and more are to come, including health and safety risk assessments toolkits, and support with blended working across our estate.
- Estates provision – making best use of our sites for staff and patients.
- Service stability and recovery – ongoing large recruitment events and reviewing demand and capacity to improve waiting lists.
- Connectivity (individual and team) – regular opportunities for staff to connect with each other and with the exec team.
- Transformation and quality improvement – bringing together all of our transformation initiatives to support quality improvement.

Awards

HSJ Partnership Award for innovation programme that is transforming ADHD diagnosis in the NHS

A scheme to speed up ADHD diagnosis in children and young people, which has involved Leicestershire Partnership NHS Trust participation, has won a national award.

Almost 57,000 people (aged 6-18 years) have received an objective assessment for ADHD since Academic Health Science Networks began to support a new digital innovation, QbTest.

The Focus ADHD scheme pioneered in the East Midlands with the support of NHS Trusts including Leicestershire Partnership NHS Trust, has been awarded the HSJ Partnership Award for Best Mental Health Partnership.

The QbTest is an approved computer-supported objective test which measures attention, motor activity and impulsivity – the core symptoms of ADHD. The results are instantly analysed and presented in a report which compares a patient's results against a normative dataset based on age and gender. ADHD practitioners then use information from the QbTest report alongside their clinical assessment to inform their decision whether the young person has ADHD.

The innovation speeds up the time to diagnosis, improving patient experience. It is being used in 59 trusts across 113 sites – just over half of the NHS providers of ADHD assessments for this age group, including consultants at Leicestershire Partnership NHS Trust. Read more: https://www.leicspart.nhs.uk/news/hsj-partnership-award-for-innovation-programme-that-is-transforming-adhd-diagnosis-in-the-nhs

Relevant External Meetings attended since last Trust Board meeting

April 2022	May 2022
LLR MP Briefing	LPT-NHFT CiC Joint Working Group
LLR System CEO & Chairs Meeting	Covid Inquiry Meeting
LLR System CEO Meeting	DCEO at NHFT
NHS Providers Board Check In Meeting	LLR ICS Board
LLR System CEO meeting with local Cllr	LLR Prevention Development Session
Strategic Gold with NHFT	LLR System Flow Partnership
Inclusive Leadership Matters Session	LLR System Executive Group
LLR System Flow Partnership	Strategic Gold with NHFT
LLR System Executive Group	LLR Prevention & Health Inequalities Board
East Midlands Alliance CEO Meeting	LLR Local Health Resilience Partnership
National Mental Health Trusts CEO meeting	Lutterworth Steering Group
National Chief Executive Working Group	LLR Local Authority & Health Leaders Discussion Meeting
NHS Providers Finance & General Planning meeting	Leicestershire Health & Wellbeing Board
LLR Integrated Care Board	NHS Midlands Leaders Update: Provider CEOs
NHS Midlands Leaders Update: Provider CEOs	Leading in the NHS during a pandemic - Speaking at In Conversation
LLR ICB Development Session	LLR QRSM
LLR System Financial Meeting	Mental Health and Dementia with NHSE/I - SRO update
NHSE/I CEO Advisory Group	
NHS National Leadership event	
Visit by Independent Veterans Advisor	
LLR CCGs System PMO meeting	
Director of Public Health at Leics County Council	

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 31 May 2022	
Paper sponsored by:	Angela Hillery, Chief Executive	
Paper authored by:	Kate Dyer, Deputy Director of Governance and Risk	
Date submitted:	17 May 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

F

Trust Board – 31 May 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

There are currently 25 risks on the ORR, of which, one is presented for closure and two new ones are presented in draft. Of the 25 risks, 10 (40%) have a high current risk score.

ORR risks (as at 23 May 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	8	8	16-20
58	Insufficient Safeguarding competency may result in 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*	*8*	*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	16	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, the Trust will not have clarity over the actions required to deliver the plan, resulting in a plan which is not fit for purpose for the Trust or LLR.	Well Governed	15	10	10	9-11
72	If we do not have the capacity and commitment to proactively reach out, we will not fully address health inequalities which will impact on outcomes within our community.	Reaching Out	16	16	12	16-20
73	If we don't create an inclusive culture, it will affect staff and patient experience, which may lead to poorer quality and safety outcomes.	Equality, Leadership and Culture	12	12	9	16-20
74	As a result of covid 19, winter pressure, service recovery and workforce restoration there is a risk that our staff's health and wellbeing will be compromised, leading to increased sickness levels.	Equality, Leadership and Culture	9	9	6	16-20
75	Increasing numbers of patients on waiting lists and increasing 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
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
79	The Cyber threat landscape is currently considered significant due to the geopolitical conflicts, high prevalence of cyber-attack vectors, increase in published vulnerabilities, etc which could lead to a significant impact on IT systems that support patient services and potential data breaches	Well Governed	16	16	12	16-20
80	If staff are not vaccinated against influenza, they pose a risk to the health and wellbeing of themselves, colleagues, patients and the wider community. This would adversely impact on Public Health, potentially leading to increased hospitalisation, increased staff sickness levels and staffing challenges and a risk to those who are vulnerable.	High Standards / Equality, Leadership and Culture	20	16	8	16-20
81	*Inadequate control, reporting and management of the Trust's 2022/23 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*	*5*		*5*	*9-11*
82	*The loss of the 11+ healthy together contract will mean a change in delivery for this service from LPT to the LA, impacting on Trust staff and income, and continuity of care for secondary school aged children.*	*High Standards*	*16*		*12*	*16-20*

Proposal

Closures

- **Risk 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.

  We are proposing the closure of this risk. The cause for this risk, winter pressures and covid are no longer having the level of impact on training to warrant this risk. There continue to be concerns over compliance with mandatory training and these are included within risk 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'.

New Risks

Since the last Trust Board meeting in March 2022, four new risks have been added to the ORR, of which two are presented in draft for approval;

- **Risk 79** The Cyber threat landscape is currently considered significant due to the geopolitical conflicts, high prevalence of cyber-attack vectors, increase in published vulnerabilities, etc which could lead to a significant impact on IT systems that support patient services and potential data breaches.

  This was approved by the Finance and Performance Committee on 26 April 2022

- **Risk 80** If staff are not vaccinated against influenza, they pose a risk to the health and wellbeing of themselves, colleagues, patients and the wider community. This would adversely impact on Public Health, potentially leading to increased hospitalisation, increased staff sickness levels and staffing challenges and a risk to those who are vulnerable.

  This was approved by the Quality Assurance Committee on 26 April 2022

- **DRAFT Risk 81** Inadequate control, reporting and management of the Trust's 2022/23 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).

- **DRAFT Risk 82** The loss of the 11+ healthy together contract will mean a change in delivery for this service from LPT to the LA, impacting on Trust staff and income, and continuity of care for secondary school aged children.

Changes to Risk Scoring

- **Risk 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

  The current risk score has decreased from 12 to 8.

- **Risk 65** 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.

  The residual risk score has increased from 12 to 16

- **Risk 80** If staff are not vaccinated against influenza, they pose a risk to the health and wellbeing of themselves, colleagues, patients and the wider community. This would adversely impact on Public Health, potentially leading to increased hospitalisation, increased staff sickness levels and staffing challenges and a risk to those who are vulnerable.

  The current risk score has increased from 12 to 16

Decision required

- Closure of risk 63
- Approval of draft risks 81 and 82

Governance Table

For Board and Board Committees:	Trust Board 31 May 2022	
Paper sponsored by:	Chris Oakes, Director of Governance and Risk	
Paper authored by:	Kate Dyer, Deputy Director of Governance and Risk	
Date submitted:	23 May 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	06/05/2022
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	2	8
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 • Revised clinical and quality governance infrastructure – recruitment complete
	Gaps:	• Embeddedness of the infrastructure consistently across all 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:	• Consistency of DMT reporting – substance and regularity.		

Actions	Date: TBC	Actions: Implementation of the Foundation 4 High Standards programme	Action Owner: DR	Progress: • Ongoing programme – no end date. Implementation in progress

Status: Green

Risk No: 58	Date included	29 November 2021	Date revised	06/05/2022		Consequence	Likelihood	Combined
Objective: S	High Standards				Current Risk	4	3	12
Risk Title:	Insufficient Safeguarding competency may result in 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 local Safeguarding Boards, two Community Safety Partnerships and the Safeguarding Vulnerabilities group. • Adult and Children's Safeguarding Team • Advice line and use of incident reporting system to raise high priority safeguarding issues for specialist oversight by safeguarding team.		
	Gaps:	• The safeguarding training offer is not fully compliant with national standards and guidelines. • Implementation and embeddedness of the recommendations from the external review and quality improvement plan • Staff skill and knowledge re MCA including Liberty Protection Safeguards		
Assurances	Internal:	Source: • Legislative Committee and Safeguarding Committee • Collaborative Safeguarding Report • Mandatory Training Compliance Report • Safeguarding Team training needs analysis • Safeguarding, Public Protection & MCA Report – April 2022	Evidence: • **Mandatory Training Report Feb 22** Safeguarding supervision 77% Amber Safeguarding Adults - Level 1 85.5% Green Safeguarding Children - Level 1 85.0% Green • **Progress with quality improvement plan / Section 'Training'** Review training - rated Red Mandatory training – rated green MAPPA training – rated Red	Assurance Rating Amber
	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 ,	Evidence: • CQC identified no major safeguarding concerns feedback from the CQC report published 10th November 2021. • Local Safeguarding Board reports and minutes	Assurance Rating Green
	Gaps:			

Actions	Date:	• Actions:	Action Owner:	Progress:
	Jun 22	• Safeguarding adult training compliance with national standards	All - Safeguarding Dept	• Update on progress to be provided in June 22
	Jun 22	• Quality Improvement Plan		
	Jun 22	• Implement and embed recommendations from the external review.		
	Jun 22	• Accuracy of training programme		• The training offer reintroduces face to face training from June 2022. This is blended with e-learning.
	Jun 22	• Training programme to be delivered from June 22		
	Jul 22	• Board Safeguarding training		

Status: Amber

Risk No: 59	Date included	29 November 2021	Date revised	06/05/2022
Objective: S	High Standards			
Risk Title:	Lack of staff capacity is 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 • Reports/ minutes from Incident Oversight Group and Quality Forum • Quality Summit March 2022 • Monthly Quality Monitoring Report – Patient Safety Incident Investigation Report – May 2022 (April 2022 data)	Evidence • Directorate improvement plans - monitored via IOG and through to QF KPI's Overdue Sis/internal investigations – rated red Outstanding and overdue action plans – rated red Outstating incidents >15 days – rated red	Assurance Rating Red
	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: July 2022	Actions: Delivery of Directorate improvement plans for Incident and SI's	Owner: F.Myers/ Michelle Churchard - Smith	Progress: Paper received at SEB 6/05/22 shows an improved position
				Status: Amber

Risk No: 60	Date included	29 November 2021	Date revised	05/05/2022
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
- Staff capacity to flex up inpatient community bed capacity to respond to Urgent and Emergency system care pressures
- Resource capacity to respond fully to system wide urgent and emergency improvement plan

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
- Weekly situational and forecast staffing meeting
- Month 12 Performance Report (March 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
Jul 22	MH Recruitment plan against 22/23 investment	John Edwards	Consultation complete - to be signed off SWC May 22	Amber
May 22	To develop a Trust wide safe staffing policy	Elaine Curtin	Funding to support accelerated recruitment	
Mar 23	Recruit additional 44 international nurses	Asha Day	Bid to be submitted May 2022	
June 22	Recruit new to healthcare HCSWs	Sarah Willis (SW)		
Aug 24	Develop a volunteer to career framework	Minaxi Patel		
Sept 22	Recruit trainees to the HEE new roles training programme	SW / Louise Evans		
	Increase our nursing associate recruitment for the Sept 22 cohort	Emma Wallis		

Risk No: 61	Date included	29 November 2021	Date revised	11/05/2022
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 12 performance report (March 2022)	Assurance Rating Green
	External:	• NHS retention support and benchmarking data		Assurance Rating Green
	Gaps:			

	Date:	Actions:	Owner:	Progress	Status
Actions	Jun 22	• New process for amending compliance requirements to position numbers	AOD / Helen Briggs	Progress ongoing, deadline moved to June 22	Amber
	Jun 22	• Manager compliance and DNA reports live on ulearn	AOD / Helen Briggs		
	June 22	• Pilot safe care and review establishment	Amrik Singh	Pilot needed software licence and can now proceed	
	Sep 22	• Deteriorating Workforce and Sepsis Group to progress and review training and compliance for ILS and BLS	Margot Emery	Ongoing	
	Sep 22	• STAR days	AOD / Helen Briggs		

Risk No: 62	Date included	29 November 2021	Date revised	09/05/2022
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)

Controls0	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 • Work programme in place for Foundation for Great Patient Care to ensure cross Trust learning.
	Gaps:	• Implementation of the Foundations 4 High Standards programme • Staff capacity to support implementation of the programme and delivering on the improvement actions. (see risk 59 for mitigations)

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: • CQC must do action plan - complete • Mental Health Act inspection action plans in progress	Assurance Rating Green
	External:	Source: • CQC Inspection 2021 / re-inspection report – published 5 May 2022 • Mental Health Act inspections • External Audit value for money conclusion 2021/22 (awaiting)	Evidence:	Assurance Rating Green
	Gaps:			

Actions	Date: Ongoing	Actions: Implementation of the Foundations 4 High Standards programme	Action Owner: Deanne Rennie/Jane Howden	Progress:
				Status: Green

Risk No: 63	Date included	29 November 2021	Date revised	11/05/2022
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	8
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 • Bank staff requirement for compliance prior to booking shift
	Gaps:	

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 March 2022 Workforce Reports to DMTs monthly Flash reports weekly QAC performance report – April 2022 Deepdive into compliance at performance reviews	Assurance Rating
	External:	Source:	Evidence:	Assurance Rating
	Gaps:			

	Date:	Actions:	Owner	Progress:	Status
Actions		CQC actions for Acute and Rehabilitation Services to improve training compliance in key areas.	Fiona Myers	CQC action closed as improvements made and ongoing monitoring in place.	
		DMH to have improved training position for core and clinical mandatory training via training improvement plans.	Fiona Myers	Each service line has a training plan monitored monthly at the Workforce DMT	

Risk No: 64	Date included	29 November 2021	Date revised	06/05/2022			
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:	Actions:	Owner:	Progress:	Status
	Ongoing	Regular attendance at ICS Board meetings, transition and steering groups	Chair & CEO	Achieving (this action will be on-going)	Green

Risk No: 65	Date included	29 November 2021	Date revised	06/05/2022		Consequence	Likelihood	Combined
Objective: E	Environments				Current Risk	4	4	16
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.				Residual Risk	4	4	16
Risk owner:	Exec: Chief Finance Officer		Local: Associate Director Estates & Facilities		Tolerance Level Significant 16-20 (Appetite Quality-Seek)			
Governance:	Estates Committee, FPC / Board - Monthly Review							

Controls	Description:	• 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		

	Date:	Actions:	Action Owner:	Progress:	Status
Actions	May 22	• Exit agreement to be agreed and staff engagement/ TUPE sessions jointly planned.	CFO	• In progress	Amber
	May 22	• Programme Board established as vehicle to agree key strategic principles with UHL through FM Transformation.	CFO	• Timescales for FM Transformation at Exec level for review and agreement at Programme Board.	

Risk No: 66	Date included	29 November 2021	Date revised	06/05/2022		Consequence	Likelihood	Combined
Objective: E	Environments				Current Risk	4	3	12
Risk Title:	The lack of detail around accommodation requirements in strategic business planning, means that the Estates Strategy cannot adequately plan for potential building solutions, leading to an estate configuration which is not fit to deliver high quality healthcare.				Residual Risk	4	2	8
Risk owner:	Exec: Chief Finance Officer		Local: Associate Director Estates & Facilities		**Tolerance** level Significant 16-20 (Appetite Quality-Seek)			
Governance:	Estates Committee, FPC / Board - Monthly Review							

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

Actions	Date: Ongoing March 23	Actions: • Implementation of Dormitory Eradication programme. • Estates delivery plan	Action Owner: Richard Brown Richard Brown	Progress: • Complex project - remains on plan • In draft – estimated trajectory 6 to 12 months	Status Amber

Risk No: 67	Date included	29 November 2021	Date revised	06/05/22
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

	Source:	Evidence:	
Internal:			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:			

Actions

Date:	Actions:	Owner:	Progress:	Status
Jun 22	Funding approval for sustainability posts	PS	Awaiting – deadline moved to Jun 22	Amber
Jun 22	Outline chapters drafted and shared with provisional chapter leads	PS	CFO taking the lead on research to support draft chapters – deadline moved to Jun 22	
May 22	Finalised Green Plan	PS	Drafted	

Risk No: 68	Date included	29 November 2021	Date revised	05/05/22
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
- Data Quality Kitemark & Framework approved by DQC, will be implemented for 22/23 reporting.

Gaps:

- Incomplete data quality reports for local and national data sets
- 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
- Accessible data for front line clinical teams

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
- Delivery of phase 1 21/22 data quality work plan

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
- DSPT 21/22 audit due Q1 2022/23 (20/21 360 assurance audit – Significant assurance)

Assurance Rating Green

Gaps:

- Data quality group revised approach started in February 2021, not yet embedded actions in to services
- External Account (quality account indicators) Not undertaken for 19/20 or 20/21 and not required for 21/22

Actions

Date:	Actions:	Action Owner:	Progress:	Status
Sept 22	• Restructure of information team	SM	In progress	Green
Sept 22	• implementing the Data Quality Plan aligned to delivery of the Data Quality framework	SM	Phase 2 plan	
Sept 22	• Delivery of tools to support clinical team data quality assessments	SM	Phase 2 plan	
Dec 22	• Delivery of data quality training	SM	Phase 2 plan	

Risk No: 69	Date included	29 November 2021	Date revised	05/05/22
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 • New automated report in place for 22/23 reporting		
	Gaps:	• Capacity of the information team due to demands from national sitrep reporting • Level 2 committee dashboards – implementation delayed due to COVID • Investment in information team capacity and a new performance team for the Trust supported by March 22 OEB, but funding in 22/23 not approved		
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 • Review of Information Team capacity & delivery model	Evidence: • Routine performance reporting with committee dashboards to FPC / QAC /Board – assurance rating green (April 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	Sept 22	• Restructure of information team	SM	In Progress	Amber
	Dec 22	• Phase 2 review of information team, including approach to performance management	SM	In Progress	

Risk No: 70	Date included	29 November 2021	Date revised	05/05/22
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) • Ongoing oversight and management of all aspects of financial position against plans • Monthly reports to OEB/SEB/FPC/Board/ICS finance committee on all aspects of delivery against plan • Mitigation plans for capital and revenue to ensure plans are delivered	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:			

Actions	Date:	Actions:	Action Owner:	Progress: All actions completed for 21/22. Awaiting final auditor report before closure of risk

Status: Green

Risk No: 71	Date included	29 November 2021	Date revised	05/05/22
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 delivered a breakeven position for LPT 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
- Culture change required across system partners, particularly for UHL to move away from PBR funding model
- LLR capital strategy not yet defined
- LPT & LLR ICS plan submissions show a combined deficit of £49m

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 • Board approval of final 2022/23 plans • Submitted LPT finance, activity, workforce & performance plans to ICS/NHSI	Evidence: • Draft plans presented to OEB, SEB, FPC & Trust Board December – April • Efficiency plan delivery presented to Transformation Committee • Draft 22/23 operational & finance plans submitted 17/03/22 • Final Trust board plan sign off 28/04/22	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:			

Actions

Date:	Actions:	Action Owner:	Progress:	Status
Jun 22	Respond to & manage actions required as a result of any NHSI escalation & plan resubmission requirements	SM		Green
Dec 22	LLR ICS capital & financial strategy development	SM		

Risk No: 72	Date included	29 November 2021	Date revised	06/05/2022
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 Regular attendance at system meetings	Evidence: Transformation Committee will review progress of internal transformational priorities. JWG reviews progress on key joint priorities. Executive, Board meetings and development sessions include a focus on our strategic priorities and transformation. Evidence available in papers, agenda and minutes	Assurance Rating: Green
	External:	Source: Internal Audit HOIAO Feedback from NHS E/I Feedback from stakeholders (CQC, CCG/ICB & local authorities) Attendance at local authority scrutiny meetings	Evidence: Formal feedback from audit opinion, formal meetings and our stakeholder feedback.	Assurance Rating: Green
	Gaps:	Calculating the impact/value of the reaching out programme to LPT and to our communities.		

	Date:	Actions:	Owner:	Progress:	Status
Actions	May 22	Reaching out delivery plan as part of the Step Up to Great (SUTG) strategy and plan	David Williams	Revised timescales – end May 2022	Amber
	May 22	Further agreement on our approach and calculating impact and value	David Williams	To be developed once the SUTG delivery plan completed – as above revised timescales end of May 2022	
	Jun 22	Development of inequalities data in an accessible format	Information Team		

Risk No: 73	Date included	29 November 2021	Date revised	11/05/2022
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 • EDI strategy QAC / TRUST BOARD	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: Ongoing Ongoing	Actions: • Embed Together Against Racism actions • Delivery of the WRES action plan and six high impact Race Equality Actions.	Owner: Haseeb Ahmed	Progress:	Status Amber

Risk No: 74	Date included	29 November 2021	Date revised	11/05/2022		Consequence	Likelihood	Combined
Objective: E	Equality, Leadership, Culture				Current Risk	3	3	9
Risk Title:	As a result of covid 19, 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 • Health and Wellbeing Lead / People Promise Manager (starting May 22)		
	Gaps:	- Impact of financial pressures on health and wellbeing – task and finish group to review cost of living in place		
Assurances	Internal:	• Financial HWB support task and finish group • Daily Sickness absence monitoring • Sickness and workforce reports to SWC / QAC • Sickness reviews within divisions • Staff side – monthly meetings • Referrals to OH and Amica	Evidence: • Sickness absence rate LPT target 4.5% - current performance (March 22) 5.2% • Staff side – feedback • Action plan reporting through SG AND ICC	Assurance Rating Amber
	External	Source: • Be well midlands staff engagement process by NHSEI • NHSI reporting • LLR workforce group • Health and wellbeing taskforce group	Evidence: • NHSI benchmarking reports • Attendance at external NHSI wellbeing workshops • MHWB hub data	Assurance Rating Green
	Gaps:			

Actions	Date: Ongoing Nov 22	Actions: • Delivery of the Health and Wellbeing Action Plan • Codesign review of the anti bullying and harassment policy	Action Owner: Claire Taylor Claire Taylor	Progress: Progressing Progressing	Status Amber

Risk No: 75	Date included	29 November 2021	Date revised	06/05/2022		Consequence	Likelihood	Combined
Objective: A	Access to Services				Current Risk	4	4	16
Risk Title:	Increasing numbers of patients on waiting lists and increasing lengths of delay in accessing services will mean that patients may not be able to access the right care at the right time and may lead to poor experience and harm.				Residual Risk	4	2	8
Risk owner:	Exec: Medical Director		Local: Operational Executive Directors		**Tolerance Level** Significant 16-20 (Appetite Quality-Seek)			
Governance:	Waiting List and Harm Prevention Committee, FPC and QAC / Board - Monthly Review							

Controls	Description:	• Access Policy / 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 • Agreed joint working approach between LLR and Northants system to undertake demand and capacity modelling	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 – reinspection report awaited for April 2022	Assurance Rating Amber
	Gaps:			

Actions	Date:	Actions:	Owner:	Progress:
	May 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 – update to be provided in May 2022
	May 22	Consideration of avoidable harm measures including impact of partial or full COVID related closures		Actively considered and covered in regular reports – update to be provided in May 2022

Status
Amber

Risk No: 77	Date included	1 December 2021	Date revised	13/05/2022
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 approved		
	Gaps:			
Assurances	Internal:	Source • SEB • 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: Jun 22	Actions: Implementation of a Public Inquiry IM&T strategy	Action Owner: Sandra Mellors /Kate Dyer	Progress: Scoping work underway	Status Amber

Risk No: 78	Environment / High Standards	Date reviewed:	05/05/2022		Consequence	Likelihood	Combined
Risk Title:	If levels of cleanliness are not sustained, the Trust will not comply with the requirements of the National Cleanliness Standards and Hygiene Code which may impact on patient safety and experience.			Current Risk	4	3	12
Director risk owner:	Director of Nursing, AHP's and Quality and Chief Finance Officer			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 • IPC operational meeting
	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.		

	Date:	Actions:	Action Owner:	Progress	Status:
Actions	Ongoing Nov 22 June 22	Implementation of the cleaning turnaround plan with evidence Implement the National Standards of Healthcare Cleanliness 2021. Next milestone to review roles and responsibilities. Align pandemic cleaning routine to the National Standards of Healthcare Cleanliness	UHL – oversight R. Brown / Emma Wallis / Helen Walton Amanda Hemsley / Helen Walton	All actions are on-going Phase 1 due at 31 March 22 complete Meeting 10 May to review	Amber

Risk No: 79	Date included	29.03.22	Date revised	06/05/22
Objective: G	Well Governed			
Risk Title:	The Cyber threat landscape is currently considered significant due to the geopolitical conflicts, high prevalence of cyber-attack vectors, increase in published vulnerabilities, etc which could lead to a significant impact on IT systems that support patient services and potential data breaches			
Risk owner:	Exec: Director of Finance & Performance/SIRO		Local: Head of Data Privacy	
Governance:	Data Privacy Committee, FPC/Bi-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:

- Multiple tiers of controls that are technical and organisational, including ongoing assessment and scanning of boundaries, geo-blocking and supporting information security policies
- Governance controls – reporting to Data Privacy Committee and IM&T Committee on Cyber and Information Security
- External scrutiny at multiple levels – Police Cyber resilience, National Cyber Security Centre (NCSC), BitSight assessment, NHS Secure Boundary scanning and reporting
- Audits on Information Security Management System (ISMS), ISO, DSPT – with significant assurance
- Internal and External Auditors – 360 Assurance (DSPT), KPMG – Understanding of IT 20/21 Audit
- Continuity Planning and Disaster Recovery – exercises and reviews
- Incident Response capabilities – active real world testing e.g. Russian Attack
- Risk averse position taken in relation to mobile and remote working such as requests for working abroad with a default 'no' position
- Cyber security training – focused for local situations and delivered by LHIS Cyber Team
- Increased collaborative working with other NHS organisations to share intelligence and learning
- SIRO Structure
- Membership of Cyber Associated Network for early notification of national and local issues
- Authentication of identity at service desk contact – implementation of multifactor authentication at all levels of the organisation
- Where weaknesses/vulnerabilities are identified there is constant learning and immediate remediation plans in place

Gaps:

- Authentication of identity at service desk contact – implementation of multifactor authentication at all levels of the organisation
- New digital posts required such as CIO
- Phishing simulations delayed due to covid
- IG training compliance remains below expected 95%

Assurances

	Source:	Evidence:	
Internal:	LHIS re-accreditation of secure email system [DCB1596] and Cyber Essentials Consultancy Review and testing of disaster recovery and business continuity processes in response to real world testing Cyber metrics reported through DPC Dashboard Reporting of incidents	Accreditation reports Output reports and remediation plans Dashboard for Committee meeting Data breach reports to Data Privacy Committee	Assurance Rating Green
External:	LHIS ISO Audit KPMG Understanding IT 20/21 Audit 360 Assurance DSPT Audit 20/21 DSPT submission – standards met 20/21	Accreditation report Audit report Audit Report NHS Digital submission	Assurance Rating Green
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
May 22	Bi-Monthly report to Data Privacy Committee – new and evolving threats, control improvements	Chris Biddle	Updates to Cyber and Information Security Report	Green
21.06.22	Board Development session re: Cyber Threat	Chris Biddle	Pencilled onto Board Development Agenda	
June 22	Cyber Threat update report to Audit Committee	Chris Biddle	Audit Committee Agenda item	
June 22	DSPT submission	TBC	Baseline submission made March 2022 – on track	

Risk No: 80	Date included	29 March 2022	Date revised	05/05/22
Objective:	High Standards / Equality, Leadership and Culture			
Risk Title:	If staff are not vaccinated against influenza, they pose a risk to the health and wellbeing of themselves, colleagues, patients and the wider community. This would adversely impact on Public Health, potentially leading to increased hospitalisation, increased staff sickness levels and staffing challenges and a risk to those who are vulnerable.			
Risk owner:	Exec: Director of Nursing AHPs and Quality		Local: Trust clinical lead for staff flu vaccinations	
Governance:	Trust Strategic Flu and Covid-19 Group / Quality Forum / 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:

- Strategic Flu and Covid-19 Group and staff vaccination workforce group
- NIVS system for uptake reporting – weekly SITREP and use of QR code to record staff who have been vaccinated outside of LPT.
- Flu vaccine order placed mid March 2022 . Sufficient for all frontline healthcare workers
- Mixed delivery model of roving vaccinators, peer vaccinators in clinical areas and co-delivery of Flu and COVID vaccinations if advised by JCVI
- Implementation of the national best practice vaccination programme principles including flexible access, board endorsement, publicity and comms and staff incentives
- Communications plan weekly for clinic availibity with dedicated Comms support
- High level action plan which aligns with national and LLR plans and uptake ambitions
- Clinical peer vaccinators to support teams on site and during the shift
- Focused work through Trust CQUIN group
- Vaccine confidence training for all peer vaccinators
- Supportive focused clinics for supporting colleagues with needle phobia
- Flu group with Directorate champions

Gaps:

- No vegan or vegetarian vaccine available
- Considerable vaccine reluctance amongst LPT staff for additional vaccination after Covid vaccination x3 in previous 12 months
- Low levels of circulating flu in the wider community has been interpreted as flu vaccination not being required
- Flu vaccination uptake correlates with increasing age – younger staff do not see Flu as a health concern for their age group

Assurances

	Source	Evidence:	
Internal:	Monthly review at the Strategic Flu and Covid-19 Group and staff vaccination workforce group with reporting to level 1 and 2 committees Update reporting from NIVS and weekly SITREP CQUIN reports CQUIN action to deliver 70% staff vaccinated	Papers to SEB / QF and QAC Data uptake and analysis presented to Strategic Flu and Covid-19 Group Update in highlight report to the Quality Forum Weekly LPT SITREP for flu uptake	Assurance Rating Green
External:	LPT reports into the situation reports for the LLR Flu and Covid-19 Board	SITREP	Assurance Rating Amber

Gaps:

- Number of staff affected by vaccine reluctance and lack of vegetarian / vegan vaccine is not known
- Staff having flu vaccination outside of LPT requires individual staff to confirm this as access through NIMS is no longer available

Actions

Date:	Actions:	Action Owner:	Progress:	Status
Mar 23	CQUIN action to deliver 70% staff vaccinated	Sarah Clements		Amber
Ongoing	Implementation of the Flu action plan (oversight by Strategic Flu Group)	Sarah Clements	commences June 2022	
July 22	Identify number of staff impacted by lack of vegan/vegetarian vaccine	Directorate Leads		
July 22	Identify number of staff by service / Directorate who have chosen not to take up staff flu vaccination (due to increased vaccinations in last 12 months and allergies	Directorate Leads		

Risk No: 81	Date included	29 April 2022 **DRAFT**	Date revised	06/05/22	
Objective: G	Well Governed				
Risk Title:	Inadequate control, reporting and management of the Trust's 2022/23 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 planning guidance followed in preparation of the plan
- LPT Financial & Operational Plan triangulated with workforce plan
- Standing Financial Instructions support control environment
- Treasury management policy , cash flow forecasting ensure robust cash management
- Capital Financing strategy & plan in place
- LPT draft medium term financial strategy in place & presented to Trust Board April 2022

Gaps:
- Culture change required across system partners, particularly for UHL to move away from PBR funding model
- LLR ICS medium term capital strategy not yet in place
- LLR ICS medium term revenue strategy not yet in place
- LPT 22/23 plan delivers a £1.4m deficit

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 • LLR ICS Finance committee oversight • £1.4m plan deficit is a technical break even position, taking one year with another; statutory break even duty still delivered in 2022/23	Evidence: • Reports & updates from Internal & external auditors • Monthly Director of Finance report to FPC / Trust Board – highlight report assurance rating Green (April 2022) • Ongoing oversight and management of all aspects of financial position against plans • Monthly reports to OEB/SEB/FPC/Board/ICS finance committee on all aspects of delivery against plan • Mitigation plans for capital and revenue to ensure plans are delivered	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 • Significant assurance • Report due Q4 – draft significant assurance	Assurance Rating Green
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress:	Status
Mar23	Continued monitoring and management of all aspects of the Trust's delivery of the financial plan	SM		Green
Dec 22	Contribute to LLR ICS capital & financial strategy development	SM		
Dec 22	Revise LPT medium term capital & financial strategy to ensure alignment with ICS strategy	SM		

Risk No: 82	Date included	10 May 2022 **DRAFT**	Date revised			
Objective: G	High Standards					
Risk Title:	The loss of the 11+ healthy together contract will mean a change in delivery for this service from LPT to the LA, impacting on Trust staff and income, and continuity of care for secondary school aged children.					
Risk owner:	Exec Lead: FYPCLD Director / Director of Strategy and Partnerships	Local: Janet Harrison				
Governance:	FYPC DMT / Ops Exec Board / Board monthly					

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

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

Controls

Description:	• LA mobilisation plan • Service specifications • National Healthy Child Programme • LPT policies and procedures / standard operating guidance / competency frameworks
Gaps:	• TUPE arrangements • Professional supervision and training • Clarity over framework requirements for SCPHNs • Safeguarding representation from health • Linkage of IT systems • Data sharing • Caseload handover • Impact of intellectual property rights • LA policies and procedures/ SOPs and competency frameworks

Assurances

Internal:	Source: • Mobilisation group for 0-11 plus transition to LA 11+ offer • Directorate Management Team • Ops Exec Board	Evidence:	Assurance Rating Red
External:	Source: • Director of Public Health • TUPE Project Group • LA Mobilisation Board	Evidence:	Assurance Rating Red
Gaps:			

Actions

Date:	Actions:	Action Owner	Progress:	Status
May 22	• Meet with Public Health Commissioning Lead to agree next steps	D Williams	Meeting in the diary	
Jun 22	• One to ones with 5-19 staff with staff side representation	H Thompson	Being planned	Amber
May 22	• Link in with LA led communication plan	LA lead / K Basra	LA led	
Jun 22	• Liaison with CCG DoN re Safeguarding	H Thompson	To be arranged	

Leicestershire Partnership NHS Trust

G

Trust Board – 31 May 2022

Review of the interim arrangements for Trust governance

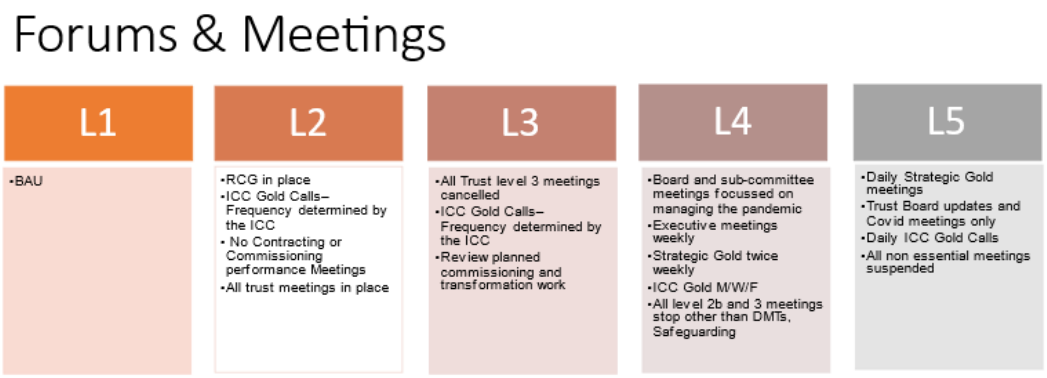
Purpose of the report

To respond to the Letter (C1647) issued by NHSI on 19 May 2022 regarding the next steps on transition from Covid-19 response to recovery, with a further review of the interim arrangements for Trust governance.

Analysis of the issue

With community cases and hospital inpatient numbers now seeing a sustained decline, the Operational Pressure Escalation Level (OPEL) has reduced from a National Level 4 Incident to a Regional Level 3 Incident.

According to the LPT COVD-19 internal executive capacity alert system, the impact of Level 3 includes the following;



Proposal

The transition to Level 3 triggers a formal review of the interim governance arrangements which were put in place to ease the burden during the Covid-19 pandemic.

Interim Governance Arrangements

Meetings were categorised to determine the governance approach, ranging from critical to low. Those meetings determined as critical or high have continued with a reduced scope and agenda, focussing on escalation. We are proposing to end the assessment of criticality for level 2 meetings and reinstate a full schedule of level 2 meetings from June 2022.

We also intend all level 1 and 2 meetings to operate with a full agenda by removing the covid restricted priorities from June 2022.

In order to balance the OPEL level with the Trust's move towards service restoration and increasing momentum with the delivery of its Step up to Great strategic objectives and priorities, the trust is placing an impetus on reinstating its level 3 meetings with a full remit. However, in line with the internal executive capacity alert system, any level 3 meetings which are risk assessed as low priority can be paused where covid continues to impact on capacity.

Assurance meetings will continue to be virtual on Microsoft Teams unless a Covid 19 secure environment can be offered to staff and/or until such time that the Covid 19 pandemic does not present further risk to health.

Trust Board, level 1 and Executive Team development meetings including workshops may be conducted face to face dependent on a covid secure environment.
Quoracy will continue to apply for all meetings including virtual meetings.

Reducing the Burden

In response to the letter from NHS England and Improvement dated 24 December 2021 (ref. C1518), the Trust put in place measures to reduce the burden of reporting and release capacity to manage the COVID-19 pandemic. Following the recent decrease in OPEL level, the following elements of that response have been formally rescinded as follows;

A. Governance and Meetings

The locally determined interim arrangements relating Board and sub-board meetings, and agile decision making have been addressed in the section above. The Trust is proposing to rescind interim measures for level 1, 2 and 3 meetings, with a flexible approach where demand is impacting capacity to risk assess level 3 meetings; those with low risk may be paused.

B. Reporting and Assurance

The Trust will continue to fulfil requirements for the following;

- To maintain constitutional standards for community crisis, Mental health, learning disability and autism services
- To continue to collect Friends and Family Test data

C. Other areas including HR and staff-related activities

- Appraisal pay step progression will be turned back on in July 2022. Communication has been issued giving notice to staff that mandatory training and appraisal must be completed to enable pay step progression.
- Non-essential workforce reports have not been impacted and continue as usual.
- Non urgent HR employment relations has not been impacted and continue as usual.
- Job evaluation panel is back up and running.
- Training programme (full programme of OD / Leadership / essential HR) has not been impacted and continues as usual.
- Process for undertaking full DBS was not impacted and continues as usual.

Public Inquiry

- The project to support the Public Inquiry into Covid-19 was paused in December 2021. In light of ongoing progress with the national Terms of Reference, work will now formally continue within the Trust to support the preparation of evidence.

ICC

The Incident Control Centre was de-escalated in March 2022 to support reset and rebuild in anticipation of a reduction in the Incident Level. The ICC moved to a 5 day per week model (subject to regional instruction) with the ICC managing routine activity as per below, using the LPT DoC as arms-length support:

- Situation – L3 Major Incident SAGE L2
- Daily 0830 Huddle – ICC Core Team & DoC (Stood down)
- Daily 1600 – By Exception
- ICC Gold Call Wed (Stood down)
- Enhanced huddle Fri 1600 – Utilise as On Call Prep for the weekend could open it to all DoC and On Call Managers (Stood down)
- No meetings at the weekends or OOH – On Call Framework to manage – No requirement to monitor ICC Inbox or telephone
- Review the SITREP Process ICC and INFO Team to manage

Decision required

- To approve the proposal for a reinstatement of level 2 and 3 committees from June 2022
- To agree to a flexible approach which allows for level 3 meetings to remain paused where risk assessed as low risk.
- To approve the current activity noted under the 'reducing the burden' categories.

Governance table

For Board and Board Committees:	Trust Board 31st May 2022	
Paper sponsored by:	Chris Oakes, Director of Governance and Risk	
Paper authored by:	Kate Dyer, Deputy Director of Governance and Risk	
Date submitted:	20 May 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):	Strategic Executive Board 27 May 2022	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	NA	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	One off	
STEP up to GREAT strategic alignment*:	High **S**tandards	
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	Yes
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trust wide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	NA
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	

H

Leicestershire Partnership NHS Trust

Trust Board Public Meeting – 31st May 2022

Documents Signed Under Seal – Quarter 4 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

Analysis

The documents shown below have been signed under seal during quarter 4 2021/22 during the period 1st January 2022 to 31st March 2022.

Seal Register Number	Type	Description	Date Recorded
327	Contract for the purchase/lease of land and/or building	Dead of Release – release of legal charge on Foxton Grange Gipsy Lane Leicester LE5 0TA	19.01.22
328	Contract for the purchase/lease of land and/or building	Lease renewal – Legion House South Street Ashby De La Zouch	19.01.22
329	Contract for the purchase/lease of land and/or building	Dead of release of covenants – relating to Gwendolen House Evington Centre Neville Centre & Hadley House	01.03.22
330	Contract for the purchase/lease of land and/or building	Lease – First Floor Anstey Frith House County Hall Leicester Road Glenfield	01.03.22

Decision required

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

Governance table

For Board and Board Committees:	Public Trust Board 31st May 2022	
Paper sponsored by:	Chris Oakes, Director of Corporate Governance and Risk	
Paper authored by:	Kay Rippin Corporate Affairs Manager	
Date submitted:	23.05.22	
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):	NA	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	NA	
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	

Leicestershire Partnership NHS Trust

I

Trust Board 31 May 2022

Annual Self-Certification with NHS Provider Licence

Purpose of the report

The annual self-certification provides assurance to NHSE/I that NHS providers are compliant with the conditions of their NHS provider licence. On an annual basis, the licence requires NHS providers to self-certify that they have:

a. effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (condition G6);
b. complied with governance arrangements (condition FT4); and
c. for NHS foundation trusts only, the required resources available if providing commissioner requested services (CRS) (condition CoS7).

Whilst non-FT trusts are not required to hold a provider licence, directions from the Secretary of State require NHSE/I to ensure that NHS trusts comply with conditions equivalent to those in the licence as it deems appropriate. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions.

Analysis of the issue

A template is provided to assist with recording of each of the self-certifications, this provides a useful tool to quickly illustrate compliance. It is not mandatory to complete, and it is not necessary to submit to NHSE/I unless the Trust is requested to do so. Each template has been completed for record keeping purposes, and in case the Trust is subject to NHSE/I request (see Appendix A and B).

NHSE/I's self-certification requirements and deadlines are set out in the table below;

Condition	Description	National Deadline
Condition G6 (3)	The provider has taken all precautions to comply with the licence, NHS acts and NHS Constitution.	31 May 2022
Condition G6 (4)	Publication of condition G6 (3) self-certification.	30th June 2022
Condition FT4(8)	The provider has complied with required governance arrangements.	30th June 2022

Proposal

Condition G6

Condition G6(2) requires NHS providers to have processes and systems that:

- identify risks to compliance with the licence, NHS acts and the NHS Constitution
- guard against those risks occurring.

Providers must complete a self-certification after reviewing whether their processes and systems were implemented in the previous financial year and were effective (condition G6(3)).

Providers must publish their self-certification by 30 June (condition G6(4)).

A self-certification has been completed using the recommended template (provided in Appendix A) which confirms that processes and systems were implemented in the previous financial year and were effective (condition G6(3)).

On the basis that LPT is compliant with its provider licence, is not subject to any imposed requirements under the NHS Acts, has regard to the NHS Constitution in delivering NHS services and has received positive assurance on its processes and systems from internal auditors, it is reasonable for the Trust to confirm it is compliance with Condition G6(3) in its self-certification this year.

Providers must publish their self-certification by 30 June (condition G6(4)). This assurance report will be presented to the public Trust Board on 31 May 2022 and will be available on the Trust's website within the Board paper pack.

Condition FT4

Condition FT4 is about systems and processes for good governance. NHS providers must make a corporate governance statement under condition FT4(8) as to current and future compliance with condition FT4 (see Appendix B).

Evidence of Compliance

The compliance declarations above have been made on a range of evidence listed in Appendix C.

Decision Required

- To confirm the Trust's compliance with Condition G6(3) for 2021/22
- To declare compliance with the self-certifications in respect of Condition FT4 for 2021/22

Appendix A: Condition G6

Excerpt from worksheet G6 (General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts))

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

LPT's Financial strategy and annual financial plan set out details of resource requirements and efficiences approved by the Board of Directors; the accounts have been prepared on a Going Concern basis.
Risk to the trusts priorities and the compliance requirements of the CQC and SOF are considered by the Board of Directors in the ORR and monthly Performance Report. A robust governance structure is in place as part of the system of internal control that maintains oversight and provides the Board with assurance.

Appendix B: Condition FT4

Excerpts from worksheet FT4 declaration (Corporate Governance Statement (FTs and NHS trusts))

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Trust has well developed systems of corporate and financial governance as evidenced by its Annual Governance Statement, Head of Internal Audit Opinion, internal and external audit reports, robust financial planning and regular review of risks by the Executive, the Board and its Committees. The Trust's Well Led provider rating improved from 'inadequate' to 'requires improvement' as reported in the Quality Commission (CQC) inspection report published in October 2021.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	NHS Improvement bulletins and any other guidance requirements are routinely reviewed and their implications identified before implementation. From the beginning of the COVID-19 pandemic, the Trust introduced a range of additional management and control processes including the establishment of an Incident Coordination Centre (Gold Command) in line with national guidance. These governance processes and arrangements helped LPT to respond effectively to the pandemic and were all approved by the Board. This is evidenced in the Annual Governance Statement.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and	Confirmed	The Board has a well developed committee structure with approved Terms of Reference which clearly state responsibilities, reporting arrangements and accountability. Level 1 committees contain cross-board membership and attendance is routinely monitored. Following each level 1 committee meeting, the Board receives a standardised highlight report to confirm assurance and highlight matters of concern; these also feed into the Strategic Executive Board.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	A. LPT has sound systems of governance in place which are underpinned by programmes of internal, external and clinical audit. All statutory audits and reporting requirements are fulfilled. B. A monthly performance report is produced, and is scruinised alternately by the Quality Assurance Commitee and the Finance & Performance Commitee one month, and the Trust Board the next. These also feed into the Strategic Executive Board. C. Detailed Board approved financial plans are in place and Internal Audit has provided significant assurance (2021/22) that LPT is delivering a sound system of financial control. The Standing Financial Instructions govern financial decision making and financial performance is scrutinised by the Finance & Performance Committee. The 2021/22 accounts have been prepared on an on-going concern basis. D. The Board and its committees work to pre-agreed work plans and are serviced by the Corporate Affairs Team which assists with agenda setting, paper circulation, minute taking, record keeping and action follow-up. Directors take responsibility for enuring that accurate, comprehensive and up-to-date information is presented for consideration. LPT uses flash reporting to brief the Board of Directors on time-sensitive matters that occur between formal meetings; this was used frequently during 2021/22 to ensure that the Board remained up to date during the pandemic. E. A well established and well embedded Organisational Risk Register (ORR) identifies key strategic risks. It is presented to each Board meeting and is reviewed at the Strategic Executive Board once a month; risks are also subject to detailed review and scrunty by the commitees. During 2021/22 the ORR was refreshed, and incorporated tolerance levels to support the consitent application of board determined risk appetite. F. The Trust's Step Up To Great strategic plan was refreshed for 2021/22 and was endorsed by the Board at its October 2021 confidential meeting. G. The Trust's regularly seeks advice from its lawyers on legal compliance.

5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	**Confirmed**	A. Robust appraisal and performance review arrangements are in place at Board level (and throughout the organisation) and portfoilos are regularly reviewed and refreshed. As part of the transition into a Group Model arrangement with Northamptonshire Healthcare NHS Foundation Trust, senior leadership capacity and support remains in place with a number of joint Directors to support the Executive Team. B. The Quality Assurance Committee, on behalf of the Board of Directors, receives assurance on issues of patient safety and quality of care, patient experience and patient outcomes, and promotes the involvement of service users, carers and the public. In addition, quality summits or thematic reviews of any indicators or areas of concern are commissioned by and shared with the Quality Assurance Committee as they arise. C. LPT is embedding a revised quality governance framework. The Quality Forum and Quality Assurance Committee receives relevant information and metrics relating to quality performance much of which is enshrined in the Quality Account. D/E. A patient story or service overview is regularly presented at the start of each Board Meeting; during the COVID-19 pandemic, this has been done virtually where possible during 2021/22. For this reason service visits for Board members (which allow for triangulation of information) were also restricted. The Board receives a range quality related reports, including reports on Serious Incidents, PALS, complaints, compliments, CQC regulatory compliance as well as regular reports from the Director of Nursing, Allied Health Professionals & Quality, and the Medical Director. F. There is clear accountability for quality of care throughout the Trust and systems of governance allow for appropriate escalation to Board of Directors. The Quality Forum meets regularly and reports to the Board's Quality Assurance Committee to provide assurance that the Trust is delivering safe, caring, responsive, effective and well-led services and to scrutinise and discuss clinical quality issues, particularly relating to best practice and national guidance. The Quality Forum's role includes the assessment of risks, patient safety and quality and ensuring that plans are developed and monitored to manage or mitigate the risks, escalating risks to the Quality Assurance Committee as appropriate for further consideration.
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed**	The composition of the Board of Directors is regularly reviewed to ensure there is sufficient capacity, capability and the requisite skills and experience to deliver the Trust's objectives and plans and to provide effective leadership at an organisational and system level.

Appendix C: Evidence of compliance

In making the above declarations, the following additional assurance can be provided to the Board;

- The Trust has Standing Orders, Standing Financial Instructions, and a Scheme of Delegation, which together describe how the Board of Directors discharge their duties through the Trust's governance structure;
- A risk management strategy which sets the standards for staff regarding the management and responsibility for risk throughout the Trust, describes the Trust's risk appetite and defines the framework and structure for risk management in LPT. This was updated during the year and approved at the December 2021 Audit and Assurance Committee.
- There is an Organisational Risk Register (ORR) and subsidiary risk registers (i.e risk assessment, counter fraud, local and directorate risk registers)**.** The Audit and Assurance Committee, Quality Assurance Committee and Finance & Performance Committee have consistently provided a high (green) assurance rating to the Trust Board over the management of risk via the highlight reports.
- A risk based Internal Audit programme has been delivered that includes audits of risk management and governance arrangements. The 2021/22 audit 'Corporate Governance and Strategic Risk Management – Trust Board and level 1 Committee Arrangements' (2122/LPT09) was issued in March 2022 and gave significant assurance, and no recommendations were made. The audit included the following summary "*Overall, we confirmed that there is a clear governance structure in place linking the Trust Board to its level 1 committees, and appropriate assurance requirements are in place…Our review found arrangements to be clear and well documented".*
- The interim Head of Internal Audit Opinion providing significant assurance on all three elements; outturn, follow up rate and strategic risk management.
- Self-assessment of performance against the CQC's 'well-led' domain.
- An Annual Governance Statement which reflects the Trust's governance structures and internal control arrangements.

Governance Table

For Board and Board Committees:	Trust Board 31 May 2022	
Paper sponsored by:	Chris Oakes, Director of Governance and Risk	
Paper authored by:	Kate Dyer, Deputy Director of Governance and Risk	
Date submitted:	23 May 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:	NA	
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	
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	NA
Is the decision required consistent with LPT's risk appetite:	NA	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed	
Equality considerations:	None	

J

Leicestershire Partnership NHS Trust

LPT Trust Board – 31 May 2022

Non-Executive Director Responsibilities with effect from 1 June 2022

Purpose of the report

To update the Board on the NED team responsibilities. Following the recruitment of 2 NEDs the transition dates for handover of responsibilities are shown below.

Proposal: 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 until 10 June) Hetal Parmar (Audit Chair designate) Alex Carpenter (representing FPC) Moira Ingham (representing QAC)
Remuneration Committee	Cathy Ellis (Chair) Alex Carpenter Faisal Hussain Moira Ingham Ruth Marchington Kevin Paterson
Charitable Funds Committee	Cathy Ellis (Chair) Ruth Marchington (until 6 June 2022) Faisal Hussain (from 6 June 2022)
Quality Assurance Committee	Moira Ingham (QAC Chair) Ruth Marchington Kevin Paterson
Finance & Performance Committee	Faisal Hussain (interim FPC Chair until 28 June) Alex Carpenter (FPC Chair from 28 June) Ruth Marchington / Moira Ingham (QAC link)
LLR ICS Finance Committee	Cathy Ellis (Chair) Alex Carpenter / Hetal Parmar
LLR ICS Quality & Performance Committee	Moira Ingham
LLR ICS Transition Committee until 1 July 2022	Faisal Hussain
LPT / NHFT Joint Working Group	Cathy Ellis (Chairing by rotation with Crishni Waring, NHFT Chair) Faisal Hussain

Decision required

To approve the NED team roles and committee responsibilities

Governance table

For Board and Board Committees:	Trust Board 31 May 2022	
Paper sponsored by:	Cathy Ellis	
Paper authored by:	Cathy Ellis	
Date submitted:	19 May 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	Next review 1 April 2023	
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	

NHS
Leicestershire Partnership
NHS Trust

Child and Adolescent Mental Health Services Presentation

May 2022

Paul Williams, Head of Service

WeAreLPT
compassion respect
integrity trust

www.leicspart.nhs.uk

Inpatient Care

Workforce challenges

COVID

Increasing numbers of complex referrals

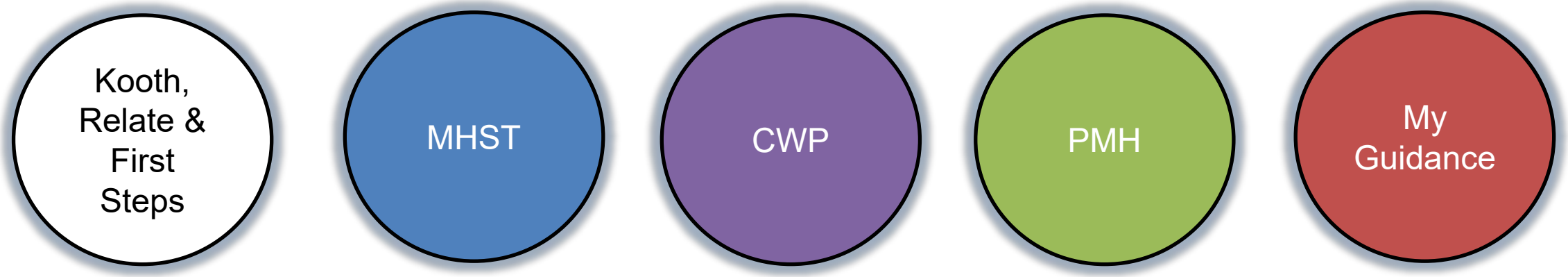
Crisis and Paediatric acute liaison, Urgent Care Hub, Home Intervention Team, Intensive Community Support

Outpatient and Specialist Teams

Increased investment

Early Intervention – Children's Wellbeing Practitioners, Mental Health Support Teams, Primary MH

Early Intervention



Improving access to early intervention and support

Improving access for CYP in Leicester City in line with the Future in Mind strategy

Strengthening the emotional and mental health offer at neighbourhood level; aligning with the Step up to Great Mental Health transformation

Co-production is at the centre of reducing inequality and improving access

CAMHS Outpatients

Nationally a record high for referrals to child and adolescent mental health services in March 2021. At 65,533, it is more than double the number in March 2020 and 68% higher than March 2019.

Locally within this, we are seeing an increase in urgent and complex referrals

Consequences

Prioritisation of urgent and acute cases
Waiting times for routine assessment appointments exceeding 13 weeks
Lengthy internal waits for treatment

Actions

Redesigned ND pathway – waits reducing
Increased investment – MHIS
Improvement plan – initial assessment waits
Restoring Group work
Improved digital offer
Improved care navigation
Weekly PTL meetings

Specialist Teams

CAMHS LD

Eating Disorders

Paediatric Psychology

Young People's Team

Increasing number of complex referrals in CAMHS LD stretching the capacity of the team – new investment allocated through MHIS

CAMHS ED increase in referrals 31% (2020/21) and further 26% (2021/22) – investment in HIT team and core team – partnership working with VCS

Crisis and urgent Care

Previous model was based on assessment, home treatment and 7 day follow up from A&E attendance

The service saw a 17% increase (2020/21) and a further 13% increase (2021/22) in referrals

New Model

Improved System working

University Hospitals of Leicester NHS
NHS Trust

Caring at its best

NHS
Leicestershire Partnership
NHS Trust

CYP Mental Health Pathway Work

Progress update…

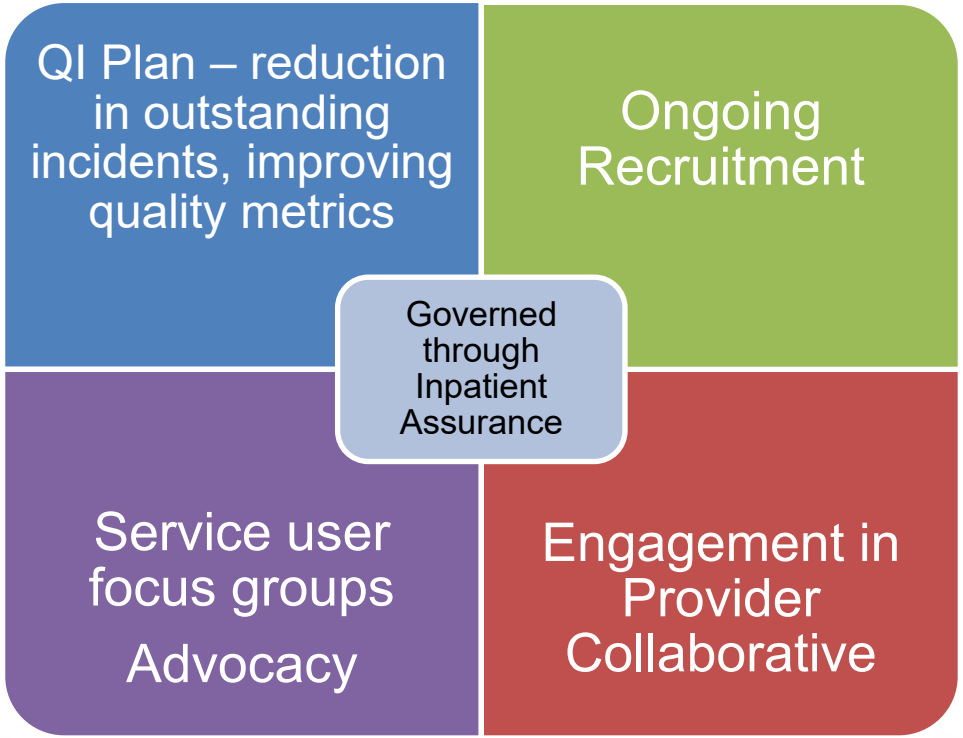
- **What was in place-** limited operational outreach, an unclear understanding of where to escalate in both ED and the wards. LOS was extended due to being unaware of what the current offer was, which at times led to delays in access to appropriate support.
- **Challenges-** Delayed interventions, LOS increased, confidence in services reduced, quality of care and safety potentially impacted. Escalations to MHA's.
- **Improved system working-** dedicated and identifiable support from CAMHS (in addition to the all age mental health offer), which is integrating into the LRI. Escalation process and working relationships between LPT/UHL are improved. UHL CYP is included in the CAMHS daily acuity meeting.
- **Current developments -**Developing a joint UHL/LPT SOP, Which includes a pathway which provides clarity on CYP's journey and when to escalate and what that would look like. Held scoping meetings with system providers and commissioners around how to improve CYP MH pathway due to the reduction in specialist CAMHS beds- this group is evolving into a delivery group, with lots of ideas being formed.
- **So what?-** Access to support is clearer (good links between all age mental health & CAMHS and aware of hours covered specifically for CAMHS), discharge is safer with the Crisis team assessing when medically fit on wards. Safer stay, ie Trust has been supported by LPT's H&S team regarding a ligature risk assessment when CYP have been admitted and were under section of the MHA. Staff consultation provided in supporting UHL colleagues. Working on how to improve data collection, however anecdotally its been reported that assessments when a CYP is medically fit is more timely and joined up and also as the number of children being seen by CAMHS has increased at the LRI, there is a reduction in 7 day follow ups, improving the patient experience. Dedicated resource when it needs to be escalated to LPT ie CYP sectioned and staff required.

Beacon

Challenges include:

- Acuity of CYP
- Availability of suitable beds e.g. PICU and LSU
- Workforce supply

Improvement Actions



K

Leicestershire Partnership NHS Trust

Trust Board – 31st May 2022

Annual Strategic Delivery Plan 2022/23

- This paper proposes the approval of the Annual Strategic Delivery Plan 2022/23.

Purpose of the report

Leicestershire Partnership NHS Trust approved a refreshed Trust Strategy earlier this year, built on the engagement and feedback of numerous stakeholders including patients, staff and partners. A detailed annual delivery plan has also been developed to support the Trust Transformation Committee and PMO in monitoring the delivery of the Trust's Strategy and measuring the impacts of our strategic priorities.

A more accessible version which has been developed for staff and the public has now been created and it is this version that is being brought to Trust Board for approval.

Analysis of the issue

The reason we use summary document to compliment a comprehension strategy is because we want staff, patients and the public to be able to pull out main messages of the document and be able to focus on specific details that make sense to them.

An effective strategy summary delivery plan will help key stakeholders to very quickly identify where our efforts and resources are being focussed and how we are working hard to ensuring we are meeting or Trust's vision for the future.

Proposal

- Approval of the Annual Strategic Delivery Plan.

Decision required

- Approval of the Annual Strategic Delivery Plan.

Governance table

For Board and Board Committees:	Trust Board 31st May 2022
Paper sponsored by:	David Williams
Paper authored by:	Samantha Wood
Date submitted:	24th May 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 – April 2022
If considered elsewhere, state the level of assurance gained by the Board Committee or	Supported with edits.

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	One-off report	
STEP up to GREAT strategic alignment*:	High **S**tandards	X
	Transformation	X
	Environments	X
	Patient Involvement	X
	Well **G**overned	X
	Reaching Out	X
	Equality, Leadership, Culture	X
	Access to Services	X
	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:	Nothing identified	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed	
Equality considerations:	This will support the E brick within the Trust Strategy	

2022/23 Annual Strategic Delivery Plan

Brick	2022/23 Focus	Intended Outcome
	1. We will build on the learning from Covid and will deliver safe care and reduce harm. 2. We will transform our patients' experience of care - making no decision about them, without them.	1a. We will demonstrably improve compliance against Health and Social care core standards and Care Quality Commission (CQC) registration requirements. 1b. Development of an implementation plan for the local National Patient Safety Strategy- includes pressure ulcers, deteriorating patient, self-harm, Infection, Prevention and Control (IPC), suicide prevention and least restrictive practice. 2a. Implementation of the Shared Decision-Making Framework.
	3. Progress our Ageing Well accelerator work. 4. Address our waiting lists, particularly in relation to continence and Neuro. 5. Work in partnership to develop and deliver a strategic plan to ensure the Best Start for Life and the importance of the 1001 first critical days. 6. Increase the focus on Learning Disability. 7. Establish Neurodevelopmental Transformation Programme and Leicester, Leicestershire and Rutland (LLR) Autism service (children, young people and adults). 8. Respond to the outcome of the public consultation on mental health services and support.	3a. Quicker response, earlier clinical intervention and decreasing urgent care attendances by target population. 4a. Reduced waiting times. 5a. Continue to participate in the system-wide coalition of organisations to agree and deliver a strategic plan for the first 1001 days. 6a. People with a learning disability are better supported to live fulfilling lives in the community and have quicker access to services when they need it. 7a. Our service users with Autism will wait less time to receive care when they need it and will be supported to stay out of hospital as much as possible. 8a. Develop a clear Step Up To Great Mental Health Delivery Plan building on the outcome and learning from the consultation.

2022/23 Annual Strategic Delivery Plan

	9. Lead a clear digital plan that makes sure digital transformation is owned by the Trust.	9a. Refresh the Trust Digital Information Management & Technology plan in line with key national initiatives.
	10. Make the Trust a better place to work by ensuring staff are safe and healthy, physically and mentally well and able to work flexibly. 11. Take action to ensure our Trust engages staff well. 12. Recruiting and retaining our people.	10a. Delivery of the objectives for this year of our Trust's People Plan. 11a. Improving our culture, leadership and inclusion with the Our Future Our Way programme, and embedding our Leadership Behaviours for All staff. 11b. Roll out of our Reset & Rebuild Programme of Big Conversations and resulting actions. 12a. Improving employment and development opportunities for our Black, Asian and Minority Ethnic people. 12b. Further develop and support the Trust's staff support networks.
	13. To capture and use the learning from patient feedback and engagement to inform and influence how the Trust delivers and designs its services, including Implementation of the new Friends and Family Test system across the organization. 14. Deliver continuous development of patient/carer participation and involvement.	13a. We will make it easy and straight forward for people to share their experiences. 13b. We will increase the numbers of people who are positively participating in their care and service improvement. 14a. We will improve the experience of people who use or who are impacted by our services.
	15. Providing leadership for ongoing improvement across our Well Led framework, informed by learning from others. 16. Contributing to the development of ICS governance and risk systems.	15a. Improvement against the well-led Key Lines of Inquiries. 16a. To have effective governance and risk systems in place with system partners to input into the Integrated Care System (ICS).

2022/23 Annual Strategic Delivery Plan

	17. Invest in our resources to deliver optimal health outcomes. 18. We have a clear data quality framework and plan that guides our delivery of great data quality.	17a. Good financial plans and delivery of plans, aligned to investment in key areas will support the Trust's ability to deliver against the vision of improving health and wellbeing. 18a. Review data quality policy, develop data quality improvement plan and submit data privacy and security toolkit.
	19. Support a sustainable local community in Leicester, Leicestershire and Rutland. 20. Positively support environmental, economic & regeneration improvements, policies and practices in LLR. 21. Supporting our most vulnerable in society; raising health equity across Leicester, Leicestershire and Rutland.	19a. Review the current work with other NHS partners, local authorities and other stakeholders and identify areas of work where the Trust can work with others to support our sustainable communities. 20a. To have an agreed set of principles that set out our commitments to this aim, agreed through our Trust public board meetings. 21a. We will be a member of the local authority and NHS group to reduce health inequalities in Leicester, Leicestershire and Rutland and play a full role in agreeing a plan and implementing that plan to improve equity.
	22. Therapeutic environments that improve outcomes for people using services by supporting safe, joined up, person-centered care. 23. A positive and effective working environment for all staff building on the learning from post Covid 'reset and rebuild' work. 24. Greener NHS buildings and identifying our route to net zero.	22a. Eradication of dormitory accommodation and update of Strategic Outline Case for health campus. 23a. Implement facilities management business case to deliver the capacity and capability for high quality estates. 24a. Develop and deliver a green action plan for the Trust.

2022/23 Annual Strategic Delivery Plan

	25. Improve access in a prompt responsive and suitable manner. 26. Ensure that the Standard Operating Procedures governing access are being adhered to consistently across all areas. 27. Improving data quality and performance monitoring in relation to access.	25a. Support the implementation of the policy framework - improving Access policy implementation across all 3 directorates. 26a. Ensure all services have a Standard Operating Process for access. 27a. Quality Improvement focused approach to waiting list management including implementation of validation and Patient Tracking Lists.
	28. We will proactively work with Northamptonshire Healthcare Foundation Trust (NHFT) on a single approach for both Trusts, optimising the shared learning approach, building on the learning from post Covid 'reset and rebuild' work. 29. We will set clear priorities for Quality Improvement initiatives. 30. Widening the opportunities for more people to participate in research to inform future health and social care.	28a. Develop joint Quality Improvement strategy with NHFT. 29a. Develop and implement the Trust's priorities for Quality Improvement. 30a. Strengthening research projects across a wider range of partnerships crossing organisational boundaries.

Leicestershire Partnership and
Northamptonshire Healthcare Group

L

Trust Board May 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 May 2022.

Analysis of the issue

- The governance arrangements and mobilisation of Joint Roles are complete
- A financial year end review of the eight Group Strategic Priorities is to be undertaken and received by the Committees in Common in July 2022. The scope will include a refresh of risks and the identification of new potential priorities
- Proposals for an over-arching Group strategic framework are in development.
- Some early work benchmarking and comparing each Trust's Financial plans has highlighted some differences regarding agency spend and capital and more work is planned to explore opportunities in relation to these.

Proposal

- This LPT-NHFT Committees in Common Highlight report (Appendix A) from the Joint Working Group meeting, along with the appended Joint Roles MoU Agreement (Appendix B), are offered to each Trust Board to reflect the approval journey of the MoU and what is being delegated to each Trust's Nomination and Remuneration Committee.

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 21st March 2022 and 3rd May 2022

Purpose of Report

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

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

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

The key headlines/issues and levels of assurance are set out below and are graded as follows:

Strength of Assurance	Colour to use in 'Strength of Assurance' column below
Pre-approval	Grey – there is a draft plan in development and actions agreed to ready it for approval to proceed
Low	Red - there are significant gaps in assurance and/or not properly assured as to the adequacy of action plans/controls
Medium	Amber - there is reasonable level of assurance but some issues identified to be addressed.
High	Green – there are no gaps in assurance and there are adequate action plans/controls

Report	Assurance level	Committee escalation	ORR Risk Reference
1. Attended & Apologies	N/A	Listed in the CiC meeting notes	N/A
2. Action Tracker	High	The 3rd May 2022 meeting of the CiCs discussed open actions as follows: **34 - Review the Strategic Priorities programme** the end of year one programme review, including the identification of any new strategic priorities will be presented at the July meeting **35 - Create an overarching Strategic Framework** Building on the Trust strategy comparison paper presented in March, work has commenced on Group strategic framework paper agreed on the forward plan to be discussed at the July meeting. The following actions were discussed on the agenda and subsequently closed **Action 36 – action closed,** circulate the new (shared role related) employment clauses	N/A

Report	Assurance level	Committee escalation	ORR Risk Reference
		Action 32 – action closed, reset the CIC JWG meeting rhythm	
3. **Group Risk Register Update**		The risk register was reviewed, and the overall level of risk considered low. It was agreed that the risk log would be refreshed as part of the Strategic priorities year one programme review and any updates will be completed for July and presented alongside the priorities.	
4. **Group Employment model mobilisation**	High	As a reminder, on the 8th November 2021 the Committees in Common supported proposals for the wider employment of people across the Group and the JWG supported a MoU agreement in respect of this at the December 2021 meeting. The Joint Employment proposal and MoU Agreement received Trust's Board approval in January 2022. The Joint Roles Memorandum of Understanding (MoU) document governs appointments to joint roles across both Trusts within the Group Oversight of joint roles will be delegated to and provided by Remuneration Committees (as set out in the Joint Roles MoU) Appointments to joint roles will only be made to roles with the recommendation of the Trusts' Committees in Common via the Joint Working Group. Oversight and approval of roles will be undertaken by each organisation's Nomination and Remuneration committee This LPT-NHFT Committees in Common Highlight report from the Joint Working Group meeting, along with the appended Joint Roles MoU Agreement, are offered to each Trust Board to reflect what has already taken place, and act as a reminder as to what is delegated.	
5. Group Strategic Priorities Programme	High	The programme of eight Group strategic priorities was finalised between July and September 2021 and it was agreed that a 2021/22-year end review and refresh of the programme would be undertaken and presented at the July 2022 CiC JWG. The scope of the end of year programme review, will include a refresh of any associated risk and the identification of any new strategic priorities	
6. Group Strategic Priorities Programme	High	The Group Strategic Priority Plans are currently RAG rated by the CiCs at the JWG meeting as follows and	N/A

Report	Assurance level	Committee escalation	ORR Risk Reference
Delivery KPIs **%** of Group Strategic Priorities Plans rated as on track (green) or off track but expected to recover (amber) off track and unrecoverable (red) in development (grey)		ratings will be updated following the programme annual review taking place in July 2022: **KPI Target = 100% of plans Green** There are eight strategic priority plans in 2021/22 0% In Development 0 100% Green 8 0% Amber 0 0% Red 0	
7. Financial Alignment		**Finance (benchmarked financial plans presentation)** The CiCs received an initial piece of work to compare the financial plans of the two Trusts from the Chief Finance Officer. Whilst in the very early stages, the comparison identified that both Trusts have deficit plans and operating surpluses and highlighted some differences in respect of Agency usage, Capital treatment and efficiency schemes. The CiCs suggested that there are potential opportunities for each Trust to learn from each other, but also to identify new efficiency schemes that can perhaps be done once collectively as one scheme. This benchmarking will continue to be developed and brought back to the Group.	
8. Strategic Alignment	High	Building on the Trust strategy comparison paper, the CiCs supported in March 2022, work has commenced on an overarching Group strategic framework and agreed on the forward plan to be discussed at the July CiC JWG meeting.	N/A

Leicestershire Partnership and Northamptonshire Healthcare Group

LPT Trust Governance Table

For Board and Board Committees:	LPT-NHFT Committees in Common	
Paper sponsored by:	LPT Trust Chair, Cathy Ellis, NHF Trust Chair, Crishni Waring	
Paper authored by:	Amanda Johnston, Strategy and Partnerships Manager	
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):**	9th May 2022 LPT-NHFT CiC JWG 3rd May 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**	Assured 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	

Dated **2022**

DRAFT

(1) NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST

- and -

(2) LEICESTERSHIRE PARTNERSHIP NHS TRUST

MEMORANDUM OF UNDERSTANDING

FOR JOINT ROLES

Contents

THIS MEMORANDUM OF UNDERSTANDING is made on the [DATE] December 2021

BETWEEN:

(1) **NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST** of St Mary's Hospital London Road, Kettering, NN15 7PW **("NHFT")**

(2) **LEICESTERSHIRE PARTNERSHIP NHS TRUST** of Bridge Park Plaza, Bridge Park Road, Thurmaston, Leicester, LE4 8PQ **("LPT")**

Each a "Party" and together the "Parties"

BACKGROUND:

(A) NHFT and LPT have been in a 'buddy' arrangement since 2019. Because of this arrangement we have been able to work together on a range of initiatives including staff programmes, quality improvement work, strategy planning and more. Each organisation has embraced the opportunity to collaborate on projects to the benefit of our staff and those we care for and work with.

(B) From April 2021, we have agreed to create a group arrangement for both of our trusts to work within. As part of the group arrangement, the Trusts have worked to make several joint appointments and explore other innovative workforce arrangements between the Trusts.

(C) This Memorandum of Understanding is intended to set out the principles by which the Trust are operating in relation to those joint appointments and in the event of liabilities arising in respect of the joint appointments.

NOW IT IS HEREBY AGREED as follows:

1 DEFINITIONS AND INTERPRETATION

1.1 In this Memorandum of Understanding the following words and expressions shall have the following meanings:

Agreed Form means a form of document agreed by the parties;

Business Day means a day other than a Saturday, Sunday or bank holiday in England;

Commencement Date means the date the Memorandum of Understanding is signed by the Parties, or on the last date that it is signed if the dates are different

Confidential Information means information, data and any material of any nature which either Party or Relevant Staff may receive or obtain in connection with the operation of this Memorandum of Understanding and:

(a) the release of which is likely to prejudice the commercial or other interests of the other Party; or

(b) is otherwise provided and/or received on the understanding that it is to be held in confidence;

Data Protection Legislation means (i) the Data Protection Act 2018 (ii) UK GDPR), and (iii) all applicable Law about the processing of personal data and privacy, including but not limited to the common law of confidentiality;

Employee Emoluments means all employment related outgoings including salaries, wages, bonus or commission, holiday pay, expenses, pay supplements, national insurance and pension contributions and any liability to taxation;

FOIA means the Freedom of Information Act 2000;

Intellectual Property Rights means any registered or unregistered patents, trademarks, service marks, trade names, copyright (including but not limited to rights in computer software and in websites and in any training material, rights in databases, rights in both registered and unregistered designs, know-how and all and any other confidential information);

Joint Roles shall mean a collaborative appointment or working arrangements used to engage or employ individuals into Positions;

Personal Data shall have the meaning given to it in the Data Protection Legislation;

Positions: positions whether at Board or other level within either NHFT or LPT or across both parties as part of the group working arrangements which are appropriate for consideration for Joint Roles;

Shared Intellectual Property Rights shall have the definition set out in Clause 12.3;

1.2 The headings in this Memorandum of Understanding shall not affect its interpretation.

1.3 In the event and to the extent only of any conflict between the Clauses and Schedules to the Memorandum of Understanding, the Clauses shall prevail.

1.4 In the Memorandum of Understanding the clauses, other than clause 3 are intended to be legally binding.

2 COMMENCEMENT AND DURATION

2.1 This Memorandum of Understanding will take effect on the Commencement Date and will continue unless terminated in accordance with Clause 9 (Termination).

2.2 Before either Party gives notice under clause 9 they shall discuss and resolve any concerns, and to devise any required exit strategies to minimise the risks of such a termination

2.3 The Parties shall undertake an annual review of operation this Memorandum of Understanding and agree any amendments as may be required.

3 JOINT ROLES AGREEMENT PRINCIPLES

3.1 When determining whether to create Joint Roles the Parties shall consider as appropriate whether:

3.1.1 the collaboration on that Joint Role will support the Parties or group working arrangement as a whole to work more effectively, efficiently and economically.

3.1.2 the Joint Role will support the delivery of each Trust's strategic objectives with respect to group working arrangements;

3.1.3 the Joint Role will assist the Parties to work together in a unified, integrated, patient-focussed culture.

3.1.4 the Joint Role draws upon the existing capability and respects the position of each Party.

3.2 The Parties shall develop effective working practices to work collaboratively to identify solutions, eliminate duplication of effort and mitigate risk arising out the Joint Roles. The Parties shall agree in each case appropriate appointment processes for each Joint Role.

3.3 The Parties shall seek to make appointments to Joint Roles on an Agreed Form of contract reflecting the nature of the employment arrangement for that Role.

4 RESPONSIBILITIES

4.1 Each Party shall remain individually responsible for ensuring that it has the appropriate workforce and staffing resources to adequately meet its own requirements. Nothing in this Memorandum of Agreement and no Joint Appointment to a Role made either before or after the Commencement Date shall make one party liable to the other for any staff resourcing issues faced by the other. The purpose of this agreement is to facilitate joint working where appropriate through Joint Appointments, not to make either Trust responsible for the other.

4.2 Each Party shall act in good faith when complying with its respective obligations arising under or in connection with this Memorandum of Understanding and provide such cooperation and assistance as may reasonably be required by the other Party for the successful operation of group working arrangements and Joint Appointments.

5 GOVERNANCE

5.1 Joint appointments will only be made to Roles with the recommendation of the "*Joint Working Group*", with oversight and approval undertaken by each organisation's Nomination and Remuneration committee.

6 JOINT ROLES

6.1 Before making a Joint Appointment to an agreed Joint Role, it must be determined:

6.1.1 What form of employment is to be used (joint employment, employment by a single Party and secondment or such other method of employment or engagement as the Parties may determine) for each Role and which Party's policies and procedures (other than concerning management of the individual under clause 7.2) shall apply to that Joint Appointment;

6.1.2 What access to each Party's premises, IT or other infrastructure shall be granted to the individual (and how such access shall be granted);

6.1.3 The division of liability for the Employee Emoluments and any other liabilities (including redundancy payments, other damages for injury to feelings or persona injury and own or third party legal costs) falling on a Party as a result of or arising out of an individual being appointed to the Joint Role (which shall be presumed to be 50/50 division unless otherwise agreed in writing); and

6.1.4 Whether the Joint Appointment is intended to be to a short-term role, or a permanent position, and if short term, what shall occur to the individual so engaged at the end of the appointment.

6.2 The Party employing an individual to a Role shall undertake all usual pre-employment checks in accordance with its policies including and Disclosure and Barring Service Checks, rights to work in the UK and confirm to the other Party that no concerns have arisen to that appointment and the individual is fit and proper person to undertake the Role.

6.3 Each Party shall provide any necessary induction to any individual appointed to a Role.

6.4 The Parties shall agree for any individual any training that is required for the Role, who shall provide or secure the provision of that training.

6.5 Either Party may immediately require that an individual is denied access to its Premises or otherwise prevented from having access to IT systems. Where either party requires such suspension of access, it shall immediately notify the other Party of this and the basis for the action.

6.6 The responsibility for termination will rest with the employing Party. The employing Party will ensure that they consult with the other Party at the commencement of and during any process and prior to a decision to terminate. Either Party may require a Joint Role to be terminated on not less than 6 months' notice.

6.7 Following the service of a notice requiring the termination of a Joint Role by a non-employing Party, an employing Party may decide to retain or redeploy the individual, but nothing in this agreement shall require the Trust to create a new role or otherwise offer employment to such individual. Where such retention or redeployment occurs, the non-employing Party shall cease to be liable for any liabilities arising after the date of redeployment or retention.

7 GRIEVANCES, DISCIPLINARY AND LIABLITY

7.1 In all matters arising in relation to individuals appointed to a Joint Role the Parties' human resource teams shall work co-operatively to determine:

7.1.1 Which Party shall carry out any investigation required for any grievance, disciplinary or other matter regarding an individual appointed to a Joint Role;

7.1.2 Where an individual was appointed to a Joint Role but the circumstances do not fit within clause 7.2, which policies or procedures shall apply to any grievance, disciplinary or other matter regarding an individual appointed to a Joint Role.

7.2 Each party acknowledges that where individuals appointed to a Joint Role are legally employed by one Party, it shall be that Party's policies and procedures that shall apply concerning the management of the individual in the Role in any disciplinary, grievance or other employee related matters. The decision-making responsibility will rest with the employer specifically including the decision to terminate an employee.

7.3 Where any claim or complaint is made by an individual or about an individual engaged in a Role, in the event that such claim or complaint leads to a claim being made, or threatened to be made, to an employment Tribunal whether by that individual or a third party the Party in receipt of the claim or complaint shall share all relevant information concerning the claim or complaint with the other Party and the Parties shall continue to share all further information concerning the claim or complaint until this is concluded.

7.4 Each Party shall be entitled to have conduct of any legal claim made against itself by a person appointed to a Joint Role. Notwithstanding this, the Parties shall seek where practicable to co-operate in defending or settling such claims as may be appropriate.

7.5 Where the Trusts have divergent views on whether to settle any proceedings, they shall, as soon as practicable discuss and agree whether any changes to the division of liability is required (with no change being presumed).

8 DISPUTE RESOLUTION

8.1 In the event of any dispute arising under or in connection with this Memorandum of Understanding, any aggrieved party shall first give notice of the dispute to the and the Parties shall seek to settle the dispute amicably as soon as possible and in any event within seven (7)

Business Days of notice of the dispute being served, at a meeting convened for the purpose of attempting to resolve the dispute.

8.2 If the dispute remains after the meeting detailed above has taken place, the Parties will make a good faith attempt to resolve their dispute through direct negotiation by escalating any dispute up to a member of senior level management of each party with authority to settle the dispute and such members of senior management will meet as soon as possible after the meeting referred to in Clause 8.1 and in any event within twenty-eight (28) Business Days of that meeting.

9 TERMINATION

9.1 This Memorandum of Understanding may be terminated in its entirety by a joint decision of the Parties.

9.2 Either Party may give 12 months' notice to terminate this Memorandum of Understanding.

10 CONFIDENTIALITY

10.1 Each Party will comply with and acknowledge the four basic principles of "Protect, Inform, Provide Choice and Improve" as set out and described in the Department of Health NHS Confidentiality Code of Practice.

10.2 In respect of any Confidential Information it may receive from the other Party ("**the Discloser**") and subject always to the remainder of this Clause 10, each Party ("**the Recipient**") undertakes to keep secret and strictly confidential and shall not disclose any such Confidential Information to any third party, without the Discloser's prior written consent provided that:

10.2.1 the Recipient shall not be prevented from using any general knowledge, experience or skills which were in its possession prior to the commencement of this Memorandum of Understanding;

10.2.2 the provisions of this Clause 10 shall not apply to any Confidential Information which:-

(a) is in or enters the public domain other than by breach of this Memorandum of Understanding or other act or omissions of the Recipient; or

(b) is obtained by a third party who is lawfully authorised to disclose such information; or

(c) is authorised for release by the prior written consent of the Discloser; or

(d) the disclosure of which is required to ensure either party's compliance with FOIA.

10.3 Nothing in this Clause 10 shall prevent the Recipient from disclosing Confidential Information where it is required to do so by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable law or where requested or required to do so by any Regulatory or Supervisory Body as defined under the NHS Standard Contract.

10.4 In consideration of the disclosure of confidential information any each of the Parties must inform the other Party immediately upon becoming aware of suspecting that an unauthorised person possesses, is using or knows of any of the Parties' confidential information. In the event of termination or expiry of this Memorandum of Understanding, each Party shall promptly return to the other all of the information which is in its possession or control and all copies thereof and shall destroy all copies of the same and certify to the party that it has done so, unless the Party

is prevented by law or any regulatory authority from destroying or returning all or part of such data, in which case the party shall keep such data confidential and shall not process it further.

11 DATA PROTECTION

11.1 The Parties acknowledge their respective duties under Data Protection Legislation. For the avoidance of doubt, each party shall take reasonable steps to ensure it is familiar with the Data Protection Legislation and any obligations it may have under such Data Protection Legislation and shall comply with such obligations.

11.2 The Parties shall ensure that Personal Data is safeguarded at all times in accordance with the Law, and this obligation will include only transferring Personal Data (a) if required, having regard to the purpose for which the transfer is conducted; and (b) that is encrypted in accordance with any standards applicable to the NHS under the Law and guidance.

11.3 The Parties agree to use all reasonable efforts to assist each other to comply with the Data Protection Legislation. This includes (but is not limited to) the parties promptly notifying each other if they receive a request from a data subject to have access to personal data or any other complaint or request relating to each other's obligations under the Data Protection Legislation and provide full co-operation and assistance to each other in relation to any such complaint or request in order to comply with the relevant timescales set out in the Data Protection Legislation where applicable (including without limitation, by allowing data subjects to have access to their personal data).

11.4 The Parties agree not to transfer Personal Data out of the European Economic Area unless such a transfer has been approved by the Parties and complies relevant safeguards.

12 FREEDOM OF INFORMATION ACT AND ENVIRONMENTAL PROTECTION REGULATIONS

12.1 Each Party acknowledges that the others are subject to the requirements of FOIA and the Codes of Practice on the Discharge of Public Authorities' Functions and on the Management of Records (which are issued under section 45 and 46 of the FOIA respectively) as may be amended, updated or replaced from time to time. Each party shall act in accordance with the FOIA, and these Codes of Practice to the extent that they apply to this Memorandum of Understanding.

12.2 Where a Party receives a request for information (a "**Request for Information**") in relation to information which it is holding on behalf of the other Party, it shall procure (and shall procure that its subcontractors shall):

12.2.1 transfer the Request for Information to the other Party as soon as practicable after receipt and in any event within three (3) Business Days of receiving a Request for Information;

12.2.2 provide the other Party with a copy of all information of the other Party in its possession or power in the form that the other party requires within five (5) Business Days (or such other period as the other party may specify); and

12.2.3 provide all necessary assistance as reasonably requested by the other Party to enable the other Party to respond to a Request for Information within the time for compliance set out in section 10 of the FOIA.

12.3 Each Party shall be responsible for determining whether the Confidential Information and or any other information is exempt from disclosure or is to be disclosed in response to a Request for Information. However, the parties acknowledge and agree that they shall consult each other and take into account the other Party's views in relation to any Request for Information relating to the other Party's Confidential Information prior to any disclosure. The Parties acknowledge

and agree that a Party may be obliged to disclose Information following consultation with the other Party and having taken its/their views into account.

13 INTELLECTUAL PROPERTY

13.1 Nothing in this Memorandum of Understanding or any activity undertaken that is contemplated by this Memorandum of Understanding shall affect the ownership by any party of any Intellectual Property Rights it held immediately prior to this Memorandum of Understanding coming into effect ("**Pre–existing IPR**").

13.2 Each Party (the "**Granting Partner**") shall grant to the other Party a royalty free, non-exclusive licence to use its Pre-Existing IPR for as long as the Granting Partner remains a Party to this Memorandum of Understanding solely to the extent that this is necessary for the carrying out of the obligations in this Memorandum of Understanding.

13.3 Any Intellectual Property Rights created by the individuals in Roles or by the Parties in the course of the activities contemplated by this Memorandum of Understanding during the term of this Memorandum of Understanding ("**Shared Intellectual Property Rights**") shall be jointly owned by the Parties (as at the date of creation of the relevant Intellectual Property Rights).

13.4 Each Party:

13.4.1 shall not enter into any licence or other contract exploiting or disposing of the Shared IPR without the agreement of the other Party;

13.4.2 shall share any receipts produced by such exploitation with the other Party from time to time in the same proportions as their liabilities under clause 6.1.3 in respect of the person who created the Shared Intellectual Property Rights or if this cannot be readily determined 50/50.

13.4.3 shall grant to the Parties at the time of creation of the relevant Shared IPR a perpetual, non-terminable, royalty free, license to use the Shared IPR for the purposes of carrying out their statutory functions.

14 WARRANTY

14.1 Each Party warrants to the others that it has all necessary power and authorisation to enter into and be bound by the terms of this Memorandum of Understanding.

15 RELATIONSHIP OF THE PARTIES

15.1 The group arrangement itself does not have a legal personality and is not a partnership or joint venture. There shall be no agency as between the Parties and accordingly no Party shall be authorised to bind any other party.

16 CONFLICT OF INTERESTS

16.1 The Parties undertake to take all necessary measures in order to avoid any conflicts of interest during the performance of the Memorandum of Understanding, as well as to identify any conflicts of interest. If any of the parties has a conflict of interest then the party shall immediately consult with the regarding further actions.

16.2 Any conflicts of interest will be documented and registered by each Party.

17 GENERAL

17.1 Save as required by law, no publicity shall be made by any of the Parties relating to any matter in connection with this Memorandum of Understanding without the prior written consent of the other parties.

17.2 Each Party shall from time to time upon the request of the other(s), execute any additional documents and do any other acts or things which may reasonably be required to implement the provisions of this Memorandum of Understanding.

17.3 Any provision of this Memorandum of Understanding which is held to be invalid or unenforceable in any jurisdiction shall be ineffective to the extent of such invalidity or unenforceability without invalidating or rendering unenforceable the remaining provisions hereof and any such invalidity or unenforceability in any jurisdiction shall not invalidate or render unenforceable such provisions in any other jurisdiction.

17.4 The failure by a Party to insist upon the strict performance of any provision, term or condition of this Memorandum of Understanding or to exercise any right or remedy consequent upon the breach thereof shall not constitute a waiver of any such breach or any subsequent breach of such provision, term or condition.

17.5 No variation or agreed termination of this Memorandum of Understanding or of any document referred to in it shall be effective unless it is in writing and executed by both Parties.

18 NOTICES

18.1 Any notice given under this Memorandum of Understanding shall be in writing and may be given either personally or by first class post or email addressed to the other parties at their addresses set out at the Schedule to this Memorandum of Understanding.

18.2 A notice given by first class post shall be deemed to be served two Business Days after posting and proof that the envelope containing the notice was properly addressed and sent prepaid shall be sufficient evidence of service. Any email shall be deemed served on the day of sending if sent on a Business Day between 9.30 and 17.00, otherwise it shall be deemed served on the next Business Day.

19 THIRD PARTY RIGHTS

19.1 A person who is not a party to this Memorandum of Understanding shall have no rights pursuant to this Contracts (Rights of Third Parties) Act 1999 to enforce any term of this Memorandum of Understanding.

20 COUNTERPARTS

20.1 This Memorandum of Understanding may be executed and delivered in any number of counterparts, each of which is an original and which, together, have the same effect as if each party had signed the same document.

21 LAW

21.1 This Memorandum of Understanding is to be governed and construed according to English law (“Law”)and the English Courts shall, subject to the provisions at Clause 8 (Dispute Resolution) have exclusive jurisdiction.

SCHEDULE 1 – NOTICE PROVISIONS

Notice may be sent to the Parties at the following addresses:

Party	Address	Email
NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST	Chief Executive St Mary's Hospital London Road, Kettering, NN15 7PW	foundationtrust@nhft.nhs.uk
LEICESTERSHIRE PARTNERSHIP NHS TRUST	Chief Executive Bridge Park Plaza, Bridge Park Road, Thurmaston, Leicester, LE4 8PQ	LPTLegal@leicspart.nhs.uk

SIGNATURE PAGE

SIGNED by [NAME]

for and on behalf of **NORTHAMPTONSHIRE HEALTHCARE NHS FOUNDATION TRUST**

.....
(Signature)

SIGNED by [NAME]

for and on behalf of **LEICESTERSHIRE PARTNERSHIP NHS TRUST**

.....
(Signature)

M

Leicestershire Partnership NHS Trust

Quality Assurance Committee – 26th April 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	Detail included updated UKHSA Infection Prevention Control guidance - being managed through the Clinical Reference Group. There has been a recent increase in Covid19 outbreaks across the trust and a number of additional control measures, actions and learning continue to be identified in this area. The Flu and Covid Vaccination Programme campaign has closed with a 60% uptake. For Winter 22/23 Staff flu vaccinations uptake is a CQUIN and has a target of 70-90%. The Safeguarding Team continue to implement the Quality Improvement plan to ensure that the Trust is compliant with its statutory safeguarding duties. Patient Safety improvement plans to recover incident reporting trajectories Trust-wide are in place and a Quality Summit held in March focussed on Serious Incidents management systems and processes. The Community Mental Health Team Quality Summit was held on 7th March 2022 and considered the safety and effectiveness of the adult and older persons teams. Key areas of quality improvement were noted during the summit and a follow up summit is planned for May 21.	
Medical Director Update – Verbal Update	NA	There has been 100% recruitment to the core and higher trainee posts. International recruitment continues to be successful. Upcoming clinical leadership vacancies will test the market and the focus is on attracting high calibre external candidates. New clinical networks are developing at system level and Medical Directors, deputies and	

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
		associates are coming together in May to discuss a common engagement framework on clinical priorities for LLR.	
Director of HR Update – Paper D	NA	A new health and wellbeing lead had been appointed and is working closely with the HR team and the well-being guardian. There has been a deep dive into staff sickness with a focus on levels of stress and anxiety. The staff survey indicators suggest that staff are tired and burnt out. Support is offered to all staff with personal issues or work-related stress. A deep dive into workforce supply is looking at recruitment, attraction and transformational work including zero plus vacancies for HCSW and the administrative workforce.	
CQC Action Plan Assurance Report – Paper E	High	All actions are on track and factual accuracy checking from the inspection held on 28th February 2022 is now complete. There are an additional 3 'Must Do'' and 2 'Should Do' requirements which will be added to the action plan. Assurance was given on the monitoring of progress regarding the dormitory accommodation programme.	57, 62,
Annual MH report – CQC – Paper F	Medium	LPT has seen a decrease in satisfaction across a number of responses as identified by the CQC. These are being considered by DMTs and details of actions were appended to the report. The action plans in place will be regularly reviewed and integrated with work under the SUTG strategy. The response rate of the survey was 37% and there is a focus on improving this. QAC received medium assurance from the report due to the current LPT position and will receive quarterly updates on actions.	61, 75
Performance Report – Paper G	Medium	QAC considered the quality and workforce measures within the report. An increase in restrictive practices noted and it was confirmed that this was specific individuals considered in detail by the Incident Oversight Group. The quality dashboard is currently in development, and this will offer further information around quality indicators. For workforce metrics it was confirmed that there were programmes of work to support compliance against all the red indicators and there has been significant focus on these areas in the executive team meetings and at the SWC. All directorates have provided trajectories for their mandatory training	59, 60, 61, 63

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
		compliance. QAC received medium assurance from the report confirming that operational grip was evidenced but some areas remain off track.	
Pressure Ulcer Update & Trajectory – Paper H	Medium	In a benchmarking exercise, LPT was in the upper quartile of PU levels (4.6 per 100). High vacancy rates and sickness, only essential visits are factors and a national as well as local issue. As these reduce there is opportunity for improvement. Trajectories were not met in March but improvement is anticipated in April with a re-prioritised action plan. QAC requested consideration of the risk on the ORR. QAC received medium assurance from the report acknowledging the improvement plans in place and levels of oversight to address the risks.	60, 61, 63, 74, 75
CQUINS – Paper I	NA	The paper was presented for information detailing the 2022-23 CQUIN requirements. There are financial incentives attached to 5, one is the uptake of flu vaccinations.	
Annual Clinical Audit Report – Paper J	High	The paper which detailed last year's audit activity and QAC received high assurance from the paper which presented a positive picture of activity and outcomes.	57
SI Quality Summit Update – Paper K	Medium	An SI Quality Summit in March and considered the trust wide SI management processes, the number of open incidents and the delays in investigations. Workforce capacity and clinical resource was cited as a key challenge. All teams are identifying staff able to act as investigators with a plan to develop a register of investigators and improved use of the Ulysses system. QAC received medium assurance from the report with evidence of progress but assurance will be sought after a second summit.	57, 59, 60, 61
Freedom To Speak Up 6 Monthly Report – Paper L	High	The paper confirmed that there has been a decrease in staff using F2SU but there was a plan to increase the F2SUG resource and visibility. The staff survey shows positive responses in relation to F2SU questions.	73, 74
ORR – Paper M	High	The annual report and annual governance statement present a strong position. A new draft risk – ORR 80 – flu vaccination, will have QAC oversight. There has been a change to the wording in the safeguarding risk and a reduction in score ORR 62 – regulatory compliance. QAC approved the changes to the ORR.	57, 58, 62
Research and	High	There is a move away from covid research	

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
Development Quarter 3 Report – Paper N		towards a recovery resilience and growth agenda. The report details research results and their effects on staff and patients.	
EDI Strategy Refresh – Paper O	NA	Extensive consultation had taken place with service users and staff and that the paper contains pledges, principles and objectives. QAC suggested that more outcome measures would be useful and that it would be good to be consistent in the objectives. QAC endorsed the plan for presentation at Trust Board	73
Health and Safety Highlight Report 3rd March 2022 – Paper P	High	Progress continues on all priority areas including fire safety. Mandatory training compliance has been prioritised and the executive team are well sighted on this.	57, 59, 61, 63
Legislative Committee Highlight Report 30th March 2022 – Paper Q	Medium	Timely reports from directorates to LEG remains a challenge. Issues around MHA census data are a reflection of staffing. QAC received medium assurance from the report and will continue to receive MHA census data with the LEG highlight report.	57, 61, 62
Safeguarding Committee Highlight Report 9th February 2022 – Paper R	High	System work activity was ongoing and there was high assurance around the work and progress to date.	58
Quality Forum Highlight Report 10th March 2022 – Paper S	Medium	A verbal update on the April meeting was given. A separate RAG rating was applied to the agenda items for performance and quality improvement. SIs were rated red for current performance and amber from a quality improvement perspective due to plans from the summit. IPC cleaning was raised as an emerging issue with low assurance in this area, but plans are in place and there is robust executive oversight.	59. 78

Chair of Committee:	Moira Ingham

N

Leicestershire Partnership NHS Trust

Trust Board – 31st May 2022

Care Quality Commission Update

Purpose of the report

This report provides assurance on our compliance with the CQC fundamental standards, an update following the CQC inspection of the Trust over May/ June/ July 2021 and the reinspection in February 2022. An overview of current inspection activities is provided including an update on the CQC visit to the Mental Health Liaison Service as part of the Leicester, Leicestershire and Rutland System Urgent and Emergency Care Inspection in April 2022. The Trust continues to prioritise quality improvement, patient care and compliance with the Care Quality Commission (CQC) fundamental standards in all care delivery.

The CQC assurance action plan accompanies this report, to accurately reflect the achievements to date against the 'must do' actions. The action plan includes the 3 new must do actions following the reinspection in February 2022. The detail of these 3 new actions is being developed and will be submitted to the CQC by the 30th May 2022.

Analysis of the issue

CQC Inspection Activity

The CQC 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 have worked 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. MHA visits are also continuing.

Key inspection activity within LPT relates to:

1. Responding to the May/June/July 2021 inspection to ensure improvement actions are taken, embedded and learning is shared Trust wide.
2. Developing actions in relation to the reinspection of the acute adult mental health wards in February 2022 (report published 5th May 2022).
3. Participation in the urgent and emergency care system wide inspection April 2022.
4. Participation in CQC Mental Health Act inspections.

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 the 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 'must do' actions from the May/June/July 2021 inspection have been completed.
2. Estates and Facilities work in relation to dormitories remains on track.
3. Trust wide learning from the inspection is shared through various forums and also communications.
4. Three new 'must do' actions following the February 2022 inspection have been added to the action plan and the detail of these will be submitted to the CQC by the 30th May 2022.

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, actions 2 and 14 – call bells and action 12 - privacy and dignity.

The CQC published the Trusts report on Thursday 5th May 2022. The report identified a significant amount of progress on the acute mental health wards against the two domains of responsiveness and safety. The warning notices have also been removed. The acute wards for adults with mental health have improved from 'requires improvement' to 'good' for responsive and from 'inadequate' to 'requires improvement' for the safety domain. This is positive progress and whilst further work is to be done this re-inspection acknowledges the improvement actions undertaken.

The Trust has a deadline of the 30th of May 2022 to submit action plans in relation to the 3 identified must do improvement actions:

1. *The Trust must ensure that staff carry out regular testing of patient wrist worn alarms and fixed room alarms and that this is recorded as per Trust policy.*
2. *The Trust must ensure that risk assessments for wrist worn alarms are uploaded into the electronic patient care record as per Trust policy.*

3. *The Trust must ensure that for each patient who wears a wrist worn alarm a care plan is in place for its' use in the electronic patient record, as per Trust policy.*

Urgent and Emergency Care Inspection

The trust has participated in a system wide CQC urgent and emergency care inspection which encompassed services across Leicester, Leicestershire, and Rutland, including primary care. The inspection took place in April 2022. As part of this inspection the CQC inspected LPT's Mental Health Liaison Service which received positive informal feedback. The Trust is waiting for the formal draft report which will then go through the factual accuracy process.

Mental Health Act visits

There have been no further Mental Health Act inspections since February 2022.

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 alongside the updated position following the reinspection of the acute mental health wards.

Governance table

For Board and Board Committees:	Public Trust Board 31st May, 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:		
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 6th March 2022 Operational Executive Board 20th May 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	Updates	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.	12/08/21 Single dormitory programme has been reviewed - there is no potential for acceleration of the existing planned timescale. Agreed timeline for the programme of works progressing to ensure single dormitory provision is concluded by 2023. Actions taken to improve privacy and dignity and storage are detailed in MD7 and MD12.The estates programme is kept under review through monthly reporting to the Estates and Medical Equipment Committee (EMEC). The latest meeting on the 15/12/21 reported the dormitory reprovision programme continues to be on track for completion by 2023. The route of escalation for any ongoing concerns is to the Finance and performance Committee and Trust Board should any delays occur.	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.	A detailed action plan was developed immediately post inspection outlining immediate actions taken: **Risk assessment and wrist pits** 1. Established and confirmed that all acute wards have access to call bell alarm systems for patients and visitors and identified areas for further action. DMT sign off on 11/08/21 where further actions were agreed and guidelines were developed and put in place. 2. Risk assessment processes were strengthened. MDT Workshop held 17/08/21 to ensure oversight and co-ordination of delivery plan. Outputs of workshop were a) triangulation of patient safety data which showed no patient safety issues related to access to call bell alarm systems over past two years including via SIs and complaints. b) MDT clinical decision related to risk assessments of appropriate call alarm systems which was mobile -v- fixed. It was agreed to continue with mobile wrist based call alarm systems within Acute and Stewart House and Mill Lodge, as these are on a different alarm system. Guidelines and patient risk assessments were put in place by the 23/08/21 and this was confirmed 31/08/21 19/08/21 Additional wrist bands ordered - actions progressed: 1. Continued clinical risk management in line with Observation Policy and guidelines whilst wrist bands are on order. 2. Individual patient risk assessment developed with guidance for staff before provision of individual wrist pit. 27/09/21 - Half of the wrist pit order has been delivered. Awaiting the other half within the next 2 weeks. 06/10/21 - Outstanding wrist pits delivered. **Estates and survey** Estates arranged for a new site survey to be carried out by the provider. 19/08/21 - The Trust has placed a Purchase Order for the survey work at Bradgate / Bennion, requested for w/c 23/08/21. Pinpoint have confirmed that all other sites apart from Bradgate/Bennion have aerials/receivers which are compatible with new wrist fobs. 19/08/21 - Request made to confirm whether current systems are able to accommodate additional pit alarms at Belvoir ward and Herschel Prins	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	14/06/2021 – Site visit from gardeners and trimmed all bushes and shrubbery 09/07/21 Environmental checklist amended to include garden areas and communication shared with staff. 16/12/21 The quality tracker tool to be used on Step up to Great Quality Checks has been submitted to Quality and Safe meeting for sign off 16/12/21. All wards will have completed the first cycle of checks by end of January 2022 23/12/21 Quality and Safety Meeting cancelled due to response to Covid -19 pandemic Level 4. Email sent to the inpatient matrons with final version of the quality check attached. This included a reminder that each ward will have completed cycle 1 of the quality checks by end of January 2022. 07/01/22 Two non clinical staff identifed to commence audit work as Matrons now clinical in response to covid 19 pressures on ward staffing. Results will be monitored at Service line Quality and Safe meetings. 13/01/22 Audits have commenced. Two completed for Aston and Heather wards. On track for completing audits . 20/01/22 Additional staff identified to undertake the Quality Checks as the Matrons are supporting ward staffing due to escalation of Omnicron COVID-19 pressure. Plans received to demonstrate the checks will be complete by the deadline. 27/01/22 All wards have now participated in the 6 weekly step up to great quality round. Results will be collated and items not being delivered on are being escalated to Directorate Management Team meetings for ongoing assurance 31/01/22 Monitoring of ongoing compliance will form part of directorate level governance.	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	07/06/21 Review of PDSA cycle to improve risk assessment completed. Actions developed and embedded as part of QI work. 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. 23/12/21 Action on track. Questions have been added onto the tool in AMAT and ready for implementation in January 2022. 29/12/21 WeimproveQ Team emailed for screen shot evidence of questions added to the audit tool. 07/01/22 Ward audit results are now available on AMaT which will be monitored at Service line Quality and Safe meetings. 13/01/22 Audits are on track for completion by 31/01/22. 20/01/22 Wards have started to use the revised audit tool, all wards will have completed an audit by the end of January 2022 and based on outcomes a quality improvement plan will be developed to ensure full compliance. 31/01/22 Confirmation received all wards have completed an audit. Monitoring of ongoing compliance will form part of directorate level governance.	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	07/06/21 Review of PDSA cycle to improve risk assessment completed. Actions developed and embedded as part of QI work. 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. 30/11/21 The PDSA cycle now includes a process to monitor that risk assessments are being updated post incident. This is reviewed at the Risk Assessment Group. Awaiting evidence of results from audit cycle. 23/12/21 Action is on track questions have been added onto the tool in AMAT and ready for implementation for January 2022. 29/12/21 WeimproveQ Team emailed for screen shot evidence of questions added to the audit tool. 07/01/22 Ward audit results are now available on AMaT which will be monitored at Service line Quality and Safe meetings. 13/01/22 Audits are on track for completion by 31/01/22. 20/01/22 All wards will have completed an audit by the end of January 2022 and based on outcomes a quality improvement plan will be developed to ensure full compliance. 31/01/22 Confirmationn received that all wards have now completed a monthly audit. Monitoring of ongoing audits will form part of directorate level governance.	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	17/06/21 Doctors were reminded of their roles and responsibilities for seclusion reviews. 23/06/21 Individual reflection session with practitioner held regarding use of appropriate language. 25/06/21 CDM's were reminded that out of hours they have an oversight and coordination role for seclusion as per Seclusion Policy. 01/09/21 – Bite size training in relation to language used by staff has now been developed and rolled out. 02/11/21 – The audit was discussed at the Positive and Safe meeting 25/10/21. A meeting is planned to complete the update of AMAT questions, and a revised version will be taken to the November Positive and safe meeting for sign off. Local training planned for staff who have not had previous training on the policy for completion by end of January 2022. 23/12/21 Meeting has taken place with team leaders at The Willows and 4 dates have been agreed to complete training. 29/12/21 Need training dates as evidence and minutes of Rehab Positive and Safe meeting in November 07/01/22 November 2021 Positive and safe meeting minutes received 13/01/22 Training booked as planned. One date was cancelled due to the impact of Omicron Covid 19 and the focus on providing safe patient care. The AMAT tool has been revised. 20/01/22 Delivered 1 session as planned, one session missed due to technical difficulties with IT - session re-booked. No further episodes of seclusion since inspection to be able to reaudit. 27/01/22 Awaiting confirmation that all staff trained following additional training being delivered 31/01/22 Currently 8 out of 18 staff have received update training, 7 members of staff are unavailable due to long term sick. Further training sessions had been arranged but as this is enhanced training and not mandatory the service has had to prioritise the safety of patient care. The wards have been adversely affected with staffing shortages due to a direct impact of Omicron Covid-19 sickness as discussed with the CQC within engagement meetings. ORR risk number 63. 03/02/22 List of outstanding staff requring training has been reviewed. Training recommenced 22/02/22 All available staff have now completed this training. This leaves only the staff currently on sick	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	immediate review of storage and additional temporary storage boxes arranged. Workshop held to review improvements required. 17/08/21 - Outputs of workshop were a) Confirmed that there is adequate storage on Ashby ward dormitories, as each bed space has access to a wall mounted wardrobe with four shelves. b) On Aston Ward we have identified an additional room for the storage of larger items for the 12 patients in the 3 dormitories to have access. Ongoing co-production through ward community meetings of patient property management and storage. The additional storage identified at the Willows has already been scoped and awaiting confirmation of the dates for works to commence. 31/08/21- Aston ward - additional storage facilities now in place in a designated room on the ward. 03/09/21- . Bosworth ward received new furniture in one bedroom. This was used as a pilot for all other wards. 06/09/21 The shelving for Sycamore ward at the Willows commenced installation 13/09/21 - Bedroom furniture evaluated by staff and patients, positive feedback received and agreement to cascade the furniture out to all the new bedrooms in line with dormitory works 13/09/21 The shelving for Acacia ward at the Willows commenced installation 21/09/21 - Acacia ward and Sycamore ward shelving complete 27/09/21- Directorate now scoping additional furniture for all rooms. 05/10/21 - Thornton ward and Bosworth ward furniture being manufactured and to inform plans for other wards (Ashby and Aston to commence in line with dormitory reprovision works). 14 week turnaround timescale. 11/10/21 - Furniture installation now extended to include all appropriate rooms – approved by Directorate of Mental Health and Anne Scott (Executive Director of Nursing/AHP's & Quality). The additional furniture has been manufactured and is currently being installed in Thornton ward. Bosworth ward to be installed at completion of Thornton ward during 2 week decant period commencing 29/10. 01/11/21 -Tilbury Douglas have started the works as planned, completing one room at a time. Timescales + 8 weeks to complete 08/11/21 - Thornton ward furniture upgrade complete. 15/11/21 - Bosworth ward furniture upgrade complete.	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	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards	08/06/2021 MDT review of individuals care plan undertaken Additional review completed 22/06/2021 Review of welcome packs undertaken by Equality and Diversity and Inclusion Lead and ward provided with the most up to date version. 30/11/21 The Amat Tool has been changed to identify the frequency of expected audits reflecting the nature of the patient group. 16/12/21 narrative sent to WeimproveQ to be add to collaborative care planning review tool which will be completed and started to be used by 01/01/22 29/12/21 Email sent to WeimproveQ team for screen shot evidence of AMaT tool including audit questions on equality and diversity needs. 04/01/22 Screen shots of amended AMaT tool received. 07/01/22 Willows welcome pack now in use, audits using new tool to commence which will be monitored at Service line Quality and Safe meetings. 13/01/22 AMAT tool amended and audits underway 20/01/22 The questions are on AMAT and wards have started to use the revised audit tool, all wards will have completed an audit by the end of January 2022 and based on outcomes a quality improvement plan will be developed to ensure full compliance. 31/01/22 Confirmation received that all wards have completed the monthly care plan audit. Ongoing monitoring of audits to be part of directorate governance oversight. 03/03/22 - second round of 6 weekly checks due by 18/03/22 and to provide updated results by end of March. 17/03/22 - Awaiting AMAT report to review question regarding protected characteristics. One round already completed and outputs from 2nd round of 6 weekly checks to be provided as evidence by end of March. 24/03/22 A further round of care plan audits have been completed using the amended AMAT audit tool which includes questions of meeting the equality and diversity needs of patients. Learning from this has also involved revising the guidance for staff on how to complete the audits more effectively.	Closed

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	20/10/21 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. 10/11/21 Taste testing sessions took place at the Beacon Unit. 10/12/21 Minutes from the Nutrition Group are required detailing steps taken to evidence progress on this action. 16/12/21 Nutrition group meeting 16/12/21 received up to date patient feedback. Nutrition Group meetings have increased to monthly from quarterly. Amended feedback form is now discussed directly with clinical team for immediate actions to be taken. SOP to be devised to address how to escalate concerns in and out of hours to Catering. Independent Food review of our menus will be undertaken by the end of March 2022 with gaps identified and capital bids submitted to address the gaps. 23/12/21 Colin Bourne attended the Nutrition Group Meeting on 16/12/21 and provided feedback from mental health rehabilitation in-patients to the group. Colin will continue to attend and to provide feedback and link to ward. 29/12/21 Rehab food tasting sessions planned- Stewart House 25/01/22, Willows 26/01/22 06/01/22 Confirmed taste testing sessions will be prioritised to go ahead. 13/01/22 Food tasting sessions to continue as planned. Helen Walton will escalate any delays 19/01/22- Willows taster session has had to be postponed due to an outbreak of Covid 19 on the ward. The session will be re-arranged.	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	Ward sisters/Charge Nurses have been 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 January 2022. 16/12/21 staff training needs mapped out. MHA -Stewart House 73%, Acacia 59%. MCA - Stewart House 84%, Acacia 83%, Maple 83% 23/12/21. All staff reminded to complete all mandatory training including MHA 29/12/21 Evidence received all staff have been reminded to undertake training. 06/01/22 Training figures to be provided with comparison of ratio from July 2021 and current. 13/01/22 Evidence shows varying degrees of compliance. Discussed at DMH DMT and decision made to priroritise new starters. Mandatory training will continue to be available and staff booked on. In light of current staffing challenges and risk to patient safety due to the impact of Omicron Covid, some mandatory training for staff may be delayed. 20/01/22 Agreed this will be placed on Risk Register re: ability to meet the action deadline due to the inability to release staff. Wards will prioritise providing safe patient care. 27/01/22 Await an update on current position as this action is at risk of not achieving the deadline. Training compliance report for the 1st February 2022 required. 31/1/22 The service has had to prioritise the safety of patient care as the wards experienced staffing shortages due to impact of Omnicron Covid-19 sickness discussed with the CQC within engagement meetings. ORR risk number 63.New deadline proposed to executive board for approval 03/02/22 Workforce agreed to revert to providing the bespoke training reports for the next 6 months whilst training compliance is addressed and improving. The reports will also detail staff non-attendance. DMH to roster staff on to attend training as part of roster planning. 04/02/22 - Executive Board approved new deadline of 28/02/22. From 7/02/22 there awill be twice weekly training huddles to review planned training for staff on each ward. Ability to release staff for training or non-attendance will be checked at the daily safer staffing huddles. 23/02/22 All remaining available staff have completed their MHA training. There are 2 members of staff who are currently not available due to being on Maternity or long term sick leave, who will complete the	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	17/08/21 Outcome of the MDT Workshop held : soundproofing including physical partitioning considered, it was confirmed that soundproofed curtains and physical partitioning would not meet the Fire, IPC and ligature risk requirements. Patients have access to lockable personal storage. We have also reviewed the safety risk assessments to ensure choice is included as a consideration and where personal care/physical care is required. Daily Environmental Checklist completed. Revised Privacy and Dignity Audit confirmed on 19/08/21. Monthly spot check audit commenced. Progress is being made to improve response timeframes. Communication sent to all staff regarding update on privacy and dignity and their responsibilities w/c 23/08/21 31/08/2021- Ward sister DMH meeting- new process in place that privacy and dignity issues are being prioritised by facilities team. They will prioritise hanging curtains if the wards highlight it is a privacy and dignity issue. 14/10/21 Completed privacy and dignity audits paper presented at Quality Forum. 08/11/21 Privacy doors between male and female place at Stewart House are in place. **Signage** 3/12/21 Patient Experience, and carer lead to ask the patients by experience group to consider wording for the signs. 7/12/21 Email sent to MH Ward Sisters and Charge Nurses to ask them to consult current inpatients on wards about the privacy and dignity signs for bedrooms/ curtains - email evidence attached. Feedback to be received by 21/12/21 for discussion and decision on wording at the Lead Nurses meeting on 22nd December 21. **Laundry** Initial review of laundry facilities completed, further scoping to determine extra capacity required. 23/08/21 - Review delayed by a week by external contractor 31/08/21- Scoping exercise complete 10/09/21 - Works end date requested from Tilbury Douglas 05/10/21 - Confirmation received that expected timescale of works is 8 weeks for both to be completed . 11/10/21 - Following Fire Officer review, this initial scope has been enhanced and 2 laundry rooms are now	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	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. 07/12/21 The admission checklist has been amended and sent to the inpatient Matrons. The updated form will be taken to the next quality and safety meeting on 21 December 2021 for sign off. 07/12/21 Ward booklets issued and will be updated due to NHS.net migration. 10/12/21 Evidence of the admission checklist audit required in January 2022 16/12/21 Checklist amended and provided as evidence, to be submitted to Quality and Safe meeting for sign off 21/12/21 23/12/21 Quality and Safe meeting cancelled due to Level 4 response to Covid -19 pandemic. Checklist approved by Chair outside of meeting and to be circulated. Information for informal patients has been sent to all Matrons. Communications and engagement officer will be completing a review of all patient facing leaflets. Agreed that an audit will be completed by Carol Scarborough and Apexa Patel in January 2022. 06/01/22 Audits to commence week commencing 10/01/22 20/01/22 Spot check tool has been developed to check leaflets are offered on admission. 31/1/22 Spot checks results for January 2022 received. Monitoring of ongoing compliance will form part of directorate level governance.	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	29/06/21 1 Ward sisters/charge nurse check each week any works required to Ward are logged on the ward spreadsheet and any outside the timescales (as specified in the estates flowchart) are escalated to Dave Wright, Acting Site Manager and the spreadsheet is updated with details of escalation. 13/07/21 – Spreadsheet has been tidied up and ward sisters/ charge nurses have been contacted to discuss individual wards and setting up meetings to review outstanding jobs. Thornton jobs have been reviewed and a meeting is scheduled with Heather on 19/07/21. 21/09/21 Work is cotinuing with the wards to update logs and escalate all jobs over the 21-day SLA to estates. 05/10/21 – The number of outstanding jobs has reduced significantly. A meeting took place 04.10.21 to discuss outstanding issues. 23/11/21 First draft of Step up to Great Quality Checks sent to Head of Nursing for sign off. This quality check has had a question added about garden/courtyard spaces as follows: •Has the ward environmental checklist been completed? •Were any identified issues from the checklist escalated/managed appropriately? •Has the environmental checklist been signed off by the Ward Sister/Charge Nurse? 07/12/21 This Quality check will go to the next Directorate Quality and Safety Meeting on 16th December, with roll out from 20th December, all wards will have been completed by end January 2022. 23/12/21 Quality and Safe Meeting cancelled due to Level 4 response to the Covid -19 pandemic. Email sent to the inpatient Matrons with final version of the quality check attached, with a reminder for each ward to have completed cycle 1 of the quality checks by end of January 2021 04/01/22 Email received confirming that there is a process in place whereby centralised spreadsheets are reviewed weekly, the process is effective as the majority of maintenance requests are now up to date. 06/01/22 Two non clinical staff identifed to commence audit work as Matrons providing clinical support to the wards in response to covid 19 pressures on ward staffing. 13/01/22 Audits have commenced. 20/01/22 Plans received to demonstrate the checks will be complete by the end of Jan 2022. 27/01/22 All wards have now participated in the 6 weekly step up to great quality round.	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 PICU 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	**1. Incidents**Directorate plan is in place for all outstanding incidents for Acute and PICU Services are being reviewed and will be signed off by the 31/01/22 07/12/21 Significant work has been undertaken to reduce the backlog such that only Beaumont and Watermead have historic EIRF's open that need actioning. The team manager and band 6s are allocating time to close outstanding EIRF's. A EIRF completion guide has been developed by the team manager to support the process and prevent any incidents exceeding 15 days without sign off for sustainability. 23/12/21 Bradgate mental health wards have progressed historical eirfs with a small number outstanding. Currently on track. Eirf system being used and monitored by team manager to highlight areas of concern each week to prioritise resources when close to breaching 15 day sign off target. 31/12/21 Need evidence from Directorate or IOG that outstanding incidents are decreasing. 06/01/22 DMH incident report submitted to the Incident Oversight group received. 13/01/22 Reviewing of timely incidents. Reduction in backlog of incidents, awaiting data for evidence. 19/01/22 Currently 137 incidents awaiting closure for PICU and acute wards. Plan in place to address these and developing sustainability plan to ensure processes are in place for timely closure going forward. 27/01/22 Confirmation received from Incidents Team only 2 incidents requiring sign off. 28/1/22 Confirmation received that the 2 outstanding incidents are closed **Action 1 closed and Green** **2. Training** Incident management update training is being provided to all ward sisters / charge nurses and deputies to be completed by the 31st Jan 2022. Session delivered ot Foundations for Great Patient Care on incident closure cross trust 24/11/21 16/12/21 Incident review training cancelled by CPST, training to be re-arranged Training booked in for 28/12/21 06/01/22 Additional training dates for band 6 and 7 ward staff arranged. 19/01/22 Further training session to be arranged for remaining charge nurses and deputies. Thornton, Belvoir, Ashby, Aston attended training. Awaiting potential dates from patient safety team for week	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	16/06/21 Ward sisters/ Charge Nurses reminded of the expectations of checking and searching when patients are returning from leave: 08/06/21 Training figures sent to ward sisters charge sisters on asking them improve compliance over the next few months. 02/1/21 – Improved compliance highlighted in the draft Nov 2021 training report however Ashby and Watermead remain under 85% compliance. Staff members have been contacted individually; some have now completed however team manager is collecting evidence as to why this is not reflected on the report. Ongoing compliance to be monitored. 03/11/21 Spot checks have been carried out over the past 3 months. Recent check indicated only 1 patient did not have a have a care plan. To move into 6 weekly Matron quality checks for sustainability. 23/11/21 First draft of Step up to Great Quality Checks sent to Head of Nursing for sign off. This quality check has had a question added about garden/courtyard spaces as follows: •Patients who smoke or secrete contra-band have a care plan detailing the checking and searching requirements •The wards are using the lighter checklist 07/12/21 This Quality check will go to the next Directorate Quality and Safety Meeting on 16th December 2021, with the plan to roll out from 20th December 2021, so all wards will have been completed by end January 2022 23/12/21 Quality and Safe Meeting cancelled due to Level 4 response to the Covid -19 pandemic. Email sent to the inpatient Matrons with final version of the quality check attached, with a reminder for each ward to have completed cycle 1 of the quality checks by end of January 2022 06/01/22 Two non clinical staff identifed to commence audit work as Matrons clinical supporting the wards in response to covid 19 pressures. 13/01/22 Audits have commenced. 20/01/22 Additional staff identified to undertake the Quality Checks due to the capacity of the Matrons with support regarding situation in relation to COVID-19. Plans received to demonstrate the checks will be complete by the end of Jan 2022.	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	23/07/21 Lead psychologist post interviewed and appointed. Once in post recruitment to wider team to be completed. Since the CQC visited staffing has increased by 4.0wte (8c lead and 3 Band 4 Assistant Psychologists) 01/09/21 – both band 3's and 5 appointed to and in post. Further recruitment will be ongoing due to staffing changes. 3/12/21 Request made for additional agency cover for 2 wte Band 8a psychologists. 09/12/21 - Inpatient OT vacancies for Band 3, 5 and 6 have been advertised with interviews on 9/12/21. Any posts not filled will be re-advertised by the end of December 2021. 5 of the 8 B3 OTA posts have been recruited to. Rehabilitation - The CERT B6 and B3 posts have now been successfully recruited to. 09/12/21 Recruitment plan for psychology posts updated with further adverts to go out . 10/12/21 Evidence required that recruitment continues through December 2021 16/12/21 No applicants as yet for advertised posts. Posts to be re-advertised week commencing 20/12/21. Chief Psychological Officer job description submitted for Agenda for Change. This will strengthen future recruitment. OT posts currently out to advert. 23/12/21 Re-advertised B8a vacancies - evidence received (link to job advert) 13/01/22 Recruitment to Psychology Post unsuccessful therefore readvertising. OT posts recruited to successfully. 20/01/22 Recruitment underway for both Psychological Therapies staff and OT 27/01/22 All OT posts recruited to remaining Psychology posts out to advert 03/02/22 All Psychology and OT posts have been recruited to and are in the onboarding stage 17/02/22 All posts recruited to, accepted and awaiting start dates	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	Ward Sisters / Charge Nurses have been implementing 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. 16/12/21 Ward Sisters / Charge Nurses now have access to book staff onto training. 06/01/22 Head of nursing reviewing all training data with comparison of compliance from inspection to current figures. Impact of current pressures on ward staffing in light of emerging increasing incidence of Covid and required Trust response to Level 4 actions acknowledged. 13/01/22 Evidence shows varying degrees of compliance. Discussed at DMH DMT and decision made to prioritise new starters. Mandatory training will continue to be available and staff booked on. In light of current staffing challenges due to Covid and risk to patient safety some mandatory training for staff may be delayed. 20/01/22 Agreed that this will be put on Risk Register for meeting the deadline to complete training due to being able to release staff. 27/01/22 Await an update on current position. 1st February 2022 compliance report needed 31/01/22 The service has had to prioritise the safety of patient care. The wards have been adversely affected with staffing shortages due to impact of covid-19 sickness. ORR risk number 63. New deadline proposed to executive board for approval. 04/02/22 - Executive Board approved new deadline of 28/02/22 - as discussed with the CQC within engagement meetings. 7/02/22 Twice weekly training huddles have been implemented to review planned training for staff on each ward. Ability to release staff for training or non-attendance will be checked at the daily safer staffing huddles 23/02/22 All available Acute and PICU staff are compliant or booked on to mandatory training including MHA. All unavailable staff due to maternity or long term sick leave will complete the training on their return to work.	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	Ward Sisters / Charge Nurses have been implementing 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. 16/12/21 Ward Sisters / Charge Nurses now have access to book staff onto training. 23/12/21 - Charge nurses booking staff on training; training is future dated so returns not immediately available. Wards have been requested for updates in terms of numbers booked and several wards have booked all outstanding staff on future training already. Training compliance is closely monitored bi-weekly to track progress against each ward. Progress from 1st Dec – 15 Dec is minimal, this should improve over the weeks following staff attendance. 06/01/22 Head of nursing reviewing all training data with comparison of compliance from inspection to current figures. Impact of current pressures on ward staffing in light of emerging increasing incidence of Omicron covid and required Trust response to Level 4 actions acknowledged. 13/01/22 Evidence shows varying degrees of compliance. Discussed at DMH DMT and decision made to prioritise new starters. Mandatory training will continue to be available for booking. In light of current staffing challenges and risk to patient safety some mandatory training for staff may be delayed. 20/01/22 Agreed that this will be put on Risk Register for meeting the deadline to complete training due to being able to release staff. 27/01/22 Await an update on current position. 31/01/22 The service has had to prioritise the safety of patient care. The wards have been adversely affected with staffing shortages due to impact of covid-19 sickness. ORR risk number 63. New deadline proposed to executive board for approval. 04/02/22 - Executive Board approved new deadline of 28/02/22 - as discussed with CQC during engagement meetings. 7/02/22 twice weekly training huddles implemented to review planned training for staff on each ward that week. Ability to release staff for training or non-attendance will be checked at the daily safer staffing huddles 24/02/22 All available staff have completed or are booked on to MCA training.	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	Ward Sisters / Charge Nurses have been implementing 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 16/12/21 Ward Sisters / Charge Nurses now have access to book staff onto training. 23/12/21 - Charge nurses booking staff on training; training is future dated so returns not immediately available. Wards have been requested for updates in terms of numbers booked and several wards have booked all outstanding staff on future trainings already. Training compliance is closely monitored bi-weekly to track progress against each ward. Progress from 1st Dec – 15 Dec is minimal, this should improve over the weeks following staff attendance. 06/01/22 Head of nursing reviewing all training data with comparison of compliance from inspection to current figures. Impact of current pressures on ward staffing in light of emerging increasing incidence of Omicron covid and required Trust response to Level 4 actions acknowledged. 13/01/22 Evidence shows varying degrees of compliance. Discussed at DMH DMT and decision made to prirortise new starters. Mandatory training will continue to be available and staff booked. In light of current staffing challenges as a direct impact of Covid and risk to patient safety some mandatory training for staff may be delayed. 20/01/22 Agreed that this will be put on Risk Register for meeting the deadline to complete training due to being able to release staff. 27/01/22 Await an update on current position 31/01/22 The service has had to prioritise the safety of patient care. The wards have been adversely affected with staffing shortages due to impact of covid-19, sickness. ORR risk number 63.New deadline proposed to executive board for approval. 04/02/22 - Executive Board approved new deadline of 28/02/22 - as discussed with the CQC during engagement meetings. 7/02/22 twice weekly training huddles implemented to review planned training for staff on each ward . Ability to release staff for training or non-attendance will be checked at the daily safer staffing huddles 24/02/22 All available staff have completed or are booked on to BLS and ILS training.	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. 04.04.22- Rapid tranq : 86.20% (13/15) 2 staff	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	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. For sustainability training and rapid tranquilisation are discussed at unit meetings. 16/12/21 All available staff have undertaken training. 23/12/21 One new starter in progress of completing rapid tranquilisation training. Audits completed -on physical health checks. 31/12/21 Rapid tranquilisation training - 87% 06/01/22 No episodes of rapid tranquilisation used in December 2021, only Preceptee staff remaining to complete training. 13/01/22 Waiting for one member of staff to complete. Two staff members not available. 20/01/22 Confirmation received that final available staff member has completed RT training. RT audit received 17.1.22 27/01/22 Evidence received that all available staff have completed training 31/01/22 Monitoring of ongoing compliance will form part of directorate level governance. 13/03/22 No incidents of rapid tranquilisation throughout February. Rapid Tranquilisation:86.7% 13/15 staff members (2 staff members completed but not showing on system, ward manager has emailed L&D asking to reflect in uLearn)	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	25/11/21 All available remaining staff are booked onto life support training. 09/12/21 - ILS 66.7% on Trust compliance report. 10 out of 11 currently available staff are trained. Further support has been put in place for one staff member to help them achieve their competencies. BLS - 72.5% on Trust compliance report - 30 ot 40 staff complete all other available staff are booked on. 16/12/21 Positive trends in training - need evidence 23/12/21 Update: ILS 10/15 (2 booked and 3 unavailable). BLS - issue with non-attendance / sickness. 31/12/21 ILS - 67% (maximum that can be achieved is 80% due to staff not available) BLS - 75% (anomolies identified with reporting) actual figure 83% 06/01/22 BLS training now 80.5%, ILS 71% of available staff showing steady improvement. 13/01/22 - ILS 9 out of 12 staff are compliant (2 unavailable) one member of staff has failed 3 tims and due to resit on 17/01. BLS remains at 80.5%. 7 staff remain non-compliant, one on long term sick. 4 staff booked on this morning (one DNA'd) and need confirmation of other 3 booked on in January. 14/01/22 3 remaining staff to complete BLS, 1 booked for 17th Jan and 2 are not available 20/01/22 ILS - no change, one person still to complete. BLS - Remaining available staff now completed therefore full compliance of available staff 27/01/22 BLS now at 92% all available staff have completed the training. ILS now at 85% which equates to 12 out of 14 staff in data with remaining 2 staff currently unavailable to complete training due to absence. Therefore all available staff have completed training. 31/01/22 Monitoring of ongoing compliance will form part of directorate level governance. 13/03/22 ILS training compliance for February: 80%- 13 out of 15 staff members have completed the training (this is all available staff, 1 completed 7th March and 2 staff members are off sick). BLS training compliance for February: 92.1%, Staff member booked for 29th March. New starter- started 7th March, booked 25th march. 1 x staff member was sick, rebooked 22nd April 04/04/22- BLS- 92.10% and ILS 80% (12/15) 2 staff unavailable, 1 booked 22nd April and 1 new starter. Actual = 93.33% Rapid tranq : 86.20% (13/15) 2 staff unavailable	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		Guidance on how to monitor side effects and complete the template on SystmOne has been implemented and shared with the team. 25/06/21 A laminated flow chart is on display in relevant clinical areas. 09/12/21 - 3 Rapid Tranquilisation's in November 2021 all of which have been audited and care in line with NICE guidance. 16/12/21 To be discussed in Directorate Operational Meeting 21/12/21 23/12/21 Discussed in Operational Meeting and DMT minutes will be provided. Since update on Audit of records in November 2021, no further episodes of seclusion. 31/12/21 Evidence of completed audits received 06/01/22 No episodes of rapid tranquilisation during December 2021. 13/01/22 Still no episodes of rapid tranquilisation. One episode of seclusion. 20/01/22 90.7% compliance with seclusion audit Jan 2022 27/01/22 Evidence received - Rapid Tranquilisation audit form 17.01.22 31/01/22 Monitoring of ongoing compliance will form part of directorate level governance.	Closed
MD25 - reinspection Feb 2022	The Trust must ensure that staff carry out regular testing of patient wrist worn alarms and fixed room alarms and that this is recorded as per Trust policy. Regulation 12(1)(2).	Testing of patient alarms	Acute / PICU	The testing of patient wrist worn alarms will be completed and recorded ****** as per Trust Policy. Fixed room alarms will be tested and recorded ******* as per Trsut Policy.			Fiona Myers / Michelle Churchard Smith					
MD26 - reinspection Feb 2022	The Trust must ensure that risk assessments for wrist worn alarms are uploaded into the electronic patient care record as per Trust policy. Regulation 12(1)(2).	Risk assessments for patient alarms	Acute / PICU	Completed patient risk assessments for the use of wrist worn alarms will be uploaded onto SystmOne as per trust Policy.			Fiona Myers / Michelle Churchard Smith					
MD27 - reinspection Feb 2022	The Trust must ensure that for each patient who wears a wrist worn alarm a care plan is in place for its' use in the electronic patient record, as per Trust policy. Regulation 12(1)(2).	Care Plans for patient alarms	Acute / PICU	SystmOne will document an up to date care plan for each patient risk assessed for the use of a wrist worn alarm.			Fiona Myers / Michelle Churchard Smith					

O

Leicestershire Partnership NHS Trust

LPT Public Trust Board

LPT Urgent & Emergency Care LLR System Inspection feedback (Psychiatric Liaison Service at LRI)

Purpose of the report

The purpose of this report is to share feedback from the CQC following feedback received as part of LLR CQC system review on Urgent and Emergency care which focused upon the Psychiatric Liaison Service, run by Leicester Partnership Trust, based at Leicester Royal Infirmary Hospital.

Analysis of the issue

The CQC are carrying out a system wide review of Urgent & Emergency Health and Care services in Leicester, Leicestershire and Rutland. As part of this review, they recently carried out an unannounced and focused inspection of the Psychiatric Liaison Service, run by Leicester Partnership Trust, based at Leicester Royal Infirmary Hospital.

A copy of the initial findings from this inspection accompanies this report.

Proposal

The key initial findings from the unannounced inspection of the Psychiatric Liaison Service recognise:

- A full complement of staff with no vacancies.
- All areas were very clean, fresh smelling, fit for purpose and access to 'high risk' room in adult ED.
- A high level of training, supervision and appraisal compliance.
- The team met agreed service standards.
- Staff working within best practice guidance.
- Staff participated in daily in Bed Management meetings and meetings between stakeholders to ensure flow between services was effective.
- Staff were proud to work within the team and showcase their work they did. A high level of staff morale and evidence of effective team and inter agency working.
- Staff were constantly looking at ways to improve their work and the patient experience.

Areas to address

- Average wait times for patients presenting with a mental health crisis or with specific mental health needs

The operational teams are reviewing their waiting time as an ongoing action and this will be tracked through the Directorate Management Team meetings.

Decision required

The Trust Board is asked to note the feedback received following this unannounced inspection.

Governance table

For Board and Board Committees:	Trust Board, 31st May 2021	
Paper sponsored by:	Angela Hillery, CEO	
Paper authored by:	Sinead Ellis-Austin, Senior Business Manager	
Date submitted:	24th May 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	One-off	
STEP up to GREAT strategic alignment*:	High **S**tandards	Yes
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	Yes
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trustwide 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	

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

By Email: Angela.Hillery@leicspart.nhs.uk

Our reference: INS2-12880712221

Angela Hillery
Chief Executive
Leicestershire Partnership NHS Trust
Bridge Park Plaza
Bridge Park Road
Thurmaston
Leicester
LE4 8BL

13 April 2022

CQC Reference Number: INS2-12880712221

Dear Angela,

Re: CQC inspection of Mental Health Crisis Services – Psychiatric Liasion Team

I thought it would be helpful to give you some written feedback following our inspection of psychiatric liasion services at UHL, Leicester Royal Infirmary that took place on 12 April 2022.

We explained that this inspection was unannounced and focused. Our inpsection was completed to assist with a sytem wide review of Urgent and Emergency health and care services in Leicester, Leicestershire and Rutland. We looked at how the psychiatric liaision team influence patient flow within the system,

This letter does not replace the draft report and evidence log we will send to you, but simply confirms initial findings and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence log, this correspondence should be used to inform discussions with the board.

An overview of our feedback

- There is a full complement of staff with no vacancies. We were pleased to hear about additional posts going out to recruitment such as pharmacist, drug and alcohol worker, a domestic violence specialist, and four care navigator.
- All areas were very clean, fresh smelling, fit for purpose and access to 'high risk' room in adult ED. All assessment rooms had good visibility, staff support if required and a shutter that was able to be drawn down to seal off ligature and equipment risks to make the room 'safer' for high risk patients. We saw this in operation.
- We noted a high level of training, supervision and appraisal compliance.
- The team met agreed service standards. The service can be accessed regardless of home address. We saw an exemplar of interagency working and high standard of consistent care with the managemtn of a patient from Scotland who needed ot access care.
- We saw staff worked within best practice guidance.
- Staff participated in daily in Bed Management meetings and meetigns between stakeholders to ensure flow between services was effective.
- All staff we spoke with were proud to work within the Liaison Team and proud to showcase the work they did. They said they loved their jobs and the service they provided – we saw high level of staff morale and evidence of effective team and inter agency working. This was also evidenced in the patient records we looked at.
- Staff we spoke with were constantly looking at ways to improve their work and the patient experience.

However, we noted one issue that could be improved.

- We found the average wait times for patients presenting with a mental health crisis or with specific mental health needs were between 1.5 hours and 1.9 hours. This was because EDU 'batch' refer sending four or five referrals at a time rather than when they arrive. We were aware the local commissioning groups had not set targets for wait times.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to th Head of Inspection leading on the system wide Urgent and Emergency Care inpsection.

Could I take this opportunity to thank your staff at the Psychiatric Liasion teamwho weloemd our inspection team and were responsive and cooperative to their requests.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

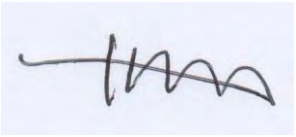
Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne

NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely



Tracy Newton

Inspection Manager

c.c. Philippa Styles, Head of Inspection, UEC
Craig Howarth, Head of Inspection, MH Midlands

P

Leicestershire Partnership NHS Trust

Public Trust Board – 31 May 2022

Safe Staffing- February 2022

Purpose of the report

This report provides a full overview of nursing safe staffing during the month of February 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.

During the month there was a two-week school holiday period 14-27 February 2022. Due to significant staffing challenges the twice weekly Trust safe staffing and safety cell huddles were stepped up to daily on the 14 February 2022. A safe staffing and patient safety review is to be carried out and presented to the Operational Executive Board in March 2022.

Analysis of the issue

Right Staff

- Temporary worker utilisation rate increased this month; 2.02 % reported at 45.1% overall and Trust wide agency usage slightly increased this month by 0.91% to 20.54% overall.
- In February 2022; 29 inpatient wards/units utilised above 6% agency staff to meet safe staffing levels, this equates to 90.62% of our inpatient Wards and Units, changes from last month include Stewart House.
- 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 are, Beacon unit, Agnes unit, Mill Lodge, Willows, Griffin, Kirby, Wakerley, North and East wards, Beechwood and Clarendon.
- The key 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, 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 March 2022 Trust wide substantive staff;
    - Appraisal at 72.5% compliance AMBER
    - Clinical supervision at 72.8% compliance RED
    - All core mandatory training compliance GREEN except for Information Governance AMBER at 91.7% and Infection Control Prevention (level 1) AMBER at 79.1%
- Clinical mandatory training compliance for substantive staff, to note.
    - BLS decreased compliance by 24.6 % to 63.2%compliance RED
    - ILS decreased compliance by 27.4% to 53.9% compliance RED
- Clinical mandatory training compliance for bank only workforce remains low.
    - BLS 43.7% at RED compliance
    - ILS 34.4% 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. During the pandemic a temporary extension of 6 months was added to each training topic compliance period. On the 1st of March 2022 the 6-month extension will be removed for clinical face to face training, with all other topics following suit on 1st April 2022. There are Learning & Development operational actions plans and each directorate is undertaking a deep dive into their services. Significant activity is underway to ensure training compliance improves across the trust.

Right Place

- The Covid-19 risk managed wards are North and Sycamore (Willows). 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 co- horting.

- 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 17.55 CHPPD in February 2022, with a range between 4.7 (Stewart House) and 79.0 (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	4.8%	0.1%	0.3%	5.2%
Enabling Services	2.0%	0.2%	0.2%	2.3%
FYPC	3.4%	0.1%	0.2%	3.6%
Hosted Service	1.4%	0.0%	0.0%	1.4%
Mental Health Services	4.9%	0.2%	0.4%	5.5%
LPT Total	**4.0%**	**0.1%**	**0.3%**	**4.4%**

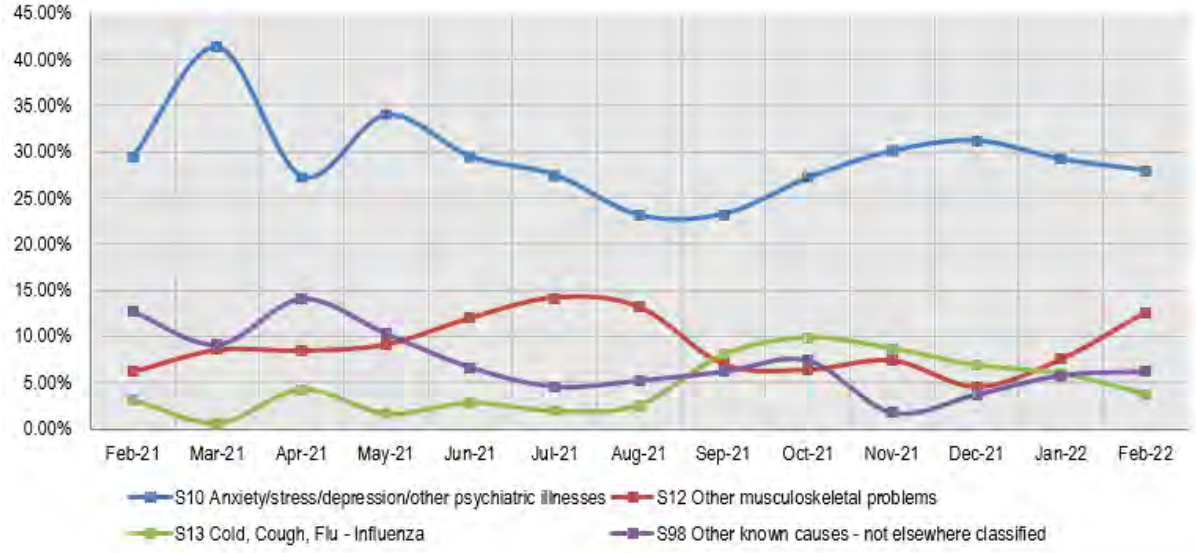
Table 1 – COVID-19 and general absence – 31 February 2022

In comparison to the previous month total absence has decreased by 3.2% associated with a decrease in general absence overall.

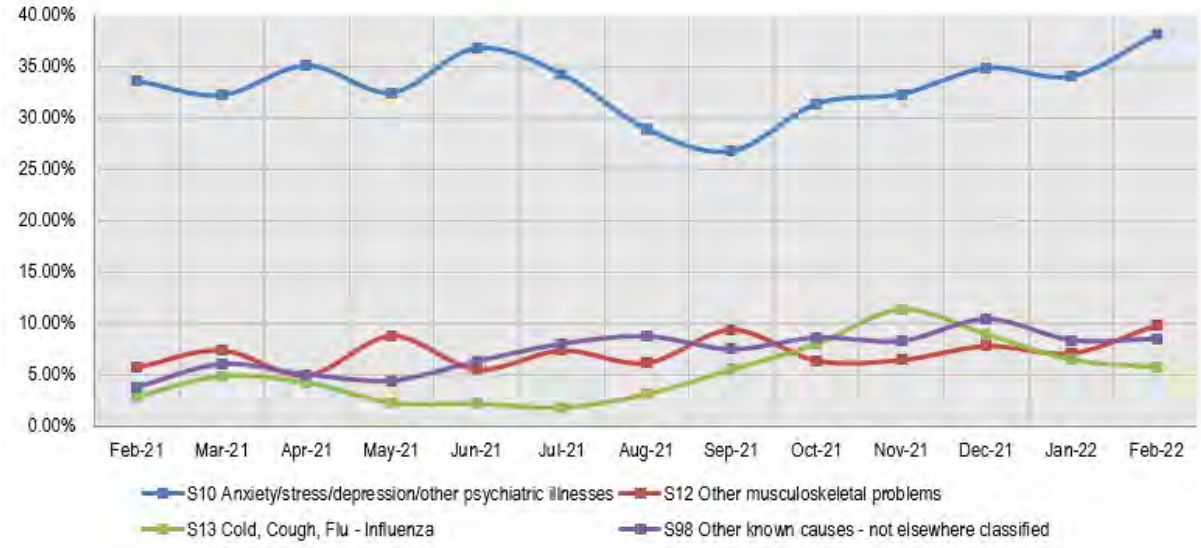
- Work pressure has been identified as an area of focus in response to the National Staff Survey 2021. A deep dive into absence due to stress, anxiety and/or depression to identify any correlations with work pressure and actions is underway and will be presented to Quality Assurance Committee (QAC) in April 2022. Absence across clinical directorates has in the main been higher throughout 2021/22 when

compared to 2020/21. Anxiety, stress, and depression has been the highest identified cause of absence across the Trust for a significant period of time, as per Directorate below.

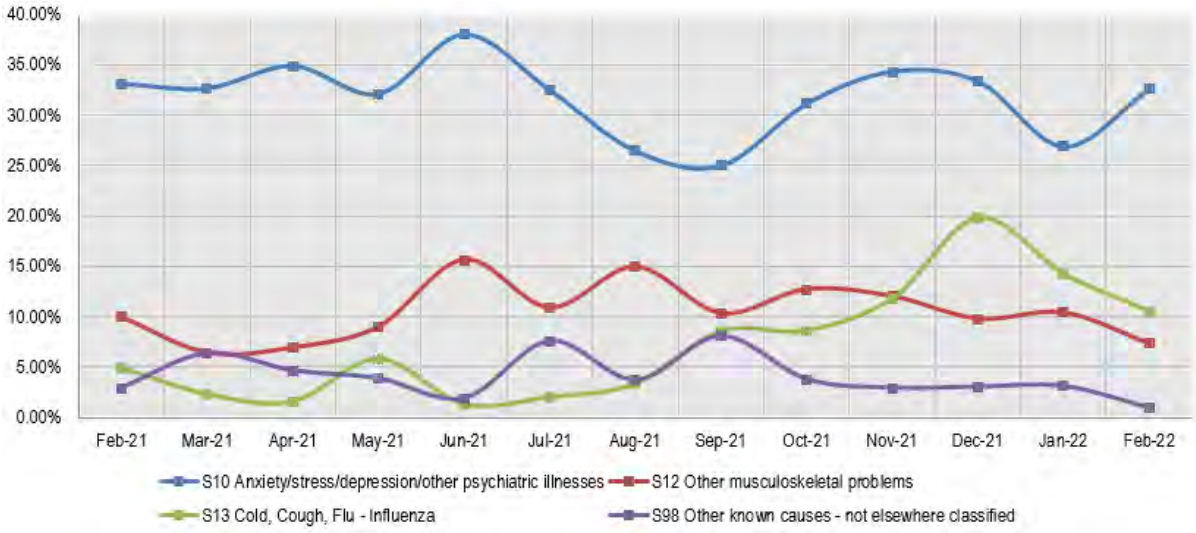
- **CHS**



DMH



FYPC.LD



Summary table of Directorate staff absence breakdown (February 2022)

Directorate	Sickness Reasons/ % breakdown			
	Anxiety/stress/ depression Other psychiatric illnesses	Other musculoskeletal problems	Cold, Cough, Flu-influenza	Other known causes
CHS	27.97%	12.59%	3.76%	6.22%
DMH	38.08%	9.87%	5.71%	8.49%
FYPC.LD	32.61%	7.33%	10.48%	0.93%

In-patient Staffing

Summary of inpatient staffing areas to note.

Wards	December 21	January 22	February 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

Wards	December 21	January 22	February 22
Coalville Ward 2	x	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	x
Stewart House	x	x	x

Table 2 – In-patient staffing areas to note

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

Covid-19 risk managed wards are also identified as areas to note, North Ward and Sycamore ward (Willows). 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. 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. Staff in non -patient facing roles with a clinical qualification are currently working within the staffing establishment to support continuity of care. Block booking of bank and agency continues to support planning for safer staffing levels.

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. Most wards were operating at 50% substantive RN and 50% bank/agency.

however, it was noted that during the half term breaks and due to a number of last-minute cancellations and sickness, there were some wards operating with 2 RN's both as temporary staff, on these shifts the mitigation is to move a substantive RN from a double site to a single site to reduce the risk rating.

Key areas to note North, East, Beechwood, and Clarendon wards. 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; Willows, Aston, Beaumont, Heather, Griffin, Kirby and Wakerley 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	December 2021	January 2022	February 2022
City East Hub- Community Nursing	x	x	x
City West Hub- Community Nursing	x	x	x
East Central	x	x	x
Hinckley Hub		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	x
CAMHS Crisis team (on call rota)	x	x	x
South Leicestershire CMHT	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	

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, *Psychology,* LD Community, Therapy Diana service and Looked After Children (LAC) teams continue to be rated to be at moderate risk due to vacancies, absence, and several staff retiring, leading to a reduced service delivery and revision of prioritisation models/waiting list reviews and RAG rating.

Healthy Together (HT) teams are unable to provide the full Healthy Child Programme and have agreed options for a reduced sustainable Healthy Child Programme offer. The Quality Impact Assessment (QIA) has been shared with Public Health (PH) Commissioners, a conversation has taken place and the options agreed. County Healthy Together are reviewing vacancy levels and recruitment.

The Diana team/service is an ongoing area to note due to staff absence and HCSW vacancies. 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 reviewing recruitment to explore 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 February 2022, Community Nursing has been reporting operating at OPEL level 3 working to level 4 actions. During half term, a peak annual leave period the service tipped into OPEL level 4 working to action level 4 and support was necessary from all other community services. 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. Essential visits were maintained by staff cancelling annual leave and working additional hours. All non-essential activities across the service line were cancelled as per level 4 OPEL actions. Additional support from all the leadership team and specialist teams including Tissue Viability, Podiatry, Phlebotomy, Continence, and all 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
- To continue to work with staff to support health and wellbeing, sharing the actions being taken to provide daily support and improve the situation long term, including actions to support safe planning and staffing and actions from the recent Quality and Safety summit
- To continue work with workforce supply group to attempt to maximise fill for non-permanent staffing gaps and continually reviewing recruitment and retention premia and bonus offers to make additional shifts more attractive
- To continue to review ways of working looking at options for cross geographical boundary working with focussed work to support effective triage, self -care options and pressure ulcers as per quality improvement action plans.
- 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 Spotify and a virtual open day. 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).

The quality improvement plan in place focuses 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 leadership team have been fully mobilised to support with clinical visits. 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. Ongoing key areas to note are 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 February 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

February 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	94.9%	166.4%	104.9%	121.4%			36.1%	25.0%	11.1%	8.4	↑1	↓0	→0		
	Aston	18	18	93.4%	235.8%	111.8%	169.8%			63.0%	24.9%	38.1%	8.1	↑2	↓1	→0		
	Beaumont	21	22	102.9%	161.1%	106.4%	206.8%			66.0%	36.0%	30.0%	14.3	↑3	↓0	↓0		
	Belvoir Unit	10	10	114.9%	147.9%	102.2%	163.5%			43.8%	28.0%	15.9%	17.0	→0	→0	→0		
	Heather	18	18	97.2%	229.8%	110.5%	185.1%			61.3%	29.2%	32.1%	8.0	↑3	↑1	↓0		
	Thornton	13	17	91.5%	168.1%	93.2%	123.5%			40.3%	30.7%	9.6%	9.1	→0	→0	→0		
	Watermead	20	20	102.3%	209.1%	114.9%	172.5%		100.0%	46.2%	22.6%	23.6%	7.2	↓0	↑2	→0		
	Griffin - Herschel Prins	6	6	111.0%	227.9%	103.1%	644.2%			61.9%	25.4%	36.5%	32.2	↑1	→0	→0		
AMH Other	Phoenix - Herschel Prins	11	12	116.0%	157.0%	104.2%	153.0%		100.0%	40.7%	23.0%	17.8%	13.0	→0	→0	→0		
	Skye Wing - Stewart House	29	30	88.2%	107.4%	134.6%	132.7%			38.7%	34.9%	3.8%	4.7	↓0	→2	→0		
	Willows	7	9	150.2%	188.8%	143.6%	180.4%			63.0%	38.0%	25.0%	15.3	→1	↑1	→0		
	Mill Lodge	11	14	111.8%	93.0%	197.6%	137.0%			61.1%	40.1%	21.0%	16.8	↓0	↑14	→0		
CHS City	Kirby	20	23	62.7%	163.5%	135.7%	383.6%	100.0%	100.0%	54.6%	28.3%	26.4%	11.5	↑4	→5	→0	→0	→0
	Welford	19	24	61.3%	117.9%	133.3%	291.0%			38.9%	23.2%	15.7%	8.2	→0	↑10	→0	→0	→0
	Beechwood Ward - BC03	21	23	88.7%	78.8%	102.1%	140.3%	100.0%	100.0%	40.0%	12.3%	27.8%	7.9	↑5	↓2	→1	↓0	→0
	Clarendon Ward - CW01	19	21	86.3%	116.6%	98.0%	128.6%	100.0%	100.0%	35.1%	13.2%	21.9%	10.4	↓0	↑8	→0	↓0	→0
	Coleman	13	21	58.0%	147.0%	137.1%	359.5%	100.0%	100.0%	49.5%	29.7%	19.8%	16.8	↑1	↓4	→0	1↑	→0
	Wakerley (MHSOP)	19	21	110.0%	136.2%	128.6%	214.2%			51.7%	34.5%	17.2%	13.6	→0	↑16	↑1	→0	→0
CHS East	Dalgleish Ward - MMDW	15	17	100.7%	81.3%	99.9%	99.7%	100.0%	100.0%	25.0%	11.9%	13.1%	7.7	↑1	↑2	→0	↑2	→0
	Rutland Ward - RURW	17	16	103.6%	121.5%	85.7%	172.0%	100.0%	100.0%	34.4%	16.7%	17.6%	8.6	→1	↑3	→0	↑3	→0
	Ward 1 - SL1	17	19	78.2%	129.5%	97.0%	145.5%	100.0%	100.0%	27.6%	17.5%	10.0%	10.6	→0	↑2	→0	→0	→0
	Ward 3 - SL3	11	12	104.2%	100.5%	99.8%	167.4%	100.0%	100.0%	23.1%	15.4%	7.7%	10.6	→0	↑1	→0	↓0	→0
CHS West	Ellistown Ward - CVEL	17	19	123.1%	97.0%	108.6%	160.0%	100.0%	100.0%	23.5%	5.7%	17.8%	9.6	↓0	↑6	→0	↓0	→0
	Snibston Ward - CVSN	17	19	95.6%	131.3%	99.8%	137.3%	100.0%	100.0%	22.9%	12.8%	10.1%	10.6	↑3	↓4	↓0	→1	→0
	East Ward - HSEW	20	23	97.1%	129.8%	112.5%	131.0%	100.0%	100.0%	34.0%	9.0%	25.0%	9.9	↑2	↑7	→0	↑3	→0
	North Ward - HSNW	16	19	101.2%	101.7%	103.6%	113.1%	100.0%	100.0%	36.6%	12.0%	24.6%	9.9	→1	↑7	→0	↓1	→0
	Swithland Ward - LBSW	17	19	99.5%	95.0%	91.1%	144.4%	100.0%	100.0%	17.5%	9.0%	8.5%	9.1	↓0	↓4	→0	↓0	→0
FYPC	Langley	14	15	87.7%	105.2%	133.3%	131.7%	100.0%		50.8%	39.7%	11.2%	13.1	→0	↑4	→0		
	CAMHS Beacon Ward - Inpatient Adolescent	8	7	100.6%	195.1%	195.7%	344.5%			70.7%	26.2%	44.5%	33.7	→0	→1	→0		
LD	Agnes Unit	2	4	106.7%	95.4%	131.2%	133.6%			54.9%	23.3%	31.7%	79.0	→0	↓1	→0		
	Gillivers	1	4	86.9%	72.8%	81.8%	104.8%			4.7%	4.7%	0.0%	68.4	↓0	→0	→0		
	1 The Grange	1	2	90.2%	83.9%	-	100.0%			15.2%	15.2%	0.0%	58.5	→0	↓0	→0		

Annexe 2: Inpatient Ward triangulation staffing and NSIs.

Trust thresholds are indicated below.

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

Mental Health (MH)

Acute Inpatient Wards

Ward	Average no. of Occupied Beds	Average % fill rate registered nurses	Average % fill rate care staff	Average % fill rate registered nurses	Average % fill rate care staff	Total	Bank	Agency	CHPPD	Medication Errors	Falls	Complaints
		>=80%	>=80%	>=80%	>=80%	<20%						
Ashby	14	94.9%	166.4%	104.9%	121.4%	36.1%	25.0%	11.1%	8.4	↑1	↓0	→0
Aston	18	93.4%	235.8%	111.8%	169.8%	63.0%	24.9%	38.1%	8.1	↑2	↓1	→0
Beaumont	22	102.9%	161.1%	106.4%	206.8%	66.0%	36.0%	30.0%	14.3	↑3	↓0	↓0
Belvoir Unit	10	114.9%	147.9%	102.2%	163.5%	43.8%	28.0%	15.9%	17.0	→0	→0	→0
Heather	18	97.2%	229.8%	110.5%	185.1%	61.3%	29.2%	32.1%	8.0	↑3	↑1	↓0
Thornton	17	91.5%	168.1%	93.2%	123.5%	40.3%	30.7%	9.6%	9.1	→0	→0	→0
Watermead	20	102.3%	209.1%	114.9%	172.5%	46.2%	22.6%	23.6%	7.2	↓0	↑2	→0
Griffin - Herschel Prins	6	111.0%	227.9%	103.1%	644.2%	61.9%	25.4%	36.5%	32.2	↑1	→0	→0
Totals										↑10	↑4	↓0

Table 4 - Acute inpatient ward safe staffing

All the wards have used a high percentage of temporary workforce throughout February 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 four falls reported during February 2022. This is a reduction in falls from ten reported in January 2022. The four falls occurred on three wards, two were first falls, one was a repeat, and one was where a patient was found on the floor. Two falls were in communal areas and two in the patient's bedrooms. Analysis has shown that staffing was not a contributory factor.

There were ten medication errors reported which is an increase compared to five in January 2022. The incidents were reported for four acute wards and one for the Mental Health Urgent Care Hub. Of the nine incidents reported for the acute wards, four were Electronic Controlled Drug (ECD) recording discrepancies that were rectified following advice from Pharmacy. Two incidents reported incorrect storage of medication, which were staff errors. One incident was regarding the use of patient's own Controlled Drugs, none of the above led to a medication administration error. One reported incident was not a medication error but the correct timescale between doses was not adhered to, and one incident was the administration of the wrong dose to a patient. This was supported through review and reflection and a theme of distraction was identified from the learning. The team are looking to use the 'do not disturb' tabards.

Analysis has shown there was no direct correlation with staffing. There is a staffing factor in relation to policies and procedures and ensuring that temporary staff are supported to access and follow policy and procedures, which substantive staff have been supporting them with.

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	116.0%	157.0%	104.2%	153.0%	40.7%	23.0%	17.8%	13.0	→0	→0	→0
Totals										→0	→0	→0

Table 5- Low secure safe staffing

Phoenix continues to use a 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 February 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	30	88.2%	107.4%	134.6%	132.7%	38.7%	34.9%	3.8%	4.7	↓0	→2	→0

Willows	9	150.2%	188.8%	143.6%	180.4%	63.0%	38.0%	25.0%	15.3	→1	↑1	→0
Mill Lodge	14	111.8%	93.0%	197.6%	137.0%	61.1%	40.1%	21.0%	16.8	↓0	↑14	→0
TOTALS										↓1	↑17	→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. Two international nurses have registered with the Nursing Midwifery Council (NMC) A new Registered Nurse band 5 is starting in April 2022 with rolling adverts out for nursing vacancies and on -going recruitment. The recruitment of additional band 6's has been agreed to support developmental posts and a regular nursing workforce

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 was one medication incident reported for rehabilitation in February 2022 which is a decrease compared to five medication errors in January 2022. This incident occurred at Willows where tablets were found to be broken from a strip of Temazepam. Pharmacy contacted to collect and dispose of these tablets. No medication administration error occurred, and this is not linked to safe staffing.

There were 17 falls across Rehabilitation during February 2022, which is an increase from 6 in January 2022. Fourteen of these were at Mill Lodge, one was at the Willows and two at Stewart House.

At the Willows the incident was not a trip/fall, a patient put themselves onto the floor. At Stewart House a patient fell from their wheelchair whilst transferring to a chair from the taxi. The second incident was where a patient stated that they had 'hit their head' whilst getting into bed to have a rest.

Analysis of the falls at Mill Lodge has shown that they were experienced by four patients in February 2022. One patient regularly slides themself from their low bed, onto the crash mat at the side of the bed.

Another patient's mental health has deteriorated and has been periodically agitated as a result, during February 2022, this patient had a number of episodes of quickly getting up

from their chair and walking towards their bedroom and falling to their knees and or laying on the floor.

Another patient has periodically slipped down their adapted chair (due to their posture). This patient was also found on one occasion in bedroom having tried to walk from their adapted chair to the bed and had fallen.

The fourth patient is still mobile with significant involuntary movements. This is known and periodically during Feb 22 this patient has tripped in the patient's lounge area and has fallen.

All the above incidents have not led to any injuries, falls huddles have taken place, there is no link to staffing, and staffing is increased if levels of therapeutic observations are enhanced due to risk of falls.

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	23	62.7%	163.5%	135.7%	383.6%	54.6%	28.3%	26.4%	11.5	↑4	→5	→ 0	→0	→0
Welford	24	61.3%	117.9%	133.3%	291.0%	38.9%	23.2%	15.7%	8.2	→0	↑10	→ 0	→0	→0
Coleman	21	58.0%	147.0%	137.1%	359.5%	49.5%	29.7%	19.8%	16.8	↑1	↓4	→ 0	1↑	→0
Wakerley	21	110.0%	136.2%	128.6%	214.2%	51.7%	34.5%	17.2%	13.6	→0	↑16	↑ 1	→0	→0
TOTALS										↑5	↑35	↑ 1	1↑	→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 for Registered Nurse recruitment.

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 continued to increase during February 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. Kirby ward and Welford ward have interviewed and recruited band 6 deputy charge nurses during this period and these are currently working through the recruitment process.

There were no pressure ulcer incidents reported in February 2022 and Wakerley ward received one complaint that the service is currently investigating.

There has been an increase in reported medication errors for both Kirby ward and Coleman ward during this period – incidents did not directly involve patient care and were relating to miscounting control drug medications, and in once instance securing the drug trolley when administering medications.

A review of falls for MHSOP wards identified; Wakerley where patients have been experiencing multiple falls during the period, and two patients with three recorded falls each –. Welford had two patients with repeated falls. Wakerley ward has a particularly high acuity to manage both physical and mental wellbeing on the ward. Patients are nursed on high level observations to maintain safety and mitigate where possible falls risks. Welford ward saw an increase in falls during this period which again related to the acuity of a specific group of patients admitted to the ward during this period.

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.

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 (month in arrears)	PU Category 4 (month in arrears)
Dalgleish Ward - MMDW	17	100.7%	81.3%	99.9%	99.7%	25.0 %	11.9 %	13.1 %	7.7	↑1	↑2	→0	↑2	→0
Rutland Ward - RURW	16	103.6%	121.5%	85.7%	172.0%	34.4 %	16.7 %	17.6 %	8.6	→1	↑3	→0	↑3	→0
Ward 1 - SL1	19	78.2%	129.5%	97.0%	145.5%	27.6 %	17.5 %	10.0 %	10.6	→0	↑2	→0	→0	→0
Ward 3 - SL3	12	104.2%	100.5%	99.8%	167.4%	23.1 %	15.4 %	7.7%	10.6	→0	↑1	→0	↓0	→0
Ellistown Ward - CVEL	19	123.1%	97.0%	108.6%	160.0%	23.5 %	5.7%	17.8 %	9.6	↓0	↑6	→0	↓0	→0
Snibston Ward - CVSN	19	95.6%	131.3%	99.8%	137.3%	22.9 %	12.8 %	10.1 %	10.6	↑3	↓4	↓0	→1	→0
East Ward - HSEW	23	97.1%	129.8%	112.5%	131.0%	34.0 %	9.0%	25.0 %	9.9	↑2	↑7	→0	↑3	→0
North Ward - HSNW	19	101.2%	101.7%	103.6%	113.1%	36.6 %	12.0 %	24.6 %	9.9	→1	↑7	→0	↓1	→0
Swithland Ward - LBSW	19	99.5%	95.0%	91.1%	144.4%	17.5 %	9.0%	8.5%	9.1	↓0	↓4	→0	↓0	→0
CB Beechwood	23	88.7%	78.8%	102.1%	140.3%	40.0 %	12.3 %	27.8 %	7.9	↑5	↓2	→1	↓0	→0
CB Clarendon	21	86.3%	116.6%	98.0%	128.6%	35.1 %	13.2 %	21.9 %	10.4	↓0	↑8	→0	↓0	→0
TOTALS										↑13	↑46	↓1	↑10	→0

Table 8 - Community hospital safe staffing

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

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

There has been a reduced fill rate for registered nurses on St Luke's Ward 1 for day shifts and for healthcare assistant (HCA) shifts on night shifts for Beechwood Ward, this is due to the impact of sickness, maternity leave, and vacancies. A review of the episodes for the reduced

fill rate for RNs on ward 1 St Luke's has identified that adjusted skill mix during the month with some of the unfilled registered nurse shifts filled with health care assistants, which also accounts for the increase in the fill rate of HCAs.

The increased fill rate for HCA on night shifts for Rutland, Snibston Stroke Ward, East Ward, and Clarendon 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 ten of the wards this is due to increased patient acuity and dependency, patients requiring enhanced observations due to one-to-one care, annual leave, vacancies, maternity leave, sickness, and impact of COVID 19 related isolation requirements.

Care hours per patient day has reduced varying between 7.7-10.6 further analysis is required to understand the differences in care hours reported, initial review this may be attributed to therapy absence and fill rates.

A review of the Nurse Sensitive Indicators (NSIs) for the community hospital wards has identified an increase in the number of falls incidents from 36 in January 2022 to 46 in February 2022 comprising of 37 first falls, 6 repeat falls and 3 patients placed on the floor. Ward areas to note are Clarendon, Ellistown, East and North 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 12 in January to 13 in February 2022. The incidents reported were across six of the wards with Beechwood Ward being the highest reporting area with 5 medication incidents. The main cause group of medication incidents related to failure of staff in following medication procedure/policy/guidance, discrepancy in counted medicine, electronic controlled drug register issues, prescribing error, lost/misplaced medication, medication unavailable. Several of the incidents where in relation to controlled drugs not being stored correctly following admittance to the ward especially if they are admitted late evening/overnight. The Ward Sister on Beechwood is currently completing supervision training with all registered nursing staff in relation to medicines management.

The number of category 2 pressure ulcers developed in our care has increased to 10. Areas to note are Rutland, East Ward, and Ward 3 St Luke's. The focus continues with the ward teams

and the ward sisters reviewing early review and oversight by the ward sisters, 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	15	87.7%	105.2%	133.3%	131.7%	50.8 %	39.7%	11.2%	13.1	→0	↑4	→0
CAMHS	7	100.6%	195.1%	195.7%	344.5%	70.7 %	26.2%	44.5%	33.7	→0	→1	→0
TOTALS										→0	↑5	→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 fall on Beacon was related to a patient who fell as she started to have a seizure. Review of the incident has not identified any staffing impact on the quality and safety of the patient.

There were no medication errors on the CAMHS Beacon Unit or Langley in February 2022.

The falls reported on Langley were related to different patients who fainted while in the presence of staff and a full review of the incidents has not identified any staffing impact on the quality and safety of the patient.

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	4	106.7%	95.4%	131.2%	133.6%	54.9%	23.3%	31.7%	79.0	→0	↓1	→0
Gillivers	4	86.9%	72.8%	81.8%	104.8%	4.7%	4.7%	0.0%	68.4	↓0	→0	→0
1 The Grange	2	90.2%	83.9%	-	100.0%	15.2%	15.2%	0.0%	58.5	→0	↓0	→0
TOTALS										↓0	↓1	→0

Table 10 - Learning disabilities safe staffing

Patient acuity on the Agnes Unit remains high 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 fall on the Agnes Unit and this related to a patient who had stepped forward towards staff and then fell forward onto the floor. 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 were no incidents in February 2022 related to medication errors, falls and no complaints received this month.

Governance table

For Board and Board Committees:	Trust Board 31.5.22	
Paper sponsored by:	Anne Scott, Interim Executive Director of Nursing, AHPs and Quality	
Paper authored by:	Emma Wallis, Interim Deputy Director of Nursing and Quality and Elaine Curtin Workforce and Safe staffing Matron	
Date submitted:	31.05.2022	
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:		

P

Leicestershire Partnership NHS Trust

Public Trust Board – 31 May 2022

Safe Staffing- March 2022

Purpose of the report

This report provides a full overview of nursing safe staffing during the month of March 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.

A safe staffing and patient safety review for the period 14 – 27 February 2022 (half-term) was presented to the Operational Executive Board on the 18 March 2022, following a deep dive to understand the challenges and actions needed outlining a number of recommendations for future bank holiday workforce planning and safe staffing governance and assurance.

Analysis of the issue

Right Staff

- Temporary worker utilisation rate increased this month; 0.56 % reported at 45.66% overall and Trust wide agency usage slightly increased this month by 2.2% to 22.74% overall.
- In March 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 Skye wing at Stewart house.
- 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, Griffin, Coleman, Wakerley, North and East wards, St Luke's ward 1.
- The community team 'areas to note', Healthy Together City, County, notably Blaby team, Looked After Children Team, Diana team, City Community Nursing, CRISIS Resolution and Home Treatment team, Melton, Charnwood, South Leicestershire Community Mental Health Teams, Assertive outreach, ADHD, 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 March 2022 Trust wide substantive staff.
    - Appraisal at 75.4% compliance AMBER
    - Clinical supervision at 77.8% compliance AMBER
    - All core mandatory training compliance GREEN except for Information Governance AMBER at 65.4 % and Fire Safety Awareness RED at 63.6%
- Clinical mandatory training compliance for substantive staff, to note.
    - BLS increased compliance by 1.1 % to 64.3%compliance RED
    - ILS increased compliance by 12% to 65.9% compliance RED
- Clinical mandatory training compliance for bank only workforce remains low.
    - BLS 55.3% at RED compliance
    - ILS 47.3% 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. During the pandemic a temporary extension of 6 months was added to each training topic compliance period. On the 1st of March 2022 the 6-month extension was removed for clinical face to face training, with all other topics following suit on 1st April 2022. There are Learning and Development operational plans and each directorate is undertaking a deep dive into their services. Significant activity is underway to ensure training compliance improves across the trust.

Right Place

- The Covid-19 risk managed wards are North and Sycamore. Risk managed is to mean that the ward is caring for patients on the emergency admission Covid-19 high and medium risk pathways, as per the national safe staffing descriptors and IPC care pathways, maintaining separation between possible and confirmed COVID-19 patients and supporting staff cohorting.
- Fill rates above and below 100% for actual HCSWs predominantly on days reflect adjusted staffing levels and skill mix to meet patient care needs.

- The total Trust CHPPD average (including ward based AHPs) is reported at 18.05 CHPPD in March 2022, with a range between 5.6 (Stewart House) and 77.2 (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	5.4%	1.2%	1.3%	7.9%
Enabling Services	3.1%	1.0%	0.7%	4.8%
FYPC	4.4%	1.1%	1.4%	6.8%
Hosted Service	0.0%	0.0%	0.0%	0.0%
Mental Health Services	4.9%	0.4%	0.9%	6.2%
LPT Total	**4.5%**	**0.9%**	**1.1%**	**6.5%**

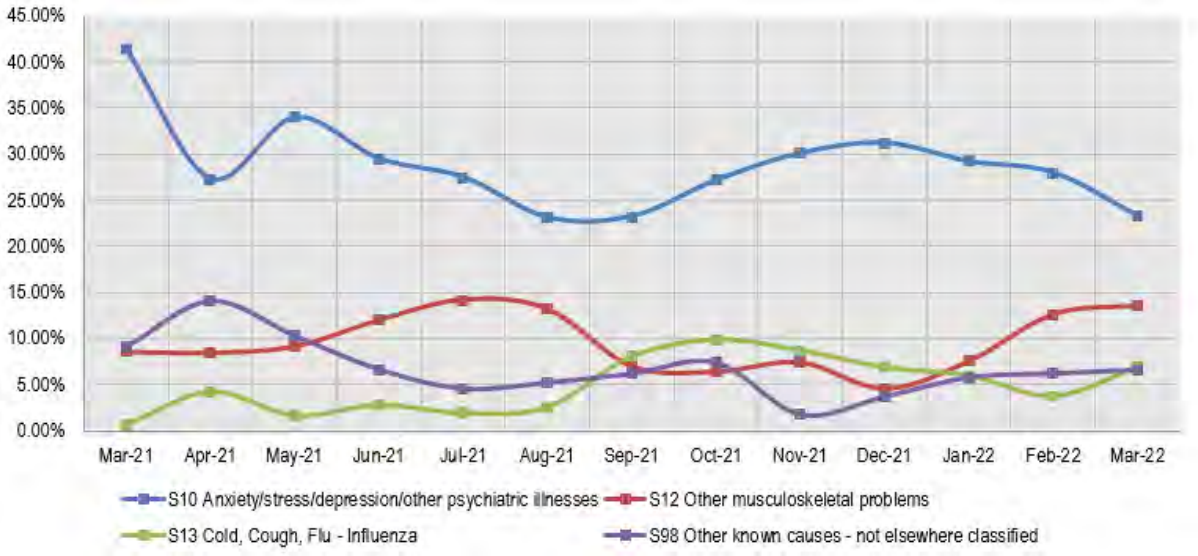
Table 1 – COVID-19 and general absence – 31 March 2022

In comparison to the previous month total absence has increased by 2.1% associated with an increase in general absence overall.

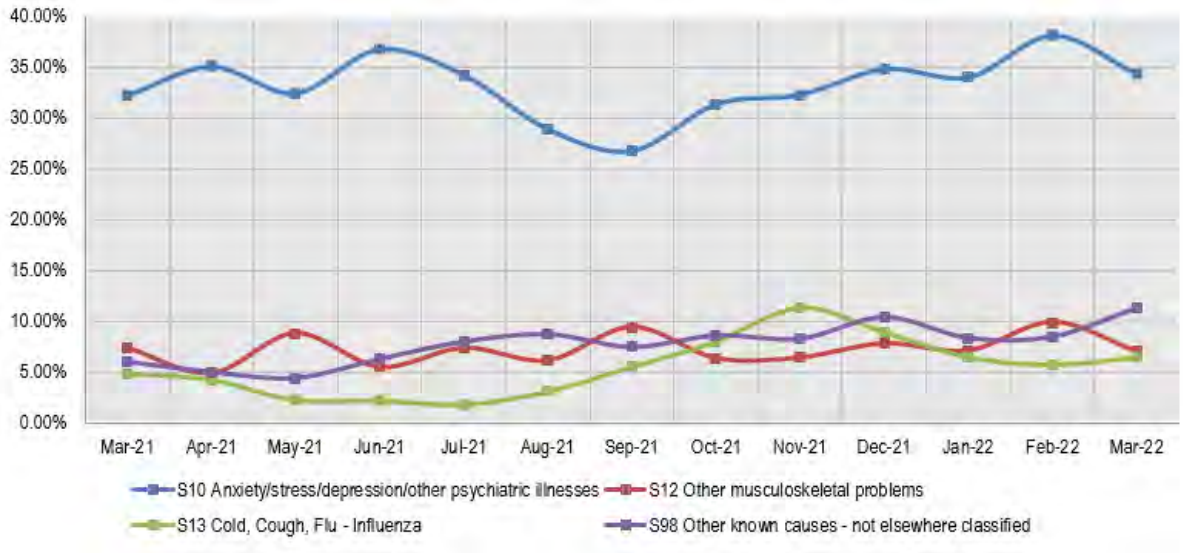
- Work pressure has been identified as an area of focus in response to the National Staff Survey 2021. A deep dive into absence due to stress, anxiety and/or depression to identify any correlations with work pressure and actions is underway and will be

presented to Quality Assurance Committee (QAC) in April 2022. Absence across clinical directorates has in the main been higher throughout 2021/22 when compared to 2020/21. Anxiety, stress, and depression are the highest identified cause of absence across the Trust for a significant period, as per Directorate below and has reduced significantly from March 2021 within CHS.

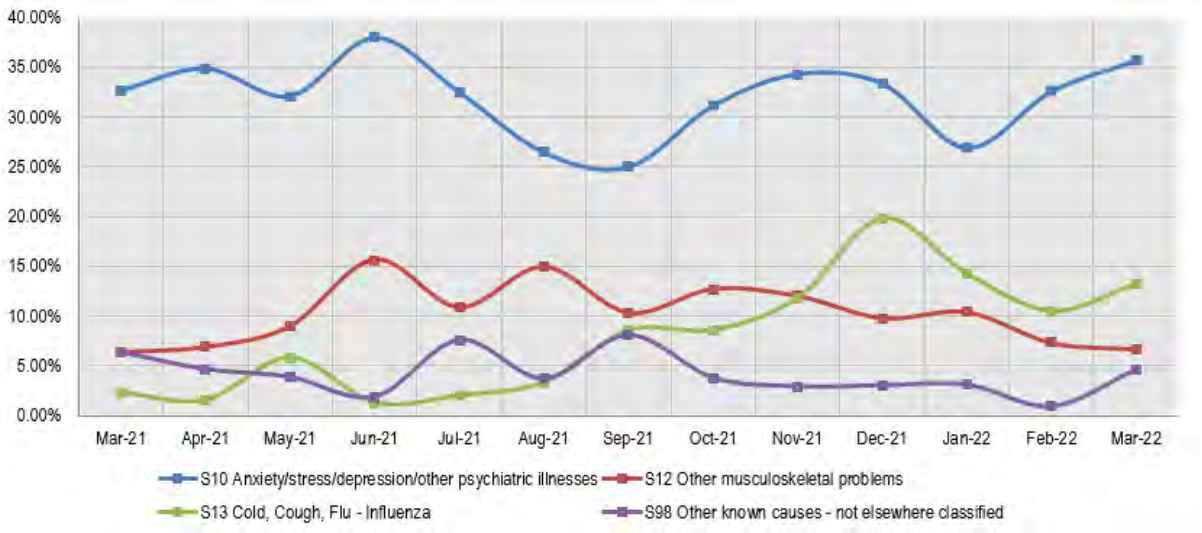
CHS



DMH



FYPC.LD



Summary table of Directorate staff absence breakdown (March 2022)

Directorate	Sickness Reasons/ Breakdown %			
	Anxiety/stress/ depression Other psychiatric illnesses	Other musculoskeletal problems	Cold, Cough, Flu-influenza	Other known causes
CHS	23.28%	13.54%	6.87%	6.62%
DMH	34.31%	7.00%	6.42%	11.34%
FYPC.LD	35.67%	6.71%	13.20%	4.65%

In-patient Staffing

Summary of inpatient staffing areas to note.

Wards	January 22	February 22	March 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	x

Wards	January 22	February 22	March 22
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	x
Stewart House	x	x	x

Table 2 – In-patient staffing areas to note

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

Covid-19 risk managed wards are also identified as areas to note, North Ward and Sycamore ward (The Willows). 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. Due to decreased substantive staff numbers, the Beacon unit has capacity to safely staff 6 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. Staff in non -patient facing roles with a clinical qualification are currently working within the staffing establishment to support continuity of care. Block booking of bank and agency continues to support planning for safer staffing levels. Throughout March 2022 the Beacon have been using two separate teams of Prometheus staff to support the complex needs of two of the patients on the unit. They are supporting with 24-hour care.

Patient acuity on the Agnes Unit remains high 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.

CHS

All in-patient wards in Community Hospitals reported operating at an amber risk overall, 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. 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, and St Luke's ward 1. 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 now registered with the NMC.

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 now registered with the NMC and a Medicines Administration Technician and a newly registered band 5 RN starting in April 2022. The annual safe staffing establishment review is progressing, and a quality summit improvement

plan continues to be implemented, 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 19 related staff isolation requirements and additional increased staff movement and promotions to urgent care pathway roles and step up to great mental health transformation. Key areas to note, Griffin, Coleman and Wakerley wards. With Covid outbreaks on Kirby and Phoenix 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	January 2022	February 2022	March 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	x
South Leicestershire CMHT			x
Melton 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, Psychology, LD Community, Therapy Diana service and Looked After Children (LAC) teams continue to be rated to be at moderate risk due to vacancies, absence, and several staff retiring, leading to a reduced service delivery and revision of prioritisation models/waiting list reviews and RAG rating.

Healthy Together (HT) teams are unable to provide the full Healthy Child Programme and have agreed options for a reduced sustainable Healthy Child Programme offer. The Quality Impact Assessment (QIA) has been shared with Public Health (PH) Commissioners, a conversation has taken place and the options agreed. County Healthy Together are reviewing vacancy levels and recruitment.

The Diana team/service is an ongoing area to note due to staff absence and HCSW vacancies. 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 reviewing recruitment to explore 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 March 2022, Community Nursing has been reporting operating at OPEL level 3 working to level 4 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. Essential visits were maintained by staff working increased hours, additional shifts and paying overtime.

Increasing staff absence due to COVID related sickness absence remained a challenge. There continued to be staff working from home due to symptomatic/COVID positive household members and pregnancy related risk assessments, which further reduced clinical capacity across 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, Continence, 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
- To continue to work with staff to support health and wellbeing, sharing the actions being taken to provide daily support and improve the situation long term, including actions to support safe planning and staffing actions from the recent Quality and safety Summit
- To continue to work with workforce supply group to attempt to maximise fill for non-permanent staffing gaps and continually reviewing recruitment and retention premia and bonus offers to make additional shifts more attractive
- To continue to review ways of working looking at options for cross geographical boundary working with focussed work to support effective triage, self- care options and pressure ulcers as per quality improvement action plans
- 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 face book and on the back of x 15 buses. 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, 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 March 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

March 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	% Temporary Workers (NURSING ONLY) – Bank	% Temporary Workers (NURSING ONLY) – Agency	Overall CHPPD (Nursing And AHP)	Medication Errors	Falls	Complaints	PU Category 2	PU Category 4
				>=80%	>=80%	>=80%	>=80%	-	-	<20%								
AMH Bradgate	Ashby	15	21	92.7%	172.2%	104.7%	146.5%			45.3%	23.2%	22.1%	8.3	↓0	→0	→0		
	Aston	14	14	98.4%	209.6%	138.6%	185.3%			68.1%	14.2%	54.0%	11.0	↓1	→1	↑2		
	Beaumont	21	22	86.9%	143.7%	110.2%	156.0%			63.7%	35.3%	28.4%	12.1	↓1	↑2	→0		
	Belvoir Unit	10	10	124.1%	164.7%	107.3%	176.2%			45.7%	30.0%	15.7%	18.4	→0	→0	→0		
	Heather	19	18	87.2%	163.9%	98.1%	123.2%			42.8%	25.8%	17.0%	6.1	↓0	↑3	→0		
	Thornton	12	17	79.9%	181.3%	101.2%	113.0%			40.2%	30.7%	9.5%	9.3	→0	→0	→0		
	Watermead	20	20	114.0%	250.9%	123.0%	221.8%		100.0%	50.1%	22.5%	27.6%	8.6	↑1	↑3	→0		
	Griffin - Herschel Prins	5	6	106.2%	287.8%	106.2%	770.8%			69.2%	33.1%	36.1%	41.3	↓0	→0	→0		
AMH Other	Phoenix - Herschel Prins	12	12	106.3%	145.1%	105.1%	140.4%		100.0%	42.4%	22.9%	19.5%	11.2	→0	→0	→0		
	Skye Wing - Stewart House	30	30	118.5%	108.8%	203.4%	206.0%			50.2%	34.0%	16.2%	5.6	→0	→2	→0		
	Willows	8	9	151.4%	173.8%	131.5%	163.7%			58.4%	38.6%	19.8%	14.3	↓0	↓0	↑2		
	Mill Lodge	12	14	126.1%	82.7%	129.0%	114.0%			58.2%	40.3%	17.9%	13.8	→0	↓7	↑1		
CHS City	Kirby	17	23	70.1%	122.0%	131.6%	275.3%	100.0%	100.0%	42.5%	26.5%	16.0%	10.6	↓0	↓2	→0	→0	→0
	Welford	16	24	60.4%	100.0%	131.0%	161.2%			35.6%	23.6%	12.0%	7.7	↑1	↓5	↑1	→0	→0
	Beechwood Ward - BC03	21	23	90.5%	95.3%	101.2%	111.5%	100.0%	100.0%	32.2%	10.9%	21.3%	8.0	↓4	→2	↓0	→0	→0
	Clarendon Ward - CW01	17	20	88.7%	104.7%	109.8%	107.8%	100.0%	100.0%	37.9%	14.1%	23.8%	10.6	→0	↓3	→0	↑2	→0
	Coleman	15	20	55.2%	150.1%	139.8%	399.5%	100.0%	100.0%	51.2%	25.3%	25.9%	14.6	↓0	↓3	→0	↓0	→0
	Wakerley (MHSOP)	16	20	96.3%	138.2%	138.1%	244.5%			58.2%	33.4%	24.8%	16.6	↑1	↓14	↓0	→0	→0
CHS East	Dalgleish Ward - MMDW	13	16	103.1%	81.1%	98.6%	99.9%	100.0%	100.0%	21.6%	7.1%	14.5%	9.4	→1	↓1	→	→2	→0
	Rutland Ward - RURW	16	16	91.7%	141.8%	82.5%	163.5%	100.0%	100.0%	41.7%	18.5%	23.2%	8.9	→1	↓1	↑1	↓0	→0
	Ward 1 - SL1	17	19	76.7%	120.7%	96.6%	151.5%	100.0%	100.0%	27.6%	18.3%	9.3%	9.9	↑3	↑4	→0	→0	→0
	Ward 3 - SL3	11	13	110.8%	87.5%	96.3%	186.5%	100.0%	100.0%	24.3%	13.4%	11.0%	10.4	↑2	→1	→0	→0	→0
CHS West	Ellistown Ward - CVEL	15	19	103.2%	103.1%	107.9%	151.6%	100.0%	100.0%	20.9%	5.5%	15.4%	10.7	↑1	↓3	→0	→0	→0
	Snibston Ward - CVSN	17	19	90.8%	115.4%	102.9%	151.8%	100.0%	100.0%	22.3%	10.4%	11.9%	10.5	↓1	↓3	→0	↓0	→0
	East Ward - HSEW	20	22	92.6%	133.4%	103.2%	152.4%	100.0%	100.0%	30.7%	9.6%	21.1%	10.1	↓0	↓5	→0	↓2	→0
	North Ward - HSNW	15	19	101.7%	107.5%	101.5%	127.9%	100.0%	100.0%	35.6%	9.9%	25.7%	10.8	↑2	↓0	→0	→1	→0
	Swithland Ward - LBSW	17	19	107.1%	97.2%	88.7%	148.0%	100.0%	100.0%	18.0%	9.4%	8.6%	9.3	↑1	↓3	→0	→0	→0
FYPC	Langley	14	15	84.2%	110.9%	129.0%	134.8%	100.0%		54.0%	37.3%	16.7%	13.3	↑1	↓1	→0		
	CAMHS Beacon Ward - Inpatient Adolescent	6	17	111.8%	227.7%	173.3%	381.4%			77.1%	25.3%	51.9%	45.5	↑4	↓0	→0		
LD	Agnes Unit	2	4	97.6%	93.8%	142.9%	129.3%			58.6%	23.9%	34.8%	77.2	→0	↑2	→0		
	Gillivers	1	5	86.3%	89.0%	90.3%	189.7%			5.6%	5.6%	0.0%	62.7	→0	→0	→0		
	1 The Grange	1	3	95.5%	98.7%	-	101.6%			19.2%	19.2%	0.0%	61.0	→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) - updated

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	21	92.7%	172.2%	104.7%	146.5%	45.3%	23.2%	22.1%	8.3	↓0	→0	→0
Aston	14	98.4%	209.6%	138.6%	185.3%	68.1%	14.2%	54.0%	11.0	↓1	→1	↑2
Beaumont	22	86.9%	143.7%	110.2%	156.0%	63.7%	35.3%	28.4%	12.1	↓1	↑2	→0
Belvoir Unit	10	124.1%	164.7%	107.3%	176.2%	45.7%	30.0%	15.7%	18.4	→0	→0	→0
Heather	18	87.2%	163.9%	98.1%	123.2%	42.8%	25.8%	17.0%	6.1	↓0	↑3	→0
Thornton	17	79.9%	181.3%	101.2%	113.0%	40.2%	30.7%	9.5%	9.3	→0	→0	→0
Watermead	20	114.0%	250.9%	123.0%	221.8%	50.1%	22.5%	27.6%	8.6	↑1	↑3	→0
Griffin - Herschel Prins	6	106.2%	287.8%	106.2%	770.8%	69.2%	33.1%	36.1%	41.3	↓0	→0	→0
Totals										↓3	↑9	↑2

Table 4 - Acute inpatient ward safe staffing

All the wards have used a high percentage of temporary workforce throughout March 2022, 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 nine reported falls reported during March 2022. This is an increase in falls from four reported in February 2022. Of the nine reported falls, these were experienced by patients from five of the acute wards, seven were first falls and two repeat falls. Seven of the falls were unwitnessed and the majority occurred in bedroom areas. One fall resulted in a patient suffering from a humeral fracture that is being investigated. Analysis has shown that staffing was not a contributory factor.

There were three medication errors reported in March 2022 which is a decrease compared to February 2022. These were reported for three different wards. One incident was an Electronic Controlled Drug register discrepancy. One incident was the formulation of the correct medication was given (i.e., not sugar free) and the third incident was an extra dose of medication was given to the patient. All incidents were reviewed in line with the Trust medication error policy and individual review was completed with staff involved and this identified a gap in the charting of medication.

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	106.3%	145.1%	105.1%	140.4%	42.4%	22.9%	19.5%	11.2	→0	→0	→0
Totals										→0	→0	→0

Table 5- Low secure safe staffing

Phoenix continues to use a 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 March 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	30	118.5%	108.8%	203.4%	206.0%	50.2%	34.0%	16.2%	5.6	→0	→2	→0
Willows	9	151.4%	173.8%	131.5%	163.7%	58.4%	38.6%	19.8%	14.3	↓0	↓0	↑2
Mill Lodge	14	126.1%	82.7%	129.0%	114.0%	58.2%	40.3%	17.9%	13.8	→0	↓7	↑1
TOTALS										↓0	↑9	↑3

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. Two international nurses have registered with the Nursing Midwifery Council (NMC). A new Registered Nurse band 5 is starting in April 2022 with rolling adverts out for

nursing vacancies and on -going recruitment. The recruitment of additional band 6's has been agreed to support developmental posts and a regular nursing workforce

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.

Stewart House and Mill Lodge have also implemented a peripatetic rota between them to provide staffing for short falls in staffing. This has increased the use of bank and agency staff being requested and booked on their rotas on alternative months.

There were 0 reported medication incidents in March 2022, compared to 1 in February 2022.

There were nine falls reported in March 2022, a decrease from February 2021. Of these nine falls, seven related to Mill Lodge and two for Stewart House.

Of the nine falls reported, six of these falls occurred in the bedroom with the remaining falls occurring in the dining room, main ward area and grounds/gardens/recreation area.

Of the two falls at Stewart House, one was a first fall and the second was a repeat fall.

For the seven falls reported at Mill Lodge; five were first falls, two repeat falls (these two will be recoded to be repeat falls) four were in the bedroom, the remaining in the dining room, main ward area and grounds/gardens recreational area. One patient has fallen three times and another patient has fell twice, this is linked to the progress of their Huntington's Disease

Mental Health Services for Older People (MHSOP)

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints	PU Category 2	PU Category 4
Kirby	23	70.1%	122.0%	131.6%	275.3%	42.5%	26.5%	16.0%	10.6	↓0	↓2	→0	→0	→0
Welford	24	60.4%	100.0%	131.0%	161.2%	35.6%	23.6%	12.0%	7.7	↑1	↓5	↑1	→0	→0
Coleman	20	55.2%	150.1%	139.8%	399.5%	51.2%	25.3%	25.9%	14.6	↓0	↓3	→0	↓0	→0
Wakerley	20	96.3%	138.2%	138.1%	244.5%	58.2%	33.4%	24.8%	16.6	↑1	↓14	↓0	→0	→0
TOTALS										↓2	↓24	↓1	↓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.

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 continued to increase during February 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. Kirby ward and Welford ward have interviewed and recruited band 6 deputy charge nurses during this period and these are currently working through the recruitment process.

There were no pressure ulcer incidents reported in February 2022 and Wakerley ward received one complaint that the service is currently investigating.

There has been an increase in reported medication errors for both Kirby ward and Coleman ward during this period – incidents did not directly involve patient care and were relating to miscounting control drug medications, and in once instance securing the drug trolley when administering medications.

A review of falls for MHSOP wards identified; Wakerley where patients have been experiencing multiple falls during the period, and two patients with three recorded falls each. Welford had two patients with repeated falls. Wakerley ward has a particularly high acuity to manage both physical and mental wellbeing on the ward. Patients are nursed on high level observations to maintain safety and mitigate where possible falls risks. Welford ward saw an increase in falls during this period which again related to the acuity of a specific group of patients admitted to the ward during this period.

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.

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
Dalgleish Ward - MMDW	16	103.1%	81.1%	98.6%	99.9%	21.6 %	7.1%	14.5 %	9.4	→1	↓1	0→	→2	→0
Rutland Ward - RURW	16	91.7%	141.8%	82.5%	163.5%	41.7 %	18.5 %	23.2 %	8.9	→1	↓1	↑1	↓0	→0
Ward 1 - SL1	19	76.7%	120.7%	96.6%	151.5%	27.6 %	18.3 %	9.3%	9.9	↑3	↑4	→0	→0	→0
Ward 3 - SL3	13	110.8%	87.5%	96.3%	186.5%	24.3 %	13.4 %	11.0 %	10.4	↑2	→1	→0	→0	→0
Ellistown Ward - CVEL	19	103.2%	103.1%	107.9%	151.6%	20.9 %	5.5%	15.4 %	10.7	↑1	↓3	→0	→0	→0
Snibston Ward - CVSN	19	90.8%	115.4%	102.9%	151.8%	22.3 %	10.4 %	11.9 %	10.5	↓1	↓3	→0	↓0	→0
East Ward - HSEW	22	92.6%	133.4%	103.2%	152.4%	30.7 %	9.6%	21.1 %	10.1	↓0	↓5	→0	↓2	→0
North Ward - HSNW	19	101.7%	107.5%	101.5%	127.9%	35.6 %	9.9%	25.7 %	10.8	↑2	↓0	→0	→1	→0
Swithland Ward - LBSW	19	107.1%	97.2%	88.7%	148.0%	18.0 %	9.4%	8.6%	9.3	↑1	↓3	→0	→0	→0
CB Beechwood	23	90.5%	95.3%	101.2%	111.5%	32.2 %	10.9 %	21.3 %	8.0	↓4	→2	↓0	→0	→0
CB Clarendon	20	88.7%	104.7%	109.8%	107.8%	37.9 %	14.1 %	23.8 %	10.6	→0	↓3	→0	↑2	→0
TOTALS										↑16	↓26	→1	↓7	→0

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 St Luke's Ward 1 for day shifts this is due to the impact of sickness and vacancies. A review of the episodes for the reduced fill rate for RNs has identified that the planned skill mix of three registered nurses has not been met but the ward has maintained two registered nurses on the day shifts. This reduction has adjusted skill mix during the month with some of the unfilled registered nurse shifts filled with health care assistants, which also accounts for the increase in the fill rate of HCAs.

The increased fill rate for HCA on night shifts for Rutland, Snibston Stroke Ward, East Ward, Swithland and Clarendon Ward is due to increased acuity and dependency and patients requiring enhanced observations, one to one supervision and additional beds that have been opened due to LLR wide system request.

Temporary workforce usage continues to remain high across ten of the wards this is due to increased patient acuity and dependency, patients requiring enhanced observations due to one-to-one care, annual leave, vacancies, maternity leave, sickness and impact of COVID 19 related isolation requirements.

Care hours per patient day has started to increase from last month, further analysis is continuing in the strengthening and reporting of CHPPD data to include AHP (physiotherapy and occupational therapy) planned fill rates.

A review of the Nurse Sensitive Indicators (NSIs) for the community hospital wards has identified a decrease in the number of falls incidents from forty six in February 2022 to twenty six in March comprising of twenty two first falls and four repeat falls. Of the twenty-six falls reported, twelve of these falls were witnessed with six of the falls being in relation to patients mobilising/standing or when being assisted to by staff or equipment. The remaining six witnessed falls were due to a fall from chair, fall from bed without bed rails and roll at low height. Ward areas to note are St Luke's Ward 1 and East 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 thirteen in February 2022 to sixteen in March 2022. The incidents reported were across nine of the eleven wards. 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, medication unavailable.

The number of category 2 pressure ulcers developed in our care has decreased to seven. The focus continues with the ward teams and the ward sisters reviewing early review and having full oversight by the ward sisters, 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	15	84.2%	110.9%	129.0%	134.8%	54.0 %	37.3%	16.7%	13.3	↑1	↓1	→0
CAMHS	17	111.8%	227.7%	173.3%	381.4%	77.1 %	25.3%	51.9%	45.5	↑4	↓0	→0
TOTALS										↑5	↓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. Recruitment remains a key focus and there has been success in appointing a band 2 HCSW however, the main concern is band 5 nurse vacancies.

The Beacon unit has agreed that it will only open six beds due to acuity and staffing levels. There are currently six patients, two are waiting for transfers to either PICU or low secure beds. There are also patients who are medically fit to be discharged but are waiting social care placements.

Throughout March the Beacon have been using two separate teams of Prometheus staff to support the complex needs of two of the patients on the unit. They are supporting with 24-hour care and are not included in the above figures.

The four medication errors were all unrelated and identified different concerns. The first concern was a documentation error as staff recorded, they gave a 30mg does of a drug instead of a 20mg dose. No administration error happened.

The second medication error was an out-of-date medication being given to a patient. This was noted by a nurse prior to administration but on review of the medication chart it was clear that the patient had been given the out-of-date medication the night before.

The third error was an omission of a dose. The medication was not given at the prescribed time as staff were assisting with an incident. when they went to administer the medication, the patient was asleep, so the dose was missed.

The final medication error was due to staff not signing for controlled drugs on the CD register (but was recorded on the patient chart). No harm to the patient and staff contacted.

There was one fall and one medication error on Langley in the month of March. The medication error was in relation to the unavailability of a semi-controlled medication. The fall incident was due to the patient physical condition and not in relation to staffing.

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	4	97.6%	93.8%	142.9%	129.3%	58.6%	23.9%	34.8%	77.2	→0	↑2	→0
Gillivers	5	86.3%	89.0%	90.3%	189.7%	5.6%	5.6%	0.0%	62.7	→0	→0	→0
1 The Grange	3	95.5%	98.7%	-	101.6%	19.2%	19.2%	0.0%	61.0	→0	↑1	→0
TOTALS										→0	↑3	→0

Table 10 - Learning disabilities safe staffing

Patient acuity on the Agnes Unit remains high 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 no medication errors or complaints in March. There were two falls reported for the Agnes unit. One incident involved a patient who was having basketball practice. The second incident was wrongly coded as a fall incident.

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 fall reported for short breaks in March 2022.

None of the incidents of falls are related to staffing & staffing fill rates.

Governance table

For Board and Board Committees:	Trust Board 31.5.22	
Paper sponsored by:	Anne Scott, Interim Executive Director of Nursing, AHPs and Quality	
Paper authored by:	Emma Wallis, Interim Deputy Director of Nursing and Quality and Elaine Curtin Workforce and Safe staffing Matron	
Date submitted:	11.05.2022	
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:		

Q

Leicestershire Partnership NHS Trust

Public Trust Board 31 May2022

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

Purpose of the report

This document is presented to the Trust Board bi-monthly for March and April 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.

This report will concentrate on the work in relation to the patient safety strategy including the investigation of incidents. To accommodate this less information has been included around individual incident categories.

Investigation compliance with timescales

There continues to be challenges in relation to compliance with serious incident and internal investigations timescales. The position has deteriorated over the course of the COVID19 pandemic partly due to staff being rediverted to clinical work and then as a result of staff illness.

At the end of March 2022 teams from across the Trust, came together in a 'Quality Summit' style to look at the challenges we face and to discuss a range of possible solutions. The Summit was well attended and whilst there were not any new/innovative actions identified on top of the work in place it was more about a coming together, acknowledgement of the need to improve and consider the use of marginal gains at all stages of the process to improve the position. Ultimately the summit concluded that senior Leadership is essential, as is thinking differently which aligns with national thinking as best practice

Actions in place

- The Governance of the Incident Review Meeting (IRM) to only escalate incidents if absolutely necessary or there is a real opportunity for learning identified (support of commissioners and regulators required for this approach)
- Prompt allocation to either corporate investigators or Directorate Teams
- Regular 'check in' with authors to support 'blockages' (time, confidence access to information)
- Senior Directorate staff commitment and availability to support and provide leadership

- Report at the point of sign off - good standard to allow focus on robust recommendations
- Prompt completion of an action plan in response to well considered recommendations.
- More robust actions should reduce repeated incidents
- Corporate investigation team focusing on complex incidents - as the backlog reduces will have more impact

Incident Oversight and action plans post investigation

The incident oversight group (IOG) 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. There remains a challenge for the completion of action plans post incident investigation. All three directorates have plans in place and have been strengthening processes to robustly oversee the implementation of actions. These foundations should start to show an improvement. We are using QI methodology to track and work towards Zero delayed reports by the end of June 2022- (current position provided in appendices). The actions are managed via IOG, and actions are described as part of the ORR.

Patient Safety Strategy

The implementation of the Patient Safety strategy has been delayed nationally as a result of the COVID pandemic. In relation to the management of incidents the Patient Safety Incident Response Framework (PSIRF) final publication nationally has also been delayed.
This PSIRF is a real shift in thinking and because of this has been trialled at earlier adopter sites. Their feedback has been evaluated by NHSE/I and changes made and we are expecting publication of the final PSIRF imminently. It is anticipated that organisations will take up to 12 months to transition to this model. The evidence from early adopters is that it is important that we do not try to slot this new process into 'old thinking'. Within the Trust, we have been, where possible, creating foundations for this new model by implementing and developing IRM, moving away from Root Cause Analysis (RCA) and instead using human factors and system thinking as an investigation response. The recruitment of independent incident investigators from a range of backgrounds is fundamental to the change in thinking and is a key strategy as part of PSIRF. The Patient Safety Strategy advises that such investigators must be appropriately trained, suitably independent, and overseen by appropriately qualified leaders. Within LPT, we have appointed 8 new investigators who are suitably trained and offer a level of independence due to centrality and nature of their portfolios.

The success of this model relies on those responsible for commissioning and overseeing and receiving these investigations also having awareness of this new thinking. This was shared with Trust Board at their development session.

The Patient Safety Strategy works on a model of Patient Safety being everyone's business. It moves us away from Safety I (reacting only to incidents) to Safety II (considering what goes well and doing more)
The model works on three stages

- **Insight** (what data/information do we have, how do we use it, triangulate it present it)
- **Involve** (do we involve the right people -most importantly our patients and their families)
- **Improve** (do we use robust methodology to agree what to improve and how)

The model also describes that organisations must use their 'insight' to develop their approach and cautions against having too many projects underway and not successfully implementing them.

The PSIRF recommends that we analyse carefully our incident profile, consider what we know to be appropriate tested and evidence-based interventions and implement them and focus our investigation efforts where there is the maximum opportunity for learning. The preparation for this cannot commence unto the updated model is published.

We are currently testing an aligned model to the PSIRF recommendations within DMH to identify the 'themes' coming out from serious incident and internal investigations that continue to feature in spite of individual action plans being developed and implemented.
The themes are gathered from a range of senior participants who attend the fortnightly sign off meeting – this allows a wide range of input from individuals who have read and heard the stories from incident investigations as well as the investigators themselves. These themes are collected over a quarter using key theme titles and logging of incident numbers against it to build up the strength of the theme. This reduces the risk of bias. There is then an extended meeting to discuss the emergent themes and agree those that need onward escalation to DMT for consideration for a Quality improvement project supported by the Improvement Knowledge Hub and with oversight and scrutiny of progress at DMT. Once this pilot is completed, the outcome, learning and developments will be shared with CHS and FYPC/LD for similar cross Trust learning and consideration within DMTs.

The strategy also requires organisations to have a Medical Devices Safety Officer (MDSO) and a Medication Safety Officer (MSO). The MSO is currently the Head of Pharmacy. This role was introduced in a patient safety alert in 2014. The patient safety strategy has re described and refreshed the role in the model of the strategy and the Heads of Patient Safety and Pharmacy have been discussing the need for this role to have more independence and dedicated time to proactively approach medication safety (Safety II).

Involving patients in patient safety

There are two areas to this:

Part A – involving patients in their own safety - this requires further consideration.

Part B - recruiting two Patient Safety Partners for two of our safety related committees.

We are working with patient experience to recruit to these posts. It is essential that we ensure we have the culture, framework, training, and support structure in place for this to be successful. The time scales have been extended for our patient safety partners to be in place to the end of September 2022.

Patient Safety Training
The patient safety training level 1 and 2 has been published and the Patient safety team and Comms are working to develop the introduction of this to LPT staff

Summary
The implementation of the strategy has been delayed across the NHS by the pandemic. We have, however, been working towards the principles and developing the right systems and processes and culture and thinking so we have not lost this time. The cultural foundations of just culture and learning are key to the success of the rest of the strategy. We have work underway in various stages of maturity in all of the areas required of the strategy. The key deadlines being recruitment of our patient safety partners by 2022, the embedding of the patient safety training level 1 + 2 as soon as possibly with an ambition to adopt across all staff. The introduction of the PSIRF over the next 12 months.

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, we continue to describe that incident reporting should not be 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' continues and is an improving picture with senior support and oversight. The position will have governance and oversight through IOG. The prompt oversight and management of incidents is part of a strong safety culture. We also have a robust 'safety net' system in place to regularly review and 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.

Review of Patient Safety Related Incidents

The overall numbers of all reported incidents remain above the previous mean and can be seen in our accompanying appendices. The majority of the increase is due to staff reporting COVID positive.

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

There continues to be no discernible reduction in the number of pressure ulcers reported. The in-depth review and listening events undertaken in CHS has elicited areas for improvement that were previously unseen. These have been worked into QI projects and these projects have recently been re invigorated and detail shared at both Quality Forum (QF) and at Quality Assurance Committee (QAC). CHS Director and HON meet regularly with the QI lead and workstream lead to receive feedback on progress and support as required.

Areas of focus are

- initial assessment -ensuring it is a qualified nurse is allocated to the first visit.
- ensuring patients/carers are enabled to be involved in their own care and understand the risks
- equipping staff with the skills and confidence to undertake Mental Capacity Assessments to support the above
- ensuring all staff are familiar with all of the equipment/interventions available to support patients

In addition to the work in CHS, the trust wide pressure ulcer prevention group is being re invigorated and will now be chaired at Deputy Director of Nursing Level. Progress will be reported via Patient Safety Improvement Group (PSIG) and updates provide through future reports.

Falls

The falls group have struggled with membership/attendance during the pandemic due to the key members of staff working clinically. The Terms of Reference for the group have been refreshed and the membership updated, and they are working to build on the work started. The group have developed a whole bed management policy to support staff to make informed decisions around keeping patient safe who may be at risk from falling from bed. It has become custom and practice to lower the patient's bed to reduce the risk of falling however, patients who can stand independently can be at more risk from standing from this low level.

Deteriorating Patients

This is the term used to describe a clinical physical deterioration. The numbers of incidents relating to this are not easy to quantify as they are often reported under different categories. The deteriorating patient group are working to develop a process so that they consider our recognition and response post any cardiac arrest, when patients are unexpectedly transferred back to the acute trust and from any relevant SI's. This focus is identifying some emerging themes around delayed escalation of patients who are deteriorating, the management of observations and management of

fluids. The Deteriorating patient group direct task and finish workstreams to strengthen staff knowledge and process and oversight of these areas and will report progress via PSIG.

All Self-Harm including Patient Suicide

We continue to report 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 may have contacted CAP have 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.

Suicide Prevention

The suicide prevention lead has retired and DMH are recruiting to this role whilst reviewing suicide prevention models to consider bets practices nationally.

The suicide prevention group has re-established and is re looking at their work program and membership.

Violence, Assault and Aggression (VAA)

The trial of body worn cameras has now commenced within DMH and early feedback is positive. Already funding has been secured to extend the scheme and purchase more to roll out in more areas.

Medication incidents

There has been a theme identified around the management of controlled drugs in the community. Early review suggests that this is a system error, and a task and finish group has been convened to consider the system and support a Human Factors approach to support staff to administer and document controlled drugs safely in the community. There is now a pharmacist member of the IRM which is providing that important link and oversight.

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. We continue to work with our other commissioners to provide assurance around our improvement work and progress towards the implementation of the patient safety strategy

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. We do have a backlog of deaths yet to be reviewed. Each directorate has a recovery plan.

Learning Lessons Exchange

The Learning Lessons exchange group joined together with the FYPC/LD group in April to consider the CQC Out of Sight report- this report looks at the use of restraint, seclusion, and segregation in care services for people with a mental health condition, a learning disability, or autistic people. The group considered the report and its recommendations using their multidisciplinary/speciality experience to consider the current position. An improvement plan is being developed

Sharing Learning

Through PSIG we are using patient stories to use within directorate and to share learning across directorate. These stories are discussed at PSIG to ensure we are really focussing on what the learning is. This is part of our culture and new way of thinking. An example of stories is shared as an appendix to this report Appendix 2

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:	Public Trust Board 31.5.22	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Tracy Ward (Head of Patient Safety)	
Date submitted:	18/05/2022	
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:		

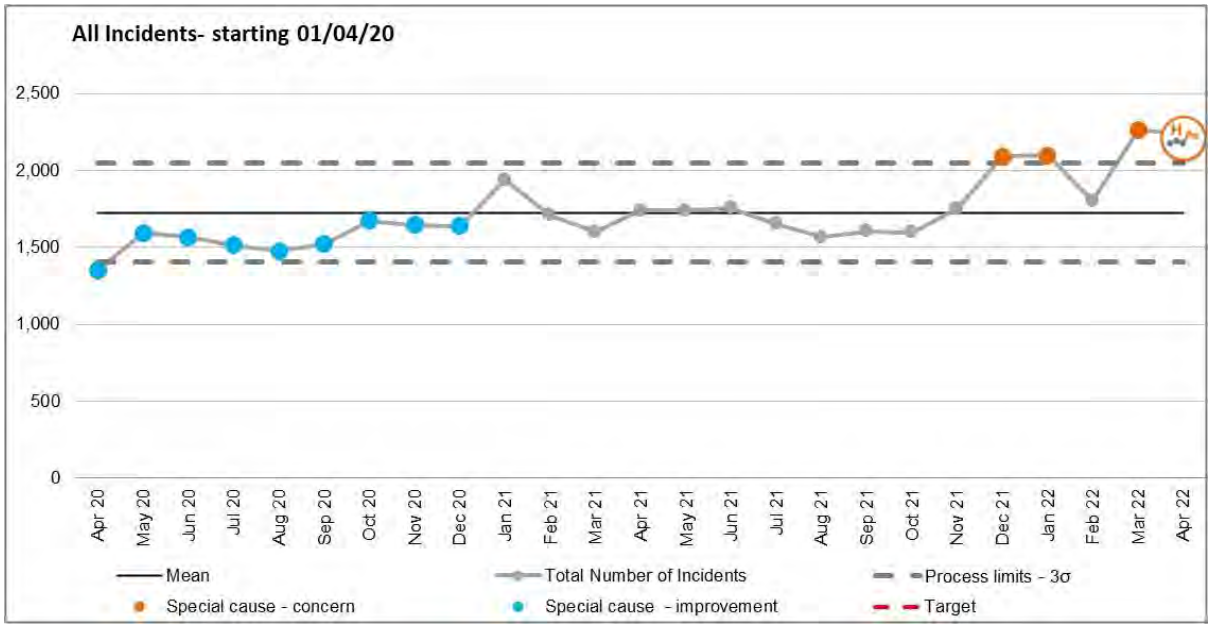
Appendix 1

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

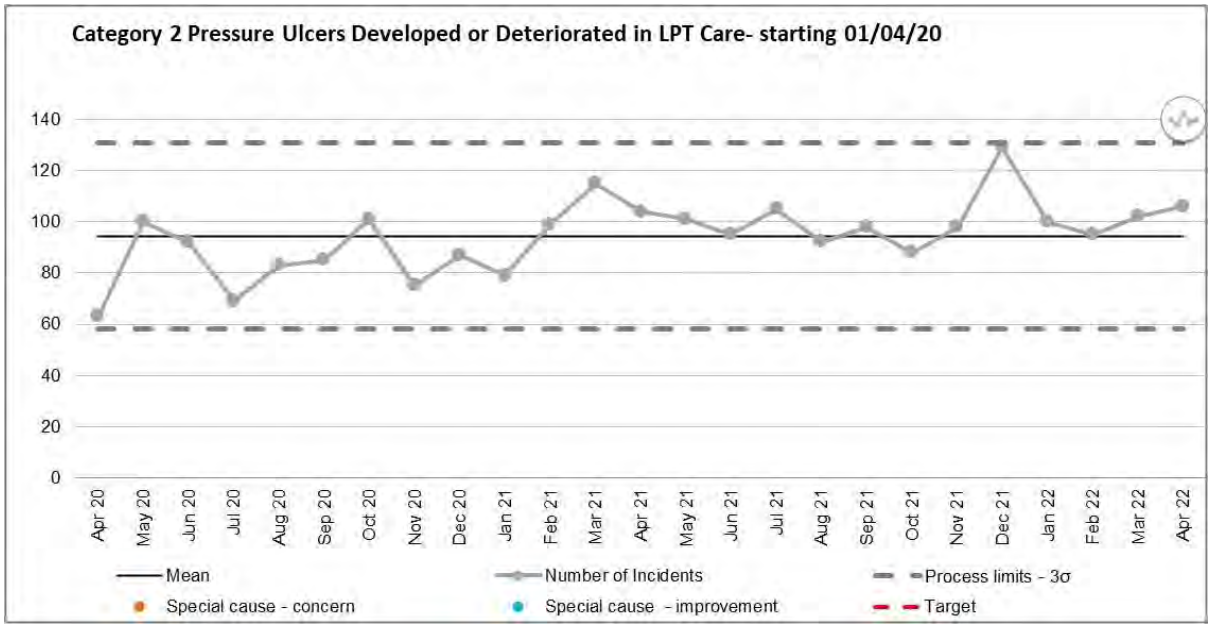
Any detail that requires further clarity please contact the Corporate Patient Safety Team

WeAreLPT
compassion respect
integrity trust

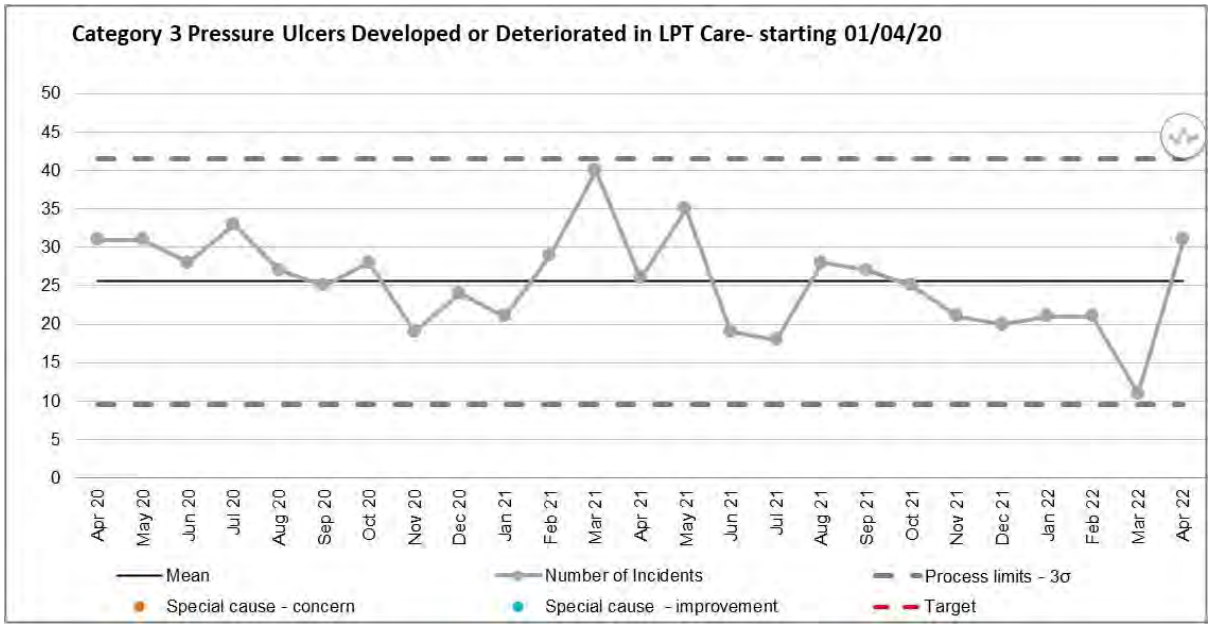
1. All incidents



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

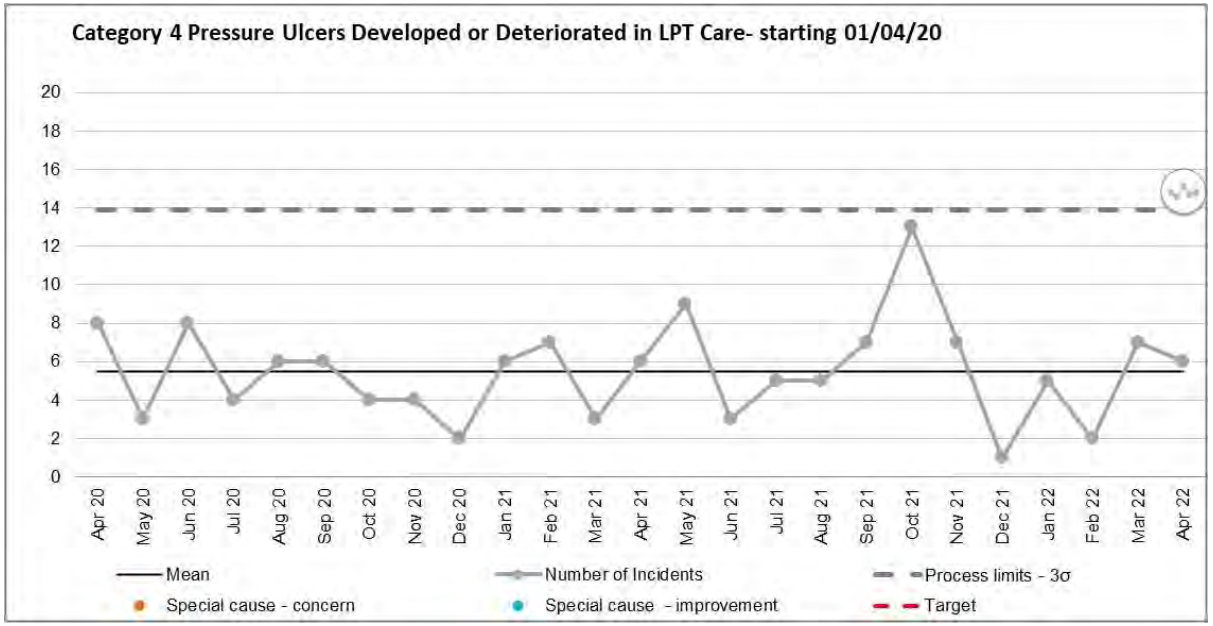


3. Category 3 Pressure Ulcers developed or deteriorated in LPT Care



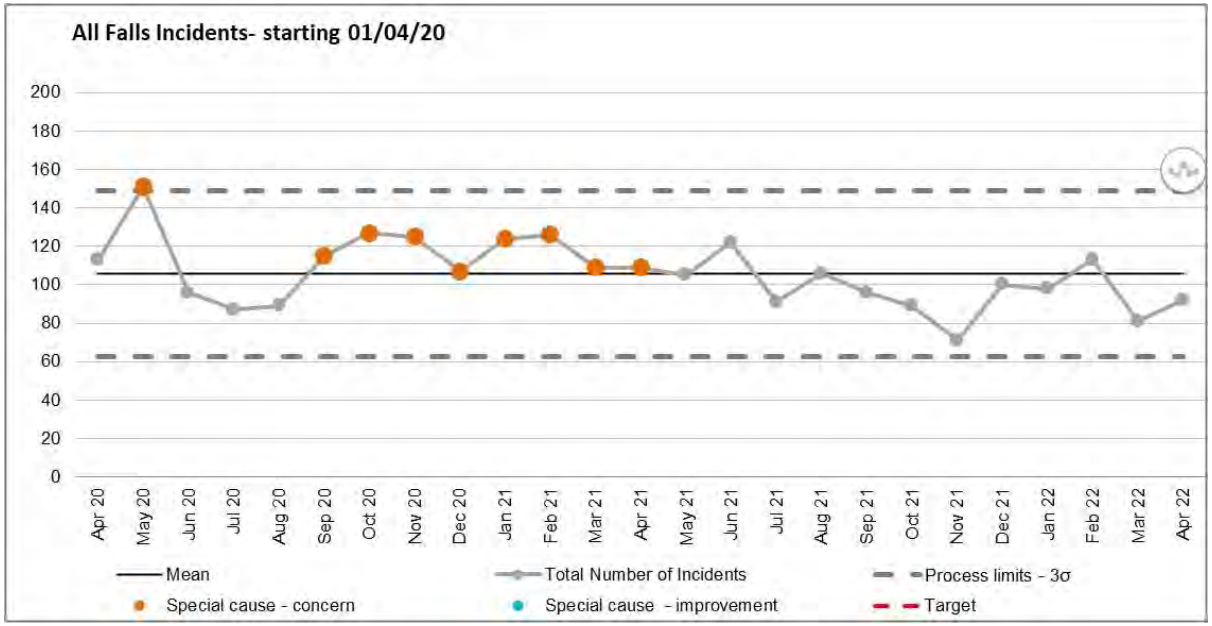
WeAreLPT
compassion respect
integrity trust

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



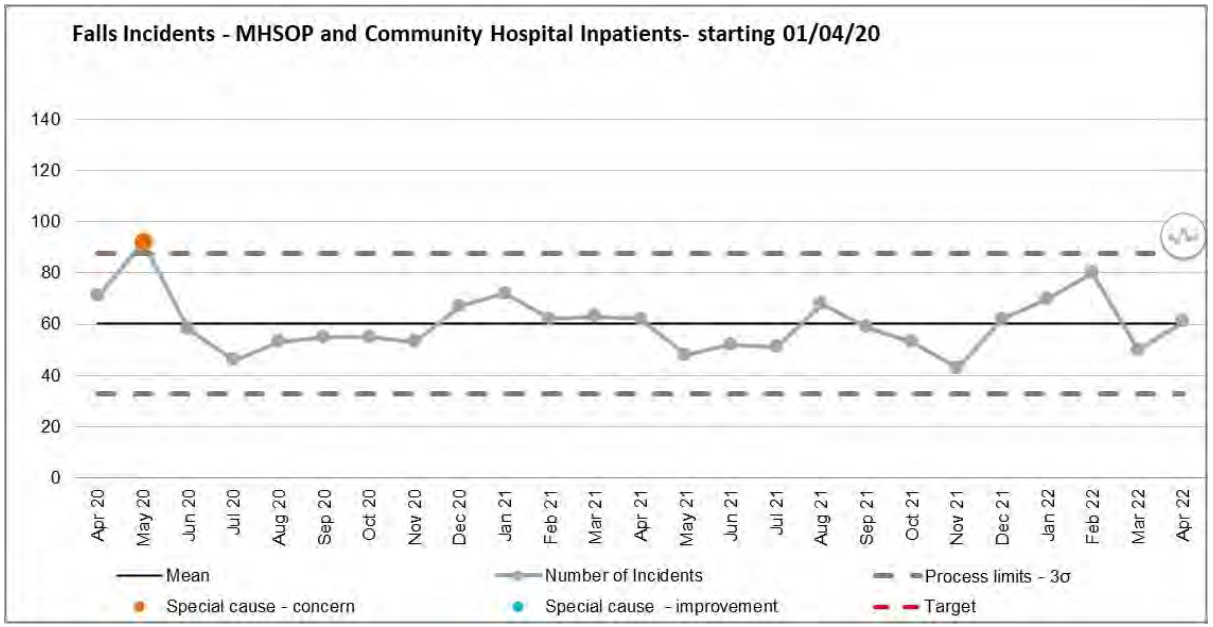
WeAreLPT
compassion respect
integrity trust

5. All falls incidents reported



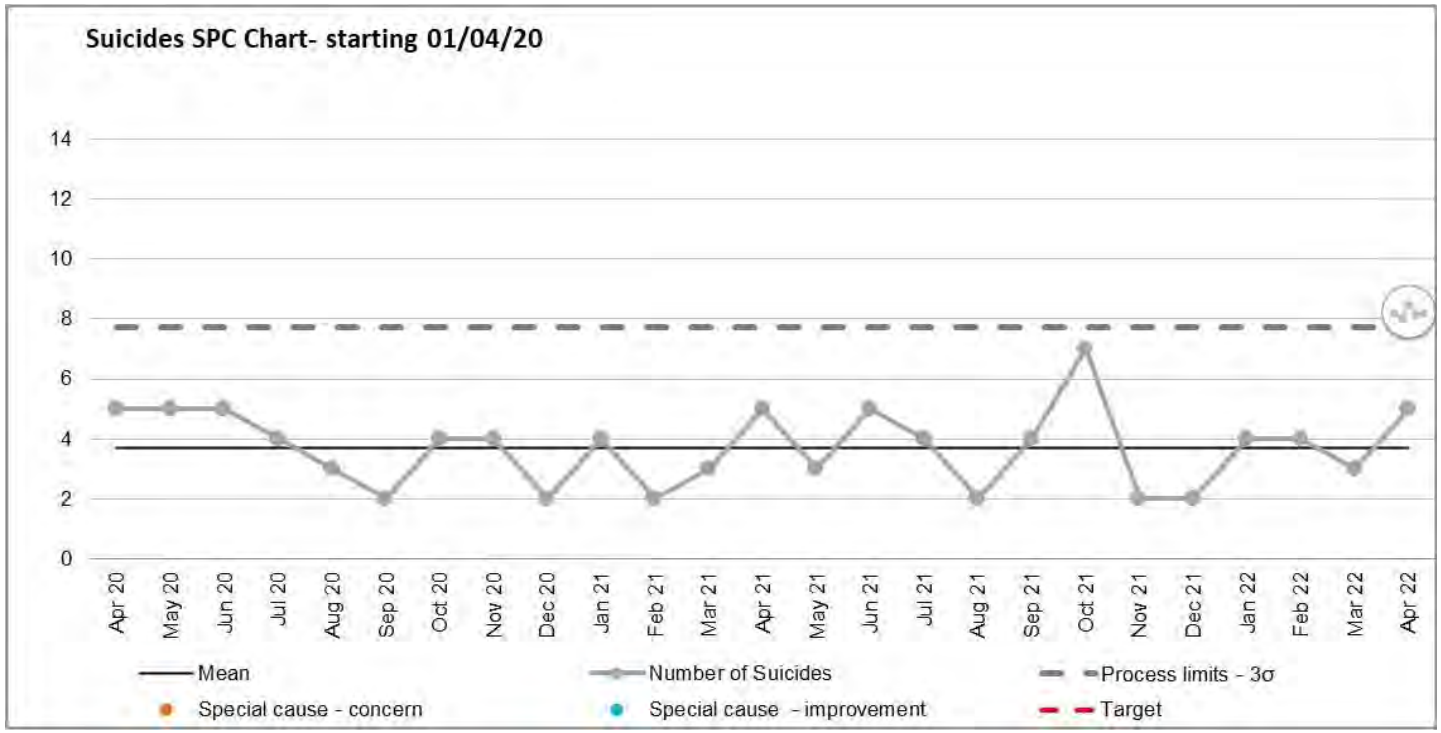
WeAreLPT
compassion respect
integrity trust

6. Falls incidents reported – MHSOP and Community Inpatients

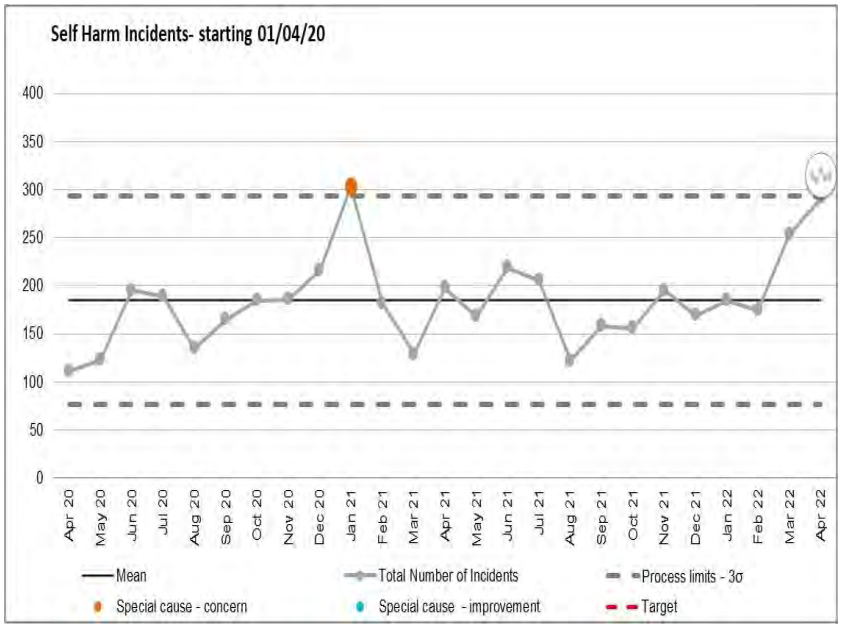


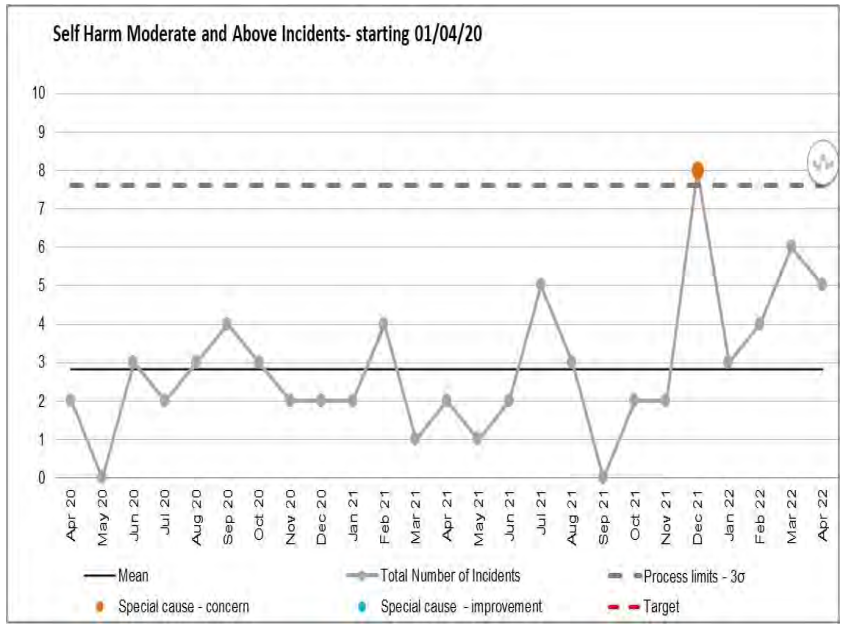
WeAreLPT
compassion respect
integrity trust

7. All reported Suicides

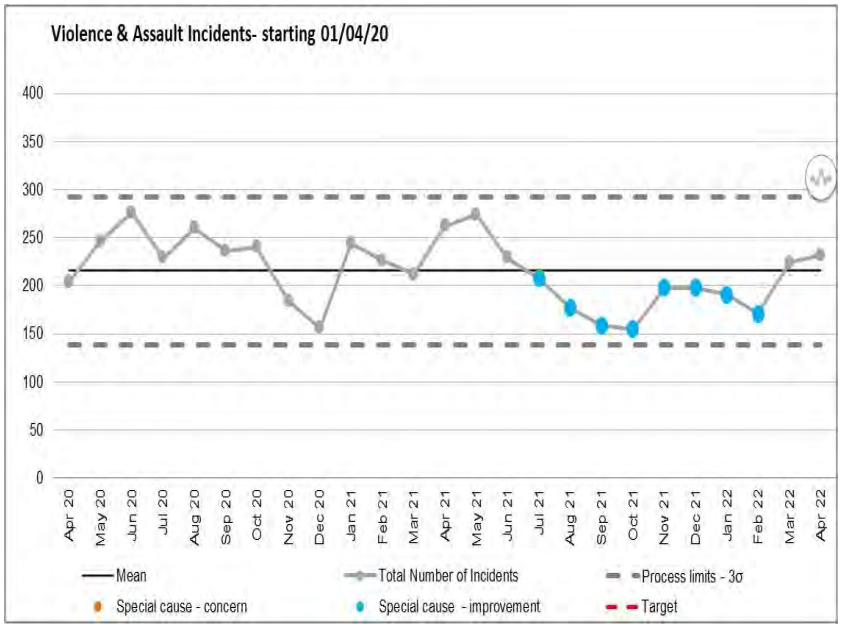


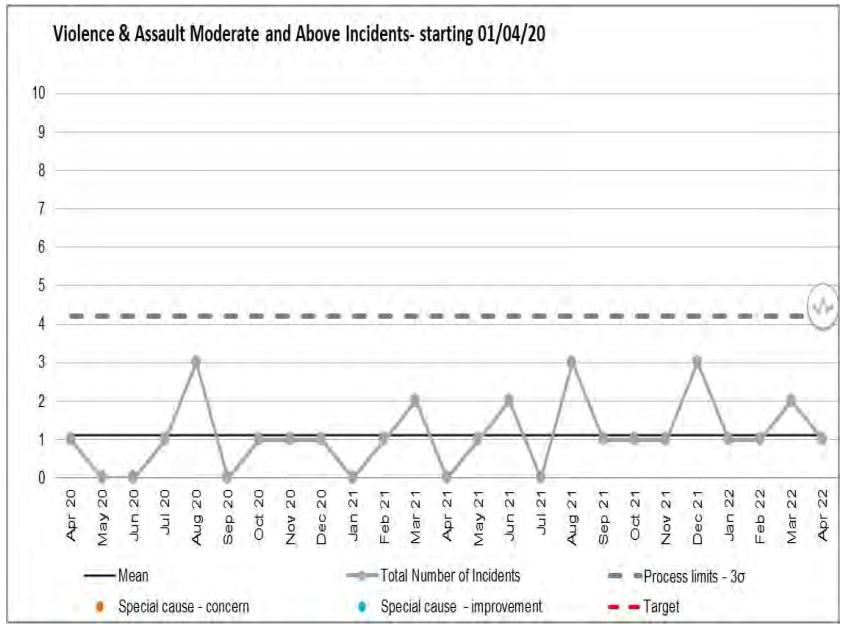
8. Self Harm reported Incidents





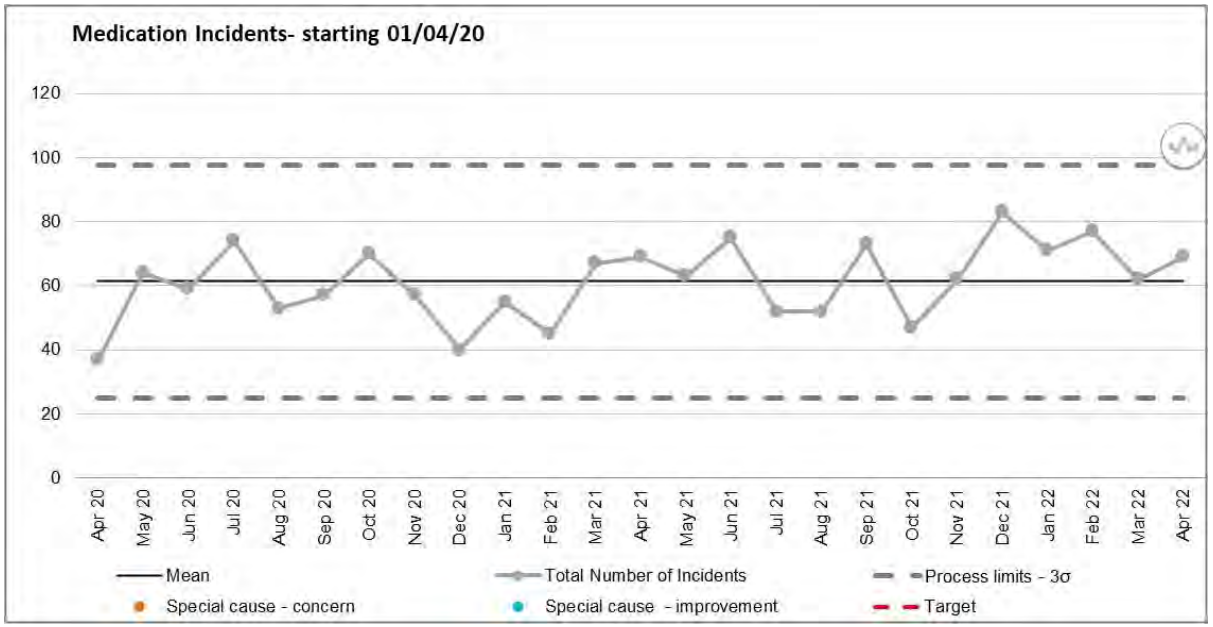
9. All Violence & Assaults reported Incidents





WeAreLPT
compassion respect
integrity trust

10. All Medication Incidents reported



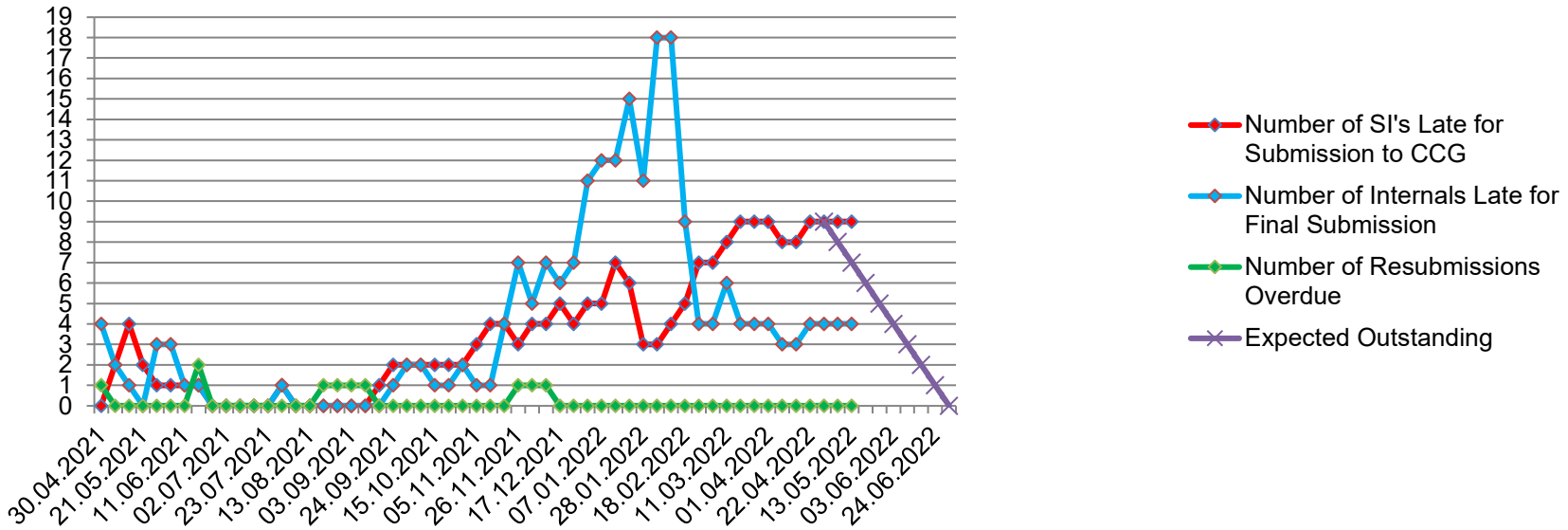
12. Ongoing - StEIS Notifications for Serious Incidents

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	0	5	0	1	4	4	2	12
YTD			83	19	29	103	58	23	66
2022/23 Q1	April	0	2	0	2	10	3	3	3
	May								
	June								

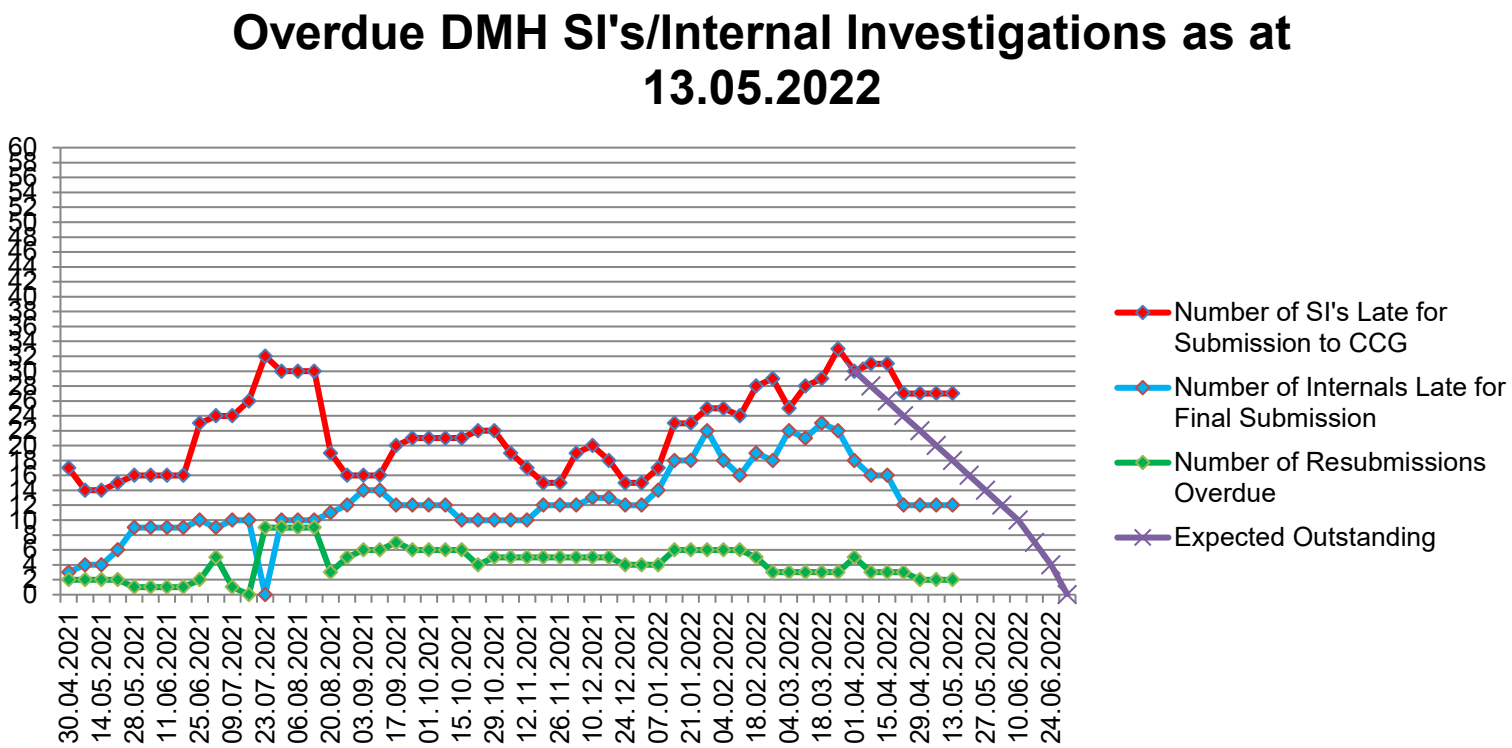
WeAreLPT
compassion respect
integrity trust

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

Overdue CHS SI's/Internal Investigations as at 13.05.2022

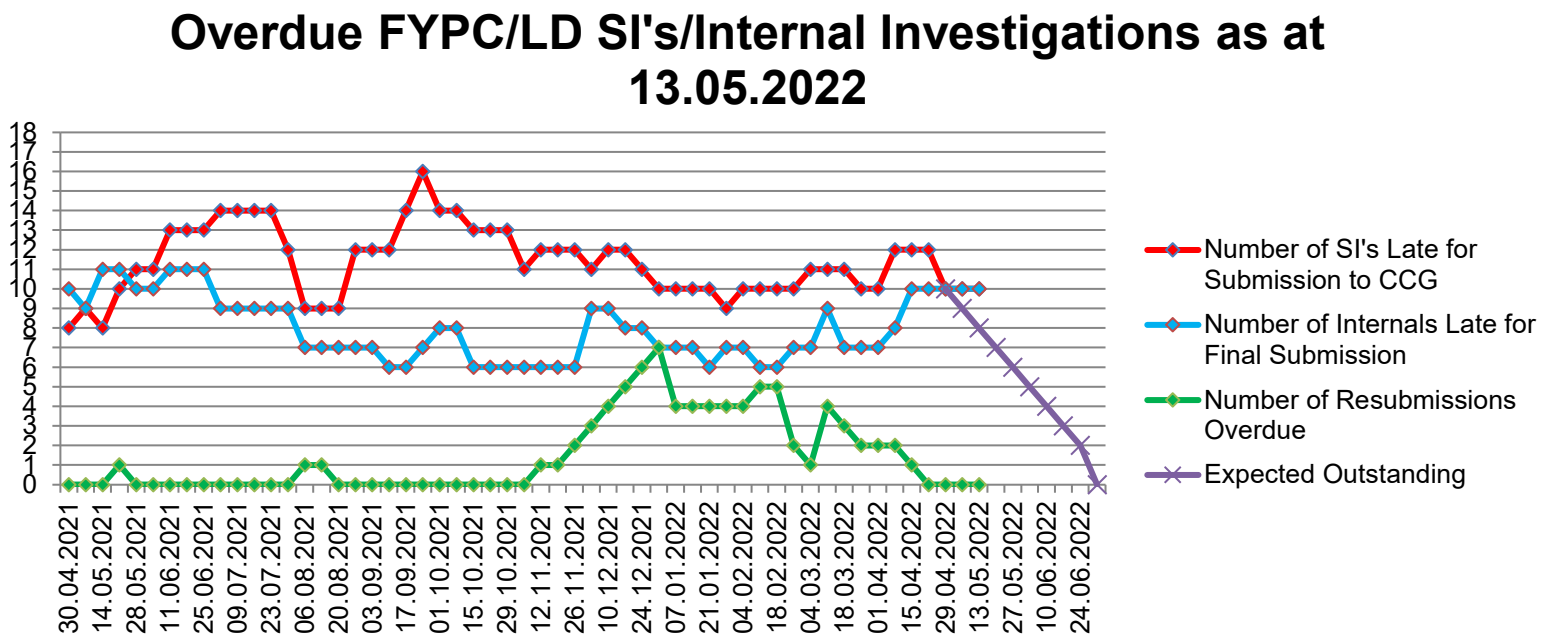


12a. Overdue Serious Incidents/Internal Investigation & CCG resubmissions (includes totals) - DMH



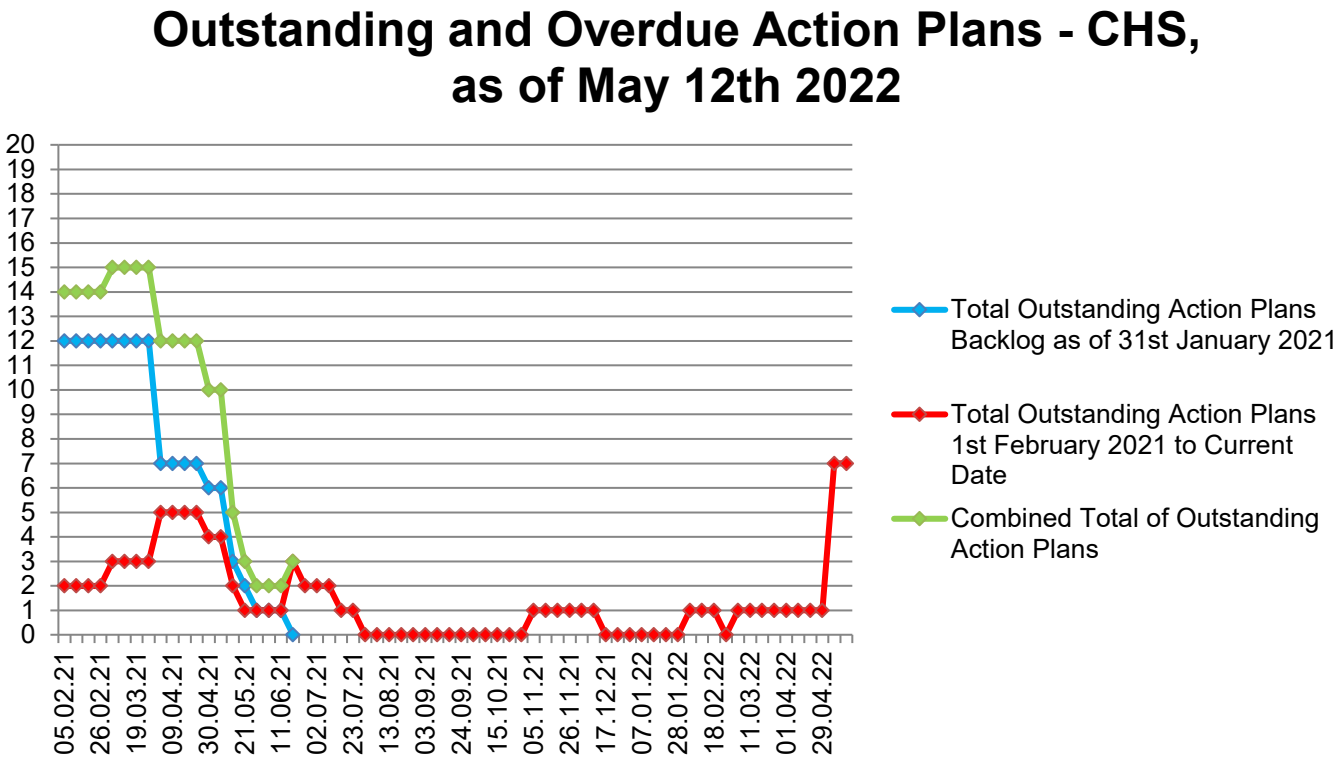
WeAreLPT
compassion respect
integrity trust

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

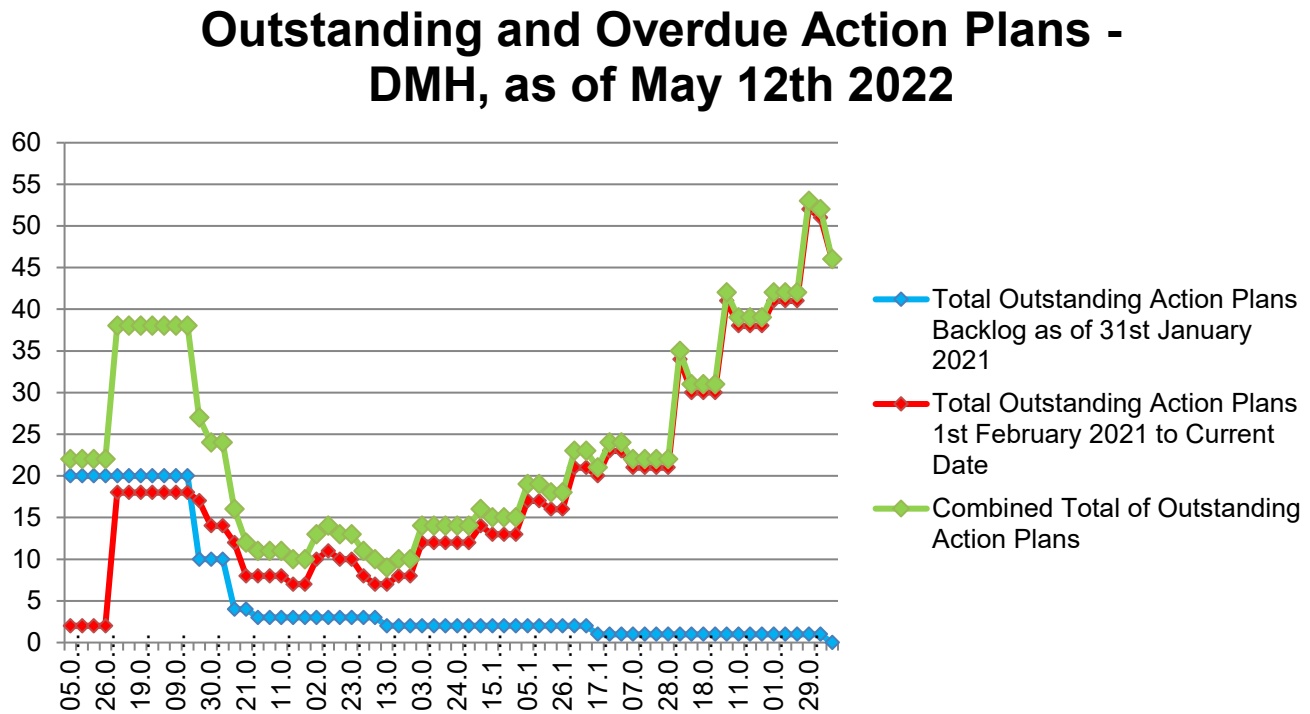


WeAreLPT
compassion respect
integrity trust

12.b Directorate SI Action Plan Compliance Status 2021 to date - CHS

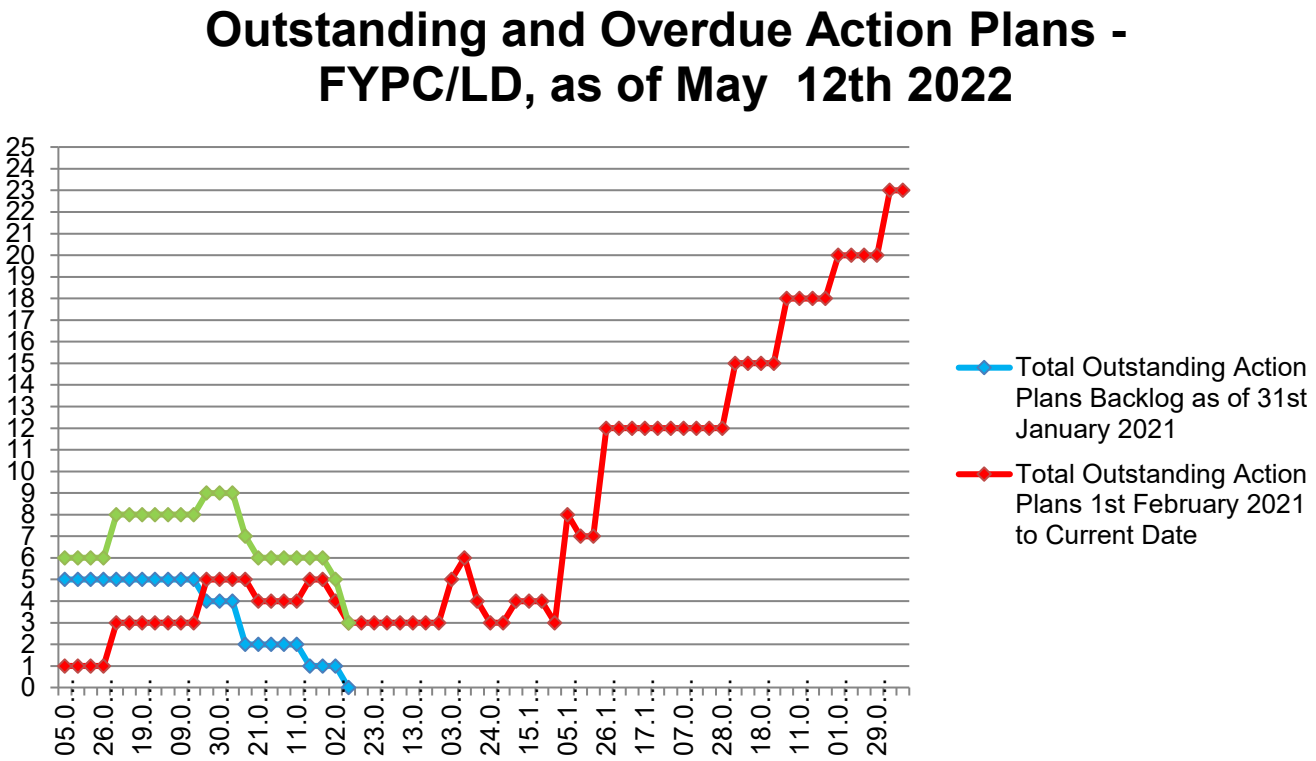


12.b Directorate SI Action Plan Compliance Status 2020/21 to date - DMH



WeAreLPT
compassion respect
integrity trust

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



WeAreLPT
compassion respect
integrity trust

12. Learning

Serious & Internal Incidents emerging themes

- Lack of communication or joined up approach between teams within LPT **Action –**shared with all Directorates as an emerging theme from IRM
- Mental Capacity Assessments **–** staff confidence to undertake **Action** training being provided to District nursing face to face and bespoke for their context
- Communication and engagement with patients families **Action** this is being considered as a whole trust action (patient safety/patient experience and clinical governance)
- Management of Controlled drugs in the community **Action** Task and finish group led by Anthony Oxley to consider the system issues

NHS
Leicestershire Partnership
NHS Trust

Gladys's story

Gladys was an 82-year-old lady who was a resident in a dual registered care home. She was diagnosed with Type 2 Diabetes, with advancing Alzheimer's dementia and was bed bound and unable to mobilise. Gladys was referred to the Community Nursing service by the GP on Monday 29th July 2019. In Oct 2020 she was relocated to another care home due to the closure of her original placement. She was placed in a residential care bed and so the Community Nursing Service supported care with insulin administration and latterly with wound care. Gladys died on Friday 29th January 2021 – the cause of death is to be confirmed and is subject to a Coroner's investigation.

Circumstances leading up to Gladys's death

The GP records show that Gladys was not for resuscitation and had a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form in place from October 2020. Her active problems were recorded as Alzheimer's disease, Type 2 Diabetes, essential hypertension and asthma.

On the three days leading up to her death, records show that blood glucose readings had been rising:

o 26th January 2021 the reading was 13mmols.

o 27th January 2021 the reading was 17.3mmols

o 28th January 2021 the reading was 19.2mmols

o 29th January 2021 the reading was 29.2mmols

These readings represented a marked difference from previous readings which ranged from 4.7mmols to 10.8mmols throughout January 2021.

For comparison the normal range for blood glucose is 4 to 7mmol/l before eating and under 8.5 to 9mmol/l 2 hours after a meal.

The blood glucose target range for Gladys was not known.

Emergent issues

- It was custom and practice that care home staff recorded residents capillary blood glucose prior to the nurse visiting.
- Staff were task focussed
- There was no “diabetes management plan” in place for Ms F.
- Increasing hyperglycaemia was not recognised, escalated or treated.
- Inadequate ownership of Ms F’s clinical condition was taken by nurses and placed instead on carers in the residential home.

Changes to practice following the lessons learnt

The case concerning Gladys occurred after a Serious Incident in 2020 involving a different patient and the management of insulin and diabetes. After consultation with front line staff a series of changes were rolled out from March 2021 across every District Nursing team. Since then, and since these events, further changes have been developed and implemented centring around hyperglycaemia recognition, escalation and management.

- Nurses no longer expect care staff to carry out capillary blood glucose monitoring prior to their visit. It is recognised that this important step is the nurse's responsibility. The readings must be carried out with an LPT issued meter that is calibrated and quality checked. Account is taken of past readings.
- Since March 2021 new insulin authorisations are in place and explicitly contain both target capillary blood glucose readings and management plans. Nurses are tasked with ensuring patients have access to prescribed and authorised rapid acting insulin.
- Since March 2022 a new hyperglycaemic pathway has been developed and implemented that sits in patient records and is carried by every nurse/ HCSW who administers insulin. The aim of the pathway is to identify hyperglycaemia as well as check for underlying reasons for hyperglycaemia using the NEWS 2 score. Treatment and escalation of hyperglycaemia will be in accordance with the pathway.

Changes to practice following the lessons learnt

- Since March 2021 the patient held documentation for those patients in receipt of insulin via a community nurse has been comprehensively overhauled and standardised across all GP practices and District Nursing teams. In addition to the recently introduced hyperglycaemic pathway changes also include:
- New A4 hard backed, professionally printed and branded documentation folders.
- New insulin electronically generated (in S1 and EMIS WEB) authorisations that include management plans and target capillary blood glucose ranges. The ranges prepopulate at 6-16mmol/l (this is seen as a safe range that suits most elderly type 2 diabetics on insulin) but can be changed by the prescriber.
- New Record of Insulin Administration Cards. These make it easy for nurses to document the insulin and dose given, the time and date of administration, the batch number together with the capillary blood glucose reading and when the patient last ate. These forms make review a simple process for a presciber.
- New insulin profile “at a glance sheets”. These are full colour and show a picture of the insulin/device, it’s profile action and when it should be administered. The insulin/s the patient is prescribed are the only profiles that are put into their documentation.
- New care plans have been developed to allow nurses to be accurate in describing the purpose of the visit. These must be individualised.
- NEWS 2 and Sepsis recognition sheets are available in each set of notes.
- The contract with Roache Medical to supply blood glucose monitors has expired. LPT now need to procure a new supplier ideally to provide meters that also record blood ketones. This will bring equipment in line with the hyperglycaemic pathway.
- Recognising Human Factors we are currently pursuing the purchase of standardised clearly labelled, lidded boxes to segregate rapid acting insulin from other insulins in order to mitigate as far as possible the risk of selecting and administering an incorrect insulin.

SERIOUS INCIDENT REVIEW 1 – Amy's Story

About Amy:
Amy is a 16 year old young lady who was admitted as an informal patient to the CAMHS Beacon unit on following a planned overdose of multiple tablets with the intent to end her life. During her admission the decision was made for her to become a formal patient under section 3 of the Mental Health Act.

Amy has a history of anxiety and depression, as well as concerns regarding her eating for which she has previously required naso-gastric feeds. She had recently disclosed that she had been groomed online and was known to ward staff to be extremely vulnerable.

Prior to this incident there had been a marked reduction in suicidal thoughts and Amy was managing to keep herself safe. She had not engaged in any self-harm behaviour for three months and was looking forward to her discharge.

↓

What happened to Amy:

During the evening of Friday the 23rd of April 2021, Amy approached a staff nurse and reported she needed to tell them "Something that happened made [her] feel uncomfortable". Amy then alleged that that morning a male Health Care Support Worker (HCSW) walked past her in the corridor, slapped her on the bottom stating that he "couldn't resist".

Note: Despite being a victim of grooming and on-line exploitation, Amy was able to recognise the behaviour of the HCSW was a concern and raise this with staff.

↓

Effect on Amy and her family:

Following the incident Amy was reported to be physically safe and well. she reported feeling anxiety and was supported appropriately by the ward staff. Psychological support was offered to her following the incident and she was supported to engage with the police investigation. Amy was also referred and accepted to 'United Against Violence and Abuse' (UAVA) and the ward facilitated his contact.

She is now being cared for in a health provision closer to her home.

Amy's mother was very upset regarding the incident and disappointed that this could happen when her daughter was in a healthcare facility. Staff kept her updated regularly.

↓

SERIOUS INCIDENT REVIEW 1 – Amy's Story

Good Practice:

CCTV: The CCTV footage was reviewed very soon after the event which showed clearly the HCSW making contact with Amy's bottom with his hand. This footage was saved and given to police when requested with no reported delays.

Support: Amy was given support immediately from the nursing staff and there were clear plans on how to ensure she had the correct ongoing support. Following this incident the patient became vocal about her being a victim and she was supported with managing her feelings around this.

↓

Learning:

Raising concerns: The junior doctor did address her concerns with the HCSW regarding this incident, however HCSW downplayed the incident leaving the junior doctor to doubt herself. This may have influenced their decision to wait to escalate this until the following week. It is positive that the junior doctor recognised that this was wrong initially however, important that all staff are aware if their responsibility in escalating concerns and ensuring the right people are notified to explore concerns further.

Escalation: The incident was witnessed by a junior doctor in the unit. They intended to raise this with the matron but were unable to find them so decided to notify them after the weekend. This member of staff was up to date with their safeguarding children training and their safeguarding supervision was delivered as part of their clinical supervision. Although the safeguarding training does cover raising concerns, his incident highlights that there is a need for staff to have more information regarding concerns about people in a position of trust. This training would have highlighted the need to take immediate action to safeguard the young person and other young people on the ward.

Action
The safeguarding team are currently delivering bi-monthly safeguarding supervision sessions and these have been expanded to include the whole of the multi-disciplinary team on the unit to ensure there is specialist oversight and support.

Amy notified senior nursing staff that evening and provided support for the child however, there was no escalation of the safeguarding concerns until the next day when this was picked up by the Acting Deputy Head on Nursing (FYPC.LD). This young person was provided support however, incident should have been escalated on the day and the LLR safeguarding Children procedures should have been initiated. The care was patient centred but the staff on shift did not recognise the need to escalate this as a safeguarding concern that day and to let the senior manager on call know so restrictions could be put in place.

SERIOUS INCIDENT REVIEW 1 – Amy's Story

Vulnerability: it is acknowledged that due to the age and the needs of the patient group, allegations against staff are high in this area of work. Staff have voiced that they are concerned about allegations being made against them and also the Local Authority Designated Officer (LADO) process. Further work has been completed on the unit to support staff in understanding the process and the support that they will be given if an allegation is made against them

↓

Actions & Transferable Learning:

Action: The allegation against staff policy was followed and referred to the police, social care and also the LADO.A full HR investigation was completed.

It was clear that staff listened to Amy and ensured that she was supported, however the safeguarding concerns were not escalated appropriately.

When working with patients who are unwell, it is paramount that shift action is taken to explore any concerns, to safeguard the patient, other patients and also staff. This learning has also been reflected in reports such as the Winterbourne report which highlighted prolonged abuse which was not acted upon. It is paramount that the safeguarding training outlines staff responsibility to act upon any concerns of abuse or poor practice, and follow local policies as well as the Safeguarding Childrens Partnership Procedures.

Recommendation: Consideration to be made to increase Beacon MDT staff awareness of Allegations that an Employee/Bank Worker may be Harming a Child, Young Person or an Adult at risk, Policy and Procedure and LADO processes.

Recommendation: To review induction and refresher training in relation to staff behaviour and maintaining safe professional boundaries to include reporting witnessed incidences.

Recommendation: Review information provided to Locum Medical staff in regard to escalating concerns in line with LPT policies.

Recommendation: Beacon Medical staff should access the current safeguarding supervision provided by LPT Safeguarding Team.

NHS
Leicestershire Partnership
NHS Trust

Patient safety – learning from a CQC Concern

Directorate of Mental Health – Acute Inpatient

Learning from Jean
Through a CQC Concern

MEET JEAN

(named changed for confidentiality)

Jean is a 53-year-old lady, who was admitted to Bradgate Mental Health Unit on 1st February 2022 under Section 3 following a Mental Health Act Assessment in the Community.

Jean has a diagnosis of Bipolar Affective Disorder and has recently been diagnosed with low grade Non-Hodgkin's Lymphoma

Leicestershire Partnership NHS Trust

WHAT DID JEAN TELL US?

- Jean told us she was prescribed the wrong dose of medication
- Jean was upset about being on a mixed gender ward when she was first admitted
- Jean felt that her treatment for Non-Hodgkin Lymphoma had been affected by her admission
- Jean was distressed over incidents involving other patients towards her
- When stood outside of the glass office on the ward Jean said that at a certain point, patients notes can be read on a computer
- The ward garden and smoking was a theme of Jean's concerns particularly in relation to litter and ability to discard cigarette ends
- Jean told us about environmental concerns ie- exposed, nails and raised manhole covers
- Infection Prevention and Control – being offered a mask

WHAT DID WE DO

One of our acute Matrons met with Jean to talk through her concerns as soon as we received the information from the CQC and importantly said sorry for her experiences

We reviewed Jean's Electronic Record and liaised with the Ward Sister

We put together a thorough response that was sent to the CQC and also talked this through with Jean

WHAT DID WE FIND

- We found that staff and medics responded to Jean's concerns and wishes regarding medication i.e. the change to Lithium dose, preference regarding time of the day of certain medications and discontinuation of other medication.
- We explained to Jean how our admissions take place due to COVID-19. Our admission ward has specific gender bedrooms on opposite gender corridors and enhanced therapeutic observations based on risk
- A member of staff from the Ward contacted Jean's Lymphoma Specialist Nurse and it was agreed to postpone Jean's treatment until she was in better mental health. The ward undertook tests requested from the Specialist Nurse and kept in regular contact
- There was one incident identified that involved a patient taking Jean's phone without her consent. We said sorry to Jean that this happened, and we acknowledge the impact of this on her
- We looked at the ability to read patient information on the computers in the office and found that the only opportunity to view the screens would be from the opposite side of the office. Even though we are assured it is not possible to read the screens, privacy screen filters will be purchased by the ward sister as an additional protective measure to be placed over the computer monitors in the office.
- Regarding litter and smoking in the garden area, we found that Jean often would tidy the area herself. This is checked as part of regular checks we do, including an annual fire risk assessment. We said sorry for her experience of patient lighting cigarette in the wrong place
- We checked the environmental concerns Jean told us about and could not find the things she told us about. The environment is checks daily and recorded
- The use of masks for patients is risk assessed and unfortunately, we found no record of Jean being offered a mask or the outcome of a risk assessment.

Leicestershire Partnership NHS Trust

WHAT DID WE LEARN

The importance of meeting and talking to a patient when a concern is received, feeding back afterwards, and saying sorry.

Positive practice in relation to listening and responding to Jean's concerns about her medication and liaising with her Lymphoma specialist nurse.

The promotion of professional curiosity or ward leaders and staff in relation to ensuring confidential information and environments.

The need to risk assess the use of masks for patients and for this to be documented.

Medication should be prescribed on admission with the involvement of patients so that they can influence times/actual dose taken

R

Leicestershire Partnership NHS Trust

Trust Board 31st May 2022

Patient and Carer Experience and Involvement (PCEI) Quarterly Report (including Complaints) Quarter 4, 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 4.
- 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

As per the agreement made in December 2021, going into Quarter 4, the Trust maintained their 45 working day investigation timeframe due to the continued pressures on the services because of the ongoing Covid-19 pandemic, coupled with issues relating to sickness, annual leave, and general staff shortages. Although the current investigation timeframe is longer than it has been in the Trust for some time, unfortunately, for a variety of reasons, a small number of cases have breached their agreed timeframes, including a timeframe extension. The Complaints Team are working hard with services to ensure the complainant is kept informed in these situations.

In Quarter 4, the Trust formally registered 58 complaints in total, which is an increase compared to 52 registered in the same period last year and a decrease from the 66 registered in Quarter 3. Although Quarter 3 saw no reopened complaints for the first time, Quarter 4 saw a general increase in contact from complainants who remained unhappy with their complaint responses. As was the case in Quarter 3, the Complaints Team continued to work with the service and the complainant to agree a way forward in these situations. This work has again helped the Trust to keep their reopened complaints as low as possible whilst aiming to provide a better journey to resolution for our complainants.

As was the case in Quarter 3, the Trust continued to receive more complaints regarding District Nursing, CAMHs, Community Paediatrics and the Community Mental Health Teams (CMHTs), which has put further pressure on these services. Quarter 4 saw both the PALS and Complaints Teams attending some training/information sessions with CAMHs and Community Paediatrics to help us understand some of the specific pathways and how the services interact with other agencies. These sessions have been invaluable in creating a better working relationship with the services involved and it is hoped that 2022/2023 will allow us to link in with other parts of the Trust to upskill the team in the areas where most complaints are currently coming from. Going forward, this will allow the teams to be more comfortable answering certain simple queries, thus reducing the numbers of concerns, enquiries and formal complaints going to the services and reducing the overall pressure on our bank of investigators.

It has been noted for some time that one of the main reasons for complainants getting back in touch with the Trust, relates to them not receiving a call from the Lead Investigator. Following extensive work in Quarter 4 with the above issue in mind, by both Victoria Clarke, Clinical and Quality Governance Manager, DMH and Mary Mahon, Complaints Manager, a new Complaints Management Document (CMD) has been drafted and sent to key individuals within the Trust to provide comments and feedback. We aim to implement this new Complaints Management Document in 2022/2023 with the hope that the new design is more user-friendly, and this will have an impact on the quality of investigations, as well as reducing the number of complainants who get back in touch.

Moving into the new year, the team will continue to work closely with our colleagues in the directorates, having open, honest, and productive conversations regarding complaints and how we can improve our complainant's journey, as well as easing some of the pressure on our staff. This work has already been vital to the new more collaborative approach in both PALS and Complaints, and we hope that we can continue to grow our relationships and knowledge within the Trust for 2022/2023 and beyond.

Complaints Activity Data – January 2022 – March 2022

Key Performance Indicator	Q4 21/22	Q3 21/22
% Of complaints acknowledged within three working days	98%	97%
% Of complaints responded to within the date agreed with the complainant	99%	97%
Number of complaints upheld or partly upheld in quarter	21	29
Number of reopened complaints	8	0

Number of complaints formally investigated by the Parliamentary Health Service Ombudsman (PHSO)	0	0
Number of complaints upheld or partly upheld by the PHSO	0	0

The number of PALS contacts received in Q4 totalled 232 (including signposting), this is a 49% reduction on the numbers received in Q3 and are in line with those numbers seen in Q1. The reduction is mainly attributable to the reduction in the number of signposting enquiries which has fallen by 186. This reduction follows discussions with University Hospitals Leicester, to which many of the signposting referrals were made, and changes to information made available to patients and carers.

The number of concerns, comments and enquiries remained static with those received in Q3 at 235 contacts. In addition to these 10 concerns were received via CQC, all relating to adult mental health services. 13 MP enquiries/concerns were received in the quarter with 4 relating to services provided by FYPC/LD, 8 provided by DMH and 1 in relation to estates management.

Themes from complaints, concerns, and compliments

Q4 as with 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 24% of all contacts received. Communication between professionals and patients, carers and families remain a key theme with 24% of all contacts relating to communications followed by 18% in relation to patient care.

The deep dive into 15 complaints categorised against the communications category was undertaken in the quarter. The findings from the review demonstrated that although part of each complaint had a communication concern within it, there were also multiple other concerns contained within the complaint. This is resulting in an over-reporting against this category which has been a key theme for concerns and complaints over the last two years. To address this work has been undertaken on the Complaints Management Document which is used to manage the complaint investigation. The new form will allow the investigator to re-categorise the complaint post investigation which will then lead to the amendment on the Ulysses reporting system. Further to this, following discussions at the Complaints Review Group it was recommended that further work is undertaken to review all the categories currently being used on the Ulysses system and to investigate changing primary, secondary and other sub-complaint categories to better reflect and concerns raised in the complaint. It was further recommended that this work is undertake alongside the incident categories used by the Patient Safety Team as this would enable better triangulation of data. This work will commence in Quarter 1.

The Directorate of Mental Health received a total of 152 complaints, concerns, comments which is an increase of 22% compared to Q3. 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 33% of all contacts received, 21% relating to communication with patients, carers, or families and 17% relating to patient care. Adult Community Mental Health Teams continued to see the highest number of issues with 38% of all concerns and 27% of all contacts relating to inpatient care. The directorate also received 10 CQC enquiries. All enquiries related to concerns that had been raised by a service user/patients/carer directly with the CQC. 80% of all contacts were received whilst the patient was admitted on an inpatient ward. 8 MP Enquiries were received, 7 of these enquiries related to accessing services provided by the Community Mental Health Teams.

Community Health Services Directorate received 53 concerns and complaints which is a decrease of 21 compared to those received in Q3. As set out earlier in this report District Nursing continues to receive a high number of concerns at 32% of all concerns and complaints received. The key areas for concern across the directorate have shifted from concerns in relation to access (including appointments and delays in treatment) to a key theme in relation to patient care at 34% of all concerns and complaints and 23% relating to communication concerns between patients, families and carers and staff.

For Families, Children, Young People and Learning Disabilities the total number of concerns received was 78 which is in line with the number received in Q3 (83). CAMHS Services, including both City and County Teams have again seen most of the concerns for the directorate with 32% of all concerns and complaints relating to these services. As with the Trust and other two service directorates, key theme for CAMHS relate to access (including appointments and delays in treatment) at 44%. Across the directorate again the key themes are aligned to those see in our other two service directorates with concerns and complaints in relation to communications at 26% and patient care 19%.

8 enquiries were received were in relation to Quality and Professional Practice and Corporate Services.

13 MP enquiries were received in the quarter.
10 CQC enquiries were received in the quarter.

Activity data – 1 January 2022 to 31 March 2022

	PALS concerns (excld signposting)	Complaints	Compliments
Number	223	61	159
Top 3 Themes	• Communications • Patient Care • Access to services	• Appointments • Patient care • Clinical treatment	• Staff Attitude • Care & Treatment • End of Life Care

Good news story

Following discussions between University Hospitals Leicester and the Trust there has been a substantial reduction in the number of concerns and enquiries in relation to UHL coming into the Trust in error. This has been a combination of working with new staff and updating communications. The result means that patients and carers who are contacting the Trust are getting through to the appropriate service on their first call and not having to be referred onto another service.

Keys areas of concern

Risks	Mitigations
The variation in investigation timescales for complaints across organisations in LLR is causing challenges when there are multi-agency complaints to investigate	A system-wide meeting is taking place in May with representation from all health commissioners and providers and NHS England to discuss and agree a process for better management of multi-agency complaints

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 and Patient Surveys

Overview

In Q4 the Trust received 5578 individual responses to the FFT question which equated to a response rate of 7% which is the same level as in Q3. Of these responses 83% (Q3 82%) reported a positive experience of care and a 9% (reduction of 1% to Q3) response rate recording negative or poor experience of care. During the year 2021/22 the Trust received a total of 22,572 individual responses in relation to FFT with an overall average response rate of 7%, of this 82% of respondents reported a positive experience of care, with just over 10% reporting a negative experience. The full breakdown of date received in Q4 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	119	0.14%
Individual Voice Message	284	0.69%
Online Survey Once Patient is home	456	0.58%
Paper Survey	71	0.08%
SMS/Text	4348	5.6%
Total	5578	

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	111	0.13%
Individual Voice Message	374	0.44%
Online Survey Once Patient is home	25	0.03%
Paper Survey	361	0.43%
SMS/Text	3489	4.4%
Total	4360	

Due to the ongoing capacity demands on staff responding to the pandemic, planned developments for Q4 were not achieved. These are currently being reviewed and will be discussed with directorates through the Patient and Carer Experience Group several priorities have been carried forward into 2022/23.

During the Q4 61 separate patient and carer facing surveys and 15 staff facing surveys were live on the Envoy survey system with 1366 completed surveys.

This is broken down in the table below

Enabling/HR Directorate	21 live staff surveys	90 responses
Directorate of Mental Health	7 live patient surveys	512 responses
Community Health Services	5 lived patient surveys	15 responses
Families, Young People, Children and Learning Disabilities	39 live patient surveys	678 responses

Key Areas of concern

Risks	Mitigations
Due to the lack of staff capacity and restrictions within services several key priorities for FFT have not been accomplished in the year	• Those priorities which have not been met have been carried forward into 2022/23 with a focus on providing staff development and training to ensure full utilisation of the Envoy system and access to local patient experience data

Good news story

Three Listen and Talk Volunteers have now been recruited and trained to support services with the collection of patient and carer feedback/experience. These roles will be offered to those serivces where traditonal collection methods for feedback are not approporiate. These will include community nursing services; older peoples services. Working with the Learning Disbailities Team new FFT cards have been designed and are now avaialable as easy red cards. These will be used to collect FFT feedback in 2022/23.

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

Involvement Framework

Our service user and carer network continue to grow at a steady pace, and we now have almost 150 service users and carers registered on the network working with us at various levels of involvement to improve services.

We have also launched our 2nd Training and Development prospectus for network members, looking to increase their skills and confidence to enable them to get involved with various projects. With a cohort of patient leaders currently attending a programme of sessions on intensive meeting skills which will support the role out of patients and carers on committee meetings across the Trust.
Link to the spring prospectus https://www.leicspart.nhs.uk/wp-content/uploads/2022/03/Spring-2022-Patient-Experience-and-Involvement-prospectus-22.3.22.pdf

Quality Improvement

As part of the QI involvement offer the co designed and co delivered session, which introduces staff to looking at patient and carer insight and involvement in their QI projects has now been delivered to over 100 staff members. We have seen an increase of services within directorates working more collaboratively with service users and carers becoming members of QI project teams. Please see below for some examples of ongoing collaborative working.

- PINMED (Patient Involvement in Medication Decisions) is an electronic tool that can help service-users be more involved in decisions about their care. The PINMED project is an outcome of research carried out at Leicestershire Partnership NHS Trust by one of the mental health pharmacists which is now being developed in an App and web-based format with a working group of staff and 2 service users.
- Learning from Lives and Deaths People with a Learning Disability and autistic people (LeDeR) aims to bring the programme in line with the new 2021 national policy from NHS England via restructuring LPT's current LeDeR programme. The steering group is made up of both staff, and a service user who receives additional support to enable their participation and contributions, and the team have also identified a carer who is currently being inducted to become a member of the steering group. Both bring great lived experience insight to the project.
- Specialist Autism Team are involving service users in the development of setting up a pilot post diagnostic support workshop for adults recently diagnosed with autism. The team have developed a survey to gain insight and have engaged with services users to work collaboratively as part of the project team.

Recruitment
During Q4 12 recruitments via the involvement network have taken place with service users and carers on the panel, these include various Mental Health Practitioner roles, Clinical Psychologist urgent care role, and an adult LD role. 3 service users from the network got involved with the recruitment of peer support roles, there was 10 people on various panels across the day and 80% of these had lived experience.

Developing Lived Experience Leadership
Engagement has continued with directorates on the development of a Lived Experience Leadership Framework across the Trust.

The Framework proposes to adopt the Patient Leadership Triangle created by Sussex Musculoskeletal (MSK) Partnership (Central). It represents the roles of, and relationships between, Patient Director (executive level), Patient and Carer Forum (governance level) and Patient & Carer Partners (improvement level).

The proposed model for the Trust is that each directorate has its own patient leadership triangle which is then overseen by a central governance approach, integrated with patients and carers. The three components of the model are:

Patient Director - **Working as part of the Directorate Management Team**

Coordination and contribution of lived experience
- Patient and Carer Partners
- Service Users and Carers
- Local communities

Alignment to Quality Improvement
- Coordination of patient and carer partners

Supporting the Shared Decision Making/Collaborative Care implementation

Working directly with services to support and connect Peer Support Workers/Volunteers to opportunities

Working with and facilitating communities of practice
- Lived experience and involvement
- Patient and Carer Involvement Champions

Representing the directorate at corporate assurance meetings e.g., Patient and Carer Experience Group and membership on the People's Council

Patient and Carer Partners
- Design and improvement partners – working alongside services for improvement
- Paid, supported, and trained - each has portfolio of activities
- Drawing on life and condition specific experiences (of living with condition and using services)
- Acting as a critical friend who check assumptions and ask questions, provide insights into reframing issues or identifying problems, change dynamics and model collaborative leadership
- Ensure alignment with other lived experience work such as Peer Support Workers and volunteers to ensure a continuum of opportunity
- Proposal to recruit first cohort (6-8 Patient Partners) in year one with full evaluation on approach to inform spread.

Integrated Governance

Patient and Carer Experience Group
Level 3 assurance group providing integrated governance through lived experience membership (Patient Director/Patient and Carer Partners) including EDI Patient Experience and Involvement Group

Peoples Council
- Providing independent advice and expertise to LPT in relation to lived experience, access, and engagement.
- Receiving assurance in relation to how the Trust is responding to the voices of its patients and carers
- Liaising and responding with services/directorates in relation to patient experience and involvement
- Mixed stakeholders including patients and carers, clinical and support staff, and external organisations (VCSO's)
- Receives Patient Director and Patient Partner reports in relation of lived experience, access, and engagement

Engagement on the proposed framework will continue until the end of May 2022.

Good news story

It has been great to hear that because of their involvement work with LPT some of the involvement network members feel ready and are applying and securing jobs.

Charles has struggled with mental health difficulties most of his life and experienced a mental breakdown 3 years ago. Charles eventually returned to education and started a Psychology degree at open university and joined the Patient Experience and Involvement Team. Charles went on to

become a volunteer working on a project with the PIER team supporting the engagement of other service users, involved in recruitment panels, then trained in peer support to become a peer supporter in PIER, and went on to develop and launch a non-profit organisation called Knus (www.knus.io) to offer peer support and life coaching.

Another fabulous network member has been volunteering with the ECT team for quite a few years now after accessing the service some years ago themselves. They are use their lived experience to support patients and their carers/families through their ECT treatment; before, during and afterwards to allow them to reflect on their experience of treatment. They have now successfully secured a Health Care supporter role at the Bradgate Unit, and intend to gather other experiences, and insight to try to find new ways to improve the service for other patients and their families.

Key areas of concern

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

Assurance

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

The People's Council

The Council has been discussing the outcome of the independent evaluation and the recommendations made. This has been done in partnership with the proposals within the proposed Lived Experience Leadership Framework which some of the Council members have been working on.

LPT Youth Advisory Board (YAB)

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

YAB met with EDI Specialist Roisin Ryan to input into the new Patient Transgender policy, adding in the perspective and considerations from a young person's perspective.

Healthy Together School Nurse Lead attended a session with YAB to follow on from previous engagements, updates included progression of improving access and communication to the SN service. This included project SN students are working on to share in assemblies with Young People in school settings.

YAB completed a mystery shop/scoping of locally recommended online MH support virtual platforms; Togetherall and Kooth. This is due to be presented and shared with CCG Lead Sam Mirandi at the end of March (29th March).

Assurance

- Both the People's Council and Youth Advisory Board's 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 once in the quarter, in February 2022.

Work has commenced on the new Care of Transgender Patients Policy which is being developed in partnership with Northamptonshire Healthcare Trust. The new policy will focus on the specific needs of patients and will be available from June 2022.

Concerns in relation to the combined impact of austerity and COVID on vulnerable service users have been raised and were discussed by the Group. These are parents of young children, predominantly female patients that need a lot of support. The lack of being able to access or use digital services has caused vulnerable clients to be discharged from services. Discussion highlighted areas of concern such as digital poverty, those who don't have access to the equipment and those patients / parents who find digital services difficult to use. Similar concerns have been raised in the Community Mental Health Services. This links into the digital strategy, there are opportunities both nationally and locally to develop digital offers with significant funding available. We need to think about how we use that offer consistently across all services and how to use it in a bespoke way to address individual needs. It was agreed that this would be raised with the Digital Committee.

Work has begun, working with a group of data analysists, looking at better understanding patient data, what digital templates are being used to capture protected characteristics and what gaps do we have that need to be improved. One area identified was sexual orientation monitoring and the issue of capturing that for under 16s. This needs a further discussion in how we progress that in the future which will also include obtaining the perspective/feedback from young people.

Good progress has been made in raising awareness of the Accessible Information Standard. The Head of EDI and the Patient Information Specialist have ran a session as part of Black history Disability Month. A video was produced and is available on the Staff Intranet and Trust website to help staff complete the accessible information standard template, to record it on SystmOne and how to find information.

During the Quarter three hours of deaf awareness training has been delivered free, by Science for Life. The evaluation report will be reviewed by the Group in quarter 1. It has been identified that clinical staff want further training in BSL.

Community Mental Health Survey 2021/22

The National Service User Survey (NPS) programme was introduced in 2001 by the Department of Health, and subsequently moved to the Healthcare Commission, and then to the Care Quality Commission.

The question content of the National Service User Surveys is determined nationally, as is the content of the covering letters that are sent to service users.

The survey is run on paper only. Survey fieldwork took place between February and June 2021. The sample for the survey was generated at random on the agreed national protocol from all clients on the CPA and Non-CPA Register seen between 1st September and 30th November 2020.

A small number of people were included in some samples who said that they had not been in contact with mental health services for a number of years, or that they had never been in contact with these services.

In Leicestershire Partnership NHS Trust, 3% of respondents said that they had never seen anyone from NHS mental health services. The response rate was 31% (371 usable responses from a usable sample of 1205).

The majority of scores within Leicestershire Partnership NHS Trust sit in the bottom 20% of the Trusts surveyed by Quality Health. There are 7 scores in the intermediate 60% range and no scores in the top 20% range. Despite this, the Trust does perform fairly well on the score for service users knowing how to contact the person in charge of organising their care if they have a concern.

Despite improvements in some scores, overall, there has been a downward trend in results across the survey between 2020 and 2021 with an **average drop of 2%** across all questions apart from **Crisis Care** which has seen an **increase in satisfaction of 4%**. However, the unique nature of care provision during the Covid-19 pandemic will have significantly affected scores and the Trust should take this into account. As the majority of scores are in the lower range, the Trust should particularly look at those among the lowest of Trusts surveyed, including possible side effects of medicines being discussed and being signposted towards support for finding or keeping work.

Top 5 and Bottom 5 questions

	Top 5 Questions	Score
12.	Do you know how to contact this person if you have a concern about your care?	97.2%
37.	Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?	81.4%
13.	How well does this person organise the care and services you need?	81.0%
18.	Did you feel that decisions were made together by you and the person you saw during this discussion?	77.0%
28.	Were these NHS talking therapies explained to you in a way you could understand?	76.9%

	Bottom 5 Questions	Score
38.	Aside from in this questionnaire, in the last 12 months, have you been asked by NHS mental health services to give your views on the quality of your care?	13.5%
34.	In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work (paid or voluntary)?	22.9%
33.	In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?	26.7%
32.	In the last 12 months, did NHS mental health services support you with your physical health needs?	39.5%
23.	Have the possible side effects of your medicines ever been discussed with you?	51.8%

Summary of responses (average score of all questions in each category)

		2020	2021
Health and Social Care Workers	5% drop in satisfaction	88%	83%
Organisation of Care	1% drop in satisfaction	96%	95%
Planning of Care	2% drop in satisfaction	84%	82%
Reviewing of Care	.05% drop in satisfaction	92.5%	92%
Crisis Care	4% increase in satisfaction	56%	62%
Medicines Management	1% drop in satisfaction	87%	86%
Support and Wellbeing	8% drop in satisfaction	58%	50%
Overall experience (top 3 scores)	1% drop in satisfaction	46%	43%
Treated with Dignity and Respect	4% drop in satisfaction	94%	90%

The results of the survey were formally published on 1 December 2021. Alongside the publication of the results from across the country. However, the CQC intend to publish a separate report which focuses on variation in results at trust level. Leicestershire Partnership NHS Trust has been identified as performing '**worse than expected'**. This is because the proportion of respondents who answered negatively to questions about their care, across the entire survey, was significantly above the trust average. The CQC have informed the Trust that they will continue to reflect the trust's performance on this survey within their Insight products as part of the information we have on how trusts are performing. CQC inspectors will be looking for evidence from the survey and following these issues up through our regular contacts. They will focus on the survey results that suggest that people's experiences were worse than expected and look for reassurance that the Trust is taking appropriate action. The Trust have been recommended to focus on

The Trust are encouraged to look at our benchmark report, to identify aspects of care that can be improved. To do this the survey provider, Quality Health, have facilitated a feedback session with service leads from across Community Mental Health Services to present and discuss the results for the year. On the back of this session all services were asked to consider the results within their own service areas and agree any relevant actions for improvement.

SUPPORT AND WELLBEING

- Scores in this section are low across the board.
- Focus on support for physical health needs, involving family members in the service users' care, and access to advice and support around employment.

Employment Support:

Within Adult Community we have an Employment Support service which was TUPE'd into LPT in 2019. ESS will be recruiting an additional 12.7 WTE employment specialists, making a total of 17 WTE. We will also be recruiting 2 Senior employment specialists to line manage with half their time working a caseload.

There is funding from NHSE to expand the team and thus employment support for adult CMHT patients.

The service is currently monitored via the IPS Grow Partnership Fidelity Review Action Plan and areas of focus will be around:

- Improved benefits planning and welfare advice
- In work coaching and support
- Increased employer engagement
- Long term follow-up
- Increased face to face appointments
- Increased working with locality MH teams to support zero exclusions
- Working with the Trust's Equality Lead to identify the local BAME population for each CMHT to monitor whether people accessing the service and gaining outcomes reflect the clinical team population

Physical Health:

The Mental Health Facilitator service (MHF) provided by LPT assist GP surgeries predominantly with annual physical and mental health reviews and the monitoring and management of the Serious Mental Illness (SMI) register. A system oversight group is in place to monitor Physical Health Checks carried out for people on the SMI register. There is a system wide action plan which aims to achieve a target of 65% of patient on the SMI register having had their annual physical health checks. LPT provide assistance with the SMI register to GP practices. A number of actions are underway by LPT to help meet this target which include:

- Training all staff to carry out blood which will ensure that all 6 physical health checks can be carried out by the MHF
- Resuming face to face appointments where clinically safe to do so with support from GP practices to accommodate clinic space
- Increased focus on and increased working with PCNs where physical health checks are significantly below expected levels
- Coding and data issues: to work through with HIS to ensure correct data is pulled through on the right systems. This will help to avoid any duplication within the system around physical health checks.
- Develop an outreach plan to engage with those who DNA their appointments with the MHF.

Community Mental Health Teams

Some Community Mental Health Teams currently provide Physical health clinics. The aim of this to carry out baseline checks for those going onto antipsychotic drugs.

There following plans/actions are in place to strengthen this within CMHTs

1. To scope out current resources and requirements to ensure all CMHT's can provide these. Short term Action
2. Develop SOP and scope key training for new staff
3. As part of the SUTG the plan is to align physical health screening as part of the first assessment. Template is already on S1 which askes additional questions around Physical Health which aims to start having conversations of other aspects of physical health care and needs that we know service users don't address (e.g dentist, screening services etc). Long term – Long term action In line with SUTG.

Action to date:

1. Task and finish group has been set up which includes reps from MHSOP to scope out secondary care responsibilities. There has also been a discussion at the Physical Health Steering Group about ECG monitoring and training of doctors and training of nurses and non-registered staff. There has also been a meeting with one of the MHF leads to ensure that checks are not being duplicated, there are issues with LPT not being able to see the templates that the MHFs use which needs resolving, Tracy is looking into this. The 2 S1 systems don't currently speak to each other.
2. Development of draft SOP in progress.
3. This will be part of the SOP. Need to establish what can be offered for those pts currently held on out-patient caseloads who at the moment get no physical health assessment.

Psychological Therapies

Essentially all service users should be involved in decisions about their psychological therapy, this should be part of the assessment and formulation process, and there should be regular reviews throughout the intervention / therapy about the progress made and the goals, so that it is an ongoing collaborative process.

At present we have large numbers of service users waiting for psychological therapy, which may contribute to the sense of not being involved in decisions at present. We are working hard to reduce these lists, have clear plans in place and are working according to trajectories that have been set. This is gradually reducing waiting times, which should improve the sense of involvement in decisions about therapy over time.

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 31.5.22	
Paper sponsored by:	Anne Scott, Director of Nursing, AHPs and Quality	
Paper authored by:	Alison Kirk, Head of Patient Experience, and Involvement	
Date submitted:	21 April 2021	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Patient and Carer Experience Group – 27 April 2022 Quality Forum 12th 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	Quarterly Report	
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	
	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 4 Complaints Breakdown

Complaints Activity for Q4 – 1 January – 31 March 2022

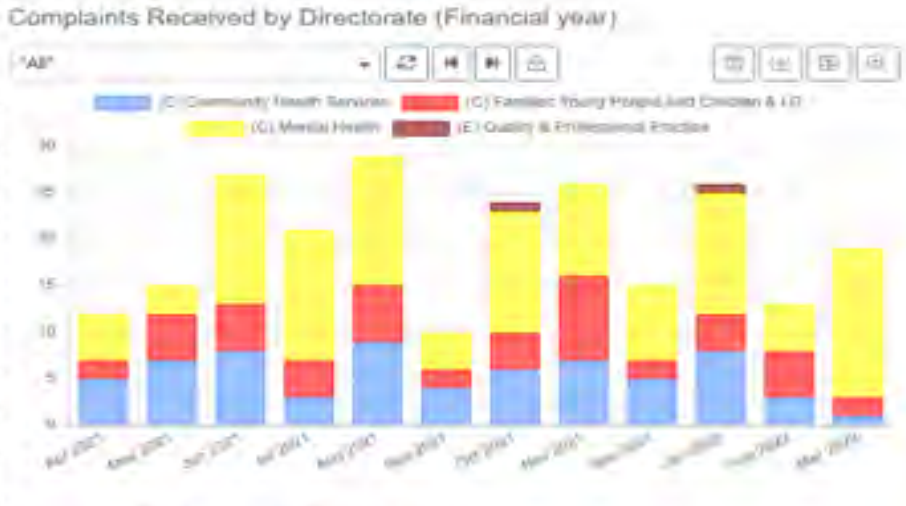
	Q1	Q2	Q3	Jan 2022	Feb 2022	Mar 2022	Total Q4	Total 21/22
Mental Health Service	22	34	30	13	5	16	34	120
Community Health Services	20	15	18	8	3	1	12	65
Families, Young People and Children & LD	12	13	18	5	5	2	12	55
Total Received	**54**	**63**	**66**	**26**	**13**	**20**	**58**	**241**
Complaints vs Patient Activity (Complaints Rate as a %)*	0.05	0.05	0.04	0.04	0.02	0.04	0.06	0.04
% of complaints acknowledged within three working days	94	92	97	100	93	100	98	95
Number of complaints responded to within the date agreed with the complainant***	13	31	30	20	12	20	52	126
Number of complaints responded to in 45 working days	13	31	23	20	12	20	52	97
Number of complaints responded to in a date agreed with the complainant	3	0	3	6	1	0	6	12
Number under investigation at the end of the Quarter	38	30	13	1	8	20	29	110
% of complaints responded to within the date agreed with the complainant ****	100	97	97	96	100	100	99	96
Number of complaints upheld or partly upheld in quarter	7	28	29	17	4	n/a	21	85
Number of complaints ongoing after 3 months**	3	2	0	0	0	0	0	5
Number of complaints ongoing after 6 months***	0	0	0	0	0	0	0	0
Number of reopened complaints	12	7	0	1	5	2	8	27
Number of complaints formally investigated by the PHSO	0	0	0	0	0	0	0	0
Number of complaints upheld or partly upheld by the PHSO	0	0	0	0	0	0	0	0

*Patients attended and seen

**Complaints ongoing after 3 months at the end of Q4

***Complaints ongoing after 6 months at the end of Q4. These do not include those complaints included in the ongoing after 3 months section

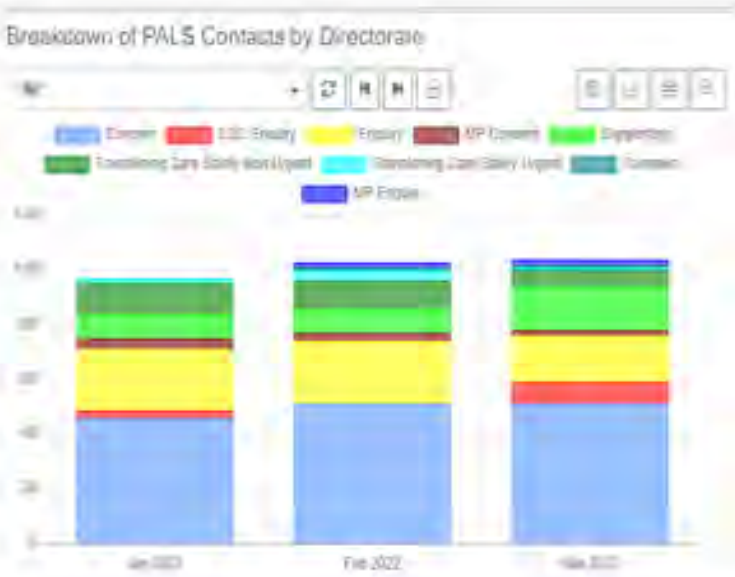
****Position statement as responses still under investigation



Complaints and PALS received by Service area:

Directorate of Adult Mental Health	ADHD Service	8	2
	Asperger Diagnostic Team	1	
	Assertive Outreach		2
	CMHT's City	18	7
	CMHT's County	18	9
	Crisis Resolution Team	6	1
	Central Access Point	7	1
	Dynamic Psychotherapy	9	1
	Inpatient Wards	24	10
	ECT Suite	1	
	Forensic CMHT	1	
	Medical Psychology	1	
	Francis Dixon Lodge	5	
	Memory Service East	1	
	Veterans Service	1	
	MH Liaison Team	2	2
	HD Community		1
	Place of Safety	1	
	Urgent Care	1	
	MHSOP CMHT – City	1	
	MHSOP CMHT County	1	
Community Health Services	District Nursing – City	9	5
	District Nursing – County	2	1
	District Nursing – Wards	4	
	Community Integrated Neurology	5	
	Community Therapies	2	
	Integrated Specialist Palliative Care	5	1
	SPA	2	
	Phlebotomy	1	
	MSK Physiotherapy	1	1
	Continence	1	
	Podiatry	1	
	SALT	1	
	Inpatient Wards	16	4
Families, Children and Young People and Learning Disabilities	Asperger Diagnostic Team	1	2
	CAMHS – City	5	1
	CAMHS Crisis	1	1
	CAMHS – County	14	3
	CAMHS – Eating Disorders		1
	Covid Vaccinations		1
	Children's PT	2	
	Eating Disorders Outpatients		1
	FYPC Area 2	1	
	FYPC Area 5	1	
	FYPC Paediatrics Administration	3	
	Healthy Together Administration	2	
	FYPC Therapy & Orana Admin Team	1	
	Nutrition and Dietetics	4	
	FYPC Blaby	1	
	FYPC NW Leicestershire	1	
	FYPC Hinckley and Bosworth	1	
	LD Outreach	1	
	LD Psychology	1	
	FYPC Paediatric Phlebotomy	2	
	Mental Health Support Team	1	1
	School Immunisations	4	

Breakdown of PALS Contacts by Contact Type

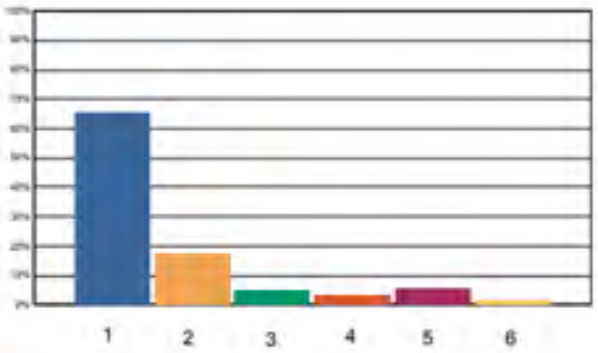


FFT Responses – January to March 2022

7%
Response Rate

Positive: 83.17%
Negative: 9.25%
Ratings

Overall Scores

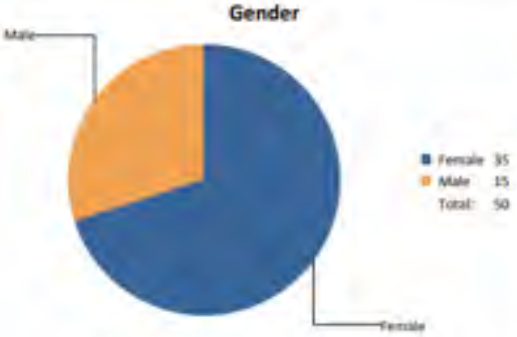


Response Option	Responses	Percentage
1 - Very good	3,658	65.58%
2 - Good	981	17.59%
3 - Neither good nor poor	308	5.52%
4 - Poor	200	3.59%
5 - Very poor	316	5.67%
6 - Don't know	115	2.06%

Top 10 Themes

+ Positive		− Negative	
1. Staff attitude	1880	1. Staff attitude	322
2. Implementation of care	1178	2. Implementation of care	299
3. Environment	772	3. Communication	
4. Communication		4. Environment	258
5. Patient Mood/Feeling	711 519	5. Patient Mood/Feeling	249 202
6. Clinical Treatment		6. Clinical Treatment	
7. Waiting time	389	7. Waiting time	159
8. Admission	226 236	8. Admission	112 142
9. Staffing levels	75	9. Staffing levels	48
10. Catering	17	10. Catering	13

Breakdown



Eligible Patients
84286

Response Rate
6.6%

Total Responses
5578

Top 10 Words

+ Positive		− Negative	
1. Good	716	1. Time	113
2. Service	432	2. Face	107
3. Helpful	379	3. Appointment	101
4. Staff	340	4. Help	101
5. Time	291	5. Waiting	98
6. Care	261	6. Phone	93
7. Friendly	257	7. Call	75
8. Excellent	213	8. Service	69
9. Professional	196	9. Health	66
10. Received	187	10. Mental	61

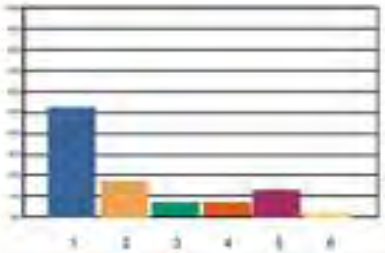
Theme Trend – Year 2021/22

Directorate of Mental Health Service Report

Adult Mental Health and Learning Disability

70.21%	20.35%

Overall Scores



Breakdown

No Gender Breakdown Available

21900	5.0%
1091	

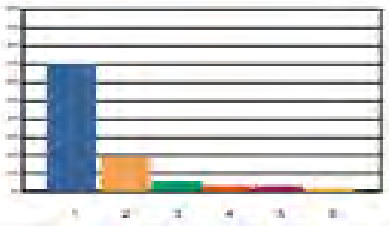
Community Health Services Service Report

Community Health Services(8877)

88.34%

4.68%

Overall Scores



Breakdown

No Gender Breakdown Available

41418

8.6%

3569

Families, Children and Young People and Learning Disability Service Report

Families, Young Peoples and Childrens Services

78.43%

13.83%

Overall Scores

Breakdown

20968

4.4%

918

Compliments Received January to March 2022

Compliments by Directorate	
Directorate of Mental Health	52
Community Health Services	65
Families, Young People, Children's & Learning Disabilities	39

Compliment by theme	
Staff Attitude	24
Care and Treatment	66
Customer Service	8
End of Life Care	25
Good communication	6
Access to Services	4
Other	26

Compliments received during the quarter

I would like to take this opportunity to thanks all your staff for the excellent care they took of my husband. he was diagnosed on 1st april with terminal pancreatic cancer and died on 11th September. From the first palliative team visit gave full support, empathy and clear direction and generally guided us through difficult times. The district nurses were excellent, efficient and pre-emptied our needs. The triage team were practical, informative and understanding. A heart felt thanks to the whole team.

A massive Thank You to you ALL for the amazing care and support you have given to our Mum. You have all been amazingly supportive too, towards us as a family. We really can't express enough gratitude not only for your care whilst with you all, but all the support enabling mum as she goes home, with the care package and aids. You are All absolutely amazing caring people, best wishes to all

S

Public Trust Board 31st May 2022

Leicestershire Partnership NHS Trust

Safety and Quality in Learning from Deaths Assurance (Quarter 4)

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 January to March 2022 inclusive (Quarter 4: Q4) as well as data reviewed and learning from Q4 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.
- Learning from deaths review meetings were Level 2 meetings and as such stepped down. Each directorate has a recovery plan in place to catch up with the back log of reviews.
- 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.
- FYPC/LD have worked to refresh their process in respect of Adult deaths.

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. We await further guidance from the directorates on how this is progressing.

Table 1: Q4 Gender & Age

Gender	Age Bands									
	1-28 (D)	Up to 12 (M)	1-10 (Y)	11-18	19-24	25-44	45-64	65-79	80+	Total
Female	0	1	4	0	0	6	10	11	34	68
Male	1	0	0	3	1	7	14	14	37	77
Unknown	1	0	0	0	0	0	0	0	0	1
Total	**2**	**1**	**4**	**3**	**1**	**13**	**24**	**25**	**71**	**144**

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

Table 2: Q4 Disability

Disability	
Disability	0
No Disability	0
Disability not recorded / not known	144
Total	**144**

Table 3: Q4 Religion

Religion	
Buddhist	0
Christian	1
Hindu	1
Jewish	0
Muslim	0
Sikh	0
Other	0
Not recorded / not known	142
No religion	0
Total	**144**

Table 4: Q3 Sexual Orientation

Sexual orientation	
Bisexual	0
Heterosexual	0
Homosexual	0
Not recorded / not known	144
Not Disclosed	0
Not applicable	0
Total	**144**

Table 2: Q4 Ethnicity

Ethnicity	
White	
English / Welsh / Scottish / Northern Irish / British / Irish	105
Any other White background	2
Mixed / Multiple ethnic groups	
White and Black African	1
White and Black Caribbean	1
Any other Mixed / Multiple ethnic background	2
Asian / Asian British	
Indian	3
Any other Asian background	3
Black / African / Caribbean / Black British	
African	1
Caribbean	1
Other ethnic group	
Not recorded / Not known	25
Total	**144**

5. Number of Deaths reported and reviewed in Q4

In adherence with NHS/I (2017) recommendations, the number and percentages of deaths reviewed through mSJR case record review and the Serious Incident (SI) process across LPT in Q4 are shown in Table 6:

Table 3: Annual backlog of deaths

Breakdown by Directorate												
	CHS				**DMH/MHSOP**				**FYPC/LD**			
	Q1 (Apr-Jun)	**Q2 (Jul-Sep)**	**Q3 (Oct-Nov)**	**Q4 (Jan-Mar)**	**Q1 (Apr-Jun)**	**Q2 (Jul-Sep)**	**Q3 (Oct-Nov)**	**Q4 (Jan-Mar)**	**Q1 (Apr-Jun)**	**Q2 (Jul-Sep)**	**Q3 (Oct-Nov)**	**Q4 (Jan-Mar)**
Number of deaths reviewed	34*	22*	21*	3	57	43	45	53	6	30	16 ***	7
Percentage of deaths reviewed	92%	65%	47%	7%	80%	57%	58%	65%	43%	83%	52%	39%
Number of deaths outstanding for Directorate review	3	12	24	41	14	32	32**	29**	8	6	15	11
Percentage outstanding for directorate review	8%	35%	53%	93%	20%	43%	42%	35%	57%	17%	48%	61%

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

* Data validation exercise for CHS identified 6 less cases in Q1 and 12 less in Q2 than previously reported. Furthermore the number of deaths reviewed for Q3 was 7, not 45.
** December, January & March's 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

- Where patient feedback from the medical examiner is received, this is included in the learning from death reviews.

DMH/MHSOP

- DMH Meetings were arranged for 1st Tuesday of the month however this clashed with the SI sign off meetings so has been re-arranged to the 2nd Tuesday of the month.
- MHSOP have no reviews outstanding from previous quarters and 10 reviews outstanding from Quarter 4.

FYPC/LD

- 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.

5.1 Learning themes identified

Learning and discussions associated with deaths in Q4 within the DMH identified that there were some examples of cases where it was not documented that families had been contacted following the death of a patient known to LPT therefore Dr Fabida Aria, Chair to write to all services re reminder to contact family following death to offer condolences. And in MHSOP, it was identified that some RESPECT forms completed by other organisations weren't as good as they could be, so a general discussion around this and what to do in these cases took place at their MCM meeting on 21st March 22. Within FYPC/LD, Learning from Death discussions identified that not all deaths were being routinely recorded on Ulysses so an email was circulated to staff to remind them to do so. Additional learning from all directorates is provided in Appendix 1.

5.2 Examples of good practice

Examples of good practice in the current Quarter Q4 and previous quarters not already reported consisted of:

- **CHS:** There were some examples of good communication with families. There was also an excellent example of meeting a patient's family's spiritual needs by arranging a Chaplin to visit prior to the patient passing away.
- **DMH/MHSOP:** There were multiple examples of Good Multiple disciplinary working and good communication with patients and their families during their care.
- **FYPC/LD:** Good practice and good management plans were noted .

6. Number of deaths reported during Q4

In adherence with NHS/I (2017) recommendations Table 7 also shows the number of deaths reported by each Directorate for Q4. Formal investigations consist of Serious Incident (SI) investigations and modified Structured Judgement Reviews (mSJR) case record reviews:

- There were 144 deaths considered in Q4.
- There were a total of 4 deaths which are for Serious Incident Investigation.
- There were 9 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 (Q4)

Q4 Mortality Data 2021										
Q4	**Jan**			**Feb**			**Mar**			**Total**
	C	**D**	**F**	**C**	**D**	**F**	**C**	**D**	**F**	**144**
Number of Deaths	16	24	1	15	28	12	13	30	5	
Consideration for formal investigation										
	C	**D**	**F**	**C**	**D**	**F**	**C**	**D**	**F**	**Total**
Serious Incident	0	3	0	0	1	0	0	0	0	**4**
mSJR* Case record review	16	24	1	15	28	12	13	30	5	**144**
Learning Disabilities deaths			1			5			3	**9**
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 31.5.22	
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		
Good practice		
2 Communication – Patients & Relatives	4 Results/Management / Discharge Plan	Good communication with family
2 Communication – Patients & Relatives	5 Imminence of death, DNACPR, Prognosis	Good clear documentation about deterioration both from the nursing staff and ANP. OOH review – as per notes – palliative / eol care started – d/w family – good approach from ooh clinician. AR to feedback to clinician / ward re good practice.
9 Monitoring, Recognition & Escalation/Ceiling of Care	27 Escalation / Ceiling of Care	Excellent escalation process.
3 Dignity & Compassion	8 Compassion / Attitude	Family visited and Chaplin arranged really quickly to meet spiritual needs.
DMH/MHSOP		
Learning		
5 Documentation – Paper & Electronic	14 Clinician documentation within the clinical record	Whilst this would have not impacted on the patient's death it would be beneficial to follow up on agreed actions. The patient did not receive any further face to face visits from the CPN following the initial assessment in July 2021. A documented rationale for this would have been beneficial.
2 Communication – Patients & Relatives	6 Reasonable adjustments	Some impact on change of professional seeing patient and to be minimised as much as possible. Patient had not asked for eligible benefits for many years and was living off an inheritance. It may help to explore finances and support needed
3 Dignity & Compassion	8 Compassion / Attitude	No evidence of call to family after death due to physical health related death. Dr Fabida Aria, Chair to write to all services re reminder to contact family following death to offer condolences.
Good practice		
7 Multi-Disciplinary Team Working	20 Inter team issues (within same specialty)	Good MDT working , awaiting commencement of treatment for Alzheimer's disease
2 Communication – Patients & Relatives	4 Results/Management / Discharge Plan	Good responsive care – good liaison with family. Referral to CMHT as high priority and allocated CPN the next day who made contact and arranged visit for 2 days later.

2 Communication – Patients & Relatives	4 Results/Management / Discharge Plan	Maintained regular contact with the son.
7 Multi-Disciplinary Team Working	20 Inter team issues (within same specialty)	Evidence of good MDT working.
2 Communication – Patients & Relatives	4 Results/Management / Discharge Plan	CPN reviewed the patient regularly and maintained contact with her daughter.
9 Monitoring, Recognition & Escalation/Ceiling of Care	25 Monitoring	Good level of care from the CMHT
2 Communication – Patients & Relatives	4 Results/Management / Discharge Plan	Good care provided by LPT, quite assessment with a plan the patient agreed to.
7 Multi-Disciplinary Team Working	19 Inter-speciality referrals/review	Effective triage from CAP in that information gathered lead to correct decision to refer on to Crisis
1 Assessment, Diagnosis & Plan	1 Assessment	Patient accessed service through duty system and was offered same day face-to-face appointment.
2 Communication – Patients & Relatives	4 Results/Management / Discharge Plan	End-of-Life documentation (died at home with husband as wished), good collaborative working, had very clear plan for both admission with regular community reviews.
Actions taken in response to identified themes and issues		
5 Documentation – Paper & Electronic	15 Completion of clinical forms i.e. DNACPR, Consent, Nursing Assessments	MHSOP had a general discussion around Respect forms received from other organisations at their MCM meeting on 21st March 22.
FYPC/LD		
Good practice		
C1 Assessment, Diagnosis & Plan	3 Management plan	Good day to day care & good practice.
C1 Assessment, Diagnosis & Plan	3 Management plan.	Good practice.
C1 Assessment, Diagnosis & Plan	3 Management plan	Good practice with well management plans.
7 Multi-Disciplinary Team Working	20 Inter team issues (within same specialty)	Peer working ensures all aspects of care covered when dealing with complex patients.
Actions taken in response to identified themes and issues		
Reminder to staff that an EIRF needs to be completed following a patient death.		

T

Leicestershire Partnership NHS Trust

Staff Survey and Staff Engagement Trust Board presentation

May 2022

WeAreLPT
compassion respect
integrity trust

www.leicspart.nhs.uk

Response rate

Leicestershire Partnership NHS Trust

2021 NHS Staff Survey

Organisation details

Completed questionnaires	2,863
2021 response rate	52%

See response rate trend for the last 5 years

Survey details

Survey mode	Online
Sample type	Census

This organisation is benchmarked against:

Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts

2021 benchmarking group details

Organisations in group: **51**

Median response rate: **52%**

No. of completed questionnaires:

116,567

Results by theme

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.9	6.8	7.4	6.6	6.1	7.1	7.4	7.4	6.5
Your org	7.5	6.3	7.0	6.2	5.7	6.8	7.0	7.0	6.0
Average	7.5	6.3	7.0	6.2	5.6	6.7	7.1	7.0	6.0
Worst	7.1	5.9	6.4	5.8	4.8	6.1	6.6	6.5	5.5
Responses	2,862	2,853	2,840	2,848	2,786	2,840	2,826	2,862	2,863

Statistical significance

People Promise elements	2020 score	2020 respondents	2021 score	2021 respondents	Statistically significant change?
We are compassionate and inclusive			**7.5**	2862	N/A
We are recognised and rewarded			**6.3**	2853	N/A
We each have a voice that counts			**7.0**	2840	N/A
We are safe and healthy			**6.2**	2848	N/A
We are always learning			**5.7**	2786	N/A
We work flexibly			**6.8**	2840	N/A
We are a team			**7.0**	2826	N/A
Themes	**2020 score**	**2020 respondents**	**2021 score**	**2021 respondents**	**Statistically significant change?**
Staff Engagement	**7.0**	2772	**7.0**	2862	Not significant
Morale	**6.0**	2773	**6.0**	2863	Not significant

WeAreLPT
compassion respect
integrity trust

The headlines

2021 Staff Survey: Results summary

All nine themes are scored on a 0-10 scale, where a higher score is more positive than a lower score. These theme scores are created by scoring question results and grouping these results together. You can see how we have scored on each of the themes compared to the national benchmark average score.

NHS
Leicestershire Partnership
NHS Trust

We are compassionate and inclusive

LPT Trust score:

7.5

Average benchmark score: 7.5

We are recognised and rewarded

LPT Trust score:

6.3

Average benchmark score: 6.3

We each have a voice that counts

LPT Trust score:

7

Average benchmark score: 7

We are safe and healthy

LPT Trust score:

6.2

Average benchmark score: 6.2

We are always learning

LPT Trust score:

5.7

Average benchmark score: 5.6

We work flexibly

LPT Trust score:

6.8

Average benchmark score: 6.7

We are a team

LPT Trust score:

7

Average benchmark score: 7.1

Staff engagement

LPT Trust score:

7

Average benchmark score: 7

Morale

LPT Trust score:

6

Average benchmark score: 6

WeAreLPT
compassion respect
integrity trust

WRES data

LPT has seen an improvement across all four indicators since 2020 and is performing significantly better than the national average across all of these. However, some of the results are slightly less positive than the pre 2020 results. The most significant improvements are seen in indicators six and seven (Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months and Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion).

Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months		
	2020	**2021**
White: LPT	22.30%	21.80%
BAME: LPT	24.40%	24.30%
White: National	25.40%	26.20%
BAME: National	32.10%	31.80%

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months		
	2020	**2021**
White: LPT	19.80%	18.80%
BAME: LPT	24.80%	20.90%
White: National	19.60%	18.10%
BAME: National	25%	22.90%

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion		
	2020	**2021**
White: LPT	65.20%	67.10%
BAME: LPT	48.20%	52.80%
White: National	60.90%	61%
BAME: National	45.50%	46.80%

Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in last 12 months		
	2020	**2021**
White: LPT	5.90%	6.40%
BAME: LPT	14.50%	13.50%
White: National	5.60%	6%
BAME: National	15.10%	14.40%

WDES data

Out of the eight indicators LPT have seen improvements in seven of these since 2020. Three of the eight indicators are performing above the national average. There has been a marked improvement in staff reporting that they have equal opportunities for career progression and development.

Percentage of staff experiencing harassment, bullying or abuse from patients / service users, relatives or the public in last 12 months		
	2020	**2021**
With Long-Term Condition: LPT	30.70%	26.30%
Without LTC: LPT	20.20%	21.40%
With Long-Term Condition: National	31.80%	32.20%
Without LTC: National	24.70%	24.70%

Percentage of staff experiencing harassment, bullying or abuse from managers in last 12 months		
	2020	**2021**
With Long-Term Condition: LPT	17.70%	16.20%
Without LTC: LPT	8.90%	7.20%
With Long-Term Condition: National	15.20%	13.40%
Without LTC: National	8.50%	7.10%

Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion		
	2020	**2021**
With Long-Term Condition: LPT	54.60%	59%
Without LTC: LPT	64.10%	65.70%
With Long-Term Condition: National	54.30%	54.40%
Without LTC: National	60%	60.20%

Percentage of staff with a long lasting health condition or illness saying their employer has made adequate adjustment(s) to enable them to carry out their work		
	2020	**2021**
With Long-Term Condition: LPT	79.40%	79.90%
With Long-Term Condition: National	81.40%	78.80%

Key themes for improvement

Level	Areas where staff feedback needs improvement	Contributors
1. Trust-wide Concerns and actions to address issues affecting the majority of colleagues regardless of role or area of Trust	• Care of patients / service users is my organisation's top priority, or that the Trust acts on patient/service user concerns • Work pressures: staff feel exhausted, burnt out and frustrated • Staff recognition and feeling valued • Not enough staff to do their job properly – recruitment • Staff empowered to make improvements in their area of work	Exec team, HR, OD, FTSU, EDI, HWB team, Staffside, communications and engagement, safety teams, change champions, etc.
2. Specific staff groups Concerns and actions to address issues affecting specific identifiable staff groups that may be spread across the Trust, such as those with protected characteristics.	• Those working in covid areas: more recognition, flexible working, and support for health and wellbeing • BME staff still experience less equal opportunities compared to white peers and experience of discrimination from managers	EDI team, Staff Networks, health and wellbeing champions, change champions (with OD and engagement teams).
3. Local areas Directorate specific - services or teams identified for intensive support	• Medical staff and DMH community, inpatient and MHSOP staff – focus as part of DMH leadership OD work • Identify any lower performing areas in FYPC.LD and CHS and link with high performing teams for peer to peer leadership support.	Directorate DMTs, service/team managers, OD team, staff engagement lead

Big 4 Trust-wide priorities

Reset and Rebuild

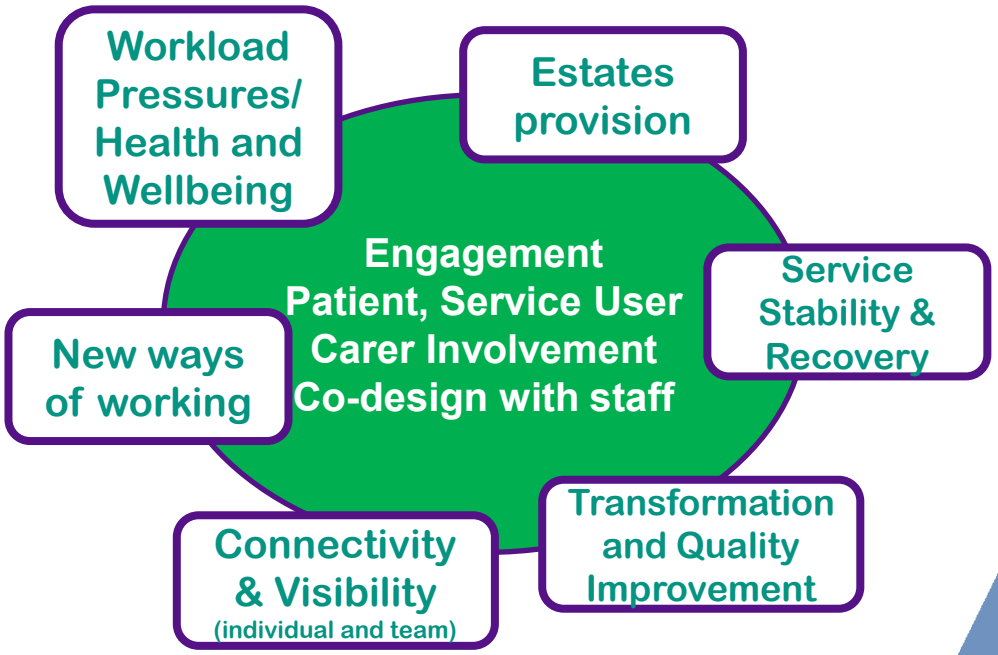
Reducing inequalities in staff experience and engagement

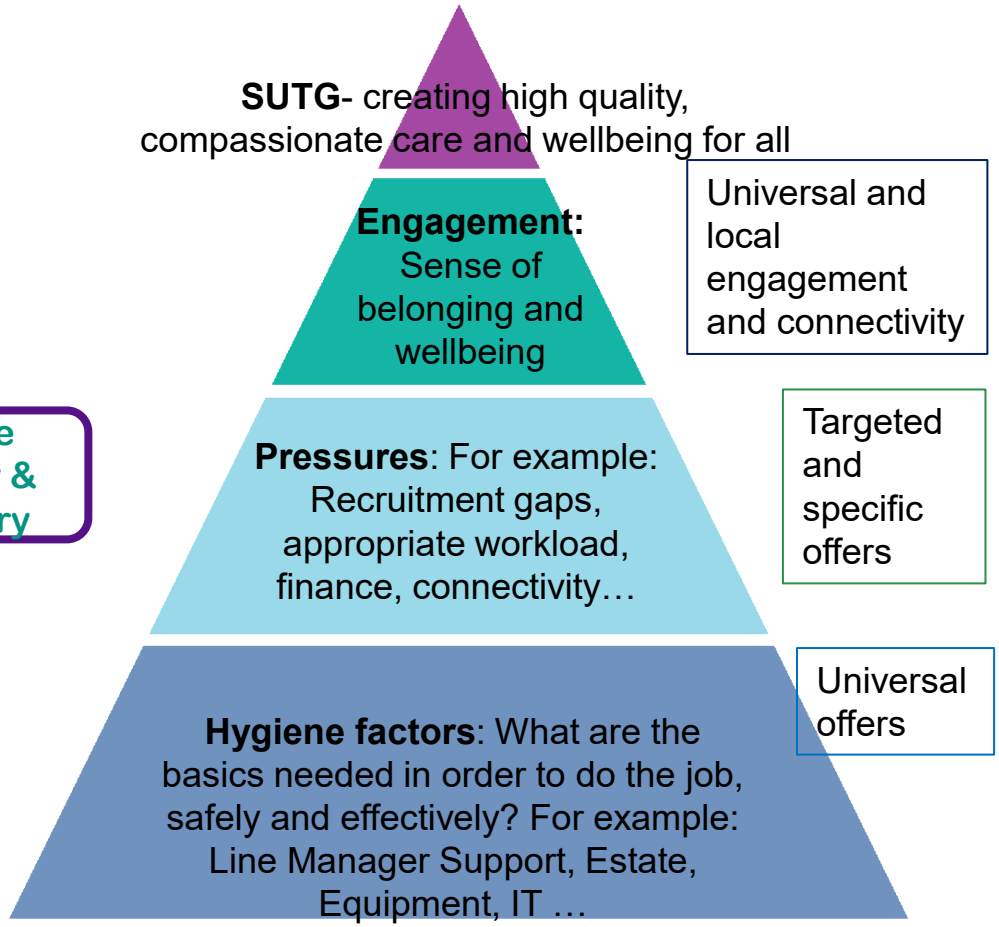
Reducing workforce capacity and demand gap

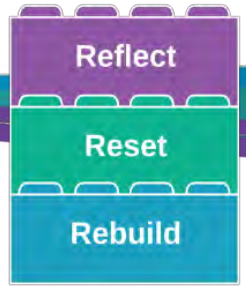
Support for targeted local plans for specific staff groups and directorates

WeAreLPT
compassion respect
integrity trust

Reset and Rebuild







WeAreLPT
compassion respect
integrity trust

Reducing the inequalities in staff experience and engagement

Equality, leadership and culture

- Refresh culture change champions programme
- Continued embedding of leadership behaviours and FTSU
- EDI objectives:
  1. Zero tolerance
  2. Cultural competency,
  3. Reverse mentoring
  4. Equality objectives in appraisals

People Promise exemplar participation

for further cultural diagnostic and review of interventions

Health and wellbeing

focus on financial wellbeing and mental health

WeAreLPT
compassion respect
integrity trust

Reducing the workforce capacity and demand gap

Recruitment marketing

Trust recruitment events

Targeted marketing at HSWC/admin, Nursing, AHPs

International recruitment

Targeted demand and capacity work

Undertaken at directorate level with targeted service areas

Quality improvement and transformation

Supporting quality improvement, local autonomy and co-design with service users linked to Foundations 4 High Standards.

Group learning and sharing through positive communications

Support for targeted local plans for specific staff groups and directorates

Each directorate has developed a number of areas of focus specific to their services around engagement, health and wellbeing and service pressures.

Specific targeted interventions can be supported by OD and staff engagement for low performing areas

Link with high performing teams for peer to peer leadership support

Specific staff group focus areas will be supported by Trust-wide and directorate level activity.

Staff communications and engagement framework

Staff feedback:
- NHS Staff survey
- Pulse
- Big conversations

Tier 1: All staff check-ins
- Monthly Team Brief
- Senior Leadership Group
- Big Conversations

Tier 2: Directorate check-ins
- Themed directorate team briefs
- Directorate Big Conversations
- Local listening events and co-design workshops

Tier 3: Targeted staff support
- Staff support networks
- Health and wellbeing champions
- Change champions network
- FTSU partners and Staff-side
- Communications champions

Tier 4: local enabling resources
- Team discussion resources
- Easy access to Pulse Survey and other feedback mechanisms
- QI network support for local ideas
- Leadership behaviours

Our Future Our Way

Improving culture, leadership, inclusion

WeImproveQ
Trustwide Quality Improvement

WeAreLPT
compassion respect integrity trust

U

Trust Board 31st May 2022

EDI strategy 2025

Purpose of the Report

To present the refreshed 2025 EDI Strategy for adoption by the Trust.

Analysis of the issue

The Trust had an existing EDI Strategy that expired in 2020. The attached streamlined 2025 EDI Strategy has undergone extensive service user and staff engagement. Key stakeholders have provided feedback and comments that have been incorporated into the refreshed EDI Strategy. The objectives which have been set within it already have action plans underpinning key EDI activities.

Proposal

It is proposed that the strategy is adopted and published on the Trust's external EDI webpages.

Decision required

To endorse the EDI Strategy for adoption and publication.

Governance table

For Board and Board Committees:	Trust Board 31.5.22		
Paper sponsored by:	Sarah Willis, Director of HR/OD		
Paper authored by:	Haseeb Ahmad – Head of EDI		
Date submitted:	26 April 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):	EDI Workforce Group 5 April 2022 QAC April 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	One off		
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	**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.
Is the decision required consistent with LPT's risk appetite:			
False and misleading information (FOMI) considerations:	N/A		
Positive confirmation that the content does not risk the safety of patients or the public	The content does not risk the safety of patients or the public		
Equality considerations:	Entire Paper focuses on equality		

WeAreLPT

compassion respect
integrity trust

NHS
Leicestershire Partnership
NHS Trust

www.leicspart.nhs.uk

2021-25

Our Equality, Diversity and Inclusion (EDI) Strategy

Creating high quality, compassionate care and wellbeing for all

Contents

Foreword

Cathy Ellis, Trust Board Chair and Health and Wellbeing Guardian for LPT

I would like to endorse the Equality, Diversity and Inclusion strategy that is set out here. Our Trust Board is absolutely committed to Equality, Diversity and Inclusion and each of us has pledged our personal support for LPT to be an anti-racist organisation. We want to have a truly inclusive culture in LPT that recognises and celebrates difference for all protected characteristics.

I want everyone to feel welcome in our Trust. It is important that this strategy is brought to life through our own actions and those of our colleagues. Feeling included and part of our team is essential for the health and wellbeing of everyone. We are stronger when we stand together.

Angela Hillery, Chief Executive

As Chief Executive of our organisation I have chosen to prioritise and strengthen our collective focus upon Equality, Diversity and Inclusion.

I am very proud of how we are embracing this and of our achievements so far; however there is more for us all to do .I want us to remain ambitious by striving together to do this and I believe this strategy enables us to drive forward together. The recent pandemic has highlighted even more reasons why this work is so very important to all of us. Everyone is a leader here at Leicestershire NHS Partnership Trust and we can all make a difference and influence what we achieve. Our culture and what we create influences the care we provide and how all our staff experience working here. I want us to become the Anti- racist organisation we aspire to be and to be recognised as a place that embraces diversity and has a fully inclusive environment for all staff to work in.

Purpose, vision, values and leadership behaviours

The purpose of this strategy is to set out how we will create a highly inclusive culture that meets the needs of all our colleagues, patients, service users and communities and takes in to full account the following strategies, plans and partnerships:

- The People Plan
- The Step Up to Great strategy
- Together Against Racism strategy
- LPT's equal opportunities policies and related policies and procedures
- LPT's legal and statutory obligations
- LPT's partnership working with national, regional and system wide stakeholders
- Staff networks

Our vision is 'Creating high quality, compassionate care and wellbeing for all.'

Our leadership behaviours

Equality and Culture Change is one of our key "bricks" within our Step Up to Great strategy. Our Culture Change Programme "Our Future Our Way" worked with Change Champions from across the Trust to develop the following Leadership Values which are embedded in all of our leadership work including staff appraisals and recruitment activities:

- **Valuing one another -** We communicate with kindness and respect, valuing everyone's contribution

- **Recognising and valuing people's differences -** We respect everyone equally by helping to create a community that demonstrates unconditional positive attitudes, where people feel they belong, are valued, empowered and proud to work at LPT

- **Working together -** We are supportive, appreciative and encouraging of each other, enabling a positive team spirit which gives the best outcomes for colleagues and patients

- **Taking personal responsibility -** We give our best at work to deliver the highest standard

- **Always learning and improving -** We embrace change and actively seek opportunities to keep improving

Setting the scene

At Leicestershire Partnership Trust we are proud of our great achievements in providing high quality care and leadership, particularly over the difficult 18 months after the first lockdown of March 2020.

The pandemic reinforced the need for the Trust to develop a much bolder strategy on equality, diversity and inclusion. We want to create and sustain an environment where our staff find their voice and feel heard, our patients' care continues to be tailored to their needs and our role as a leading NHS organisation in the local economy brings tangible benefits to all people.

Many challenging equality, diversity and inclusion issues emerged from Covid-19. The disproportionate negative effect of the virus on people from Black, Asian and Minority Ethnic and disabled backgrounds has been a particular concern. We have also learned more about the challenges for people with disabilities of working remotely. We have had to display great flexibility in our workforce in transforming our services to meet the recovery needs of those hospitalised as a result of Covid-19 and to provide a safe environment for those receiving care in all services.

The death of George Floyd in the United States of America in May 2020 led to direct action from the Black Lives Matter movement and public bodies across the world are being challenged to remove racist practices. As a significant employer of Black, Asian and Minority Ethnic staff – both British and from overseas LPT have made a commitment to remedy previous injustices and create an environment that is fair and equal for all.

Our chief executive and Trust Board have made a firm stand against racism and have pledged to create an organisation which is "anti-racist."

We are Together Against Racism pledges from our Trust Board:

Cathy Ellis, chair:

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

Angela Hillery, chief executive:

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

Mark Powell, deputy chief executive:

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

Faisal Hussain, non-executive director and deputy chair:

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

Moira Ingham, non-executive director:

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

Professor Kevin Paterson, non-executive director:

I strongly believe that an active commitment to equality, diversity and inclusion is essential to modern healthcare and to meet the needs of patients. My pledge is to promote equality and inclusion and acknowledge and value diversity in all of the activities I undertake.

Ruth Marchington, non-executive director:

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

Darren Hickman, non-executive director:

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

Sharon Murphy, executive director of finance:

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

Sam Leak, director of community health services:

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

Fiona Myers, interim director of adult mental health:

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

Sarah Willis, director of human resources and organisational development:

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

Chris Oakes, director of corporate governance and risk:

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

Avinash Hiremath, medical director:

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

David Williams, director of strategy and business development:

Racism is wrong, it harms all of us. I show my commitment by championing equality and speaking out against racism when I can.

Anne Scott, director of nursing, AHPs and quality:

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

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

Every interaction, everyday shapes the culture of LPT and by working together against racism, we will build a culture of fairness and equity with our staff and the communities we serve. I show my commitment by making time to listen and understand, recognising my own privilege and ensuring that racism is identified, explored and challenged.

Paul Sheldon, chief finance officer*:

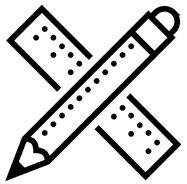
I believe in a fully inclusive and diverse world where people have equal opportunities.
I will continue to educate myself and listen to the voices of people who experience racism as well as challenge racism and discrimination.

Strategic Principles

In order to ensure we deliver our equality, diversity and inclusion objectives we will adhere to the following principles:

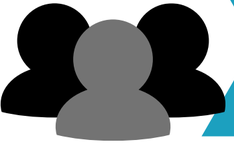
Valuing lived experience

All staff will be able to share their experiences and have them heard



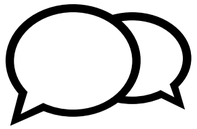
Well-led but co-designed

We will ensure all our leaders work to embed inclusive decision making in all they do and that organisational and service changes are co-designed to reflect the diversity of staff and patients



Shared responsibility

It is everyone's responsibility to eliminate inequality. All staff at LPT will be supported to create a culture that allows people to speak up when things are not right



Clear communications

Wherever possible we will use language that is clear and does not rely on stereotypes or outdated concepts. We will make sure materials are available in alternative formats and community languages

Our local population

LPT provides integrated mental health, learning disabilities and community health services to just over one million people across Leicester, Leicestershire and Rutland. According to the 2011 census 28% of the population are from Asian, Black and Minority communities (including communities from Eastern European countries) and this rises to 50% in the City of Leicester. Black, Asian and Minority Ethnic Communities have a younger age profile than White communities. Over two thirds of Leicester's school children are from minority ethnic background.

Approximately 17% of our population have disabilities and/or long term ill health. 1.4% of our population identify as Lesbian, Gay or Bisexual. It is hoped that the 2021 census data when available will provide us with far more information regarding our LGBTQ+ communities.

LPT does monitor and produce detailed population demographic analysis reports on people accessing its services. These can be found here: https://www.leicspart.nhs.uk/about/equality-diversity-and-inclusion/publication-of-equality-

Our staff profile

LPT has...

BAME staff make up 24.4% of the workforce - 13.4% are band 8a or above

5.8% of our workforce declare that they have a disability

3% of staff identify as LGBTQ+

The Trust produces detailed analysis of its staff profile. The full report can be found here: https://www.leicspart.nhs.uk/about/equality-diversity-and-inclusion/publication-of-equality-information/

Some of our achievements so far...

In the last two years we have seen some key developments relating to our Equality, Diversity and Inclusion agenda. Some notable achievements over the past 12 months are:

- We have seen a substantial growth in our existing six staff networks and developed a Women's Staff Network
- We have established our People's Council, which has a diverse representation of membership from our communities and patient leaders
- We are embarking on LPT's third reverse mentoring programme for Black, Asian and Ethnic Minority and Disabled staff
- We have introduced a requirement to have ethnically diverse interview panels and reporting diverse panel data as part of Workforce dashboards
- We have launched the Rainbow Badge initiative within the Trust in support of our LGBT+ patients and staff
- We have implemented listening events to hear the experiences of our staff on Equality, Diversity and Inclusion
- We have offered compassionate leadership training to managers
- We were shortlisted for the 2020 HSJ Workforce Race Equality Category in recognition of the Trust's work on Race Equality
- We have continued to identify and 'flag' people with an accessible information need
- We have taken part in free deaf awareness training delivered to front line staff as part of a NHSEI funded pilot

Equality objectives 2021- 2025

The following equality objectives have been developed as part of ongoing engagement with staff, patients and service users. They will be included in other key strategy documents, objectives and work streams and will have action plans to ensure their outcomes are delivered. These objectives have been grouped under distinctive themes to clarify how the objectives relate to specific work streams:

- **Disability Workforce Equality**

Objective one

To guarantee dignity at work for all disabled staff (and those with long-term ill health) by creating a culture free from bullying, harassment and discrimination.

Objective two

Examine and prioritise issues facing disabled staff and have strategies in place to support individuals.

Objective three

All disabled staff have the confidence to declare their disability on Electronic Staff Record.

Objective four

Embed inclusive recruitment practice towards the employment and retention of candidates with disabilities to guarantee fairness throughout the process.

Objective five

Ensure career progression for staff with disabilities through the talent management and succession planning approach.

➢ Workforce Race Equality

Objective one

Ensure recruitment and selection processes are inclusive and free from bias where candidates from Black, Asian and Minority Ethnic backgrounds have an equitable outcome compared to their white colleagues from application to appointment across all employment roles with an aim of eliminating any race equality disparities by 2025.

Objective two

Ensure that BAME staff are benefiting from Talent Management, Succession Planning and Career Progression leading to achievement of LPT model employer target of 24% by 2025.

Objective three

Create a culturally inclusive organisation for Black, Asian and Minority Ethnic Colleagues in order that there are demonstrable improvements in WRES staff survey indicators 7 and 8.

➢ Patient Experience and Involvement

Objective one

Introduce Cultural Intelligence training co-produced with patient leaders for staff leading to increase in cultural competencies.

Objective two

To co-design and involve patients and service users in shaping services which meet their needs.

➢ Access to services

Objective one

To capture and analyse the protected characteristics of patients and service users in order to identify access gaps.

Objective two

Ensure that the system wide inclusive decision-making framework is used across all service areas and projects to ensure that health inequalities are addressed in the planning and delivery of services.

Objective three

Create one stop shop services wherever possible.

Objective four

Ensure the effective implementation of the Accessible Information Standard.

Objective five

Carry out a programme of access audits of estates and facilities.

How this strategy will be monitored

This strategy will be monitored through LPT's EDI governance. The Trust has a number of committees who are responsible for the delivery of EDI priorities. These include:

- Trust Board
- Quality assurance committee
- The EDI Patient Experience and Involvement group
- Patient engagement and consultation group
- The EDI workforce group
- Strategic workforce group
- The People's Council
- Directorate level EDI groups

V

Finance & Performance Committee (FPC) – 26th April 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	NA	The 22-23 financial plan had been approved by Trust Board. The £1.4m deficit was based on inflation pressures and the impact of inflation would be monitored through the FPC Finance Report.	70, 71
CFO – Strategic Estates Verbal Update	NA	Facilities Management Transformation conversations continue including negotiations around the proposed transfer date which is to be confirmed. Emerging risks around the cleaning standards are being considered in the transfer plans. The dormitory eradication programme remains on track.	65, 66, 78
Director of Strategy and Business Development Verbal Update	NA	NHS.net migration took place on 6th April 2022 offering new ways of working and supporting transformation. SystmOne issues are being addressed with Trust wide workshops bringing together managers and clinicians to discuss the system.	64
Finance Report Month 12 – Paper C	High	All statutory duties have been met for 21-22. The accounts have been submitted with a break even position reported. The Better Payment Practice Code achieved the 95% target in all 4 categories.	70, 71
Patient Level Costing Development (PLICS) – Paper D	High	The national 20/21 Reference Costs feedback has not been received by the Trust to date. The next phase of PLICS will address the 'so what' questions and make this information useful for our clinicians by looking at where there is variation. FPC approved the report. LPT's learning will help inform the national forum work.	
CQUINS – Paper E	High	FPC received the report and noted the detail.	

Agenda Item:	Assurance level:		Committee escalation:	ORR Risk Reference:
Business Pipeline – Bids & Tenders Update – Paper F	High		FPC received the report and noted the contents. All business opportunities are considered on full merit and aligned to ensure maximum benefits for patients, service users, the families and carers of LPT.	64
Strategic Delivery Plan – Paper G	High		This plan is monitored through the Transformation Committee. Targets lying beneath this plan are in a separate document. The committee discussed the plan and made a number of suggestions for amendments which are noted in the minutes and on the will be tracked on the FPC action log. FPC approved the plan subject to the revisions detailed.	67, 68, 72,
Performance Report Month 12 – Paper H	H	L	The performance report shows broadly static wait times. The 52 week waits have all reduced with the exception of Learning Disabilities (LD). The LD community referral reporting has a new system data transfer issue, so the data is not currently accurate – this is being resolved. HR targets mandatory training and supervision metrics have reduced and appraisals increased. There is a concern around Information Governance training compliance which is being discussed at Executive Board. The Board Performance Metrics Review paper proposes the 22-23 metrics and includes CQUINS and strategic performance as a region. A quality dashboard is being developed to support these metrics. FPC agreed a split assurance – the performance management framework was working well and as such offered high assurance but there continued to be work to do on the performance and this remained at low assurance. The 22-23 metrics for the performance report were approved by FPC.	68, 69, 75
Improving Access Report – Paper I taken with Improving Access Committee Highlight Report 1st March 2022 (Paper T)	L	M	The report detailed many services remaining steady and some slippage in CAMHS & ED. Common themes are increasing demand along with static or reduced capacity – including both a covid and non-covid impact. A range of key mitigations are in place and are robust. FPC held discussions around assurance levels and what needs to be done to be assured that everything possible was being done in this area. FPC agreed a split	68, 69, 75

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
		assurance on the paper – the waiting times remain a concern and low assurance was received in this area. Keeping people safe and free from harm whilst waiting offered medium assurance – huge amount of work has gone into this area and is continuing	
CQC Action Plan Assurance Report – Paper J	High	The paper was taken as read. All must do actions were completed. All should do actions were also completed with only two on track to be completed shortly. No issues or questions were raised.	All
360 Assurance Annual Report – Paper K	High	FPC received the report and agreed high assurance was received from the detail within it provided by 360 Assurance. Good service performance for the service was noted along with the strong user satisfaction feedback. A slight slippage in mandatory training had mitigations in place to address them.	All
HIS Annual Report - Paper L	NA	This item was withdrawn from the agenda following discussions with FPC Chair and is now on the June FPC agenda.	
Local Security Management – Paper M	NA	Annual Report was not ready - FPC are to receive the Local Security Management Annual Report at the June FPC meeting.	
ORR – Paper N	High	Work is ongoing on the Annual Governance Statement and Annual Report which are both positive pictures. There has been significant assurance given for the annual governance and risk audit and the interim Head Of Internal Audit Opinion gives significant assurance in all 3 areas. The ORR monthly review had 1 update which is the addition of a new risk 79 which relates to the threat of a cyber-attack. FPC approved the addition of risk 79. The ORR will continue to be reviewed each month.	All
Estates and Medical Equipment Committee Highlight Report 16th February 2022 – Paper O	Medium	All significant issues covered within the agenda. Medium assurance due to some key issues on the highlight report still being in progress.	65, 66, 78
Transformation Committee Highlight	High	No issues or questions were raised on the report.	64, 72,

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
Report 8th March 2022 – Paper P			
IM&T Committee Highlight Report 11th March 2022 – Paper Q	High	There were three medium assurance areas on the report however improvement measueres are in place and these will be evident at the next committee.	79
Data Quality Committee Highlight Report 8th February 2022 – Paper R	High	There was one amber area relating to the kite mark of the data quality self-assessment for board performance report metrics– there has been good progress in this area.	68, 79
Capital Management Committee Highlight Report 9th March 2022 – Paper S	High	It was confirmed that there has been extensive recent work on medical devices and an improvement will be evidenced on the next report.	66
Improving Access Committee Highlight Report 1st March 2022 – Paper T	L / M	Discussed detailed above Paper I; Improving Access Times.	68, 69, 75

Chair of Committee:	Faisal Hussain

Leicestershire Partnership NHS
NHS Trust

W

Finance Report for the period ended
30 April 2022

For presentation at the
Trust Board meeting
31 May 2022

Contents

Executive Summary and overall performance against targets

1. This report presents the financial position for the period ended 30 April 2022 (Month 1). A net income and expenditure deficit of £497k is reported for the period. This is in line with the planned position for month 1 (forming part of the overall planned deficit of £1.4m for the year).

2. It should be noted that, in line with previous years, the month 1 position includes a much higher degree of estimation than will be the case in subsequent months (due to prior year final accounts process still being underway, the release of prior year reserved debtors and creditors still pending and new financial year activity information not yet being available)

3. Within the overall month 1 position, net operational budgets report a £688k overspend. Directorate overspends include DMH (£512k), LD Services (£85k), FYPC (£63k) and CHS (£56k). Hosted services are underspending by £19k, Estates by £10k and Enabling services are reporting breakeven.

4. Central reserves report a temporary surplus of £191k which partially offsets the net operational deficit, resulting in the net £497k deficit reported for the Trust.

5. Closing cash for April stood at £33.6m. This equates to 42.3 days' operating costs.

Performance against key targets and KPIs

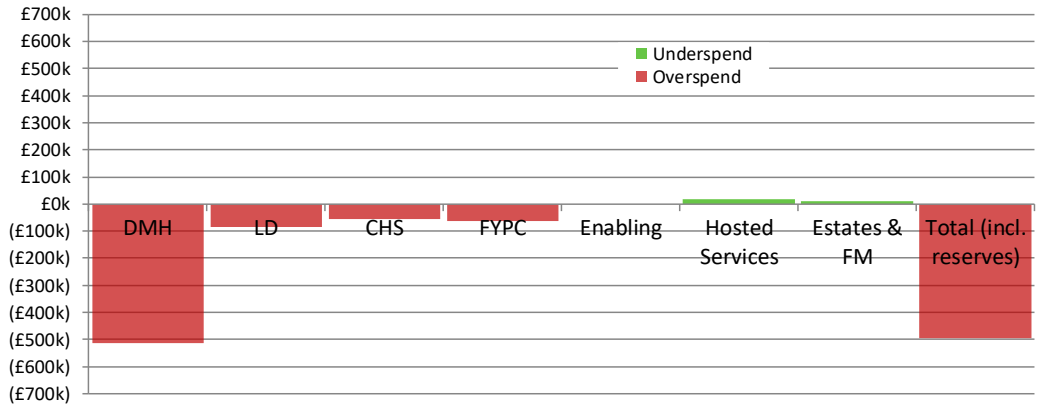
NHS Trust Statutory Duties	Year to date	Year end f'cast	Comments
1. Income and Expenditure break-even.	G	G	The Trust is reporting a financial deficit position at the end of April 2022. **[see 'Service I&E position' and *Appendix A*]**. *[Note: NHS Statutory Break-even Duty has a tolerance of 0.5% of turnover. The planned £1.4m deficit for the year is within that tolerance]*
2. Remain within Capital Resource Limit (CRL).	G	G	The capital spend for April is £33k, 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 £33.6m. The year-end forecast is £23m.

Secondary targets	Year to date	Year end f'cast	Comments
5. Comply with Better Payment Practice Code (BPPC).	G	G	The target is to pay 95% of invoices within 30 days. Cumulatively the Trust achieved all of the BPPC targets in April.
6. Achieve Efficiency Savings targets.	R	A	Efficiency savings performance has not been fully analysed in the high level month 1 position. However, agency reduction schemes make up a significant proportion of efficiency targets. Month 1 agency spend shows no evidence of a reduction, suggesting that overall efficiency performance is currently under target. This is also likely to impact on delivery of the target for the year.
7. Deliver a financial surplus	n/a	n/a	NHS Financial planning currently assumes no requirement to deliver a financial surplus (only a 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 still scoring a '2', despite the deficit position.
9. Achieve retained cash balances in line with plan	G	G	A cash balance of £33.6m was achieved at the end of April 2022. **[See 'cash and working capital']**
10. Deliver capital investment in line with plan (within +/- 15% YTD planned spend levels)	A	G	Capital expenditure totals £33k at the end of Month 1. This is £378k below the planned level of £411k. **[See 'Capital Programme 2022/23'].**

Income and Expenditure position

The month 1 position shows a net operational overspend against year-to-date budgets, partially offset by an underspend within reserves, resulting in the net £497k I&E deficit Trust position.

Month 1 year to date operational income and expenditure budget variances by service



The Mental Health directorate is overspending by £512k at Month 1. This is largely due to continuing high levels of agency staff to cover vacancies and in response to wait times. Spend for agency was £1.3m for the month of April. The average overall monthly expenditure run-rate for DMH increased in the second half of last year, correlating with the increase in agency spending. It is therefore imperative that the plans to reduce agency spending are implemented and then maintained in order to support a reduction in overall costs. The DMH deficit also includes a continuation of the Covid bank incentive payments, which results in increased costs of c. £100k per month.

The FYPC financial position at month 1 is an overspend of £63k. The Beacon Unit continues to face significant staffing pressures and high patient acuity resulting in high levels of agency. Langley ward overspends have also continued into this financial year. Both wards also saw low occupancy in the month resulting in an under recovery of income against budget. Healthy Together budgets reported an underspend due to staff vacancies in the month which was similar to the last financial year.

The LD financial position at month 1 reports an overspend of £85k. The Agnes Unit continues to incur significant agency costs due to staff sickness, acuity on the ward and through generally operating over all 5 pods (although a patient discharge resulted in one pod being closed during April). Community services remained underspent, albeit the rate of underspend reduced in the month mainly due to covering further vacancies.

The CHS Service is reporting a pay overspend of £56k for the first month of the year, with non-pay and income budgets initially reporting no variances. Bank and agency expenditure spend is £1.15m in the first month of which £78k is Covid related (at this stage last year, the bank and agency cost was £0.57m). The pressures within the Inpatient service continue and

are currently being offset by the significant vacancies that exist within the community nursing services. The bank and agency use within the inpatient wards remains high over April, 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.

Enabling Services are reporting a breakeven position as at M1.

Forecast position

The forecast position for the year is a deficit of £1.4m in line with the plan submitted by the Trust (and via the ICS) to NHSE/I. The £1.4m deficit is driven by the forecast impact of the increases in energy costs and also the general cost of living pressures. Whilst the Trust (and ICS) is in receipt of national funding to support inflationary cost increases, this funding has been assessed to be insufficient to cover actual cost rises.

The previous draft plan produced in March showed a £4.9m deficit, and this included £3.1m costs relating to delivery of LTP priorities. To support an improved financial position and the final April plan submission, the £3.1m cost was subsequently removed. In addition, an increase to the original efficiency target was actioned, to the effect that the overall deficit was reduced to the current £1.4m.

Both plan improvement actions introduce significant additional risk to the Trust, both in terms of the impact of not investing in priority services, and also in terms of finding additional efficiency savings when the original efficiency target was already extremely challenging. These risks have been communicated to the wider ICS so that they can be assessed as part of the wider system discussion.

The year-to-date planned position for April was a £497k deficit. Plans for subsequent months assume a gradual reduction to the in-month deficit, to the extent that this reaches a break-even position by the end of the first half of the financial year. The plan for the second half of the year sees the position move to a slight surplus, to deliver the overall deficit for the year of £1.4m.

This improvement to the position relies to some extent on efficiency savings coming on line across the year. However, the majority of the improvement is expected to be linked to a reduction in agency costs, which reached unprecedentedly high levels last financial year (£27m for 2022/23, £15m in 2021/22 and c. £8m - £10m during the preceding years).

Whilst the month 1 position has been assessed and reported at a fairly high level, there is no indication that agency costs have begun to reduce, with those identified for April appearing to show the highest monthly cost on record (although some caution is always advised when interpreting month 1 figures due to the impact of 2021/22 reserved creditors not yet being released).

At present, the year end forecast is assumed to be in line with the plan, however should clear month-on-month improvement not be evident by the end of quarter 1, it is likely that the Trust will need to report an off-plan position to NHSE/I.

Inflation cost pressures

As part of the national NHS price uplift, the Trust received a 2.8% uplift on NHS income as part of the 2022/23 planning round.

For pay costs, this was to support an assumed 2% cost of living rise, with 0.8% to cover the impact of the national insurance increase (0.8% being the overall net impact of the 1.25% increase on the NI rate, as this only affects pay costs over a certain threshold). Whilst the cost of living pay award has not yet been agreed, it is generally assumed that should a pay rise in excess of 2% be agreed, the national funding offer will flex accordingly. The impact of the NI uplift for LPT has been calculated and this is felt to be affordable within the 0.8% funding uplift. Overall therefore, pay inflation is not currently expected to create a cost pressure in 2022/23.

The same rate 2.8% inflation rate is also applied to non-pay. However the national funding uplift was agreed prior to the impact of the cost of energy increases being fully understood. Since then, assessments of the likely cost increases suggest a significant gap nationally between funding and costs for 2022/23. Currently there has been no firm indication from NHSE/I that the non-pay inflation impact will be re-assessed (although a separate data-gathering exercise was undertaken by NHSE/I in early April to understand the pressures being highlighted by organisations).

For LPT, this non-pay inflation gap has been calculated at £1.4m and this has been reflected in the financial plan (and as mentioned above, this is the driver of the overall £1.4m deficit). Updated cost estimates were based on information supplied by UHL via the Trust's Estates and FM services contract.

As actual energy charges start to be incurred, the position will continue to be monitored and reported in future updates.

Efficiency Savings

Efficiency savings

The Trust has an efficiency target of £5.6m for 2022/23. Given the absence of any material efficiency target (and none which has been allocated to operational directorates) since 2019/20, it has been challenging for services to adjust back to this way of managing financial delivery.

The original Trust target was £5.1m, and this was increased to £5.6m as part of the Trust's approach to improving the 2022/23 planned position in the final iteration of the financial plan.

Schemes to deliver the full £5.6m have been identified as a result of the work initiated by the Productivity and Efficiency group and the subsequent efforts of directorates to work up individual schemes. Formal EQIA sign-off has taken place for the majority of schemes and all of those implemented from month 1. However, there are significant delivery risks for a number of schemes, most notably with the agency reduction schemes, and also the additional £0.5m late requirement which relies on central savings that can't be confirmed at this stage of the year.

As a result of the high level financial position assessment for month 1, performance against individual schemes has not fully been assessed (this level of monitoring will be re-introduced from month 2, supported by the Productivity and Efficiency group meetings). However, approximately £80k of the April efficiency expectation relates to agency reduction, and it is clear that this has not happened. Therefore, whilst agency costs continue at current levels, overall efficiency savings delivery is likely to be significantly below target.

Provider Collaboratives update

The Trust is currently a partner in 3 provider collaboratives (1 as lead provider). As the collaboratives become more established, and as we move away from the indicative 'block' income arrangements that have prevailed during the Covid pandemic, it is anticipated that involvement in the collaboratives will expose the Trust to greater levels of financial risk (or reward).

A summary of the 3 collaboratives is given below:

Adult Eating Disorders (AED - LPT as Lead Provider)

The 2022/23 total budget for AED is £6.3m, of which £3.2m is paid to other providers within the collaborative and £3.1m has been allocated to LPT as a provider.

£2.1m relating to a 2021/22 underspend is expected to be carried forward into 2022/23 (not reflected in the above budget figures), to be invested in community projects to help prevent inpatient admissions.

CAMHS (NHFT as Lead Provider)

The total 2022/23 CAMHS PC budget is expected to be £25.9m for Tier 4 inpatient activity. Initial 2022/23 income for LPT is expected to be £1.5m based on 2021/22 activity x 2022/23 bed price. However, the arrangement has moved to cost-per-case for 2022/23 and during the year, income will be re-calculated on this basis. This could result in an income shortfall for LPT based on current activity levels, and so represents a financial risk.

Low Secure (Notts Healthcare FT – 'IMPACT' as Lead Provider)

The total 2022/23 Low Secure PC budget is expected to be c. £100m, of which the element relating to LPT services is £2.1m. Based on analysis conducted by the lead provider, there is a potential underlying shortfall within the overall funding available to the collaborative. Non-recurrent mitigations in 2021/22 meant that this did not impact financially on other providers in the collaborative last year. Going forward, as part of an agreed risk share process, any recurring shortfall could affect LPT income.

Statement of Financial Position (SoFP)

PERIOD: April 2022	2021/22 31/03/22 Draft (Restated) £'000's	2022/23 30/04/22 April £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	192,037	191,274
Intangible assets	4,818	4,784
IFRS16 - Right of use (ROU) assets	45,430	45,430
Trade and other receivables	932	933
Total Non Current Assets	**243,217**	**242,421**
CURRENT ASSETS		
Inventories	418	417
Trade and other receivables	8,087	12,795
Cash and Cash Equivalents	31,991	33,624
Total Current Assets	**40,496**	**46,836**
Non current assets held for sale	**0**	**0**
TOTAL ASSETS	**283,713**	**289,257**
CURRENT LIABILITIES		
Trade and other payables	(28,460)	(34,523)
Borrowings	(286)	(285)
Borrowings - IFRS16 ROU assets	(3,390)	(3,390)
Capital Investment Loan - Current	(185)	(186)
Provisions	(3,588)	(3,565)
Total Current Liabilities	**(35,909)**	**(41,949)**
NET CURRENT ASSETS (LIABILITIES)	**4,587**	**4,887**
NON CURRENT LIABILITIES		
Borrowings	(7,177)	(7,178)
Borrowings - IFRS16 ROU assets	(42,040)	(42,040)
Capital Investment Loan - Non Current	(3,021)	(3,021)
Provisions	(1,256)	(1,256)
Total Non Current Liabilities	**(53,494)**	**(53,495)**
TOTAL ASSETS EMPLOYED	**194,310**	**193,813**
TAXPAYERS' EQUITY		
Public Dividend Capital	101,831	101,830
Retained Earnings	39,058	38,561
Revaluation reserve	53,421	53,422
TOTAL TAXPAYERS EQUITY	**194,310**	**193,813**

Non-current assets

Property, plant, and equipment (PPE) amounts to £191.3m. Depreciation charges more than offset capital additions of £33k.

Due to the adoption of IFRS-16 leases from 1st April 2022, non-current assets have increased by £45.4m, with a corresponding liability shown against current and non-current borrowings. The opening balance sheet has been restated to include the transition of lease balances for Right Of Use assets.

The change of accounting treatment for IFRS-16 leases creates an additional 'cost' to the Trust's capital programme (this replaces our previous revenue lease cost and so does not impact on our overall net cashflow). An equivalent increase to our capital resource limit (the total amount the Trust can spend on capital) is anticipated but the national approach has not yet been confirmed.

Current assets

Current assets of £46.8m include cash of £33.6m and receivables of £12.8m.

Current Liabilities

Current liabilities amount to £42m and mainly relate to payables of £34.5m.

Net current assets / (liabilities) show net assets of £4.9m.

Working capital

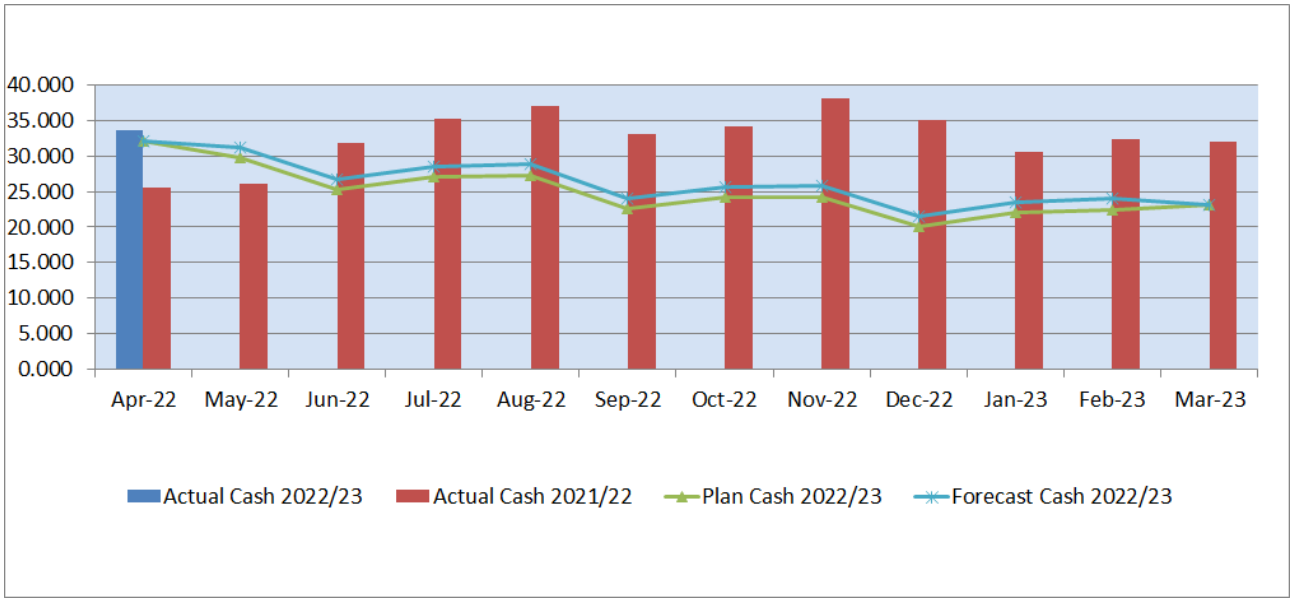
Cash and changes in working capital are reviewed on the following pages.

Taxpayers' Equity

April's deficit of £497k is reflected within retained earnings.

Cash and Working Capital

12 Months Cash Analysis Apr 22 to Mar 23



Cash – Key Points

The closing cash balance at the end of April was £33.6m, an increase of £1.9m during the month.

The positive cash movement is due to net favourable working capital movements: Receivables increased by £4.7m during the month, mainly due to an increase in accrued income and pre-payments. However an increase in payables of £6.1m more than offset this negative cash impact. The inclusion of new year expenditure accruals (due to outstanding supplier invoices) and the receipt of deferred income in April, have both contributed towards the increased cash balance.

The year end forecast is currently £23.1m. This represents a cash reduction of nearly £9m during the year. £6m of this is to support the in-year capital programme.

A cash-flow forecast is included at ***Appendix D.***

Receivables

Current receivables (debtors) total £12.8m; an increase of £4.7m during the month.

Receivables	Current Month April 2022					
	NHS	Non NHS	Emp's	Total	% Total	% Sales Ledger
	£'000	£'000	£'000	£'000		
Sales Ledger						
30 days or less	973	140	2	**1,115**	**8.1%**	**46.5%**
31 - 60 days	327	156	5	**488**	**3.6%**	**20.3%**
61 - 90 days	69	52	9	**130**	**0.9%**	**5.4%**
Over 90 days	211	249	206	**666**	**4.9%**	**27.8%**
	1,580	597	222	**2,399**	**17.5%**	**100.0%**
Non sales ledger	3,748	6,648	0	**10,396**	**75.7%**	
Total receivables current	**5,328**	**7,245**	**222**	**12,795**	**93.2%**	
Total receivables non current		933		933	**6.8%**	
Total	**5,328**	**8,178**	**222**	**13,728**	**100.0%**	**0.0%**

Debt greater than 90 days reduced by £85k since March and now stands at £666k. Receivables over 90 days should not account for more than 5% of the overall total receivables balance. The proportion at Month 1 is 4.9% (last month: 8.1%). This is the first time that the Trust has been able to report over 90 days debt below 5% since this became a national target, and so represents a significant achievement. Additional processes were devised by the Accounts Receivable team to achieve this improved performance.

The non-current receivables balance stands at £933k. It comprises of a £249k long term debtor with NHSI to support the clinical pensions' tax provision and a £684k prepayment to cover PFI capital lifecycle costs.

The provision for bad debts stands at £320k; this has not moved from the closing 2021/22 balance.

Payables

The current payables position in Month 1 is £34.5m. This is an increase of £6.1m since the start of the year. Expenditure accruals and deferred income liabilities have increased – 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.

Provisions

Trust provisions have reduced by £25k since the start of the year and now stand at £4.8m.

Better Payment Practice Code (BPPC)

The specific target is to pay 95% of invoices within 30 days. The Trust achieved all of the 4 BPPC targets in April. Further details are shown in ***Appendix B***.

Capital Programme 2022/23

Capital expenditure totals £33k for the first month of the year.

	Annual Plan	April Actual	Year End Forecast	Revision to Plan
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**
Depreciation & technical adjustments	9,500	33	9,500	0
Dormitory elimination - Bradgate (PDC)	4,000	0	4,000	0
Agnes unit PFI lifecycle costs	100	0	100	0
Cash utilisation from previous years' surplus - LPT	3,633	0	3,633	0
Cash utilisation to support stroke ward reserve - ICS	1,000	0	1,000	0
Cash utilisation to support system resource reserve - ICS	1,532	0	1,532	0
IFRS-16 leases - borrowings	3,913	0	3,913	0
Total Capital funds	**23,678**	**33**	**23,678**	**0**
Application of Funds	**£'000**	**£'000**	**£'000**	**£'000**
Estates				
Estates Service Improvements	(6,395)	0	(6,395)	0
Estates backlog	(2,637)	0	(2,637)	0
Estates other rolling programmes	(1,090)	0	(1,090)	0
Estates Staffing	(431)	(33)	(431)	0
Estates & FM Transformation	(470)	0	(470)	0
Medical Devices	(200)	0	(200)	0
Estates Directorate bids	(2,847)	0	(2,847)	
	(14,070)	**(33)**	**(14,070)**	**0**
IT Programme				
IM&T Rolling Programmes	(1,705)	0	(1,705)	0
IM&T Directorate bids	(1,158)	0	(1,158)	0
	(2,863)	**0**	**(2,863)**	**0**
Other				
ICS limits allocation	**(2,532)**	**0**	**(2,532)**	**0**
Contingencies	**(300)**	**0**	**(300)**	**0**
IFRS16 Leases / ROU Assets	**(3,913)**	**0**	**(3,913)**	**0**
Total Capital Expenditure	**(23,678)**	**(33)**	**(23,678)**	**0**
(Over)/underspend	**(0)**	**0**	**(0)**	**0**
Total - excluding IFRS16 leases	**(19,765)**	**(33)**	**(19,765)**	**0**

Following the adoption of International Financial Reporting Standard (IFRS) 16 – Leases, on the 1st of April 2022, this year's capital plan now includes the impact/capitalisation of any new property and equipment leases. At the start of the year 5 new leases with a combined capitalisation of value of £3.9m were forecast. So far this year none have been approved.

A system approved capital limit of £2.5m has been allocated to the Trust; £1m is ringfenced for the Stroke ward and £1.5m relates to the system reserve. Plans to spend the system reserve, either by LPT or UHL need to be determined.

Capital leads are reviewing last year's out-turn and identifying those schemes that were not completed as at 31st March 2022 (due to delays in materials, site access etc). The financial impact of completing these schemes in this financial year will be included in next month's capital report, as the current plan will need to be flexed to accommodate any additional costs.

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 30 April 2022	YTD Actual M1 £000	YTD Budget M1 £000	YTD Var. M1 £000
Revenue			
Total income	29,815	28,794	1,020
Operating expenses	(29,731)	(28,711)	(1,020)
Operating surplus (deficit)	**83**	**83**	**0**
Investment revenue	0	0	0
Other gains and (losses)	0	0	0
Finance costs	(119)	(119)	0
Surplus/(deficit) for the period	**(35)**	**(36)**	**0**
Public dividend capital dividends payable	(461)	(461)	0
I&E surplus/(deficit) for the period (before tech. adjs)	**(497)**	**(497)**	**0**
NHS Control Total performance adjustments			
Exclude gain on asset disposals	**0**	**0**	**0**
NHSE/I I&E control total surplus	**(497)**	**(497)**	**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:	**(496)**	**(497)**	**0**
Trust EBITDA £000	**1,234**	**1,234**	**0**
Trust EBITDA margin %	**4.1%**	**4.3%**	**-0.1%**

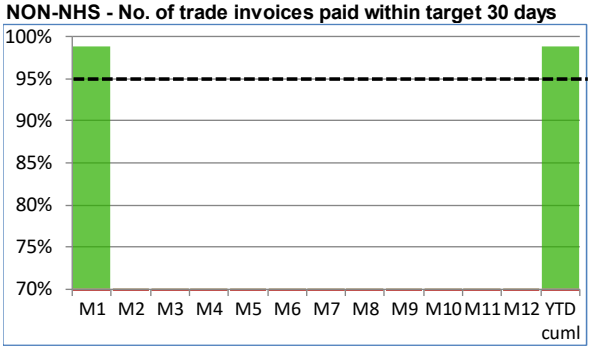
APPENDIX B – BPPC performance

Trust performance – current month (cumulative) v previous

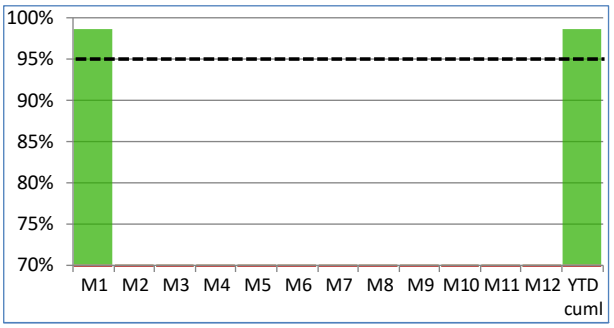
Better Payment Practice Code	April (Cumulative)	
	Number	£000's
Total Non-NHS trade invoices paid in the year	2,320	12,163
Total Non-NHS trade invoices paid within target	2,293	12,003
% of Non-NHS trade invoices paid within target	**98.8%**	**98.7%**
Total NHS trade invoices paid in the year	43	4,077
Total NHS trade invoices paid within target	43	4,077
% of NHS trade invoices paid within target	**100.0%**	**100.0%**
Grand total trade invoices paid in the year	2,363	16,240
Grand total trade invoices paid within target	2,336	16,080
% of total trade invoices paid within target	**98.9%**	**99.0%**

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

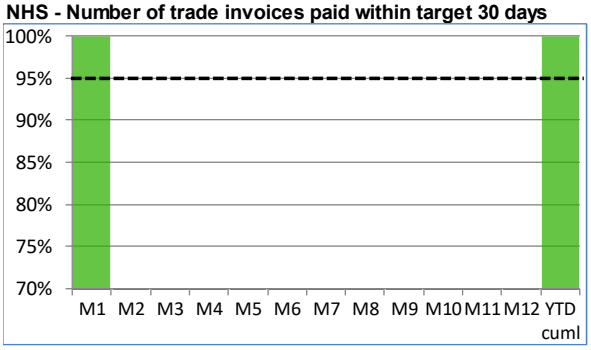
NON-NHS - No. of trade invoices paid within target 30 days



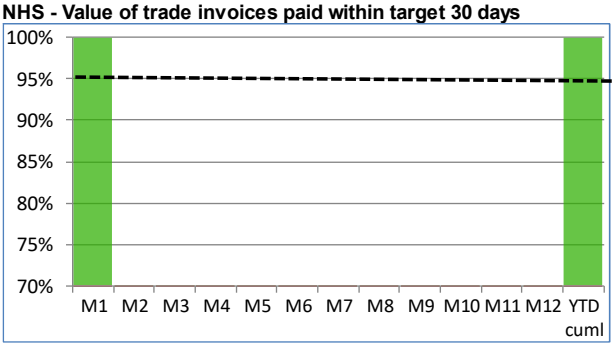
NON-NHS - Value of trade invoices paid within target 30 days



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 analysis			2022/23
2022/23 Agency Expenditure	2021/22 Outturn £000s Actual	2021/22 Avg mth H1 £000s Actual	2021/22 Avg mth H2 £000s Actual	2022/23 M1 £000s Actual
DMH				
Agency Consultant Costs	-3,586	-200	-398	-330
Agency Nursing	-6,589	-385	-713	-965
Agency Scient, Therap. & Tech	-203	-23	-11	-8
Agency Non clinical staff costs	-317	-38	-15	-16
Sub-total for Directorate - DMH	**-10,694**	**-646**	**-1,137**	**-1,319**
LEARNING DISABILITIES				
Agency Consultant Costs	-133	-9	-13	-37
Agency Nursing	-2,418	-154	-249	-200
Agency Scient, Therap. & Tech	-25	-3	-1	0
Agency Non clinical staff costs	-14	0	-2	-1
Sub-total for Directorate - LD	**-2,590**	**-333**	**-528**	**-239**
CHS				
Agency Consultant Costs	0	0	0	0
Agency Nursing	-5,864	-388	-589	-746
Agency Scient, Therap. & Tech	-639	-37	-69	-50
Agency Non clinical staff costs	-31	-4	-1	0
Sub-total for Directorate - CHS	**-6,534**	**-430**	**-659**	**-796**
FYPC				
Agency Consultant Costs	-754	-59	-67	-82
Agency Nursing	-4,172	-278	-417	-391
Agency Scient, Therap. & Tech	-48	-1	-7	-2
Agency Non clinical staff costs	-117	-7	-13	-2
Sub-total for Directorate - FYPC	**-5,091**	**-345**	**-503**	**-476**
Enabling, Hosted & reserves				
Agency Consultant Costs	-10	-2	0	-2
Agency Nursing	-89	0	-15	0
Agency Scient, Therap. & Tech	-290	-19	-29	-18
Agency Non clinical staff costs	-1,592	-97	-168	-99
Sub-total for Directorate - Enab/Host	**-1,982**	**-119**	**-212**	**-119**
TOTAL TRUST				
Agency Consultant Costs	-4,483	-270	-477	-450
Agency Nursing	-19,132	-1,206	-1,983	-2,302
Agency Scient, Therap. & Tech	-1,192	-77	-121	-79
Agency Non clinical staff costs	-2,072	-146	-199	-118
Total	**-26,891**	**-1,706**	**-2,776**	**-2,949**

An initial analysis of agency costs for April showed that these totalled £2.9m. Further work is required to validate the month 1 figures due to a greater level of estimation required at the start of the year and also due to the potential impact of the release of 2021/22 reserved creditors. At this level (£2.9m) this would be higher than any previous month.

Additional analysis in the table (left) provides comparative figures for 2021/22. Average monthly costs are shown for half-year 1 and half-year 2. This illustrates the significant increase in costs in the latter part of last financial year. A return even to H1 levels of cost would deliver significant savings in 2022/23, even above those anticipated in the plan.

An agency forecast for 2022/23 will be included in future reports.

APPENDIX D – Cash flow forecast

Statement of cash flows	Apr Forecast £'000	Apr Actual £'000	Apr Variance £'000	May Forecast £'000	Jun Forecast £'000	Jul Forecast £'000	Aug Forecast £'000	Sep Forecast £'000	Oct Forecast £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Year Ending Forecast £'000
Cash flows from operating activities															
Operating surplus/(deficit)	83	83	0	184	246	340	417	502	579	642	667	653	627	622	**5,562**
Non-cash income and expense:															
Depreciation and amortisation	1,151	829	(322)	1,151	1,151	1,151	1,152	1,152	1,152	1,152	1,153	1,153	1,153	1,161	**13,510**
(Increase)/decrease in receivables	0	(4,708)	(4,708)	(500)	(500)	1,000	(500)	(500)	1,000	(500)	(500)	2,000	1,500	1,130	**(1,078)**
Increase/(decrease) in trade and other payables	156	6,063	5,907	(1,783)	(1,467)	873	913	(3,644)	607	617	(173)	35	274	(1,201)	**1,114**
Increase/(decrease) in provisions	0	(23)	(23)	0	(750)	0	0	(750)	0	0	(750)	0	0	770	**(1,503)**
All other movements in operating cash flows	1	2	1	1	1	1	0	0	0	0	(1)	(123)	(360)	399	**(80)**
Net cash generated from/(used in) operations	**1,391**	**2,246**	**855**	**(947)**	**(1,319)**	**3,365**	**1,982**	**(3,240)**	**3,338**	**1,911**	**396**	**3,718**	**3,194**	**2,881**	**17,525**
Cash flows from investing activities															
Purchase of intangible assets	0	0	0	0	0	0	0	0	0	0	0	0	0	(300)	**(300)**
Purchase of property, plant and equipment and investment prope	(331)	(32)	299	(553)	(2,275)	(772)	(772)	(2,628)	(882)	(882)	(3,747)	(882)	(1,826)	(3,915)	**(19,166)**
Net cash generated from/(used in) investing activities	**(331)**	**(32)**	**299**	**(553)**	**(2,275)**	**(772)**	**(772)**	**(2,628)**	**(882)**	**(882)**	**(3,747)**	**(882)**	**(1,826)**	**(4,215)**	**(19,466)**
Cash flows from financing activities															
Public dividend capital received	0	0	0	0	0	0	0	2,000	0	0	0	0	0	2,000	**4,000**
Loans from Department of Health and Social Care - repaid	0	0	0	0	0	0	0	0	0	0	0	0	0	(163)	**(163)**
Capital element of lease payments	(306)	0	306	(306)	(306)	(306)	(306)	(306)	(306)	(306)	(306)	(306)	(306)	(518)	**(3,578)**
Capital element of PFI, LIFT and other service concession payme	0	0	0	0	0	0	0	0	0	0	0	0	0	(285)	**(285)**
Interest paid	(6)	(6)	0	(6)	(6)	(6)	(6)	(6)	(5)	(5)	(5)	(5)	(5)	(8)	**(69)**
Interest element of lease payments	(34)	(34)	0	(34)	(34)	(34)	(34)	(34)	(34)	(34)	(34)	(34)	(34)	(41)	**(415)**
Interest element of PFI, LIFT and other service concession obliga	(79)	(79)	0	(79)	(79)	(79)	(79)	(79)	(79)	(79)	(79)	(79)	(79)	(77)	**(946)**
PDC dividend (paid)/refunded	(461)	(461)	0	(461)	(461)	(461)	(461)	(461)	(461)	(461)	(461)	(461)	(461)	(461)	**(5,532)**
Cash flows from (used in) other financing activities															**0**
Net cash generated from/(used in) financing activities	**(886)**	**(580)**	**306**	**(886)**	**(886)**	**(886)**	**(886)**	**1,114**	**(885)**	**(885)**	**(885)**	**(885)**	**(885)**	**447**	**(6,988)**
Increase/(decrease) in cash and cash equivalents	**174**	**1,634**	**1,460**	**(2,386)**	**(4,480)**	**1,707**	**324**	**(4,754)**	**1,571**	**144**	**(4,236)**	**1,951**	**483**	**(887)**	**(8,929)**
Cash and cash equivalents at start of period	31,990	31,990	0	**33,624**	**31,238**	**26,758**	**28,465**	**28,789**	**24,035**	**25,606**	**25,750**	**21,514**	**23,465**	**23,948**	**31,990**
Cash and cash equivalents at end of period	**32,164**	**33,624**	**1,460**	**31,238**	**26,758**	**28,465**	**28,789**	**24,035**	**25,606**	**25,750**	**21,514**	**23,465**	**23,948**	**23,061**	**23,061**

Note - The above table shows the planned cashflow forecast submitted to NHSE&I. The usual detailed cashflow showing receipts and payments by organisation or expenditure type will be included from Month 2.

APPENDIX E – Covid-19 expenditure, April 2022

Cost of Covid response

CATEGORY	AMH	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	1	2	0	0	0	0	0	0	**3**
Bank	102	39	0	0	0	0	0	0	**141**
Agency	0	38	0	0	0	0	0	0	**38**
Existing workforce additional shifts									
Substantive	0	0	0	0	0	7	0	0	**7**
Bank	0	0	16	9	0	18	0	0	**43**
Agency	0	0	0	0	0	0	0	0	**0**
Backfill for higher sickness absence									
Substantive	0	0	0	0	0	0	0	0	**0**
Bank	0	0	0	0	0	0	0	0	**0**
Agency	0	0	0	0	0	0	0	0	**0**
Sick pay at full pay (all staff types)	0	0	0	0	0	0	0	0	**0**
NON-PAY	£000	£000	£000	£000	£000	£000	£000	£000	£000
NHS Staff Accommodation - if bought outside of national process	0	0	0	0	0	0	0	0	**0**
PPE - locally procured	0	0	0	0	0	2	0	0	**2**
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	4	0	0	0	0	0	0	0	**4**
NHS 111 additional capacity	0	0	0	0	0	0	0	0	**0**
After care and support costs (community, mental health, primary care)	0	0	0	0	13	0	0	0	**13**
Infection prevention and control training	0	0	0	0	0	0	0	0	**0**
Remote working for non patient activites:									
IT/Communication services and equipment	0	0	0	0	0	1	0	0	**1**
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 FOR MONTH 1:	**107**	**79**	**16**	**9**	**13**	**28**	**0**	**0**	**252**
TOTAL YTD COVID COSTS:	**107**	**79**	**16**	**9**	**13**	**28**	**0**	**0**	**252**

Covid Vaccination costs

Total Covid vaccination costs incurred to date (April 22) are £719k. Virtually all the costs relate to staffing - £680k, plus £39k non-pay including support to SAIS, security costs at Feilding Palmer and medical supplies. The Trust plan assumes total vaccination costs of £2.5m for the 6 months to 30 September 2022.

Leicestershire Partnership NHS Trust

Trust Board meeting 31/05/2022

Month 1 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 plan.

Decision required: N/A

Governance table

For Board and Board Committees:	Finance & Performance Committee	
Paper sponsored by:	Sharon Murphy, Director of Finance & Performance	
Paper authored by:	Amjad Kadri, Acting Head of Corporate Finance Jackie Moore, Financial Controller	
Date submitted:	23/05/2022	
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 20/05/2022	
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	

X

Leicestershire Partnership NHS Trust

Public Trust Board – 31.05.22

Board Performance Report April 2022 (Month 1)

Purpose of the report

To provide the Trust Board with the Trust's performance against KPI's for April 2022 Month 1.

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 following should be noted by the Trust Board with their review of the report:

- The addition of metrics under the a 'Mental Health Core Data', 'CQUIN' and 'NHS Oversight' sections.
- Removal of the 'SI action plans implemented within timescales' metrics from the 'Quality and Safety' section.
- Updated 'Quality Account' metrics to reflect latest guidance.

Decision required

The Trust Board is asked to

- Approve the performance report

Governance table

For Board and Board Committees:	Trust Board 31.5.22	
Paper sponsored by:	Sharon Murphy, Interim Director of Finance and Performance	
Paper authored by:	Prakash Patel, Acting Head of Information	
Date submitted:	23.05.22	
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
31 May 2022

Board Performance Report
April 2022 (Month 1)

Highlighted Performance Movements - April 2022

Improved performance:

Metric	Performance	
Cognitive Behavioural Therapy - 52 Weeks	9	Reported 24 in December 2021, steadily decreasing
CAMHS Eating Disorder – one week (complete pathway) Target is 95%	100.0%	Reported 100% for over 12 months

Deteriorating Performance:

Metric	Performance	
CAMHS Eating Disorder – four weeks (complete pathway) Target is 95%	20.0%	
Delayed Transfers of Care Target is <=3.5% across LLR	6.4%	Reported 3.3% in November 2021, the last time it was below the target

Other areas to highlight:

Metric	Performance (No)	
Serious Incidents	1	Decreased from 6 reported last month
No. of episodes of seclusions >2hrs *Target decreasing trend*	19	Increased from 10 reported last month
No. of episodes of prone (Supported) restraint	2	Decreased from 3 reported last month
No. of repeat falls *Target decreasing trend*	31	Decreased from 37 reported last month

1. Hospital Acquired COVID Infection Reporting

A nosocomial infection is an infection that is acquired in a hospital or other health care facility. How likely each patient Covid-19 case is to be a nosocomial case is based on the duration of time between admission to a healthcare facility and positive specimen date;.

- **Hospital-Onset Probable Healthcare-Associated** – positive specimen date 8 -14 days after hospital admission.
- **Hospital-Onset Definite Healthcare-Associated** – positive specimen date 15 or more days after hospital admission.

Indicator	Trust Position												
Total Admissions		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Sparkline
	Total Admissions	398	437	418	404	412	391	436	403	379	400	359	397	
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Sparkline
	Total Admissions	360												
Covid Positive Prior to Admission		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Sparkline
	Total Covid +ve Admissions	1	0	3	6	20	12	13	12	17	30	4	25	
	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%	6.3%	
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Sparkline
	Total Covid +ve Admissions	13												
	Covid +ve Admission Rate	3.6%												*
Covid Positive Following Swab During Admission	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	Mar-22	Sparkline
	0-2	0	0	0	0	1	1	2	1	3	4	6	5	
	3-7	0	1	0	0	2	1	1	1	8	6	7	9	
	8-14	0	0	0	0	1	0	3	1	7	6	2	7	
	15 and over	1	0	0	0	2	2	11	0	38	43	11	22	
	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%	7.3%	
	No of Days	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Sparkline
	0-2	3												
	3-7	17												
	8-14	15												
	15 and over	34												
	Hospital Acquired Rate *	13.6%												*
	• 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.*												
Overall Covid Positive Admissions Rate		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Sparkline
	Total Covid +ve Admissions	2	1	3	6	26	16	30	15	73	89	30	68	
	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%	17.1%	
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Sparkline
	Total Covid +ve Admissions	82												
	Average Covid +ve Admissions	22.8%												*

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 forty nosocomial cases reported in March 2022. This is broken down into fourteen at 8-14 days and thirty four at greater than 15 days. These have been managed as patient and staff Covid-19 outbreaks, identified in the following areas:

8-14 days

15+ days

Heather Ward - Bradgate Unit

Ward 1 Coalville Hospital

Ward 2 Coalville Hospital

Beechwood Ward - Evington Centre

Clarendon Ward - Evington Centre

Ashby Ward - Bradgate Unit

Dalgleish Ward - Melton Hospital

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 are being reported against in 2022/23 until the new metrics have been agreed.

Standard	Trust Performance						RAG/ Comments on recovery plan position	SPC Flag	
								Assurance of Meeting Target	Trend
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period Target is >=95%	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22		?	UP
	97.2%	100.0%	100.0%	98.5%	100.0%	98.4%		Over the series of data points being measured, key standards are being delivered inconsistently	
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 No Target		2017/18	2018/19	2019/20	2020/21	2021/22	The majority of scores within Leicestershire Partnership NHS Trust sit in the bottom 20% of the Trusts surveyed by Quality Health. There are 7 scores in the intermediate 60% range and no scores in the top 20% range. Despite this, the Trust does perform fairly well on the score for service users knowing how to contact the person in charge of organising their care if they have a concern.	n/a	n/a
		7.4	6.4	7.1	6.9	6.4		*Not applicable for SPC as reported infrequently*	
The percentage of inpatients discharged with a subsequent inpatient admission within 30 days No Target	**Age 0-15**							n/a	n/a
	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22			
	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%			
	Age 16 or over								
	8.0%	4.5%	5.8%	3.7%	5.9%	5.8%			
The number and, where available rate of patient safety incidents reported within the Trust during the reporting period No Target	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22		n/a	n/a
	1070	1170	1167	1132	1203	1386			
	59.8%	54.6%	53.5%	60.7%	54.0%	59.8%			
The number and percentage of such patient safety incidents that resulted in severe harm or death No Target	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22		n/a	n/a
	11	10	8	14	9	11			
	1.0%	0.9%	0.7%	1.2%	0.7%	0.8%			
72 hour Follow Up after discharge Target is >=80% *Aligned with national published data* *(reported a quarter in arrears)*	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	• LPTs internal reports have been amended to reflect the national reporting which has resulted in a fall in performance. • Investigation of LPTs data indicates differences in reporting methodology and, therefore, a proportion of follow up contacts recorded in LPT will not flow into the MHSDS. • This does not mean that performance has dropped in terms of clinical interventions. • The data will be corrected retrospectively.	N/A	N/A
	60.0%	68.0%	54.0%	56.0%	60.0%	59.0%			

3. CQUINs

The following indicators form part of the 2022/2023 National CQUIN scheme. These will be reported in line with the national submission requirements

4. Mental Health Core Data Pack

The following indicators are LPT's performance as per the Mental Health Core Data Pack. The source for this data is the nationally submitted MHSDS. Performance is published a quarter in arrears.

Target	Trust Performance							RAG/ Comments on recovery plan position (LPT)
(B1) Discharges followed up within 72hrs Target is >=80%		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	• LPTs internal reports have been amended to reflect the national reporting which has resulted in a fall in performance. • Investigation of LPTs data indicates differences in reporting methodology and, therefore, a proportion of follow up contacts recorded in LPT will not flow into the MHSDS. • This does not mean that performance has dropped in terms of clinical interventions. • The data will be corrected retrospectively.
	LLR	59.0%	65.0%	52.0%	57.0%	61.0%	64.0%	
	LPT	60.0%	68.0%	54.0%	56.0%	60.0%	59.0%	
(D1) Community Mental Health Access (2+ contacts) No Target		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	
	LLR	7280	7875	8545	9120	9520	9980	
	LPT	7140	7760	8450	9035	9475	9940	
(E1) CYP access (1+ contact) Target is 8566		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	
	LLR	8465	8795	8505	8465	8480	10465	
	LPT	5680	5695	5680	5740	5710	5795	
(E4) CYP eating disorders waiting time - Routine Target is >=95%		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	
	LLR		40.9%			33.0%		
	LPT		41.5%			32.7%		
(E5) CYP eating disorders waiting time - Urgent Target is >=95%		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	
	LLR		62.5%			64.2%		
	LPT		62.5%			64.2%		
(G3) EIP waiting times - MHSDS Target is >=60%		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	
	LLR	76.6%	68.7%	65.6%	67.8%	79.5%	79.2%	
	LPT	76.9%	69.9%	65.2%	69.0%	77.8%	80.9%	
(I1) Individual Placement Support Target is 230		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	
	LLR	155	165	190	210	220	245	
	LPT	155	170	190	210	220	245	

(K2) OOA bed days - inappropriate only No Target		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
	LLR	0	0	0	0	0	0
	LPT	0	0	0	0	0	0
(L1) Perinatal access - rolling 12 months No Target		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
	LLR	430	455	430	420	405	495
	LPT	420	450	430	415	395	485
(L2) Perinatal access - year to date Target is 542		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
	LLR	295	345	345	350	350	455
	LPT	295	345	345	345	345	445
(N1) Data Quality - Consistency No Target		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
	LLR	80.0%	100.0%	100.0%	80.0%	80.0%	100.0%
	LPT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
(N2) Data Quality - Coverage Target is >=85%		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
	LLR	66.7%	83.3%	80.0%	80.0%	83.3%	83.3%
	LPT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
(N3) Data Quality - Outcomes Target is >=40%		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
	LLR	38.0%	37.5%	36.8%	36.2%	36.1%	36.0%
	LPT	38.0%	37.5%	36.8%	36.2%	36.1%	36.0%
(N4) Data Quality - DQMI score Target is >=80		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
	LLR	57.3	63	57	55.8	57.3	59
	LPT	93.0	93.0	90.0	90.0	93.0	93.0
(N5) Data Quality - SNOMED CT Target is >=85%		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
	LLR	64.8%	65.7%	73.4%	71.5%	73.7%	72.3%
	LPT	65.2%	67.4%	75.0%	74.7%	74.9%	75.7%

5. NHS Oversight

The following targets form part of the 2021/22 NHS Oversight Framework that are being reported against in 2022/23. We continue working with Commissioners to understand the metrics to be reported at system/organisational level.

Target	Trust Performance						RAG/ Comments on recovery plan position
2-hour urgent response activity Early Implementer Target is 70% *(Local data)*	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	April data meets the 70% target, however performance for April will increase at the next data refresh when DQ issues will have been corrected. None of the Palliative Care UCR data is included due to reporting challenges that are currently being worked on with service and information team.
						71.1%	
Daily discharges as % of patients who no longer meet the criteria to reside in hospital No Target	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	
	Performance to be added next month						
Reliance on specialist inpatient care for adults with a learning disability and/or autism *(CCG data)* No Target	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	
						30	
Reliance on specialist inpatient care for children with a learning disability and/or autism *(CCG data)* No Target	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	
						4	
Overall CQC rating (provision of high quality care) No Target		2021/2022					
		2					
	2 = requires improvement						
Potential under-reporting of patient safety incidents - Number of months in which patient safety incidents or events were reported to the NRLS No Target	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
National Patient Safety Alerts not completed by deadline No Target	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	
						0	
	Reporting is at point in time and cannot be backdated.						
MRSA Infection Rate No Target *(local data)*	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	
	0	0	0	0	0	0	

Clostridium difficile infection rate No Target *(local data)*	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	
	0	2	1	3	1	0	
E.coli bloodstream infections No Target *(local data)*	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	
	Performance to be added next month						
VTE Risk Assessment No Target	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	
	Indicator is a placeholder as is not yet defined in the SOF Technical Guidance						
Percentage of people aged 65 and over who received a flu vaccination No Target *LLR data*	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	
	32.8%	63.6%	80.1%	83.1%	83.2%	83.5%	
	February 2022 is the most recent data published						
Proportions of patient activities with an ethnicity code No Target	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	
	Indicator is a placeholder as is not yet defined in the SOF Technical Guidance						

6(a). Access - Waiting Time Standards - DMH

The following performance measures (reported a month in arrears) are key waiting time standards for the Trust:

Target	Performance							RAG/ Comments on recovery plan position	SPC Flag	
									Assurance of Meeting Target	Trend
Adult CMHT Access Six weeks routine Target is 95%		Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	• New assessment model is being trialled and will be rolled out across all CMHTs. This will link into system wide working including working in system partnership. Project brief to be updated. • Caseload reviewing the skill mix of each of the teams to ensure that each patient is seeing the the most appropriate practitioner and that caseloads are aligned to the appropriate clinician. • Develop a 'step up' community offer. Teams are in the process of reviewing and amending the project brief as part of the workstream work / system. • Workstream in place to review and re- design the workforce.	N/A	N/A
	Complete	68.4%	66.6%	71.7%	62.2%	61.6%	65.4%			
	Incomplete	68.8%	73.5%	72.5%	72.1%	71.1%	61.5%		NO	UP
									Key standards are not being delivered but are improving	
Memory Clinic (18 week Local RTT) Target is 95%		Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	• Patients are waiting longer for an assessment due to the build-up of the waiting list from the suspension of the service due to the Covid -19 pandemic. Referral rates now back to pre-covid levels. • 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.	N/A	N/A
	Complete	39.5%	51.4%	49.2%	30.8%	44.3%	43.3%			
	Incomplete	77.1%	79.5%	79.7%	78.6%	72.7%	64.8%		N/A	N/A
ADHD (18 week local RTT) Target is: Complete - 95% Incomplete - 92%		Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	• A recovery plan has been developed with engagement through a time out day including clinicians and commissioners. • A task and finish group has been set up with commissioners, chaired by Head of Service to lead development of a new hub and spoke model with a more integrated approach for people with mental health needs and an associated diagnosis of ADHD. • There is MHIS funding which will be used to deliver System wide ADHD support.	N/A	N/A
	Complete	21.4%	18.5%	6.3%	14.3%	7.1%	12.5%			
	Incomplete	31.4%	29.7%	29.8%	28.0%	26.1%	21.9%		N/A	N/A
Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral Target is >=60%		Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22		?	NO CHANGE
		66.7%	89.5%	90.9%	85.7%	75.0%	94.1%			
									Over the series of data points being measured, key standards are being delivered inconsistently	

6(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%	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-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
	21.3%	20.9%	32.2%	32.3%	21.1%	26.4%			
Continence (Complete Pathway) Target is 95%	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-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
	39.7%	46.1%	36.6%	41.2%	47.6%	42.1%			

6(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%		Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-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. CYP are supported in the community whilst waiting through First Steps	?	UP
		77.8%	83.3%	100.0%	100.0%	100.0%	83.3%		Over the series of data points being measured, key standards are being delivered inconsistently	
CAMHS Eating Disorder – four weeks (complete pathway) Target is 95%		Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-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 being filled slower than anticipated. However, once new staff in post we expect the trajectory to recover.	NO	DOWN
		20.0%	30.8%	25.0%	50.0%	30.0%	20.0%		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%		Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-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%		Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	A recent spike in referrals is being addressed through additional clinics	?	NO CHANGE
		100.0%	100.0%	100.0%	90.0%	86.3%	84.4%		Over the series of data points being measured, key standards are being delivered inconsistently	
Aspergers - 18 weeks (complete pathway) Target is 95%	Wait for Treatment	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	The service did not meet the measure, with 9 out of 14 seen outside the measure. The service has received record referrals with 847 referrals by the end of 2021/22. This would be an increase of 122% from the 2020/21 referral rate of 20/21 or 54% from the previous record of 549 referrals in 2019/20.	N/A	N/A
		95.8%	97.1%	75.0%	6.5%	30.0%	35.7%			
	No. of Referrals	47	88	92	70	67	78			
LD Community - 8 weeks (complete pathway) Target is 95%	Wait for Assessment	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	The service has implemented a new 'Access' pathway, which completes the initial core assessment for all pathways and then directing to the apprpriate pathway. The KPI's for this new process are being completed. The current data is illustrating the backlog of patients waiting prior to new Access pathway as the last few complete	N/A	N/A
		79.2%	84.2%	72.1%	49.3%	20.7%	16.7%			
	No. of Referrals	104	93	78	3	0	0			
6-week wait for diagnostic procedures (Incomplete) Target is >=99%		Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	In line with national COVID-19 guidance, this service was suspended. It was re-established in October 2020. We were able to address a significant amount of the backlog in 2021/22 with additional Headroom Investment. The service is struggling with staffing issues now with 2 staff going on maternity/adoption leave and we are in the process of recruiting cover. The service has reviewed their COVID IPC arrangements and are now offering close to pre-covid numbers per clinic. A new trajectory for the service has been completed and there is a slow recovery until August then with recruitment completed this rapidly increases from September with expected full recovery in December 2022	YES	DOWN
		64.9%	72.9%	57.9%	67.9%	79.0%	85.9%		Key standards are being delivered but are deteriorating	

7. 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	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	128 weeks	The CBT improvement plan remains effective in supporting the number of 52 week waiters to fall.	NO	DOWN
	17	24	23	16	10	9			Key standards are not being delivered but are improving	
Dynamic Psychotherapy	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	79 weeks	The number of 52 week waiters are below the planned trajectory. Long term, sustainable reduction in wait times to be delivered via Step Up to Great Mental Health transformation plan, integrating assessment and intervention within the locality Treatment and Recovery Teams.	NO	DOWN
	21	21	24	24	14	11			Key standards are not being delivered but are improving	
Therapy Service for People with Personality Disorder - Treatment waiters over 52 weeks	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	244 weeks	• Jan-April 2022 the service has commenced with training SCM groups. These groups have also trained SCM staff to begin the roll out of locality SCM-Decider programme. • Following recruitment of new staff and the development of the SCM decider programme, a significant number of service users being offered and completing treatment within locality teams over the next 12-18 months. • Implementing a QI approach to evaluate this implementation plan.	NO	UP
	460	473	472	490	479	478			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)	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	182 weeks	• The TSPPD Service is achieving against the agreed trajectory to reduce the number of patients waiting for assessment for over 52 weeks. • As part of step-up-great the service continues to work to a position whereby all first assessments for planned treatment, which includes those going onto the TSPPD pathway, will be provided through the planned treatment and recovery teams as part of a pathfinder/consulter assessment process. This will serve as the initial assessment as part of an integrated planned community offer.	N/A	N/A
	360	341	324	330	329	326				
CAMHS	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	92 weeks	As at 3rd May 96 waiting over a year, 83 for treatment and 13 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 25 weeks down from a peak of 38 weeks, this is a sustained gradual recovery	NO	NO CHANGE
	141	169	148	150	136	138			Key standards are not being delivered and are deteriorating/ not improving	
All LD - No's waiting over 52 weeks	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	84 weeks	The majority of these are with the Adult Autism Service. There are still a few not wishing to be seen due to increase vulnerabilities.	N/A	N/A
	21	18	30	42	55	58				

8. 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%	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-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
	81.3%	85.4%	80.1%	83.8%	81.2%	74.8%		Over the series of data points being measured, key standards are being delivered inconsistently	
Occupancy Rate - Community Beds (excluding leave) Target is >=93%	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-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
	85.1%	84.3%	82.7%	90.2%	87.9%	91.8%		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.	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	The Trust consistently is below the national benchmark of 25 days.	YES	UP
	18.3	18.2	19.5	20.3	21.1	21.1		Key standards are being delivered but are deteriorating	
Delayed Transfers of Care Target is <=3.5% across LLR	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-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.	?	UP
	3.3%	3.8%	3.7%	4.9%	5.1%	6.4%		Over the series of data points being measured, key standards are being delivered inconsistently	
Gatekeeping Target is >=95%	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22		?	UP
	97.2%	100.0%	100.0%	98.5%	100.0%	98.4%		Over the series of data points being measured, key standards are being delivered inconsistently	
Inpatient Admissions to LD and MH Wards with a Learning Disability *(Rolling 12 Month)* Target: Adult =36 CYP=3	**Adult**							N/A	N/A
	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22			
	13	12	13	14	14	11			
	CYP								
	Work is ongoing to define and agree methodology. Back-dated information will be produced once information is signed off.								
Admissions to adult facilities of patients under 18 years old Target = 0	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22		n/a	n/a
	0	0	0	0	0	0			

9. Quality and Safety

Target	Trust Performance							RAG/ Comments on recovery plan position	SPC Flag	
									Assurance of Meeting Target	Trend
Serious incidents		Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22		?	NO CHANGE
		8	5	6	7	6	1			
	Indicator under review								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		Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22		NO	NO CHANGE
	Day	3	7	7	4	5	3			
	Night	1	1	1	0	0	0			
									Key standards are not being delivered and are not improving *SPC based on day shift*	
Care Hours per patient day No Target		Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22		N/A	N/A
		12.4	11.6	12.1	11.9	12.1	12.7			
									Key standard has no target; however performance is consistent	
No. of episodes of seclusions >2hrs Target decreasing trend		Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22		N/A	DOWN
		7	9	19	16	10	19			
									Key standard has no target; however performance is consistent	
No. of episodes of prone (Supported) restraint Target decreasing trend		Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22		N/A	DOWN
		2	1	3	2	3	2			
									Key standard has no target; however performance is consistent	
No. of episodes of prone (Unsupported) restraint Target decreasing trend		Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22		N/A	NO CHANGE
		1	0	0	0	1	0			
									Key standard has no target; however performance is consistent	
Total number of Restrictive Practices (No target)		Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22		N/A	N/A
		272	204	267	246	353	317			

No. of Category 2 and 4 pressure ulcers developed or deteriorated in LPT care Target decreasing trend (RAG based on commissioner trajectory)		Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22		N/A	NO CHANGE
	Category 2	90	97	122	100	95	90			
	Category 4	11	6	1	4	2	6		N/A	NO CHANGE
									Key standard has no target; however performance is consistent for category 2 and consistent for category 4	
No. of repeat falls Target decreasing trend		Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22		N/A	DOWN
		32	25	38	33	37	31			
									Key standard has no target; however performance is consistent	
LD Annual Health Checks completed - YTD Target is 70%		Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Year To date from 1 April 2022	N/A	N/A
		30.8%	39.4%	43.9%	62.0%	73.1%	2.5%			
LeDeR Reviews completed within timeframe (No Target)		Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	New LeDeR system is in place – need to redefine.	N/A	N/A
	Allocated	12	12	28	23	18	37			
	Awaiting Allocation	19	29	22	10	9	7		N/A	N/A
	On Hold	3	1	2	3	1	0		N/A	N/A

10. 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%	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	The Trust is below the ceiling set for turnover.	YES	NO CHANGE
	9.6%	9.4%	9.4%	9.2%	9.4%	9.6%		Key standards are being consistently delivered and are improving performance	
Vacancy rate Target is <=7%	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-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
	10.5%	11.4%	11.1%	10.7%	11.3%	12.3%		Key standards are not being delivered and are deteriorating	
Health and Well-being Sickness Absence (1 month in arrears) Target is <=4.5%	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Sickness Absence rate has significantly decreased in March 2022, however it is still slightly above the trust target of 4.5%, all absence is being appropriately managed within the services with support from HR.	NO	NO CHANGE
	5.4%	5.8%	5.4%	5.9%	5.3%	4.7%		Key standards are not being delivered and are deteriorating	
Health and Well-being Sickness Absence Costs (1 month in arrears) Target is TBC	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Sickness absence is being appropriately managed within the services with support from HR.	n/a	n/a
	£790,515	£848,444	£816,587	£877,250	£686,317	£737,217			
Health and Well-being Sickness Absence YTD (1 month in arrears) Target is <=4.5%	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Sickness absence is being appropriately managed within the services with support from HR.	n/a	n/a
	5.1%	5.2%	5.2%	5.3%	5.0%	5.2%		Not applicable for SPC as measuring cumulative data	
Agency Costs Target is <=£641,666 (NHSI national target)	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22		NO	UP
	£2,086,944	£2,752,153	£2,751,823	£2,611,046	£3,816,160	£2,949,230		Key standards are not being delivered and are not improving	
Core Mandatory Training Compliance for substantive staff Target is >=85%	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	The Trust is meeting the target set.	YES	NO CHANGE
	93.4%	93.9%	93.7%	90.0%	82.1%	87.8%		Key standards are being consistently delivered and are improving	
Staff with a Completed Annual Appraisal Target is >=80%	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-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
	76.0%	75.0%	73.7%	72.5%	75.6%	76.8%		Key standards are being delivered but are deteriorating	
% of staff from a BME background Target is >= 22.5%	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	The Trust is meeting the target set.	?	UP
	24.4%	24.7%	24.7%	24.8%	24.8%	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%	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22		n/a	n/a
	46.3%	57.9%	59.6%	59.8%	59.8%	n/a			
% of staff who have undertaken clinical supervision within the last 3 months Target is >=85%	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-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
	78.6%	72.7%	71.3%	73.1%	72.1%	77.7%		Key standards are not being delivered and are deteriorating/ not improving	
Health and Wellbeing Activity - No of LLR staff contacting the hub in the reporting period (1 month in arrears)	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22		N/A	N/A
	139	210	301	360					
	Data currently unavailable from the LLR MHWB team								

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 – April 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

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
C Length of stay - Community Services

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:	23/05/2022	
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:		

Y

Leicestershire Partnership NHS
NHS Trust

Trust Board meeting 31/05/2022

Operational and Financial Planning update

Purpose of the Report

To provide a summary of the final 2022/23 plan

Proposal

The Trust Board is recommended to review the summary plan position (noting that the full plan was formally approved at the Trust Board session held on 26th April).

Decision required: N/A

Governance table

For Board and Board Committees:	Trust Board 31.5.22	
Paper sponsored by:	Sharon Murphy, Director of Finance & Performance	
Paper authored by:	Anne Senior, Associate Director – Contracts, Planning & Workforce Bureau Chris Poyser, Acting Deputy Director of Finance & Procurement	
Date submitted:	24/05/2022	
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):	(full plan approved) Trust Board session 26/04/2022	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	Approved	
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 report	
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	
	Trustwide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	
Is the decision required consistent with LPT's risk appetite:	NA	
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:	NA	

Leicestershire Partnership Trust
2022/23 Summary Operational Plan

WeAreLPT
compassion respect
integrity trust

Operational Planning Priorities
Community Health Services

Support services to recover from Covid with particular focus on reducing our waiting times

Transform our Community Services to help avoid admission and support timely discharge through:

- Deliver a 2hr/2-day Urgent Community Response
- Support for more complex patients in community
- Enhanced support in care homes

Maximise the use of technology to support patients at home

Work with partners to:

- Integrate physical therapies
- Develop an integrated asthma service
- Transfer some stroke rehabilitation from University Hospitals of Leicester to LPT

Ensure our estate is fit for purpose

Operational Planning Priorities
Families Children and Young People

Expand our Eating Disorder Service for children and young people

Enhance our Crisis and Early Intervention offer

Build on our digital provision to provide support for children and young people with mental health needs.

Enhance our inpatient wards with increased clinical and support staff

Expand our children's physiotherapy service to reduce waiting times

Partner with local authorities to improve provision for children and young people with special educational needs (SEND)

Operational Planning Priorities
Learning Disabilities

Enhance our provision of Adult Autism Services to reduce waiting times and increase post diagnostic support

Enhance our community forensic service to support timely discharge and to improve our crisis management offer

Train more of our staff to provide our positive behaviour support programme in the community

Operational Planning Priorities
Directorate of Mental Health

Deliver on Mental Health Investment Standard commitments to:

- Continue development of maternal mental health provision
- Expand Individual Placement and Support (IPS) (our mental health employment service)
- Enable our Early Intervention Psychosis to deliver against national standards
- Implement the outputs of our public consultation

Continue our work to improve our mental health wards by:

- removing all dormitory accommodation
- planning for new mental health inpatient unit

Continue our quality improvements to deliver our Care Quality Commission remedial plans.

Workforce Priorities

- **We will continue to deliver the LPT People Plan which focuses on:**
  - Looking After Our People
  - Belonging in the NHS
  - New Ways of Working
  - Growing for the Future

- **As we progress through our Covid recovery programme we will:**
  - Continue to support our staff in their health and wellbeing.
  - Ensure digital solutions and new ways of working make best use of skills, experience and capacity
  - Put workforce at the centre of our plans so we can to sustain and where possible increase capacity
  - Support our staff in developing their careers and enable them to progress so retaining them in the NHS.
  - Ensure our workforce plans enable us to recruit a workforce to meet our future needs
  - Focus on meeting our requirement for registered staff including international recruitment.

Workforce Growth

Staff group	Growth in w.t.e*	Notes
Registered Nursing	61 w.t.e	Includes 46 w.t.e internationally trained nurses
Allied Health Professionals, Pharmacy and Psychological Therapies	38.3 w.t.e	Predominantly in child and adolescent and adult mental health services following MHIS* and SDF* funding
Support to clinical staff	60.6 w.t.e	Includes 13.6 w.t.e Registered Nursing Associates and recruitment to existing Healthcare Assistant vacancies
Estates	230 w.t.e	Facilities management transfer
Medical	2.2 w.t.e	Child and adolescent and adult mental health services following MHIS and SDF funding
TOTAL WTE:	**392.1 w.t.e**	

* w.t.e – whole time equivalent

- MHIS – Mental Health Investment Standard
- SDF – Service Development Funding

Leicestershire Partnership Trust
2022/23 Summary Financial Plan

WeAreLPT
compassion respect
integrity trust

LPT 2022/23 financial plan

£1.4m deficit plan for the year (equating to 0.4% of budget – within NHS statutory break-even duty limits)

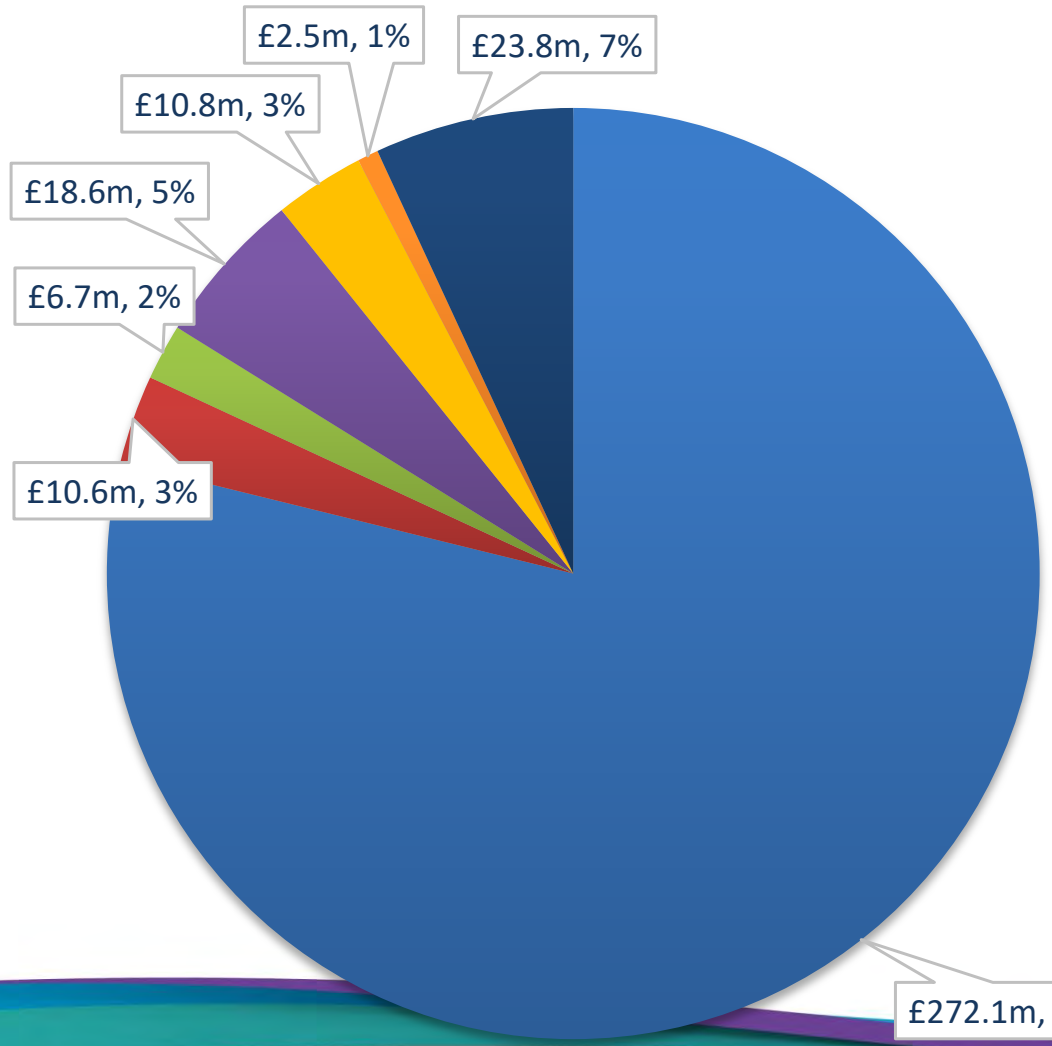
	£m
Planned Income:	**345.1**
Planned Expenditure:	**(346.5)**
Deficit:	**(1.4)**

Deficit due to shortfall on inflation funding

	£m
Inflation funding:	**8.9**
Inflation costs:	**(10.3)**
Deficit:	**(1.4)**

WeAreLPT
compassion respect
integrity trust

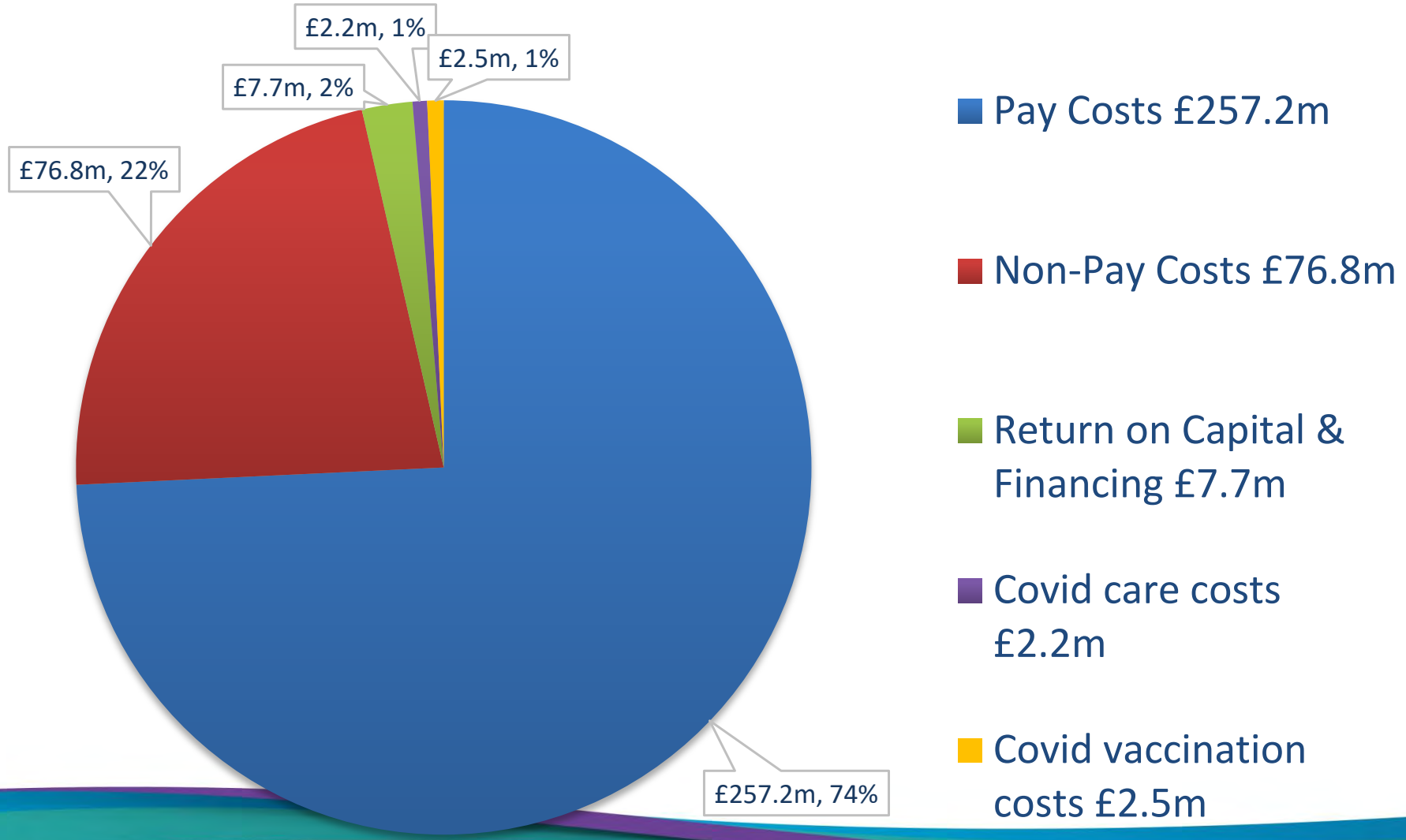
Breakdown of £345.1m planned income



- CCG patient care income £272.1m
- NHSE patient care income £10.6m
- NHS Trust patient care income £6.7m
- Local Authority patient care income £18.6m
- Education & Training income £10.8m
- Covid Vaccination income £2.5m
- All other income £23.8m

WeAreLPT
compassion respect
integrity trust

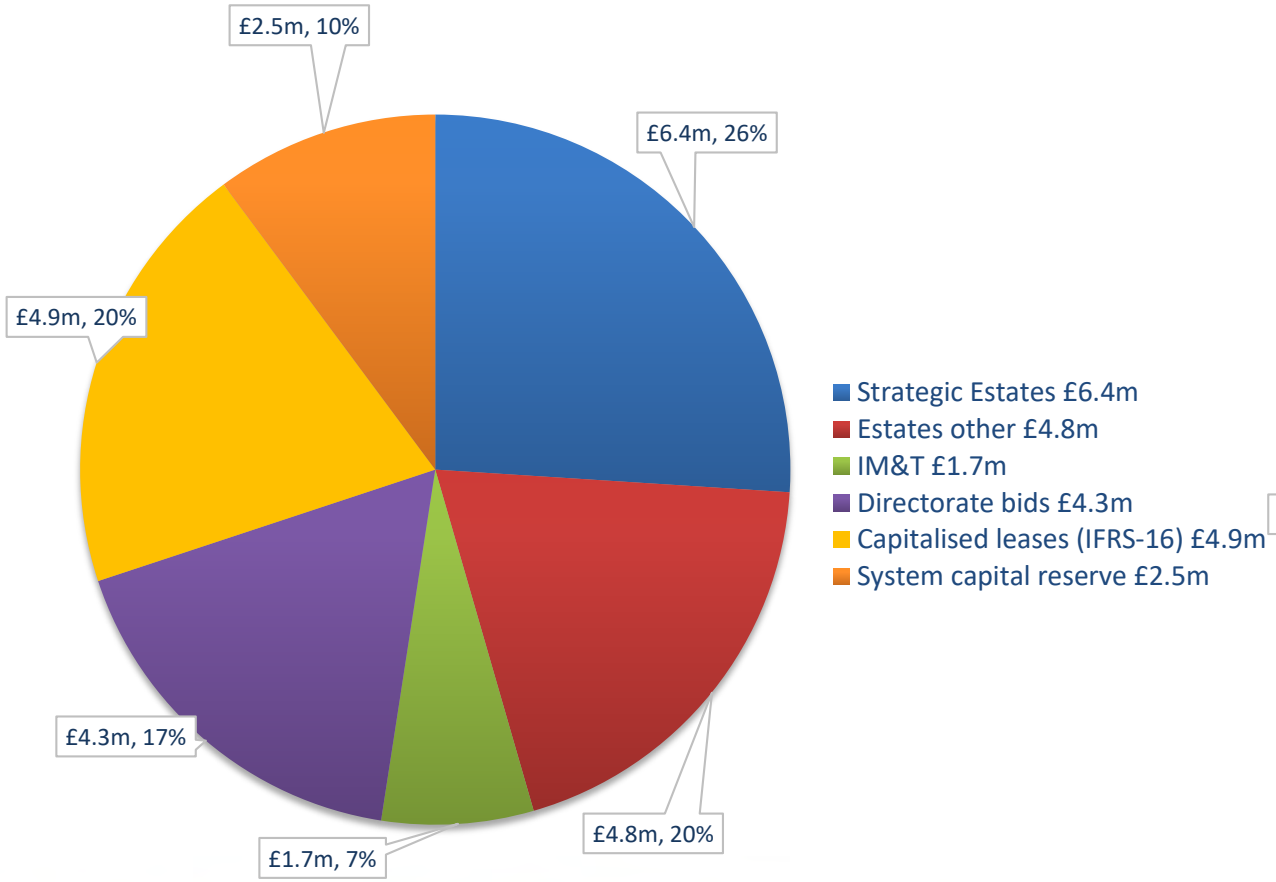
Breakdown of £346.5m planned expenditure



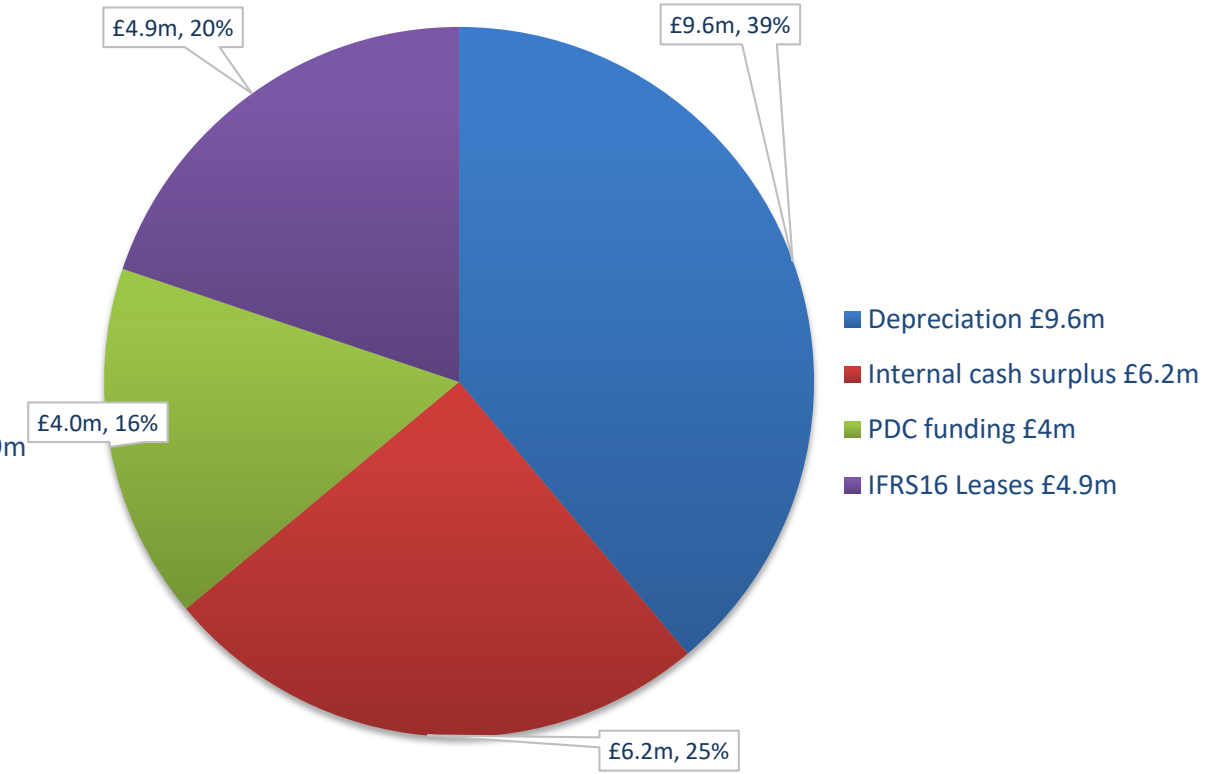
WeAreLPT
compassion respect integrity trust

Capital plan

Capital Expenditure



Capital Sources of Funds



LLR ICS financial plan

- LPT deficit contributes to a much larger ICS deficit overall
- National deficit of £3bn after initial ICS plans submitted
- Further plan submission now required 20th June with aim to reduce national shortfall
- Impact of further planning submission on LPT's own plans not yet confirmed