The theme of today's board is AMH

Leicestershire Partnership NHS Trust

Public Meeting of the Trust Board
9.30 am Tuesday 30 July 2019
Venue: Gartree Room, County Hall

Public Meeting

Item No.	Timings	Item	Purpose	Paper Ref	Discussion to be led by
1	**9.30**	**Welcome:** • Angela Hillery, Chief Executive • Anne-Maria Newham, Director of Nursing AHPS and Quality • Cathy Geddes, NHS Improvement Director • Anna Pridmore, Interim Associate Director of Corporate Governance • Mark Farmer, Healthwatch • John Edwards, Head of Business Development and Transformation (for item 10) • Haseeb Ahmad, Equalities Lead (for item 11) • Pauline Lewitt Freedom to Speak Up Guardian (for item 24) • Deanne Rennie, Deputy Clinical Director FYPC and AHPs Lead • Kamy Basra, Head of Communications • Mariam Dindar (Reverse Mentor to Cathy Ellis) • Dan Collard, Service Manager for Temporary staff & BAME Lead Advocate • Olivia Hay, Graduate Management Trainee • Sinead Ellis-Austin, Business Manager, NHFT **Apologies for absence:** • Darren Hickman, Non-Executive Director • Ruth Marchington, Non-Executive Director			Cathy Ellis

2	10 mins	Patient voice film	Quality Improvement		Anne-Maria Newham
3	9.40	Declarations of interest in respect of items on the agenda			
4		Minutes of the previous meeting, 23 May 2019	Assurance	A	Cathy Ellis
5		Matters arising actions	Assurance	B	Cathy Ellis
6		Chair's Report	Information	C	Cathy Ellis
7		Chief Executive's Report	Information	D	Angela Hillery
Risk					
8	9.50 10 mins	Corporate Risk Register	Assurance	E	Anna Pridmore
Total for section = 30 minutes					
Strategy					
9	10.00 5 mins	Better Care Together (BCT), Sustainability and Transformation Partnership (STP) status, and System Leadership Team (SLT) update • Community Services Redesign	Information	F Oral	Angela Hillery Rachel Bilsborough
10	10.05 30 mins	STP Workstream update Mental Health all age transformation progress	Assurance Links to STEP up to GREAT: Transformation Brick	Present -ation	Helen Thompson
11	10.35 20 mins	Equality & Diversity annual report including WRES	Assurance Links to STEP up to GREAT: Equality, Leadership, Culture Brick	G	Sarah Willis
Total for section = 55 minutes					
Performance and Assurance Reports					
Highlight reports (taken as read) from board committees: (those highlighted have been reviewed at one or more of the board committees)					
12	10.55 5 mins	Joint Quality Assurance and Finance and Performance committees meeting 18 June 2019	Assurance	H	Liz Rowbotham/ Geoff Rowbotham
13	11.00 10 mins	Quality Assurance Committee (QAC) highlight report, 21 May 2019, 18 June 2019, 16 July 2019	Assurance	I	Liz Rowbotham
	11.10 10 mins	**Break**			

14	11.20 10 mins	Finance and Performance Committee (FPC) highlight report, 21 May 2019, 18 June 2019, 16 July 2019	Assurance	J	Geoff Rowbotham
15	11.30 5 mins	• Finance monthly report – month 3	Performance	K	Dani Cecchini
16	11.35 10 mins	Integrated Quality and Performance monthly report	Performance	L	Dani Cecchini
17	11.45 5 mins	Audit and Assurance Committee (AAC) highlight report, 5 July 2019	Assurance	M	Darren Hickman
18	11.50 5 mins	Strategic Workforce Group highlight report, 10 July 2019	Assurance	N	Ruth Marchington
19	11.55 5 mins	Mental Health Act Assurance Group highlight report 11 June 2019	Assurance	O	Faisal Hussain
20	12.00 5 mins	Charitable Funds Committee highlight report 11 July 2019	Assurance	P	Cathy Ellis
Total for section = 70 minutes					
Quality Improvement and Compliance Reports					
21	12.05 10 mins	Quality Improvement Plan	Quality Improvement Links to all STEP up to GREAT bricks	Q	Angela Hillery
22	12.15 10 mins	Care Quality Commission progress update	Quality Improvement Links to all STEP up to GREAT bricks	R	Anne-Maria Newham
23	12.25 10 mins	Safe Staffing June 2019 Review 6 Monthly Safe and Effective Staffing review	Assurance	Si Sii	Anne-Maria Newham
24	12.35 10 mins	Biannual Freedom to Speak Up Guardian Report (Pauline Lewitt FTSUG in attendance)	Assurance	T	Angela Hillery
25	12.45 5 mins	Annual Report on Medical Appraisal and Revalidation	Assurance	U	Sue Elcock
Total for section = 45 minutes					
Governance and Risk					
26	12.50 5 mins	Performance Management and Accountability Framework progress update	Approval	Oral	Dani Cecchini
27	12.55 10 mins	Board Committees' annual reports 2018-19	Assurance	V	Frank Lusk/Anna Pridmore

28		Any additional risks highlighted as a result of Board discussion today?			Cathy Ellis
29	13.05	Information Pack (circulated to Board members only) containing: • Documents Signed Under Seal Q4 2018-19 and Q1 2019-2020 • Mental Health Act Annual report • WRES Action Plan • Disability Confident Employment – Self-assessment Level 2 • CQC Action Plan	Information		Cathy Ellis
30		Any other urgent business			Cathy Ellis
31		Public questions on agenda items			Cathy Ellis
32		**Date of next meeting:** The remaining public Trust Board meetings in 2019 have been rescheduled as follows: • 1st October 2019 • 1st November 2019 • 3rd December 2019			Cathy Ellis
It is recommended that, pursuant to Section 1 (2), Public Bodies (Admission to Meetings) Act l960, representatives of the press and other members of the public be excluded from the following meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.					

Leicestershire Partnership NHS Trust

Confidential Trust Board Meeting
1.30 on Tuesday 30 July 2019
Venue: Gartree Room, County Hall

AGENDA

Item No.	Timings	Item	Purpose	Paper Ref	Discussion to be led by
1	1.30	**Welcome:** • Angela Hillery, Chief Executive • Anne-Maria Newham, Director of Nursing AHPS and Quality • Cathy Geddes, NHS Improvement Director • Anna Pridmore, Interim Associate Director of Corporate Governance • Kamy Basra, Head of Communications • Olivia Hay, Graduate Management Trainee (for staff voice item) **Apologies for absence:** • Sarah Willis, Director of HR and OD • Darren Hickman, Non-Executive Director • Ruth Marchington, Non-Executive Director			Cathy Ellis
2	1.30 30 mins	Staff voice – AMH	Quality Improvement		Helen Thompson
3	2.00	Declarations of interest in respect of items on the agenda			Cathy Ellis
4		Minutes of the previous confidential meeting, 24 June 2019	Assurance	AA	Cathy Ellis
5		Matters arising	Assurance	BB	Cathy Ellis
6	2.05 10 mins	Chief Executive's report	Assurance	Oral	Angela Hillery
Total for section = 40 minutes					
Strategy					
7	2.15 15 mins	Sustainability and Transformation Partnership	Assurance	Oral	Angela Hillery
Total for section = 15 minutes					

Quality					
8	2.30 15 mins	Serious Incidents Level 2 investigation reports SI 226618 SI 233785 SI 226905	Learning lessons	 CCi CCii CCiii	Anne-Maria Newham
Total for section = 15 minutes					
9	2.45 10 mins	Break			
Governance and Risk					
10	2.55 5 mins	Reportable Issues Log	Information	DD	Anne-Maria Newham
Total for section = 5 minutes					
Finance and performance					
11	3.00 10 mins	Confidential Finance Report – month 3	Performance	EE	Dani Cecchini
12		Confirmed minutes available to Board members on request (matters have previously been highlighted in the Chairs' reports): • Quality Assurance Committee • Finance and Performance Committee • Audit and Assurance Committee • Charitable Funds Committee • Strategic Workforce Group • Mental Health Act Assurance Committee	Assurance		Cathy Ellis
Total for section = 10 minutes					
Board development					
13	3.10 30 mins	Service presentation – AMH operations	Quality Improvement Links to High Standards and Quality Improvement bricks	Oral	Helen Thompson
14	3.40 5 mins	Board development action tracker on priorities	Assurance	FF	Cathy Ellis
15	3.45	Any Other Business and Review of the meeting	Assurance	Oral	Cathy Ellis
16	4.00	Close			

UNCONFIRMED

Leicestershire Partnership NHS Trust

Trust Board

Minutes of the Meeting held in public on Thursday 23 May 2019, 9.30 am

NSPCC Training Centre, Beaumont Leys

A

Present: Ms C Ellis, Chair
Mr G Rowbotham, Non-Executive Director/Deputy Chair
Ms R Marchington, Non-Executive Director
Mr D Hickman, Non-Executive Director
Mr F Hussain, Non-Executive Director
Mrs E Rowbotham, Non-Executive Director
Professor K Harris, Non-Executive Director
Dr P Miller, Chief Executive
Ms D Cecchini, Director of Finance
Dr S Elcock, Medical Director
Dr Anne Scott, Interim Chief Nurse

In Attendance:
Ms R Bilsborough, Director of Community Health Services
Ms H Thompson, Director, Families, Young People & Children Services and Adult Mental Health & Learning Disability Services
Mrs S Willis, Director of Human Resources & Organisational Development
Mr F Lusk, Trust Secretary
Mrs M Morton, Minute Secretary
Ms Cathy Geddes, NHSI Improvement Director

		ACTION
TB/19/089	Apologies and welcome The Chair welcomed Cathy Geddes (NHS Improvement), Kamy Basra (Head of Communications) and Michele Morton (minute taker). The Chair also welcomed for item TB/19/098 from ELRCCG Mrs Sarah Warmington, Associate Director, Commissioning, MH/LD, Mrs Cheryl Bosworth, Commissioning Manager, LD, Mrs Clare Nagle, Transforming Care Programme Manager and Mrs Tracy Burton, Interim Chief Nurse and Quality Officer at East Leicestershire & Rutland CCG. Apologies for absence were received from Mark Farmer, Healthwatch.	
TB/19/090	Patient Voice	
	The patient voice film featured Linda, carer for her twin sister Julie,	

		ACTION
	aged 57. They had never had contact with the learning disability services previously and Linda had carried out all of the caring herself until Julie went into crisis, and was admitted to UHL. At that point they realised they needed help. They received a new top for the shower cradle; Julie received a hospital bed in the front room, together with a ceiling hoist and assessments were ongoing by Lucy. Julie at 57 had never had a bed. There were problems in the hospital as Julie had no sleep patterns and was continually falling over and lodging herself on the sides of the hospital bed. It was not possible to put pillows or pads at the sides because of the risk of suffocation. Julie's drinking was reassessed where it was found her coughing was due to feeling tired trying to drink a full cup in one go. So she was only given half a cup now and this was working much better. Before she was ill Julie had no-one except for a GP and a dentist, and now she had everybody. Linda did not have a negative thing to say about the services that Julie was now receiving. Whenever she had a problem it was sorted. Following assessment, if she was admitted to hospital they knew how to feed her, give her drinks and how she was feeling from her facial expressions. They had worked out a simple communication system between Julie, Linda and the professional staff.	
	The Chair queried why Linda and Julie had received no support for 57 years and she commended Linda for the tremendous job she was carrying out in respect of continuity of care for Julie.	
	Ms Thompson said that Linda was very positive through the management of her sister in such a complicated situation. She added the whole future of wrapping Primary Care Networks around the patient was critical for the GP and all associated staff. Ms Thompson said she had discovered one of the most difficult things for Linda was articulating how she communicated with Julie. A disability assessment tool was used to help interpret what she was trying to say. Information had been added to a passport and helped the professions to understand her communication and behaviour. Communication passports were a national tool and LPT had developed a local version. The SALT service had developed an eating and drinking plan for Julie. Her case had been closed but the family knew how to use if the services needed to be contacted again.	
	Mrs Rowbotham asked if a learning disability register was in existence which would help people to receive appropriate services and Ms Thompson replied work was in progress to gain a better understanding of how services were accessed and that included the use of the register.	
	Dr Miller commented the fact that Linda had devoted her life to the care of Julie was remarkable. As a result Julie had remained out of institutional care. He added it was the aim of the Trust not to have	

		ACTION
	people with learning disabilities in institutional care in the future. It would not be possible to replicate the level of care Linda gave to Julie, but it would be possible to replicate the home environment in a different way.	
TB/19/091	Declarations of interest Board members confirmed that they had no conflicts of interest in relation to the agenda items. The Chair encouraged all Board members to record any declarations, or a nil return, on the self-service LPT Declare.	
TB/19/092	Minutes of the previous public meeting, 25 April 2019 **Resolved: The minutes of the meeting held on Thursday 25 April 2019 were confirmed.**	
TB/19/093	Matters arising actions	
	Trust Board members reviewed the list of matters arising actions at Paper B. All actions were green and complete. 860i – Dr Elcock agreed to add an update as part of the Suicide Prevention Strategy	
TB/19/094	Chair's report	
	The Chair presented Paper C, which provided a report on her activities between 25th April 2019 and 23rd May 2019 with patients, staff and stakeholders, and the events/committees she had attended. Also included were the activities of the Non-Executive Directors (NEDs). The following key highlights were noted:	
	Hearing the patient and staff voice • Dr Miller had received a valued star as part of the Celebration of Excellence awards held recently. Dr Miller thanked all of those people who attended the event that had many stories where staff achievement was recognised. •	
	Quality Improvement • The Chair gave the opening speech at the 'Learning from when Young People took their own lives' – a multi-agency conference that focused on Quality Improvement. There had been a huge clinical presence with considerable learning where people engaged heavily with the agenda. Dr Elcock added she would be feeding information from the conference into the Suicide Prevention Strategy. • Attended the LPT nurses conference that had a strong focus on accountability, leadership and Quality Improvement.	

		ACTION
	Equality, Leadership and Culture • A new Chief Executive had been appointed for the Trust, Mrs Angela Hillery. She would be joining LPT on a shared basis with Northamptonshire Healthcare (NHSFT) and would commence in July 2019. Arrangements were currently being finalised. Dr Scott said she had attended a nurse meeting the previous day where a level of anxiety had been expressed over the sharing of the Chief Executive post, and the fact Mrs Hillery would only be at LPT for 2.5 days a week. From the perspective of providing more assurance the Chair agreed to pick that issue up with Mrs Hillery and any communication message produced would need to be circulated between the two organisations. • Attended two STEP up to GREAT staff briefings which focused on the 9 priorities for 2019/20. • Was interviewed by Change Champion as part of the LPT culture programme 'Our Future Our Way'. •	**CE**
	Stakeholder liaison meetings • Attended with Dr Miller a CEO and Chairs meeting with Simon Stevens (NHS Chief Executive) and Baroness Dido Harding (NHSI Chair). •	
	Good Governance/Board Development • Attended Audit committee to observe as part of the governance reviews and NED appraisal process.	
TB/19/095	Chief Executive's Environmental Scan	
	Dr Miller highlighted the following from Paper D:	
	National; • Publication of an NHS people plan was due soon where the key priorities were culture, making the NHS a great place to work, leadership, nursing supply and flexible careers. • At their visit to the Midlands region on 15th May 2019 Simon Stevens and Baroness Dido Harding had focused on the NHS 10 year plan, Primary Care Networks (approximately 27 in LLR, all with a clinical director), a new focus for community health services 'synching' response times, obsolete outpatient appointments, workforce and estate.	
	Regional; • The NHSi performance rating for LPT stood at level 3, due to the impact of the CQC report • An undertakings letter had been received outlining the expectations of the CQC response on the reduction of waiting times and the development of a quality improvement plan.	
	Local Stakeholders	

		ACTION
	• SLT, publication of 'next steps' document, focusing on STP planning and delivery and developing an approach to an integrated care system, understanding Primary Care Networks where there would be significant variations. Funding would be allocated at PCN level for the appointment of key professional roles. There was also the expectation of provider alliances. • A monthly performance review meeting with NHSI that considered the risks on CQC rating, CAMHs waiting list trajectory and a well led framework.	
	Organisational Development • The cultural transformation approach was launched in March, with the recruitment of 90 change agents. Training had taken place in May and interviews had commenced. • International Nurses week was celebrated across the Trust and Mrs Mason, Senior Coroner for Leicester and South Leicestershire, coroner had given the key note address.	
	Service Areas • A visit by the CQC had taken place to the city district nursing teams. • All acute wards were now smoke-free and staff were offering alternatives to smoking on admission, that included vapes and other NRT products.	
	Resolved: The Trust Board considered the Chief Executive's report and environmental scan.	
	Risk	
TB/19/096	Board Assurance Framework	
	Dr Miller reported a bid had been made for extra capacity to develop the BAF, a large piece of work that linked with the QI work. Some work had been carried out on identification of the key priorities and risks, however further detail was required. An early draft had been included in the information pack and a fuller version would be prepared for the June Board.	
	Resolved: The Trust Board received an update on the Board Assurance Framework.	
	Strategy	
TB/19/097	Better Care Together (BCT) and Sustainability and Transformation Partnership (STP) status and System Leadership Team (SLT) updates	
	Dr Miller presented paper E, the Better Care Together Partnership update. The update informed the Board on the key business and strategic work programme being discussed and taken forward by SLT.	

		ACTION
	Dr Miller reported that a development session had been held the previous week where time had been spent considering how organisations were going to work towards an integrated care system and how that might be governed through an effective partnership group and the SLT.	
	Mr Hussain asked Dr Miller for further clarification on the inter-dependencies of the Partnership Group with other health and social care organisations. Dr Miller replied the plan was to produce a governance pack to show how decision making worked which would include a diagram on the way decision making fitted together. It included how local authorities would be engaged in addition to the traditional NHS organisations.	
	Resolved: The Trust Board received the Better Care Together Partnership update.	
TB/19/098	STP Workstream – Leicester Leicestershire and Rutland LD Transforming Care Programme & Marmot Report	
	As part of the national transforming care programme, the national plan outlined three key expectations from local commissioners; implementing enhanced community provision, reducing inpatient capacity, and rolling out Care and Treatment reviews in line with the published policy. Mrs Warmington gave a presentation on the learning disability work stream that included the following highlights:	
•	The background to transforming care that included reduction in adult LD admissions reduced length of stay and delayed transfers of care.	
•	Achievements to date including enhancement of the LD Outreach service.	
•	Admission avoidance and the introduction of an LLR dynamic risk register with RAG ratings.	
•	LLR trajectory – monitored and overseen for escalation concerns by the TCP executive leadership	
•	LD STOMP (Stop Over Medicating Patients)– a call to action assurance tool led by NHS England, in place since 2015 and launched in 2016	
•	Reporting requirements: • NHS England • Adhoc • Programme	
•	2019/20 plans	

		ACTION
	With regarding to the workforce audit, Mrs Willis asked for more information on the risks and Mrs Warmington replied there were some staffing issues around recruitment and skills, and the data was currently being further scrutinised. Mrs Willis suggested that the issue be placed on the Local Workplace Action Board agenda.	**SW**
	Mrs Marchington said that on a recent boardwalk staff had explained tensions existed between a number of issues around targets, standards and research and the triangulation of the data to ensure that patients were receiving appropriate medication and in that respect she felt the STOMP was a notably bespoke piece of work. She also raised the issue of a realistic approach and the importance of making sure the right balance was reached between keeping patients safe, enabling them to have more independence and the best quality of life possible.	
	Mr Rowbotham said the situation was being moved from a reactive to a proactive position. He added that Leicester and Leicestershire supported a very diverse and culturally different population to most across the country, and he asked how those challenges and opportunities were being reflected within the service. Mrs Warmington replied that because the population was so diverse, the differences were well reflected in service access. There was a cultural issue about how families wrapped around services. Work also continued in primary care on clarifying who was on the learning disability register and ensuring the content was appropriate in terms of identifying differences and ensuring an accurate picture of that particular cohort.	
	Mr Rowbotham referred to patients currently out of area and he asked how assurance was gained that they were receiving the appropriate quality of care. Mrs Warmington replied out of area was a challenge as Leicestershire had no local provision for rehabilitation. With regard to quality of care, CQC inspections were held, commissioning groups locally carried out quality visits and people in inpatient settings were also entitled to CPA. Board members noted that the whole agenda was evidence based on a national programme of care.	
	In respect of diversity Mr Hussain said it was often difficult to reach out to the diverse community and he felt there was a mis-match between the system understanding and those people knowing what they could actually access. Some individual cases just did not think there were any services they could access as a family, and organisations needed to do better as a system to reach out.	
	With such a unique and diverse population Mr Rowbotham said that should be one of the big issues being looked into. Dr Scott replied that LPT did have representation at the Executive Board and Mr Hussain said the issue was wider than LPT.	
	Dr Miller said it was important to maintain the trajectory in terms of	

		ACTION
	recovery and halting of long term institutional care for people with learning disabilities. He asked if there was one piece of action that might help the situation. Mrs Warmington said everything that was being done was the right thing to do, and it was more about bringing all of the initiatives together to speed up progress. There was a need for clearer direction and to work out how to move forward with complex care, keeping people local and in community settings as soon as possible. As a result of the BBC Panorama programme shown the previous evening, Board members acknowledged the risk that the public would make negative assumptions about the standard of care in institutions and it would be important as a system to rise to any challenge and be able to react positively if necessary. Mrs Warmington and the commissioning team left the meeting.	
	Ms Cecchini pointed out the importance of being clear as a Board what LPT was accountable for and what the commissioners were accountable for, specifically with the development of the performance management framework, so that LPT was assured enough they were doing everything possible. Ms Bilsborough said there was a fundamental broader issue across the system as organisations entered into new shared ways of working and how LPT as a Board would receive their assurance. It was possible to receive answers but not assurances around some of the bigger questions. The Chair pointed out LPT was the only Board that received information on the STP work streams on a monthly basis, and the issue of overall assurance was an important one.	
	Resolved: The Trust Board received a presentation on STP Workstream – Leicester Leicestershire and Rutland LD Transforming care Programme & Marmot Report	
	Performance and assurance reports	
TB/19/099	Quality Assurance Committee (QAC) highlight report, 21 May	
	Mrs Rowbotham gave an oral update (due to the earlier timing of the Extraordinary Board for financial year end) on the above as follows:	
•	A joint QAC and F&P Committee meeting was due to be held in June.	
•	Two visits were planned over the summer, one from the Health and Safety Executive (also to be discussed at a Board Development Session) and NHS Improvement regarding Infection Prevention and Control.	
•	Some concerns were expressed about the staffing levels on Griffin Ward.	
•	Ms Bilsborough reported her team had commenced a piece of work on	

		ACTION
	harm indicators through the IQPR, the coding that related to pressure ulcers and the number of incidents reported in total. Clarity was required around the categories of harm which for pressure ulcers was usually minor and often not acquired whilst patients were in the care of LPT. The patient improvement group would pick that issue up across all of the directorates as part of the review.	
	Resolved: The Trust Board noted the oral update	
TB/19/100	Patient and Carer Experience and Involvement (including complaints) quarter 4 report	
	Dr Scott presented paper F that outlined how services were making consistent efforts to involve and consult with patients and their carers and how feedback was being gathered on their experience of LPT services. The report also detailed the areas where services were taking action on improvements, sharing learning and evidencing positive change for patients and their families as a result of listening to patients and their carers, and through the robust systems in place to manage and learn from complaints.	
	Dr Scott said the report was a work in progress and would change as the content started to reflect the new elements in the quality schedule. Some of the dates required adjusting and a greater focus was being placed on learning and outcomes. Any feedback from Board members was welcome.	
	Further highlighted points included:	
•	Four priorities had been agreed for delivery in 2019/20 following discussion with service users, carers and staff that included the successful delivery of a Café Conversation held on 5 March 2019. Those priorities would inform a revised Patient Involvement and Experience Strategy.	
•	The PCEG agenda and work plan had been restructured where time would be spent discussing the important areas.	
•	An 'Expert by experience' had attended PCEG to inform a view on what regular attendance might look like.	
•	In quarter 4 zero complaints had been formally referred to the PHSO for investigation; one case had been requested with the decision awaited whether the PHSO would investigate; one case was returned in quarter 3 which upheld a concern regarding a delay in the provision of physiotherapy.	
•	70 complaint action plans were currently in progress and 54 of those were overdue. This was being followed up : the complaints team had revised the performance monitoring of the complaints progress in their	

		ACTION
	updates to directorates, highlighting complaints and actions outstanding. Those were also discussed in weekly complaint meetings with directorates. 2,700 contacts were managed by the PEI team during 2018/19.	
	Mr Hussain welcomed the report as champion for engagement, and in particular the plan on a page displayed at appendix 1. He said in the NHS it was not always easy to point out why sometimes things could not be achieved and it would be useful to try and develop a more mature relationship on engagement. Dr Scott replied that recently engagement with the community had increased. She had recently spent a morning with carers who had performed a very powerful play about the day in the life of a carer which she felt the Board might benefit from watching.	
	Resolved: The Trust Board received assurance on the Patient and Carer Experience and Involvement (including complaints) quarter 4 report	
TB/19/101	Patient safety Report – quarter 4	
	Dr Scott presented paper G, being developed to provide an overview of incidents across the organisation and key learning identified. Commissioners had asked for the wider report as of quarter 1 2019/20 and the patient safety team had begun to look at how that could be achieved and how the data could best be presented. Further key points included:	
•	The highest numbers of reported serious incidents related to patients under the care of LPT who had taken their own lives. The majority of those patients were under the care of community services; however both locally and nationally there had been an increase in deaths of patients under the care of the crisis team.	
•	There were a number of high profile examples of organisations moving towards taking a zero tolerance approach to suicide. That provided a very powerful message to staff and communities that any death was a death too many.	
•	Work was currently underway with the medical director to develop an action plan to support a zero tolerance approach to in patient suicide. That included patients on authorised leave and absent without leave.	
	Mrs Rowbotham pointed out that some of the detail in the charts required amendment.	**AS**
	Mr Hussain welcomed the direction the report was taking and what was being highlighted. He still did not however feel assured that learning was being shared across the organisation and he asked if the infra-	

		ACTION
	structure was in place for that to happen. Dr Scott gave the recent learning disability and adult mental health newsletters as a method of how teams were communicating better across the directorates, though she acknowledged the challenges were wider than that.	
	Mrs Marchington welcomed the work to further develop the report which she felt would improve considerably in the future.	
	Resolved: The Trust Board received the patient safety report quarter 4.	
TB/19/102	Mortality Data Quarterly Report	
	Dr Elcock presented paper H and explained that an effective review of mortality was an important element of the Trust's approach to learning and ensuring that the quality of services was continually improved. She added that work continued to formulate the fundamental structures to ensure that learning would be embedded throughout the organisation.	
	Mr Rowbotham felt limited progress had been made since the beginning of the year and Dr Elcock replied it was only possible to generate a report that indicated a move towards improvements. Funding was now available for a suicide prevention post and a national benchmarking exercise had taken place.	
	The Chair said a discussion had been held at the QAC around ensuring appropriate information was embedded into reports, and there was an acknowledgement that improvements were needed.	
	Mr Rowbotham asked if there was a sense of when improvements would be achieved in getting learning fully shared and Dr Elcock replied that was a very difficult question to answer. Dr Scott added progress was usually over a two year programme and would form part of the culture and quality improvement work. She said the right people needed to be in post to look at skills and competencies of staff and to develop a definition of what good learning looked like. Discussions had been held at the executive team over the past two weeks on how to gain a better understanding of the plan.	
	Mr Hussain commented that LPT would not be starting from the beginning. He said existing groups working on shared learning must be helped to join together and share learning. Great progress was being made in pockets of the organisation which needed sharing with others in order to create a seismic shift organisation-wide.	
	Dr Elcock reported that the quality improvement work was carried out in phases and the learning element was part of the second phase. As directorates had entirely different structures there was no simple answer in terms of alignment. Once further progress had been made	

		ACTION
	that would be articulated to the Board.	
	Mrs Willis said the situation was underpinned by the cultural leadership programme which centred on performance, innovation and learning and that did have a timescale. The organisation was currently in the first phase, would move to design in September 2019, closely followed by the implementation stage. Some quality improvement time was scheduled for the June Board.	
	Resolved: The Trust Board received the information related to all deaths in scope for quarter 3 of 2018/19 and noted the themes. **The Trust Board also noted the priorities for further work as set by the Mortality Surveillance Group.**	
TB/19/103	Finance and Performance Committee, 21st May Highlight Report	
	Mr Hussain gave an oral update (due to the earlier timing of the Extraordinary Board for financial year end) on the F&P Committee meeting held on 21st May. Key highlights included:	
•	Bradgate Site Strategic Business Case for mental health inpatients – F&P discussed consultation/engagement and the importance of having patients, carers and service users involved and engaged in the early stages.	
•	BAF – some concerns over the redesign of the BAF were expressed, and the need to ensure that no crucial details were lost around the risk areas.	
•	Financial Position – LPT was currently in an overspend position at month 1 – that would be picked up in the Finance Report. Committee members felt the position would be clearer at the end of months 2 and 3.	
•	Proposals and projects – a detailed report was received and agreement reached on the importance of having the appropriate skills and resources in place when opportunities arose.	
•	Waiting Times – the reports had been viewed in detail a slight improvement had been noted. Significant improvements had been made in CAMHS waits.	
•	Estates and Facilities Management – a review of the must do actions on the CQC action plan took place. A number of actions would be complete by 27th May. The CAMHS unit would commence in June and be completed by August 2020. Ms Marchington said that on one of her board walks staff had showed her screws sticking out. They had not been screwed flat to the door and	

		ACTION
	had been highlighted as a ligature risk. She pointed out the importance of having appropriate standards as well as timeliness when work was carried out. Ms Cecchini replied a process existed for the sign off of work and she agreed on the importance of having the opportunity to raise any issues over standards. She added it would be a good opportunity to refocus the estates group which would enable a more pro-active approach.	
	Resolved: The Trust Board received an oral update on the Finance and Planning Committee held on 21st May 2019.	
TB/19/104	Finance Monthly Report – month 1	
	Ms Cecchini presented paper I that outlined the financial position for the period ended 30th April 2019 (month 1). The report showed a £1k surplus which was in line with plan. As was normal at the beginning of the year, owing to the ongoing audit of the prior year draft accounts and the limited availability of new year date, the month 1 position included a greater degree of estimation than usual. In addition detailed forecasts would not yet be available.	
	Ms Cecchini informed the Board that NHS Improvement had requested a further revision and submission of the Financial Plan. That was due to the fact that the plans in the East Midlands did not align as expected, both from a revenue and capital position and the revised Plan was requested to show a £0.5 million improvement. The control total would remain as breakeven and the £0.5 million was deemed to be a stretch target. At the point of submission which was 22nd May no solution had been identified. NHS Improvement had offered their support to identify scope for saving. The ask from NHS Improvement had been in the form of a request and would contribute towards an overall national balance for the NHS.	
	Mr Hickman said the NEDs had held a discussion previously and had nominated Mrs Rowbotham to speak on their behalf. Mrs Rowbotham said she felt it was highly irregular that LPT was being asked to submit a second Plan. LPT completely accepted responsibility for breaking even and she said it was inappropriate to agree to anything other than that, and the organisation should not consider compromising quality in order to be able to deliver a stretch target. She recognised there might not be a choice, but felt such an arrangement was not a good message to be sending out to staff.	
	Ms Cecchini said NHS Improvement was not expecting quality and safety to be compromised and she asked the Board to be mindful that NHS Improvement was likely to be supporting LPT with a number of initiatives from a financial perspective in the coming year, particularly in relation to support for a strategic outline case, and the Board needed to be aware of that reliance. However, a solution to the request for a £0.5 million stretch target remained outstanding.	

		ACTION
	Ms Scott supported Mrs Rowbotham's comments and she said the Board needed to be clear on the narrative used to support the conversation around not compromising quality and safety and what that actually meant. Savings needed to be identified and if it was done correctly on safety then it should cost less. Ms Cecchini replied she wasn't certain the structures would align to allow for that in 2019/20 which placed the Board in a difficult position.	
	Mr Rowbotham said it would be important to hold the quality line and he supported a wider mature discussion with NHS Improvement about how the financial position should be shaped from the perspective of the £0.5 million. There was a danger of an unsuccessful outcome however it was paramount to protect investment in the quality of care.	
	Board members agreed to accept the position and Mr Rowbotham suggested a proposal be brought back to the Board to confirm that there would be no impact on the quality of care. The stretch target would manifest itself in the revised plan and would become apparent in the finance reports for months 2, 3 and 4. Ms Geddes said the £0.5 million should be presented in the form of an increased CIP which would be red rated until a Quality Impact Assessment had been completed	**DC**
	Resolved: The Trust Board received the Finance Report for the period ended 30th April 2019 and noted the position on the request for a revised Financial Plan.	
TB/19/105	Integrated Quality and Performance monthly report (IQPR)	
	Ms Cecchini presented paper J that summarised the Trust's performance against key NHS Improvement, Commissioner and other targets. It also provided analysis and commentary on those areas which required additional actions to ensure targets and objectives were achieved. Key highlights included:	
•	Performance on Care Programme Approach 7 day follow up and 12 month follow up had improved since February 2019 following the implementation of sustainable new processes, and improvements would continue to be seen over the next few months as overdue reviews were completed.	
•	Following recommendation from the Executive Team, the Board agreed to remove 'gate keeping' from national reporting for 2018/19 quarter three and four. Following the completion of remedial actions, national reporting from 2019/20 quarter one had recommenced. Performance against that standard as at April 2019 was 66.2%. That performance was expected to rise to approximately 80% by the end of 2019/20 quarter one as the actions were embedded into business as usual practice.	

		ACTION
•	Staff sickness and absence had reduced.	
	Resolved: The Trust Board; received the Integrated Quality and Performance Report.	
TB/19/106	Audit and Assurance Committee highlight report, 3 May 2019	
	Mr Hickman presented paper K which set out the key headlines on the levels of assurance in relation to the Audit and Assurance Committee. Of particular note:	
•	A deep dive was held on the External Governance Review and CQC Actions oversight. A presentation had focused on the committee's areas of interest and the CQC oversight arrangements for addressing actions were outlined.	
	Resolved: The Trust Board; received the Audit and Assurance Committee highlight report, 3 May 2019.	
TB/19/107	Strategic Workforce Group (SWG) highlight report, 15 May 2019	
	Mrs Willis presented paper L that set out key headlines on the levels of assurance in relation to the SWG. Of particular note:	
•	Work continued on monitoring bank staff compliance with mandatory training. The Professional Standards Group would be reviewing the possibility of not allowing bank staff to work unless they were fully compliant.	
•	Improvements had been identified over the time taken to recruit new staff.	
•	An audit report was received confirming that job plans were in place for consultants, and further work was required to ensure they were updated annually.	
	Mrs Willis confirmed to Mrs Rowbotham that Clinical Supervision should be amber instead of green, and that significant actions for improvement were underway.	
	Resolved: The Trust Board; received the Strategic Workforce Group highlight report, 15 May 2019.	
	Quality improvement and compliance reports	
		ACTION
TB/19/108	Safer Staffing	
	Dr Scott presented paper M and explained that the format of the report	

		ACTION
	had been revised and this was an ongoing piece of work. The Chair suggested a "deep dive" could be considered for Griffin Ward and the Dr Scott replied that this had already been requested at the recent Quality Assurance Committee. Mr Hickman felt the report gave assurance for clarity of the staffer staffing position and Mrs Marchington conveyed appreciation of the triangulation of falls and medications data currently being reported, along with the impact of the strategic work underway in the Trust.	
	Resolved: The Trust Board received assurance that the processes were in place to monitor and ensure that inpatient and community staffing levels were safe and that patient safety and care quality were maintained.	
TB/19/109	Care Quality Commission progress update	
	Paper N, the CQC progress update as at 10 May 2019 was presented by Dr Scott. Further progress on actions had been seen since the report was submitted and updates again were due ahead of the forthcoming Quality Review meeting with the CQC, NHS Improvement and other stakeholders.	
	Hot spots were identified in the report and feedback for the CQC included the query as to why "Amber" rating was not permissible for the status of actions. LPT is showing "Green" where an action is completed and evidence obtained, "Red" for actions that are ongoing or where the evidence to demonstrate completion is awaited.	
	Dr Scott explained that she had been visiting inpatient wards regularly to check the embeddedness of the actions completed to date. It was also very valuable to re-inforce key messages to ward based staff. Dr Scott added that two new senior matrons had been seconded to support the Bradgate Mental Health Unit; one was Mental Health and the other a General Nurse. Both had been matrons and came with positive track records of supporting clinical improvements.	
	Dr Miller described to the Board how the Executive Team had discussed the progress of actions in the CQC Action Plan with the designated leads at a compliance review meeting held the previous week. He added that going forward the Trust's Rehabilitation wards also needed focus for assurance around compliance. Ms Thompson gave some operational context to that by explaining that whilst the Rehabilitation wards had less environmental issues than the Bradgate Unit they did have some very specific issues such as Single Sex accommodation compliance. Progress had already been made in that regard with the Willows wards now being either all female or all male. Ms Thompson added that the environmental issues at the Bradgate Mental Health Unit would take longer to resolve and required a rebuild	

		ACTION
	of the older wards.	
	Mrs Marchington expressed a concern as to whether staff would be aware of actions needed when CQC visited service areas, especially those that had had issues raised previously by CQC. Dr Scott responded that a narrative was needed for the actions so they were understood by staff and that discussions took place where necessary. The phased Quality Improvement work would help in that regard with the progressive improvement steps plan.	
	Resolved: The Trust Board considered the progress against the CQC Action Plan.	
TB/19/110	Suicide Prevention Plan (inpatients) Report to NHS England Dr Elcock presented paper O and corrected the title of the paper to read “LPT ambition for zero suicide of inpatients”. Dr Elcock outlined that a draft plan was needed by the end of Quarter 4. Trusts in the East Midlands had shared feedback on their development of plans. The key point taken had been to make the plan more strategic going forward but so far the Trust plan was in-line with the approach being taken elsewhere. Dr Elcock added that an Associate Medical Director for Quality would be taking the plan forward with staff and she thanked the Patient Safety team for their support in getting the plan to the current stage of development.	
	Dr Elcock highlighted that whilst the data included Crisis Team patients the recommendations were for inpatients only. Dr Miller felt that the risk with numerate targets was their difficulty to be met and that as a result practice could change in unhelpful ways. It was important that there was no negative impact on clinical care in order to achieve zero patient suicides. Ms Thompson stated the importance of engagement with clinicians in the strategic development of the plan and Dr Elcock reiterated that was the intention going forward.	
	Resolved: The Trust Board approved the approach to LPT Ambition for Zero Suicide for Inpatients.	
TB/19/111	Guardian of Safe Working Hours (Junior Doctors contract) quarterly report	
	Dr Elcock introduced paper P and explained that the report had been mandated. There had only been one exception report in the last twelve months and time off in lieu was taken the next day. The new Guardian Dr Jesu had met new trainees and was engaging	

		ACTION
	with Junior Doctors. Mr Rowbotham enquired whether the Rota gaps for Junior Doctors were a significant issue or otherwise. Dr Elcock reassured him that appropriate cover was in place for Junior Doctors and the Specialist Registrars did not usually have cover arrangements. If there were issues they would as a matter of course be reported back.	
	Resolved: The Trust Board received assurance that doctors in training in LPT were safely rostered and had safe working hours that complied with the Terms and Conditions of Service.	
TB/19/112	NHS Provider Licence - Self-Certification	
	Mr Lusk introduced paper Q and there were no points of clarification raised by Board members.	
	Resolved: The Trust Board authorised that LPT for its Annual Self-Certification did not meet the NHS Improvement Licence Conditions G6 and FT4.	
TB/19/113	Review of Risk Board members felt the following should be re-considered in light of the current Board discussions: • Finance Risk • STP Governance • CQC compliance	
TB/19/114	Receipt of documents for information	
	Resolved: The Trust Board confirmed receipt of; • **Draft Revised Board Assurance Framework** • **Step up to Great Presentation**	
TB/19/115	Any other Business	
	There was no other business.	
TB/19/116	Public questions on agenda items	
	There were no public questions.	
TB/19/117	Date of next meeting	
	The next public meeting would be held at 9.30 am on Tuesday 30 July 2019 at 0930 – County Hall. (This date has been rescheduled to avoid a clash with the Board meeting at Northamptonshire Healthcare NHS Foundation Trust).	

B

Leicestershire Partnership NHS Trust

TRUST BOARD 30 July 2019

MATTERS ARISING FROM THE PUBLIC TRUST BOARD MEETINGS

All actions raised at the Trust Board will be included on this 'Matters Arising action list' master. This will be kept by the Assistant Trust Secretary. 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 month and minute ref	Action/issue	Lead Officer	Due date	Outcome/evidence (actions are not considered complete without evidence)
889	May TB/19/094	Dr Scott said she had attended a nurse meeting where a level of anxiety had been expressed over the sharing of the Chief Executive post. From the perspective of providing more assurance the Chair agreed to pick that issue up with Mrs Hillery and any communication message produced would need to be circulated between the two organisations.	Cathy Ellis	June/July	Mrs Hillery start date is likely to be during July. A communications programme is being planned and will be released once the new CEO start date is confirmed.
890	May	Mrs Willis suggested that the	Sarah Willis	June	Matter has been placed on the Local Workforce Action

Action No	Meeting month and minute ref	Action/issue	Lead Officer	Due date	Outcome/evidence (actions are not considered complete without evidence)
	TB/19/098	issue of more information on the risks for workforce associated with STP LD Transforming Care Programme be placed on the Local Workplace Action Board agenda.			Agenda Also a recent LWAB workshop included LD transforming care programme.
891	May TB/19/101	Patient Safety Report Q4 - Mrs Rowbotham pointed out to Dr Scott that some of the detail in the charts required amendment.	Anne-Maria Newham	June	There was a potential error noted but subsequently checked and determined as statistically correct by the Head of Patient Safety.
892	May TB/19/104	Board members agreed to accept the stretch financial position and a proposal would be brought back to the Board to confirm that there would be no impact on the quality of care.	Dani Cecchini	June	The additional requirement will be the subject of discussion at the QIA Panel meeting on 14 June. Where additional savings can be identified, this will be subject to a Quality Impact assessment in the usual way. Propose Close and monitoring to be through joint FPC/QAC meeting.

C

LPT Chair's report summarising activities and key events which are part of our STEP up to GREAT journey:

Trust Board 30th July 2019

The period covered by this report is from 23rd May 2019 to 30th July 2019

Hearing the patient and staff voice	• Boardwalks to Stewart House (Adult Mental Health rehab services) and Hinckley Hospital • Non-Executive Directors (NEDs) 11 boardwalks to: o FYPC (LD services, Paediatric psychology, CAMHS Eating Disorders) o CHS (St Lukes Hospital , Feilding Palmer Hospital , Coalville Hospital , Rutland Hospital and Melton District Nursing) o AMH Bradgate Unit (Thornton, Heather and Watermead wards)
Connecting for Quality improvement	• CQC Quality Review meeting with all stakeholders focused on improvement of warning notices, followed by CQC/LPT engagement meeting • "Sod-cutting" event for the CAMHS new building on the Glenfield site with patients and staff, the new unit opens in August 2020 • Madani High School Health Fair event for children and parents hosted by LPT school nurses and partners from other support services • As the UNICEF Baby Friendly Guardian for LPT I attended the Infant Feeding network for training, focus on perinatal mental health
Promoting Equality Leadership & Culture	• Meeting with the "Our Future, Our Way" Change Champions to hear their views on the staff focus groups held so far • We Nurture celebration event for staff on our talent management programme • Freedom to Speak up Guardian 6 monthly meeting • First Reverse Mentoring meeting with my Mentor, Mariam Dindar. Great to learn about and reflect on her experience of living in different cultures both in the UK and overseas. • Mentoring meeting with an Aspirant Chair
Building strong Stakeholder relationships	• Met with Chief Constable Simon Cole and Police & Crime Commissioner Lord Willy Bach to discuss partnership working to improve the experience for mental health patients in crisis • Leicester Academic Health Partnership (LAHP) launched in conjunction with University of Leicester and UHL. Aiming to work together on key research projects for our population. Interviewed for the new LAHP Director and appointment made. • University of Leicester : Council meeting and Council strategy Awayday • DeMontfort University graduation ceremony for nurses and nurse associates • LLR STP multi-agency Partnership Board development session to agree terms of reference and next steps • NHSI Performance Review monthly performance meetings
Good Governance	• LPT public Annual General Meeting held as part of the Leicester Health Fair • Attended Quality Committee, Finance & Performance Committee and Strategic Workforce Group • Panel Chair for 4 Consultant LPT interview panels - appointments made in MHSOP, FYPC and AMH services • NED timeout meeting • Completed 6 NED appraisals

Abbreviations:

LLR = Leicester, Leicestershire & Rutland; **STP** = Sustainability and Transformation Partnership; **NHSI** = NHS Improvement – regulatory oversight & support improvement of NHS provider trusts; **CQC** = Care Quality Commission; **UHL** – University Hospitals of Leicester; **CCG** –Clinical Commissioning Group; **FYPC –** Families Young Persons and Children's services**; CHS –** Community Health Services**, AMH –** Adult Mental Health Services; **CAMHS** – Children's and Adolescents Mental Health Services;

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board - 30/7/19
Paper number	D
Name of Report CEO Environmental Scan	

For approval		For assurance		For information	Yes

Presented by	Angela Hillery, CEO	Author	Angela Hillery, CEO

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe		Safe	Y	S – High Standards	
Effective		Staff	Y	T - Transformation	Y
Caring		Partnerships	Y	E – Environments	
Responsive		Sustainability	Y	P – Patient Involvement	
Well-Led	Y			G – Well-Governed	Y
				R – Single Patient Record	
				E – Equality, Leadership, Culture	Y
				A – Access to Services	Y
				T – Trustwide Quality improvement	Y
Any equality impact (Y/N)		N			

Report previously reviewed by	
Committee / Group	Date
N/A	

Assurance : What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers

Recommendations of the report
The Board is asked to receive the report for information only. The report provides an update on areas of focus locally, regionally and nationally.

JULY 2019: ENVIRONMENTAL SCAN

National

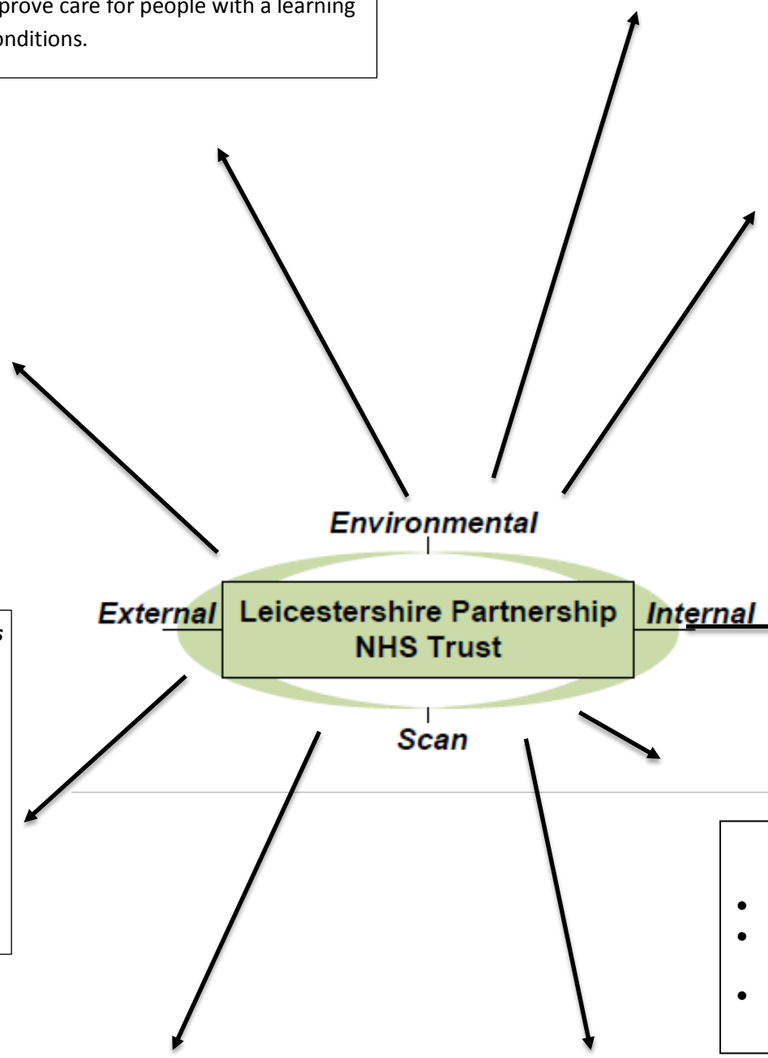
- Launch of the Interim NHS People Plan: I am pleased to confirm I have been asked to join the Advisory Group for this national programme, the overview of which is attached at appendix 1.
- NHS Providers announced Sir Ron Kerr will take over as the next chair of NHS Providers on 1st January 2020, when the term of the current Chair, Dame Gill Morgan, ends.
- Amanda Pritchard has been appointed as the NHS' Chief Operating Officer (COO).
- The NHS has announced an additional £5 million will fund reviews to improve care for people with a learning disability and committed to renewed national action to tackle serious conditions.

Board of Directors

- LPT AGM 6th July 2019
- Angela Hillery took over accountability of CEO role for LPT from Peter Miller on 15th July 2019
- Board Development session on Risk scheduled 30th August 2019
- Inaugural LPT Buddy Forum took place 22nd July 2019
- Cathy Geddes (NHS/i), continues to support LPT as Improvement Director

Regional

- LWAB regional development workshop took place - future focus on interim people plan, workforce supply, OD and new care models.
- East Midlands strategic event on future models for Mental Health
- Capital discussions with regional colleagues ongoing
- Congratulations to EMAS colleagues for new CQC rating GOOD and Outstanding for caring domain



Organisational Development

- We Nurture celebration; 24 employees on cohort 3 graduated and celebrated their achievements on the programme.
- Interim people plan priorities acknowledged and mapped against existing Trust work plans.
- Cultural change: Our future our way' - Board interviews and leadership behavior survey complete focus groups underway and final synthesis day of discovery on 31st July 2019.
- Trust wide living our values video launched with positive feedback and interaction
- Equalities - WRES - Interview skills training, unconscious bias training and cultural appreciation group launched, zero tolerance campaign launched and well received.
- Rainbow badge campaign launched significant engagement and support received.

Directorate Focus: FYPC

- CQC safeguarding review in Rutland commencing on 22.07.2019
- Signs of Safety principles to be embedded into FYPC's QI plan
- All children referred to CAMHS are now waiting less than 13 weeks to be assessed. 100 children are waiting to access the service; reduced from 600 in February. Capacity is now focused on reducing treatment waits, especially for children with neurodevelopmental needs.
- QI projects commencing to improve approach to clinical outcomes in services.

Local Stakeholders

- STP undertaking a prioritisation exercise around provider capital spend in 2019/20. Completed capital plan forms submitted on 15 July 2019,
- SLT: Focus continues on establishing an LLR Partnership Group. ICS: an approved action plan has been developed to move the group towards increasing system maturity.
- System workshop on ICS planned for August
- Initial meeting with Andy Williams – new Accountable Officer for CCGs
- Meeting with John Adler CEO UHL/Andy Williams

Directorate Focus: CHS

- CCG Board have approved the CSR business case and LPT service specification
- PCN footprints confirmed and alignment of LPT services incorporated within CSR implementation plan
- Community services shortlisted in Nursing Times Award for deployment of TPP Autoplanner in community nursing services

EM Research/Innovation

- Leicestershire Health Partnership Board (LAHP) - The memorandum of understanding to establish the partnership has been signed
- Prof Susan Corr, Head of Research and Development at LPT has been awarded the title and status of Honorary Professor at the University of Leicester
- LPT are one of the top ten trusts for healthcare staff who have undertaken the Joint Dementia Research Awareness tool learning, helping healthcare professionals to learn how they can promote opportunities for those with and without dementia to take part in essential research.

Directorate Focus: AMH/LD

- New Mum's Mind perinatal mental health text messaging service received an excellent response from the official launch on 24th June 2019.
- Nervecentre on hand held devices for physical health observations has been successfully piloted on 6 wards and roll-out across all 27 mental health wards will be completed by September 2019. Mental health observation functionality will go live from September 2019.
- Training for 16 peer support workers through imROC commenced in July 2019.
- Financial pressures in M3 require the development of a recovery plan.

Angela Hillery
Chief Executive

Appendix 1:

Programme structure

NHS England & NHS Improvement, Delivery, Quality and Performance Committee

Health Education England Board

NHS People Plan Advisory Group

Chair: Dido Harding

Social Partnership Forum

National People Board

Chair: Prerana Issar
SRO for NHS People Plan

Professional workstreams
medical, nursing, allied health professions, healthcare science, pharmacy and dental

LTP national service programmes
maternity, mental health, learning disability/autism, prevention, health inequalities, ageing well, CYP, cancer, diabetes, emergency care, CVD and respiratory, genomics, personalised care, planned care, patient safety

Making the NHS the best place to work

Chair: Navina Evans
Lead: Caroline Corrigan

Improving the leadership culture

Chair: Julian Hartley
Lead: Steve Hart

Delivering 21st century care
Chair: David Behan

Releasing time for care

Chair: Hugh McCaughey
Lead: Rhydian Phillips

Workforce redesign: optimising skills

Chair: Patrick Mitchell
Lead: Kirstie Baxter

Securing current & future supply

Chair: Wendy Reid
Lead: Sam Illingworth

Analysis, insight and affordability

Chair: Ben Dyson/Rob Smith
Lead: Ed Kendall/John Stock

Urgent 2019/20 actions on nursing supply

Chair: Ruth May
Lead: Mark Radford

A new operating model for workforce

Chair: Rob Webster
Lead: Philippa Hunt

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 30th July 2019
Paper number	E

Name of Report **Corporate Risk Register**

For approval		For assurance	X	For information	X

Presented by	Angela Hillery, Chief Executive	Author (s)	Kate Dyer, Head of Assurance

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe	X	Safe	X	S – High Standards	X
Effective	X	Staff	X	T - Transformation	X
Caring	X	Partnerships	X	E – Environments	X
Responsive	X	Sustainability	X	P – Patient Involvement	X
Well-Led	X			G – Well-Governed	X
				R – Single Patient Record	X
				E – Equality, Leadership, Culture	X
				A – Access to Services	X
				T – Trustwide Quality improvement	X
Any equality impact (Y/N)		No impact on equal opportunities			No

Report previously reviewed by	
Committee / Group	Date
Earlier version presented to ET Verbal update provided to QAC	July 2019

Assurance : What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers
The paper provides the Trust Board with a progress report on the work being undertaken to strengthen the risk system.	Whole BAF

Recommendations of the report
The Trust Board is asked to note the information included in the report and take assurance that work to strengthen the risk system is progressing.

Leicestershire Partnership NHS Trust

Corporate Risk Register

1. Introduction/Background

In February 2019 the CQC judged the governance of the Trust to be inadequate. The Trust commissioned an external review of governance which identified aspects of the risk system that should be strengthened.

2. Discussion points

This work is progressing and our new Chief Executive is reviewing the way forward to ensure that the BAF and CRR are simple and effective to use. This will include reviewing the existing external information as well as the overall strategic framework for the organisation that the BAF/CRR will need to reflect and align with. A Board risk development session in August will be utilised to examine the approach for BAF/CRR and the organisational risks within these.

The Risk Strategy has been re-drafted and a consultation with staff has begun.

Further work is planned as follows;

August 2019

- On-going development of the BAF/CRR
- Board risk development session to determine CRR risks
- Risk Strategy to be presented to Executive Team
- Implementation plan for the BAF and CRR at Committee's
- Directorate risk validation days
- Targeted training for directorate risk owners

September 2019

- On-going development of the risk register
- Executive Team review of BAF and CRR
- Risk Strategy, BAF and CRR to be presented to the Audit and Assurance Committee
- Development of a series of e-learning videos
- Training Needs Analysis

Leicestershire Partnership NHS Trust

Meeting	Trust Board – 30/7/19
Paper number	F

Name of Report Better Care Together Update

For approval		For assurance		For information	✓

Presented by the Accountable Director	Chief Executive , Angela Hillery	Author (s)	BCT Office

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe		Safe		S – High Standards	
Effective		Staff		T - Transformation	X
Caring	X	Partnerships	X	E – Environments	
Responsive	X	Sustainability		P – Patient Involvement	
Well-Led	X			G – Well-Governed	X
				R – Single Patient Record	
				E – Equality, Leadership, Culture	
				A – Access to Services	X
				T – Trustwide Quality improvement	X

Report previously reviewed by		
Committee / Group	Date	Assurance obtained (Significant/Limited/None)

Assurance : What level of assurance does this report provide in respect of the Board Assurance Framework Risks? (Significant / Limited / No Assurance)	Links to BAF risk numbers
Significant	

Recommendations of the report
The Board is asked to note the Better Care Together Update Bulletin for June/July 2019.

This is an update about the Better Care Together programme which aims to transform health and social care in Leicester, Leicestershire and Rutland. Issued on behalf of partner organisations.

Better care together

Leicester, Leicestershire & Rutland health and social care

BCT Bulletin

June/ July 2019

Facebook Twitter Website

Welcome to the June/July 2019 edition of the Bulletin – the newsletter from the Better Care Together (BCT) partnership, which is responsible for transforming health and social care in Leicester, Leicestershire and Rutland (LLR).

This newsletter

The Better Care Together partnership includes local NHS organisations working alongside local authorities in Leicester, Leicestershire and Rutland and a range of other independent, voluntary and community sector providers. The partnership's aims are to keep more people well and out of hospital; move care closer to home; provide care in a crisis; and deliver high quality specialist care. This newsletter details some of the progress being made and how you can get involved and have your say.

Introducing primary care networks

From 1 July 2019, GP practices across the country began working with other practices in their local area in groups called primary care networks (PCNs). The three clinical commissioning groups in Leicester, Leicestershire and Rutland, who oversee the care

provided in local GP practices, have recently announced which practices will be grouped together locally.

PCNs were announced as part of NHS England's Long Term Plan earlier this year. They have been put in place to improve and extend the range of services that are available in the community and join up the care that is provided from different organisations. It is expected that by working together, practices will be able to make resources go further and care for patients more creatively. Each PCN will look after between 30,000 and 50,000 patients.

A much wider team of health professionals is increasingly becoming involved in patients' care in GP practices. Through primary care networks there will be more clinical pharmacists, physiotherapists, physician associates, community paramedics and social prescribing link workers looking after patients day-to-day. GPs and the health professionals in practices will work together with others in their group, as well as with other health, social care and voluntary sector organisations, to plan the care patients need and prevent ill-health in a co-ordinated way. These wider teams will include pharmacists, district nurses and specialists who care for certain types of conditions or groups of patients with particular needs.

GP practices will remain independent. Patients will continue to be registered at their existing GP practice and it will still be the main point of contact for their care. Each primary care network will decide how it will provide care for its patients. Examples could include sharing health professionals between practices or offering appointments at a different practice in the network to improve access – particularly if they have a non-urgent problem or that practice specialises in an area of care they need. Further details on PCNs, and which practice is within which network, are available from your local clinical commissioning group.

Improving the care and support of community services

Patients, carers, staff and the public have been involved in redesigning community health services in Leicester, Leicestershire and Rutland.

Community health services cover a wide range of care, from supporting patients to managing long-term conditions like complex diabetes or respiratory conditions to treating those who are seriously ill with complex conditions.

Most community health care takes place in people's homes and other out of hospital settings like GP practices. This is support by care in the community hospitals, with teams of nurses and therapists coordinating care working with GPs and social care professionals.

People have been involved in shaping the future service in many ways. Through one-to-one interviews, focus groups, as well as public events, people have shared their experiences and what matters most, as well as their views.

All of these insights have been captured in three reports. The three reports represent a total of 4,712 patients, staff, family carers and stakeholder insights. These rich insights have and will continue to be used to shape changes and develop further options and proposals to improve community services.

We will continue to involve people in redesigning the service and will announce opportunities towards the autumn.

Read more about the redesign work.

UK first as perinatal team launches mental health text messaging support service

Specialist NHS advice and information to support the mental health of mothers during pregnancy and baby's first year is now available by confidential text messaging. The perinatal mental health service at Leicestershire Partnership NHS Trust has launched the UK's first mental health ChatHealth text messaging service – called *Mum's Mind*. The new confidential service supports mothers and their families across Leicester, Leicestershire and Rutland via a dedicated text line – 07507 330 026.

Operating from 9am to 4pm on weekdays, the *Mum's Mind* ChatHealth line can provide advice on a range of issues ranging from sleep problems, anxiety management and panic attacks to depression, psychosis, obsessive compulsive disorder and medication concerns. The service can signpost service users to other support from GPs, midwives and health visitors, psychological therapies, benefits advisers and social care providers. It can help with practical advice on issues such as mums who may be identifying bonding and attachment issues in pregnancy and after the birth of their baby.

The perinatal service offers specialist perinatal mental health care close to home for mothers referred to them with moderate to severe mental illness, and support and advice for their families. The service also provides training for midwives and health visitors to help

them identify women who need mental health care.

Donna Stafford, the perinatal team manager, says: *"Every year our team provides support in the community for more than 400 women who experience mental illness during pregnancy and in the months following birth. Our ambition has always been to ensure that women who need access to perinatal mental health support or expertise can access it. And with technology such an integral part of day-to-day life for so many families today, we hope that the launch of the Mum's Mind ChatHealth text messaging service will be a step change in expanding that access."*

The *Mum's Mind* service is not a crisis service and does not provide general advice on baby care – this is available through the original ChatHealth service on 07520 615381 (Leicester) or 07520 615382 (Leicestershire and Rutland).

Connecting carers to support

The valuable role played by carers has been celebrated by Leicestershire County Council and partner organisations which hosted a special event at County Hall in June to mark Carers Week. Established by Carers UK 25 years ago, Carers Week is an annual awareness campaign which takes place to celebrate and recognise the vital contribution made by the UK's 6.5 million carers. It is also a time of intensive local activity with hundreds of events taking place across the UK. The drop-in event at County Hall was themed around getting carers connected to advice and information as well as services for carers, support for friends and family, connecting with other carers and the use of assistive technology.

Richard Blunt, cabinet member for adult social care, said: "Looking after someone can be a hugely rewarding experience, but it is vital that we encourage people to self-identify as carers, as many don't. We need to identify carers in our communities early to ensure they can access the right support and feel valued and respected."

The Joint Carers Strategy 2018-2021, Recognising, Valuing and Supporting Carers in Leicester, Leicestershire and Rutland, was formally launched at this event. Leicester City Council, Leicestershire County Council, Rutland County Council and the Clinical Commissioning Groups (CCGs) for Leicester, Leicestershire and Rutland have signed up to the strategy and are committed to working together to deliver a local vision for carers.

Paul Gibara, chief commissioning and performance officer at East Leicestershire and Rutland Clinical Commissioning Group said: "Being a carer can be very rewarding, but it can also be challenging juggling an unpaid caring role with work and life. It is important that carers are able to access the support they need so that they are able to fulfil their caring role while having a well-balanced quality of life. We will continue to work with our local partners to deliver our local vision and ensure our local carers are properly connected and supported."

Progressing plans in Hinckley and Bosworth

Plans continue to be progressed to transform community health services in the Hinckley and Bosworth area. Architects' drawings have now been talked through with staff delivering services to ensure they meet their needs and, most importantly, the needs of patients now and in the longer term. In recent weeks, the equality impact assessment has been updated to ensure the changes being proposed do not discriminate against any disadvantaged or vulnerable people.

The proposal, to be consulted on, focuses on making better use of all available existing space in Hinckley Health Centre (Hill Street) and at Hinckley and Bosworth Community Hospital (Sunnyside) by:

- refurbishing Hinckley Health Centre, to accommodate X-Ray/Ultrasound, physiotherapy and increase the number of consulting rooms;
- creating a combined day case surgery and endoscopy unit with day-case beds at Sunnyside, which will provide an increased range of day case procedures and cancer screening services for local patients; and
- Relocation of the out-of-hours primary care service from Hinckley and Bosworth Community Hospital (Sunnyside) into Hinckley Health Centre providing out-of-hours urgent care for local patients.
- Removing services from buildings like Hinckley and District Hospital that are unfortunately not fit for purpose and relocate physiotherapy services into Hinckley Health Centre.
- Relocating some inpatient beds from Sunnyside to provide space for day-case beds

A key next step is for the pre-consultation business case (a document which explains in detail the case for changing and improving services) to go to the board of West Leicestershire Clinical Commissioning Group. It then needs to be approved by NHS England and NHS Improvement, prior to public consultation.

Encouraging support within the community

Plans are being progressed in Leicester, Leicestershire and Rutland to focus on encouraging healthier lifestyles, ending social isolation and preventing ill-health. The old saying of 'prevention is better than cure' is particularly relevant here. Partner organisations are working together under the oversight of a Unified Prevention Board (UPB) to take forward prevention activities and raise awareness of such support among the public. An element of this approach is to encourage the spread of 'social prescribing' – when health professionals refer patients to support in the community in order to improve their health and wellbeing.

Hinckley and Bosworth, along with North East Leicestershire and Rutland, have been chosen as test sites to see how teams can work together to improve the care of patients with complex needs. Local area co-ordinators, who work with individuals and communities to improve their health and wellbeing, will be working within these areas

to help tackle issues of loneliness and isolation in the community and with housing adaptations for residents.

Gaining insights into GP practice visits

Research is being carried out in Leicester, Leicestershire and Rutland to find out more about why some people visit their GP for concerns that do not need a medical response.

The project, called Preventions at Scale, funded by the Local Government Association, is carrying out research, including patient interviews, to see what improvements could be made to ensure that people can access the right information, from the right sources, at the right time. Early insights emerging from the first part of the project include that people respond to solutions when support is from a trusted source such as a GP, friends or family, and that people want a tangible output from the GP or service visit. The interview process is on-going. An updated will be provided in a future Better Care Together newsletter.

Work underway on a new inpatient mental health facility for young people

The start of construction of Leicestershire Partnership NHS Trust's new £8m purpose-built mental health inpatient unit for young people officially got underway on Thursday 13 June, as Trust chair Cathy Ellis symbolically 'cut the first sod' on the greenfield site opposite the Bradgate Unit at Glenfield Hospital in Leicester.

Cathy was joined by young service users and by staff from the child and adolescent

mental health service (CAMHS) and colleagues from the hospital school. Interserve Construction Ltd is building the unit, which will open in August 2020, and their national operations director, Andrew Jowett, also took part in the special occasion.

Funding for the new unit, through Better Care Together, was announced in July 2017. The clinical model behind the design of the new 15-bed facility was developed through engagement with staff, service users and families. The current CAMHS inpatient ward is temporarily based at Coalville Community Hospital, and only has 10-bed provision. The new unit will be able to offer additional beds for young people with eating disorders - previously they had to go out of area for this specialist care.

Share your news

We know that there are loads of great examples of innovative and integrated ways of work happening right across Leicester, Leicestershire and Rutland. If you have a story that you'd like to share in this bulletin please send us details.

Better Care Together, 1st Floor, St Johns House, 30 East Street, Leicester, LE1 6NB

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board- 30th July 2019
Paper number	G

Name of Report: Workforce Equality Report 2018/19

For approval	√	For assurance		For information	

Presented by	Haseeb Ahmad, Equality, Diversity and Inclusion Lead	Author (s)	Haseeb Ahmad, Equality, Diversity and Inclusion Lead

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe		Safe		S – High Standards	√
Effective		Staff	√	T - Transformation	
Caring		Partnerships	√	E – Environments	
Responsive		Sustainability		P – Patient Involvement	
Well-Led	√			G – Well-Governed	√
				R – Single Patient Record	
				E – Equality, Leadership, Culture	√
				A – Access to Services	
				T – Trustwide Quality improvement	
Any equality impact (Y/N)		Y			

Report previously reviewed by	
Committee / Group	Date
SWG	10th July 2019

Assurance : What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers
Assurance that the Trust is meeting its statutory duties in relation to reporting and progressing the equalities work and priorities.	7ab

Recommendations of the report
Trust Board is recommended to: 1. Receive assurance that the Trust is meeting its statutory duties under the Equality Act 2010 and contractual requirements to publish certain information on the equality profile of its workforce. 2. Agree to the actions highlighted in the WRES and WDES Action Plans included in the information pack. 3. Approve the equality information including the Trust's WRES and WDES reports and action plans for publication, in line with our statutory duties.

1. Introduction/Background

The Annual Equality Report for the period April 2018 to March 2019 encompasses the Annual Workforce Equality Report, the Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES) Reports. The Gender Pay Gap (GPG) main findings are included in the Workforce Equalities Report however the detailed GPG Report will be presented at a future meeting, the statutory deadline for GPG reporting is March 2020, which the Trust will comfortably meet. These reports aim to fulfil Leicestershire Partnership NHS Trust's duty to publish information regarding the protected characteristics of its employees, whilst ensuring that the Trust also has 'due regard' to the aims of the Equality Act with respect to its workforce by using this equality monitoring information in decision-making and planning. The WRES and WDES, in particular, are mandated in the NHS standard contract, as is the need to meet the Public Sector Equality Duty.

The reports and action plans presented to and supported by SWG on 16 July highlight the Trust's equality profile:

- a snapshot of the workforce at the end of March 2019 (5307 substantive employees (up from 5259 in March 2018), with a further 1061 bank only workers (those without substantive contracts, a slight decrease from 1067 in March 2018);
- recruitment, training, promotion, incremental progression, and workforce leavers (including reasons for leaving) for the year to the end of March 2018;
- employee relations cases in a two-year window covering the 2017/18 and 2018/19 financial years;
- the WRES, which concentrates in particular on the ethnicity profile of the Trust's substantive staff at the end of March 2019 using a set of specified indicators;
- the WDES, which concentrates in particular on the disability profile of the Trust's substantive staff at the end of March 2019 using a set of specified indicators.

2. Aim

The aim of the paper is to provide:

- A summary of the Trust's annual report on the workforce equality profile at end of March 2019 considered at SWG on 16th July 2019;
- An overview of the WRES and WDES metrics and Trust data (included in this report);
- To provide Trust Board with assurance that LPT is taking appropriate action to address equality, diversity and inclusion issues which have arisen as a consequence of data analysis and engagement with staff.

3. Discussion

3.1 Key areas of Focus

The Annual Workforce Equality Report, analysis against the WRES and WDES have identified key areas of focus for the Trust in taking action to address inequality for certain groups within the workforce. All relevant actions have been developed into two specific prioritised action plans which have been included in the Trust Board information pack. (these replace the race and disability equality actions included in the consolidated equalities action plan presented to Trust Board in 2018). The key findings from the workforce equalities analysis are highlighted below:

1. Equality monitoring was incomplete on Disability, Religion or Belief and Sexual Orientation.
2. There was occupational segregation within the workforce by ethnic group, and an underrepresentation of Asian British people in the workforce particularly in clinical areas.
3. BME job applicants were less likely to be appointed from shortlisting.
4. BME staff and especially Black British staff, were more likely than White staff to be employed solely on a Bank contract.
5. BME staff were overrepresented at lower pay bands.
6. BME staff were less likely to feel that LPT acts fairly in respect of career progression.
7. Black British staff were less likely to receive a pay increment .
8. Asian British staff were less likely to undertake non-mandatory training
9. Black British staff were more likely to have experienced discrimination and bullying and harassment from other staff.
10. BME staff were not more likely to be subject to disciplinary proceedings.
11. Men were overrepresented at middle and upper middle levels in Non-clinical roles.
12. Disabled staff were less likely to feel that LPT acts fairly in respect of career progression;.
13. Disabled staff were more likely to report discrimination, bullying and harassment at work .from managers and from other colleagues
14. LGBO staff were more likely to report discrimination from other staff.

Table 1 Workforce Race Equality Indicators

For each of these four workforce indicators, compare the data for White and BME staff			
18/19	**17/18**	**Narrative**	**Action**
1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff.			
Pay band / **Total n*** / **% BME** Non-clinical Under Band 1: 14 / 50.0% Band 1: R / R% Band 2: 265 / 34.0% Band 3: 298 / 32.2% Band 4: 194 / 25.3% Band 5: 145 / 31.7% Band 6: 104 / 28.8% Band 7: 103 / 29.1% Band 8A: 55 / 25.5% Band 8B: 38 / 5.3% Band 8C: 21 / 9.5% Band 8D: R / R% Band 9: R / R% VSM: R / R%	**Pay band** / **Total n*** / **% BME** Non-clinical Under Band 1: 11 / 63.6% Band 1: R / R% Band 2: 263 / 34.6% Band 3: 276 / 32.6% Band 4: 194 / 22.7% Band 5: 132 / 29.5% Band 6: 98 / 28.6% Band 7: 104 / 26.0% Band 8A: 50 / 24.0% Band 8B: 38 / 5.3% Band 8C: 18 / 11.1% Band 8D: R / R% Band 9: R / R%	At March 2019: Non-clinical: • BME people were overrepresented at lower pay bands (2 and 3). This largely reflected an overrepresentation of Asian British people in lower-level Administrative roles. There was also a notable drop in the representation of BME people when comparing Bands 8A and under with Bands 8B and above – a gap which has increased since last year and which has been increasing since at least 2012.	Items linked to the Trust's June 2019 WRES Action Plan: • Provide interview Skills training for BME colleagues (June 2019) • Offering targeted support in making strong applications (June 2019) • Establish matching relationships within the current LLR wide Reverse mentoring programme (June 2019) • Maximise opportunities for BAME staff to access any career development opportunities such as the Stepping Up Programme, Mentoring, coaching, specific BAME leadership Programmes and organise specific sessions as requested by BAME

Clinical	Under Band 1	23	26.1%
	Band 1	No staff	-
	Band 2	496	31.3%
	Band 3	468	16.2%
	Band 4	229	12.7%
	Band 5	782	22.9%
	Band 6	1107	15.1%
	Band 7	406	11.8%
	Band 8A	144	10.4%
	Band 8B	58	19.0%
	Band 8C	14	7.1%
	Band 8D	R	R%
	Band 9	No staff	-
	VSM	No staff	-
Medical	Consultant (not senior medical manager)	109	64.2%
	Senior medical manager (consultant)	R	R%
	Non-consultant career grade	25	48.0%
	Trainee grade	55	58.2%
	Other	No staff	-
		Overall	***5178***	***22.6%***

Clinical	VSM	R	R%
	Under Band 1	R	R%
	Band 1	No staff	-
	Band 2	483	31.3%
	Band 3	472	13.3%
	Band 4	209	11.5%
	Band 5	826	22.8%
	Band 6	1097	13.1%
	Band 7	409	10.8%
	Band 8A	147	10.9%
	Band 8B	60	16.7%
	Band 8C	14	7.1%
	Band 8D	R	R%
	Band 9	No staff	-
	VSM	No staff	-
Medical	Consultant (not senior medical manager)	109	65.1%
	Senior medical manager (consultant)	R	R%
	Non-consultant career grade	32	50.0%
	Trainee grade	17	76.5%
	Other	39	64.1%

Clinical:

- Unqualified roles (Bands 2 to 4; essentially Additional Clinical Services): BME people were overrepresented at the lowest pay band (Band 2) and underrepresented at higher bands (Bands 3 and 4). This largely reflected the distribution of Black British staff.
- Qualified roles (Band 5 and above): BME people were underrepresented at middle to higher pay bands (Bands 6, 7, and 8A). This largely reflected the distribution of Black British staff.
- Medical: BME staff, specifically Asian British staff, were overrepresented in Medical roles. This reflected occupational segregation, with Asian British staff underrepresented in

employees (September 2019)

- Celebrating the success and role modelling of BME staff in senior roles (December 2019)
- Promotion of mentoring, coaching and development programmes targeted at under-represented groups and specific pay bands (Non-clinical Bands 2 to 4, and Clinical Bands 2 and 5) (September 2019)
- Development and articulation of career pathways for admin and clerical staff (September 2019)
- Introduce system of routinely recording on U-Learn the reason that an increment has not been awarded. To be picked up through the review of the appraisal process necessitated by the 2018 Contract Refresh, with increments being replaced by 'pay steps'. (April 2019)
- Identify staff to be put forward for Midlands

	Overall 5127 21.8% * total of known ethnicity	registered Nursing roles. The distributions of BME staff within the workforce at March 2019 and at March 2018 were similar	and East Talent Pool (December 2019)

Indicator	2018/19		2017/18		Compared to previous year
2. Relative likelihood of White British staff being appointed from shortlisting across all posts.	1.97		1.33		
3. Relative likelihood of BME staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	1.35		1.92		
4. Relative likelihood of BME staff accessing non-mandatory training and CPD.	White 61.7% BME 56.8%		White 62.3% BME 59.1%		
5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.	White 23.1%	BME 24%	White 24.7%	BME 23%	
6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.	White 18.8%	BME 20.1%	White 19.7%	BME 18.5%	
7. Percentage believing that trust provides equal opportunities for career progression or promotion.	White 90.7%	BME 75.3%	White 90.6%	BME 72.7%	
8. In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleagues	White 4.3%	BME 10.8%	White 5.7%	BME 10.3%	
9. Ethnicity profile of the Board. Percentage difference between (i) the organisations' Board voting membership and its overall workforce (ii) the organisations' Board executive membership and its overall workforce.	Percentage differences: %BME total board - %BME workforce = -15.5% %BME voting board - %BME workforce = -13.5% %BME executive board - %BME workforce = -22.6%		Percentage differences: %BME total board - %BME workforce = -12.7% %BME voting board - %BME workforce = -10.7% %BME executive board - %BME workforce = -1.8%		

Table 2 WDES Indicators

Metric 1: Percentage of staff in AfC pay bands or medical and dental subgroups and Very Senior Managers (including Executive Board members) compared with the percentage of staff in the overall workforce.

The disability profile of substantive staff at LPT, by pay band cluster, at March 2019

Pay Band			Disability Status				% of unknown disability status	Grand Total N
			Dis-abled	Not Dis-abled	Total n (of known disability status)	**% difference (%Disabled staff in Band minus %Disabled staff in workforce overall)**		
Non-clinical		Bands 4 and under	6.3%	93.7%	650	**+0.9%**	17.9%	**792**
		Bands 5 to 7	7.8%	92.2%	293	**+2.4%**	21.0%	**371**
		Bands 8a and 8b	1.5%	98.5%	67	**-4.0%**	29.5%	**95**
		Bands 8c, 8d, 9, and VSM	3.4%	96.6%	29	**-2.0%**	23.7%	**38**
Clinical		Bands 4 and under	4.2%	95.8%	971	**-1.2%**	21.0%	**1229**
		Bands 5 to 7	5.7%	94.3%	1875	**+0.2%**	20.8%	**2366**
		Bands 8a and 8b	3.6%	96.4%	137	**-1.8%**	32.5%	**203**
		Bands 8c, 8d, 9, and VSM	0.0%	100.0%	R	**R%**	73.7%	**19**
	Medical	Trainee	7.1%	92.9%	56	**+1.7%**	R%	**R**
		Career grade	11.1%	88.9%	18	**+5.7%**	28.0%	**25**
		Consultants	4.0%	96.0%	50	**-1.4%**	55.8%	**113**
LPT Substantive Workforce Overall			**5.4%**	**94.6%**	**4151**		**21.8%**	**5307**

Metric 2: Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.

The relative likelihood of not disabled and Disabled people being appointed from amongst those shortlisted at LPT during 2018/19

Disability Status		Shortlisted	Appointed (% out of number shortlisted)		Relative likelihood of appointment from shortlisting
		n	n	%	(Not disabled / Disabled)
Disability	Disabled	419	24	5.7%	**1.4**
	Not Disabled	5952	477	8.0%	
	% not known	*2.2%*	*2.5%*		
	Overall	**6517**	**514**	**7.9%**	

Metric 3: Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

The relative likelihood of Disabled and not disabled people entering the formal capability process at LPT during the two-year window 2017/18 to 2018/19

Disability Status		LPT Substantive Workforce Overall (March 2019)	Formal capability (2017/18 - 2018/19) (% of workforce)		Relative likelihood of entering formal capability process
		n	n	%	(Disabled / Not disabled)
Disability	Disabled	226	R	R%	**2.5**
	Not disabled	3925	R	R%	
	% not known	*21.8%*	*31.4%*		
LPT Substantive Workforce Overall		**5307**	**R**	**R%**	

Metric 4: 4 a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: i) Patients/Service users, their relatives or other members of the public, ii) Managers, iii) Other colleagues; 4 b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

Metric 4a: The percentages of Disabled and not disabled people who experienced harassment, bullying or abuse from patients / service users, their relatives or other members of the public, managers, and other colleagues, Staff Survey 2018

Source of harassment, bullying or abuse	Disability Status	Overall number of respondents (of known disability status)	Number and percentage who experienced harassment, bullying or abuse	
		n	n	%
Patients / service users, their relatives or other members of the public	Disabled	557	181	32.5%
	Not disabled	1957	411	21.0%
Managers	Disabled	554	88	15.9%
	Not disabled	1952	148	7.6%
Other colleagues	Disabled	548	115	21.0%
	Not disabled	1934	242	12.5%

Metric 4b. The percentages of Disabled and not disabled people who saying they, or a colleague, reported their last incident of harassment, bullying or abuse, Staff Survey 2018

Disability Status	Overall number of respondents (of known disability status)	Number and percentage saying they, or a colleague, reported their last incident of harassment, bullying or abuse	
	n	n	%
Disabled	217	118	54.4%
Not disabled	451	260	57.6%

Metric 5: Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

Metric 5. The percentages of Disabled and not disabled people who felt that the organisation provides equal opportunities for career progression or promotion, Staff Survey 2018

Disability Status	Overall number of respondents (of known disability status)	Number and percentage who believed that the organisation provides equal opportunities for career progression or promotion	
	n	n	%
Disabled	391	320	81.8%
Not disabled	1397	1248	89.3%

Metric 6: Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

The percentages of Disabled and not disabled people who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties, Staff Survey 2018

Disability Status	Overall number of respondents (of known disability status)	Number and percentage who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	
	n	n	%
Disabled	395	110	27.8%
Not disabled	952	159	16.7%

Metric 7: Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

The percentages of Disabled and not disabled people who were satisfied with the extent to which the organisation valued their work, Staff Survey 2018

Disability Status	Overall number of respondents (of known disability status)	Number and percentage who were satisfied with the extent to which the organisation valued their work	
	n	n	%
Disabled	558	233	41.8%
Not disabled	1957	1027	52.5%

Metric 8: Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.

The percentages of Disabled staff reporting that their employer has made adequate adjustment(s) to enable them to carry out their work, Staff Survey 2018

Organisation	Overall number of disabled respondents	Number and percentage of disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work	
	n	n	%
Leicestershire Partnership NHS Trust	327	257	78.6%
National (except LPT)	47175	34404	72.9%

Metric 9: 9 a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation; 9 b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (yes) or (no)

The engagement score, overall and on each of the three subscales, for Leicestershire Partnership NHS Trust overall, and for Disabled and not disabled staff separately, Staff Survey 2018

Engagement score: overall and sub-scales		Leicestershire Partnership NHS Trust Overall	Disability	
			Not disabled	Disabled
	Engagement Score Overall	**7.0**	**7.1**	**6.7**
Sub-scales	Motivation	7.3	7.4	7.1
	Ability to contribute to improvements	7.0	7.1	6.6
	Recommendation of the organisation as a place to work / receive treatment	6.7	6.8	6.4

9 b)

Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?	Yes

Metric 10: Percentage difference between the organisation's Board membership and its organisation's overall workforce, disaggregated: by Voting membership of the Board; by Executive membership of the Board.

Differences in the levels of representation of Disabled staff amongst board members (overall, voting members, and executives), relative to the level of representation in the workforce overall, at March 2019

Board or workforce overall		Total of known disability status (March 2019)	Disabled staff or board members		Percentage difference in representation of Disabled people (Board minus Workforce)	% of unknown disability status	Grand Total
		n	n	%			N
LPT Substantive Workforce Overall		4151	226	5.4%		21.8%	5307
Board	All members	R	R	8.3%	+2.9%	14.3%	R
	Executive members	R	R	0.0%	-5.4%	0.0%	R
	Voting members	R	R	11.1%	+5.7%	18.2%	R

3.2 Appendices

The WRES and WDES action plans are included in the information pack.

4. Conclusion

There is evidence that in some areas of the Trust's work there is much to be celebrated. For example there is no evidence of disproportionate treatment of BME staff entering the disciplinary procedure. Disabled people are more likely to apply for jobs, be shortlisted and just as likely to be appointed as their non-disabled counterparts. The Rainbow Badge Initiative has been extremely successful with more demand for badges than anticipated. The latter will continue to be supported throughout 2019/2020.

However, there is much work to be done following the visit from the WRES national team which has started in earnest. The action plans demonstrate a real desire and momentum for change which fits well with the STEP Up to GREAT Our Future Our Way programme.

5. Recommendations

Trust Board is recommended to:

1. Receive assurance that the Trust is meeting its statutory duties under the Equality Act 2010 and contractual requirements to publish certain information on the equality profile of its workforce.
2. Agree to the actions highlighted in the WRES and WDES Action Plans included in the information pack.
3. Approve the equality information including the Trust's WRES and WDES reports and action plans for publication, in line with our statutory duties.

H

Leicestershire Partnership NHS Trust

TRUST BOARD – 30 JULY 2019

FINANCE AND PERFORMANCE COMMITTEE AND QUALITY ASSURANCE COMMITTEE JOINT MEETING – 18 JUNE 2019

OVERVIEW REPORT TO BOARD

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

Assurance level	Colour to use in 'Assurance level*' column below
Not assured	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"
Partially assured	Amber - there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Terms of Engagement / Scope of Work G Well-governed		The scope of work was presented for agreement on how FPC and QAC would work together. The committee agreed only the core members of each committee would attend the joint meeting with key officers attending for specific items as required. In-depth discussion took place around how topics would be presented to the individual FPC and QAC meetings and at the joint meeting and how they would make recommendations to Trust Board. The similarity of the role of Trust Board with this joint committee was acknowledged especially as membership was largely the same. The committee agreed that having a joint committee would allow time for the Board to focus on the more strategic issues it needed to and for the joint committee to hold detailed discussion to ensure assurance on finance and quality aspects were balanced. Agreement was reached that papers would be presented to the Executive Team and agreed by the FPC and QAC chairs and lead directors prior to coming to this committee.	The joint committee would provide joint assurance on agreed topics to Board on a quarterly basis A review of the scope and committee membership would be undertaken in six months time. The relationship between Trust Board and this committee would be reviewed regularly to ensure it was still relevant. The scope of work was agreed but would be amended to reflect the issues highlighted by the committee.	September 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Work Programme 		Discussion focused on the key topics to be included in the work programme for the joint committee. Already included were electronic patient record, estates, facilities, capital plan and quality assurance of CIP. The Committee agreed that the issue of waiting lists, particularly the lower priority ones was included, in view of the significant number of patients waiting a long time for treatment and to enable discussion on clinical risk. Consideration would also be given to areas of the Board Assurance Framework including out of area placements of mental health service patients and transformation, in light of the work taking place on the financial envelope of the clinical model for the All Age Transformation project. Other potential topics included IM&T and digital because of the relevance to the well led debate, and health and safety.		
Elimination of Dormitory Accommod-ation 		An update on the progress to date on the arrangements to eliminate dormitory accommodation in the Trust was presented, the priority for LPT would be AMH and MHSOP areas rather than community. The Executive Team had agreed in the long term, to continue to progress the SOC for the reprovision of inpatient mental health facilities which would provide a permanent solution for the elimination of dormitory accommodation in LPT's mental health services. However, given the extended timeline for the re-provision of facilities, the Executive Team had also considered options on how privacy, dignity and safety could be maintained during the interim period. Discussion focused on what action the Trust should be taking in the interim period ahead of the visit by the CQC in the autumn.	The committee agreed a detailed plan would be presented to the next meeting.	September 2019
Quality Impact Assessment Report		The relationship between the cost improvement programme (CIP) and quality impact assessment (QIA) process was explained. Assurance was provided that the process for quarterly quality reviews was now robust.		January 2020

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		An update on in-year CIPs and process would continue to be reported through FPC from a quality improvement perspective. It was agreed the review process on outcome of CIPs would be presented to the joint committee for wider discussion on proposals and assurance.		

Recommendation	The Trust Board receives and notes the issues raised in the highlight report
Author	Geoff Rowbotham, Non-Executive Director Liz Rowbotham, Non-Executive Director Danielle Cecchini, Director of Finance, Business and Estates Val Glenton, PA to Director of Finance, Business and Estates
Presented by (Chair of committee)	Geoff Rowbotham, Non-Executive Director

TRUST BOARD – 30th July 2019

QUALITY ASSURANCE COMMITTEE – 21st May 2019

HIGHLIGHT REPORT

Not assured	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
Partially assured	Amber - there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance

Section 1 – Assurance Topic			
Topic	**Assurance Level (RAG)**	**Rationale for Assurance Level**	**Action being taken**
External Serious Incident Review. Hilary McCallion presented her recommendations.		The committee received the recommendations of the report. Discussion highlighted that it was not yet clear which recommendations would be accepted as further discussion at the board and ET had yet to take place. Alignment of the two external reviews required-Executive Team to address but to consult with NEDs on final recommendation. A solution for resources would be required. There was positive support from CCGs for the recommendations made. Reputational implications were discussed.	Further discussion planned at Trust Board development session in June 2019. Composite action plan to be produced by the Executive Team.
Proposals for governance structure		Further work was required to implant the changes in the governance structure from the governance review. This would be	Discussion at June 2019 QAC.

		amalgamated with the recommendations from the QAC annual review.	
Monthly Quality Risk Report		Quality risks were considered but waiting for the next iteration of the Board Assurance Framework in June 2019. Assurance received that the ligature risk is to be developed and will be re-presented. There is a review of the risk relating to Safeguarding learning and this will be discussed at the next QAC	Discussion at June 2019 QAC.
Draft Integrated Quality and Performance Report (IQPR)		100% performance for Care Programme Approach (CPA) was noted.	
360 Assurance report-Stakeholder Engagement – progress update received		A number of recommendations have been made however these have not yet been signed off by Executive Team. Concerns raised around accountability and achieving outcomes	Future assurance will be directly to Trust Board.
LPT Quality Account 2018-19		Received at Trust Board May 2018. QAC queried how feedback received from stakeholders is addressed in year.	Assurance was provided post QAC that all comments and actions will be tracked and incorporated.
Care Quality Commission (CQC) Inspection 2018 progress update		Discussion that there are some areas where actions have not been achieved but much work is underway.	

Quality Improvement progress update		Verbal update on work programme was provided.	Further discussion at QAC in June 2019.
Positive and Safe and Seclusion Update Q4 2018-19		Mixed progress was reported for the quarter. QAC welcomed confirmation that new post (Trust wide Positive and Safe Lead) is being developed.	

Section 2 – Other items for Escalation			
Topic	**Level of Concern (RAG)**	**Rationale**	**Action being taken**
Directorate highlight reports		Early sight of issues raised by the CQC in Community Health Services. Assurances that the Directorate has responded and progress is underway.	QAC requested that Executive Team is sighted on the report and outcomes are aligned to existing work programmes.
Policy Adoption		Agreement to use Chair's action to adopt several policies which are in progress to support the CQC action plan.	QAC will receive via Board Adoption template in June 2019.
Joint QAC and FPC		Agenda being worked up for first joint QAC and FPC meeting.	First meeting to take place in June 2019.
Trust visits- expectation that 2 visits will be made over the coming months.		Health and Safety Executive – August/September 2019. CQC Infection Prevention and Control – August 2019.	QAC to receive update on both visits in June 2019.
Griffin Ward at		Issues relating to Griffin	QAC to receive a

Bradgate Mental Health Unit		ward, including staffing concerns have been referenced in several reports received by QAC.	briefing on Griffin ward in June 2019.
Recommendation	The Trust Board receives the issues raised from the Quality Assurance Committee held on 21st May 2019.		
Author	Liz Rowbotham, Non Executive Director, Chair of QAC.		
Presented by (Chair of committee)	Liz Rowbotham, Non Executive Director, Chair of QAC.		

Leicestershire Partnership NHS Trust

TRUST BOARD – 30th July 2019

QUALITY ASSURANCE COMMITTEE – 18th June 2019

HIGHLIGHT REPORT

Not assured	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
Partially assured	Amber - there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance

Section 1 – Assurance Topic

Topic	Assurance Level (RAG)	Rationale for Assurance Level	Action being taken
Quality Risks.		Assurance that low scoring for Risk 3604 (Safeguarding lessons learned) is appropriate and agreement to de-escalate from the corporate risk register.	De-escalation of Risk 3604. Development of new Corporate Risk register underway and awaited.
Corporate Risk Register (CRR) and Board Assurance Framework (BAF).		Support for new Board Assurance Framework and Corporate Risk Register structure as detailed in report. Discussion that it is quite large and the reasons for this were explained. It may reduce over time and QAC will eventually only receive it quarterly. A new system of risk appetite is to be introduced.	CRR awaited. Request for a Development session for QAC to include the differential use of the BAF and the CRR. Also to include risk appetite.
Draft Integrated Quality and Performance Report (IQPR)		QAC noted improvement in performance measures for 2018-19 for : • Clostridium Difficile • Care Programme Approach (CPA) 7	Further progress in relation to CPA 12 month performance anticipated as a result of successful appointment to CPA Lead post.

		day discharge • Delayed Transfers of Care (DToC) Slow progress related to 12 month follow up CPA target.	
QAC Annual Review 2018-19 and revised terms of reference		Minor changes to draft annual report agreed to include recommendations from the sub committees. Discussion regarding new terms of reference drafted in line with the governance review noted all changes including responsibilities for oversight of risk moving to the AAC. Further discussion re frequency of the meeting resulted in a change to no less than 6 times to enable flexibility and changes mid year to be introduced if considered appropriate.	QAC annual review 2018-19 to be presented to Audit and Assurance Committee on 5th July 2019 along with revised terms of reference. They will then be approved at the July 2019 Trust Board.
NHSI Infection Prevention and Control CQC Inspection update		QAC received a report detailing the actions being undertaken in response to the CQC findings and that preparations are underway for the NHSI visit on 7th August 2019.	
Care Quality Commission (CQC) Inspection 2017 and 2018 progress update		Assurance that the two outstanding 2017 actions are being overseen by SWG (clinical supervision) and FPC (targets for referral to treatment). Initial feedback from the CQC regarding the	The responsibilities for outstanding actions to be confirmed. QAC requested timescales against

		improvement notice actions was optimistic but the written report is still awaited. Concerns were expressed regarding capacity and capability to deliver against the CQC warning notice actions and also the must and should do actions that were issued following the 2018 Inspection.	delivery of “should do” actions at its next meeting. Planning for the next Provider Information Request (PIR) is already underway for the next inspection expected in November 2019. Director of Nursing AHPs and Quality to discuss way forward at the June Trust Board.
Safeguarding Committee highlight report-new enabling team Risk 3756 Safeguarding Team capacity		Executive Team has discussed. Business case is in development to support requirement for additional resource in Safeguarding Team.	Executive Team to review and confirm actions. Safeguarding Committee to update on progress to QAC via highlight reports.
Formal adoption of a number of policies as presented via the Board Adoption Template (including several which were adopted virtually using Chair’s action in May 2019).		Significant amounts of work being undertaken to review, update and agree policies in recent weeks particularly and to support CQC actions. QAC has received reports from all its subcommittees regarding status of policies and the work underway to address backlog.	There are plans for the Interim Associate Director of Corporate Governance to undertake piece of work on Trust policies going forward.
Patient Safety Improvement Group highlight report-concerns around existing governance arrangements in sub groups of PSIG		No assurance in regard to meetings and escalations from sub groups of PSIG. QAC requested that weaknesses in governance structure are addressed as a priority.	Patient Safety Lead taking forward and to update QAC on progress in August 2019.

Infection Prevention and Control Committee highlight report-		Discussion re padded walls at Mill Lodge. Assurance that correct replacement has been sourced although funding is still to be confirmed.	Capital bid being developed. QAC to receive update on progress via AMHLD Directorate/IPCC highlight report.
Items for escalation from the Clinical Effective Group		CEG approved the CAMHS Risk Tool and the Clinical Audit and NICE Report Forward Plan.	
QAC subcommittees		Discussion took place re the effectiveness of the working groups that report to the sub committees. It was agreed that there may be duplication, and that without these groups working effectively the flow of assurance to QAC could not be delivered effectively. In addition time and resources were committed to these working groups which if not delivering on their mandate was concerning.	Medical Director and Director of Nursing AHPs and Quality agreed to take actions to review this in line with the terms of reference of the sub committees and bring an update back to a future QAC.
Infection Control- listeria in sandwiches		Assurance that there are no implications for LPT services at present. The contract with the provider has been stopped. There is ongoing dialogue with Public Health colleagues.	
Quality Improvement Plan –Quality Strategy, Clinical priorities and CQUINs		Progress for Q4 2018-19 reported. It was agreed that whilst there was good progress being reported within the plan there	Action underway supported by the Associate Director of Corporate Governance. Integrated plan

		needed to be a single plan linked to the Trust priorities that brings together various plans to ensure there is one overall Quality Improvement Plan.	together with progress on achievement to come to a future QAC.

Section 2 – Other items for Escalation			
Topic	**Level of Concern (RAG)**	**Rationale**	**Action being taken**
LPT NHFT Buddy Forum proposal		QAC received for information a confidential and commercially sensitive draft proposal for a buddying arrangement with Northamptonshire Healthcare NHS Foundation Trust.	LPT Programme support Lead is to be identified. Director Nursing, AHPs and Quality to visit NHFT.
Safeguarding Committee highlight report- Implications from the Mental Capacity (Amendment) Bill which will receive Royal Assent imminently.		Plans in place for Trust to undertake robust scoping exercise on introduction of the legislation and develop appropriate processes. Further reports will be received once this is complete.	Update on progress to QAC via Safeguarding Committee highlight reports.
Seasonal Flu Vaccination campaign 2019-20- update on progress		Progress on actions for delivery of campaign. Confirmation was received that the Executive Team is sighted on this, has agreed funding and will monitor.	
Health and Safety Executive Inspection-		QAC received a report detailing that a pre-Inspection self	Progress to be monitored by Executive Team

management of Violence and aggression and musculoskeletal disorders-briefing		assessment is to be undertaken and the results will inform actions.	and actions to address will be agreed by them. Health and Safety Committee to update QAC via highlight report.
Presentation in response to concerns about Griffin Ward at Bradgate Mental Health Unit		The committee received a presentation of the work related to the Griffin ward. The Medical Director had commissioned a review of the operational working of the unit. As a result actions are now underway to develop personality disorder pathway, introduce a robust clinical model with the multi-disciplinary team and address staffing issues.	Updates in future to be received through the AMHLD oversight report.
Complaints		The committee received an update on the review of complaints handling process and classification.	
External visits report		Discussion about purpose and usefulness of report. Further discussion needed about development. This should coincide with the development of the single repository for feedback from external bodies being developed.	Director of Nursing, AHPs and Quality to feed back progress at a future QAC once established.
Quality Improvement Plan – letter of undertaking from NHSI		Received for information. QAC assured of progress in pulling together multiple aspects to provide a single Quality Improvement Plan. Awareness of the	To be discussed at June 2019 Trust Board.

		(negative) implications of LPT being classified as NHSI Segment 3 was discussed.	
Medicines Management Oversight Group			Terms of Reference to be received at July 2019 QAC along with first report.
Serious Incidents		Numbers have increased in month due to late notification of suicides following information from the Coroner. Going forward numbers will increase due to new classification in formal SIs related to pressure ulcers.	

Recommendation	The Trust Board receives the issues raised from the Quality Assurance Committee held on 18th June 2019.
Author	Liz Rowbotham, Non Executive Director, Chair of QAC.
Presented by (Chair of committee)	Ruth Marchington, Non Executive Director.

TRUST BOARD – 30 July 2019

QUALITY ASSURANCE COMMITTEE –16 July 2019

HIGHLIGHT REPORT

Not assured	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
Partially assured	Amber - there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance

Section 1 – Assurance Topic			
Topic	**Assurance Level (RAG)**	**Rationale for Assurance Level**	**Action being taken**
Risks update		Corporate Risk Register (CRR) was not presented. Work continuing to align to the Board Assurance Framework (BAF) and to the quality improvement plan to ensure that the risks are current and appropriate. QAC were not assured as they did not have oversight of any risks this month although acknowledged the amount of work being undertaken in developing new approach.	An updated CRR and BAF will be present at August QAC.
Draft Integrated Quality and Performance Report (IQPR)		QAC asked for the zero harm indicator to be removed from the IQPR, with a view to replacing with a more appropriate indicator(s). CPA 7 day and 12 month performance improving but not on target for all patients	Update on progress to QAC via the IQPR report

		discharged (7 day) and 12 month follow up. Further progress in relation to CPA performance anticipated as a result of successful appointment to CPA Lead post.	
Care Quality Commission (CQC) Inspection 2017 and 2018 progress update		There has been a decline in the promptness of completing actions. QAC asked for the last column in the action plan to be split to show action completed and compliance achieved. Initial feedback from the CQC regarding the improvement notice actions was positive. The written report is anticipated to be available in the next couple of weeks.	QAC supported the reintroduction of the panel meetings to monitor progress on actions.
Items for escalation from Safeguarding Committee Highlight report (including Safeguarding Adults Review - Board Briefing)		Concerns about the impact of reducing the Early Start programme raised with Public Health Services. FYPC have an internal plan in place, to mitigate any risks of the decommissioning of the service.	Safeguarding Committee requested a report with robust mitigations against the decommissioning of the service and an update will be provided to QAC via the highlight report.
Items for escalation from Patient Safety Improvement Group highlight report		Increase of aggression and violence incidents particularly on the Bradgate unit was discussed. A number of incidents have been investigated internally or as a Serious Incident. Staff are reviewing in	Patient Safety team is working on developing a more formal way of escalation of incidents in partnership with Senior Clinicians, Health and Safety

		the context of the Safe Wards initiative and carrying out a deep dive.	and the Police. Update on progress via the PSIG highlight report.
Items for escalation from the Clinical Effective Group (CEG)		Physical Health: - Resource implications of the six monthly health checks require a discussion at CQRG. The Physical health medical lead post is a pilot. The strategy/work plan for physical health across mental health services is being finalised and will feed into the review of the clinical strategy. Care of deceased policy still outstanding. The 'recording of protected characteristics' group continues to meet with the Patient Monitoring tool being tested. Monitoring established and compliance low at present. Group working with the quality lead to interpret the data for what it means for patients, services and staff.	CEG will receive a full update on progress in August and feedback to QAC CEG setting target for completion CEG will review the performance figures in October 2019 and they will review impact of the quality lead work in teams and update QAC via the highlight report.
Research and Development quarterly report		Quarterly report of achievements discussed and challenges to progress highlighted.	Feedback on the difficulties staff experience to obtain release and time for research activities to be fed into culture and leadership programme by change champion.

Section 2 – Other items for Escalation			
Topic	**Level of Concern (RAG)**	**Rationale**	**Action being taken**
Medicines Management Group		Terms of Reference were approved subject to minor amendments for this new governance group. Directorates are required to nominate a representative to attend the meetings.	The Medicines Management Group will meet on a monthly basis and provide updates to QAC via the highlight report.
Oversight reports from the Directorates		The timing of the reports for the directorate will change to be one directorate per month on a rolling basis and be more Quality Improvement focused providing QAC with opportunity for a more meaningful discussion.	The QAC agenda and work plan will reflect the changes to one directorate oversight report per month.

Recommendation	The Trust Board receives the issues raised from the Quality Assurance Committee held on 16 July 2019.
Author	Ruth Marchington, Non-Executive Director, deputising for Chair of QAC and Deborah McMahon, PA
Presented by	Anne-Maria Newham

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Leicestershire Partnership NHS Trust

TRUST BOARD –23 MAY 2019

FINANCE AND PERFORMANCE COMMITTEE – 21 MAY 2019

OVERVIEW REPORT TO BOARD

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

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Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Director of Finance Report		**Financial Plan;** NHSI/E has confirmed there remained a significant shortfall in the affordability of the financial plan at a national level. LPT has been asked to improve its planned position from breakeven to £0.5m surplus based on the perceived windfall benefit of the non recurrent receipt of agenda for change funding to support local authority contracts. LPT has responded and outlined the constraints in terms of its contractual position, CQC requirements and NHSI undertakings. **NHSI Single Oversight Framework Segmentation Changes:** Following the CQC report, NHSI has reviewed LPT's requirements and had moved us from segment 2 to segment 3. The move to segment 3 meant that the Trust would be provided with mandated rather than targeted support.	Review and discussion at Board to confirm acceptance of the stretch target.	May 2019
Bradgate Site Strategic Outline Case (SOC)		The project initiation document to develop the SOC for all-age mental health acute inpatient, crisis and outpatient services was presented. FPC received assurance of the process in place but highlighted the need for alignment of the SOC with the overarching Estates Strategy.	Work on the SOC was expected to be completed by September 2019, it would then be sent to the DHSC for permission to proceed to the next stage.	

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		Discussion took place, FPC acknowledged that although detailed consultation was not required until the outline business case stage, the committee was keen to stress that early engagement with stakeholders, beyond those listed as well as from a patient experience point of view should be included.		
Board Assurance Framework and Corporate Finance Risk Register		Work on the development of the new BAF for 2019/20 was ongoing. Proposed mapping of current corporate risks to draft BAF and new FPC corporate risk register was presented. The committee acknowledged that a cohesive approach for the transition of the BAF and CRR was required across the organisation. The June FPC/QAC meetings were expected to agree a number of BAF and risk register related proposals.	BAF to be presented in draft to Trust Board in May. Once the new-format FPC risks were confirmed, a work plan would be devised to ensure that appropriate focus was given to the risks by FPC.	May 2019
Finance Report Month 1 2019/20		• Confirmation had been received of £2.2m PSF funding as a result of delivering the £3.3m surplus in 2018/19. • Operational budgets were already reporting an overspend of £325k which was a significant concern. • An underspend on capital was reported. Some schemes were being delayed because they were waiting for CRL approval from NHSI, there was however, no delay for the Bradgate site or CQC schemes. • Cash balances were higher than plan already. • BPPC was delivering across all targets. • Work continued to address the shortfall for CIP schemes. Good progress was being made on the QIA sign off. In considering the favourable year-end financial position for 2018/19 the committee agreed that communications should make clear the internally generated surplus on top of which significant additional PSF was awarded which drove the £5.5 surplus reported.	Work was being undertaken by the Finance Team to fully understand what was causing the overspend together with its impact on the run rate. Consideration would be given to how the financial position was reported at the AGM particularly in view of the surplus.	June 2019 May 2019
AMH/LD Finance Summary-		• The directorate was reporting a £76k overspend at month 1 due mainly to spend on out of area placements and issues around income. A new 'progress beds' model, agreed with		June 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		commissioners which would see patients moving to out of area beds at the end of their pathway, rather than the beginning was expected to have a positive impact. • Income had not been received as expected, specifically for Mill Lodge but work was ongoing to improve bed occupancy going into the new financial year.		
FYPC Finance Summary		• FYPC was reporting an overspend of £47k, the pay award for the 0-19 services had not been factored in but a better position was expected to be seen by month 3. • The Eating Disorder Service was overspending on pay at month 1, in addition target income was not being met. • The CAMHS inpatient ward was overspending due to 2:1 ratio and under occupancy of beds.		June 2019
CHS Finance Summary		• The CHS directorate was reporting an overspend of £65k for the first month of 2019/20, relating mainly to continued pay pressures within Gwendolen Ward and City East District Nursing Team, where there had been a higher than anticipated use of agency. An improved position was expected at Q2.		June 2019
Business Pipeline		Current projects included; • CAMHS additional capacity, the plan was to engage an online provider of assessment for children with autism spectrum disorder and CBT with effect from late June. Once live, the service would deliver limited additional capacity to families waiting extended periods for intervention. • Longer term planning was underway to procure provider to deliver online therapy as part of CAMHS core offer. • The contract for IAPT, currently held by Nottinghamshire Healthcare NHS Trust was due to end 31 March 2020. It was important for LPT to have a link to IAPT as there was strong alignment to the wider community offer, mental health and long term conditions, and to the concept of an LLR ICS. A project team had been established to drive this forward. • LPT had been successful in its bid for Individual Placement Support to enhance current employment support. • The transfer of the Neonatal Paediatric		

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		and ECMO Call Handling service to a new provider had been postponed for three months, the delay had been agreed with NHSE and contract varied to support this. • The County Integrated Weight Management Service (Adults and Children) was on track to transfer to Leicestershire County Council from 1 October.		
Integrated Quality and Performance Report (IQPR)		The IQPR end of April 2019 position was presented. Key issues were; • There had been no NHSI identified triggers again this month. • National reporting for gatekeeping had resumed from 1 April. Performance was currently at 66.2%, this was expected to improve to around 80% by the time of submission. • A pilot for ethnicity data collection and protected characteristics had gone live at 1 May. The aim was to feed lessons learned into the work taking place on single EPR. • FPC was provided with a first view of how the 'data quality flag', representing the six domains of data quality could be presented in the IQPR.		June 2019
Waiting Times Summary Report		An update of the four strategic objectives for waiting times was received on the position as at 31 March 2019. **52 week waits;** there were no genuine waiters (waiting for first contact) and no data quality issues. Nine people were waiting in AMH CMHTs. **National targets;** a better position than the previous month was reported. There was only one exception; completed pathways for Adult ADHD 81.6% (target 95%). A longer-term plan to implement a non-consultant-led model and use of non-medical prescribers would increase capacity but would not create sufficient capacity to support delivery of target. **CAMHS backlog;** **Access** – a significantly improved position was reported since 1 April, capacity was broadly sufficient to meet current demand. **Treatment -** capacity broadly sufficient to meet current demand. Slightly improved position in numbers waiting was reported. **Priority services;** eleven targets were incomplete across eight services identified as a priority for action. Of these six were	Initial discussion had been held at ET, confirmation was received that a more detailed trajectory would be presented to FPC in June.	June 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		red, three were green and one not rated. Within this there was significant improvement in the position compared to that at 28 February in most services. **CAMHS Eating Disorders** - deterioration in position was reported, the number of referrals was growing rapidly and flow through the service was slow.		
Estates and Facilities Management		An update on progress was presented, key issues were; • NHS PS facilities management service provision commenced April 2019 to their own properties, there were currently no issues or problems arising for LPT. • Initial baseline assessments had been completed on dormitory accomm-odation and a draft report would be presented to ET. There were limited options to improve position, without adversely compromising bed capacity, ahead of any new build schemes. • Signed contracts for CAMHS had been received from Interserve, the anticipated start was June 2019 with completion at August 2020. • All CQC warning notice identified actions were either complete or scheduled to be completed by the end of May 2019. • Discussion focused on refurbishment of specific areas ahead of the next inspection by the CQC. FPC agreed that assurance of a process to demonstrate that estate issues were being managed proactively would be addressed through the SCIE Group.	Dormitory options paper to be considered by ET and subsequently FPC	June 2019 June 2019
Health Informatics Service; IM&T Strategy Six Monthly Update HIS Six Monthly Update		**IM&T Strategy** An update on progress was provided on delivery of the 2018 – 2020 LPT IM&T Strategy. The Single EPR work was the main focus currently and good progress was being made. TIARA migration was complete and options for data migration were currently being considered. **Progress of HIS's performance for the last six months of 2018/19;** • At the end of March 2019, 39% of HIS's income was outside of the core SLA with the LLR stakeholders. This was significantly higher than the 23% planned in the opening budgets. HIS	Review of the IM&T Strategy was likely to commence late 2019. The focus would be on quality improve-ment and enhancing service improvement, linked to Step up to Great.	

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		was busy with commercial activity and new developments outside of the stakeholders however, the need to seek new work to offset the funding shortfall introduced the Teckal compliancy risk which needed careful management. • All three CCGs and LPT had agreed a new three year SLA with LHIS until 31 March 2021. There was however, a business risk to LHIS as it was possible that the CCGs could cease to exist before then. • The biggest risk for LHIS continued to be cyber. There were seven controls actively pursued to manage this risk. The support provided by LHIS to service innovation was acknowledged. Thanks were extended to the Head of LHIS and his team.		

Recommendation	The Trust Board receives and notes the issues raised in the highlight report
Author	Faisal Hussain, Non-Executive Director Danielle Cecchini, Director of Finance, Business and Estates Val Glenton, PA to Director of Finance, Business and Estates
Presented by (Chair of committee)	Geoff Rowbotham, Non-Executive Director

TRUST BOARD – 30 JULY 2019

FINANCE AND PERFORMANCE COMMITTEE – 18 JUNE 2019

OVERVIEW REPORT TO BOARD

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

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Assured	Green – there are no gaps in assurance

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Director of Finance Report Well-governed		NHSE had launched the New Care Models programme in 2015 to improve quality and efficiency in commissioning and delivery of specialised mental health services. The Executive Team had considered putting the Trust forward as a potential lead provider for the Adult Eating Disorder Service (AED) but had decided against it because of the onerous requirements of a lead provider and requirement to be a segment 2 Trust. However, it had since been made clear the expectation was that LPT would be expected to put itself forward as lead provider for AED Service. Colleagues at Northamptonshire Healthcare NHS FT would be helping LPT produce the submission of interest. The Internal Audit Terms of Reference for Review of Estates Maintenance had been agreed. The final report was expected to be issued in September 2019 and provide external assurance on LPT's arrangements.	FPC recommended that Trust Board approve submission of expression of interest to be lead provider for the AED Service .	July 2019
Annual Review of Committee's Effectiveness Well-governed		The Annual Report for FPC for 2018/19 was received. The report provided details of the work of the committee during 2018/19 and summarised the successes and challenges. It also provided details of the governance arrangements for the functioning of the committee following a review and proposed changes to be made to the terms of reference around	FPC recommended to AAC that the terms of reference provided the oversight the committee was required to provide and	

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		membership and frequency of meetings. The review had also recommended a number of items move from the FPC to the Audit and Assurance Committee as they were part of the system of internal control and core responsibility of the AAC.	supported the internal control mechanisms of the Trust. FPC also recommended approval of the Terms of Reference by Trust Board.	
Board Assurance Framework 		An overview of the approach to the new BAF was presented, the committee received an explanation on how the document would provide support to the organisation in understanding the assurance it was receiving. The proposal was to present the BAF at each meeting until it was embedded and then to only report on it quarterly as it did not change significantly from month to month. FPC acknowledged that training would be required on how to use it and a development session would be arranged for the Trust Board and its committees.		September 2019
Finance Report Month 2 2019/20		• Operational budgets continued to overspend, with the year-to-date overspend now reaching £529k.Whilst the overspend rate had slowed, the level of overspend after only 2 months was a considerable cause for concern. In terms of financial forecast, a gross overspend position of £2.3m was expected at year end. • In-depth discussion took place on how the Trust would show the additional NHSI stretch target of £0.5m in it's accounts. The current position was that NHSI was concerned about what LPT was forecasting. No schemes that had gone through a rigorous quality impact assessment process had been identified yet to achieve the £0.5m but NHSI had agreed to help the Trust identify some schemes.	A proposal and timescale would be presented to the next meeting	July 2019
AMH/LD Finance Summary-		• The directorate was reporting it expected a £600k overspend position at year end. • Out of area spend had reduced in June.		July 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
FYPC Finance Summary		• FYPC was reporting it expected an overspend position of £300k at year end.		July 2019
CHS Finance Summary		• The CHS directorate was forecasting a break even position at year end.		July 2019
Integrated Quality and Performance Report (IQPR) 		The IQPR end of May 2019 position provided a summary of those 2018/19 standards/ performance measures showing the most improvements, those showing a decline in performance or an unstable trend; and those highlighted through audits as needing improvements to data quality. Key issues were; • Gatekeeping performance was currently at 82% which was still below the 95% national target but where the Trust expected to be. The positive position was highlighted but FPC acknowledged the national target would not be met yet. • Data quality issues had been picked up in RiO which were inflating the figures for out of area placements and CPA 7 day, these issues were being resolved with CCG colleagues and NHSI/E. Concern was raised about how the true position for CPA 7 day was being reported due to the restrictions with the reporting system.		July 2019
Waiting Times Summary Report 		An update of the four strategic objectives for waiting times was received on the position as at 30 April 2019. **52 week waits;** there were no genuine waiters (waiting for first contact) and no data quality issues. Ten people were waiting in AMH CMHTs. Work on waiting times had revealed a number of unreported waits for treatment leading to an incomplete understanding of performance and delivery of LPT's stated waiting time priorities, including a number of services with service users waiting over 52 weeks for treatment. **National targets;** there were two exceptions; completed pathways for Adult ADHD 81.6% and Adult ASD 89.2% (target 95%). Weekly PTL meetings were being held to identify upcoming breaches for Adult ADHD and to secure additional capacity over and above commissioned capacity to bring in as many people as possible to avoid breaches. This work would continue until a plan agreed by ET was in place.		July 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Waiting Times Improvement		**CAMHS backlog;** **Access** – a significantly improved position was reported since 1 April, capacity was broadly sufficient to meet current demand. **Treatment -** capacity was broadly sufficient to meet demand. Improved position in numbers waiting for treatment was reported. The Committee noted however, the position for neuro-developmental was some way behind plan. **Priority services;** The committee agreed that following a review, PIER and Paediatric Psychology targets would be removed from the priority list as they were green and the position should be sustained. However, also as a result of the review, Integrated Neurology and Stroke, Continence, CBT, Dynamic Psychotherapy and Personality Disorder services would be added. The Waiting Times Improvement Group quarterly report was presented, highlighting the priority services for enhanced scrutiny and targeted improvement.	Impact of the work agreed by the group to be presented as part of the deep dive at the August FPC meeting	
Estates and Facilities Management 		An update on progress was presented, key issues were; • The Trust was on track with the backlog programme of work. NHSI had asked LPT to reduce its capital spend by 20% which could be a risk to the capital programme. LPT would push back on this. • Bradgate phase 1 refurbishment of Ashby and Bosworth wards remained on target for completion by the end of July 2019 and mid August 2019 respectively. • The review of the Estates Strategy was on track to be presented to the Committee in September 2019. • Work on the new CAMHS Unit had started and was currently on target. • Assurance was provided that a robust process for the estates maintenance programme was in place. • The next national Patient Led Assessment of the Care Environment (PLACE) was scheduled for September 2019 and would now report to FPC rather than QAC.		July 2019

Recommendation	The Trust Board receives and notes the issues raised in the highlight report
Author	Geoff Rowbotham, Non-Executive Director Danielle Cecchini, Director of Finance, Business and Estates Val Glenton, PA to Director of Finance, Business and Estates
Presented by (Chair of committee)	Geoff Rowbotham, Non-Executive Director

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NHS
Leicestershire Partnership
NHS Trust

TRUST BOARD –30 JULY 2019

FINANCE AND PERFORMANCE COMMITTEE – 16 JULY 2019

OVERVIEW REPORT TO BOARD

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

Assurance level	Colour to use in 'Assurance level*' column below
Not assured	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"
Partially assured	Amber - there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Director of Finance Report		• An update on progress of New Care Models was received. LPT had submitted an expression of interest to undertake the role of lead of an East Midlands Provider Collaborative for Adult Eating Disorders with support from colleagues at Northamptonshire Healthcare NHS FT. The development of the Provider Collaborative for AED was in the very early stages and it was anticipated that LPT's expression of Interest would be allocated to the 'further development track' with a likely go live date of April 2021. • With regard to Step up to Great and performance monitoring, ET was finalising the outcomes and measures related to its strategic priorities. These included finalising the Performance Management Framework, adopting the new Board Assurance Framework and receiving the Quality Improvement Plan together with its governance arrangements. FPC was informed commissioners had raised concern at the Clinical Quality Review Group that the IQPR did not all fulfil the reporting of assurances they required. • The 2018/19 Internal Audit review of Capital Planning received a limited assurance rating. All actions had been implemented with the exception of one medium risk for which a plan was in place, to be agreed by 360 Assurance.	LPT on behalf of the local NHS partners, supported by NHSE, was proposing to lead the development of the business case for future provision. LPT reps would be attending a panel meeting on 6 August and would update FPC. A new IQPR, which would meet commissioner requirements was expected to be developed by the end of 2019, draft document outlining timescales and outcomes to be presented to the next meeting.	August 2019 August 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		• LLR STP had received a request from NHSI to prioritise the system's capital expenditure to deliver a capital control total of £55m. Working together, LPT and UHL had drafted capital plans which delivered the control total. For LPT, this had not required any adjustment to the total capital plan of £13.9m as UHL had been able to reduce their plan and still deliver priority schemes. As part of the return, LPT requested confirmation that the outstanding CRL approval of £1.6m could now be approved but this approval has not yet been received. The Capital Management Group requested that strategic capital groups should plan for the worst, and re-prioritise 19/20 schemes. • Work on the STP's Five Year Plan was taking place. A draft would be submitted at the end of September, year 1 of the plan was expected to be LPT's final plan for 2020/21.		
Major Incident Plan		The committee approved the annual review of LPT's Major Incident Plan for 2019/20. The most significant aspect of the review, was the insertion of the new LPT Cyber Attack Response Plan, this was aimed to support LPT's response to a cyber emergency. FPC requested assurance on elements of the plan that were tested. The team was congratulated on the work undertaken on the plan.	A test of the plan and live exercise was expected to take place in Q4, the outcome would be reported to the Health and Safety Committee and to FPC.	January 2020
Patient Level Information Costing System Development		LPT was still making good progress on implementing PLiCS in Adult Mental Health services. FPC noted that the planned migration from RiO to SystmOne may have an impact on the ability to extract full year activity for 2019/20, depending on the timing of the migration. It was LPT's intention to progress with community PLiCS internally, learning from the work already done with MH PLiCS.		
Corporate Finance Risk Register		FPC was informed that during the interim period of updating the BAF and corporate risk register, existing FPC risks had essentially been paused.	Work would be taking place to develop an e-learning package, and with director-	August 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		The committee did not receive the report as there were no assurances that could be given on the current risk register and no timelines for validating the information that currently existed on it. Concern had also been expressed by ET about the system for archiving risks and how they were scored. Assurance was however received of a very robust process in directorates to manage existing risks so that none were overlooked during this review.	ates and Trust Board on how the BAF, CRR and directorate risks related to each other. A paper would be received at the August meeting on the action being taken during the interim period.	
Finance Report Month 3 2019/20		• Operational budgets continued to overspend, with the year-to-date overspend now reaching £1,125k. There was a significant worsening of the run-rate from month 2 to month 3. An issue around pay was the cause of some overspend but further investigation was required to establish the underlying reason. Agency spend was also significantly higher than this time the previous year. The forecast overspend operationally was £3.3m. • Closing cash for June stood at £7.5m. This equated to 10.1 days' operating costs, and was above the planned cash level of £7.1m for June. • At the end of June, CIP delivery amounted to £630k against an overall year to date target of £655k, this equated to 96.3% delivery. AMH and CHS had submitted all schemes for QIA sign off, there were now only one or two outstanding for estates and enabling. There was still a shortfall for CIP overall of c£1m, which included the £500k stretch target.	A recovery plan was being developed which would be presented to ET on 29 July. Meetings would be held with finance lead to review run rates by service. The positive positions for BPPC and cash flow were noted. However, an update on the actions proposed to recover the financial position was requested at the next meeting and to include any potential impact on quality of care.	August 2019
AMH/LD Finance Summary-		• AMH/LD directorate reported an overspend of £360k. The AMH.LD financial recovery group would oversee the development and delivery of a plan to improve this position. • Increased patient acuity and workforce supply had significantly contributed to the deteriorating position.		August 2019
FYPC Finance Summary		• Two wards were the main factors for the deteriorating position. Langley and Ward 3 were jointly £106 under recovered on income for the first 3 months and over budget for bank and agency. 3:1 staffing ratio had also impacted on the ability to fill beds.	A recovery plan was being developed for Ward 3 and work was taking place to identify how bed occupancy could	August 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
			be improved on Langley Ward	
CHS Finance Summary		• The CHS directorate was reporting an overall overspend of £170k for the first three months of this year, presenting a considerable adverse movement of £103k during the month. • Bank and agency costs had increased significantly, particularly within the inpatient wards relating to reported high acuity of patients and vacancies. In addition the use of 'off framework' agency increased due to the inability of LPT's Master-vend agency provider to fill the shifts.		August 2019
Reference Costs		An outline of the process undertaken to produce mandatory reference costs for 2018/19 was presented. The committee recognised there was a small weakness in the reporting process but that there were checks in place to address the issue. FPC approved the process and agreed that the Director of Finance would formally sign off the reference costs submission by the date due 26 July 2019. FPC focused on what could be done with the outputs of the work on reference costs.	Consideration would be given to this aspect and reported back to FPC at a date to be confirmed.	
Data Quality Improvement Plan Progress 		The committee received an update on the implementation of the data quality kite mark used to measure data quality compliance. The Trust was on track to implement a data quality assessment tool to assess against priority waits and KPIs against the six data quality domains.		
Integrated Quality and Performance Report (IQPR) 		The IQPR end of June 2019 position was presented. With regard to the accuracy of CPA 7 day figures, confirmation was received the issue was due to the process for reporting on RiO. NHS Digital had agreed that for the national return, LPT would validate the information from RiO and the national return would be correct but the local data may be incorrect. The committee noted the data quality issues impacting on the figures for CPA, gatekeeping and out of area would be resolved with the migration to SystmOne but consideration would be given, in the meantime, to the root cause of the errors to ensure they did not happen again.	ET would be asked to confirm the stance it wanted to take in resolving the issue of data quality errors.	August 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Waiting Times Summary Report 		An update of the four strategic objectives for waiting times was received on the position as at 31 May 2019. **52 week waits;** there were no genuine waiters (waiting for first contact) and no data quality issues. Ten people were waiting in AMH CMHTs. **National targets;** there were two exceptions; completed pathways for Adult ADHD 82.1% and Adult ASD 68.8% (target 95%). With regard to ADHD,– implementation of non-consultant-led pathway with non-medical prescribers would increase capacity but would not deliver target. Extra resource was in place to maintain current performance pending agreement on alternative service model. Numbers of patients referred continued to increase and exceeded numbers discharged resulting in a continuing growth in service caseload. Adult ASD – the aim was to remove this service from national reporting. **CAMHS backlog;** Access – service showing improved position for all waits. 20 patients were waiting over 13 weeks which was a significant reduction. Progress was in line with agreed trajectories. Treatment - capacity was broadly sufficient to meet demand. Numbers waiting for treatment over one year had reduced but numbers waiting less than one year had increased. **Priority services;** 12 targets across 9 services identified as a priority for action. Of these, 7 were red, 5 were green and 2 had mixed position. This was an improved position however there was some deterioration in a number of the services RAG-rated red.	FPC was scheduled to undertake a deep dive review of waiting times at its August meeting. The scope and outcomes proposed to be approved by the Executive Team.	August 2019
Estates and Facilities Management 		An update on progress was presented, key issues were; • The backlog, schemes were generally on track with the original programme. • The review of the Estates Strategy had commenced and was on target. • Detailed work had commenced on the AMH SOC and was currently on track. Discussion took place around engagement with stakeholders.	An update on the Estates Strategy would be presented to the committee in August and AMH SOC in September.	August 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		• Work had commenced on the CAMHS site. • With regard to performance for facilities management services, ongoing issues were reported for routine and urgent matters. • In relation to elimination of dormitory accommodation, FPC noted good progress was being made at Westcotes House. • The Estates Team was thanked for the good work undertaken regarding the refurbishment programme to date. The refurbishment at the Bradgate Unit had been very well received.	An update on how the FM issue would be resolved to be presented to FPC at a date to be agreed following discussion by ET. . Plan and timeline to be brought back to FPC at a date to be confirmed.	
Electronic Patient Record Project Progress Report 		Despite some delays, the project workstreams remained on target to conclude on agreed timeframes for May 2020. The project was currently reviewing the financial position and closer monthly monitoring to ensure LPT reflected accurate costings. Concern was raised by the committee about the length of the delay, discussion focused on mitigations to overcome the risks.	An update on key risks and mitigations in place to be brought back to FPC at a date to be agreed with Sue Elcock, executive lead.	
360 Assurance Six Monthly Review 		The committee received an update on the performance of 360 Assurance, the key areas outlined were: • 360 Assurance achieved a surplus of £63,200 for the 2018/19 financial year. A contribution of £55,000 was made towards LPT in addition to their paying accommodation and service costs. • 360 Assurance had agreed a 2019/20 business plan and budget with the Management Board of Consortium members which equated to a deficit of £12,800 for the year and a contribution to LPT of £55,500. The planned 2019/20 position including the 2018/19 surplus was a surplus of £50k. • Trust performance targets remained green. There was, however, scope to improve the completion of appraisals and fire training. • Client satisfaction levels remained very good overall. A recent completed client		

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		satisfaction questionnaire demonstrated very good performance by staff given the resource pressures encountered in the 2018/19 year. • The committee thanked 360 Assurance for their efforts.		

Recommendation	The Trust Board receives and notes the issues raised in the highlight report
Author	Geoff Rowbotham, Non-Executive Director Danielle Cecchini, Director of Finance, Business and Estates Val Glenton, PA to Director of Finance, Business and Estates
Presented by (Chair of committee)	Geoff Rowbotham, Non-Executive Director

Leicestershire Partnership NHS Trust

Meeting Name and date	**PUBLIC Trust Board, 25th July 2019**
Paper number	**K**

Name of Report: **Public Finance Report M3**

For approval		For assurance	X	For information	X

Presented by	Danielle Cecchini, Director of Finance	Author (s)	Chris Poyser, Head of Corporate Finance

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe		Safe		S – High Standards	
Effective		Staff		T - Transformation	
Caring		Partnerships		E – Environments	
Responsive		Sustainability	X	P – Patient Involvement	
Well-Led	X			G – Well-Governed	X
				R – Single Patient Record	
				E – Equality, Leadership, Culture	
				A – Access to Services	
				T – Trustwide Quality improvement	
Any equality impact (Y/N)		N			

Report previously reviewed by	
Committee / Group	Date
N/A	N/A

Assurance : What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers
Provides assurance that the Trust financial position is intensely monitored and managed, with any perceived adverse impact immediately and clearly highlighted to senior management	All FPC finance risks

Recommendations of the report
The Trust Board is recommended to accept the reported financial position, and to support any further actions designed to improve the year end forecast as agreed / discussed during the meeting.

Finance Report for the period ended **30 June 2019**

For presentation at the **PUBLIC Trust Board** **25 July 2019**

Contents

Executive Summary and overall performance against targets

Introduction

1. This report presents the financial position for the period ended 30 June 2019 (month 3). The report shows a £168k surplus, which is in line with plan.

2. Operational budgets are currently overspending by £1,125k. The run-rate overspend for month 3 was £596k, compared to £204k in month 2. This is a significant worsening of the run-rate.

3. Adult Mental Health Services budgets show the highest level of overspend (£360k) followed by Estates services (£338k) and FYPC Services (£191k). The operational overspend is offset by the release of central reserves, allowing the Trust to report an on-target position against the month 3 plan. However, as in previous years, the central reserves are front-loaded in terms of the monthly profile, and this level of central support will reduce in future months. When forecasting reserves balances forwards, the value used at month 3 equals the forecast net reserves position.

4. Closing cash for June stood at £7.5m. This equates to 10.1 days' operating costs, and is above the planned cash level of £7.1m for June.

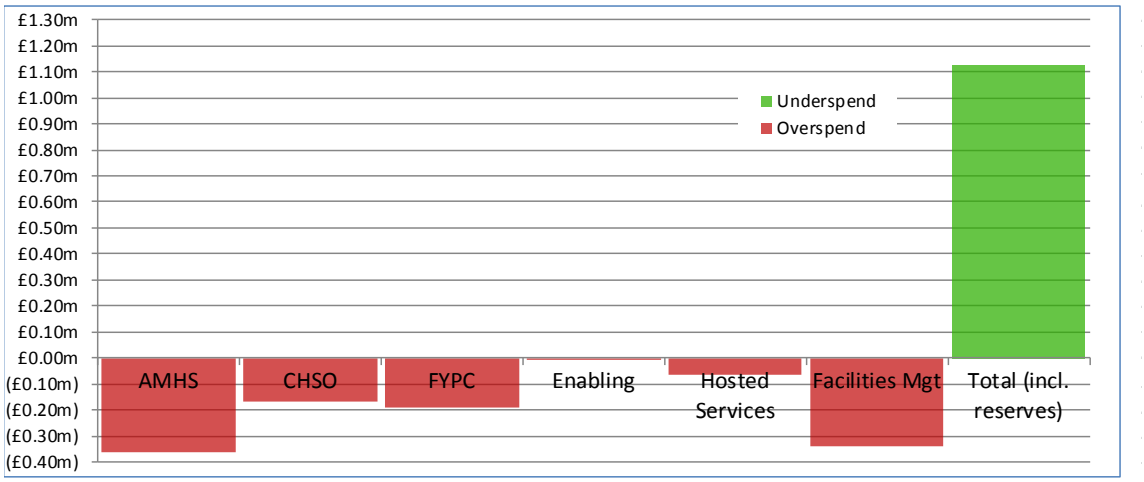
NHS Trust Statutory Duties	Year to date	Year end f'cast	Comments
1. Income and Expenditure break-even.	G	A	The Trust is reporting a surplus of £168k at the end of June 2019. This is in line with the Trust plan. The worsening run-rate increases the risk to delivery of a year end break-even **[see 'Service I&E position' and *Appendix A*]**.
2. Remain within Capital Resource Limit (CRL).	G	G	The capital spend for June is £993k, which is within limits.
3. Achieve the Capital Cost Absorption Duty (Return on Capital).	G	G	The dividend payable is based on the actual average relevant net assets; therefore the capital cost absorption rate will automatically be 3.5%.
4. Remain within External Financing Limit (EFL).		G	Cash levels of £7.5m are currently above target. The forecast year end cash balance will deliver the EFL requirement.

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 4 BPPC targets in June.
6. Achieve Cost Improvement Programme (CIP) targets.	G	R	CIP schemes are currently under delivering, showing £630k achieved compared to a £655k year to date target (equating to 96.3% delivery) at the end of month. **[See 'Efficiency Savings Programme'].** The year end forecast (for operational schemes) currently shows 63% achievement by the end of the year.
7. Deliver financial plan surplus	G	A	(Also see target 1 above). A surplus of £168k has been reported in month 3, in line with plan. The Trust plan for the year assumes a £0.5m LPT generated surplus, plus £2.1m PSF funding dependant on delivery of the NHSI breakeven control total. Delivery of the stretch target surplus by the year end will be challenging due to the emerging risks.
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	The Trust is currently scoring 2 for year-to-date performance. Despite the potential risks to the year end I&E surplus stretch target, the strong cash position means that a score of 2 overall for the year is still likely.
9. Achieve retained cash balances in line with plan	G	G	A cash balance of £7.5m was achieved at the end of June 2019. Delivery of the year end cash forecast is expected to exceed target due to the notification of 2018/19 incentive PSF. **[See 'cash and working capital']**
10. Deliver capital investment in line with plan (within +/- 15% YTD planned spend levels)	A	G	Capital expenditure totals £993k at the end of month 3; £0.5m below plan. **[See 'Capital Programme 2019/20']**

Income and Expenditure position

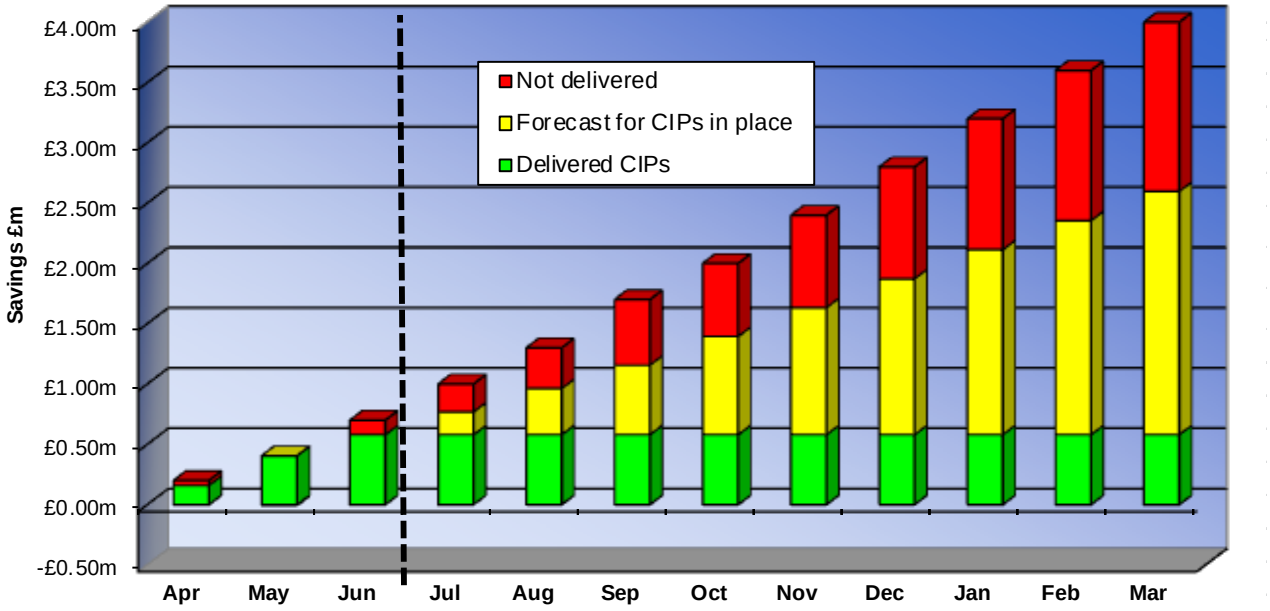
The month 3 position includes a significant operational overspend that is currently offset by the release of central reserves.

The chart below shows the year-to-date I&E variance against budget/plan and the individual service surplus/deficits contributing towards this overall position.



Directorate Efficiency Savings Programme

CIP performance (directorate schemes) as at month 3



	Apr £000	May £000	Jun £000	Jul £000	Aug £000	Sep £000	Oct £000	Nov £000	Dec £000	Jan £000	Feb £000	Mar £000
Monthly plan total:	**202**	**408**	**655**	**951**	**1,292**	**1,653**	**2,049**	**2,446**	**2,844**	**3,244**	**3,645**	**4,047**
Actual performance to date												
Achieved	159	455	630	630	630	630	630	630	630	630	630	630
Forecast achieved	*0*	*0*	*0*	*190*	*383*	*577*	*815*	*1,054*	*1,293*	*1,534*	*1,774*	*2,017*
Total savings:	**159**	**455**	**630**	**820**	**1,013**	**1,207**	**1,445**	**1,684**	**1,924**	**2,164**	**2,405**	**2,647**
Variance:	**(43)**	**47**	**(24)**	**(131)**	**(279)**	**(446)**	**(604)**	**(762)**	**(921)**	**(1,080)**	**(1,240)**	**(1,400)**

At the end of June, CIP delivery amounted to £630k, against an overall year to date target of £655k. This equates to 96.3% delivery.

However, the year end forecast predicts performance significantly lower than plan by the end of March 2020 (65% delivery). The expected worsening performance is due to additional unidentified CIPs, the savings for which are phased in later in the year. This unidentified element includes the additional £500k CIP required to deliver the higher surplus target set for the Trust by NHS Improvement.

Statement of Financial Position (SoFP)

PERIOD: June 2019	2018/19 31/03/19 Audited £'000's	2019/20 30/06/19 June £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	200,260	199,416
Intangible assets	1,909	1,837
Trade and other receivables	653	653
Total Non Current Assets	**202,822**	**201,906**
CURRENT ASSETS		
Inventories	319	394
Trade and other receivables	13,802	20,444
Cash and Cash Equivalents	8,357	7,477
Total Current Assets	**22,478**	**28,315**
Non current assets held for sale	**0**	**0**
TOTAL ASSETS	**225,300**	**230,221**
CURRENT LIABILITIES		
Trade and other payables	(14,856)	(19,687)
Borrowings	(220)	(220)
Capital Investment Loan - Current	(190)	(190)
Provisions	(1,202)	(1,206)
Total Current Liabilities	**(16,468)**	**(21,303)**
NET CURRENT ASSETS (LIABILITIES)	**6,010**	**7,012**
NON CURRENT LIABILITIES		
Borrowings	(8,025)	(8,025)
Capital Investment Loan - Non Current	(3,510)	(3,429)
Provisions	(1,129)	(1,129)
Total Non Current Liabilities	**(12,664)**	**(12,583)**
TOTAL ASSETS EMPLOYED	**196,168**	**196,336**
TAXPAYERS' EQUITY		
Public Dividend Capital	83,675	83,674
Retained Earnings	48,288	48,456
Revaluation reserve	64,205	64,205
TOTAL TAXPAYERS EQUITY	**196,168**	**196,336**

Non-current assets

– Property, plant and equipment (PPE) amounts to £199m. For the first few months of the year depreciation charges are likely to exceed capital spend, resulting in a reduced PPE balance.

Current assets

– Current assets of £28.3m include cash of £7.5m and receivables of £20.4m.

Current Liabilities

- Current liabilities amount to £21.3m and mainly relate to payables of £19.7m

– Net current assets / (liabilities) show net assets of £7m.

Working capital

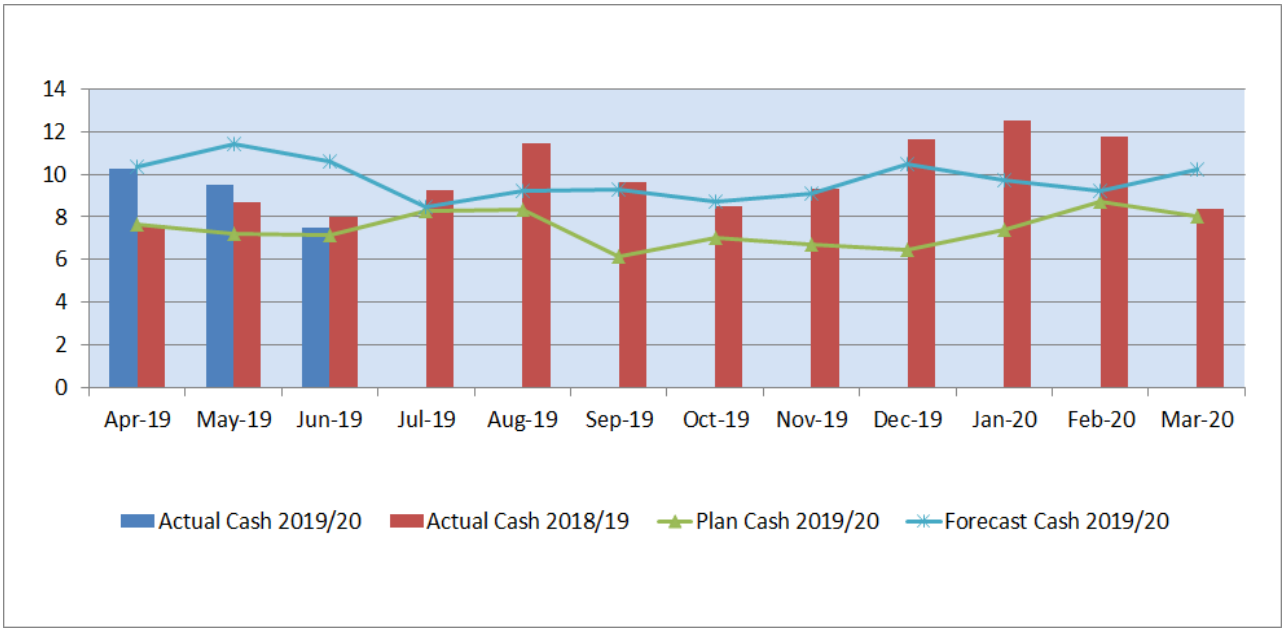
– Cash and changes in working capital are reviewed on the following pages.

Taxpayers' Equity

– June's year to date surplus of £168k is reflected within retained earnings.

Cash and Working Capital

12 Months Cash Analysis Apr 18 to Mar 19



Cash – Key Points

June's closing cash balance is £7.5m and equates to 10.1 days' operating expenses - this is £0.4m above the planned cash balance of £7.1m.

Internal cash forecasts are updated each month. The updated forecast for June had predicted a closing cash balance of £10.6m. Whilst the June closing cash balance did exceed plan, the updated in-year forecast of £10.6m was not met due to income which remained outstanding for Health Informatic Services, Internal Audit and Out of Area recharges. In addition to this, non-pay expenditure exceeded forecast due to the payment of an annual Informatics contract.

The year end cash forecast as at 31st March 2020 is £2.2m above the planned year end cash balance of £8m. This is due to NHSI notification in April of the incentive PSF funding awarded to the Trust for achieving its 2018/19 financial duties (£2.2m). The revised forecast of £10.244m is therefore reliant on the receipt of this incentive PSF funding and delivery of the planned I&E outturn.

The in-year cashflow has been updated to reflect the additional 2018/19 PSF funding of £114k, notified to the Trust in July. The year end forecast has not been adjusted due to the additional cash being used to support working capital balances.

Receivables

Current receivables (debtors) total £20.4m. It should be noted that financial instruments such as accruals are also included in this calculation.

Receivables	Current Month (June 2019)					
	NHS	Non NHS	Emp's	Total	% Total	% Sales Ledger
	£'000	£'000	£'000	£'000		
Sales Ledger						
30 days or less	1,365	2,139	12	**3,516**	**16.9%**	**45.3%**
31 - 60 days	704	71	7	**782**	**3.8%**	**10.1%**
61 - 90 days	106	29	1	**136**	**0.7%**	**1.8%**
Over 90 days	2,562	601	168	**3,331**	**16.0%**	**42.9%**
	4,737	2,840	188	**7,765**	**37.3%**	**100.0%**
Non sales ledger	8,842	3,837	0	**12,679**	**60.9%**	
Total receivables current	**13,579**	**6,677**	**188**	**20,444**	**98.3%**	
Total receivables non current		360		360	**1.7%**	
Total	**13,579**	**7,037**	**188**	**20,804**	**100.0%**	**0.0%**

Debt greater than 90 days amounts to £3.3m, an increase of £893k since last month. Receivables over 90 days should not account for more than 5% of the overall total receivables balance. The proportion at Month 3 is 16% (last month: 13.3%).

Aged debts > 90 days

These have now been RAG rated to reflect a number of factors (see key). £543k is deemed to be red, a small reduction since last month, with the majority relating to AMHS out-of-area recharges.

The Accounts Receivable team focus on the green and amber debts, whilst the red debts are passed to Service areas once all general debt recovery processes have been exhausted. The overall monthly increase relates to 120 additional 'green' invoices (i.e. debts that have just moved into the over 90 days bracket) and represent those invoices raised at year end. Work is ongoing with finalising these debts.

RAG	M2		M3		Diff	
	£000	No	£000	No	£000	No
Green	844	283	**1,732**	**403**	888	120
Amber	1,048	104	**1,056**	**98**	8	(6)
Red	546	44	**543**	**45**	(3)	1
	2,438	**431**	**3,331**	**546**	**893**	**115**

Key:

Green – invoice is in early stages of being chased / no queries or issues
Amber – invoice query raised / has been passed to requester to help resolve any disputes
Red * – invoice query raised which AR team cannot resolve / chased twice with requester

* If debts are red rated, this does not imply that they need to be written-off, just that more work is required to get disputes or queries resolved. There has not been any movement in the general bad debt provision of £374k since the start of the financial year.

Payables

The current payables position in Month 3 is £19.7m. The over 90 days NHS supplier debt of £894k continues to relate to two suppliers: UHL (£125k) and NHS Property Services (£763k). Work is ongoing to resolve these invoice disputes.

Payables	Current Month June 2019				
	NHS £'000	Non NHS £'000	Total £'000	% Total	% Purchase Ledger
Purchase Ledger					
30 days or less	2,094	2,028	**4,122**	**20.9%**	**76.2%**
31 - 60 days	1	25	**26**	**0.1%**	**0.5%**
61 - 90 days	362	8	**370**	**1.9%**	**6.8%**
Over 90 days	877	17	**894**	**4.5%**	**16.5%**
	3,334	2,078	**5,412**	**27.5%**	**100.0%**
Non purchase ledger	2,245	12,030	**14,275**	**72.5%**	
Total Payables Current	**5,579**	**14,108**	**19,687**	**100.0%**	
Total Payables Non Current	0	0	**0**		
Total	5,579	14,108	19,687	**100.0%**	

Better Payment Practice Code (BPPC)

The specific target is to pay 95% of invoices within 30 days. Cumulatively the Trust achieved all of the 4 BPPC targets in June.

The Finance team will continue to meet with any non-complying departments to help maintain this position and support achievement of all four targets at the end of the financial year.

Further details are shown in ***Appendix B***.

Capital Programme 2019/20

Capital expenditure totals £993k at the end of month 3, £545k below plan. Spend will increase from July, following payment of Interserve invoices relating to the construction of the CAMHS unit.

The annual expenditure plan of £13.96m is reliant on NHSI approval of the Trust's capital resource limit (CRL). £1.6m of the plan is supported by internally generated cash, however due to the national constriction on capital spend in 2019/20, CRL approval to spend Trust cash has not yet been granted. The commencement of several schemes has been delayed until funding is confirmed.

	Annual Plan	June YTD Plan	June YTD Actual	June YTD Variance	Year End Forecast
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Depreciation	7,179	974	993	19	7,179
PDC capital for CAMHS	5,102	564	0	(564)	5,102
PFI Agnes Unit capital lifecycle replacement	100	0	0	0	100
I&E Surplus (CRL adjustment not confirmed)	1,576	0	0	0	1,576
Asset Sales	0	0	0	0	0
Total Capital funds	**13,957**	**1,538**	**993**	**(545)**	**13,957**
Application of Funds	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Estates & Innovation					
Service Improvements	(7,138)	(727)	(499)	228	(7,325)
Estates & Equipment	(2,911)	(382)	(105)	277	(2,761)
Sub-total:	**(10,049)**	**(1,109)**	**(604)**	**505**	**(10,086)**
IT Programme	**(3,908)**	**(429)**	**(389)**	**40**	**(3,871)**
Total Capital Expenditure	**(13,957)**	**(1,538)**	**(993)**	**545**	**(13,957)**
(Over)/underspend against resource available	**0**	**0**	**0**	**0**	**0**

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 30th June 2019	YTD Actual M3 £000	YTD Plan M3 £000	YTD Var. M3 £000	Year end forecast £000
Revenue				
Total income	70,797	70,017	780	278,567
Operating expenses	(68,852)	(68,072)	(780)	(269,305)
Operating surplus (deficit)	**1,945**	**1,945**	**(0)**	**9,262**
Investment revenue	9	9	(0)	36
Other gains and (losses)	0	0	0	0
Finance costs	(249)	(249)	0	(996)
Surplus/(deficit) for the period	**1,705**	**1,705**	**(0)**	**8,302**
Public dividend capital dividends payable	(1,537)	(1,537)	0	(6,154)
I&E surplus/(deficit) for the period (before tech. adjs)	**168**	**168**	**(0)**	**2,148**
IFRIC 12 adjustments	0	0	0	0
Donated/government grant asset reserve adj	0	0	0	0
Technical adjustment for impairments	0	0	0	0
NHSI I&E control total surplus	**168**	**168**	**(0)**	**2,148**
Other comprehensive income (Exc. Technical Adjs)				
Impairments and reversals	0	0	0	0
Gains on revaluations	0	0	0	0
Total comprehensive income for the period:	**168**	**168**	**(0)**	**2,148**
Trust EBITDA £000	**3,838**	**3,838**	**(0)**	**16,836**
Trust EBITDA margin %	**5.4%**	**5.5%**	**-0.1%**	**6.0%**

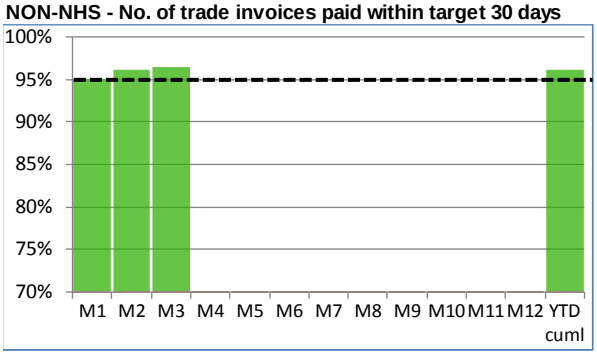
APPENDIX B – BPPC performance

Trust performance – current month (cumulative) v previous

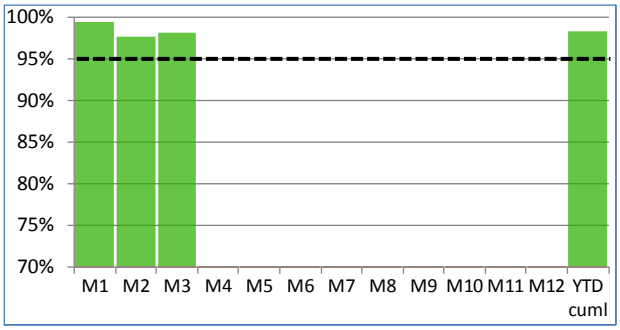
Better Payment Practice Code	June (Cumulative)		May (Cumulative)	
	Number	£000's	Number	£000's
Total Non-NHS trade invoices paid in the year	6,488	24,297	3,649	14,820
Total Non-NHS trade invoices paid within target	6,236	23,890	3,495	14,585
% of Non-NHS trade invoices paid within target	**96.1%**	**98.3%**	**95.8%**	**98.4%**
Total NHS trade invoices paid in the year	200	11,844	124	7,300
Total NHS trade invoices paid within target	194	11,833	120	7,291
% of NHS trade invoices paid within target	**97.0%**	**99.9%**	**96.8%**	**99.9%**
Grand total trade invoices paid in the year	6,688	36,141	3,773	22,120
Grand total trade invoices paid within target	6,430	35,723	3,615	21,876
% of total trade invoices paid within target	**96.1%**	**98.8%**	**95.8%**	**98.9%**

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

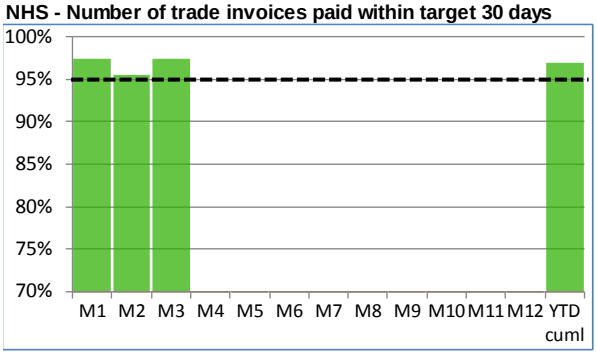
NON-NHS - No. of trade invoices paid within target 30 days



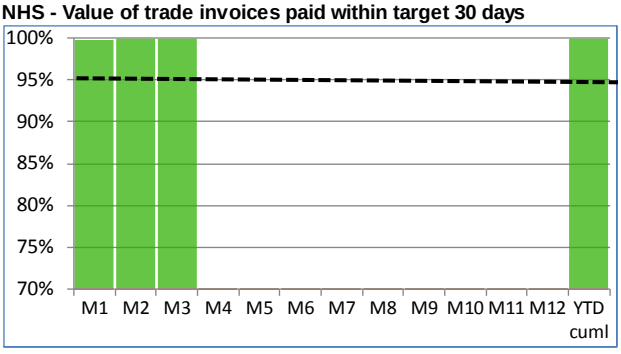
NON-NHS - Value of trade invoices paid within target 30 days



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

2019/20 Agency Expenditure (includes prior yr comparators)	2018/19 Outturn £000s Actual	2018/19 Avg. £000s Actual	2019/20 M1 £000s Actual	2019/20 M2 £000s Actual	2019/20 M3 £000s Actual	2019/20 M4 £000s F'Cast	2019/20 M5 £000s F'Cast	2019/20 M6 £000s F'Cast	2019/20 M7 £000s F'Cast	2019/20 M8 £000s F'Cast	2019/20 M9 £000s F'Cast	2019/20 M10 £000s F'Cast	2019/20 M11 £000s F'Cast	2019/20 M12 £000s F'Cast	19/20 YTD £000s Actual	19/20 Year End £000s F'cast
AMH/LD																
Agency Consultant Costs	-609	-51	-60	-64	-94	-105	-105	-92	-62	-45	-45	-45	-45	-45	-218	-807
Agency Nursing	-1,528	-127	-122	-142	-158	-155	-155	-135	-115	-110	-120	-120	-110	-110	-421	-1,551
Agency Scient, Therap. & Tech	-232	-19	-33	-18	-21	-25	-25	-25	-25	-25	-25	-25	-25	-25	-72	-297
Agency Non clinical staff costs	-409	-34	-48	-43	-31	-40	-40	-40	-40	-40	-35	-35	-30	-30	-122	-452
Sub-total	**-2,778**	**-231**	**-264**	**-267**	**-303**	**-325**	**-325**	**-292**	**-242**	**-220**	**-225**	**-225**	**-210**	**-210**	**-834**	**-3,108**
CHS																
Agency Consultant Costs	-182	-15	-15	-15	-12	-15	-15	-15	-15	-15	-15	-7	-7	-7	-42	-150
Agency Nursing	-3,579	-298	-306	-243	-305	-280	-260	-260	-260	-260	-290	-250	-250	-250	-855	-3,215
Agency Scient, Therap. & Tech	-644	-54	-54	-41	-47	-50	-50	-50	-50	-50	-50	-50	-50	-50	-143	-593
Agency Non clinical staff costs	-43	-4	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Sub-total	**-4,447**	**-371**	**-375**	**-299**	**-365**	**-345**	**-325**	**-325**	**-325**	**-325**	**-355**	**-307**	**-307**	**-307**	**-1,039**	**-3,958**
FYPC																
Agency Consultant Costs	-429	-36	-42	-12	-29	-35	-35	-35	-30	-30	-30	-30	-30	-30	-83	-368
Agency Nursing	-521	-43	-118	-160	-163	-160	-160	-160	-140	-140	-140	-140	-140	-140	-441	-1,761
Agency Scient, Therap. & Tech	-26	-2	-4	-7	-11	-10	-5	-5	-5	-5	-5	-4	-4	-4	-23	-70
Agency Non clinical staff costs	-32	-3	-8	-15	-15	-15	-10	-10	-10	-10	-10	-9	-8	-8	-38	-128
Sub-total	**-1,007**	**-84**	**-172**	**-194**	**-218**	**-220**	**-210**	**-210**	**-185**	**-185**	**-185**	**-183**	**-182**	**-182**	**-585**	**-2,327**
Enabling, Hosted & reserves																
Agency Consultant Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Agency Nursing	-49	-4	0	29	0	0	0	0	0	0	0	0	0	0	29	29
Agency Scient, Therap. & Tech	-42	-4	-7	-4	-8	-7	-10	-10	-10	-10	-10	-10	-10	-10	-19	-106
Agency Non clinical staff costs	-623	-52	-22	-31	-24	-25	-25	-30	-30	-30	-30	-30	-30	-30	-77	-337
Sub-total	**-714**	**-60**	**-28**	**-6**	**-32**	**-32**	**-35**	**-40**	**-40**	**-40**	**-40**	**-40**	**-40**	**-40**	**-66**	**-413**
TOTAL TRUST																
Agency Consultant Costs	-1,220	-102	-117	-90	-136	-155	-155	-142	-107	-90	-90	-82	-82	-82	**-342**	-1,325
Agency Nursing	-5,676	-473	-546	-516	-626	-595	-575	-555	-515	-510	-550	-510	-500	-500	**-1,688**	-6,498
Agency Scient, Therap. & Tech	-944	-79	-99	-71	-87	-92	-90	-90	-90	-90	-90	-89	-89	-89	**-256**	-1,065
Agency Non clinical staff costs	-1,107	-92	-78	-89	-70	-80	-75	-80	-80	-80	-75	-74	-68	-68	**-237**	-917
Total	**-8,946**	**-746**	**-839**	**-766**	**-918**	**-922**	**-895**	**-867**	**-792**	**-770**	**-805**	**-755**	**-739**	**-739**	**-2,523**	**-9,805**
Agency ceiling (£8,122k)			-675	-677	-677	-677	-677	-677	-677	-677	-677	-677	-677	-677	-2,029	-8,122
Variance (+better/-worse)			**-164**	**-89**	**-241**	**-245**	**-218**	**-190**	**-115**	**-93**	**-128**	**-78**	**-62**	**-62**	-494	**-1,683**
Trust financial plan			-710	-681	-680	-678	-677	-675	-674	-670	-673	-675	-673	-656	-2,071	-8,122
Variance (+better/-worse)			**-129**	**-85**	**-238**	**-244**	**-218**	**-192**	**-118**	**-100**	**-132**	**-80**	**-66**	**-83**	-452	**-1,683**

At month 3, total Trust agency costs were £2,523k. This is higher than year-to-date planned spend of £2,071k, and also higher than the year-to-date agency spend ceiling of £2,029k set by NHS Improvement.

The year end plan was initially set to deliver the NHSI agency spend ceiling of £8,122k. However, since the plan was set, agency projections have increased significantly, mainly as a result of much higher spend within FYPC, due to the work to reduce CAMHS waiting lists.

After month 3, the revised forecast for the year is £9.8m against the plan / NHSI ceiling of £8.1m

Leicestershire Partnership NHS Trust

Meeting	Trust Board
Date of meeting	30th July 2019
Paper number	L

Name of Report	Data Quality Improvement Plan

For approval		For assurance	X	For information	

Presented by the Accountable Director	Dani Cecchini – Director of Finance, Business and Estates	Author (s)	Laura Hughes – Head of Information

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe		Safe		S – High Standards	
Effective		Staff		T - Transformation	
Caring		Partnerships		E – Environments	
Responsive		Sustainability	X	P – Patient Involvement	
Well-Led	X			G – Well-Governed	X
				R – Single Patient Record	
				E – Equality, Leadership, Culture	
				A – Access to Services	
				T – Trust wide Quality improvement	

Report previously reviewed by		
Committee / Group	Date	Assurance obtained (Significant/Limited/None)
Finance and Performance Committee Quality Assurance Committee	16th July 2019	not assessed

Assurance : What level of assurance does this report provide in respect of the Board Assurance Framework Risks? (Significant / Limited / No Assurance)	Links to BAF risk numbers
TBC	TBC

Recommendations of the report
The Trust Board is recommended to: • Receive assurance with regard to areas of quality and performance where performance improvement action is being undertaken; • Receive the NHSI compliance segment rating of three.

1 Introduction/ Background

1.1 The Integrated Quality and Performance Report (IQPR) summarises the Trust's performance against key NHS Improvement (NHSI), Commissioner and other targets; and provides analysis and commentary on those areas which require additional actions to ensure that we achieve our targets and objectives.

1.2 The strategic objective measures aligned to the Trust's 'STEP up to GREAT' priorities will be reviewed during 2019/20 and included in a future iteration of this report.

1.3 The report format is continually evolving to ensure it is aligned to the:
a) key performance indicators (KPIs)
b) Trust governance groups
c) corporate risk register (CRR) and board assurance framework (BAF)
d) Trust priorities

1.4 It should be noted that from May 2019, the following NHSI compliance is demonstrated in the report:

Segment Rating	3 - Providers receiving mandated support for significant concerns

2 Aim

2.1 The aim of this report is to provide the Trust Board with an integrated quality and performance report showing levels of compliance with the NHS Improvement's (NHSI) Single Oversight Framework and Care Quality Commission (CQC) registration, together with detailed analysis for those areas requiring additional action to ensure achievement of targets.

3 Discussion

3.1 The next three chapters highlight the key quality and performance indicators for each of the committees:
i. Quality Assurance Committee (QAC)
ii. Finance and Performance Committee (FPC)
iii. Strategic Workforce Assurance Group (SWAG)

3.2 Each chapter is separated into two themes:
i. NHS Improvement (NHSI) Single Oversight Framework (SOF)
ii. Trust identified quality of care/ performance/ organisational health indicators

3.3 The full integrated quality and performance review (IQPR) dashboard is available in Annex A and is referred to throughout the paper. Annex A provides monthly trends and supporting exception reports to support discussions.

4 Quality Assurance Committee (QAC)

NHS Improvement (NHSI) quality of care indicators

4.1 There is one identified NHSI trigger(s) in 2018/19 quarter four relating to the care programme approach seven day (CPA seven day) indicator. It is anticipated this trigger will be removed after 2019/20 quarter one following the improvements in performance since February 2019.

4.2 Trust performance against the CPA seven day follow up standard is reported as two separate measures to account for:

i. only those patients discharged from a general psychiatric unit on a CPA;
ii. all patients discharged from a general psychiatric unit on CPA and on non-CPA.

4.3 Performance for patients discharged on CPA during May 2019 is 95.1% against a national lower limit target of 95% (reported one month in arrears).

4.4 The performance for all patients discharged on CPA and on non-CPA during May 2019 is 92.8% against a national lower limit target of 95% (reported one month in arrears).

4.5 In May 2019, there were nine patients who breached the CPA seven day standard – of which, three were not contacted; four were not contacted with attempts made; two were contacted after the seventh day. A record of data quality errors affecting this indicator are retained to support the audit for this Quality Account indicator.

4.6 The 2019/20 trajectory for clostridium difficile (C. Diff) has been set by the Leicester, Leicestershire and Rutland (LLR) clinical commissioning groups (CCGs) as an upper limit of twelve cases per annum. There has been one (1) cases of C. Diff in the month of June 2019 at the Evinton Centre – Beechwood Ward. The year to date total occurrences of C.Diff is one (1). (see Annex A - detailed exception report – clostridium difficile (C Diff) cases).

Trust quality of care indicators

4.7 The CPA 12 month standard performance as at June 2019 is 90.4% against a lower limit threshold of 95%. The performance continues to improve following the implementation of patient level reporting and reminders to care co-ordinator. As per the new process, the circumstances leading to patients not receiving their 12 month review in a timely manner will be investigated following escalation to the appropriate manager(s). A CPA lead has been successfully recruited to and is due to commence with the Trust in July 2019 to further support improvements. (see Annex A - detailed exception report – CPA 12 month review).

5 Finance and Performance Committee (FPC)

NHS Improvement (NHSI) use of resources indicators

5.1 The NHSI single oversight framework (SOF) uses financial metrics to assess financial performance. Providers are scored from one to four against each metric and an aggregate overall score is derived (see Appendix One for details).

5.2 As at 2019/20 month 03, the year to date financial assessment is scored at two (2). The 2019/20 forecast outturn score is also two (2).

NHS Improvement (NHSI) operational performance indicators

5.3 There are no identified NHSI trigger(s) in June 2019.

5.4 The Trust continues to meet its national access targets for 18 week referral to treatment (RTT) services (incomplete pathways >=92% target), six week diagnostic services and two week early intervention in psychosis services. The Trust has no patients waiting more than 52 weeks for treatment on RTT pathways (see Annex A – detailed exception report – national access standards).

5.5 Inappropriate adult mental health out of area (OOA) bed days are showing a continued overall reduction since April 2018 as the Trust works to reduce mental health OAAs bed days to zero by 2020/21. Over the last 12 months, the Trust has seen a sustained decline in OOA bed days from 1673 in 2018/19 quarter one to 423 in 2019/20 quarter one.

5.6 It should be noted that OAP bed days are slightly inflated due to the source data held on RiO being incorrect. Actions are being taken to reduce the occurrence of data quality errors made at source and to ensure errors are rectified at source in a timely manner. This issue is technical in nature and is specific to data held on RiO. It is expected the ongoing issues will be mitigated as part of the planned migration from RiO to SystmOne in 2020/21.

5.7 In May 2019, the Trust, in partnership with Leicester, Leicestershire and Rutland (LLR) commissioners, provided access to ‘progress beds’ for patients nearing the end of their acute mental health inpatient spell. This ‘progress bed’ initiative aims to increase availability of AMH acute beds for patients presenting with acute needs so enabling prompt admission to a local bed.

5.8 This arrangement is anticipated to be an interim arrangement pending the commissioning of enhanced crisis and early discharge provision later in 2019/20. The qualitative and quantitative impact of progress beds will be formally reviewed every two months with findings reported via contract monitoring and internal governance routes. As progress beds are provided by Cygnet Healthcare in a range of units located outside of LLR, it is anticipated that there will be an increase in the total number of out of area placements in the first instance; however as acute OOA placements are repatriated the expectation is that overall OOA numbers will either remain static or potentially reduce.

5.9 The Trust's data quality maturity index (DQMI) score is now published nationally one month in arrears by NHS Digital. NHSI have specifically identified the mental health services data set (MHSDS) as an area for provider scrutiny. Nationally, NHS Digital are supporting NHS regulatory bodies to access and use this submitted data to develop tools such as the model hospital and more recently the STP mental health dashboards.

5.10 The DQMI MHSDS criteria expanded during 2019/20 and the Trust anticipated a drop in compliance to approximately 80% when the new criteria were implemented. . The Trust has agreed to a data quality improvement plan (DQIP) as part of the 2019/20 contract with the CCG commissioners to focus on improving performance against the new DQMI standards.

5.11 To support these improvements, three specific work streams have been implemented:

i. recording of patient demographics - in May 2019, a pilot data collection form was introduced in mental health outpatient services. A review of success is arranged for August 2019;
i. clinical coding - a review is underway to understand processes relating to the recording of primary diagnosis codes;
ii. technical submission process – a review is underway to understand processes relating to the development and validation of submission files.

5.12 The March 2019 DQMI MHSDS compliance rate has increased to 86.7% from 81.4% the previous month in line with expectation. (see Annex A – detailed exception report – data quality maturity index (DQMI)).

5.13 The percentage of patients admitted to inpatient services who are given access to Crisis Resolution/ Home Treatment teams ('gate keeping') in line with best practice standards will return to national submissions for 2019/20 quarter following recommendation from the Executive Team, the Trust Board agreed to remove 'gate keeping' from national reporting for 2018/19 quarter three and four.

5.14 2019/20 quarter one gate keeping performance is achieving 84.5% against a lower limit threshold of 95%. It should be noted, the monthly performance breakdown for this quarter is 69.5%, 82.8% and 100% for April, May and June 2019 respectively, which suggests the improvements made over the period following the implementation and embedding of the new gatekeeping protocol from April 2019 had the desired impact. This indicator will continue to be closely monitored in the directorate to maintain the level of improvements.

5.15 The Trust has submitted the gatekeeping rate as 84.5% for the period April 2019 to June 2019 to NHS Digital.

Trust operational performance indicators

5.16 The management of patients experiencing a delayed transfer of care (DToC) remains high on the Trust agenda. As at June 2019, the Trust is above the 3.5% upper limit threshold at 5.3%. It should be noted the Leicester, Leicestershire and Rutland (LLR) DToC rate, which incorporates delays in the acute trust and LLR patients delayed in non-LLR hospitals is within the target threshold.

6 Strategic Workforce Assurance Group (SWAG)

NHS Improvement (NHSI) organisational health indicators

6.1 There are zero (0) identified NHSI trigger in June 2019.

6.2 Staff sickness absence remains above target at 3.8% in April 2019 (reported one month in arrears) – of which, 2.4% is long term sickness and 1.4% is short term sickness. Support to manage staff sickness absence is pro-actively offered to managers by the human resources department (see Annex A – detailed exception report - % staff sickness).

6.3 Staff turnover (normalised) was 9.0% for May 2019, which meets the Trust threshold of between 10% and 12%.

Trust human resources – workforce performance indicators

6.4 The Trust vacancy rate in June 2019 remains at 8.1%, which is above the upper limit threshold of 7%.

6.5 Cumulative year-to-date Trust agency costs were £2523K as at 30 June 2019 (month 03). This is above the planned spend of £2071k for the same period. The June 2019 year-to-date NHSI agency ceiling target is £2029k. This Trust is exceeding this limit by £494k.

7 Conclusion

7.1 This report demonstrates that whilst there are a significant number of targets being achieved, along with some notable areas of improvement, there remain a number of targets which are not currently being achieved and where attention is now being directed to ensure continued improvement in the coming months.

8 Recommendations

1 The Trust Board is recommended to:

i. Receive assurance with regard to areas of quality and performance where performance improvement action is being undertaken;
ii. Receive the NHSI compliance segment rating of three.

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i. Appendix One – description of NHSI segmentation
ii. Annex A – Integrated Quality and Performance Report

9 Appendices

Appendix one – description of NHSI segmentation

Segmentation helps NHSI determine the level of support required. It does not give a performance assessment in its own right, nor is it intended to predict the ratings given by CQC. It also does not determine the specifics of the support package needed − this is tailored by teams working with the provider in question. NHSI are segmenting the sector into four, depending on the extent of support needs identified through the oversight process.

1 - Providers with maximum autonomy − no potential support needs identified across our five themes – lowest level of oversight and expectation that provider will support providers in other segments.

2 - Providers offered targeted support − potential support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/ or formal action is not needed.

3 - Providers receiving mandated support for significant concerns – the provider is in actual/ suspected breach of the licence (or equivalent for NHS trusts).

4 - Special measures − the provider is in actual/ suspected breach of its licence (or equivalent for NHS trusts) with very serious/ complex issues that mean that they are in special measures.

Paper Li

Leicestershire Partnership NHS Trust

Integrated Quality and Performance Report

Advancing health and well-being

End of June 2019 Position

Data to 30 June 2019 unless otherwise stated

Previous month's data refreshed where available

Leicestershire Partnership NHS Trust

Contents

NHS Improvement Themes of the Single Oversight Framework

Themes		Measures	Q1 Self Assessed Concerns	Q2 Forecasted Concerns
Quality of Care	Care Quality Commission (CQC) judgements on the Quality of Care provided by the Trust; safe, effective, caring and responsive	CQC 'inadequate' or 'requires improvement' assessment in one or more of:- 'safe', 'effective', 'caring', 'responsive' -CQC warning notices -Any other material concerns identified through, or relevant to, CQC's monitoring process, e.g. civil or criminal cases raised, whistleblower information, etc. -Concerns arising from trends in our quality indicators (Appendix 2) -Delivering against an agreed trajectory for the four priority standards for 7-day hospital	Yes current CQC rating of 'requires improvement'	Yes
Finance & Use of Resources	Strengthening financial performance and accountability by overseeing financial efficiency and financial control total	-Poor levels of overall financial performance (average score of 3 or 4) -Very poor performance (score of 4) in any individual metric -Potential value for money concerns	No	No
Operational Performance	Improve and sustain performance against NHS Constitution standards	For providers with Sustainability and Transformation Fund (STF) trajectories in any metric: failure to meet the trajectory for this metric in more than two consecutive months (quarterly for quarterly metrics) For providers without STF trajectories: failure to meet any standard in more than two consecutive months	No	No
Strategic Change	Delivering strategic changes set out in the Five Year Forward View focussing on sustainability and transformation plans (STP)	Material concerns with a provider's delivery against the transformation agenda, including new care models and devolution	Governance arrangements of STP under review. Consultation and implementation yet to be confirmed	Governance arrangements of STP under review. Consultation and implementation yet to be confirmed
Leadership & Improvement Capability	Good governance and leadership	-Material concerns -CQC 'inadequate' or 'requires improvement' assessment against 'well-led'.	Yes current CQC rating of 'inadequate'	Yes

Segment Rating: 3

The five themes above are used by NHS Improvement to support providers to improve to attain and/or maintain a CQC 'good' or 'outstanding' rating.

Segmentation:
NHS Improvement (NHSI) use information from data monitoring processes and insights gathered though work with providers, to identify where providers have a potential support need under one or more of the five themes. NHSI will also use judgement, based on consistent principles, to determine whether or not providers are in breach of licence – or the equivalent for NHS trusts – and to determine, as part of that judgement, if providers should go into special measures (segment 4).

Rated **GREEN** No issues identified or Universal or Targeted support is agreed with NHSI **RED** where mandated support is issued by NHSI. Where the trust identifies a concern, a written description stating the issue and any associated actions to address those concerns will be accompanied and is locally rated as **Amber**.

Leicestershire Partnership NHS Trust

NHS Improvement Quality of Care Metrics

	NHSI Sector	Indicator	NHSI Monitoring Frequency	Monthly Performance: Reporting Period (rolling three months) Apr-19	May-19	Jun-19	Sparkline Feb 19 - to date	Quarterly Performance: 2018/19 Q4	2019/20 Q1	Q2	Q3	Q4	Annual Performance: 2018/19 Year End Total	2019/20 Year to Date Total	Trigger (two consecutive monthly breaches)	Current month directorate performance: Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children	Enabling Services	Comments
SAFE	All	**Occurrence of any Never Event**	Monthly *(six month rolling)*	**0**	**0**	**0**		**0**	**0**				**1**	**0**	0	**0**	**0**	**0**	**0**	Methodology: count of 'never events' in rolling six- month period
	All	**NHS England/NHS Improvement Patient Safety Alerts not completed by deadline**	Monthly	**0**	**0**	**0**		**0**	**0**				**0**	**0**	0	**0**	**0**	**0**	**0**	Methodology: number of NHS England or NHS Improvement patient safety alerts outstanding in most recent monthly snapshot
	Acute	**VTE Risk Assessment**	Monthly	**219**	**272**	**246**		**793**	**737**				**3249**	**737**	0		**246**			
	Acute	**Clostridium Difficile Occurrence (against contractual year to date target of 12)**	Monthly	**0**	**0**	**1**		**2**	**1**				**5**	**1**	0	**0**	**1**	**0**		
	Acute	**Clostridium Difficile - infection rate (per 100,000 bed days)**	Monthly	**0**	**0**	**38.1**		**26.74**	**13.06**				**13.06**	**0**	0	**0**	**37.88**	**0**		Source of methodology is DoH website Cdiff annual data report
	Mental Health	**Admissions to adult facilities of patients who are under 16 years**	Monthly	**0**	**0**	**0**		**0**	**0**				**1**	**0**	0	**0**	**0**	**0**		Methodology: number of children and young persons under 16 who are admitted to adult wards
EFFECTIVE	Mental Health	**Care Programme Approach (CPA) follow up - proportion of discharges from hospital followed up within 7 days**	Monthly	*National data published in quarterly periods*				**94.6%**	*Not due*						1					Methodology: proportion of discharges from general psych wards followed up within 7 days (including MHSOP) Awaiting publication of quarterly national data
	Mental Health	**% clients in employment (two months in arrears)**	Monthly					**0.0%**	*Not due*						0	**0.0%**				Methodology: percentage of people aged 18 to 69 period in contact with mental health services in employment Latest data is for March 2019 Low performance is linked to a technical submission issue and is not reflective of practice. Work continues with NHS Digital to resolve the reported performance
	Mental Health	**% clients in settled accommodation (two months in arrears)**	Monthly					**37.0%**	*Not due*						0	**35.0%**				Methodology: percentage of people aged 18 to 69 in contact with mental health services in settled accommodation Latest data is for March 2019
CARING	All	**Written complaints - rate**	Quarterly	**67.4%**	**80.0%**	**66.7%**		**68.2%**	**70.2%**				**70.2%**	**80.0%**	0	**58.3%**	**100.0%**	**71.4%**		Methodology: count of written complaints/ count of total complaints
	Acute	**Mixed sex accommodation breaches (sleep breaches only)** *National methodology aligned to NHS England guidance*	Monthly	**0**	**0**	**0**		**0**	**0**				**0**	**0**	0	**0**	**0**	**0**		Methodology: The number of breaches of mixed-sex accommodation (MSA) sleeping accommodation
	All	**Staff Friends and Family Test % recommended - care**	Quarterly												0					
	Acute	**Inpatient scores from Friends & Family Test - % positive**	Monthly	**96.7%**	**96.4%**	**95.8%**									0	**80.0%**	**96.7%**	**100.0%**		Methodology: count of those categorised as extremely likely or likely to recommend/ count of all responders
	Community	**Community scores from Friends & Family Test - % positive**	Monthly	**98.2%**	**97.6%**	**98.3%**									0	**-**	**97.9%**	**99.3%**		Methodology: count of those categorised as extremely likely or likely to recommend/ count of all responders
	Mental Health	**Mental Health scores from Friends & Family Test - % positive**	Monthly	**92.3%**	**91.0%**	**97.1%**									0	**100.0%**	**95.7%**	**97.6%**		Methodology: count of those categorised as extremely likely or likely to recommend/ count of all responders

Identified Triggers	1

NB: The NHSI Single Oversight Framework has no specified target for the Quality of Care Monitoring Metrics

NHS Improvement Financial and Use of Resources Metrics (2019/20 M3)

Area	Weighting	Metric	Definition	Scoring				YTD Score/ weighted score		F/OT Score/ weighted score	
				1	2	3	4				
				Year to Date (YTD)		Forecast/ Outturn (F/OT)					
Financial sustainability	0.2	Capital servicing capacity	Degree to which provider's generated income covers its financial obligations	>=2.5x	1.75 - 2.5x	1.25 - 1.75x	<1.25x	2	0.4	2	0.4
				2.1		2.3					
	0.2	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>=0	(7) - 0	(14) - (7)	<(14)	1	0.2	1	0.2
				9.0		4.8					
Financial efficiency	0.2	Income and expenditure (I&E) margin	I&E surplus or deficit / total revenue	>=1%	0-1%	(1) - 0%	<=(1%)	2	0.4	2	0.4
				0.24%		0.77%					
Financial controls	0.2	Distance from financial plan	Year-to-date actual I&E margin (surplus/deficit) in comparison to year-to-date plan I&E margin (surplus/deficit) on a control basis	>=0%	(1)-0%	(2) - (1%)	<=(2)%	1	0.2	2	0.4
				0.00%		-0.20%					
	0.2	Agency spend	Distance from provider's cap	<=0%	0% - 25%	25 - 50%	>50%	2	0.4	2	0.4
				24%		21%					

	YTD		F/OT
FINANCE SCORE:	**2**		**2**

Comments:
Under the Single Oversight Framework (SOF), NHS Improvement use these financial metrics to assess financial performance by:
• scoring providers 1 (best) to 4 against each metric
• averaging individual providers' scores across all the metrics to derive a use of resources score for the provider.

Note: Where providers have a score of 4 or 3 in the 'financial and use of resources' theme, it will identify a potential support need, as will providers scoring a 4 (i.e. significant under performance) against any of the individual metrics. Providers in financial special measures will score a 4 on this theme.

NHS Improvement Operational Performance

	NHSI Sector	Indicator	Target	NHSI Monitoring Frequency	Monthly Performance: Reporting Period (rolling three months) Apr-19	May-19	Jun-19	Sparkline Feb 19 - to date	Quarterly Performance: 2018/19 Q4	2019/20 Q1	Q2	Q3	Q4	Annual Performance: 2018/19 Year End Total	2019/20 Year to Date Total	Trigger (two consecutive monthly breaches)	Current month directorate performance: Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children	Comments
OPERATIONAL PERFORMANCE METRICS	Acute & Specialist	**Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway**	>=92%	Monthly	**98.0%**	**97.7%**	**94.9%**		**96.5%**	**96.8%**				**96.8%**	**97.8%**	0	**94.9%**			Methodology: count of the number of patients whose clock period is less than 18 weeks during the calendar months of the return/ count of number of patients whose clock has not stopped during the calendar months of the return
	Acute & Specialist	**Maximum 6-week wait for diagnostic procedures - patients on an incomplete pathway**	>=99%	Monthly	**100.0%**	**100.0%**	**100.0%**		**100.0%**	**100.0%**				**100.0%**	**100.0%**	0			**100.0%**	Methodology: proportion of patients referred for diagnostic tests who have been waiting for less than six weeks
	Mental Health	**People with a first episode of psychosis begin treatment with a NICE-recommended package of care within 2 weeks of referral (Unify2 and MHSDS) - patients on a completed pathway**	>=53%	Quarterly *(three month rolling)*	**81.0%**	**100.0%**	**66.7%**		**76.5%**	**83.3%**				**83.3%**	**88.9%**	0			**66.7%**	Methodology: percentage of people with a first episode of psychosis beginning treatment with a NICE-recommended care package within two weeks of referral
	Mental Health	**Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:**																		
		a) Inpatient Wards	>=90%	Annually												0				Methodology: the number of patients in the defined audit sample who have both: - a completed assessment for each of the cardio-metabolic parameters with results documented in the patient's electronic care record held by the secondary care provider. - a record of interventions offered where indicated, for patients who are identified as at risk as per the red zone of the Lester Tool. a) Internal mental health provider sample submitted to national audit provider for the CQUIN b) Early intervention: Internal mental health provider sample submitted to the Royal College of Psychiatrists CCQI EIP Network c) Mental health: Internal mental health provider sample submitted to national audit provider for the CQUIN
		b) Early Intervention in Psychosis Services	>=90%	Annually												0				
		c) Community Mental Health Services (people on CPA)	>=65%	Annually												0				
	Mental Health	**Inappropriate adult mental health out of area placements (OAPs)**	0 by March 2020	Monthly	**147**	**162**	**114**		**538**	**423**				**3462**	**423**	0				Methodology: Total number of bed days patients have spent out of area in period This measure should show a demonstrable reduction in total number of bed days patients have spent inappropriately out of area against rolling annual baseline, working towards elimination of inappropriate out of area placements by 2020/21
	Mental Health	**Data quality maturity index (DQMI) score (mental Health services only)**	>=95%	Quarterly	See DQMI exception report for details				*not yet available*							0				Methodology: MHSDS quarterly score in DQMI (ethnic category, general medical practice code (patient registration), NHS number, organisation code (code of commissioner), person stated gender code, postcode of usual address)

Identified Triggers	0

Leicestershire Partnership NHS Trust

NHS Improvement Organisational Health

	NHSI Sector	Indicator	NHSI Monitoring Frequency	Monthly Performance: Reporting Period (rolling three months) Apr-19	May-19	Jun-19	Current Year to Date Total	Quarterly Performance: 2018/19 Q4	2019/20 Q1	Q2	Q3	Q4	Annual Performance: 2018/19 Year End Total	2019/20 Year to Date Total	Trigger (two consecutive monthly breaches)	Current month directorate performance: Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children	Enabling Services	Comments
ORGANISATIONAL HEALTH	All	**Staff Sickness (month in arrears)**	Monthly	**4.6%**	**3.8%**			**4.3%**					**TBC**	**not due**	0	**4.4%**	**4.2%**	**4.1%**	**2.0%**	Methodology: number of days sickness reporting within the month/ number of days available within the month
	All	**Staff Turnover**	Monthly	**9.3%**	**9.1%**	**9.0%**			*not applicable to quarterly reporting*				**9.6%**		0	**9.3%**	**9.7%**	**8.7%**	**6.8%**	Methodology: number of leavers reported within the period / average of number of total employees at end of the month and total employees at end of the month for previous 12 month period
	All	**NHS Staff Survey** Key Finding 2. Staff satisfaction with the quality of work and care they are able to deliver	Annual	**3.69**					*not applicable to quarterly reporting*						0					2018 staff survey results Methodology: staff recommendation of the organisation as a place to work or receive treatment
	All	**Proportion of Temporary Staff**	Monthly	**11.7%**	**11.4%**	**12.7%**		**12.2%**	**12.7%**						0					Methodology: agency staff costs (as defined in measuring performance against the provider's cap) as a proportion of total staff costs. Calculated by dividing total agency spend over total pay bill.
	Acute	**CQC Inpatient/MH and Community Survey: Community**	Annual	**6.1**					*not applicable to quarterly reporting*						0					Survey results for 2018. Rating of Overall Experience out of 10.0, where 10.0 is the highest rating.
	Mental Health	**CQC Inpatient/MH and Community Survey: Mental Health**	Annual	**6.6**					*not applicable to quarterly reporting*						0					Survey results for 2018. Rating of Overall views of care and services out of 10.0, where 10.0 is the highest rating.

Identified Triggers	0

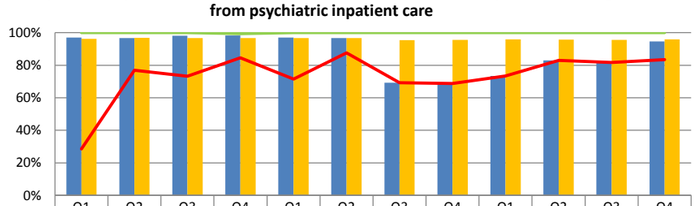
NB: The NHSI Single Oversight Framework has no specified target for the Quality of Care Monitoring Metrics.

Leicestershire Partnership NHS Trust

LPT Benchmarking Information

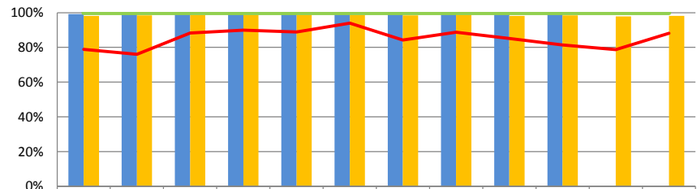
Description	Benchmarking comparisons are taken from NHS England's official statistics publications. Each graph show the Leicestershire Partnership NHS Trust performance against the highest and lowest performing trusts in that period **IMPORTANT**: National data conforms to strict data quality requirements and is a reflection of performance at specific points in time. For this reason, the nationally reported performance may differ slightly from the Trust's locally reported performance. The aim is to reduce these differences by improving timely and accurate data entry onto the Trust's clinical systems.

Proportion of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care



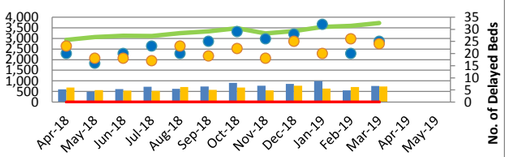
	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
LPT	96.9%	96.6%	98.1%	98.3%	96.9%	96.7%	69.2%	68.8%	73.4%	83.0%	81.6%	94.6%
England	96.2%	96.8%	96.7%	96.7%	96.7%	96.7%	95.4%	95.5%	95.8%	95.7%	95.5%	95.8%
Highest	100.0%	100.0%	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Lowest	28.6%	76.9%	73.3%	84.6%	71.4%	87.5%	69.2%	68.8%	73.4%	83.0%	81.6%	83.5%

Proportion of admissions to acute wards that were gate kept by the CRHT teams



	Q1 2016/17	Q2 2016/17	Q3 2016/17	Q4 2016/17	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
LPT	99.2%	100.0%	99.6%	100.0%	99.6%	99.2%	100.0%	99.5%	99.6%	100.0%	0.0%	0.0%
England	98.1%	98.4%	98.7%	98.8%	98.7%	98.6%	98.5%	98.7%	98.1%	98.4%	97.8%	98.1%
Highest	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Lowest	78.9%	76.0%	88.3%	90.0%	88.9%	94.0%	84.3%	88.7%	85.1%	81.4%	78.8%	88.2%

Delayed Transfer of Care (DToC)



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
LPT Days Delayed	600	490	613	719	631	737	912	767	862	994	548	762		
UHL Days Delayed	682	563	544	527	711	574	689	554	768	632	717	739		
Highest Days Delayed	2927	3059	3130	3106	3244	3326	3480	3231	3345	3542	3588	3718		
Lowest Days Delayed	0	0	0	0	0	0	0	0	0	0	0	0		
LPT DToC Beds	20	16	20	23	20	25	29	26	28	32	20	25		
UHL DToC Beds	23	18	18	17	23	19	22	18	25	20	26	24		

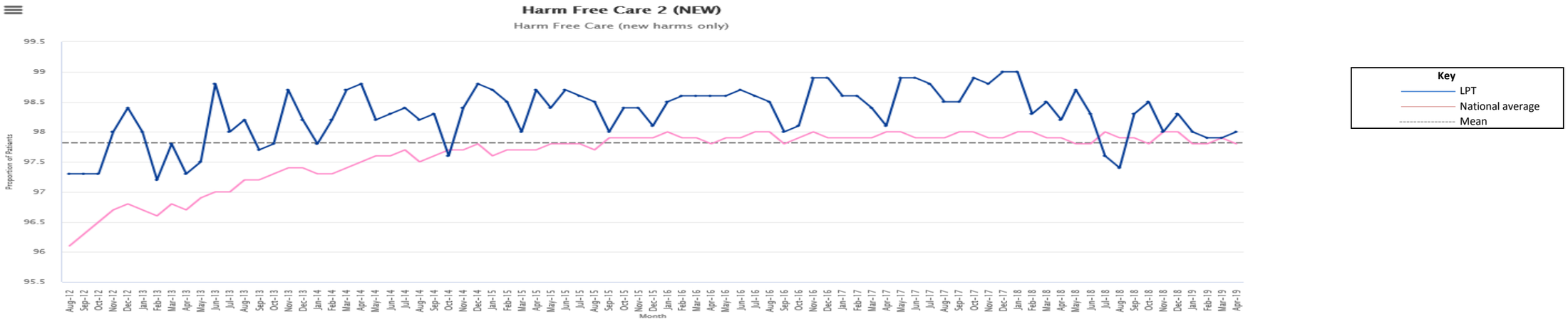
Comments:

Gatekeeping: The LPT national gatekeeping figures for 2017/18 Q2 reflects the inclusion of one elective patient; and 2017/18 Q2 reflects one excluded A&E patient. NHS Digital have advised they are not accepting amendments to national data for this financial year. The Trust is not reporting national gatekeeping data for 2018/19 Q3 and Q4

CPA 7 Day: As a result of data quality work undertaken in 2018/19 quarter one and quarter three, we are awaiting confirmation from NHS Digital to allow us to resubmit the national CPA seven day 2018/19 information, which will reflect in increased performance for the period

LPT Safety Thermometer

Description	The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing 'harm free' care. The data shown relates to prevelance of harm (VTEs, falls, pressure ulcers, UTIs), collected on a specific day; and is not directly comparable to the NRLS harm free rates, which is representative of all harms. Safety Thermometer data is not intended for benchmarking against other organisations.

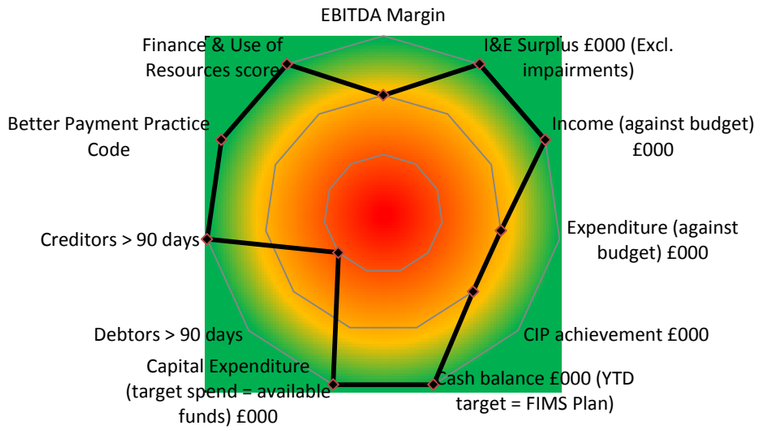


Comments:

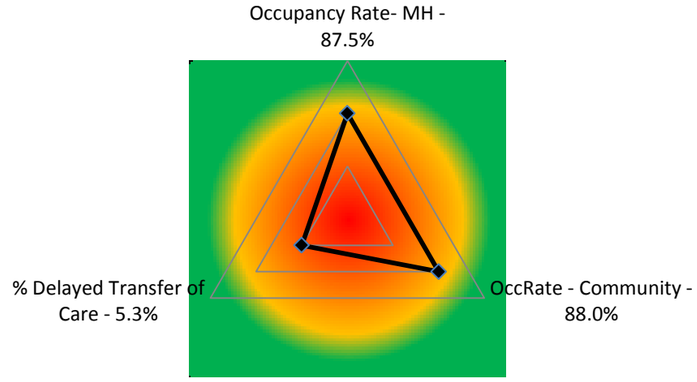
Leicestershire Partnership NHS Trust

Committee Key Performance Measures

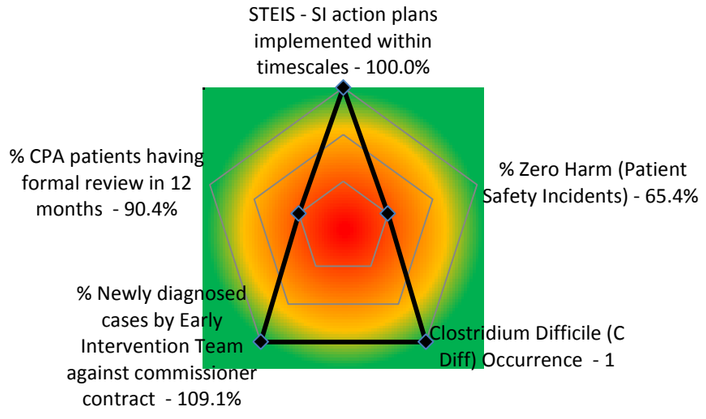
Finance and Performance Committee (Finance)



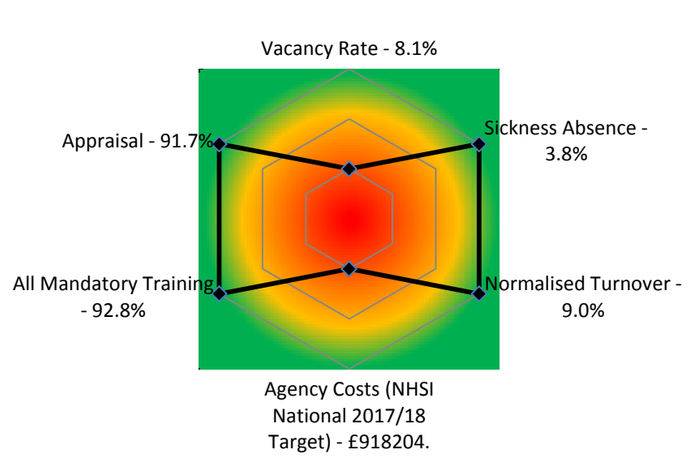
Finance and Performance Committee (Performance)



Quality and Assurance Committee



Strategic Workforce Group



Key: 3= Green achieved target, 2= Amber Within 5% of Target, 1= Red Failing Target

Leicestershire Partnership NHS Trust

Quality of Care

		Trust Performance													Current month directorate performance					
		Source	Reporting Frequency	Quality Indicator	Reporting Period (rolling three months)			Sparkline Feb 19 - Apr 19	2018/19	2019/20				Year to Date Position	Year End Target	Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children	Enabling Services	3rd party/ External	Comments
					Apr-19	May-19	Jun-19		Q4	Q1	Q2	Q3	Q4								
SAFE	Total incidents reported (including near misses) taken from Safeguard	TRUST	Monthly		1431	1616	1490		4316	4537				4537		524	726	151	13	76	
	- of which Total Serious Incidents (SIs)	COM	Monthly		3	12	13		14	28				28		3	9	1	0	0	
	STEIS - SI action plans implemented within timescales	COM	Monthly	=100%	100.0%	100.0%	100.0%		96.3%	100.0%				100.0%	=100%	100.0%	100.0%	-			
	Total patient safety incidents reported (including near misses) (NRLS)	TRUST	Monthly		851	967	948		2753	2766				2766		378	454	111	5		
	- of which % Zero Harm (Patient Safety Incidents) (refreshed each month)	TRUST	Monthly	>=70%	59.9%	58.0%	65.4%		65.3%	61.2%				61.2%	>=70%	78.6%	49.3%	86.5%			
	MRSA Bacteraemia cases - Community	COM	Monthly		0	0	0		0	0				0	0	0	0	0			
	Clostridium Difficile (C Diff) Occurrence	COM	Monthly	<=12 (per annum)	0	0	1		2	1				1	12	0	1	0			
	NHSE/ NHSI Patient Safety Alerts Outstanding	NHSI	Monthly	=0	0	0	0		0	0				0	0	0	0	0			
CARING	Total compliments received	TRUST	Monthly		93	100	105		243	298				298		23	70	12	0		
	Total complaints received	TRUST	Monthly		43	20	21		107	84				84		10	7	3	0		
	Complaints acknowledged within 3 working days	TRUST	Monthly	=100%	97.7%	100.0%	100.0%		100.0%	98.8%				98.8%	=100%	100.0%	100.0%	100.0%			
EFFECTIVE	Meeting commitment to serve new psychosis cases by early intervention teams: % newly diagnosed cases against commissioner contract	COM	Monthly	>=95%	163.6%	136.4%	109.1%		145.5%	136.4%				136.4%	>=95%			109.1%			
	Care Programme Approach (CPA) patients: % receiving follow-up contact within seven days of discharge (in arrears)																				
	- Only patients identified as being discharged on CPA	TRUST	Monthly	>=95%	96.3%	95.1%			96.8%	*not due*				93.6%	>=95%	92.6%	100.0%	100.0%			
	- All patients discharged from a psychiatric inpatient unit *(national methodology aligned to Quality Account)*	TRUST	Monthly	>=95%	92.7%	92.8%			94.6%	*not due*				92.7%	>=95%	91.8%	100.0%	50.0%			
	Care programme approach (CPA) patients: % having formal review within 12 months	TRUST	Monthly	>=95%	89.6%	89.7%	90.4%							90.4%	>=95%	90.8%	95.2%	79.2%			
	Access to Healthcare for All		Monthly	=4	4	4	4		4	4				4	4						

Comments and Actions:
The pressure ulcer indicator has been removed from the IQPR due to a change in National guidance from NHSE around ceasing to describe as Avoidable and Unavoidable. The Trusts intends to reinstate a pressure ulcer measure following recommendation at the Trust Patient Safety Improvement Group of a new indicator definition.

Incident Reporting: The approach taken by LPT in monitoring incident related KPIs is to encourage a reporting culture in line with the National Patient Safety Agency (NPSA) and the National Reporting and Learning System (NRLS) reports into incident reporting rates.

Total Serious Incidents (SIs): Previous months' figures have been updated and amended after a review to reflect accurate position.

STEIS - SI action plans implemented within timescales: Previous months' figures have been updated and amended after a review to reflect accurate position.

Total patient safety incidents reported (including near misses): Previous month's figures have been updated to reflect accurate position.

MRSA Bacteraemia - Community: Cases are not validated until 15th of each month following lock down on the national system MESS. This process could result in current month figures changing. Year end target of zero (0) is based on the Commissioner target.

Clostridium Difficile (C Diff) Occurrence: The trajectory for 2019-20 for Clostridium difficile is twelve (12).

Compliments: All figures received are subject to continual validation and any changes will be reported in the next IQPR.

Complaints: All figures received are subject to continual validation and any changes following data validation will be reported in the next IQPR.

Complaints Acknowledged within 3 working days: 1 acknowledgement letter did not meet the 3 working day target for April 2019. The complaint was for Community Services and was very complex with issues from 2013. Due to this the acknowledgement was also used to advise some of the issues were out of time to be investigated and the letter therefore took longer to compose due to needing to tailor the information.

Meeting commitment to serve new psychosis cases by early intervention teams - % newly diagnosed cases against commissioner contract: The small numbers involved in the denominator for the calculation of this indicator can equate to significant swings in performance month on month. The figures are refreshed each month to ensure an accurate position is monitored and accounts for data entry after IQPR production cut off. The service enters data by the 15th of the month therefore performance maybe underinflated due to the early deadline set for the IQPR.
109.1% for the month of June 2019 is the result of 12 newly diagnosed cases against the provisional monthly commissioner target of 11. The service is dependent on the number of referrals received and the appropriateness of the referral.

Care Programme Approach (CPA) patients: % receiving follow-up contact within seven days of discharge (All patients discharged from a psychiatric inpatient unit): The Trust has undertaken a deep dive data quality review on CPA 7 day data. The outcome is an improvement in 2018/19 Q1 performance in line with the Q2 performance of approximately 80%. We are awaiting confirmation from NHS Digital to resubmit this information nationally.

Care programme approach (CPA) patients: % having formal review within 12 months: Please refer to CPA 12 Month exception report for further details.

National CQUINS 2018-19

CQUIN No	Description	Services	Funding Available	Q1 Target	Current month	Q1	Q2	Q3	Q4	Comment on Red & Amber Ratings
1a	Introduction of health & wellbeing of NHS staff		£182,801						0.0%	
1b	Healthy food for NHS staff, visitors and patients		£182,801						100.0%	
1c	Improving the uptake of flu vaccinations for frontline clinical staff		£182,801						25.0%	
3a	Improving Physical healthcare - SMI		£438,722			100.0%			100.0%	
3b	Improving Physical healthcare collaboration with GPs		£109,680			100.0%	100.0%	100.0%	100.0%	
4	Improving services for people with MH at A&E		£346,359			100.0%	100.0%	100.0%	100.0%	
5	Transitions out of Children and Young People's MHS		£346,359			100.0%	27.5%		32.5%	Partial payments achieved for discharge readiness (12.5%) and post transition goal (15%). 0% achived for planning for transition
9 a-e	Preventing ill health by risky behaviours - Smoking & Alcohol		£548,402			30.0%	67.0%	75.0%	90.0%	Q1 - 30% partiel payment achieved Q2 - 67% achieved Q3 - Achieved 100% for 9a,b,c,d, and no payment for 9e
10	Improving the assessment of wounds		£346,359				100.0%		100.0%	
11	Personalised care and support planning		£346,359						100.0%	

Key: Blue = Forecast/unconfirmed; **Green** = Fully achieved; **Amber** = Partially achieved; **Red** = Not achieved

Commentary:
All payments for quarter 1 have been confirmed except for CQUINs 9a-e. Quarter 2 payments have been confirmed except for CQUINs 5 and 9a-e.

National CCG CQUINS 2019-20

CQUIN No	Description	Min Threshold	Max Threshold		Q1	Q2	Q3	Q4	Commentary
CCG 2	Staff Flu Vaccinations	60%	80%				50.0%	60.0%	Forecasted minimum threshold of 60%. By achieving the minimum threshold the payment will be £0
CCG 3a	Alcohol & Tobacco- Screening	40%	80%			50.0%	80.0%	80.0%	2019/20 Q1 requirements are to provide a position statement. New systems are in place to capture data and training is being provided.
CCG 3b	Tobacco Brief Advice	50%	90%			50.0%	75.0%	90.0%	
CCG 3c	Alcohol Brief Advice	50%	90%			50.0%	75.0%	90.0%	
CCG 4	72 Hour follow up post discharge	50%	80%				71.0%	80.0%	Not due to report until 2019/20 Q3. Early indications show LPT are meeting the minumum threshold.
CCG 7	Three high impact actions to prevent hospital falls	25%	80%			30.0%	50.0%	80.0%	2019/20 Q1 position statement required. Only applicable to community hospitals. Templates are being introduced to enable data capture.
CCG 9	Stroke 6 Months reviews	35%	55%		55.0%	55.0%	55.0%	55.0%	SSNAP is a new way of reporting in LPT. Service is embracing the new system and CQUIN; and are forecasting to achieve maximum thresholds.

NHSE CQUINS 2019-20

CQUIN No	Description	Min Threshold	Max Threshold		Q1	Q2	Q3	Q4	Commentary
PSS4	Health weight in adult secure MH services	N/A	N/A		100.0%	100.0%	100.0%	100.0%	The Phoenix Ward staff are establishing new programmes including physical activity and healthy eating to help inpatients to maintain a healthy weight. The level of staff involvement and engagement with the Clinical Reference Groups work streams support the likelihood of achieving the milestones for this NHSE CQUIN.
PSS5	Addressing CAMHS T4 staff training Needs	N/A	N/A		100.0%	100.0%	100.0%	100.0%	

Key: Blue = Forecast/unconfirmed; **Green** = Fully achieved; **Amber** = Partially achieved; **Red** = Not achieved

Commentary:
These forecasts are based on quality performance of the CQUINS, rather than achievement forecasts and payment calculations.

Leicestershire Partnership NHS Trust

Operational Performance

	Trust Performance														Current month directorate performance		
	Source	Reporting Frequency	Monthly target	Reporting Period (rolling three months)			Sparkline Feb 19 - Apr 19	2018/19	2019/20				Year to Date Position	Year End Target	Adult Mental Health/ Learning Disabilities	Community Health	Families, Young People & Children
				Apr-19	May-19	Jun-19		Q4	Q1	Q2	Q3	Q4					
Occupancy Rate - Mental Health Beds	TRUST	Monthly	<=85%	87.2%	88.6%	87.5%		83.4%	87.7%				87.7%	<=85%	90.2%	82.6%	71.7%
Occupancy Rate - Community	TRUST	Monthly	>=93%	85.7%	90.1%	88.0%		89.4%	87.8%				87.8%	>=93%		88.0%	
% Delayed Transfer of Care (DTOC)	DOH	Monthly	<=3.5%	4.9%	4.3%	5.3%		4.7%	4.8%				4.8%	<=3.5%	5.8%	5.3%	Reported only by exception
Patients admitted to inpatient services who are given access to Crisis Resolution/ Home Treatment teams in line with best practice standards - % patients gatekept *(national methodology aligned to Quality Account)*	TRUST	Monthly	>=95%	69.5%	82.8%	100.0%		*not available*	84.5%				84.5%	>=95%	100.0%		
Total number of Home Treatment episodes carried out by Crisis Resolution team year to date	COM	Monthly	>=145	221	286	230		743	737				737	1740	230		

Comments and Actions:

Mental Health Bed Occupancy Rate: The Trust figure does not consider that certain services have different targets, e.g., MHSOP has a 90% target; Specialist Services represents Eating Disorders with a 80% target and EXCLUDES patients on leave; CAMHS INCLUDES patients on leave; Adult represents Adult Acute only and LD represents the Agnes Unit with a target of 95% for the four new Intensive Support beds but 85% otherwise. There are no service targets set therefore they are based on the Trust target of 85%. The RAG ratings are:
Green: Actual > Target AND Actual < Target + 5%; Amber: Actual >= Target + 5% AND Actual <= Target + 10% OR Actual <= Target AND Actual >= Target - 5%; Red: Actual > Target + 10% OR Actual < Target - 5%

% Delayed Patients (DToC) - Please see 'DETAILED EXCEPTION REPORT - % Delayed Transfer of Care (DToC)' for detailed commentary.

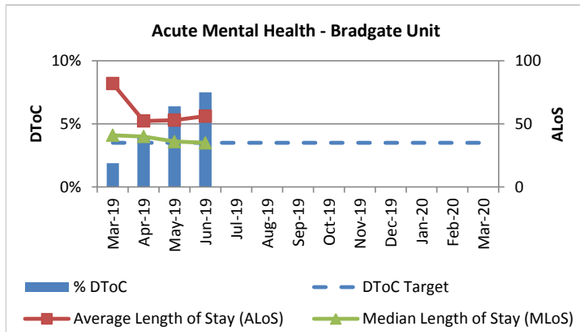
Patients admitted to inpatient services who are given access to Crisis Resolution/ Home Treatment teams in line with best practice standards: This item is no lomnger subject to significant data quality concerns and national report has recommenced from 1st April 2019.

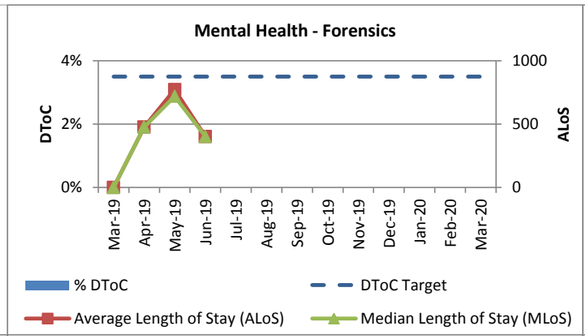
Total number of Home Treatment episodes carried out by Crisis Resolution team year to date: Year to date performance is currently 169.4% which equates to 737 episodes against a pro-rata target of 435.

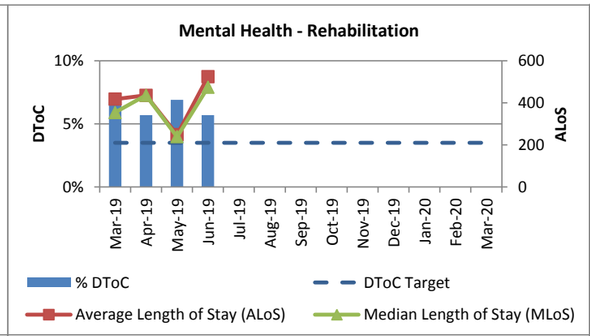
Leicestershire Partnership NHS
NHS Trust

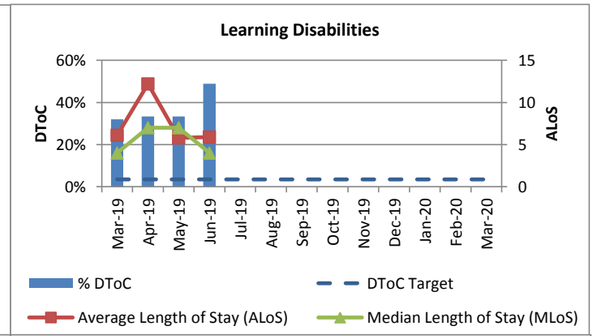
Inpatient Performance

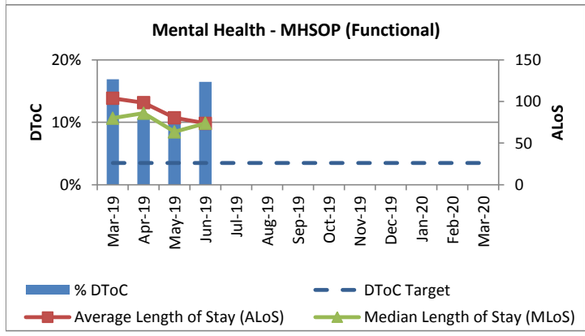
The Better Care Fund (BCF) planning guidance requires cross system organisations to work together to achieve the local, agreed ambition for delayed transfer of care (DToC) to not equate to more than 3.5% of hospital beds. DToC rates are aligned to national Unify submissions.

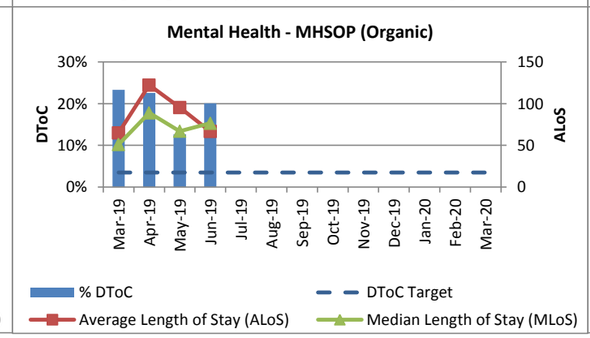


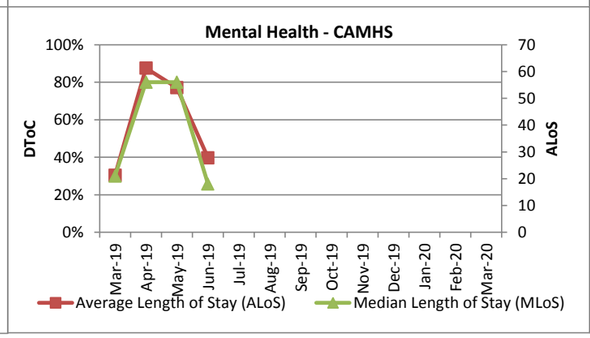


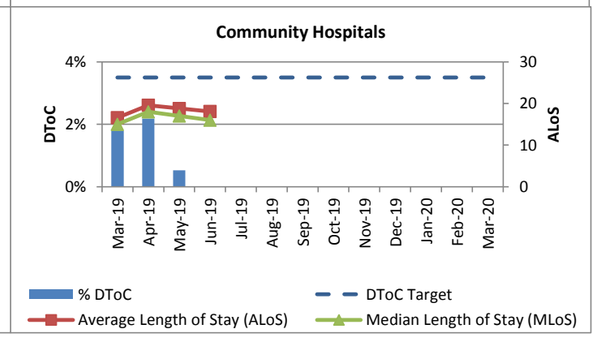












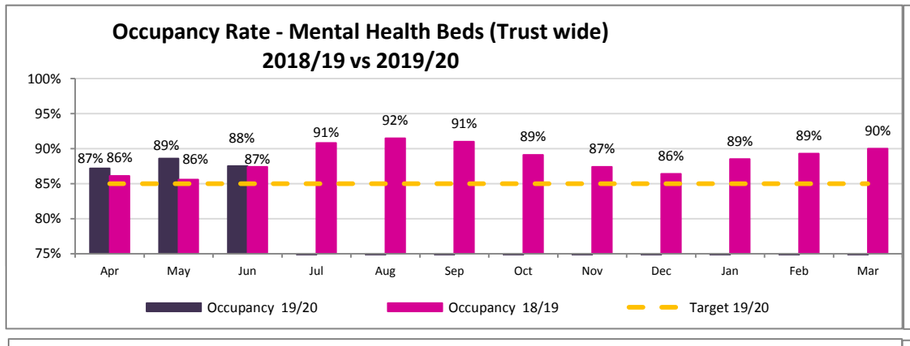
Comments and Actions

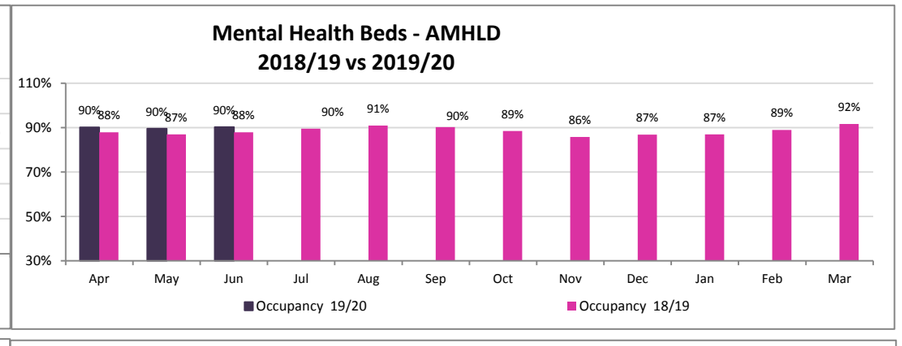
Delayed Transfer of Care (DToC)
The calculation methodology for DToC is*:
Numerator: the number of non-acute patients (aged 18 and over on admission) per day under consultant and non-consultant-led care whose transfer of care was delayed. For example, one patient delayed for five days counts as five.
Denominator: the total number of occupied bed days (consultant-led and non-consultant-led).
Delayed transfers of care attributable to social are included.

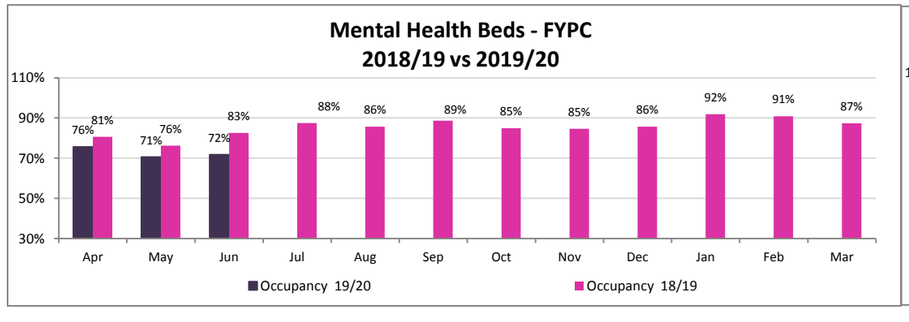
Actions to improve DToC across the Leicester, Leicestershire and Rutland system include:
- implementing an integrated discharge team and trusted assessor model which will be extended to community hospitals and mental health wards during 2017/18 following a pilot at the acute trust;
- improvements in pathways into community hospitals - for which an audit of step down beds will be used for clinical engagement;
- improvements to patient/ family choice policies and information across hospital sites, this includes clear policies around 'choice' with an agreed training and communications plan.

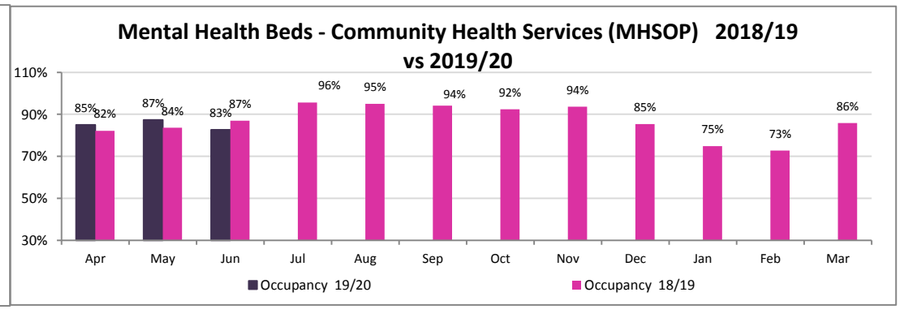
Length of Stay (LoS)
The length of stay displayed is the national operating framework definition, which takes data from Hospital Episode Statistics (HES) and includes ALL services and lengths. LoS is measured from admission to discharge, therefore a ward with no discharges in the period will not have a LoS calculated. All previous month's figures are updated each month to allow for late entry of data.
IMPORTANT: There are no patients excluded from this calculation and this KPI is not comparable with the LoS CQUIN or national benchmarking which is calculated using different exclusion parameters.

Mental Health Bed Occupancy Rate (%)









Responsible Lead: Directors of Services
Indicator Source: COM/DOH Operating Framework

Comments and Actions:

CAMHS (FYPC) - On leave beds counted as admitted

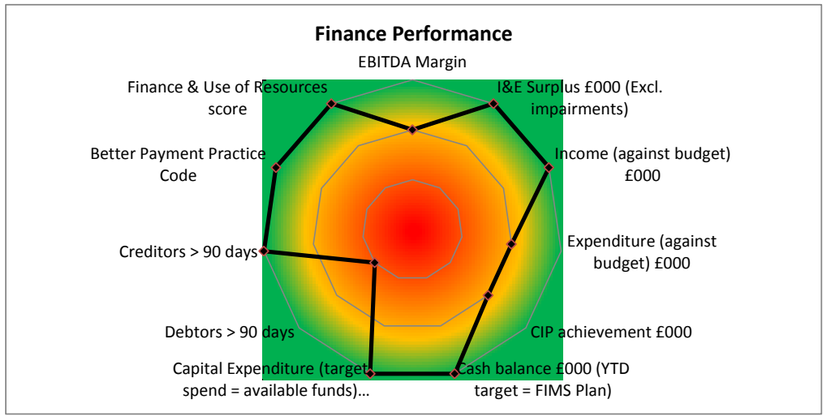
LD - On leave beds counted as admitted
This may result in occupancy rates above 100%

Leicestershire Partnership NHS Trust

Performance - Finance June 2019 (Month 3)

Comments and Actions:

- **Position:** As at 2019/20 month 3, the Trust is achieving the planned year to date surplus of £168k. A year end surplus of £2.1m is forecast based on the receipt of Sustainability and Transformation funding of £2.1m.
- **EBITDA:** The EBITDA margin as at 2019/20 month 3 is 5.4%. 96.2% of the 2019/20 year to date CIP target was achieved as at June 2019.
- **Cash Balance:** The cash balance at the end of 2019/20 month 3 is £7.5m. Planned cash for the month end was £7.1m. Debtors over 90 days are 16%. Creditors over 90 days are 4.5%.



FINANCE KPIs	TOTAL TRUST				Services											
					AMHLD		COMM SERVICES		FYPC		ENABLING		RESERVES		HOSTED	
	YTD Target (Budget)	YTD Actual	Year end target	Year end forecast	YTD Target	YTD Actual	YTD Target	YTD Actual	YTD Target	YTD Actual	YTD Target	YTD Actual	YTD Target	YTD Actual	YTD Target	YTD Actual
EBITDA Margin	5.5%	5.4%	6.0%	6.0%												
I&E Surplus £000 (Excl. impairments)	168	168	2,648	2,148												
Income (against budget) £000	70,149	70,797	278,567	278,930												
Expenditure (against budget) £000	69,981	70,629	275,919	276,782												
CIP achievement £000	655	630	4,047	2,647	107	151	200	200	147	147	139	121	0	0	63	12
Cash balance £000 (YTD target = FIMS Plan)	7,133	7,477	8,000	8,000												
Capital Expenditure (target spend = available funds) £000	993	993	13,957	13,957												
Debtors > 90 days	5.0%	16.0%	5.0%	5.0%												
Creditors > 90 days	5.0%	4.5%	5.0%	5.0%												
Better Payment Practice Code	95.0%	96.6%	95.0%	95.0%	95.0%	94.4%	95.0%	94.7%	95.0%	97.0%	95.0%	96.9%	100.0%	100.0%	95.0%	98.0%

FINANCE & USE OF RESOURCES SCORE			SCORE	
Risk Assessment Framework	Annual target	Achieved	Annual target	Updated annual forecast
Combined Score	2	2	2	2

RAG rules
Green: On target/exceeding target
Amber: Adverse variance - within 5% target
Red: Adverse variance - distance from target greater than 5%

Human Resources - Workforce Performance

		Trust Performance													Current month directorate performance				
		Source	Reporting Frequency	Monthly target	Reporting Period (rolling three months)			Sparkline Feb 19-Apr 19	2019/20				Year to Date Position	Year End Target	Adult Mental Health/ Learning Disabilities	Community Health	Enabling Services	Families, Young People & Children	Hosted Services
					Apr-19	May-19	Jun-19		Q1	Q2	Q3	Q4							
Workforce Profile	Number of WTE Employed	TRUST	Monthly		4630.40	4648.42	4638.03		4638.03						1143.1	1737.8	466.2	1068.5	222.4
	Substantive Staff Headcount	TRUST	Monthly		5320	5338	5331		5331						1273	2015	514	1296	233
	Bank Only Headcount	TRUST	Monthly		1054	993	1047		1047										
	% Vacancy Rate	TRUST	Monthly	G: <=7% R: >10%	8.1%	8.1%	8.1%		8.1%					G: <=7% R: >10%	14.0%	7.9%	6.8%	3.1%	0%
	% Staff From a BME Background	TRUST	Quarterly	>=20%	20.2%	22.3%	22.1%		22.1%					>=20%					
	% of Males Employed	TRUST	Quarterly		17.1%	16.9%	17.0%		17.0%										
	% Staff Aged 16-29 Years	TRUST	Quarterly	>=12%	12.6%	12.4%	12.5%		12.5%					>=12%					
Sickness Absence (one month in arrears)	% of Sickness Absence (1 month in arrears)	TRUST	Monthly	<=4.5%	4.6%	3.8%			0.0%					<=4.5%	4.4%	4.2%	2.0%	4.1%	1.4%
	WTE Days Lost to Sickness (1 month in arrears)	TRUST	Monthly		6385.4	5575.2			11961				11960.51		1565	2263	288	1359	100
	% Short Term Sickness (1 month in arrears)	TRUST	Monthly		1.8%	1.4%			0.0%						1.7%	1.6%	0.9%	1.4%	1.0%
	% Long Term Sickness (1 month in arrears)	TRUST	Monthly		2.8%	2.4%			0.0%						2.8%	2.6%	1.1%	2.7%	0.4%
	Cost of Sickness (£) (1 month in arrears)	TRUST	Monthly		£ 562,639	£ 502,099			£ 1,064,738				£ 1,064,738		£137,864	£187,447	£28,069	£136,519	£12,201
Turnover	% Normalised Workforce Turnover (Rolling previous 12 months)	TRUST	Monthly	G: <=10% R: >12%	9.3%	9.1%	9.0%		9.0%					G: <=10% R: >12%	9.3%	9.7%	6.8%	8.7%	7.6%
	% Total Workforce Turnover (Rolling previous 12 months)	TRUST	Monthly	G: <=10% R: >12%	9.6%	9.4%	9.3%		9.3%					G: <=10% R: >12%	9.3%	10.2%	7.0%	8.7%	9.0%
	Executive Team Turnover	TRUST	Monthly		12.8%	13.2%	13.2%		13.2%										
	Starters minus Leavers (headcount)	TRUST	Monthly		30	21	-8		14				43		1	-3	1	-6	-1
	Stability Index No. of employees with one or more years' service now/ No. of employees employed one year ago x 100	TRUST	Monthly	G: >90% R: <85%	90.1%	90.6%	91.3%		90.7%					G: >90% R: <85%	92.1%	90.1%	95.1%	90.9%	95.2%
Temporary Staffing	Bank Costs	TRUST	Monthly		£ 1,232,377	£ 1,261,511	£ 1,319,753		£ 3,813,641				£ 3,813,641						
	Agency Costs (NHSI National 2017/18 Target)	TRUST	Monthly	<=£7.7m (p/a)	£ 839,337	£ 765,766	£ 918,204		£ 2,523,307				£ 2,523,307	<=£7.7m					
	Agency Costs (LPT Internal Target)	TRUST	Monthly	<=£9.5m	£ 839,337	£ 765,766	£ 918,204		£ 2,523,307				£ 2,523,307	<=£9m					
	Temporary Staffing Spend as a % of Total Paybill (Inc. bank, agency and additional hours worked)	TRUST	Monthly		11.7%	11.4%	12.7%		12.7%										
	No of Off Framework Agency Usages	TRUST	Monthly		80	155	179		414				414						
	No of Breaches to Agency Price Cap	TRUST	Monthly		523	462	546		1531				1531						
	Agency volume (number of shifts filled by agency)	TRUST	Monthly		2426	2535	2746		7707				7707						
	Roster approval period (weeks)	TRUST	Monthly	>6	5.05	5.28	5.26		5.20				15.59						
	% Split of Substantive to Bank to Agency Staff (Nurses band 2-6, inpatient areas only, taken from Safer Staffing portal)	TRUST	Monthly		69.1%, 27.4%, 3.5%	67.1%, 28.9%, 4.0%	66.8%, 29.6%, 3.6%												
	% Split of Qualified to Unqualified Staff (Nurses band 2-6, inpatient areas only, taken from Safer Staffing portal)	TRUST	Monthly		35.5%, 64.5%	36.5%, 63.5%	36.9%, 63.1%												
Organisational Change	Number of Staff Made Redundant	TRUST	Monthly		0	0	0		0				0		0	0	0	0	0
	Number of Staff on Pay Protection	TRUST	Monthly		23	30	30		28				30		6	13	4	7	0
Employee Relations	Number of open formal grievances	TRUST	Monthly		2	1	1		1						1	0	0	0	0
	Number of open bullying and harassment cases	TRUST	Monthly		1	1	2		1						0	1	0	1	0
	Number of open formal disciplinary cases	TRUST	Monthly		8	7	6		7						5	1	0	0	0
	Number of open employment tribunals	TRUST	Monthly		1	2	1		1						0	1	0	0	0
	Concerns raised to an external organisation	TRUST	Monthly		1	0	1		2				2		1	0	0	0	0
	Concerns raised in house	TRUST	Monthly		6	5	5		16				16		1	1	2	1	0
Employee Engagement	% Staff recommend LPT as a place to work	TRUST	Quarterly	>=57%	N/A	N/A	N/A		N/A					>=57%					
	% Staff happy with standard of care provided	TRUST	Quarterly	>=67%	N/A	N/A	N/A		N/A					>=67%					
	Pulse and Staff Survey Response Rate	TRUST	Quarterly	>=50%	N/A	N/A	N/A		N/A					>=50%					
Learning and Development Overview	% of Consultants with a completed annual appraisal	TRUST	Monthly	>=90%	97.0%	96.0%	96.0%		96.3%					>=90%	97%	100%		94%	
	% of Staff with a Completed Annual Appraisal	TRUST	Monthly	>=80%	92.3%	92.2%	91.7%		92.0%					>=80%	89.6%	93.3%	92.5%	91.4%	88.4%
	% All Mandatory Training Compliance for substantive staff	TRUST	Monthly	>=85%	92.7%	93.0%	92.8%		92.8%					>=85%	90.9%	93.4%	93.3%	94.1%	91.5%
	% All Mandatory Training Compliance for bank-only nursing staff	TRUST	Monthly	>=75%	78.6%	82.7%	81.8%		81.0%					>=75%					
	% of new starters who attended Trust Induction on their first day (excluding bank staff)	TRUST	Monthly	>=85%	100.0%	100.0%	100.0%		100.0%					>=85%					
	% of staff who have undertaken clinical supervision within the last 3 months	TRUST	Monthly		79.1%	81.7%	81.3%		80.7%						75.6%	84.7%	59.4%	81.9%	100.0%
Learning and Development (Detail for Substantive Staff)	% Core Mandatory Training Compliance	TRUST	Monthly	>=85%	95.2%	95.5%	95.4%		95.4%					>=85%	94.5%	96.3%	94.8%	96.0%	92.1%
	% Fire Safety training compliance	TRUST	Monthly	>=85%	89.4%	89.1%	88.1%		88.9%					>=85%	85.2%	88.8%	90.6%	89.9%	84.1%
	% of Information Governance training compliance	TRUST	Monthly	>=95%	90.9%	91.1%	90.6%		90.9%					>=95%	86.5%	92.1%	91.1%	91.4%	94.0%
	% Clinical Mandatory training compliance	TRUST	Monthly	>=85%	92.7%	92.9%	92.9%		92.8%					>=85%	91.3%	94.0%	78.7%	93.3%	75.0%
	% Mental Health Act training compliance	TRUST	Monthly	>=85%	79.6%	80.6%	82.4%		80.9%					>=85%	81.3%	86.8%	60.0%	83.2%	-
Declaration of Protected Characteristics	Declared Disability	TRUST	Monthly	>=85%	78.3%	78.4%	78.6%		78.4%					>=85%					
	Declared Sexual Orientation	TRUST	Monthly	>=85%	80.3%	80.4%	80.4%		80.4%					>=85%					
	Declared Religious Belief	TRUST	Monthly	>=85%	79.2%	79.3%	79.3%		79.2%					>=85%					

Comments and Actions:

*** Year to Date position: Indicators in arrears show year to date for 2018/19**

% Sickness Absence - see exception report

Agency Usage - see exception report
Vacancy Rate and Agency Costs for March 2019 will not be available until mid-April 2019, this is due to the financial year end

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - Clostridium Difficile (C Diff) Cases

Responsible Director	Anne Scott
Responsible Committee	QAC

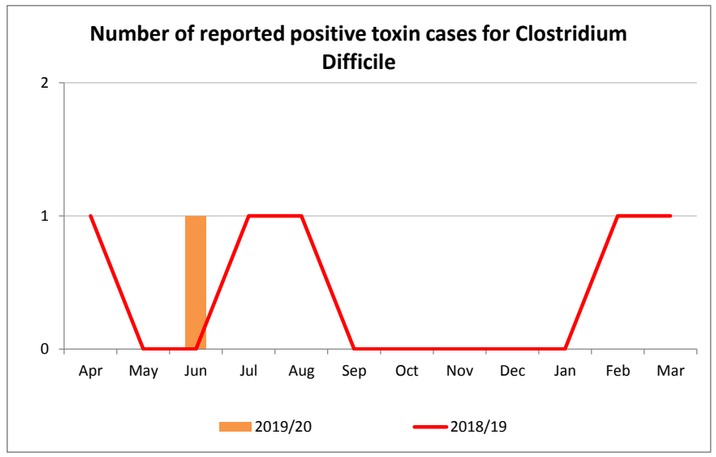
Responsible Services	All
KPI Reference ID	MSP.02

Risk Reference	
Risk Owner	

Risk Description:

Calculation Method	Count of the number of reported positive toxin cases for Clostridium Difficile each month

Clostridium Difficile (C Diff) Cases	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
2018/19	1	0	0	1	1	0	0	0	0	0	1	1	**5**
Wards	EC - Beechwood Ward	-	-	EC - Clarendon Ward	CV - Snibston Ward	-	-	-	-	-	BC - Langley Ward	H&B - North Ward	
2019/20	0	0	1										**1**
Wards	-	-	EC - Beechwood Ward										



Key: CV - Coalville Hospital
FP - Feilding Palmer Hospital
H&B - Hinckley and Bosworth Hospital
SL - St Luke's Community Hospital
EC - Evington Centre
LGH - Loughborough General Hospital
MMH - Melton Mowbray Hospital
BC - Bennion Centre

Comments and Actions:

The trajectory for 2019-20 for Clostridium Difficile is twelve (12).

There was one (1) reported Clostridium Difficile case for the month of June 2019 on Beechwood Ward, Evington Centre.

The total Clostridium Difficile cases for this year is one (1).

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - CPA 7 Day Follow-up

Responsible Director	Helen Thompson, Rachel Bilsborough
Responsible Committee	QAC

Responsible Services	AMH, CHS
KPI Reference ID	

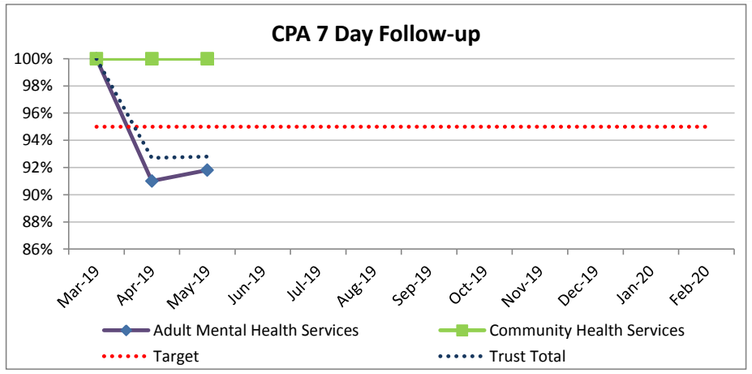
Risk Reference	
Risk Owner	

Risk Description:

Calculation Method	**Numerator:** The number of people under adult mental illness specialties who were followed up (either by face to face contact or by phone discussion) within 7 days of discharge from psychiatric in-patient care during the period **Denominator:** The total number of people under adult mental illness specialties discharged from psychiatric in-patient care during the period

Performance (%)	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20
Adult Mental Health Services	100.0%	91.0%	91.8%									
Community Health Services	100.0%	100.0%	100.0%									
Trust Total	100.0%	92.7%	92.8%									

CPA 7 Day is reported one month in arrears



Comments and Actions:

To improve performance against the CPA seven day standard, the Adult Mental Health and Learning Disabilities directorate (AMH.LD) have redesigned the monitoring process for CPA seven day with an aim to undertake the CPA seven day follow-ups within 48 hours. Daily individualised proactive reports and reminders will be provided to wards to undertake reviews; and missed reviews will be escalated to the service manager. Weekly performance reports will be reviewed by the business team with escalations made to the business manager for relevant action.

The new processes will be incorporated into the existing standard operating process (SOP) in March 2019.

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - CPA 12 Month Review

Responsible Director	Helen Thompson, Rachel Bilsborough
Responsible Committee	QAC

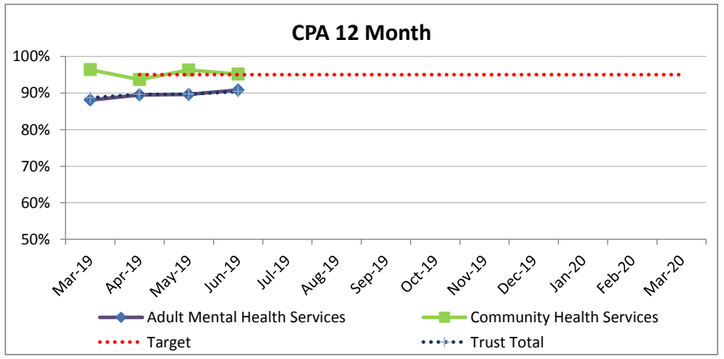
Responsible Services	AMH, CHS
KPI Reference ID	

Risk Reference	
Risk Owner	

Risk Description:

Calculation Method	**Numerator:** The number of patients on CPA (who have been on CPA for 12 months) **and** who have had a CPA review within the last 12 months **and** whose record has been authorised by a responsible clinical officer **Denominator:** The number of patients on CPA (who have been on CPA for 12 months)

Performance (%)	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Adult Mental Health Services	88.1%	89.5%	89.6%	90.8%									
Community Health Services	96.4%	93.7%	96.3%	95.2%									
Trust Total	88.7%	89.6%	89.7%	90.4%									



Comments and Actions:

All care plans entered against a patient record must be authorised by a responsible clinical officer in order to count as a positive contact.

To improve performance against the CPA 12 month standard, the AMH.LD directorate have produced an action plan with an aim to increase operational team focus on out of date CPA 12 month reviews, with targeted support by the directorate business team. Individualised performance information is directed to care co-ordinators, detailing their out of date reviews and those that are upcoming within the next three months. Self-service performance reports are also available to support the management of CPA 12 month performance.
As anticipated, performance has improved in February 2019 where these actions have been implemented.

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - % Delayed Transfer of Care (DToC)

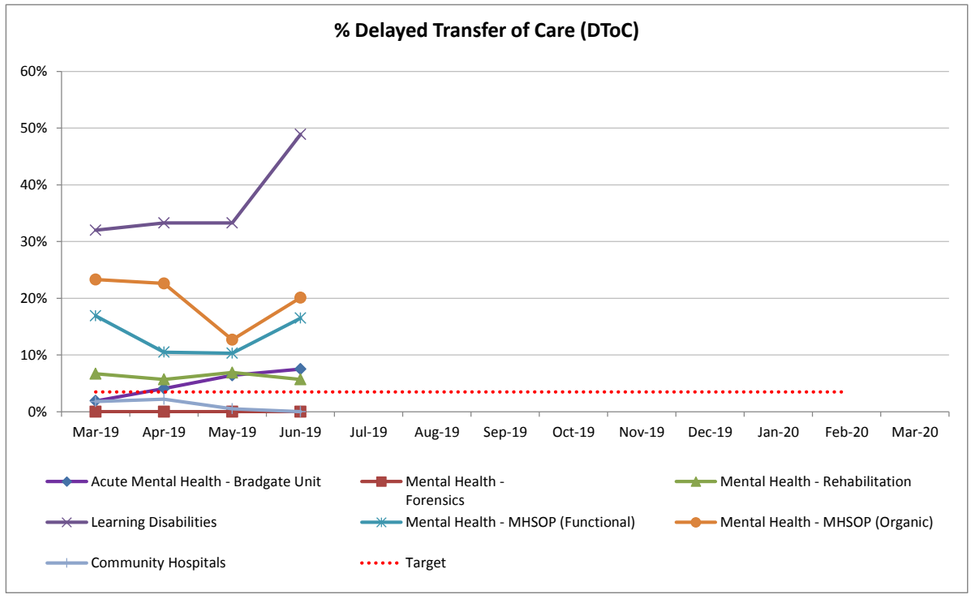
Responsible Director	Rachel Bilsborough, Helen Thompson
Responsible Committee	FPC

Responsible Services	AMH
KPI Reference ID	QEFS.06

Risk Reference	2403	**Risk Description:** Delayed Transfer of Care (DToC) is high in most of the inpatient areas in LPT reducing the bed flow within LPT and in the LLR system
Risk Owner	Sue Elcock	

Calculation Method	**Numerator:** the number of non-acute patients (aged 18 and over on admission) per day under consultant and non-consultant-led care whose transfer of care was delayed. For example, one patient delayed for five days counts as five. **Denominator:** the total number of occupied bed days (consultant-led and non-consultant-led). *Delayed transfers of care attributable to social are included.* *Delays are aligned to National Unify reporting.*

DTOC (%)	Target	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Acute Mental Health - Bradgate Unit	<=3.5%	1.9%	4.1%	6.4%	7.5%									
Mental Health - Forensics	<=3.5%	0.0%	0.0%	0.0%	0.0%									
Mental Health - Rehabilitation	<=3.5%	6.7%	5.7%	6.9%	5.7%									
Learning Disabilities	<=3.5%	32.0%	33.3%	33.3%	48.9%									
Mental Health - MHSOP (Functional)	<=3.5%	16.9%	10.5%	10.3%	16.5%									
Mental Health - MHSOP (Organic)	<=3.5%	23.3%	22.6%	12.7%	20.1%									
Community Hospitals	<=3.5%	1.8%	2.2%	0.5%	0.0%									
TRUST TOTAL	<=3.5%	4.8%	4.9%	4.3%	5.3%									



LLR System DTOC figures are reported nationally in arrears, they are shown below for illustrative purposes

		Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
LLR SYSTEM TOTAL *(inc UHL, out of area patients etc.)*	<=3.5%	3.1%	2.1%											

Comments and Actions:

% DToC - Mental Health: Patients delayed during discharge for the month of June 2019 are the result of the following top four categories : Social Services (19.4%), Joint (13.4%), NHS (13.4%), Homes (11.9%) and all other reasons (41.7%).

% DToC - Community: Delays for community hospital patients during the month of June 2019 are the result of two categories: There were 0 days delayed.

A clinical discharge meeting is chaired by the Clinical Director and covers all wards in mental health and forensic inpatient areas. The meeting is attended by all relevant multi agency partners to focus on manging DToCs as well as potential / emerging DToCs in the system. Similar arrangements are also in place in MHSOP, rehabilitation and learning disability services. DToCs in learning disability services are escalated to the Transforming Care Board; and complex clinical decisions are escalated to a clinical cabinet for resolution. Multi-agency issues that cannot be addressed by the group are escalated to the multi-agency DToC meeting chaired by the Medical Director and attended by the director/ senior management representation from all partner organisations.

A multi agency action plan is in progress to improve the DToC position (an update on actions since January 2018):
- The redesign of discharge pathway 2 (home with new support) and pathway 3 (complex transfers – unable to go straight home) led by Home First is due to take place. This will include agreeing and implementing an LLR-wide model for Discharge to Assess and reablement.
- The development of a trusted assessment between multi agency staff.
- Bring the Housing Enablement Team into the integrated discharge team (IDT) and increase in resources to support IDT presence at the front door.
- Review the discharge hub environment usage to ensure multi agencies can work together to pursue complex discharges.
- Explore opportunities for all adult social care staff facilitating discharges to have access to NHS systems to share information about patient needs.
- Combining the IDT with Red2Green to allow a wider resource to be focused on similar issues and responses.
- A review of the effectiveness of the continuing healthcare end to end process implemented within Community and Community Hospitals
- A phased implementation of the continuing healthcare end to end process for UHL with an assessor for MLCSU commencing in March 2018 to support the Complex Discharge Team

Risk Associated Actions:

- Implementation of Red Green approach in mental health to improve the inpatient pathway leading to timely identification of patients needs and addressing the needs
- Consistent approach to managing patient choice through development and implementation of a guidance appropriate to community hospitals and mental health
- Improve the engagement of nursing homes with trusted assessment to reduce the delays
- Operationalise move on housing for DToC from Bradgate unit and ensure robust process in place for maintaining the flow
- Improve the process for speedy resolution of AHP placements working with CCG
- Improving the process of CHC funding working with CCG and social care for Community Hospital patients
- Ensuring the sustainability of Red to Green approach across all areas within the community hospitals in a sustainable manner

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - National Access Standards

Responsible Director	Helen Thompson
Responsible Committee	FPC

Responsible Services	AMHLD/ FYPC
KPI Reference ID	18wkRTT; DM01

Risk Reference	n/a	**Risk Description:**
Risk Owner	n/a	

Description	NHS Improvement (NHSI) monitors the Trust against three access standards: % of service users on incomplete referral to treatment (RTT) pathways (yet to start treatment) waiting no more than 18 weeks from referral (92%) % of service users on incomplete referral to diagnostic pathways (yet to start treatment) waiting no more than six weeks from referral (99%) zero tolerance RTT waits over 52 weeks for incomplete pathways (0%) *Targets are taken from the NHSI Single Oversight Framework (SOF) 2017* *Referrals waiting and compliance are taken from the national monthly returns (18wkRTT and DM01) and may be reported in arrears due to the timings of national reports* *Reason for breaches are taken form service patient tracking list (PTL) meetings*

18 Week Referral to Treatment (Asperger's and ADHD Services)

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
STF RTT Trajectory - max no. of referrals breaching in month	6	6	6	9	9	6	6	6	9	9	6	6	6	6	6	9	9	6	6	6	9	9	6	6
Referrals waiting over 18 weeks	0	11	8	9	1	2	1	7	30	31	16	8	0	11	26	0	0	0	0	0	0	0	0	0
- of which patient choice	*4*	*11*	*8*	*9*	*1*	*2*	*1*	*7*	*30*	*31*	*16*	*8*	*11*	*11*	*26*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
- of which Trust delays	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Incomplete waiting time compliance (%)	98.3%	96.7%	97.6%	97.4%	99.7%	99.4%	99.7%	98.5%	94.1%	94.0%	97.0%	98.5%	98.0%	97.7%	94.9%									

Key: Forecast figures (may change)

6 Week Referral to Diagnostic Test (Children's Audiology Service)

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
STF RTT Trajectory - no. of referrals breaching in month	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Referrals waiting over 6 weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
- of which patient choice	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
- of which Trust delays	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Incomplete waiting time compliance (%)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%									

Zero tolerance RTT waits over 52 weeks for incomplete pathways (0%)

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
No. of RTT referrals over 52 weeks	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0									

Comments and Actions:
The RTT services participate in regular patient tracking list (PTL) meetings to manage patient access. This process allows the service to predict potential and known breaches as shown in the pink trajectory section of the table. Patient choice allows patients the right to defer their treatment to a date to suit them, which may breach the 18/ 6 week target and these instances are recorded in the trajectory table.

In some cases, a patient who has requested an appointment 18/ 6+ weeks in the future may show as a breach in the trajectory table; however if they do not attend (DNA) or cancel multiple appointments, the clinician may use professional clinical judgement to cancel the referral and refer the patient back to their GP. In this case, the patient will be removed from the waiting list and will not be identified as an 18/ 6 week breach in line with national guidelines. However, if the decision to remove the referral from the waiting list is after the breach date, the referral breach may still be reported nationally. These scenarios are managed by the service PTL on a case by case basis.

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - Data Quality Maturity Index (DQMI)

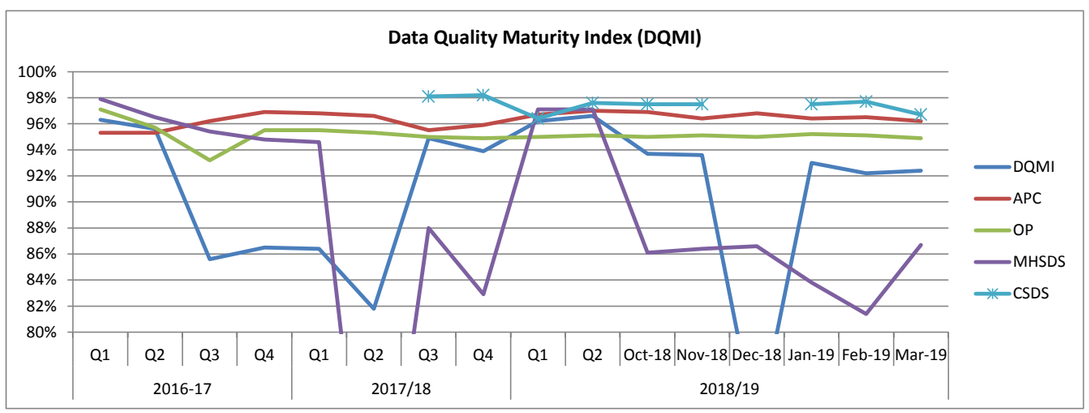
Responsible Director	Dani Cecchini
Responsible Committee	FPC

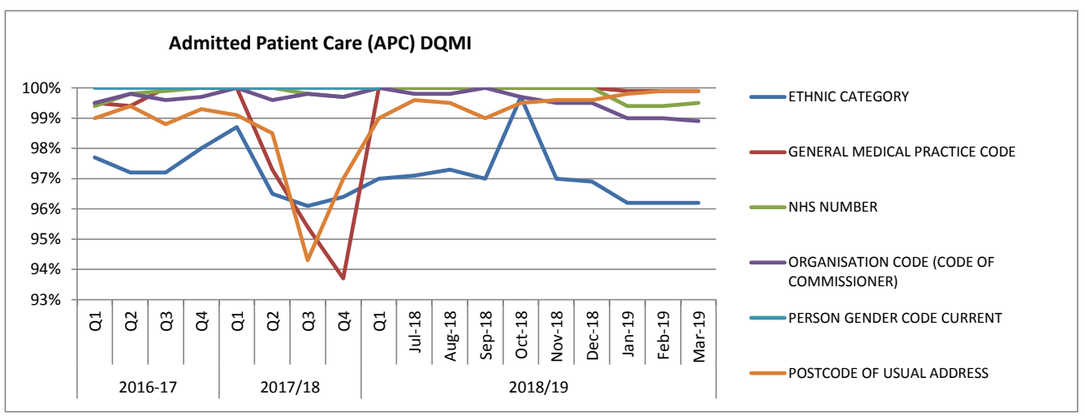
Responsible Services	AMH, CHS, FYPC
KPI Reference ID	

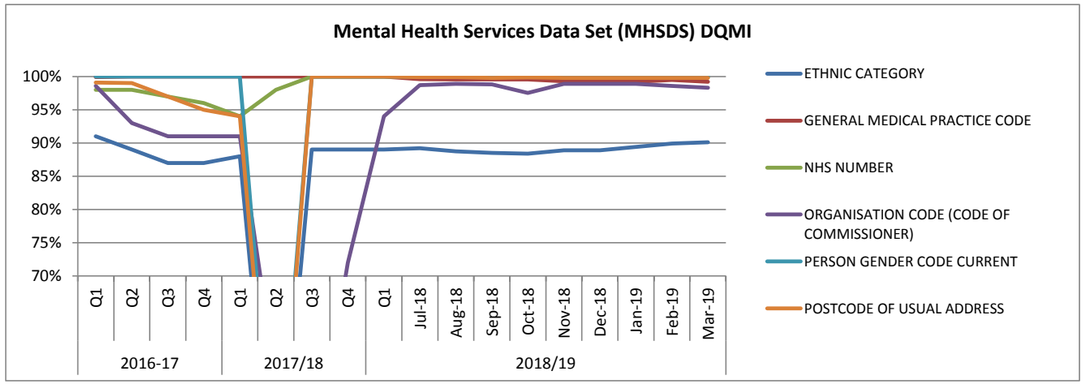
Risk Reference	1119
Risk Owner	Dani Cecchini

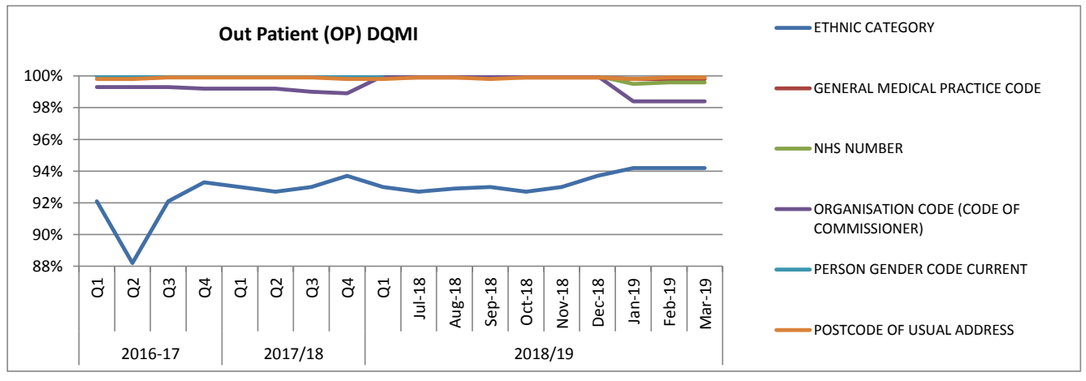
Risk Description: There is a risk we cannot assure ourselves of the accuracy and validity of all information we provide from our patient information systems; which could adversely affect patient outcomes where information is required to make decisions.

Calculation Method	Proportion valid and complete data items **Numerator:** ((Coverage)*(mean proportion valid and complete for each data item)*100))









Comments and Actions:

National dataset compliance is published six months in arrears. Local performance is shown monthly where available in lieu of nationally published performance.

Data Quality Maturity Index (DQMI)

The sudden decrease in compliance during 2017/18 Q2 is attributed to a technical error which is not linked to data quality.

Work to improve completeness and validity of DQMI in submissions was completed in May 2018. We expect to see a change in DQMI compliance for 2018/19 Q1 in line with the improved submission process.

The recording of ethnicity data is being managed through the clinical effectiveness group (CEG) from June 2018. We expect to see improvements to ethnicity recording from July 2018.

The spine matching processes across the Trust and primary care services is being reviewed for improvements. We expect to see incremental improvements to all indicators from July 2018 as actions are completed.

Leicestershire Partnership NHS
NHS Trust

DETAILED EXCEPTION REPORT - % Staff Sickness

Responsible Director	Sarah Willis
Responsible Committee	SWG

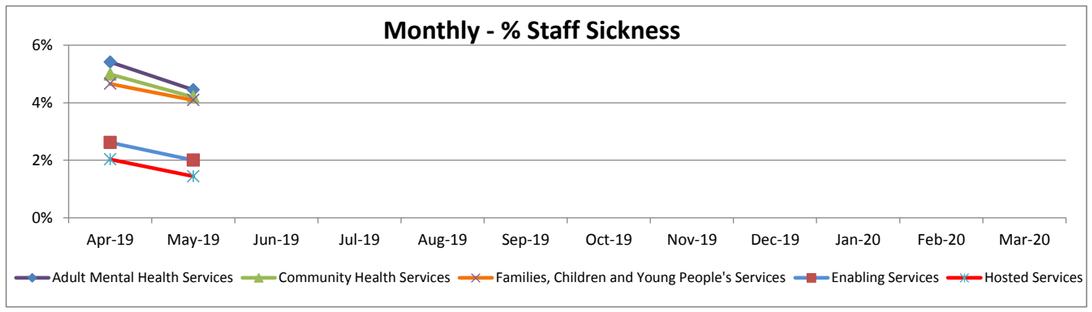
Responsible Services	AMH, CHS, FYPC, Enabling
KPI Reference ID	

Risk Reference	1833
Risk Owner	Kathryn Burt

Risk Description: Quality of service provided to our patients and service users will be affected by the high level of sickness absence within the Trust. There will also be an impact on the health and wellbeing linked to the increased reliance on use of temporary staffing.

Calculation Method	**Numerator:** the number of available calendar days lost to staff sickness in the period **Denominator:** the total number available calendar days in the month

Performance (%)	Target	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Adult Mental Health Services	<=5.6%	5.4%	4.4%										
Community Health Services	<=4.8%	5.0%	4.2%										
Families, Children and Young People's Services	<=4.3%	4.7%	4.1%										
Enabling Services	<=2.3%	2.6%	2.0%										
Hosted Services	<=2.3%	2.0%	1.4%										



Comments and Actions:

% Sickness Absence:

AMH.LD sickness is showing significant improvement from last year. The cumulative rate for 2018/19 was 5.4 % (below target of 5.6%). This is a 0.8% reduction from 2017/18 and builds on improvements made in 2016/17. This indicates that the initiatives being used in AMH.LD to reduce sickness absence are having a sustained impact. Although advice from Amica and Occupational Health is that the complexity of the client group supported in AMH.LD means that higher levels of sickness absence should be anticipated.
Actions in place:
HR support to focus on supporting, training and coaching Managers.
Target setting for staff who reach the Trust triggers and if breached formal action taken.
Monthly teleconference for managers, HR and the Director to discuss actions being taken to tackle sickness absence.
HR Team focusing on supporting staff with underlying health conditions using guidance from the Reasonable Adjustment Policy and Tailored Adjustment Agreements.

CHS Sickness absence remains high on the workforce agenda with community services receiving a daily situation report on all staffing and sickness concerns. They have also undertaken a review of sickness trends and patterns and HR have provided a number of bespoke training sessions. Across CHS a commitment has been made to identify and support all current line managers to undertake the four training courses designed to support with staff management. A focus on health and wellbeing has been initiated to support staff with expanding the health and wellbeing agenda within their own areas.

FYPC There has been another decrease in sickness absence and is now showing as green, this is a significant improvement since last year. This is discussed in length at Workforce Meetings, FYPC SMT have also agreed to discuss this in more detail in the FYPC Operational Meetings on a monthly basis. Work will continue with Teams and Managers, including training, advice on target setting and continued monthly monitoring of staff sickness within teams. Information has been provided to SMT on staff who are line managers and have not attended Management of Ill Health Training and also to encourage Managers to attend half day refresher training. Stress Tools are discussed at Workforce Group and communicated to Managers through Comms and individual Team Meetings. The HR team will undertake further 1 x 1 work with Managers who have a 6% and over the target rate. Hot spots will be identified and fed back to SMT for discussion.

Enabling - services sickness has seen a slight decrease in sickness absence and is now showing as green All absence is being appropriately managed within the services with support from HR.

Risk Associated Actions:

1. Managers to be reminded on an ongoing basis of the need to input sickness absence in a timely way.
2. HR staff to ensure that all sickness absence cases are recorded on case management system to aid reporting.
3. Management of Ill-Health Policy to be revised and agreed by staff side.
4. Programme of health and wellbeing interventions to be available for staff.

Leicestershire Partnership NHS Trust

DETAILED EXCEPTION REPORT - Agency Costs

Responsible Director	Anne Scott
Responsible Committee	FPC/ SWG

Responsible Services	All
KPI Reference ID	PW.35

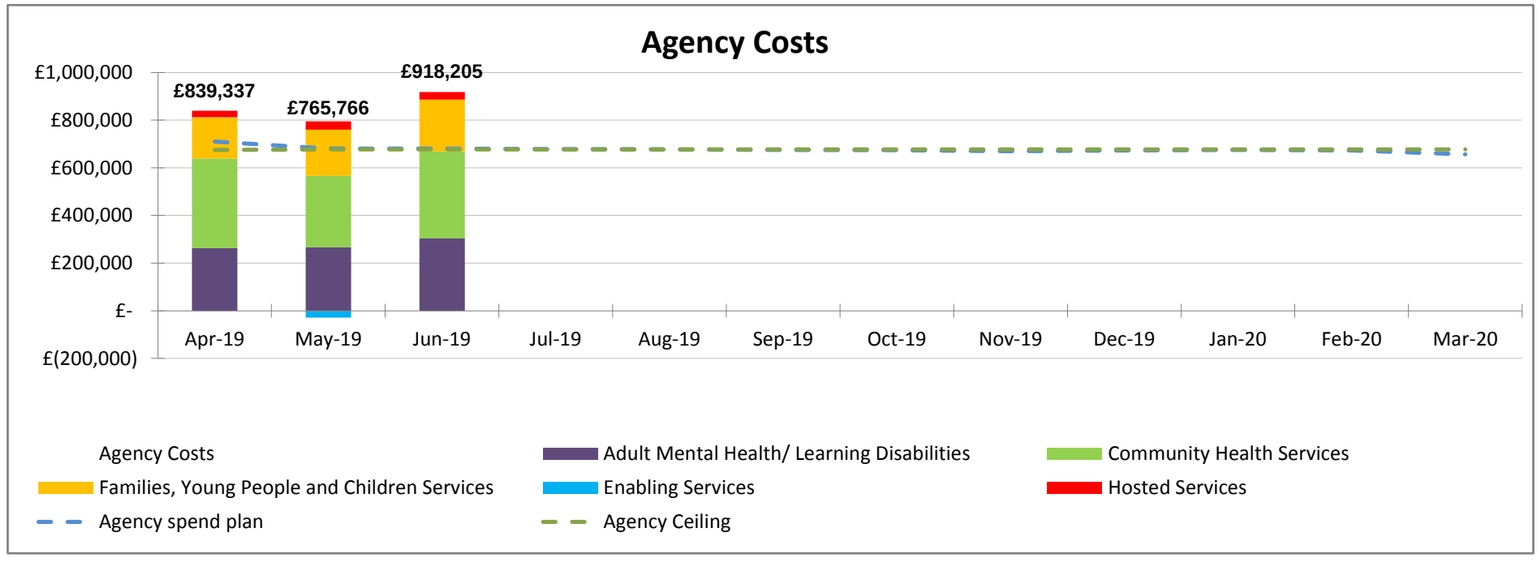
Risk Reference	1932	**Risk Description:** Inability to achieve sufficient workforce supply to deliver the workforce requirements set out within the Trust business plan and people strategy. . Links to risks 1037, 1038, 2515 and the safer staffing risk.
Risk Owner	Sarah Willis	

Risk Reference	1260	**Risk Description:** Substantive staffing on inpatient units is below the funded establishment and this could have an impact on patient care and the ability to deliver effective care on a consistent basis. Links to risk 1932.
Risk Owner	Anne Scott	

Calculation Method	Total cost of Trust agency pay bill

Split by Services

	Current Month	Previous Month
Adult Mental Health/ Learning Disabilities	£ 303,349	£ 266,736
Community Health Services	£ 364,976	£ 299,137
Families, Young People and Children Services	£ 218,283	£ 194,212
Enabling Services	£ -	-£ 29,179
Hosted Services	£ 31,597	£ 34,860



Comments and Actions:

Cumulative year-to-date Trust agency costs were £2523K as at 30 June 2019 (month 03). This is above the planned spend of £2071k for the same period.

The June 2019 year-to-date NHSI agency ceiling target is £2029k. This Trust is exceeding this limit by £494k

Risk Associated Actions:

Appendix 1: IQPR Change Log

Date	Indicator Code	Indicator Description	Requested by	Change
Apr-17		Quality Pages	QAC	All Quality indicators reviewed
Jul-17		Operational Performance	FPC	re-formatted layout in line with Quality pages
Oct-17		DToC for Community Health	ET	Community moved to national methodology

	<target	>=target	target			
	Reliable	Valid	Timely	Complete	Accurate	Relevant
Care Programme Approach (CPA) follow up - proportion of discharges from hospital followed up within 7 days	Y	Y	Y	Y	Y	Y

Paper Lii

WeAre C.B.I.T
Corporate Business Information Team

Waiting Times Compliance - Adult Mental Health Services and Learning Disabilities

Leicestershire Partnership NHS
NHS Trust

Service Details				Patient Flow (referrals and discharges in month)							Incomplete Pathways (at end of month)										Complete Pathways (in month)										Information Assurance Framework				
				No. of New Referrals Received				No. of Discharges			No. of Referrals Waiting		Length of Wait		Waiting Time Compliance						No. of Referrals Seen			Length of wait		Waiting Time Compliance									
Service Spec	Service Name	Target Waiting Time (all targets are locally agreed unless otherwise stated)	Wait Time Measure	Apr-19	May-19	Jun-19	Referrals Trendline (Rolling 12 Months)	Apr-19	May-19	Jun-19	Discharge Trendline (Rolling 12 Months)	No of Patients Within Target	Patients > target < 52 weeks	Patients > target >= 52 weeks	Longest Waiter Over target < 52 Weeks	Longest Waiter >= 52 Weeks	Target	Apr-19	May-19	Jun-19	Incomplete Compliance Trendline	No of Patients Within Target	Patients > target < 52 weeks	Patients > target >= 52 weeks	Longest Waiter Over target < 52 Weeks	Longest Waiter >= 52 Weeks	Target	Apr-19	May-19	Jun-19	Complete Compliance Trendline	Service Line Mapping Agreed	Targets Agreed	SOP in place	PTL in place	KPI authorised as correct by executive
LD02	LD - Community Teams	8 Weeks	Referral to Assessment	104	124	104		86	110	110		127	12	0	12	0	95%	95.8%	94.8%	91.4%		90	7	0	14	0	95%	95.3%	91.3%	92.8%						
MH02	Assertive Outreach	6 Weeks	Referral to Assessment	3	1	1		1	2	1		0	0	0	0	0	95%	100.0%	100.0%	N/A		1	0	0	0	0	95%	N/A	100.0%	100.0%						
MH06	Personality Disorders	13 Weeks	Referral to Assessment	96	105	96		61	40	42		293	301	0	44	0	95%	51.3%	51.7%	49.3%		4	38	0	47	0	95%	40.7%	51.3%	9.5%						
MH07	Dynamic Psychotherapy	13 Weeks	Referral to Assessment	28	24	23		6	10	3		43	0	0	0	0	95%	100.0%	100.0%	100.0%		17	0	0	0	0	95%	100.0%	100.0%	100.0%						
MH08	Perinatal Mental Health Service	4 Weeks	Referral to Assessment	79	90	84		59	81	96		44	25	0	12	0	95%	65.0%	61.4%	63.8%		76	20	0	12	0	95%	70.7%	79.6%	79.2%						
		2 Working Days		28	29	14		27	28	16		1	0	0	0	0	95%	25.0%	N/A	100.0%		12	1	0	0	0	95%	75.0%	87.1%	92.3%						
		4 Hours		0	2	0		0	2	0		0	0	0	0	0	95%	N/A	N/A	N/A		0	0	0	0	0	95%	N/A	0.0%	N/A						
MH09	Psycho-oncology (Routine and Urgent)	4 Weeks	Referral to Assessment	23	22	26		16	19	16		36	64	0	18	0	95%	26.5%	28.6%	36.0%		3	13	1	21	99	95%	38.9%	12.0%	17.6%						
		48 Hours		5	6	5		2	2	2		3	2	0	17	0	95%	50.0%	33.3%	60.0%		1	2	0	6	0	95%	66.7%	42.9%	33.3%						
MH10	Liaison - Psychiatry	1 Working Day	Referral to Assessment	31	38	34		27	28	46		1	1	0	0	0	95%	100.0%	N/A	50.0%		24	9	0	0	0	95%	87.1%	82.5%	72.7%						
		13 Weeks		13	25	18		36	28	23		49	7	0	32	0	95%	69.6%	85.0%	87.5%		18	1	1	27	83	95%	73.5%	61.9%	90.0%						
MH11	Cognitive Behavioural Therapy	13 Weeks	Referral to Assessment	48	44	36		39	39	57		95	3	0	17	0	95%	99.1%	96.9%	96.9%		32	2	0	17	0	95%	93.0%	95.3%	94.1%						
MH13	Forensic - Community and Out Patients	8 Weeks	Referral to Assessment	25	14	30		8	10	7		40	15	0	17	0	95%	85.7%	64.3%	72.7%		5	7	0	20	0	95%	94.4%	75.0%	41.7%						
MH18	Adult General Psychiatry - Community Mental Health Teams and Outpatients - Treatment	6 Weeks	Referral to Assessment	404	351	412		458	443	422		544	659	7	47	83	95%	47.7%	40.6%	45.0%		203	148	2	43	112	95%	52.9%	54.4%	57.5%						
		5 Days		11	8	21		12	9	9		6	7	0	11	0	95%	100.0%	50.0%	46.2%		11	3	0	4	0	95%	100.0%	85.7%	78.6%						
MH20	Mett Day Centre and Linnaeus Nursery	4 Weeks	Referral to Assessment	25	2	1		10	9	5		1	0	0	0	0	95%	100.0%	100.0%	100.0%		2	0	0	0	0	95%	89.5%	78.6%	100.0%						
MH21	Huntington's Disease	4 Weeks	Referral to Assessment	1	2	2		2	0	2		1	1	0	5	0	95%	0.0%	33.3%	50.0%		1	1	0	11	0	95%	50.0%	100.0%	50.0%						
MH23	Adult ADHD Service Consultant-Led Service	National incomplete target 92%: 18 Weeks	Referral to Treatment	98	90	96		66	33	51		361	10	0	23	0	92%	99.2%	99.2%	97.3%		86	11	0	20	0	95%	93.2%	92.1%	88.7%						
MH24	Homeless Service	1 Week	Referral to Assessment	35	32	25		34	27	36		3	16	0	11	0	95%	47.6%	38.1%	15.8%		16	14	0	7	0	95%	66.7%	53.3%	53.3%						
MH25	Aspergers Assessment Consultant-Led Service	National incomplete target 92%: 18 Weeks	Referral to Treatment	52	38	51		34	39	39		107	15	0	41	0	92%	94.5%	92.9%	87.7%		30	22	0	44	0	95%	89.2%	68.9%	57.7%						
MH48	Crisis Intervention (Crisis Level 1 and 2)	4 Hours	Referral to Assessment	0	9	2		0	7	3		1	0	0	0	0	95%	N/A	N/A	100.0%		2	0	0	0	0	95%	N/A	44.4%	100.0%						
		24 Hours		273	353	281		270	352	292		2	0	0	0	0	95%	100.0%	100.0%	100.0%		265	22	0	1	0	95%	95.1%	93.9%	92.3%						
MH49	Mental Health Triage Team	1 Hour	Referral to Assessment	351	457	421		339	495	355		0	0	0	0	0	95%	N/A	N/A	N/A		188	221	0	0	0	95%	49.3%	56.7%	46.0%						
		Emergency 2 Hours	Referral to Assessment	351	457	421		339	495	355		16	8	0	5	0	95%	26.1%	50.0%	66.7%		311	98	0	0	0	95%	69.6%	51.5%	76.0%						
		Crisis 4 Hours	Referral to Assessment	69	52	27		66	54	20		3	2	0	5	0	95%	11.1%	50.0%	60.0%		24	1	0	0	0	95%	84.1%	76.5%	96.0%						
MH16	Adult General Psychiatry-Acute Recovery Team	3 Working Days																																	
		48 hours																																	
		7 days																																	

Comments and Actions:

MH16 - Mental Health Triage Team 1 hour
Emergency referral via the Leicester Royal Infirmary Emergency Department – As LPT are working towards the NHS England Liaison target 20/21 which states that no acute hospital is without an all age mental health service in an emergency department. Compliance against the 1 hour target will be measured as part of the service development planned in order for the mental health triage to deliver the Core24 standards. Achievement of the target is subject to ongoing review of capacity, performance and resource.

Methodologies

RTT Methodology:
The RTT methodology is correct as per the way that RiO electronic patient record functions. There are system level action dates that are needed to sequence the information for the calculation. This means that the front end processing of RTT needs to happen as it occurs and entered in to RiO. Therefore, any information entered into RiO that is back dated will take the

Incomplete:
Incomplete waiting list performance is based on the number of patient referrals on an active waiting list at month end; and the percentage of those within the target waiting times.

Complete:
Complete wait time performance is based on the number of patient referrals completed with or without treatment during the reporting period; and the percentage of those within the target waiting times.

WeAreC.B.I.T
Corporate Business Information Team

Waiting Times Compliance - Community Health Services

Leicestershire Partnership NHS
NHS Trust

Service Details				Patient Flow (referrals and discharges in month)								Incomplete Pathways (at end of month)									Complete Pathways (in month)									Information Assurance Framework				
				No. of New Referrals Received				No. of Discharges				No. of Referrals Waiting			Length of Wait		Waiting Time Compliance					No. of Referrals Seen			Length of wait		Waiting Time Compliance											
Service Spec	Service Name	Target Waiting Time (all periods 52 weeks unless agreed unless otherwise stated)	Wait Time Measure	Apr-19	May-19	Jun-19	Referrals Trendline (Rolling 12 Months)	Apr-19	May-19	Jun-19	Discharge Trendline (Rolling 12 Months)	No of Patients Within Target	Patients > target < 52 weeks	Patients > target >= 52 weeks	Longest Waiter Over target < 52 Weeks	Longest Waiter >= 52 Weeks	Target	Apr-19	May-19	Jun-19	Incomplete Compliance Trendline	No of Patients Within Target	Patients > target < 52 weeks	Patients > target >= 52 weeks	Longest Waiter Over target < 52 Weeks	Longest Waiter >= 52 Weeks	Target	Apr-19	May-19	Jun-19	Complete Compliance Trendline	Service Line Mapping Agreed	Targets Agreed	SOP in place	PTL in place	KPI authorised as correct by executive
CHS03	Continence Nursing Service	20 Working Days	Referral to first clinically relevant contact	560	599	637		793	657	3500		598	1142	0	50	0	95%	29.1%	31.9%	34.4%															
		Level 1 Assessment																				29	142	0	50	0	95%	11.9%	8.1%	17.0%						
CHS04	Respiratory Specialist Service	Urgent	Referral to first clinically relevant face to face contact	7	9	5		4	4	6		1	0	0	0	0	95%	100.0%	100.0%	100.0%		5	0	0	0	0	95%	100.0%	100.0%	100.0%						
		Routine 20 Working Days		177	153	133		191	168	187		109	14	0	7	0	95%	93.5%	94.4%	88.6%		136	18	0	8	0	95%	87.3%	85.8%	88.3%						
		Palliative 10 Working Days		0	0	0		0	0	0		0	0	0	0	0	95%	N/A	N/A	N/A		0	0	0	0	0	95%	N/A	N/A	N/A						
CHS07	Heart Failure Service	Urgent	Referral to first clinically relevant face to face contact	17	12	10		13	2	7		1	0	0	0	0	95%	N/A	100.0%	100.0%		10	0	0	0	0	95%	100.0%	100.0%	100.0%						
		Routine 20 Working Days		178	192	145		141	139	161		96	2	0	7	0	95%	99.2%	97.6%	98.0%		168	6	0	7	0	95%	97.4%	93.9%	96.6%						
		Palliative 10 Working Days		0	0	0		0	0	0		0	0	0	0	0	95%	N/A	N/A	N/A		0	0	0	0	0	95%	N/A	N/A	N/A						
CHS10	Physiotherapy	Routine 4 Weeks	Referral to first clinically relevant contact	0	0	0		1462	1006	645		4	166	0	37	0	95%	2.5%	2.4%	2.4%		8	101	0	30	0	95%	5.9%	7.9%	7.3%						
		Urgent 5 Working Days		0	0	0		370	207	141		0	0	0	0	0	95%	N/A	N/A	N/A		0	0	0	0	0	95%	N/A	N/A	N/A						
		Non self Urgent RTT 5 Working Days	Referral to Treatment	56	25	38		42	41	31		13	6	0	4	0	92%	22.2%	100.0%	68.4%		24	3	0	2	0	95%	83.6%	80.8%	88.9%						
		Non self Routine RTT 30 Working Days		390	411	375		156	285	283		212	493	0	20	0	92%	36.9%	31.7%	30.1%		271	229	0	19	0	95%	65.8%	48.1%	54.2%						
		Self Referrals Urgent RTT 5 Working Days		381	391	390		116	189	228		102	52	0	3	0	92%	52.6%	71.1%	66.2%		138	176	0	4	0	95%	86.6%	72.0%	43.9%						
		Self Referrals Routine RTT 30 Working Days		1683	1877	1731		330	728	877		868	280	0	20	0	92%	54.7%	69.6%	75.6%		1545	139	0	18	0	95%	93.3%	85.7%	91.7%						
CHS19	Podiatry	Routine 20 Working Days	Referral to first clinically relevant face to face contact	1327	1492	1356		1555	1146	1374		1081	45	0	10	0	95%	97.6%	96.5%	96.0%		1331	100	0	10	0	95%	95.0%	91.9%	93.0%						
		Urgent 5 Working Days		34	26	23		12	8	10		1	1	0	1	0	95%	100.0%	100.0%	50.0%		17	1	0	2	0	95%	100.0%	95.2%	94.4%						
CHS22	Speech Therapy	Routine 4 Weeks	Referral to first clinically relevant face to face contact	300	273	276		277	293	256		203	30	0	23	0	95%	82.7%	84.1%	87.1%		231	52	0	27	0	95%	79.9%	80.4%	81.6%						
		Urgent 10 Working Days		35	42	42		39	42	26		13	1	0	2	0	95%	100.0%	100.0%	92.9%		37	0	0	0	0	95%	79.3%	91.1%	100.0%						
CHS69/70/80	Community Therapy	3 Working Days (P1)*	Referral to first clinically relevant contact	154	173	135		144	181	145		12	0	0	0	0	95%	94.1%	85.7%	100.0%		117	22	0	2	0	95%	89.6%	84.6%	84.2%						
		20 Working Days (P2)*		620	636	522		542	589	497		424	479	0	18	0	95%	51.6%	48.6%	47.0%		213	321	0	18	0	95%	47.1%	43.9%	39.9%						
		60 Working Days (P3)*		89	92	85		58	83	82		219	65	0	21	0	95%	80.0%	82.2%	77.1%		30	49	0	24	0	95%	66.7%	37.5%	38.0%						
CHS87	Stroke & Neuro	3 Working Days	Referral to first clinically relevant contact	4	7	6		6	8	5		0	0	0	0	0	95%	N/A	N/A	N/A		6	0	0	0	0	95%	100.0%	100.0%	100.0%						
		20 Working Days		199	190	182		186	198	195		144	62	0	16	0	95%	51.3%	57.7%	69.9%		125	85	0	19	0	95%	47.6%	48.6%	59.5%						
MH37	MHSOP Community Teams	High Priority 4 Weeks	Referral to first clinically relevant face to face contact	9	18	13		19	16	18		12	1	0	5	0	95%	54.5%	100.0%	92.3%		16	0	0	0	0	95%	84.6%	75.0%	100.0%						
		Routine 6 Weeks		112	126	104		106	119	90		98	7	0	14	0	95%	86.0%	81.8%	93.3%		84	21	0	13	0	95%	78.8%	79.8%	80.0%						
MH40	MHSOP - Memory Clinics	RTT 18 Weeks	Referral to Treatment	187	229	210		127	175	150		685	65	0	48	0	92%	88.2%	89.5%	91.3%		183	57	0	42	0	95%	73.3%	74.4%	76.3%						
		High Priority 4 Weeks	Referral to first clinically relevant face to face contact	0	0	0		0	0	0		0	0	0	0	0	95%	N/A	N/A	N/A		0	0	0	0	0	95%	N/A	N/A	N/A						
		Routine 6 Weeks		0	0	0		9	9	8		0	0	0	0	0	95%	N/A	N/A	N/A		0	0	0	0	0	95%	N/A	N/A	N/A						
MH45	MHSOP Outpatient Service	High Priority 4 Weeks	Referral to first clinically relevant face to face contact	1	5	4		4	5	5		0	0	0	0	0	95%	0.0%	N/A	N/A		4	0	0	0	0	95%	100.0%	100.0%	100.0%						
		Routine 6 Weeks		138	123	133		122	81	88		145	39	0	19	0	95%	81.1%	77.5%	78.8%		106	26	0	12	0	95%	80.0%	75.6%	80.3%						
CHS05a	Planned End of Life Care Service (Hospice at Home)	2 Weeks	Referral to first clinically relevant face to face contact	3	4	0		4	3	0		0	0	0	0	0	95%	N/A	N/A	N/A		0	0	0	0	0	95%	100.0%	100.0%	N/A						
		24 Hours		98	106	68		67	105	69		0	0	0	0	0	95%	100.0%	100.0%	N/A		63	4	0	0	0	95%	97.8%	95.0%	94.0%						
		2 Hours		66	84	65		67	85	65		0	0	0	0	0	95%	N/A	N/A	N/A		60	4	0	0	0	95%	95.1%	95.1%	93.8%						
MH55	Integrated Care – Mental Health	15 Working Days	Referral to first clinically relevant face to face contact	31	25	26		26	34	26		19	1	0	3	0	95%	95.8%	93.8%	95.0%		16	6	0	4	0	95%	88.5%	78.8%	72.7%						
CHS17	City Reablement Service	5 Working Days																																	
CHS05b	Specialist Palliative Care Nursing Service (Macmillan)	2 Working Days																																	
		5 Working Days																																	
MH38	Care Homes In Reach Team	72 Hours																																	

Comments and Actions:
General Notes:

CHS03 - Continence Nursing Service
The increase in discharges was expected in June 2019 as patients have been discharged from the Annual Review caseloads within the old LLR Specialist Services unit. as part of the discharge process, patients have been provided with the relevant information to contact the service. In addition the supplier for the prescription products has changed and patients have been informed. Patients that self-refer (including carer/relative referrals) into the service will be seen under the 'Reassessment' pathway. There has been an increase in the number of referrals from the referral sources: patient, carer and relative.

In April 2019, the service underwent a migration phase from the LLR Specialist Services unit into its own LLR Continence Service unit in SystmOne. The migration took 3 weeks during April 2019 to complete. Therefore, fewer patients were on the complete pathway.

CHS10 - Physiotherapy
Provided New MSK Physiotherapy RTT data. Still awaiting final sign off by commissioners.

The service started to accept referrals from 1st February 2019 on the referral to treatment (RTT) pathway.
The different 'Target Waiting Time' are:
• Urgent RTT 5 working days (Non-self Referrals) – these referrals exclude referrals sources: 'Self Referral' and 'Self-Referral: GP Suggested'
• Routine RTT 30 working days (Non-self Referrals) – these referrals exclude referrals sources: 'Self Referral' and 'Self-Referral: GP Suggested'
• Urgent RTT 5 working days (Self Referrals) – these referrals only include referrals sources: 'Self Referral' and 'Self-Referral: GP Suggested'
• Routine RTT 30 working days (Self Referrals) – these referrals only include referrals sources: 'Self Referral' and 'Self-Referral: GP Suggested'

Methodologies

RTT Methodology:
The RTT methodology is correct as per the way that RiO electronic patient record functions. There are system level action dates that are needed to sequence the information for the calculation. This means that the front end processing of RTT needs to happen as it occurs and entered in to RiO. Therefore, any information entered into RiO that is back dated will take the action date as the RTT status/outcome. We are educating staff to outcome appointments within a timely manner as defined by Trust policy for record keeping.

Incomplete:
Incomplete waiting list performance is based on the number of patient referrals on an active waiting list at month end; and the percentage of those within the target waiting times.

Complete:
Complete wait time performance is based on the number of patient waits completed with or without treatment during the reporting period; and the percentage of those within the target waiting times.

WeAre C.B.I.T
Corporate Business Information Team

Waiting Times Compliance - Families, Young People and Children's Services

Leicestershire Partnership NHS
NHS Trust

Service Details				Patient Flow (referrals and discharges in month)								Incomplete Pathways (at end of month)										Complete Pathways (in month)										Information Assurance Framework				
				No. of New Referrals Received				No. of Discharges				No. of Referrals Waiting			Length of Wait		Waiting Time Compliance					No. of Referrals Seen			Length of wait		Waiting Time Compliance									
Service Spec	Service Name	Target Waiting Time (all targets are locally agreed unless otherwise stated)	Wait Time Measure	Apr-19	May-19	Jun-19	Referrals Trendline (Rolling 12 Months)	Apr-19	May-19	Jun-19	Discharge Trendline (Rolling 12 Months)	No of Patients Within Target	Patients > target < 52 weeks	Patients > target > = 52 weeks	Longest Waiter Over target < 52 Weeks	Longest Waiter >= 52 Weeks	Target	Apr-19	May-19	Jun-19	Incomplete Compliance Trendline	No of Patients Within Target	Patients > target < 52 weeks	Patients > target > = 52 weeks	Longest Waiter Over target < 52 Weeks	Longest Waiter >= 52 Weeks	Target	Apr-19	May-19	Jun-19	Complete Compliance Trendline	Service Line Mapping Agreed	Targets Agreed	SOP in place	PTL in place	KPI authorised as correct by executive
CHS23	Childrens Audiology	National incomplete target 99%: 6 Weeks	Referral to clinically relevant contact	471	474	464		348	455	482		354	0	0	0	0	99%	100.0%	100.0%	100.0%		355	1	0	11	0	92%	99.5%	100.0%	99.7%						
CHS24	Childrens Occupational Therapy	18 Weeks	Referral to Treatment	31	51	25		44	33	29		93	0	0	0	0	92%	100.0%	100.0%	100.0%		30	0	0	0	0	92%	100.0%	100.0%	100.0%						
CHS25	Childrens Physiotherapy	18 Weeks	Referral to Treatment	10	22	9		19	26	35		48	2	0	23	0	92%	93.4%	95.2%	96.0%		20	1	0	22	0	92%	100.0%	96.0%	95.2%						
CHS27	Childrens Speech & Language Therapy	18 Weeks	Referral to Treatment	219	259	138		326	246	244		669	17	0	28	0	92%	99.7%	99.6%	97.5%		269	0	0	0	0	92%	98.5%	99.6%	100.0%						
CHS29	LNDS & HENS Domiciliary	4 Weeks	Referral to Assessment	134	155	94		170	127	118		60	92	0	22	0	95%	50.6%	48.6%	39.5%		60	66	0	19	0	92%	51.9%	55.4%	47.6%						
	LNDS & HENS Outpatients	18 Weeks	Referral to Assessment	400	398	390		323	313	262		933	80	0	36	0	95%	95.5%	94.6%	92.1%		268	18	0	43	0	92%	94.4%	96.0%	93.7%						
CHS34	Community Paediatrics	18 Weeks	Referral to Treatment	89	107	63		76	37	80		237	8	0	36	0	92%	95.0%	95.0%	96.7%		76	5	0	40	0	92%	93.2%	94.1%	93.8%						
MH19	PIER - First Episode in Psychosis Service	National complete target 53%: 2 Weeks	Referral to Treatment	49	67	52		48	47	44		18	12	0	4	0	53%	75.0%	67.9%	60.0%		6	3	0	5	0	53%	78.9%	100.0%	66.7%						
MH30	CAMHS Young People's Team	13 weeks	Referral to Treatment	26	35	36		38	18	42		39	0	0	0	0	92%	100.0%	100.0%	100.0%		36	0	0	0	0	92%	100.0%	100.0%	100.0%						
MH31	CAMHS Learning Disabilities	18 weeks	Referral to Treatment	12	11	9		6	1	9		17	0	0	0	0	92%	95.5%	91.7%	100.0%		8	1	0	19	0	92%	100.0%	100.0%	88.9%						
MH33	CAMHS Paediatric Psychology	18 weeks	Referral to Treatment	34	37	29		29	24	25		86	4	0	22	0	60%	84.4%	94.5%	95.6%		24	8	0	27	0	60%	77.3%	69.7%	75.0%						
MH47	CAMHS - Eating Disorders	Routine 4 Weeks	Referral to face to face assessment	10	14	14		11	13	8		11	1	0	6	0	60%	66.7%	100.0%	91.7%		8	4	0	11	0	60%	66.7%	76.9%	66.7%						
		Urgent 1 Week	Referral to face to face assessment	1	3	3		2	0	0		1	2	0	3	0	60%	N/A	N/A	33.3%		1	0	0	0	0	60%	100.0%	100.0%	100.0%						
MH47	CAMHS - Eating Disorders	Commissioner: Routine 6 Weeks	Referral to NICE Concordant Treatment	10	14	14		11	13	8		11	2	0	43	0	95%	85.7%	100.0%	84.6%		0	2	0	8	0	95%	83.3%	60.0%	0.0%						
		Commissioner: Urgent 4 Weeks		1	3	3		2	0	0		2	0	0	0	0	95%	N/A	N/A	100.0%		1	0	0	0	0	95%	100.0%	100.0%	100.0%						
MH47	CAMHS - Eating Disorders	National monitoring: no target Routine 4 Weeks	Referral to NICE Concordant Treatment	10	14	14		11	13	8		9	4	0	43	0		57%	83%	69%		0	2	0	8	0		83%	40%	0.0%						
		National monitoring: no target Urgent 1 Week		1	3	3		2	0	0		2	0	0	3	0		N/A	N/A	100%		1	0	0	0	0		100%	100%	100%						
MH50	CAMHS Access and Outpatients	4 weeks	Referral to first clinically relevant contact	43	68	55		51	56	67		25	0	0	0	0	92%	94.4%	87.5%	100.0%		39	0	0	0	0	92%	76.8%	92.0%	100.0%						
		13 weeks		179	162	188		350	219	193		139	2	0	19	0	95%	71.5%	86.8%	98.6%		139	47	0	20	0	92%	57.4%	69.7%	74.7%						
MH51	CAMHS Crisis and Home Treatment	24 Hours	Referral to first clinically relevant contact	87	73	66		56	54	65		0	6	0	13	0	92%	0.0%	0.0%	0.0%		60	8	0	7	0	95%	67.1%	81.9%	88.2%						
CHS28a	CAfSS :- Diana Community & Family Service	28 calender days	Referral to Assessment																																
CHS28b	DIANA CHILDRENS COMMUNITY NURSING	2 Working Days	% of acute referrals actioned within 2 working days																																
CHS29	LNDS & HENS Community Hospital Inpatients	Urgent 48 Hours																																	
		Routine 5 days																																	
CHS67	Childrens Respiratory Physiotherapy	Urgent 48 Hours																																	
		Routine 4 Weeks																																	
MH04	Eating Disorders Outpatients and Day Care	Urgent 10 Days																																	
		Routine 13 Weeks																																	

Comments and Actions:
Services working to national wait times definitions have targets aligned to national guidance.

Services working to Referral to Treatment methodologies have a 92% target

Services working to Referral to Assessment/ First relevant clinical Contact methodologies have a 95% target.

Methodologies:

RTT Methodology
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Complete:
Complete wait time performance is based on the number of patient waits completed with or without treatment during the reporting period; and the percentage of those within the target waiting times.

Information Assurance Framework Definition	
Indicator	**Description**
Targets have been agreed in the service spec and are reflected correctly in the report	o Green – Targets agreed as correct in the report against the service line o Red – Targets not agreed as correct in the report against the service line
SOPs are in place to support the data entry and management of the KPI	Continence Nursing Service
PTLs are undertaken by the service to validate the waiting list prior to release of this report	o Green – PTL in place and compliance agreed as correct o Amber - PTL in place and cleansing waiting lists o Red – PTL not yet in place – show a date when PTLs will start
The KPI has been authorised for release using the Trust authorisation process	o Green – report signed-off by authorised executive o Red – report not signed-off by authorised executive

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Leicestershire Partnership NHS Trust

TRUST BOARD – 30 July 2019

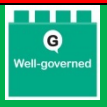
AUDIT AND ASSURANCE COMMITTEE – 5 July 2019

OVERVIEW REPORT TO BOARD

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

Assurance level	Colour to use in 'Assurance level*' column below
Not assured	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans If red, commentary is needed in "Next Actions" to indicate what will move the matter to "full assurance"
Partially assured	Amber - there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
BAF/Corporate Risk Register	Well-governed	Concern over high-level nature of controls and lack of risk scores at this stage of development.	Revised BAF to the next committee.	October 2019
Internal Audit Progress Report	Well-governed	The progress to date was reviewed and the poor start to Internal Audit First Follow-up completion of management risk actions discussed.	Next report to committee	October 2019
External Auditors Progress report	Well-governed	A summary of KPMG's work since May 2019 was received, with positive progress was reported.	Next report to committee	October 2019
Annual Audit Letter 2018/19	Well-governed	Annual Audit letter 2018/19 was received and areas of attention noted.	Post Annual Audit letter 2018-19 to Website	July 2019
Counter Fraud Progress Report and Annual Report	Well-governed	Reports received and the change of strategic governance focus was supported.	Next report to committee	October 2019
Financial Waivers	Well-governed	Assurance received with a query raised over need for NHS P membership via waiver route.	Next report to committee	October 2019
Internal Audit Follow-Ups	Well-governed	The lack of delivery for First Follow-Up agreed management actions was discussed at length. A possible next	Executive Directors to consider the completion rate for	October 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		step was to invite Executive Director leads to the Committee to help understand issues around progress rates.	internal audit report follow-ups. Next report to committee	
Committees' Annual Report Reviews: Quality Assurance Committee Finance and Performance Committee Audit and Assurance Committee		Three Board committee draft annual reports were presented by the Chairs. Debate considered their "look back" and "look forward" reviews in the light of the external governance review considerations. The transfer of specified oversight assurance duties between these three assurance committees was reviewed and agreed. Assurance for successful enactment of changes was needed post Trust Board approval of Terms of Reference changes. .	Finalised annual reports to be produced by Committee Chairs/Executive leads ahead of submission to the Trust Board.	July 2019 Trust Board

Recommendation	The Trust Board receives and reviews the issues raised in the highlight report.
Author	Frank Lusk, Trust Secretary
Presented by (Chair of Committee)	Darren Hickman, Non Executive Director

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Leicestershire Partnership NHS Trust

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TRUST BOARD 30 July 2019

Strategic Workforce Group (SWG) 10 July 2019

OVERVIEW REPORT TO BOARD

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

Assurance level	Colour to use in 'Assurance level*' column below
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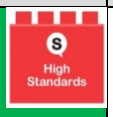
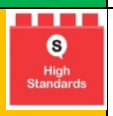
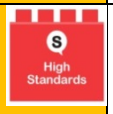
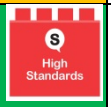
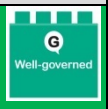
Partially assured	Amber - there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Assurance on Mandatory Training Position • Mandatory Training Report • Role Essential Training Report Clinical Supervision Report		Compliance remains good for substantive, bank staff there are concerns. Clinical supervision report received. Review the number of mandated training courses including frequency. Currently 29 topics.	To receive exception reports for teams in relation to non-compliance. Learning and Education team with liaise with the Director of Nursing AHP and Quality	September 2019 August 2019
Mandatory Training Report - Bank Staff		Concerns regarding bank staff training compliance detailed action plan discussed. Records keeping and medicines management to be next area of focus in relation to bank staff being blocked form working until compliant. Phased approach	Further focused work on bank staff training compliance to be done.	September 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		is being taken to manage risk.		
Workforce Resourcing, Attraction and Retention • Recruitment • Retention		Report received noted improvements in time taken to recruit and vacancy rate has decreased. Nursing vacancies remain a concern. Staff retention turnover of nursing has decreased overall in line with the plan.	Continue with recruitment initiatives. Launch of your working life initiatives over summer flexible working and stay conversations.	Ongoing September onwards.
Talent Management		Draft strategy received and approved with comments.	Next steps are to include the feedback from our future our way and then rollout the strategy over the phased three year plan.	Nov 2019
Culture and Leadership Update		Received an update on the programme. The board interviews and the leadership survey are complete. Staff focus group is underway including patient group and a volunteer's focus group.	Continue with phase 1 discovery complete synthesis day.	31st July 2019
Equality, Diversity and Inclusion Update		Equality, Diversity and Inclusion annual report was received including. • Appendix A: Annual Workforce Equality Report 2018/2019 • Appendix B: Workforce Race Equality Standard 2018/2019 • Appendix C: Workforce Disability Equality Standard 2018/2019 • Appendix D: WRES Action Plan 2019/20 • Appendix E: WDES Action plan 2019/20	Continue to progress actions.	September 2019
NHS Health and Wellbeing Improvement Programme Data Pack		Received the national benchmarking from NHSI. Noted the benchmarking data which is positive.	Progress health and wellbeing work and engage with the NHSI national work.	Oct 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Assurance Dashboards • Temporary Staffing • Clinical Supervision		Received reports and actions are on track. Noted increase in agency due to Camhs additional resource and additional staffing acuity in certain areas requiring more temporary staff.	ET to continue to review off framework use 2 weekly.	September 2019
IQPR – Workforce Section		noted		
CRR Risks		Updated.		
Celebratory Acknowledgements		• Queens Nurse Award S Swanson. • Change Champions engagement and work. • Volunteers team expanded now at 444. • Payroll team for the consistent effort to keep the service running.		

Recommendation	The Trust Board receives and notes the issues raised in the highlight report.
Author	Sarah Willis – Director of HR & OD
Presented by (Chair of committee)	Sarah Willis – Director of HR & OD

Leicestershire Partnership NHS
NHS Trust

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TRUST BOARD

30th July 2019

Mental Health Act Assurance Committee (MHAAC) – 11 June 2019

OVERVIEW REPORT TO BOARD

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

Assurance level	Colour to use in 'Assurance level*' column below
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Partially assured	Amber - there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	Green – there are no gaps in assurance

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Governance Review		The Chair updated the group following a review of the governance arrangements led by Anna Pridmore and read out some of the summary report currently in draft. The draft recommendations are currently subject to executive review. The Chair led discussions about possible implications for the MHAAC /Governance Structures and Trust wide learning to ensure that the organisation is assured as opposed to reassured as it moves forward. The group welcomed sharing the learning from the report	Proposal to consider future implementation of MHA & CoP - AMN	August MHAAC

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		moving forward. The Committee also discussed how MHAAC has operated in the past including its establishment as Board Subcommittee, its successes on implementing MHA and CoP leading to improvements in MH services and whether we needed to review this in light of Governance Review.		
Community Treatment Orders CTOs		The group received a number of papers following a recent audit undertaken around compliance with CTO standards for community patients. The papers authors were unable to attend the meeting and lead the discussions due to last minute operational pressures. The group felt that they were not assured around the content or purpose and agreed for this to be brought back to August's meeting for further discussion and understanding.	Papers to be brought back for discussion at next MHAAC meeting -JN to be invited to attend	August 2019
Service Highlight Reports		The group discussed the three Service Highlight reports and how lessons were learnt and being demonstrated/shared. A representative from AMHLD was not present due to unexpected operational issues connected to CQC unannounced visit and the report was received. Concern was expressed around bank staff compliance with	Highlight reports/progress are received at every meeting.	August 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		attendance at mandatory MHA training. It was agreed that staff should be supported to attend training as this is once every three years. The group welcomed receipt of the MHA Reviewer visit reports and noted the increasing breadth of these visits.		

Recommendation	The Trust Board receives and notes the issues raised in the highlight report.
Authors	Faisal Hussain, Non-Executive Director and Chair of MHAAC Helen Wallace, Regulation & Assurance Lead
Presented by (Chair of committee)	Faisal Hussain, Non-Executive Director and Chair of MHAAC

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Leicestershire Partnership NHS Trust

TRUST BOARD – 30 JULY 2019

CHARITABLE FUNDS COMMITTEE – 9 JULY 2019

OVERVIEW REPORT TO BOARD

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

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Assured	Green – there are no gaps in assurance

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
Fundraising manager's report		The fundraising manager's report highlighted: • Colour My Memories Appeal – Dementia wards at Evington Centre - Dementia Garden. It was highlighted that progress was slow due to difficulties gaining consensus on safe tile surfaces. • Website development - website was launched on 5th March. Analysis of traffic, donations etc was provided. Traffic had decreased after the initial launch. Increased communications would be needed to keep traffic to the site. • Topping out for the new CAMHS unit would happen in September 2019. It was agreed that this would be a good opportunity to raise awareness of the charity and raise funds for a garden and sensory items at the unit, over and above	Quarterly updated to be provided Chair to write to LPT Health & Safety team to request assistance Fund manager to review website PID to ensure it was delivering as expected and define KPIs to assess future performance against LPT comms team to include Raising Health in topping out comms	September 2019 July 2019 September 2019 September 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		what was included in the core unit specification. • The charity had joined the Association of NHS Charities (also known as NHS Charities Together), in April 2019. This will provide good networking and information sharing opportunities.		
Quarter 4 2018/19 Finance Report, including 3 year business plan		The finance report for quarter 4 was presented. Highlights include: • The overall fund value stands at £1.6m, a reduction of £54k. • 2018/19 total expenditure totals £353k; commitments in the pipeline total £240k. • 2018/19 total income totals £299k, comprising donations (£64k), fundraising appeals (£38k), lottery income (£54k), dividends (£73k), "unrealised" (ie notional) investment gain (£35k), "realised" investment profit on disposal (£14k) and legacy income (£21k).	Next quarterly update	September 2019
Run rate review and 2019/20 budget setting		A run rate summary was presented, showing the charity's income and expenditure from 2015/16, forecasting forward to 2021/22. It showed that there was an imbalance each year between recurrent income and expenditure of c£16k. It was agreed that the charity would aim to break even on the recurrent position each year. Any non recurrent imbalance could lead to further capital drawdowns. It was agreed that the fundraising focus this year should be on legacies & donations, linked to the LPT sites where Raising Health were targeting promotional materials.	Keep under review Fund raising manager to bring a proposal for Raising Health involvement in national "make a will" month to next meeting	September 2019 September 2019
2018/19 Annual accounts timetable		The annual accounts & annual report timetable was approved	December Charitable funds committee needs to change to accommodate	September 2019

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
			Trust board. Date to be changed in the timetable when known.	
Procurement of Investment Advisors		An update was provided following the bidder presentation day in March. Schroders had been appointed and would replace Sarasin from 1st July 2019. Funds need to transfer between the advisors and close down report requested from Sarasin.	Finance staff to follow up funds transfer progress	July 2019
Charitable Funds processes and Procedures Update		The charity's procedures had been updated and included some agreed departures from the Trusts SFIs. It was agreed that this would help the running of the charity. A discussion took place around the issues that Bosom Babies were having in accessing funds in a simple way.	Shared folder to be set up for storing charity governance documents. Finance staff to review processes and see what is feasible and appropriate	September 2019 August 2019
Trustee Membership 3 yearly refresh update		Geoff Rowbotham would be replaced as NED trustee by Ruth Marchington. Following discussions with the new Chief Executive, it was agreed that the Trust's nominated senior manager trustee would be nominated by the Director of Finance.	New senior manager trustee to be nominated	September 2019
Terms of Reference		The Terms of reference were reviewed, following changes requested by the Audit & Assurance committee during the annual review of the charitable funds committee at Audit committee. The Terms of reference were approved.	Terms of Reference to be sent to appropriate board meeting	July 2019
Approval, deferral and rejection of bids		Approved bids: • LPT Finance recharge (£26K) • Staff lottery running costs staff recharge (£10k) • Audit fees for 2018/19 annual accounts independent examination and 2019/20 internal audit review (£6k)	Assess if future recharges could reduce	March 2020

Key issue	Assurance level*	Committee update	Next action(s)	Timescale
		Rejected bids: • Hinckley & Bosworth staff room chairs (£3.5k). It was agreed that the charity would focus on supporting patient health & well-being bids this year, specifically gyms and gardens.	Quote needed and check against Raising Health criteria	July 2019
Bids approved post meeting		• None.		
Any other business		• None.		

Recommendation	The Trust Board receives and notes the issues raised in the highlight report.
Author	Cathy Ellis – Trust Chair / Committee Chair Sharon Murphy – Deputy Director of Finance & Procurement
Presented by (Chair of committee)	Cathy Ellis

Leicestershire Partnership NHS Trust

Step up to Great

Our Quality Improvement Plan 2019-2021

WeAreLPT

compassion respect integrity trust

www.leicspart.nhs.uk

Contents

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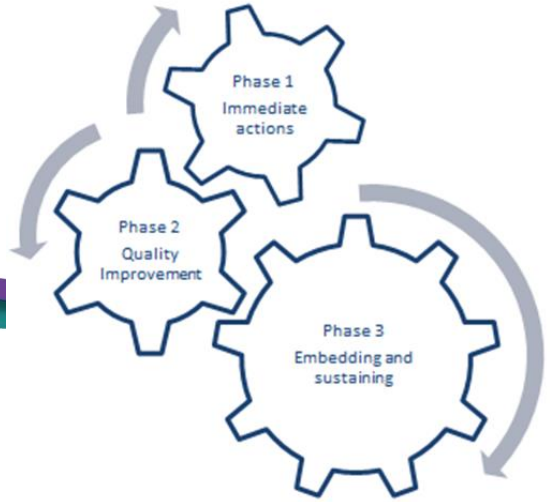
Introduction

Welcome to our new Quality Improvement Plan.
This strategic plan, and the Directorate plans which underpin it, mark an important step forward for our Trust. They have been drawn up with input from our staff, patients, carers and other key stakeholders and reflect some of the things which matter most to these important groups.

They set out our ambitious plans over the next three years to deliver a longer term sustainable approach that makes sense to the front line and helps to deliver improvements in the priority areas communicated in STEP up to GREAT.

In keeping with or values we aim to use the actions set out in these plans to deliver the right care in the right place for our patients and ensure staff will feel proud to be part of LPT.

Having focused considerable time and effort on delivering some immediate improvements and tackling some of our most urgent quality and safety issues post the publication of our CQC report, we are now seeking to move from a short term, reactive approach to quality and safety to a more comprehensive, strategic approach.



This approach will help to make a real difference for the better for our patients and support our staff in their efforts to deliver the high standards of care to which they aspire. This will be reflected within our CQC ratings at our next inspection.

Whether you are a patient, carer, member of staff or anyone else with an interest in the quality and safety of local health care, we hope you will find in these pages a clear statement of our intent, a strong commitment to continual improvement and a realistic and easy to follow route map of the next stages of our improvement journey.

Angela Hillery, Chief Executive
Sue Elcock, Medical Director
Anne-Maria Newham, Director of Nursing, AHPs and Quality

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How we define quality and quality Improvement

Quality must be the organising principle of our health and care service. It is what matters most to people who use services and what motivates and unites everyone working in health and care. But quality challenges remain, alongside new pressures on staff and finances.

In the past few years the NHS has had a number of inquiries that have identified poor practices and raised concerns about the quality of the services being delivered. These have been reported widely in the press and have caused the public to loose confidence in the services they may receive. Reports such as the Francis Report into Mid Staffordshire Hospital, the Morecambe Bay inquiry and the report into care at Winterbourne View Care Home are just a few.

Quality Improvement is a formal approach to analysing performance and systematic efforts to improve.

Improving quality is about continuously evaluating and iteratively improving what we do to make it better, ensuring that we **do the right thing at the right time for EVERY patient**. To deliver this it is key that all staff are empowered to lead and make improvements in their everyday work and that all performance and outcomes are measured and monitored in a systematic manner to ensure that quality improvements are made and sustained.

At Leicestershire Partnership NHS Trust we are taking an organisation-wide approach to improving quality. This can ensure that local activities are aligned, coordinated and appropriately resourced, helping to avoid the fragmentation and duplication often associated with working only at the microsystem level. It also provides the strategic constancy of purpose, momentum and infrastructure necessary for multifaceted, cross-organisational initiatives to emerge.

What are the enablers of organisational improvement?

Translating a desire for change in an organisation-wide programme capable of delivering sustained improvements in safety, quality and experience presents a set of challenges. Through analysis of the peer-reviewed improvement literature and Health Foundation improvement programmes and publications, the enabling factors that contribute to the success of an organisational approach to improvement fall into four broad categories:

- **Leadership and governance**
- **Infrastructure and resources**
- **Skills and workforce**
- **Culture and environment**

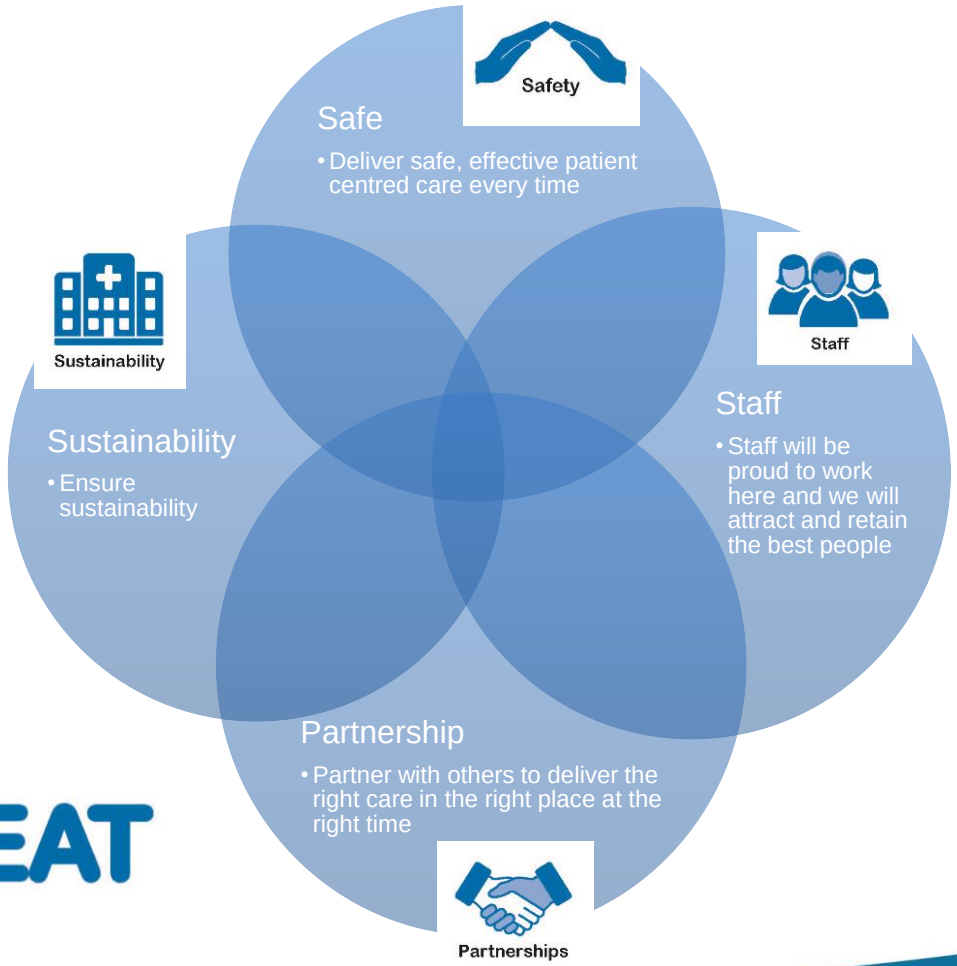
Joining up the pieces

Underpinning the many and varied policy initiatives designed to improve the quality of care have been multiple approaches to improving quality, reflecting competing beliefs on how improvements are best achieved.

We have 4 key objectives that will help us to deliver high quality care.

Safe, Staff, Sustainability, Partnership

Underpinning our objectives we have **9 priorities – STEP up to GREAT**



STEP up to GREAT

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Our Vision

"Providing high quality integrated physical and mental health care"

Our Priorities

STEP up to GREAT

- **S** High Standards
- **T** Transformation
- **E** Environments
- **P** Patient Involvement
- **G** Well-governed
- **R** Single Patient Record
- **E** Equality, Leadership, Culture
- **A** Access to Services
- **T** Trustwide Quality Improvement

Our Objectives

Safety

Partnerships

Staff

Sustainability

Our Values

- Compassion
- Respect
- Integrity
- Trust

NHS
Leicestershire Partnership
NHS Trust

What the CQC said about us

What has happened so far?

The Care Quality Commission visited the Trust in November 2018 and published their findings in February 2019. Five complete services which were previously rated as requires improvement or risk assessed as requiring an inspection were inspected. The Trust was rated overall as 'Requires Improvement'.

Overall rating: Requires Improvement		
Are services safe?		Requires improvement
Are services effective?		Requires improvement
Are services caring?		Good
Are services responsive?		Requires improvement
Are services well led?		Inadequate

This section provides a summary of the CQC's findings about our services. The Summary report and full CQC report can be found on the CQC website: https://www.cqc.org.uk/sites/default/files/new_reports/AAAH7279.pdf

1. Ensuring services are safe

The CQC rated LPT as Requires Improvement because:

- The trust had not fully ensured that clinical premises where patients received care were safe, clean, well equipped, well maintained and fit for purpose.
- The management of seclusion documentation was poor.
- Medicines management within four of five services inspected, was unsafe and raised serious concerns.
- The CQC were not assured the trust had full oversight of risks within core services with inconsistent management of patient risk in three services.
- The trust did not comply with guidance on eliminating mixed sex accommodation in some services.
- Staffing shortages, sickness and use of agency presented issues for three services visited.

2. Ensuring services are effective

The CQC rated LPT as Requires Improvement because:

- Staff did not routinely complete individualised, person centred and holistic care plans for or with patients.
- Staff supervision and appraisal compliance on some wards fell below 75%.
- The trust did not provide data to demonstrate medical staff appraisal compliance.

What the CQC said about us

- Not all teams had access to a full range of skilled staff to deliver treatment under best practice guidance.
- Staff did not routinely complete or record physical health checks on admission in some areas.
- Staff did not demonstrate evidence of collaborative working between wards, learning from incidents and sharing of best practise.

3. Ensuring Services are Caring

The CQC rated LPT as Good because:

- Staff showed caring attitudes towards their patients and demonstrated a respectful manner when working with patients, carers, within teams and showed kindness in interactions.
- Patients and carers gave positive feedback about the caring nature and kindness of staff .
- Patients had access to advocacy services.

4. Ensuring Services are Responsive

The CQC rated LPT as Requires Improvement because:

- Trust oversight for access to care and treatment within four services was below expectation.
- Patients waited for long periods to access community services, bed occupancy within inpatient wards was high.
- Use of out of areas beds for acute wards for adults of working age.
- Waiting lists were considerable for specialist community mental health services for children and young people; children and young people in crisis had difficulty accessing help urgently, and carers had difficulty accessing beds in short breaks units.
- There were facilities that did not promote comfort, dignity and privacy.
- At times, services did not meet the diverse needs of those patients who used services.

5. Ensuring Services are Well Led

The CQC rated LPT as Inadequate because:

- A high number of concerns had not been addressed from the previous inspections. Significant issues with trust level governance, oversight of environments, a failure to address keys issues and a lack of pace with delivering essential improvements.
- There was a lack of an overarching strategy and vision for the Trust.
- Lack of robust governance procedures to identify and address issues in a timely way.
- Improvements were needed to how the Trust identifies and manages risk.
- Lack of a framework for co-ordinating, endorsing and therefore learning from the positive quality projects taking place.
- Limited approach to patient involvement and slow pace for implementing equality and diversity initiatives across the organisation.

What are we trying to achieve?

Our Vision:

"Providing high quality integrated physical and mental health care."

The STEP up to GREAT Quality Improvement Plan is a high level document that sets out our intentions to deliver excellent care every time to every patient.

Our aim is to create a culture of continuous improvement and learning which is both patient centered and safety-focused.

Our objectives and priorities are set out in STEP up to GREAT. To deliver our priorities we must embed our four values in everything we do.

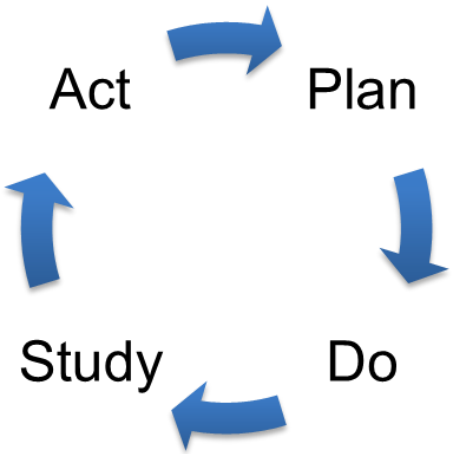
Compassion, Respect, Integrity, Trust

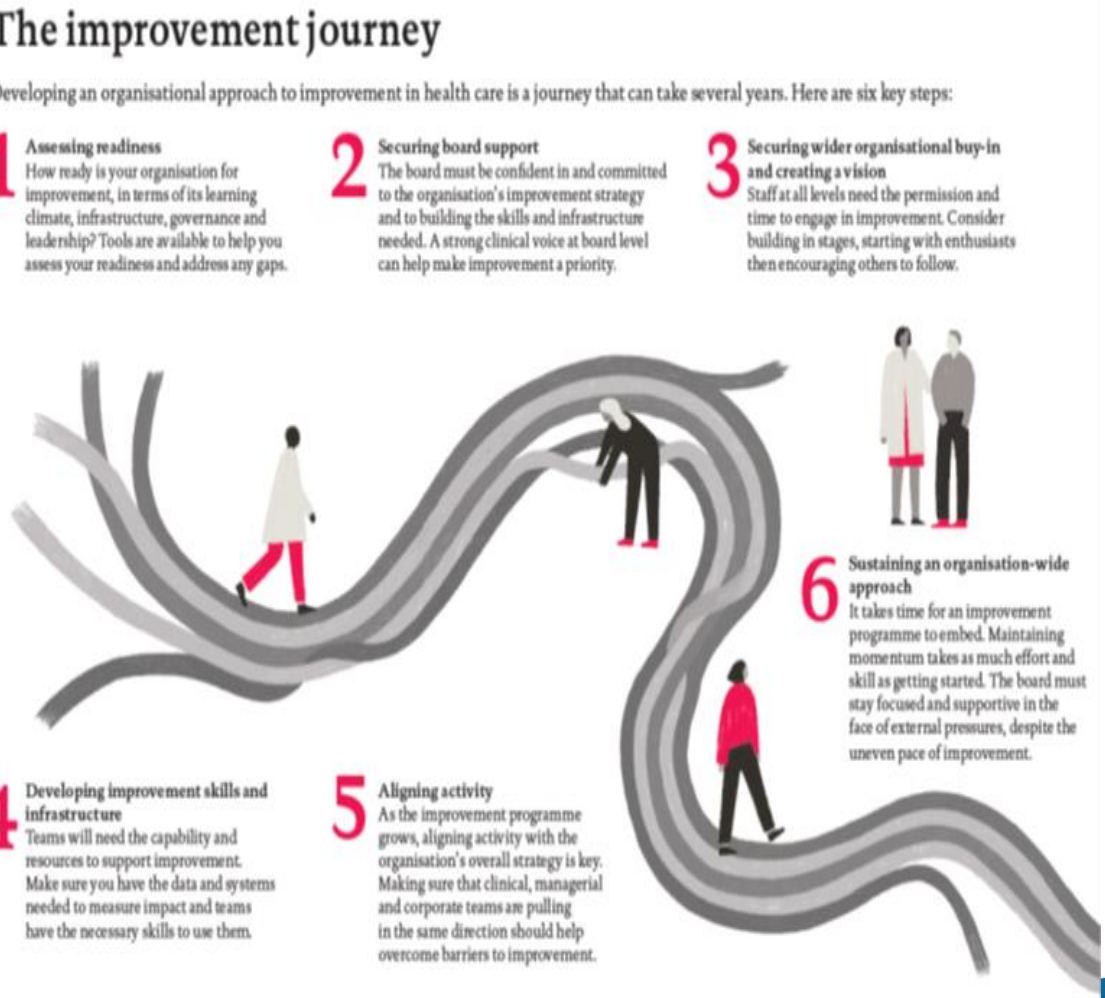
This plan will be closely linked with delivery of our clinical priorities as outlined within our Quality Account, our Clinical Quality Strategy, The People Strategy, the Care Quality Commission's (CQC) domains **of safe, effective, caring, responsive and well-led** and be supported by annual planning.

Our model for improvement

Trustwide model for improvement:

- Focussing quality improvement on our strategic objectives
- Diverse and engaged steering group with multiprofessional leadership
- Defined methodology: PDSA (see below)
- Single point of access for support from a virtual faculty
- Training in a tiered approach based on the IHI model





Our objectives and priorities

Strategic Objective	Priorities
Safe Deliver safe, effective, patient centred care every time.	**High Standards** - Improve standards of safety and quality
	Trust-wide QI - Implement a Trust wide approach to quality Improvement
	Access to Services - Make it easy for people to access our services
Partnership Partner with others to deliver the right care in the right place at the right time	**Patient Involvement -** Involve our patients, carers and families
Staff Staff will be proud to work here and we will attract and retain the best people	**Equality, Leadership, Culture -** Improve Culture equality and Inclusion
Sustainability Ensure sustainability	**Transformation -** Transform our mental health and community services
	Well Governed - Be well governed and sustainable
	Environments - Environments will be welcoming, clean and safe
	Single Patient record - Implement single electronic patient record

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Measuring for success – Safe

High standards

We will improve our standards of care and professionalism through:

- Developing an agreed set of clinical and professional standards and values that describe what constitutes safe and effective care to ensure consistent provision of high quality care with person-centred outcomes
- Nursing standards to be linked to the NMC Code & RCN Principles of Nursing Practice and Trust clinical priorities
- Reducing avoidable harm
- Co-creating personalised care plans and risk assessments
- Establishing a Professional Practice Model, benchmarking clinical practice, professional values, practice and career enhancing clinical education, and research and innovation
- Driving continuous improvements in patient outcomes, and increase patient satisfaction and staff experience at ward and team/unit level using QI methodology
- Focusing on developing the Ward/Team Leader role accountability and responsibilities to ensure there are systems and processes for patients to receive high standards of care
- Increasing the number of improvement programmes undertaken using a QI methodology

We will measure this by:

- Trust wide accreditation programme to monitor and improve clinical standards
- Clinical audit and clinical practice benchmarking:
  - Medicines management
  - Infection control
  - Safeguarding
  - Risk assessment
  - Care planning
  - Physical health care
  - Seclusion practices
  - Tissue viability
  - Falls reduction
- Clinical audit and clinical practice benchmarking
- Nurse sensitive indicators – monthly safe staffing
- Trust training compliance report - monthly
- Patient Safety Thermometer - monthly
- Serious Incident Log - monthly
- Number of disciplinary cases – Quarterly report from Professional Standards Learning Group
- Number of referrals to the NMC/HCPC- Quarterly report from Professional Standards Learning Group
- Adherence to up-to-date evidence based policies to support practice
- Clinical care complaints and concerns

Measuring for success - Safe

Trustwide Quality Improvement

We will design and implement a Trustwide programme of Quality Improvement that equips staff with the skills and resources to drive improvements by:

- Identifying and embedding an agreed QI methodology across the Trust
- Training and supporting staff in acquiring QI knowledge
- Establishing a 'virtual QI Faculty' utilising the skills of staff within the organisation and linking with partners across the system.
- Agreeing and launching our QI principles
- Embedding PDSA (plan, do, study, act) as the routine QI methodology in use across the Trust during 2019
- Ensuring a single point of access for support from QI teams
- We will start training our Ambassadors
- We will standardise our governance of and paperwork for QI projects across the Trust

We will measure this by:

- Including staff surveys of knowledge of the QI principles
- Evaluation of the single point of access for QI support
- A clear training plan in place
- Percentage of ambassadors trained
- Evidence from directorate meetings of use of standardised governance and paperwork
- Monitoring the number of QI projects in place

Measuring for success – Safe

Access to Services

We will make it easier for people to access our services by reducing our waiting times through:

- Determining our priority services for waiting time improvements using a risk based approach
- Developing demand and capacity capability and a schedule of demand and capacity reviews across our services
- Engaging with our commissioners to review access targets to ensure they are safe, appropriate and deliverable
- Reviewing, amending and publishing a revised LPT Patient Access Policy
- A relentless focus on data quality improvements
- Providing the services with performance dashboards to support service level performance management
- Executive oversight through our revised performance management processes

We will ensure equality of access for all our patients by:

- Ensuring accurate and robust data collection to identify our patients diverse needs.
- Reviewing this data on an on-going basis and ensuring we make reasonable adjustments to support access to healthcare services.
- Collecting and reviewing patient feedback to ensure we are listening and acting upon concerns raised.

We will measure this by:

- Waiting time reports via service and directorate governance processes, executive team, performance management oversight group, FPC and Board which include:
  - ➢ Our 6 national waiting time targets
  - ➢ Our local waiting time targets (including CAMHS)
- Service line performance against waiting time improvement trajectories
- Patient and carer satisfaction surveys, complaints and compliments

Our expected outcomes - Safe

High standards

By improving our standards of care and professionalism the expected outcomes are:

- An increase in patient and carer satisfaction with their care and experiences
- Increased learning from patient and carer experience
- An increase in patients actively involved in the care they receive
- Reduction in complaints for clinical standards of care
- Our rates of “harm free’ care will increase with a reduction in harms associated with falls, pressure ulcers, Catheter Acquired Infections, medication errors and Clostridium Difficile infections
- Our mortality rates will reduce and robust Learning from Deaths process will be in place.
- Our compliance rates will increase with the Trust five markers of Infection Prevention and Control
- Improved record keeping and care planning
- Reduction in practice concerns related to safe and therapeutic observations and seclusion practice
- Reduction in clinical care complaints and concerns
- Improved culture of learning and improvement to improve the overall safety of healthcare
- High level of training compliance

Trust wide Quality Improvement

By designing and implementing a Trust wide programme of Quality Improvement the expected outcomes are:

- A programme of improvements in place that are delivered using a consistent methodology and are sustained over a prolonged period.
- Strong clinical engagement with senior leaders driving change.

Access to Services

By making it easier for people to access our services the expected outcomes are:

- Improvements in achievement of national waiting time targets
- Improvements in patient and carer satisfaction surveys
- A reduction in complaints relating to waiting times and access
- Improvements in health outcomes for our patient population.

Measuring for success - Partnership

Patient Involvement

We will make is easy and straight forward for people to share their experiences by:

- Capturing the experiences of those who access our services where feedback is currently not proactively sought.
- Improving the way we collect feedback and make better use of alternative methods such as working with volunteers, social media and computerised systems.
- Working with our Experts by Experience to ensure we gather feedback from under-represented groups and our most vulnerable members of the community.
- Publicising where we have made changes as a result of feedback, refreshing the use of “You said…We did” posters.
- Clearly communicating the available feedback channels to those who access our services and raising awareness of how to pay a compliment, raise concerns, or make a complaint and how to access the Patient Advise and Liaison Service (PALS).
- Review our website to ensure it is inviting and accessible to patients

We will measure this by:

- Quarterly reports that evidence patient feedback through a range of mechanisms including Friends and Family Test (FFT), patient surveys and complaints
- Quarterly and annual report that triangulate the range of patient feedback and provide thematical reviews of patient experience, identifying trends and areas for improvement
- Evidence of implementation of action plans in response to patient experience, detailing lessons learnt and service improvement/change undertaken
- Quarterly and annual complaints reports

Measuring for success - Partnership

We will increase the numbers of people who are positively participating in their care and in service improvement by:

- Co-creating and producing our five year Patient Experience and Involvement Strategy
- Actively involving patients in decisions about their care and co-creating collaborative care plans
- Continuing our co-design approach in the development of our Experts by Experience programme
- Working closely with our volunteers to develop opportunities for involvement such as Talk and Listen volunteers
- Adopting best practice approaches to involvement and improvement such as Always Events and 15 Steps Challenge
- Creating a People's Council to discuss changes to the way we deliver services
- Ensuring there is a commitment at every level in the organisation to involve patients and carers in service improvement and design
- Exploring and trial various ways of facilitating and encouraging involvement across the organisation
- Ensuring we share great examples of where involvement is happening
- Communicating to all our staff the value, importance and expectation for meaningful involvement across all our services
- Strengthening our links with voluntary and community organisations so we can work together to involve patients and the public

We will measure this by:

- Producing a five year Patient Experience and Involvement Strategy
- Number of Experts by Experience recruited onto the EBE Programme
- Number of volunteers involved in patient experience and involvement activities
- Number of improvement programmes undertaken
- A central repository of patient involvement activities and improvements delivered
- A range of communication approaches/tools available to inform staff of the organisations ambition for patient experience and involvement
- Uptake of patient experience and involvement training by staff

Measuring for success - Partnership

Patient Involvement

We will improve the experience of people who use or are impacted by our services by:

- Undertaking an organisation self-assessment using the Patient Experience Improvement Framework
- Making sure our staff have the right knowledge, skills, tools, and confidence to undertaken meaningfully involvement wherever possible
- Ensuring the Patient Experience Team work alongside frontline staff to translate feedback into local actions.
- Creating a positive learning approach to complaints handling and ensuring complaints and compliments are shared widely
- Regularly review and report within the organisation on progress against our patient experience improvement plans and actions
- Integrating feedback from patients about their experience into governance processes and board meetings.
- Evaluating our response to feedback with service users and patients to ensure that we are continually learning and improving patient experience

We will measure this by:

- Number of patient involvement and improvement projects/programmes taking place across the organisation
- Evidence of improvements/changes made to service delivery as a result of patient experience/involvement
- Improvement in self-assessment scores through the Patient Experience Improvement Framework
- Improvement in patient satisfaction captured through annual surveys and FFT feedback
- Improvement in CQC ratings
- Evidence of spread and adoption of patient experience and involvement approaches across the organisation

Our expected outcomes - Partnership

Patient Involvement

By making it easy and straight forward for people to share their experiences.

The expected outcomes are:

- A reduction in complaints
- Improved FFT (friends and family test) and patient survey scores.
- An increase in the number of ‘Experts by Experience’ working with us
- Greater patient engagement in co-design of services
- Greater involvement of local community groups and the third sector in supporting us deliver care to our patients and community.

Measuring for success - Staff

Equality, Leadership, Culture

Equality

In Jan 2019 we worked with the national WRES team and launched our WRES improvement programme co-designing solutions with our BAME workforce to the barriers they have identified. We will encourage and improve equality, diversity and inclusion of our workforce by:

- Support for our BAME staff to improve opportunities for and chances of career progression.
- Delivering Unconscious Bias training
- Rolling out the LLR Reverse Mentoring programme
- Undertake interview skills training for the first cohort of BAME staff by the end of June 2019
- Launching a zero tolerance campaign.
- Delivering co-designed cultural competence training.
- Recruiting and training a number of BAME staff to be on interview panels by the end of August 2019
- Rewriting our recruitment policy by Oct 2019

We will measure this by:
- Numbers of staff engaging in reverse mentoring
- Performance against the WRES measures
- Staff experience ratings in the NHS staff survey

Leadership and Culture

We will co-create a culture of collective leadership that engages staff and empowers them to improve the services we provide, demonstrated through:

- The five key elements which shape high quality care cultures: Vision and Values, Goals and Performance, Support and compassion Learning and innovation, Team work.

- In 2019 we launched the NHSi Culture and Leadership programme: The programme enables us to co-design solutions to our barriers together so that our staff feel more valued, supported and empowered. We are committed to creating an inclusive and compassionate culture that we can all feel proud of.

We will measure this by:
- Staff experience ratings in the NHS Staff survey
- Demonstrating effective leadership
- Staff retention, sickness, performance, staff experience, teamwork

Our expected outcomes - Staff

Equality

By implementing a programme to improve equality, diversity and inclusion of our workforce the expected outcomes are:

- By the end of March 2019 will have agreed key actions with our BAME workforce to improve their experience.
- By end of May 2019 we will have commenced our reverse mentoring programme and our unconscious bias training.
- By the end of June 2019 we will have undertaken interview skills training for the first cohort of BAME staff.
- By end June 2019 we will launch our zero tolerance campaign.
- By the end of July 2019 we will have delivered co-designed cultural competence training.
- By the end of August 2019 we will have recruited and trained a number of BAME staff to be on interview panels.
- By the end of Oct 2019 will have re-written our recruitment policy.

Long term outcome measures

- Further improvement in staff experience reflected in NHS staff survey
- Improvements in workforce race equality standard WRES

Leadership and Culture

By creating a culture of collective leadership that engages and empowers staff the expected outcomes are:

Outcome / Measures

Phase 1 Discovery

- Launch of the discovery phase of the culture leadership programme in April 2019, with a Board report in September 2019

Phase 2 Design -

- Co-design solutions and formation of a new People Strategy between September to November 2019

Phase 3 Deliver -

- By November 2019 and 2020 onwards we will launch the People Strategy, roll out solutions and embed into everyday practice.

Long term outcome measures

- Further improvement in staff experience reflected in NHS staff survey
- Improved staff retention, sickness, performance, staff experience, teamwork

Measuring for success - Sustainability

Transformation

We will transform our all age mental health services by:

- Agreeing a preferred new model of service delivery from the range of options co-produced with patients, carers and staff
- Agreeing the workforce and finance required to deliver the new model
- Engaging the public about the proposed new delivery model
- Testing features of the new model including trailing a newly configured and enhanced locality team in one area
- Developing a network of peer support workers, who have lived experience, to strengthen our clinical delivery teams
- Setting out a 30-month phased implementation plan with associated outcome measures

We will measure this by:

- Delivery against the phased implementation plan which will be in place by the end of October 2019
- Measuring referrals, activity and response times
- Patient and carer satisfaction surveys
- At least 10 peer support workers will be visible in practice and feel capable and supported
- Seeking the views of stakeholders who refer to the service
- Staff survey and engagement score

Measuring for success – Sustainability

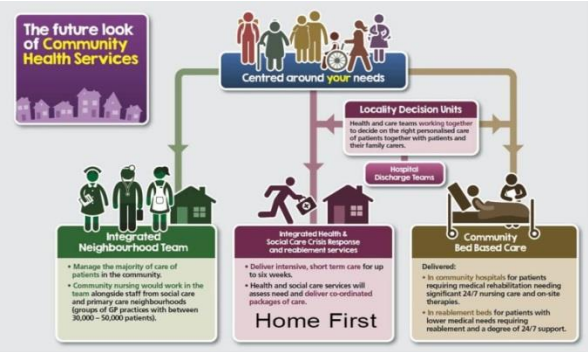
Transformation

We will implement a new model of care in our community nursing and therapy services by :

- Reviewing the evidence base and best practice examples to give us the best chance of success
- Co-creating a new model of care which reflects the involvement of our staff, service users and local population and will ensure:
  - People are managed in the most appropriate setting
  - People with long term conditions will be identified earlier and proactive care put in place to avoid exacerbation of their condition(s).
  - People are enabled to self-care within defined clinical thresholds for their long term condition.
  - People are supported to restore their health, wellbeing and independence after illness or hospital admission.
  - Health and social care services are available when the patient needs them.
  - Peoples' experiences improve through a easy to navigate and better co-ordinated system.
  - We will work with our commissioners to develop a new service specification and implement these changes during Quarter 3/4

We will measure this by:

- Patient and carer satisfaction surveys
- Attendance at primary care network MDT meetings
- Auditing patient involvement in their care plan and their goals
- Seeking the view of partners who refer to our services
- The percentage of people whose Modified Westcomes Outcome score is maintained or improves
- The number of people who die in their preferred place of death
- The number of patients with a named key worker
- Measuring our referral, activity and response times



Measuring for success - Sustainability

Well governed

We will ensure the Trust's positive achievement of external regulatory body inspections and introduce effective governance arrangements across the Trust to maintain ward to board understanding by:

- Developing robust corporate governance arrangements that ensure Executives, Board Committees and Trust Board have oversight of key challenges in the Trust
- Revise governance structures to improve the robustness of the information flows and establish standards to provide a consistent framework for reporting information from ward to board and from board to ward
- Strengthen and embed the risk management and assurance framework arrangement
- Introduce revised Trust performance management arrangements including a revised accountability framework

We will measure this by:

- Ensuring all our frameworks keep the organisation safe for patients and are working effectively and efficiently.
- Achieving significant assurance opinion from internal audit.
- Testing our governance arrangements to ensure that they are fit for purpose and support delivery of the Board's strategic objectives.
- Monitoring and managing the delivery of our quality improvement programme.

Measuring for success - Sustainability

Well governed

We will ensure the Trust's positive achievement of external regulatory body inspections and introduce effective governance arrangements across the Trust to maintain ward to board understanding by:

- Scoping the introduction of a central corporate governance office
- Creating a supporting structure that develops a culture of learning across the Trust
- Continue to develop Ward to Board activity
- Introducing changes to the leadership and operational structures
- Providing additional governance training for officers and staff in key areas
- Ensuring the key internal control mechanisms are operating effectively and are reported through the governance structures

We will measure this by

- Ensuring all our frameworks keep the organisation safe for patients and are working effectively and efficiently.
- The visibility of the Executive and Non-Executive team to Trust staff
- Achieving significant assurance opinion from internal audit.
- Testing our governance arrangements to ensure that they are fit for purpose and support delivery of the Board's strategic objectives.
- Monitoring and managing the delivery of our quality improvement programme.

Measuring for success – Sustainability

Well-governed

Well Governed - Stakeholder Engagement

Together with our Leicester, Leicestershire and Rutland (LLR) partners and stakeholders we will develop the LLR Integrated Care System (ICS) by 2021 by:

- Co-producing the LLR ICS plan with our Health and Social Care partners.
- Developing the LLR Health System Plan in 2019/20 alongside that of the Trust.
- Playing our part in delivering the overall financial control total for the LLR health system.
- Developing the LLR long term plan to ensure the clinical and financial sustainability of our wider system.
- Developing, with our partners, the architecture and governance arrangements that allow us to operate as an ICS, in the interim and in the long term.

We will measure this by:

- Production of an LLR ICS delivery plan.
- Production and delivery of the LLR plan for 2019 including the system financial control total.
- Production and agreement of the LLR long term plan.
- Production and agreement of the ICS governance arrangements.

Better care **together**

A partnership of Leicester, Leicestershire & Rutland Health and Social Care

Measuring for success - Sustainability

Well Governed - Financial Sustainability

We will deliver our statutory financial duties and financial plan by:

- Devolving clinical service revenue budgets to our divisions for delivery. Corporate budgets will be devolved to our enabling directorates.
- Developing and implementing a cost improvement programme with clear and clinically agreed quality impact assessment.
- Developing and implementing a capital programme that meets the requirements of our CRL (capital resource limit) and supports of estates and IM&T requirements.

To progress these priorities in 2019/20 we will:

- Set and agree a financial plan which is aligned to our overall Trust plan.
- Develop an approach to future efficiency and effectiveness which is fully aligned to our quality improvement priorities and informed by our current performance against national requirements or benchmark.

We will measure this by:

- Monitoring delivery against our financial plan on a monthly basis.
- Monitor our efficiency and effectiveness against national benchmarks (e.g. GIRFT and Model Hospital)
- Production of a QI enabled efficiency strategy.

Measuring for success - Sustainability

Environment

We will improve the quality of our buildings and ensure they are safe clean and welcoming by:

- Eliminating all dormitory style accommodation in our acute and older peoples mental health inpatient and replace with en-suite single rooms by 2030.
- Developing a business case for an interim solution
- Ensuring mitigations are in place to manage privacy, dignity and safety in the existing dormitory accommodation
- Ensuring all buildings are maintained to appropriate standards of safety and cleanliness.
- Enhancing the efficiency and effectiveness of our estate and our estate management and governance arrangements.

To progress these priorities in 2019/20 we will:

- Refresh our estates strategy to ensure it meets the current and future needs of our patients
- Develop the Strategic Outline Business Case for the replacement of our adult and older peoples mental health beds
- Ensure that our estate backlog maintenance programme is prioritised to meets the needs of our most high risk areas
- Continue to rationalise the estate
- Review our facilities management arrangements to ensure that our estate remains clean and safe on a day to day basis.

We will measure this by:

- Producing a revised estates strategy which will be presented to the Board in September 2019.
- Producing a Strategic Outline Business Case which will be approved by the Board and submitted to NHSi in September 2019.
- Timely delivery of our estates backlog maintenance programme.
- Achievement of our milestones for the building of the new CAMHS inpatient unit on the Bradgate site.
- Ensuring facilities management response times and escalation processes in line with national expectations
- Ensuring facilities are in line with infection prevention and control national requirements
- Ensuring cleanliness scores are in line with national requirements
- Monitoring the number of sites we manage

Measuring for success - Sustainability

Single Electronic Patient Record

We will improve patient care through a single electronic patient record by:

- Delivering the Single Electronic Patient Record project plan by ensuring there are adequate resources in line with the plan and that there is robust project management.
- Facilitating all staff to access one electronic patient record across LLR and that staff are trained accordingly.
- Facilitating more effective and responsive communication between clinicians and between primary and secondary care services

We will measure this by:

- Meeting the key milestones within the detailed project plan
- Safe transfer to one electronic patient record
- The production of a benefits realisation project review post completion

Our expected outcomes - Sustainability

Transformation

In transforming our all age mental health services and a new model of care in community nursing and therapy services, the expected outcomes are:

- Development of models of care that enables the Trust to better manage capacity and demand.
- Improvements in achievement of national performance standards
- Improvements in key quality indicators
- Improved patient satisfaction
- Improved staff recruitment and retention

Well Governed

By positive achievement of external regulatory body inspections and introducing effective governance arrangements across the Trust, the expected outcomes are:

- Improvements in CQC ratings for the Well-Led domain
- Achievement of a significant assurance opinion from internal audit
- A reduction in the emergence of unknown risks across the Trust resulting in harm to patients or staff
- Full compliance achieved with regulatory requirements
- Greater ownership and understanding of governance throughout the organisation from Board to Ward

In delivering our statutory financial duties and financial plan the expected outcomes are:

- A reduction in risk to the quality of care we deliver by ensuring services are delivered in the most efficient and effective way.
- Achievement of all statutory financial duties

Our expected outcomes - Sustainability

Environment

By improving the quality of our buildings and ensuring they are safe, clean and welcoming the expected outcomes are:

- The risk of harm to patients is reduced
- Patient satisfaction will be improved
- Staff satisfaction at work will be improved
- Privacy and dignity for our patients is improved.
- The risk of breaches of health and safety regulations is reduced.
- The Trust will meet all IPC regulations and best practice
- Environmental audit results will improve
- The delays in backlog maintenance will be reduced.

Single Electronic Patient Record

Through implementing a single EPR the expected outcomes are:

- Patient safety incidents will reduce through the provision of better real time information
- Staff satisfaction will improve due to the provision of patient information via a single format.
- Communication between the Trust and external health partners will improve thus reducing patient risk.

Governance

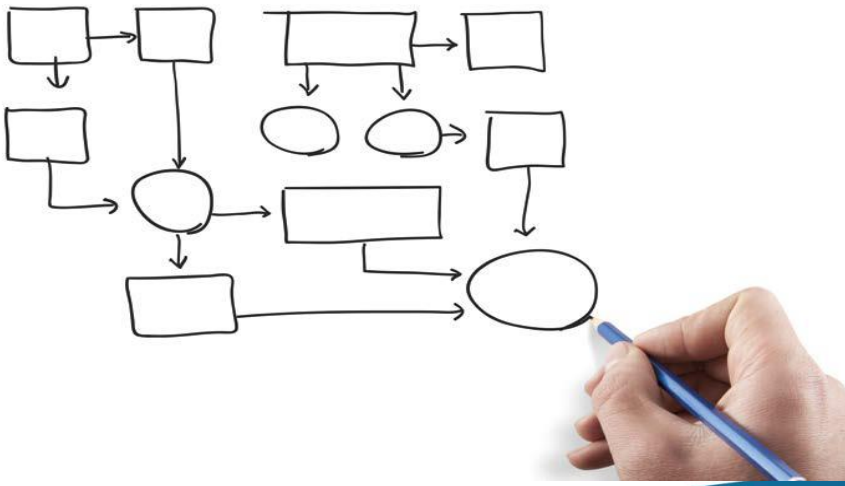
Each Directorate will develop a **directorate improvement plan** which will be the vehicle to deliver the priorities within this Strategy, however these will be localised to the issues and ambitions of each Directorate. Each plan will be developed with the Directorate leadership team and will include all of the improvement plans required to deliver the Directorate business plan.

The Directorate Improvement plans will be the **single plan** that will draw together and monitor all action plans across the Directorate. Within each ward and department there will be a lead who will own their local plan as the single plan to deliver all quality improvements in their area.

The Directorate improvement plans will be managed through the **monthly performance review process** and will be reviewed formally at a monthly Trust **Quality Improvement Board**.

The plans will be led at ward and department level by **clinical and operational leaders who are responsible for quality** in their area as part of their leadership role.

Each Directorate will support their clinical and operational leaders to design and deliver local improvement plans. This will **involve engagement** of ward and departmental teams.



Leadership and Oversight

	Priorities	Executive Lead	Performance monitoring	Board Assurance	Trust Board reporting
S High Standards	1. High Standards	Director of Nursing, AHPs and Quality	Monthly Executive Quality Improvement Board with summary report to joint QAC/FPC	QAC	Reporting to Board via highlight reports and direct assurance from quarterly joint QAC and FPC
T Trustwide Quality Improvement	2. Trustwide Quality Improvement	Medical Director/Chief Nurse		QAC	
A Access to Services	3. Access to Services	Divisional Directors		QAC/FPC	
P Patient Involvement	4. Patient Involvement	Director of Nursing, AHPs and Quality		QAC	
E Equality, Leadership, Culture	5. Equality, Leadership Culture	Director of HR & OD		SWG	
T Transformation	6. Transformation	Divisional Directors		QAC/FPC	
G Well-governed	7. Well - Governed	Chief Executive/Director of Finance		FPC/AAC/QAC/ SWG	
E Environments	8. Environments	Director of Finance		FPC	
R Single Patient Record	9. Single Patient Record	Medical Director		FPC	

Leicestershire Partnership NHS Trust

Meeting	Trust Board
Date of meeting	30/07/2019
Paper number	Q

Name of Report Quality Improvement Plan

For approval	X	For assurance		For information	

Presented by the Accountable Director	Angela Hillery	Author (s)	C.Geddes, NHSE/I

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe	X	Safe	X	S – High Standards	X
Effective	X	Staff	X	T - Transformation	X
Caring	X	Partnerships	X	E – Environments	X
Responsive	X	Sustainability	X	P – Patient Involvement	X
Well-Led	X			G – Well-Governed	X
				R – Single Patient Record	X
				E – Equality, Leadership, Culture	X
				A – Access to Services	X
				T – Trustwide Quality improvement	X

Report previously reviewed by		
Committee / Group	Date	Assurance obtained (Significant/Limited/None)
Trust Executive Group	28/05/19 & 10/06/19	
Trust Board	24/06/19	

Assurance : What level of assurance does this report provide in respect of the Board Assurance Framework Risks? (Significant / Limited / No Assurance)	Links to BAF risk numbers

Recommendations of the report
The Board are asked to note the progress in the development of the Trust Quality Improvement Plan and support the next steps in finalising and delivering the plan.

1. Introduction/Background

Following the development of an action plan in response to the most recent CQC inspection and subsequent report, the Trust has adopted Quality Improvement methodology in order to continue to drive improvements and ensure these are sustained.

It is well recognised that in order to deliver sustained continuous improvement, the adoption of an organisation wide improvement methodology and plan is best practice.

A draft three year Trust wide Quality Improvement Plan was presented to the June Board and this report now presents the next iteration of that strategic plan (Annex). The plan ties together the Trust values, current strategic objectives, the nine key priorities identified in STEP up to GREAT, the Clinical Priorities as outlined within the Quality Account and is directly aligned to the key areas within the CQC action plan.

The measures for success identified within the plan are currently focussing on year 1, recognising that healthcare is a dynamic environment and the plan should be refreshed annually.

Each Directorate is currently in the process of developing their plans with KPI's and trajectories for improvement.

2. Aim of the plan

The purpose of the Quality Improvement Plan is to provide an overarching framework that identifies the key Trust priorities for driving improvement within the organisation.
Underpinning the plan is a framework of Quality Improvement methodology and the proposal for a Quality Improvement resource to support staff in the delivery of this plan.

The Medical Director is leading the work with clinical teams to develop the QI methodology. The Finance Director is currently working with the Executive Team to identify resources required to support this programme of work. A PMO resource is required in order to ensure robust monitoring and reporting on delivery of the Directorate plans.

A monthly Trust Quality Improvement Board has been established in order to monitor delivery of the priorities identified within the plan. Dates for the meetings are currently being organised.

3. Where the plan sits within the Trust's strategic framework

On arrival within the Trust the new CEO has been undertaking a stocktake of the current strategic framework with a view to streamlining it. There is a risk that the launch of the

Quality Improvement Plan alongside the current objectives plus Step up to Great may cause confusion amongst staff and stakeholders. Therefore, as the CEO shapes her thinking there may be some slight changes to the wording and formats in order to simplify and strengthen opportunities for alignment.The detail sitting under the 9 Step up to Great priorities will however not change.
It will be important to finalise these changes before the document is launched within the organisation.

4. Next Steps

The next steps are to:

- Confirm where the QIP sits within the Trust Strategic Framework.
- Develop KPIs for each priority with one year trajectories for improvement
- Identify resources available to support delivery and establishment of a PMO
- Launch and share widely with staff and key stakeholders
- Develop a dashboard to monitor progress

5. Recommendations

The Board is asked to note the progress on development of the Trust Quality Improvement Plan and support the proposed next steps in finalising and delivering the plan.

Annex: Quality Improvement Plan 2019-2012

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 30th July 2019
Paper number	R

Name of Report **Care Quality Commission Report**

For approval		For assurance	X	For information	

Presented by	Anne-Maria Newham, Director of Nursing, AHP's and Quality	Author (s)	Kate Dyer, Head of Assurance

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe	X	Safe	X	S – High Standards	X
Effective	X	Staff	X	T - Transformation	X
Caring	X	Partnerships	X	E – Environments	X
Responsive	X	Sustainability	X	P – Patient Involvement	X
Well-Led	X			G – Well-Governed	X
				R – Single Patient Record	X
				E – Equality, Leadership, Culture	X
				A – Access to Services	X
				T – Trustwide Quality improvement	X
Any equality impact (Y/N)		No impact on equal opportunities			No

Report previously reviewed by	
Committee / Group	Date
QAC	July 2019

Assurance : What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers
The paper provides the Trust Board a progress report on the implementation of actions resulting from the last CQC inspection.	Whole BAF

Recommendations of the report
The Trust Board is asked to note the information included in the report and take assurance that work to implement actions is progressing.

Leicestershire Partnership NHS Trust

Care Quality Commission Report

1. Introduction / Background

1.1 The CQC report published in February 2019 relates to the inspection dated 19th November 2018 to 13th December 2018. The report describes the CQC's judgement of the quality of care provided with respect to the Trust's well led framework and an inspection of five of our core services. The CQC issued a Warning Notice to the Trust on the 30th January 2019.

2. Aim

To provide an update on Care Quality Commission (CQC) related activity, including delivery against the actions identified following the 2018/19 inspection findings.

3. Recommendation

The Trust Board is asked to note the information included in the report and take assurance that work to implement actions is progressing.

4. Discussion

4.1 Overall the Trust has made 49% progress against the action plan. In terms of the warning notice actions, 75% progress has been made. We note a slowing of pace around the completion of actions.

The table below provides a summary of overall progress as at 5th July 2019.

Theme	Warning Notice % Complete	Must Do % Complete	Should Do % Complete	Total No. (%) complete by theme
Access	67%	n/a	0%	**4 (44%)**
Care planning	n/a	100%	0%	**1 (50%)**
CTO	n/a	n/a	0%	**0**
Environmental / estates	67%	50%	0%	**3 (43%)**
Fire safety	67%	100%	0%	**5 (63%)**
Governance	20%	0%	0%	**1 (20%)**
Infection Control	n/a	40%	0%	**2 (40%)**
Medicines mgt / medical devices	67%	0%	0%	**4 (44%)**
Meet diverse need	n/a	n/a	0%	**0**
Patient involvement	n/a	n/a	0%	**0**
Physical healthcare	100%	n/a	0%	**5 (83%)**
Privacy and dignity	100%	100%	n/a	**8 (100%)**
Risk assessments	83%	n./a	n/a	**5 (83%)**
Safeguarding	n/a	n/a	0%	**0**

Seclusion environments/ paperwork	86%	0%	n/a	**6 (75%)**
Workforce	n/a	n/a	0%	**0**
Total % complete by action type	38 (75%)	6 (46%)	0	44 (49%)

This table includes seven new themes due to the addition of the open 'should-do' actions this month. This has impacted on the overall total % complete.

4.2 The Trust is taking a number of steps to ensure that traction is maintained with the delivery of the CQC action plan, and in particular, provide support for action owners where any difficulties may exist.

July 2019

- The format of the action plan will be updated to distinguish between the completion of an action, and the completion of the testing to establish whether action has been embedded and sustained. This will be done ahead of the next scheduled action plan update on the 22nd July 2019.

August 2019

- During the 1st – 15th August 2019 the Trust will;
  - Determine which actions are related to longer term projects and decide what timescales we are willing to tolerate for completion.
  - Be clear about the timescales for delivery for all remaining must and should do actions.
  - Begin to populate the AMaT software with the CQC action plan.
- 6th August 2019. We will be re-introducing the CQC oversight panels. These will now be monthly to coincide the CQC progress meetings which focus on the preparation of the 2019/20 inspection regime. The panels will provide support for any hotspots by addressing any barriers to completion. These will continue until further notice.
- 15th August 2019. Catch up meeting with the CQC to discuss progress to date with the CQC action plan. The Trust will provide clarity over timescales for delivery; discuss the revised format of the action plan and the re-introduction of the panels.

September 2019

- To start reporting on CQC action plan progress from the AMaT database.
- CQC engagement meeting 27th September 2019.

4.3 Re-inspection

The CQC undertook a warning notice follow up inspection during the week beginning 10th June 2019. Preliminary findings conclude that significant improvements had been made in all nine warning notice themes. Initial feedback indicates that the areas identified by the CQC for on-going improvement reflect the Trust's improvement action plan.

4.4. Compliance with fundamental standards

The latest poster continues to contain an inaccuracy. The rating for wards for people with a learning disability or autism has a 'not rated' section on the poster for the Well Led component of the inspection. In the report this had been rated as 'requires improvement'.

The latest poster is displayed at each premises where a regulated activity is being delivered (including main place of business and our website). This will be updated as soon as a revised poster has been issued.

5. Conclusion

The Trust continues to make progress against the CQC inspection action plan however the pace has slowed. The Trust is taking a number of steps to ensure that traction is maintained with the delivery of the CQC action plan, and in particular, provide support for action owners where any difficulties may exist.

Leicestershire Partnership NHS Trust

Meeting	Trust Board
Date of meeting	30 July 2019
Paper number	Si

Name of Report - **SAFE STAFFING – JUNE 2019 REVIEW**

For approval		For assurance	☑	For information	

Presented by the Accountable Director	Anne-Maria Newham	Author (s)	Emma Wallis

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe	☑	Safe	☑	S – High Standards	☑
Effective		Staff		T - Transformation	
Caring		Partnerships		E – Environments	
Responsive		Sustainability		P – Patient Involvement	
Well-Led				G – Well-Governed	☑
				R – Single Patient Record	
				E – Equality, Leadership, Culture	
				A – Access to Services	
				T – Trustwide Quality improvement	

Report previously reviewed by		
Committee / Group	Date	Assurance obtained (Significant/Limited/None)
Direct report to Trust Board		

Assurance: What level of assurance does this report provide in respect of the Board Assurance Framework Risks? (Significant / Limited / No Assurance)	Links to BAF risk numbers

Recommendations of the report
The Trust Board is recommended to receive assurance that processes are in place to monitor and ensure the inpatient and community staffing levels are safe and that patient safety and care quality are maintained.

Leicestershire Partnership NHS Trust

TRUST BOARD – 30 JULY 2019

SAFE STAFFING – JUNE 2019 REVIEW

Introduction/Background

1 This report will provide an overview of the nursing safe staffing during the month of June 2019, triangulating productivity, workforce metrics, quality and outcomes linked to Nurse Sensitive Indicators (NSIs) and patient experience feedback.

2 Part one refers to inpatient areas and part two relates to community teams.

3 Actual staff numbers compared to planned staff numbers are collated for each inpatient area. A summary is available in Appendix 1.

Aim

4 The aim of this report is to provide the Trust Board with assurance that arrangements are in place to safely staff our services with the right number of staff, with the right skills at the right time. Including an overview of staffing hot spots, potential risks and actions to mitigate the risks, to ensure that safety and care quality are maintained.

Recommendations

5 The Trust Board is recommended to receive assurance that processes are in place to monitor and ensure the inpatient and community staffing levels are safe and that patient safety and care quality are maintained.

Trust level highlights for June 2019

Right Staff

- Overall the planned staffing levels were achieved across the Trust. Where inpatient staffing actual fill rate is less than 80% and or 50% substantive staff are utilised this is a moderate risk, referred to as a 'tipping- point' indicating a Lead Nurse review of staffing establishments and staff deployment.
- Temporary worker utilisation rate slightly increased this month by 0.3%; reported at 33.2%. Utilisation is associated with meeting planned staffing levels where there are vacancies and sickness. It is also associated with increases in patient acuity and dependency requiring additional staff to maintain quality of care and patient safety.
- Agency usage slightly decreased this month 0.4% to 3.6%.
- The total number of Trust wide Registered Nurse (RN) vacancies reported this month is 206.67 w.t.e posts (116.55 inpatients and 90.12 community). This is an increased position this month by 26.91 w.t.e RN posts. The increase sits within community teams; planned community teams and FYPC.

- The total number of Trust wide Health Care Support Worker (HCSW) vacancies reported this month is 86.97 w.t.e. posts (68.98 in-patients and 17.99 community). This is a decreased position this month by 1.37 w.t.e posts.
- As of the 1 July 2019 there are 49.3 w.t.e candidates in the recruitment pipeline, expected to join the Trust over the next few months.
- There are nine hotspot inpatient areas, hotspots have been identified either by; exception to planned fill rates, high percentage of temporary worker utilisation or by the Lead Nurse due to concerns relating to increased acuity, high risk patients, staff sickness, ability to fill additional shifts and the impact to safe and effective care.
- There are also twelve community team hot spots areas across CHS and FYPC. Two emerging hot spots in June 2019; East Central hub, Community Nursing (due to vacancies) and City West CMHT, MHSOP (due to increased registered nurse sickness and lack of bank or agency to backfill). Where community teams are considered a hot spot, staffing and case-loads are reviewed and risk assessed across teams using patient prioritisation models to ensure appropriate action is taken.
- A review of the Trust's NSIs and patient feedback has not identified any correlation between staffing and impact to quality and safety of patient care/outcomes.

Right Skills

- In consideration of ensuring staff have the 'right skills', a high level overview of clinical training, appraisal and supervision for triangulation is presented. As of the 1 July 2019 Trust wide;
    - Appraisal sustained GREEN at 91.7%
    - Clinical supervision AMBER at 81.3% with an improving trend over the last six months
    - Of the 29 core and clinical mandatory compliance subjects, all sustained GREEN with the exception of six topics (five at AMBER and one RED).
    - Compliance with mandatory training for bank staff remains lower than that of substantive staff. Following targeted action there is improvement in bank staff compliance in June 2019. During 2019/20 we plan to use HealthRoster to prevent bank staff from booking shifts if they are not compliant with mandatory training. Subject topics have been prioritised. This will help to sustain the improvement achieved and to provide assurance that bank workers who are actively working in our services have the right skills.

Right Place

- The increased fill rates for the percentage of actual HCSWs reflects the high utilisation and deployment of additional temporary staff in response to patient acuity and increased levels of therapeutic observation in order to maintain safety of all patients.
- The total Trust CHPPD average (including ward based AHPs) is reported at 11.26 CHPPD in June 2019, with a range between 5.1 (Ashby Ward) and 35.2 (Agnes Unit) CHPPD. The variation in range reflects the diversity of services, complex and specialist care provided across the Trust.
- Analysis of the CHPPD has not identified variation at service level, indicating that staff are being deployed productively across services.

Part One – In-patient Staffing

1 The overall trust wide summary of planned versus actual hours by ward for registered nurses (RN) and health care support workers (HCSW) in June 2019 is detailed below:

	DAY		NIGHT		
	% of actual vs total planned shifts RN	% of actual vs total planned shifts care HCSW	% of actual vs total planned shifts RN	% of actual vs total planned shifts care HCSW	Temp Workers%
April 19	104.9%	216.0%	107.6%	194.5%	30.9%
May 19	105.5%	206.7%	108.6%	195.5%	32.9%
June 19	**103.5%**	**199.7%**	**107.2%**	**187.5%**	**33.2%**

Table 1 - Trust level safer staffing

2 Overall the planned staffing levels were achieved across the Trust. The increased fill rates for the percentage of actual HCSWs reflects the high utilisation and deployment of additional temporary staff in response to patient acuity and increased levels of therapeutic observation in order to maintain safety of all patients.

3 Temporary worker utilisation rate slightly increased this month by 0.3%; reported at 33.2%. Utilisation is associated with meeting planned staffing levels where there are vacancies and sickness. It is also associated with increases in patient acuity and dependency requiring additional staff to maintain quality of care and patient safety.

4 Agency usage decreased slightly this month 0.4% to 3.6% in line with previous months.

Summary of safer staffing hotspots – Inpatients

Planned staffing and/or high utilisation of temporary workers	April 2019	May 2019	June 2019
Hinckley and Bosworth - East Ward	X	X	X
Short Breaks - The Gillivers	X	X	X
Short Breaks – Rubicon Close	X		X
Mill Lodge	X	X	X
Kirby		X	
Coleman	X	X	
Belvoir	X	X	X
Griffin	X	X	X
Agnes Unit	X	X	
Langley	X	X	X
Feilding Palmer	X	X	X
St Lukes Ward 3	X	X	X
Ward 3 Coalville (CAMHS)	X	X	

Table 2 - Safer staffing hotspots

5 East Ward, Mill Lodge and Short Breaks are hot spot areas as they did not meet the threshold for planned staffing across all shifts, on these occasions staffing was reported to be within safe parameters for all areas.

6 Belvoir and Langley Wards are hot spots due to utilising over 50% temporary staff. The high utilisation is associated with both vacancies and increased patient acuity.

7 Griffin ward and St Lukes Ward 3 remain as hot spots due to concerns relating to increased acuity, high risk patients, staff sickness, ability to fill additional shifts and the impact to safe and effective care.

8 Number of occupied beds, planned staffing levels versus actual staffing levels and percentage of temporary staff utilised is presented in the tables below per in-patient area by service and directorate. For planned versus actual levels; Green indicates threshold achieved and red indicates an exception.

- For temporary workers; green indicates threshold achieved, amber is above 20% utilisation and red above 50% utilisation.
- The NSIs that capture care or outcomes most affected by nursing staffing levels are also presented in conjunction with patient experience feedback. This report indicates if there has been an increase or decrease in the indicator position against the previous month for the NSIs and patient experience feedback.

Adult Mental Health and Learning Disabilities Services (AMH/LD)

Acute Inpatient Wards

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers%	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
Ashby	21	91.7%	126.7%	101.7%	136.7%	31.0%	5.1	17.1%↑	2↑	1↓	1	100%
Aston	19	90.6%	156.7%	96.7%	170.0%	43.0%	6.2	26.1%↓	0↓	0↓	0	nil
Beaumont	21	90.6%	170.8%	100.0%	340.0%	41.1%	6.5	7.8%↓	5↑	8↑	0	100%
Belvoir Unit	9	109.6%	399.2%	190.0%	431.6%	57.1%	23.8	36.8%	0	0	0	nil
Bosworth	20	92.2%	210.8%	103.3%	376.7%	46.8%	7.4	18.7%	0	1	0	nil
Heather	17	97.1%	137.5%	90.0%	143.3%	23.7%	6.2	5.7%↓	0↓	1↑	0	nil
Thornton	20	95.0%	157.5%	100.0%	133.3%	35.0%	6.4	8.9%	2↑	0↓	0	100%
Watermead	19	95.0%	178.3%	100.0%	256.7%	40.1%	6.9	13.5%	2	1↑	0	nil
Griffin F PICU	5	178.9%	234.1%	200.0%	136.7%	36.4%	17.8		0	0↓	0	nil
TOTALS									**11↑**	**12↓**	**1**	

Table 3 - Acute inpatient ward safe staffing

9 All wards met the threshold for planned staffing across all shifts.

10 Temporary worker utilisation is Amber for all wards with the exception of Belvoir Ward rated Red at 57.1%. The high utilisation of temporary staff is associated with vacancies, sickness and patient acuity; several patients over the month had violent and aggressive episodes and required 2:1 staffing.

11 To mitigate the risks associated with utilising higher numbers of temporary staff and the impact on quality and patient experience, the service block book regular bank and agency RNs and HCSWs across the acute inpatient wards, substantive staff are also moved across areas dependant on the skill mix and patient need. This is reviewed at the twice weekly staffing meeting and daily safety huddle.

12 A review of the NSIs and patient feedback has not identified any staffing impact on the quality and safety of patient care/outcomes for all wards. Beaumont Ward has seen an increase in falls and medication errors this month. Falls are related primarily to one patient who was self putting on to the floor not falling. The medication incidents increased due to an issue with the pilot of the electronic CD register and recording, both should reduce as plans put in place to mitigate the risks.

Learning Disabilities (LD) Services

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers %	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
3 Rubicon Close	2	100.0%	98.3%	70.0%	80.0%	30.5%	18.9	11.3%↑	0	0	0	nil
Agnes Unit	8	193.9%	806.1%	142.9%	707.1%	46.5%	35.2	20.0%↑	1↑	1	0	nil
The Gillivers	2	66.7%	92.6%	20.0%	130.0%	22.3%	22.2	-0.4%	1↑	0	0	nil
The Grange	1	-	142.9%	-	185.0%	15.4%	20.3	30.0%	0	0↓	0	nil
TOTALS									**2↑**	**1↓**	**0**	

Table 4 - Learning disabilities safe staffing

13 Short break homes continue to utilise a high proportion of HCSWs who are trained to administer medication and carry out delegated health care tasks. The Gillivers and the Grange support each other with RN day cover. Night cover is shared across the site as the homes are situated next to each other in conjunction with utilisation of additionally trained HCSWs. Patients do not always need the support of registered nurses.

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

Low Secure Services – Herschel Prins

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers%	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
HP Phoenix	10	97.5%	133.3%	100.0%	146.7%	32.2%	9.4	27.8%	0	0	0	Nil

Table 5- Low secure safe staffing

15 Phoenix Ward achieved the thresholds for safe staffing. High levels of temporary workers continue to be utilised to cover vacancies, sickness and a high number of level one and level two patient observations.

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

Rehabilitation Services

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers%	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
Skye Wing	27	107.5%	174.4%	190.0%	156.7%	49.2%	5.4	9.2%↑	1↓	7↑	0	nil
Willows Unit	30	151.3%	172.6%	125.0%	240.5%	29.0%	9.2	-0.1%↓	1	0	0	68.4%
Mill Lodge	13	106.7%	242.7%	58.3%	220.0%	38.8%	11.5	17.9%↑	1↑	7↑	0	nil
TOTALS									**3↓**	**14↑**	**0**	

Table 6 - Rehabilitation service safe staffing

17 Mill Lodge remains a hot spot for meeting planned RN levels on nights only 58.3% of the time. The service adopts a staffing model based on patient acuity and dependency, staff skills and competencies and increasing the number of HCSWs and sharing RN support with Stewart House. The establishments on nights for RN's are expected to be filled from autumn 2019.

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

The increase in falls at Mill Lodge was related to new patients who were moving through the phase of Huntington's disease and associated mobility is changes. Stewart House increase in falls was related to one particular patient on Skye being recently diagnosed with epilepsy. The patient had a change to medication which at times made them unsteady on their feet. To mitigate the risks the patient was on level 1 observation and the MDT are closely monitoring daily.

Community Health Services (CHS)

Community Hospitals

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers%	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
FP General	7	123.3%	78.4%	103.7%	-	27.7%	7.6	36.8%	1↑	4↑	0	100%
MM Dalgliesh	14	95.0%	118.9%	95.0%	100.0%	20.5%	8.4	-4.3%↓	0	4↑	0	100%
Rutland	14	98.3%	122.5%	93.3%	93.3%	11.2%	6.2	29.5%↑	0	4↑	0	88.0%
SL Ward 1	11	105.0%	194.2%	101.7%	132.2%	25.6%	14.3	26.9%↑	0	3	0	100%
SL Ward 3	9	94.1%	101.7%	190.0%	103.3%	38.6%	8.3	37.9%↑	0↓	1↓	0	100%
CV Ellistown 2	18	108.4%	175.6%	200.0%	100.0%	13.8%	8.5	9.5%↑	0↓	1↓	0	100%

CV Snibston 1	12	113.2%	166.4%	105.3%	124.6%	12.3%	12.8	15.8%	0	2	0	77.8%
HB East Ward	18	75.1%	195.8%	101.7%	103.3%	35.8%	8.3	13.2%	2↑	2↓	0	nil
HB North Ward	15	113.3%	177.5%	100.0%	101.7%	16.2%	8.0	9.2%	0	1↑	0	nil
Loughborough Swithland	18	100.0%	198.3%	100.0%	200.0%	9.0%	9.6	24.1%	1↓	7↑	0↓	81.8%
CB Beechwood	19	81.9%	210.0%	96.7%	103.3%	18.4%	9.5	24.1%	2↑	2↑	0↓	nil
CB Clarendon	17	89.6%	236.4%	95.0%	136.7%	21.6%	8.1	22.6%↑	0↓	2↓	0	nil
TOTALS									**6↓**	**33**	**1**	

Table 7 - Community hospital safe staffing

19 East Ward remains a hot spot as it only met the planned RN level during the day 75.1% of the time. The ward runs with two RNs on occasion, which meets safer staffing parameters. A review of the NSIs for the community hospital wards has identified that there was one moderate harm incident on East Ward, however the investigation has not identified any direct correlation between staffing and the impact to quality and safety of patient care/outcomes.

20 Feilding Palmer is a hot spot associated with increased temporary workforce usage due to vacancies and sickness.

21 Ward 3 St Lukes remains a particular hotspot with 70% of registered substantive nursing vacancies plus a further 20% of registered nurses being unavailable on the ward, with an increasing sickness absence rate of 9.27% (May 2019 figure). Although the nurse sensitive indicators remain stable for this ward, there is considerable clinical and staffing pressure mitigated by actions taken by the lead nurse and senior matron team to support and ensure safe staffing. The Matron is currently reviewing recruitment for the ward, planning an open day and further Facebook and Twitter campaigns.

22 There has been an increase in the number of reported staffing incidents where shifts fell below the agreed staffing parameters however analysis of the NSIs has shown that there was no direct impact to the quality of patient care/outcomes.

23 The Matrons review rosters across the service line on a weekly basis to support safe staffing and best practice in roster management.

24 There has been an increase in the use of off framework nursing staff across the community hospital wards due to the number of vacancies, increased sickness absence rate of 6.56% and lack of supply of temporary workforce both bank and agency. A deep dive into the use of off framework nurses is being undertaken by the Lead Nurse and Matrons in collaboration with the Centralised Staffing Team, to identify the root cause including Healthroster planning reviews.

Mental Health Services for Older People (MHSOP)

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers%	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
BC Kirby	22	80.7%	226.4%	95.0%	118.3%	20.5%	5.9	17.8%↓	0↓	6↓	0	66.7%
BC Welford	19	90.3%	200.0%	100.0%	98.3%	23.3%	6.4	17.4%↑	1↑	4↓	0	nil
Coleman	18	85.5%	327.9%	93.3%	243.3%	44.3%	10.3	9.1%↑	0	6↓	0	nil
Gwendolen	15	102.2%	210.8%	103.4%	140.7%	18.7%	9.4	26.1%	0↓	14↑	0	66.7%
TOTALS									**1↓**	**30↓**	**0↓**	

Table 8 - Mental Health Services for Older People (MHSOP) safe staffing

22 All wards met the threshold for planned staffing in June 2019.

23 Increased utilisation of temporary staff to meet planned staffing levels where there are vacancies and sickness and also due to increased patient acuity and level 1 observation.

24 The falls on Gwendolen have not been related to staffing shortages. There is currently an investigation being scoped due to a patient who repeatedly fell and has sustained harm. Initial investigation has identified that staffing is not a factor; the patient was under one to one observation. The procedure the staff member followed is being explored.

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

26 MHSOP in-patient wards have a substantive peripatetic team (not temporary workforce) to facilitate consistency and continuity of care. The team comprises of 5 WTE HCSWs who are permanently based on Coleman Ward to meet the patient needs due to increased acuity and dependency.

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

Ward	Occupied beds	DAY % of actual vs total planned shifts RN	DAY % of actual vs total planned shifts care HCSW	NIGHT % of actual vs total planned shifts RN	NIGHT % of actual vs total planned shifts care HCSW	Temp Workers%	CHPPD Care Hours Per Patient Day	Vacancy Factor	Medication errors	Falls	Complaints	FFT Promoter % (arrears)
Langley	8	117.9%	288.9%	103.3%	250.0%	56.2%	16.2	-9.6%↓	0	0↓	0	100%
CV Ward 3 - CAMHS	7	125.9%	251.2%	116.7%	275.9%	42.9%	18.1	11.1%	0	0	0	nil
TOTALS									**0**	**0↓**	**0**	

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

27 Both wards continue to utilise an increased number of temporary workers to manage increases in patient acuity and maintain patient safety.

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

Recruitment, Retention and Workforce planning

Recruitment

29 The current Trust wide nurse vacancy position for inpatient wards as reported real time by the lead nurses is detailed below. Staff identified as starters/pipeline, are staff that have been interviewed and in the recruitment process of which may or may not have a start date.

Area	Vacant Posts		Potential Leavers		Starters/Pipeline	
	RN	HCSW	RN	HCSW	RN	HCSW
FYPC	4.0	2.0	0	0	0	1.0
CHS (Community Hospitals)	47.0	23.0	2.9	2.0	5.0	4.0
MHSOP	15.7	3.4	1.0	0	0	2.0
AMH/LD	49.85	40.58	4.0	2.0	5.0	4.0
Trust Total June 2019	**116.55**	**68.98**	**7.9**	**4.0**	**10.0**	**11.0**
Trust Total May 2019	**104.4**	**66.58**	**5.6**	**5.8**	**13.0**	**22.9**

Table 10 - Recruitment summary in-patients

30 Rolling adverts for all RN posts including implementation of Trust incentivised schemes for hard to recruit areas. Accessing recruitment fairs at local universities, schools and colleges.

31 Rotational posts across Trust services and graduate frail older people's rotation programme in partnership with UHL

32 Increased work experience placements and increased recruitment of clinical apprentices

33 Pre-recruitment workshops taking place over June/July 2019 for the next cohorts of trainee nursing associates. LLR wide there are 133 places for 2019/20 with the next cohort due to commence in December 2019.

Part Two

Trust level summary community teams

34 The current Trust wide position for community hot spots as reported by the lead nurses is detailed in the table below. There are no hotspots identified in Adult or MHSOP Community Mental Health Teams this month.

Community team hot spots	April 2019	May 2019	June 2019
City East Hub- Community Nursing	X	X	X
City West Hub- Community Nursing	X	X	X
East Central Hub – Community Nursing			X
Hinckley and Bosworth – Community Nursing	X	X	X
Healthy Together – City (School Nursing)	X	X	X
Healthy Together – East	X	X	X

Health Together - West	X	X	X
Looked After Children team	X	X	X
CAMHS City - FYPC		X	X
CAMHS County - FYPC		X	X
CAMHS Crisis - FYPC	X	X	X
City West CMHT - MHSOP			X

Table 11 – Community Hot Spot areas

35 There are 29 community nursing teams that work together in zones called 'hubs'. There are 8 hubs in total.There remains a number of vacancies across the community planned care nursing hubs with City East and West and East Central carrying the largest number. Adverts are open to recruit Band 5 nurses for City East, City West, East Central, Charnwood and North West. Hinckley and Bosworth Hub is a hotspot as they have four registered nurses on maternity leave.

36 City West CMHT (MHSOP) is a hot spot due to increased registered nurse sickness and lack of bank or agency to backfill. Internal moves have been secured to support the clinical risk and activity. The service is also piloting an additional team lead in the city community teams.

37 Looked After Children team and Healthy Together City (School Nursing only), East and West Healthy Together , Outpatient and CRISIS teams are hot spot areas within FYPC Community; they are rated to be at Amber escalation level due to only 70% of the established team being available to work. Mitigation plans are in place within the service for moving staff internally where possible, overtime offered and vacant posts are being proactively advertised. Locum support recruited to and additional hours in place for existing substantive staff where possible to increase capacity. Risks continue to be monitored internally on a weekly basis.

38 There are no hot spots in June 2019 for AMH/LD Community.

Recruitment

39 The current Trust wide position for community teams as reported real time by the lead nurses is detailed below.

Area	Vacant Posts		Potential Leavers		Starters/Pipeline	
	RN	HCSW	RN	HCSW	RN	HCSW
CHS – Community Nursing Hubs	22.5	5.79	5.0	0	5.0	0
CHS - ICS	8.4	1.0	6.0	0	0	0
MHSOP	1.8	0	1.0	0	1.0	0
AMH/LD	25.1	7.2	0	0	8.0	0
FYPC	32.32	4.0	1.0	1.0	3.0	1.0
Trust Total June 2019	**90.12**	**17.99**	**13.0**	**1.0**	**17.0**	**1.0**
Trust Total May 2019	**75.36**	**21.76**	**10.8**	**1.0**	**12.4**	**1.0**

Table 13 - Recruitment summary community

Retention

40 There is a Trust wide Retention group with a number of initiatives linked to health and well-being programmes, learning and development, a Trust wide Preceptorship programme for all

newly registered staff, leadership and professional development programmes, time out days and career development opportunities.

Conclusion

41 The Trust continues to demonstrate compliance with the National Quality Board (NQB) expectations to publish safer staffing information each month. The safer staffing data is being regularly monitored and scrutinised for completeness and performance and reported to NHS England (NHSE) via mandatory national returns on a site-by-site basis.

42 Each directorate has a standard operating procedure for the escalation of safer staffing risks and any significant issues are notified to the Director of Nursing, AHPs and Quality on a weekly basis.

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

Presenting Director:	Anne-Maria Newham – Director of Nursing, AHPs and Quality
Author(s):	Emma Wallis – Associate Director of Nursing and Professional Practice

*Disclaimer: This report is submitted to the Trust Board for amendment or approval as appropriate. It should not be regarded or published as Trust Policy until it is formally agreed at the Board meeting, which the press and public are entitled to attend.

Appendix
Appendix 1 – In-patient Safer staffing supporting information - scorecard

June 2019

Ward Group	Ward name	Average no. of Beds on Ward	Average no. of Occupied Beds	Fill Rate Analysis (National Return) – Actual Hours Worked divided by Planned Hours: Nurse Day (Early & Late Shift) – Average % fill rate registered nurses	Nurse Day – Average % fill rate care staff	Nurse Night – Average % fill rate registered nurses	Nurse Night – Average % fill rate care staff	AHP Day – Average % fill rate registered AHP	AHP Day – Average % fill rate non-registered AHP	Skill Mix Met (NURSING ONLY)	% Temporary Workers (NURSING ONLY) – Total	Bank	Agency	Overall CHPPD (Nursing and AHP)
				>= 80%	>= 80%	>= 80%	>= 80%	-	-	(based on 1:8 plus 60:40 split)	<20%	-	-	
AMH Bradgate	Ashby	21	21	91.7%	126.7%	101.7%	136.7%			83.3%	31.0%	31.0%	0.0%	5.1
	Aston	19	19	90.6%	156.7%	96.7%	170.0%			77.8%	43.0%	42.4%	0.7%	6.2
	Beaumont	22	21	90.6%	170.8%	100.0%	340.0%			82.2%	41.1%	39.8%	1.3%	6.5
	Belvoir Unit	9	9	109.6%	399.2%	190.0%	431.6%			100.0%	57.1%	55.5%	1.5%	23.8
	Bosworth	20	20	92.2%	210.8%	103.3%	376.7%			76.7%	46.8%	45.1%	1.7%	7.4
	Heather	18	17	97.1%	137.5%	90.0%	143.3%			85.6%	23.7%	18.3%	5.3%	6.2
	Thornton	20	20	95.0%	157.5%	100.0%	133.3%			85.6%	35.0%	31.8%	3.2%	6.4
	Watermead	20	19	95.0%	178.3%	100.0%	256.7%			86.7%	40.1%	38.6%	1.5%	6.9
	Griffin Female PICU	5	5	178.9%	234.1%	200.0%	136.7%			94.4%	36.4%	24.8%	11.7%	17.8
AMH Other	HP Phoenix	11	10	97.5%	133.3%	100.0%	146.7%			92.2%	32.2%	31.0%	1.2%	9.4
	SH Skye Wing	29	27	107.5%	174.4%	190.0%	156.7%			88.9%	49.2%	48.7%	0.5%	5.4
	Willows Unit	32	30	151.3%	172.6%	125.0%	240.5%			90.0%	29.0%	28.7%	0.3%	9.2
	ML Mill Lodge (New Site)	14	13	106.7%	242.7%	58.3%	220.0%			60.0%	38.8%	35.1%	3.7%	11.5
CHS City	BC Kirby	24	22	80.7%	226.4%	95.0%	118.3%			64.4%	20.5%	19.9%	0.6%	5.9
	BC Welford	24	19	90.3%	200.0%	100.0%	98.3%			68.9%	23.3%	22.7%	0.6%	6.4
	CB Beechwood	20	19	81.9%	210.0%	96.7%	103.3%	100.0%	96.5%	66.7%	18.4%	14.2%	4.3%	9.5
	CB Clarendon	20	17	89.6%	236.4%	95.0%	136.7%			80.0%	21.6%	12.3%	9.3%	8.1
	EC Coleman	21	18	85.5%	327.9%	93.3%	243.3%			53.3%	44.3%	43.9%	0.4%	10.3
	EC Gwendolen	20	15	102.2%	210.8%	103.4%	140.7%			80.0%	18.7%	18.5%	0.2%	9.4
CHS East	FP General	8	7	123.3%	78.4%	103.7%	-	100.0%	103.1%	64.4%	27.7%	18.6%	9.1%	7.6
	MM Dalgleish	16	14	95.0%	118.9%	95.0%	100.0%	91.7%	98.7%	92.2%	20.5%	14.2%	6.4%	8.4
	Rutland	16	14	98.3%	122.5%	93.3%	93.3%			95.6%	11.2%	7.2%	4.0%	6.2
	SL Ward 1 Stroke	16	11	105.0%	194.2%	101.7%	132.2%	93.7%	94.3%	96.7%	25.6%	18.2%	7.4%	14.3
	SL Ward 3	10	9	94.1%	101.7%	190.0%	103.3%	107.8%	107.5%	84.4%	38.6%	28.7%	10.0%	8.3
CHS West	CV Ellistown 2	24	18	108.4%	175.6%	200.0%	100.0%	98.1%	100.1%	96.7%	13.8%	6.8%	7.0%	8.5
	CV Snibston 1	14	12	113.2%	166.4%	105.3%	124.6%	94.0%	100.0%	88.9%	12.3%	9.1%	3.2%	12.8
	HB East Ward	20	18	75.1%	195.8%	101.7%	103.3%	99.7%	100.0%	47.8%	35.8%	20.8%	15.1%	8.3
	HB North Ward	16	15	113.3%	177.5%	100.0%	101.7%			97.8%	16.2%	8.5%	7.7%	8.0
	Lough Swithland	22	18	100.0%	198.3%	100.0%	200.0%	101.0%	100.1%	100.0%	9.0%	7.3%	1.7%	9.6
FYPC	Langley	13	8	117.9%	288.9%	103.3%	250.0%	99.5%		87.8%	56.2%	55.0%	1.2%	16.2
	CV Ward 3	8	7	125.9%	251.2%	116.7%	275.9%	116.7%		93.3%	42.9%	32.3%	10.6%	18.1
LD	3 Rubicon Close	4	2	100.0%	98.3%	70.0%	80.0%			64.4%	30.5%	29.3%	1.2%	18.9
	Agnes Unit	12	8	193.9%	806.1%	142.9%	707.1%			100.0%	46.5%	44.3%	2.2%	35.2
	The Gillivers	4	2	66.7%	92.6%	20.0%	130.0%			40.0%	22.3%	22.3%	0.0%	22.2
	The Grange	5	1	-	142.9%	-	185.0%			95.6%	15.4%	15.4%	0.0%	20.3
Trust Total				**103.5%**	**199.7%**	**107.2%**	**187.5%**			**81.8%**	**33.2%**	**29.6%**	**3.6%**	

Leicestershire Partnership NHS Trust

Meeting	Trust Board
Date of meeting	30 July 2019
Paper number	Sii

Name of Report 6 Monthly Safe and Effective Staffing review

For approval		For assurance	☑	For information	

Presented by the Accountable Director	Anne-Maria Newham	Author (s)	Emma Wallis with input from; Head of Nursing/Lead Nurses Head of Workforce Support Head of Employment services Head of Education, Training & Development

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe	☑	Safe	☑	S – High Standards	☑
Effective		Staff		T - Transformation	
Caring		Partnerships		E – Environments	
Responsive		Sustainability		P – Patient Involvement	
Well-Led				G – Well-Governed	☑
				R – Single Patient Record	
				E – Equality, Leadership, Culture	
				A – Access to Services	
				T – Trustwide Quality improvement	

Report previously reviewed by		
Committee / Group	Date	Assurance obtained (Significant/Limited/None)
Direct report to Trust Board		

Recommendations of the report
The Trust Board is recommended to receive assurance that processes are in place to ensure compliance with the NQB and Developing Workforce Safeguards policy to deliver high quality care through safe and effective staffing; by combining evidence based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time.

TRUST BOARD 30 July 2019

Six monthly Safe and Effective Staffing review

1. Introduction

1.1 All NHS Trusts are required to deploy sufficient, suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively, National Quality Board (NQB) [1], *Safe sustainable and productive staffing.*

1.2 Building on the NQB guidance, *Developing Workforce Safeguards* policy*,* NHS Improvement (NHSi) [2] supports organisations to use best practice in effective staff deployment and workforce planning with recommendations and a framework to support; safe staffing establishment reviews, board reporting, deployment of new roles and how to respond to unplanned changes in workforce.

1.3 In line with the NQB guidance and NHSi Developing Workforce Safeguards policy the Leicestershire Partnership NHS Trust (LPT) six monthly staffing review includes; overview of right staff, right skills, right place; establishment reviews, workforce planning, new and developing roles and recruitment and retention.

1.4 The six monthly reviews are supported by the Trust Board monthly safe staffing reports.

2. Aim

2.1 This paper provides a progress update following the January 2019 staffing review and outlines the national overview including the NHSi workforce safeguards recommendations and NQB guidance. The report will also highlight any emerging risks and their impact on the Trust.

3. Recommendations

3.1 The Trust Board is asked to:

Receive and consider the information and related risks highlighted within this report. Receive assurance that actions are in place to review safe staffing in line with NHSi Developing Workforce Safeguard policy and NQB guidance.

Discussion

4. National Overview

4.1 NQB's (2016) guidance states that providers must deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively, with a systematic approach to

determining the number of staff and range of skills required to meet the needs of people using the service keeping them safe at all times.

4.2 The NHS Long Term Plan, NHS England [3] (2019) identified a number of specific workforce actions; wider reforms are to be finalised when the education and training budget for Health Education England (HEE) is set later in 2019 and the future workforce strategy is published.

4.3 A critical challenge is the current national workforce shortage, reported to be more than 100,000 vacancies' The Health Foundation [4] (2019). Nursing has the largest shortfall; 34,724 vacancies as of November 2018' NHS Digital [5] (2019) with higher percentages in learning disabilities, mental health and community nursing' House of Commons Health Committee [6] (2018). It is also reported that there are 27% more nurses leaving the profession than joining, with one in three nurses due to retire within the next ten years RCN, [7](2018).

4.4 NHSi and the Shelford Group launched a national faculty programme for Safe Staffing in February 2019. The Trust Associate Director of Nursing and Professional Practice was successfully recruited to the first cohort.

In June 2019, the NHS Deputy Chief Nursing Officer England outlined the national drive for safe staffing and actions to be taken across the system to the fellows;

- Boost pre-registration supply options and increase placements nationwide by 5,000 places with funding to ensure placements
- Reduce attrition from Higher Education Institutes (HEIs) - RePAIR (Reducing Pre-registration Attrition and Improving Retention) programme to reduce by 30%.
- The Trust submitted an expression of interest to NHSi Workforce to access placement infrastructure funding to develop plans to grow clinical placement capacity by 25% for the 2019 intake, and support students in practice to reduce attrition and improve retention. We have received notification that the bid was successful in July 2019.
- Improved Perceptions of the nursing profession
- Gender neutral/technical message
- Link to education cycle to boost applications
- Drive retention with a key on flexibility and culture
- Building a common improvement method and accreditation for Nursing
- Significant overseas recruitment

5. LPT overview - 'Right staff, Right Skills, Right Place'

Right Staff

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

	DAY		NIGHT		
Trust wide	% of actual vs total planned shifts RN	% of actual vs total planned shifts care HCSW	% of actual vs total planned shifts RN	% of actual vs total planned shifts care HCSW	Temp Workers %
Jan 19	103.2%	205.1%	107.8%	187.2%	30.2%
Feb 19	103.2%	202.4%	108.0%	184.6%	32.6%
Mar 19	101.4%	209.6%	108.1%	184.6%	33.2%
April 19	104.9%	216.0%	107.6%	194.5%	30.9%
May 19	105.5%	206.7%	108.6%	195.5%	32.9%
June 19	103.5%	199.7%	107.2%	187.5%	33.2%
Average	**103.6%**	**206.5%**	**107.8%**	**188.9%**	**32.1%**

5.2. Overall the planned staffing levels were achieved across the Trust. Over the last six months; East and Coleman Wards, Mill Lodge and Short Breaks are hot spot areas as they did not meet the threshold for planned staffing across all shifts, on these occasions staffing was reported to be within safe parameters for all areas.

5.3 Increased utilisation of additional HCSWs remains high in Mental Health Services for Older People (MHSOP) wards, Adult Mental Health (AMH) wards, Ward 3, Families Young People and Children's (FYPC) and Learning Disabilities (LD) services. Additional HCSWs are deployed to support increased patient acuity and high levels of patients requiring increased levels of observation within these areas.

5.4 The average percentage use of temporary workers is 32.1%; utilisation of temporary workers is to support vacancies, sickness and increased patient acuity and dependency.

5.5 The Trust safer staffing 'Hot-Spot' areas presented monthly to Trust Board have remained predominantly unchanging over the past six months for both in-patient wards and community teams.

5.6 'Hot-Spot's are determined by analysis of the fill rates, utilisation of temporary workers and triangulation with Nurse Sensitive Indicators (NSIs) and patient experience feedback.

Right Skills

5.7 In consideration of ensuring staff have the 'right skills', a high level overview of clinical training, appraisal and supervision for triangulation is presented in the monthly safe staffing reports for both substantive and bank only staff.

5.8 For substantive staff during the last six months;

- Appraisal sustained GREEN end of June 2019 position 91.7%
- Clinical supervision AMBER end of June 2019 position 81.3% with an improving trend over the last six months
- Of the 29 core and clinical mandatory compliance subjects, all have sustained GREEN with the exception of six topics (five at AMBER and one RED).

5.9 The Trust has a bank only workforce of around 900 individuals working across a wide range of professions, roles and services. Compliance with mandatory training for bank staff has historically been lower than that of substantive staff. This has raised concerns about the safety of those staff, of their colleagues and patients, particularly in areas where bank use is high. We have identified the main organisational barriers for bank staff accessing mandatory training as:

- Difficulty reaching bank workers in order to communicate what they need to do and when
- Difficulty maintaining oversight and taking action against a large and transient workforce
- Lack of engagement and bank workers not feeling part of LPT
- Lack of IT literacy amongst some bank workers

Following targeted action we have seen an improvement in bank staff compliance. During 2019/20 we plan to use HealthRoster to prevent bank staff from booking shifts if they are not compliant with mandatory training. Subject topics have been prioritised. This will help to sustain the improvement we have achieved and to provide assurance that bank workers who are actively working in our services have the right skills.

Right Place

5.10 Care Hours Per Patient Day (CHPPD) is a measure of workforce that is most useful at ward level to compare workforce deployment over time, with similar wards in the trust or at other trusts, as part of a review of staff deployment and overall productivity. This measure should be used alongside clinical quality and safety outcome measures to reduce unwarranted variation and support delivery of high quality, efficient patient care.

5.11 NHS Improvement published the first national nursing CHPPD data in December 2018. The national nursing average is 8.91 CHPPD, the Trust nursing average was reported at 8.61 CHPPD.

5.12 Over the last six months the trust average is 10.84 CHPPD, it should be noted that the Trust submissions include ward based AHPs and nurses. Analysis of the CHPPD has not identified variation at service level, indicating that staff are being deployed productively across services.

6.0 Establishment reviews – In-patient Wards

6.1 An assessment or re-setting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the board twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.

6.2 The Shelford Group Safer Nursing Care Tool (SNCT) is the recommended evidence based tool to review acuity and dependency in the NHSi

Developing Workforce Safeguards policy. The tool is currently applicable to acute physical care settings and not suitable for assessing acuity and dependency in community hospitals.

6.3 In May 2019 the Mental Health Optimal Staffing Tool (MHOST) was launched. MHOST is a safe staffing care tool developed by the Shelford Group in partnership with Imperial College London and the NHS Chief Nursing Officer for England.

The tool can be used to convert acuity and dependency data into a workload index and required FTEs to ensure that ward establishments reflect patient needs. The tool is suitable for use in both adult and child, older peoples, acute and rehabilitation in-patient mental health settings.

In June 2019 the Trust received the license to use the tool with a plan to train senior nursing staff to utilise the tool across CAMHS Ward 3, Adult Eating Disorders, AMH/LD and MHSOP in-patient areas later this year.as part of the next six monthly reviews

FYPC

Ward 3 CAMHS inpatient unit

6.4 Ward 3 consistently meets the planned staffing levels required for the unit. As a result of increased patient acuity and caring for children who are repatriated to other areas (such as adult provision) whilst awaiting an out of area bed. Staffing is increased to ensure all service user needs are met safely and appropriate safeguards are in place when nursing young people within adult environments or other additional areas such as the Place of Safety Assessment unit and the Leicester Royal infirmary as required.

6.5 The risk in having to utilise an increased temporary workforce to support additional areas and increased acuity is being felt by Ward 3 as it is necessary to move substantive staff from the Ward to ensure the appropriate level of expertise is available to deliver safe, consistent care to all patients including those who have been repatriated to other areas.

6.6 Increased acuity has resulted in high levels of increased observations and numbers of staff required to provide safe observation e.g. 2/3/4 staff to 1 patient. As a result, the use of off framework providers, i.e. Thornberry nursing have been high. Due to these higher than average safe staffing levels the ward has required up to 15 additional staff per 24 hours to safely mange the levels of observations over the past 6 months. The potential impact to the quality and effectiveness of patient care and patient and staff experience are monitored through FYPC service line governance groups.

6.7 Funding has been secured for a new build CAMHS Tier 4 mental health inpatient facility. In addition to the existing ten commissioned general acute beds there will be an additional five beds specialising in CAMHS inpatient Eating Disorders. A staffing review was undertaken to establish a robust

clinical staffing model for this new provision and current position, inclusive of the use of apprentice and nursing associate roles. As a result there will be an increase to the establishment of 3.00 WTE band 5 Nurses and 4.00 WTE Band 2 HCSWs with an aim to recruit staff with physical health expertise to compliment skill mix. A Trainee Nursing Associate role was recruited in December 2018.

6.8 Nursing leadership; a full time Ward Sister and three WTE band 6 deputy Charge Nurse/Sisters supported by a Matron. The Matron role is to be split between Crisis Resolution and Home Treatment (CRHT) team and Ward 3 CAMHS moving forward.

6.9 There continues to be a wide and well established Multi-disciplinary team, including a full time family therapist, as well as a band 5 assistant psychologist and a 0.6 WTE band 8A senior psychologist. Recruitment is underway for an additional 0.8 band 7 psychologist. Due to maternity leave the ward is exploring options for a band 5 OT years secondment with clinical oversight by the band 8A OTs two days a week.

6.10 A flexible model of shifts continues to be offered within the unit, monitored in accordance with staff stress levels, long and short term sickness and patient acuity.

6.11 The service no longer offers rotational posts between Ward 3 and the CRHT team. This is due to feedback from the fist cohort of these staff and some negative experiences within this role.

6.12 Ongoing challenges remain in respect of recruitment of staff and permanent RMN cover for the ward. The directorate continue to look at a range of options to reduce the use of agency; including the use of retention premiums, rolling adverts, targeted events such as attendance as national and local recruitment fairs and open days.

Langley

6.13 Langley Ward has trialled the use of the MHOST tool in advance of it being rolled out to all appropriate areas. The results are detailed in Appendix 2. Evaluation of the trial is to be shared at the Lead Nurse and Therapy meeting in August 2019 to shape the Trust wide implementation programme.

6.14 The ward has seen consistently high levels of acuity over the last 6 months and this is reflected in the utilised higher than normal numbers of Bank and Agency works to cover increased levels of therapeutic observations. This is being managed within the operational and nursing teams to deliver a plan to reduce the usage and the associated overspend.

CHS

Community Hospitals

6.15 Over the last six months the main hot spot areas for Community Hospitals have been Feilding Palmer, Ward 3 St Lukes and East Ward Hinckley.

6.16 Feilding Palmer and Ward 3 St Lukes are hot spots due to higher numbers of registered nurse vacancies resulting in consistent utilisation of temporary workers above 20% over the last six months. Substantive staff are moved daily across all wards to maintain safe staffing and skill mix across the service. Matrons work closely with centralised staffing to source block booking of temporary workers to improve continuity.

6.17 East Ward Hinckley is a hotspot area as the planned staffing is to have three registered nurses during the day; however the ward operates with a minimum of two registered nurses on occasions, this meets safe staffing parameters.

6.18 The number of vacancies across the twelve community hospital wards has remained above 41 WTE band 5 registered nurses between January and June 2019. There has been a notable increase in the use of off framework agency staff for the community hospitals over the last six months linked to both the vacancy rate and increase in sickness rates of greater then 4.80% average across the wards. Challenges with recruitment of registered nursing staff remain. The service continues to look at a range of options; new roles including Assistant Practitioners, Nursing Associates and Medicines Administration Technicians, recruitment and retention premiums for hard to fill areas, attendance at recruitment fairs and using Facebook and Twitter campaigns.

6.19 The first two Community Hospital Nurse Associates completed their training and became registered with the NMC in January 2019, they are currently on the Trust preceptorship programme. The scope of the role continues to be developed, and work is currently being undertaken to ensure that the role is fully utilised and enhances the skill mix on the ward, including review of the nursing Assistant Practitioners.

6.20 Beechwood, Clarendon and Ellistown Wards each have a Medicines Administration Technician working Monday to Friday within the nursing establishment. The role and impact is being reviewed by the Pharmacy Manager and Lead Nurse.

6.21 A third Band 6 night sister has been recruited to provide senior clinical support across community hospital wards and review and maintenance of night clinical standards.

6.22 A review of nurse sensitive indicators has not identified any direct correlation between staffing and impact to quality and safety of patient care and outcomes.

6.23 Following successful introduction of post fall safety huddles, a quality improvement project at Hinckley and Bosworth Community Hospital, the process of huddles has now been shared with falls champions across the Trust.

Support and education is available to ensure a standardised approach and Loughborough Hospital will formally commence post fall huddles on 1 August 2019. As a result of the PDSA cycles, changes to the incident reporting process have been actioned so that reporting now identifies first and repeat falls.

Moving forward the post fall huddle tool will also be incorporated into standard reporting of the incident. This will support more meaningful learning in identifying the contributory factors and provide a focus for future quality improvement initiatives by the falls steering group.

6.24 There have been challenges and delays in recruiting band 7 Ward Sisters/Charge nurses with the right experience and skills on Rutland and Beechwood Wards. The Matrons for the areas have supported and led the wards in the absence of a substantive ward leader. The posts have now been appointed to. As a result, further targeted work focusing on succession planning and developing band 6 Deputy Sister/Charge nurses is to commence over the next six months.

6.25 Priority Actions for the next six months:

- Further work is required to review available valid and evidence based tools to measure patient acuity and dependency within community hospital wards. For the past three years the community hospitals have used an adapted version of the Safer Nursing Care Tool, amendments made to reflect the acuity of community hospital patients has invalidated the results and cannot therefore be used as evidence to re-set the establishment at this mid year review.
- To scope completing a functional mapping exercise to support establishment setting for the next three to five years.
- Continue to implement added incentives to improve fill rates for temporary staff
- Review the benefits and outcomes of the Medicines Administration technicians role
- To identify trainee Nurse Associates for January 2020 intake
- To review with the operational service leads the role of Meaningful Activity Coordinators being incorporated into the current healthcare assistant role
- Review the development plan for roles at band 6 to support succession planning into ward sister roles

MHSOP

6.26 The hotspot wards continue to be the Evington Centre, Gwendolen and Coleman Ward. This is primarily due to increased acuity with patients

requiring more one to one nursing and staff to support with personal care needs.

6.27 The vacancy profile has continued to slowly increase with the rolling advert for band 5 registered nursing not having attracted any applicants for two months. A previous recruitment and retention premium will be scoped to support the uptake in these roles. Other strategies such as the support and development opportunities will also be clearly identified in the recruitment advert.

6.28 A formal acuity and dependency tool has not been adopted however, MHSOP inpatients have successfully reviewed the staffing skills profile using Workforce Profiling, this is based on three fundamental principles;

- The impact of the context of a service and an individual's circumstances on the level of skill required to deliver safe high-quality care.
- Focused, facilitated debate with clinical workforce, HR and service improvement experts can identify the skills required to provide quality care for individual patients in the local context. This approach does not focus on the person who might provide that care or their job title, grade, employer organisation, rather on what the patient needs.
- The difference between staff mix and skill mix.

The work has recently been costed and remains a neutral position with the proposed model. This model has introduced further new roles including additional Technical Instructors, Medication Administration Technicians and Nursing Associates and opportunities to enhance the MDT compliment. The ward rotas will also be viewed from a site perspective, allowing more dynamic cross cover arrangements.

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6.29 A Physician Associate post is being recruited to, to bridge the gap in the management of physical ill health for inpatients. This is a new post that will be supported through a rotational experience to enhance their knowledge and skill set.

6.30 The peripatetic team now has five health care support workers who at present are predominantly working on Coleman Ward due to the increased patient acuity. We are continuing to proceed with recruiting into these posts to support the reduction of bank and agency utilisation and increase continuity of patient care.

6.31 The service is currently reviewing the Bennion accreditation with the Royal College of Psychiatrists to extend for a further year. The Evington wards will look to undertake a similar process to support quality assurance.

AMH/LD

6.32 Over the last 18 months all adult mental health and learning disability inpatients services (18 wards) have piloted the safe staffing tools recommended in the National Quality Board (NQB), *Safe, sustainable and*

productive staffing: An improvement resource for mental health with a separate version for Learning Disability Services.

6.33 Short Breaks (LD) Services (3 homes) were not part of this review as the service is currently part of a joint health and social care review regarding future provision of short break services.

6.34 The final Agnes Unit review was completed in July 2019 and the report will be considered within the Directorate for further action.

6.35 An action plan was devised to ensure all elements were included to ensure a robust staffing review occurred in each inpatient area. National and local guidance publications were included, a selection of recommended tools, professional and clinical judgement, review of service pathway with a confirm and challenge session of the findings culminating in the development of staffing proposals.

6.36 The following tools, publications and recommendations were utilised throughout the review:

- Evidence based guidance specific to acute, rehabilitation mental health and learning disability services
- Aims Accreditation Standards
- Models of care – local provision
- Service specification
- Recent service tenders
- Team and organisational level metrics
- Efficiency of rota
- Bank and agency use
- Incident data
- Training compliance
- Care Hours Per Patient Day (CHPPD)
- Ward Activity Data Collection
- Staffing numbers
- Staffing activity
- Ward Multiplier tool (K Hurst)
- based on patient dependency
- Professional judgement
- Telford Model
- Confirm and challenge session

6.37 The outcome of the reviews have been implemented over the last twelve months, enabling and supporting re-skill mixing across staff teams and professions; for example in rehabilitation services, nursing vacancies were changed to Occupational Therapy and psychology posts to ensure the clinical pathway could be delivered effectively.

6.38 In acute services further skill mix review has released funding for physical health nurses and additional health care support workers for flexible use at night.

6.39 Across the services Directorate funding has supported the release of health care support workers to undertake nursing associate training to help support difficulties in registered nurse recruitment and enhance skill mix.

6.40 The reviews will be repeated using the new MHOST tool during quarter 3 and 4 2019/20 in line with the new twice yearly establishment review standard.

6.41 Over the last six months the main hot spot areas for Adult Mental Health and Learning Disability Services have been Mill Lodge, Griffin Ward, LD Short Breaks and a number of the Acute Mental Health Wards.

6.42 Vacancies have remained high in inpatient areas with high use of bank and agency staff over the last 6 months; in the last few months staffing has improved considerably with focused recruitment, a robust induction and initial supernumerary status for all new staff.

6.35 The Acute Mental Health and PICU Wards have struggled with a higher turnover of staff, recruitment difficulties at Band 5 level and high sickness, maternity leave and staff not able to work clinically. Ward Sisters and Charge Nurses have worked hard to improve sickness monitoring, rostering, and in conjunction with centralised staffing have increased block booking for bank and agency staff. The staffing across all wards on the Bradgate site is reviewed daily by the Clinical Duty Managers and within the morning safety huddle to ensure substantive staff are moved daily across all wards to maintain safe staffing and skill mix across the service.

6.43 In April 2019 the staffing levels on Griffin Ward (female PICU) were badly affected by vacancies, sickness and staff unable to work clinically, coupled with extremely complex patients requiring high staff support for self harm and challenging behaviour this resulted in a clinical and management decision to close two beds on the unit for six weeks. Staffing levels were increased using block booked agency and rotation of staff from other acute wards to safeguard patients and provide support to the staff team. This has been temporarily resolved by the blocked booked agency but a longer term piece of work to develop a revised staffing model and career pathway commenced in July 2019.

6.44 In the learning disability short break homes there has been an increase in bank use but due to the complex needs of some patients, it has been difficult to source staff with the required skills; this recently resulted in The Grange closing for two days in July 2019 and alternative respite being offered before or after the two days or within other homes.

6.45 The homes continue to utilise a high proportion of HCSWs who are trained to administer medication and carry out delegated health care tasks. The Gillivers and the Grange support each other with RN day cover. Night cover can be shared across the site as the homes are situated next to each other in conjunction with utilisation of additionally trained HCSWs.

6.46 As part of new roles to support registered nurses Bosworth Ward at the Bradgate Unit Wards has a Medicines Administration Technician working Monday to Friday within the ward establishment. The impact of the role is being reviewed by the Pharmacy Manager and Matron.

6.47 The first ward Nursing Associate completed training in January 2019 and is based on Heather Ward at the Bradgate Unit. All acute wards are supporting the development of one nursing associate going forward.

6.48 A further Clinical Duty Manager with learning disability nursing experience has been recruited to enhance the skills base of support to all areas.

6.49 Each month the nurse sensitive indicators are reviewed against staffing and there has not been any evidence to suggest a direct correlation between staffing and impact to quality and safety of patient care and outcomes. The findings from reviews have enabled learning around medication administration processes and changes in practice.

6.50 Priority Actions for the next six months:

- To consider the transfer of the functional mapping work completed in MHSOP to support staffing and skill mix reviews.
- Establish a specific recruitment and development approach for both the female and male Psychiatric Intensive Care Units (PICU)
- Review the benefits and outcomes of the Medicines Administration technicians role
- To establish further trainee Nursing Associates posts and how they will be effectively included in establishment reviews and sustainably funded.
- To review with the operational service leads the role of Meaningful Activity Coordinators being incorporated into the current healthcare assistant role
- Review the development plans for Ward Sisters and Charge Nurses and band 6 Deputies to support retention and succession planning.
- Review initial work on Occupational Therapy Mental Health Practitioners as ward staff supporting direct care
- Review the new safe staffing tools for use when completing the next safer staffing review in quarter 3 & 4 2019.
- Further exploration of rotational posts, retention of retired staff, Advanced Clinical/Nurse Practitioners and Physician Associates roles.

7.0 Community reviews

FYPC

CAMHS Crisis and Home Treatment team (CRHT)

7.1 The CRHT team has two band 7 team leaders with split clinical and operational management. Due to levels of sickness and vacancies both leaders have predominantly worked clinically to maintain the service. In August 2019 a band 8a Matron/ operational lead will be spending two days a

week offering operational cover. This is a role split between the CRHT and Ward 3 CAMHS inpatient unit.

7.2 The team currently has 3.0 WTE band 6 and 3.0 WTE band 5 mental health practitioner vacancies. Two of the Band 6 vacancies are being backfilled with agency nurses on mid-term fixed contracts. Due to challenges in recruiting registered nursing staff into the band 6 and 5 posts there is discussion about utilising other health care professionals, such as social workers and Occupational Therapists in line with the adult CRHT model.

7.3 Following the recent CQC inspection and action plan, there has been agreement for additional qualified practitioners to be recruited, due to a capacity and demand review that took place of the existing staffing model.

7.4 The team are supported by three band 3 HCSWs, one of which is currently on long term sick and potentially will be going through redeployment.

PIER Team

7.5 Current service caseload is 430 with 22.2 WTE Care coordinators. The average caseload is 20. EIP Guidance suggests maximum EI caseloads of 15 patients, this is just a recommendation.

7.6 There is one Care Coordinator currently on maternity leave with one due to start in August 2019, one on career break and one leaving on 24 July 2019. This will leave the team short by 2.0 WTE Care Coordinators. These posts are part of the CIP scheme with a review of staff and skill mix for these posts to be completed.

Looked After Children (LAC) Health Nursing Team

7.7 The LAC team cover all three local authorities with approximately 1,000 LAC in LLR. The team comprises of 1.6WTE Band 7, 4.55WTE Band 6s and 3WTE Band 5s. The service core hours are 8am-6pm, Monday-Friday.

7.8 Reconfiguration of SystmOne continues to reflect staffing and caseload alignment. The team is now divided as follows:

- Foster care team
- Unaccompanied Asylum Seeking Children
- Residential homes
- 16+ semi-independent

7.9 The Out Of Area (OOA) caseload remains a challenge as the work is currently being picked by the LAC nursing team.

7.10 Monthly staffing reports are provided and sickness is at a minimum. The LAC team adhere to a draft Standard Operating Procedure (SOP) to support the delivery of safe, effective and responsive care. The SOP is currently under review.

7.11 A duty rota has been implemented and is working well to ensure new referrals and tasks are managed in a timely manner ensuring safeguarding tasks are managed as priority.

7.12 Use of Bank staff from the wider 0-19 workforce continues to support Review Health Assessments and of Leaving Care Health Summary.

7.13 Capacity and demand work is progressing well. This programme will help the team maximise service user flow through the LAC healthcare system. It will also support the team to be more resourceful (for example planning the number of clinics that would be required to meet demand), as well as supporting a case for additional clinical practitioners in the future.

Paediatric Phlebotomy

7.14 The phlebotomy service operates Monday to Friday 08.00am tol16.00 or18.00pm. The team have 7.8 WTE paediatric phlebotomists and 3.0 WTE Play Support.

7.15 The service contract was due for completion in September 2017. The contract has only recently been secured for one year; the negotiation period took longer than anticipated. This has created a backlog in appointments as the service could not meet increasing demand. The team are currently recruiting to reduce the back log and meet on-going demand.

7.16 The service has seen an increase in GP referrals. This is on trend with previous years. The current GP referral rate is 738 per month. The current capacity available due to staffing levels is 671 per month, therefore creating a backlog. In addition the service accepts referrals from Community Paediatrics, CAMHS, Serenity, Alliance and LAC (referral figures for these areas not known).

7.17 The service is currently negotiating the Blood Born Virus Contract with UHL. This will increase referral rate by an additional 175 referrals per year.

School aged immunisations

7.18 The current staffing establishment has enabled service delivery over the last 6 months without any cancellations of sessions.

7.19 Any risks remains tolerated as the service sees peaks in activity due to the fluctuating needs of the different programmes and the risk is tolerated with the use of core bank staff that support delivery of the service.

7.20 The service has had 0.8 WTE Band 6 0 nurse on long term sickness. The service has recently recruited to two Band 5 posts equating to 1.62 WTE to support the introduction of the additional 6000 vaccination programme.

Healthy Together

7.21 Healthy Together operates a prioritisation model to support business continuity of the service. The focus of the model is to ensure that standards for safeguarding and Healthy Child Programme assessment are delivered to those most in need. The model highlights priority contacts with the template supporting flexible and safe service delivery during periods of reduced staffing. .

7.22 The Healthy Together leadership teams skills and knowledge have developed a capacity and demand tool, informed by a safe staffing model used to monitor vacancies and sickness within a locality team. The tool was developed with the support of Sameer Thanki, Place Based Intelligence Lead, focusing on the following areas;

- Current performance date
- Workforce details with a breakdown of task undertaken by different skill mix bands
- Agreed contact times for activities this including other non-clinical facing activities such as training, meetings, supervision etc.
- Current staff capacity

7.23 The tool triangulates multiple data sources to support informed decision on workforce capacity and activity. The tool has been evaluated and validated with a revised prioritisation template due to be trialed in practice. Extracts from the Capacity & Demand tool detailed in Appendix 3.

Healthy Together Early Start

7.24 Early Start County resource provision will be significantly reduced in the next two months. The year 4 commissioning changes require review of the service within the reduced financial envelope from April 1st 2020 and commissioner's plans for future service provision. This necessitates a review of care provision for first time parents currently receiving support through the Early Start programme of intensive 1:1 support in their local area and throughout the first two years plus of their infants life.

7.25 County East and West Early Start Intensive support programmes; families currently referred and receiving care will be affected by the ability of a reduced number of staff 4.7 (WTE) to provide intensive support. This is as a result of team members seeking alternative employment and two staff members reducing their hours following retirement. There is also a vacancy management process in place across all Healthy Together teams as a result of the commissioning changes to the Public Health contract funding by the end of financial year 2019.

7.26 Families within the programme will require a robust and safe plan of transition to a Named Health Visitor, to provide continuity of care through a Healthy Together programme of intervention at Universal plus or Universal Partnership Plus pathways. Initially fifty families are to be transitioned within the next two months with a further thirty families throughout the quarter, dependant on staffing resource and the number of active referrals.

7.27 Clients on the programme will be affected and there is a risk in the provision of reduced care for vulnerable families who are not receiving this high level of support or being reviewed on a regular basis as per the current Early Start programme pathway. This may result in escalating concerns that are not addressed at the time of need or the provision of timely interventions, advice and support when necessary. Mitigations to reduce this risk;

- A robust and safe plan of transition to a named Health Visitor has been implemented to provide continuity of care through a reduced programme of intervention at Universal plus or universal partnership plus package of care, based on need at the time of intervention.
- Public Health Commissioners in Leicestershire are producing a statement for stakeholders to inform them of the changes
- The Safeguarding Committee and Deputy Director of Nursing and AHPs are sighted on the risk and mitigations

DIANA Children's Community Services

7.28 The service do not currently use an acuity or dependency tool however proposed work with SystmOne will provide this in the future. Tables below capture referrals and discharges in the last six months;

Referrals:

	Jan	**Feb**	**March**	**April**	**May**	**June**
Acute - Diana Service	107	102	81	105	89	25
Continuing Health Care	1	4	8	10	7	-
Macmillan Nurse Service	12	18	3	8	3	-
Short Break Care	-	-	-	-	2	-
Total	**120**	**124**	**92**	**123**	**101**	**25**

Discharges:

	Jan	**Feb**	**March**	**April**	**May**	**Jun**
Acute - Diana Service	98	105	71	84	87	24
Continuing Health Care	6	2	14	4	4	-
Macmillan Nurse Service	6	8	-	12	2	2
Short Break Care	-	4	-	-	1	-
Total	**110**	**119**	**85**	**98**	**92**	**26**

7.29 The service are currently working with the SystmOne team to use 'Auto Planner' to improve visiting schedules for nurses, reducing time in

administration and travel and review acuity, dependency and caseload size for individual nurses.

7.30 The service commenced a review with Commissioners in 2017, work continues with progress made on the service specifications. The portfolio of services currently delivered by the team will likely change with some areas of provision being removed and other areas added. This has already had an impact on the provision for the 'Training Team' now providing Adrenaline Auto Injectors with Anaphylaxis and changes to the amount provision of Epilepsy Awareness and Emergency Medication for epilepsy.

7.31 It is anticipated that the proposed move from Bridge Park Plaza this year will impact the service, additional benefits for future service delivery both for face to face clinical nursing care, delivery of training and reduced administration and travel time.

7.32 Staff work flexibly to ensure there is cover across the week. Bank Nurses are being used to cover regular blood lists (increased to 2 days after Feb 2019 half term) and a regular day in the training team

7.33 The service therefore is considering a new recruitment strategy; open afternoon, 'meet the service', staff and families due to the inability to recruit to Band 3 HCSW posts.

CHS

Community Nursing

7.34 LPT Community Services continues to progress the Community Service Review (CSR) transformation work, which involves the implementation of a new clinical and operational model of delivering Core Community Nursing, Therapy, Rapid Response and Home First.

7.35 The aim includes ensuring that the right people, with the right skills, are in the right place at the right time. To reduce transfer of patients across services, maintaining and improving opportunities for working in an integrated way with Social and Primary Care, to improve patient pathways and the overall quality of care provided to patients. The programme also intends to support a transformation of the mind-set, culture and behaviours of the workforce and supporting systems and structures into a culture of excellence, continuous improvement, innovation and creativity.

7.36 Patient caseloads, capacity versus demand continues to be under review alongside re-modelling plans. Within community nursing an electronic planning and work allocation tool is embedded that is aligned to signed-off staff skill sets, to support safe allocation of work.

7.37 The electronic tool supports visibility of staff' s workload and enables a daily view of the caseload pressures against agreed skill mixes for each Hub. This

is supported by an escalation process to the Lead Matron via the Situation Report, who will review capacity and demand across all the areas and then take any appropriate actions.

7.38 A safer staffing dashboard is under development and will take into account the changes that result from the CSR transformation work.

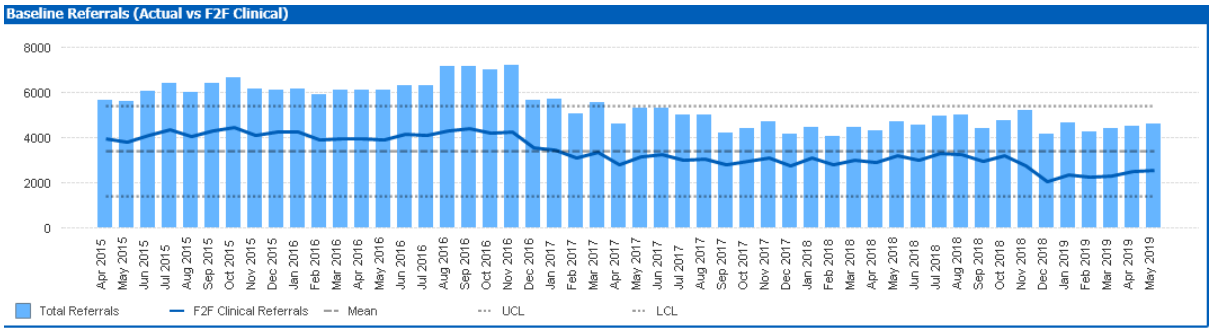
7.39 The areas that continue to be community staffing hot spots are both the city areas due to vacancy factor of between 15% and 30% and Hinckley due to maternity leave. The fill for bank and agency shifts shows an improving picture over the last few months from 56% fill rate to between 72-92% across the hubs.

7.40 A rolling cycle of recruitment remains in place, bolstered by responsive interviewing processes having been introduced. This has been further supported, in the city area, by the implementation of the band 5 Retention Prema.

7.41 A robust induction programme for all new starters continues to be embedded with role specific workbooks, to support staff to transition in to their new role and teams.

7.42 Staff mandatory training, clinical and appraisal rates show an improved position across the planned care service line, with only City west showing amber on clinical supervision and appraisals, last month. There are a slightly higher number of complaints, concerns and incidents with the two city hubs, which is monitored monthly through the service line governance meetings.

7.43 The graph below shows the number of referrals into service and how that has then equated into face to face patient contacts. This shows that there has been little change over the last 6 months. This shows the embedding of the triage processes within the Hubs, but also the need for ensuring that the referral goes to the right service first time. The latter is being picked up through the transformation work.



MHSOP – CMHTs

7.44 The City West CMHT is experiencing high levels of sickness absence and there is also a pending internal investigation. Bank and agency use is in place and following risk assessment a 12 month pilot project introducing an additional band 7 team lead to the city CMHT's has been implemented. The posts are split clinically and operationally to increase oversite of the team, funded from a recent band 6 vacancy. Both post holders will carry a small clinical caseload, supporting clinical leadership and be based in one of the City teams rather than splitting their time between two bases. The plan is to advertise this secondment post over the next 2 weeks, following consultation with the existing service lead for the city teams. A further strategy meeting is being convened for the two city teams and including staff side and senior clinician's to look at the model and current way of practice and barriers. Staff side will also be integral to this alongside the Freedom to Speak up Guardian.

7.45 MHSOP have also pulled resources across the CMHT's to support the short falls within City West CMHT which includes; covering new urgent referrals, duty worker and the caseloads of the staff off sick have been reviewed, risk assessed and redistributed where appropriate.

7.46 Waiting time management continues to be reviewed bi monthly within the PDSA cycle iterations to continue to review and challenge practice to support a positive ongoing improvement and position. This is also reviewed through the PTL's reviewing in depth the areas of non compliance to understand how to proceed.

7.47 MHSOP are fully engaged with the access and single point of access planning in line with the Trust All Age Transformation project with the initial planning meeting scheduled for 1 August 2019 with the All Age Transformation team.

7.48 The community managers attended a capacity and demand training workshop and will be working with the business team to begin scoping this for community, memory services and OP services.

7.49 The caseload complexity tool is currently on hold awaiting finance to purchase Intellectual Property (IP) for the tool developed by the Aneurin Bevan Health Board. This will be revisited once agreed.

7.50 The MHSOP community team have one registered Nursing associate working within South Leicester CMHT. The post holder is currently working through the Trust preceptorship programme and is clinically working within the team. The role remains subject to ongoing development and review.

7.51 The service is currently reviewing roles and responsibilities of HCSW's in line with the recovery model, looking to explore recovery worker job plans.

7.52 A review of medical outpatients is currently in progress to understand capacity and demand, referrals, caseload sizes and discharges to ensure that the service has the right cover where required.

AMH/LD

Adult Mental Health and Learning Disability Community Services

7.53 Over the last six months, the main hotspot areas for community services have been Charnwood and City East CMHTs and the Mental Health Triage Team. Challenges have included leavers as well as sickness, secondments, maternity leave and staff not being available to work clinically. The teams have taken a number of approaches to covering the shortfalls, including block booking of bank staff, supporting retire and return options for experienced staff and more creative approaches such as the introduction of band 5 development roles and Nursing Associates.

7.54 Vacancies have been stable at around 29 WTE qualified nurses and 6 WTE healthcare support workers across all teams, however, in May and June registered nurse vacancies reduced to 20.7 and 22.5 respectively. The CMHTs have successfully recruited ten new healthcare support workers and, once in post, these additional workers will provide clinical support for registered staff to support recent work undertaken on caseload sizes and flow through the services.

Learning Disability Community Teams

7.55 Two healthcare support workers have been supported to undertake Nursing Associate training; one from County West CLDT and one from the Autism Team. The two workers will qualify early in 2021, and work is underway to consider their new roles.

7.56 A Community Learning Disability Nurse from the city team has been seconded for three days per week for one year to work as CPA Lead for the Trust. The service is advertising to cover the role.

7.57 Within the Learning Disability Community teams, a 12 month pilot of a Forensic Network is underway following a review of the community caseload.

The review looked at cases where the individual patient had either come into contact with the criminal justice system, or would have come into contact if they had not received intensive support. The overall aim of the service is to maintain individuals in the community.

It has been made possible by £200K received from NHS England through Transforming Care. The team consists of two WTE Band 6 seconded staff and 0.8 WTE clinical psychology input with additional psychiatry support as required. The network has three aims:

- To develop and deliver a training package for 200 staff across health and social care to enhance the skills of staff in identifying and managing risk of offending behaviours.
- For a core group of staff to be trained in HCR-20 to further enhance the risk assessment and management of patients.
- For the central team of staff to case manage the most complex patient cohort.

Community Mental Health Teams

7.58 In 2017, the CQC identified that community nurses in CMHTs held caseloads that were too high. This concern has been placed on the risk register and a quality improvement programme across AMH community services, overseen by a steering group that meets monthly, has undertaken an extensive programme of work. This work is directly linked to the all Age Transformation Project.

In order to sustain the improvements achieved by the programme there is a need to ensure a consistent and fully recruited staffing establishment as high nursing vacancy rates will impact on caseload numbers and complexity of caseloads.

The national picture of high vacancy rates within community mental health still exists, however, locally vacancies have stabilised due to the implementation of robust recruitment monitoring, rolling recruitment and the introduction of innovative new posts. An overview of progress is as follows:

- Caseload reviews have been completed with all CPNs in City East and Loughborough CMHT. All other teams have commenced caseload reviews for CPNs with a second review to commence in August 2019 to establish if this piece of work has been successful.
- Work has been undertaken to increase the numbers of Non-Medical Prescribers (NMPs) across the teams in order to improve flow of service users through the service. Several staff have now been identified to train, and a peripatetic NMP CPN has been recruited to run outpatient clinics to help reduce the overall waiting lists. One additional peripatetic NMP will shortly be advertised to roll this approach out further. An NMP clinic specifically for service users who have been prescribed the Olanzapine depot has been introduced.
- A RAG rating tool has been developed to robustly manage waiting lists. This has been successfully trialled in City East and City Central and rolled out across the other teams. A review is underway to ensure consistent practice across all CPN caseloads within clinical supervision.
- The quality improvement steering group is exploring the possibility of introducing a caseload cap with the aim or reducing caseloads, reducing stress for staff, and implementing robust clinical supervision so that all cases could be discussed for flow through the service. This would need to incorporate a process for intensifying support and supervision, and ensuring the right interventions are in place to either reduce complexity or consider more intensive input.

- A Caseload Complexity Monitoring Tool has been developed by the Aneurin Bevan Continuous Improvement (ABCi) team at Aneurin Bevan University Health Board, and in 2017/2018, West Leicestershire Adult CMHT participated in a pilot project of the tool. As the pilot progressed, a number of concerns about the tool emerged, including technical issues, a concern that the pilot sites in Wales were not 'like for like' with LPT CMHTs and the scores were not sensitive enough to be clinically valuable.

  A detailed evaluation of the project was produced by Lyn Williams, Head of Service, MHSOP, and discussion took place with the AMH senior leadership team. The pilot ended and the tool is not currently in use in either AMH or MHSOP. Further plans include ongoing liaison with the team in Wales with a view to improving the ease of use and efficacy of the tool and exploration of a pilot of capping of high and/or complex caseloads, incorporating a process for intensifying support and supervision.
- Job plans are currently being developed for band 7 CPNs – this will link in with the need to ensure band 7 team leaders have some capacity to undertake clinical leadership and support team managers with performance in the CMHT.
- Design and recruitment of band 5 development posts has taken place, which has offered a supported pathway to band 6 and improved the appeal of the posts to external candidates.
- The recruitment of additional healthcare support worker roles at band 3 into each team with a newly developed role is being undertaken, which will support both the out-patient caseloads and CPN caseloads by providing metabolic monitoring and discharge facilitation.

  These workers will also undergo training in collaborative conversations and motivational interviewing to support the co-production of care plans. Each CMHT will have 2 WTE posts and these posts have been advertised and a successful recruitment event took place in July 2019. Each team will also have 1 WTE Peer Support Worker (anticipated start date of early September) and 0.5 WTE of a Mental Health Employment Support Advisor.

Perinatal Mental Health Team

7.59 Towards the end of 2018, the Trust secured £460,000 from NHS England to double the size of the Perinatal Mental Health Team. The new funding is from the second wave of a £365 million national package of additional funding from NHS England to improve access to mental health care.

7.60 The new funding has enabled the Trust to enhance the service to meet national staffing standards. The team establishment has increased from 9.5 to 19.75 full time roles. As well as increasing nursery nursing, community mental health nursing and medical staffing, the service has recruited occupational therapists and psychologists and there are plans to expand its peer support and recovery worker roles.

Crisis Resolution and Home Treatment Team

7.61 Staffing has been challenging over the past six months, particularly within the Mental Health Triage Team. The teams have taken a number of approaches to cover the shortfalls; including block booking of bank staff, improved staff support, clinical supervision and the introduction of registered Nursing Associates.

7.62 The CRHT has supported the development the Nursing Associate role and three team members participated in the first cohort and are now registered. Work was undertaken to liaise with the students, clinicians and senior leaders in the team and the duties and responsibilities were clarified. Nursing Associates' duties will include running clinics for physical health observations, updating care plans, carry out home visits for CRT and crisis house patients and joint visits for patients already open to services such as community mental health teams.

8.0 Workforce Planning

8.1 NHSi Developing Workforce Safeguards policy recommends a two-step approach to workforce planning. First, to take account of actual staffing levels and second, understand the gaps and what is required to close them, supported by a workforce planning model.

8.2 In March 2019 the Trust Director of HR and Associate Director of Nursing and Professional Practice facilitated a workshop to review NHSi Developing Workforce Safeguards policy recommendations; including evidence based establishment reviews, workforce planning linked to Trust wide transformation and new roles linked to the Trust 'Grow Our Own' (GOO) strategy.

One of the key aims of the workshop was to strengthen the GOO strategy by identifying actual numbers against new and developing roles such as the Nursing Associate. This outcome was not achieved; partly due to this being a new role with recent NMC standards of proficiency and further work required to fully realise the scope of this role. It was agreed to repeat the workshop later in 2019 in conjunction with functional mapping and the yearly re-setting of establishments.

Grow Our Own

8.3 Grow our own is the programme of support for the development of our existing workforce to meet our future knowledge and skills requirements, particularly focusing on two categories:

- Roles that impact on the establishment
- Roles that need specific (predetermined) education

Roles that impact the establishment	Roles that need specific education
Nursing Associates	Health Visitor
Medicine Administration Technicians	School Nurse
Physicians Associate	District Nurse
Advanced Clinical/Nurse Practitioner	Physiotherapy
Medical Assistants	Occupational Therapy
Peer Support Worker	Nursing
Assistant Practitioner	Nursing Associate
	Clinical Apprentice
	Non-Medical Prescriber
	Clinical/Medical Psychology
	Advanced Clinical Practitioner

8.4 The following has been developed with each directorate workforce group and they have approved the recruitment plan for new starts in 2019-20.

Education/ Training	Approved Nos	Additional funding support	Recruitment progress	Comments
Health Visitor	FYPC - 7	HEE approved Salary Support approx. £27,260 pp	Recruited 7	1-year programme- Sept 2019 at DMU
School Nursing	FYPC - 2	HEE expenses contribution £2,00 pp	In progress	1-year programme -Sept 2019 at DMU
District Nurse	CHS - 9	HEE approved Salary Support approx. £27,260 pp	Recruited 5 Out to recruit 1 more place	1-year programme starting Sept 2019 at DMU
Nursing Associate	Pending	HEE fund approx. £7,200 pp for 2019 starts	Pending	2-year part-time programme with UHL/DMU/ LPT
Nurse Graduate Entry	0	n/a	0	2-year programme with Derby University
Nurse Apprenticeship	CHS – 2 FYPC – 1 AMH – 2	Course fees Levy funded	3 confirmed 1 pending placement 1 MH nurses 2 Adult nurses	4-year part-time programme with Open University
Physiotherapy Apprenticeship	CHS-5 FYPC - 1	Course fees Levy funded	Recruited 6	4-year part-time programme with Coventry University
Occupational Therapy Apprenticeship	FYPC – 1 AMH – 1 CHS – 1	Course fees Levy funded	Recruited 3	4-year part-time programme with Coventry University
Advanced Clinical Practitioner	4	HEE funding course fees	Pending	2 year programme at various universities
Non-Medical Prescriber	35	HEE Workforce Development Fund covers course fees. Available funds will only cover 12 places	In progress Need to interview to fill 12 places from over 35 applicants	6 – 9 month programme. HEI to be confirmed.
Clinical Apprentice	18	Course feed Levy funded	In process of recruiting to 12 post in AMH	18 month programme with UHL

8.5 A GOO working group has been established with representation from service leads, staff side and Learning & Development. The group are tasked with designing a programme that outlines all steps, documents and processes from pre recruitment to training, support during the training and commitment to recruit to substantive posts once our staff have qualified.

8.6 In January 2019, the first cohort of trainee nursing associates in LLR completed their academic programme. The Trust have ten trainees of which eight are now registered with the Nursing Midwifery Council (NMC). A quality impact assessment has been completed and actions in place to mitigate against any associated potential risks of deployment including; a core standardised LLR job description, bespoke Trust preceptorship programme, clinical supervision and a scope of practice policy (working document).

8.7 The Trust currently has two further cohorts of trainee NAs; cohort 2 (eleven NAs) are due to finish the course in January 2020 and cohort 3 (seventeen NAs) commenced their programme in December 2018 due to finish in January 2021.

8.8 Recruitment to the next three cohorts for 2019/2020 is due to start in September 2019 with cohort 4 commencing in December 2019.

8.9 Full realisation, scope, impact and capacity of the role will continue to be explored through the LLR, Trust workforce and professional groups.

eRoster

8.10 LPT uses Allocate HealthRoster to manage the deployment of substantive, bank and agency staff for around one third of the Trust. All inpatient wards use HealthRoster as well as some community teams.

8.11 Using recommendation from the Carter Review, the focus is supporting services to make the best use of staff time by:

- Improving timeliness of rosters being published (minimum 6 weeks before they are due to be worked)
- Reducing unused hours (hours staff have been paid for but not yet worked)
- Reducing accrued time off in lieu (TOIL) (hours that have been worked but not paid for)
- Effective planning of annual leave to avoid pressure points at certain times of the year

These actions will help services to better plan their workforce and manage staffing levels on a shift by shift basis.

8.12 Detailed reports on rostering effectiveness are provided to services each month to measure the impact of different initiatives and to help identify areas for improvement.

Safe care

8.13 In the next year the Trust plans to procure and implement Allocate SafeCare.

8.14 SafeCare integrates fully with HealthRoster and offers the ability to monitor actual patient demand at key points during the day and accurately align staffing to match. The objective data identifying actual staffing requirement also helps avoid habitual temporary staff use and allow informed decision making as to when temporary staff are required. The user interface is accessible and easy to use and provides live user-friendly dashboard reporting.

8.15 SafeCare also has a positive impact on improving accuracy of rosters through contemporaneous updating of changes which further informs decision making and visibility. The net result of the above is an improved utilisation of substantive staff and reduction in temporary staff requirement.

9.0 Recruitment and Retention

9.1 The Trust wide inpatient staffing vacancies from January 2019 to June 2019 are detailed below, with a six monthly average;

Trust Total	Vacant posts	
	RN	HCSW
Jan 19	124.44	57.13
Feb 19	127.66	52.98
Mar 19	115.21	57.2
April 19	114.31	58.15
May 19	104.4	66.58
June 19	116.55	68.98
Average	**117.09**	**60.17**

9.2 The Trust wide community staffing vacancies as reported from January 2019 to June 2019 are detailed below with a six monthly average;

Trust Total	Vacant posts	
	RN	HCSW
Jan 19	57.81	15.2
Feb 19	74.6	20.44
Mar 19	58.64	22.64
April 19	71.16	16.44
May 19	75.36	21.76
June 19	90.12	17.99
Average	71.28	19.07

9.3 Collaborative work to address nursing vacancies continues, including; joint working with both Leicester and DeMontfort University to retain newly registered nurses at the point of completion of training, participation in local and national recruitment fairs, rolling adverts, internal and UHL rotation

programmes and continued development of new roles and ‘grow our own’ strategy.

9.4 Adaptations to existing approaches and additional activity that can be utilised to support recruitment attraction were recently endorsed by the Trust Strategic Workforce Group in May 2019, recommendations/actions included

- To attend the RCN recruitment fair in November 2019
- To hold a Trust wide recruit fair early 2020
- Collaborative work with DMU to increase recruitment to mental health and learning disabilities fields of practice for pre-registration nursing
- Review of HEI provider engagement outside of LLR including Birmingham, Nottingham, Sheffield, Lincoln and Warwick
- Continue to advertise on Facebook/social media
- Resourcing directly from CV library
- Refer a friend scheme
- Return to Practice
- International recruitment to be explored and scoped fully
- Recruitment and retention financial schemes

9.5 There is a Trust wide Retention group with a number of initiatives linked to health and well-being programmes; learning and development, a Trust wide Preceptorship programme for all newly registered staff, leadership and professional development programmes, time out days and career development opportunities.

10. Conclusion

10.1 The Trust continues to maintain compliance with the NQB reporting expectations and associated deadlines. The safer staffing data is regularly monitored and scrutinised for completeness and performance by the Director of Nursing, AHPs and Quality.

10.2 Ongoing changes through the service transformation plans are considered alongside the regular staffing reviews that are undertaken on a monthly basis. All services continue to work to safer staffing risk escalation procedures and safer staffing risks are reviewed on a regular basis.

10.3 This report provides the Board with assurance that processes are in place to ensure compliance with the NQB and Developing Workforce Safeguards policy to deliver high quality care through safe and effective staffing; by combining evidence based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time.

References

1. National Quality Board (July 2016): Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time*. Safe sustainable and productive staffing.*

2. NHS Improvement (October 2018) Developing Workforce Safeguards *Supporting providers to deliver high quality care through safe and effective staffing.*

3. NHS England (2019) *The NHS Long Term Plan.* NHS England

4. The Health Foundation (2019) *A critical moment: NHS staffing trends, retention and attrition.* The Health Foundation.

5. NHS Digital (2019) *NHS Workforce Statistics- November 2018*. London: NHS Digital.

6. House of Commons Health Committee (2018) *The Nursing Workforce Second Report of Session 2017-19*. House of Commons.

7. Royal College of Nursing (2018) *Left to chance: the health and care workforce supply in England.* London, Royal College of Nursing.

Appendix 1 Langley Ward MHOST pilot results

	Dependency/Acuity			
1	Dep.1 (daily average)	**0.00**		
2	Dep.2 (daily average)	**2.00**		
3	Dep.3 (daily average)	**2.70**		
4	Dep.4 (daily average)	**4.60**		
6	Dep.5 (daily average)	**4.00**		
7	Patients	13.3		
	Adjustments			
8	Preferred time-out?	**25.0%**		
9	Preferred RfA time?	**10.8%**		
10	Preferred RP proportion?	**52%**		
	MHOST Multipliers		**FTEs**	
11	Dep.1 CHPPD (no headroom, RfA included)	6.21	1.16	
12	Dep.2 CHPPD (no headroom, RfA included)	6.70	1.25	
13	Dep.3 CHPPD (no headroom, RfA included)	6.64	1.24	
14	Dep.4 CHPPD (no headroom, RfA included)	8.52	1.59	
16	Dep.5 CHPPD (no headroom, RfA included)	25.50	4.45	
	Recommended CHPPD and FTEs			
17	RP CHPPD (excludes headroom, RfA included)	6.1		
18	FTE equivalent (includes headroom, RfA included)	18.3		
19	SW CHPPD (excludes headroom, RfA included)	5.6		
20	FTE equivalent (includes headroom, RfA included)	17.1		
21	Total CHPPD (excludes headroom, RfA included)	11.7		
22	FTE equivalent (includes headroom, RfA included)	35.4		
	Actual Staffing converted to CHPPD			
23	Actual and temporary staff FTEs?	**24.1**		
24	Actual bed occupancy (**C7**)	13.3		
25	Total CHPPD (headroom deducted)	7.8		
	Indicative Staff per Shift	**Three Shifts**	**Two Shifts**	
26	Early shift headcount	7.2	Day	8.2
27	Late shift headcount	7.2	Night	4.2
28	Night shift headcount	4.2		
	Patient to RP Ratio	**Three Shifts**	**Two Shifts**	
29	Early	3.6	Day	3.1
30	Late	3.6	Night	6.2
31	Night	6.1		
	Cost per Patient Day			
32	Actual	£123		
33	Recommended	£181		

Appendix 2 Extracts from the Health Together Capacity & Demand tool

Contact	Clinical Time (Mins)	Admin Time (Mins)	Total Time (Mins) Per Contact	No. Per Group	Band	Setting
Antenatal	60	30	90	1	6	Home
10-14 Day contact	60	30	90	1	6	Home
6-8 Week	30	15	45	1	6	Clinic
4 Month	90	30	120	10	4	Clinic
12 Month	45	15	60	1	6	Clinic
24 Month	45	15	60	1	6	Clinic
Group - Bumps to babies			0			Clinic
Group - Lets get talking groups			0			Clinic
Group - Babies next Steps			0			Clinic
UP	45	15	60	1	4,6	-
UPP	60	25	85	1	4	-
Safeguarding	60	25	85	1	6	-

Table 1: Band 6 Available working time (Weekly)

Band 6 (WTE)	Hrs
Additional role High (Chat Health, LPT, PT, NBBS)	0.30
Additonal Role Low.(Infection Control, ALS lead, fant feeding)	0.25
Audit e.g perinatal audit, peer health record	0.17
Bumps to Babies	0.30
Clinical Communication including calls, letters, other professional contact, recording on S1 for these activities, non face to face communication with parents	7.50
Individual Professional role management: Easy pay, emails , IT issues	1.00
Leadership role: 1:1 , appraisals, LCAT	1.00
Link meeting- GP	0.05
Mandatory & role specific training,staff development additional course	0.29
Meetings: Allocation, neighbourhood, Early Years meeting	2.00
Strat Calls	2.00
Supervision-Clincial, safeguarding, restorative, informal supervision	1.00
Support for pre reg student, new starters, preceptorships	0.50
Travel	5.00

Table 2: Band 3/4 Available working time (Weekly)

Band 3 & 4	Hrs
Additional role Low (Infection control, Infant feeding)	0.25
Babies next Steps	
Clinical communication incl telephone / General Admin Time	5.00
Individual management Easy pay, emails , IT issues	1.00
Lets get talking groups	0.30
Mandatory & Role Specific Training	0.26
Meetings:Allocation, neighbourhood, Early Years meeting	2.00
Staff development/supervision	0.50
Targeted group work- behaviour etc	0.00
Travel	5.00

Predicted Contact Demand		2019/20	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
UP		7,560	936	690	886	739	789	886
UPP		4,916	223	164	211	175	187	211
Safeguarding		12,090	1,998	1,471	1,889	1,580	1,689	1,889
Total		24,565	3,156	2,325	2,986	2,494	2,664	2,986

Expected Contacts	% To Offer	Total	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Antenatal	80	3,857	733	540	695	579	617	695
Antenatal	0	0	0	0	0	0	0	0
10-14 Day Contact	100	5,242	996	734	944	786	840	944
6-8 Week	100	5,240	996	734	944	786	839	944
4 Month	50	2,622	498	367	472	394	420	472
12 Month	100	5,648	1,074	791	1,017	848	905	1,017
12 Month	0	0	0	0	0	0	0	0
24 Month	10	603	115	84	109	90	97	109
24 Month	90	5,428	1,031	760	977	814	869	977
UP	50	3,780	468	345	443	369	394	443

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board – 30th July 2019
Paper number	T

Name of Report Freedom to Speak Up Report

For approval	X	For assurance		For information	X

Presented by	Angela Hillery - CEO	Author (s)	Pauline Lewitt – Freedom to Speak Up Guardian

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe		Safe	X	S – High Standards	X
Effective		Staff	X	T - Transformation	
Caring		Partnerships		E – Environments	X
Responsive		Sustainability		P – Patient Involvement	
Well-Led	X			G – Well-Governed	
				R – Single Patient Record	
				E – Equality, Leadership, Culture	X
				A – Access to Services	
				T – Trustwide Quality improvement	X
Any equality impact (Y/N)					

Report previously reviewed by	
Committee / Group	Date

Assurance : What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers

Recommendations of the report

Trust Board is recommended to:

1. Note progress made in respect of strengthening the FTSU arrangements and plans for on-going development of this work.

2. Support the current mechanisms and activities in place for raising awareness of the FTSU agenda.

3. To approve the proposed next steps to maintain momentum and embed FTSU in a culture of openness and transparency within the Trust.

T

Leicestershire Partnership NHS Trust

TRUST BOARD – July 2019

Freedom to Speak Up Report (6 monthly)

Introduction/Background

1. The Freedom to Speak Up (FTSU) review led by Sir Robert Francis into speaking up in the NHS provided independent advice and recommendations on creating a more open and transparent culture in the NHS.

2. The role of the FTSU Guardian incorporates being an additional route for speaking up but extends well beyond, aiming to develop cultures where safety concerns are identified and addressed at an early stage. FTSU has three components: improving and protecting patient safety, improving and supporting staff experience and visibly promoting learning cultures that embrace continual development.

Aim

3. This report intends to give an update from the Trust's FTSU Guardian on progress and the ongoing plans for strengthening arrangements for staff to speak up creating effective speaking up systems and processes that help to protect patients and improve the experience of NHS workers.

4. This report will provide a breakdown on the speaking up figures raised with the FTSU Guardian during the period January 2019 – June 2019.

5. This report will highlight updates from the National Guardians Office.

Recommendations

Trust Board is recommended to:

6. Note progress made in respect of strengthening the FTSU arrangements and plans for on-going development of this work.

7. Support the current mechanisms and activities in place for raising awareness of the FTSU agenda.

8. To approve the proposed next steps to maintain momentum and embed FTSU in a culture of openness and transparency within the Trust.

Discussion

9. The FTSU Guardian has received support from Peter Miller Chief Executive and Sarah Willis Director of HR & OD, with scheduled monthly meetings, Darren Hickman Non-Executive Director to the Trust Board through quarterly meetings and Cathy Ellis Chair at six monthly meetings.

10. The FTSU Guardian has been proactive in understanding how it has felt for staff members to raise concerns and is continually using this learning to reduce barriers and encourage staff to speak up.

11. The following actions have been undertaken since the last board report:

a. The newly formed FTSU Partners forum met in June 2019. This provided an opportunity for Partners to share their experience of being a FTSU partner with the rest of the group and learn through discussion about how they are embedding the key messages across the organisation. In addition, they had a chance to examine the case reviews including recommendations for 5 NHS Trusts published by the National Guardians Office (NGO). This information is to be used to inform and improve existing LPT speaking up processes with particular reference to the LPT FTSU processes and self-assessment completed in the autumn of 2018.

b. Raising awareness of FTSU agenda at corporate, student and medical trainee's induction sessions (420 delegates). This feedback was received in relation to the induction session presentation – *"I really think it sent a very strong message that the Trust is reflective, striving for the highest standards and supportive of its employees so it has given me a really positive impression of the Trust from the outset. Thank you!"*

c. Presentation of FTSU agenda at Health and Wellbeing event for student nurses at De Montfort University (33 delegates).

d. Presenting at Essential HR for Managers training sessions reiterating the importance of managers being clear about their roles and responsibilities when handling staff concerns using the 5 step approach and linking this to the Trust values of Respect, Integrity, Compassion and Trust (55 delegates) Delegates response to question, What was most useful? *"reminder of the Francis enquiry", "how you are making cultural changes/managing complaints- speaking up" and "the 5 step approach".*

e. Completed full round of monthly 'Here for You' drop-in events across the organisation (including all community hospital sites) linking in with FTSU Guardian for UHL and the Chaplaincy 'Listening Ear' service for staff.

f. Time-tabled regular meetings with patient safety team and wider assurance and risk teams.

g. Joined the reference group working with the Learning and Development team as part of the Our Future, Our Way - improving culture, leadership and inclusion.

h. LPT hosted the East Midlands Regional Group and the FTSU Guardian has attended the most recent National Conference and regularly engages with the NGO as part of the national FTSU training team.

<u>Freedom to Speak Up activities in the Trust</u>

Raising Concerns

12. In the last 6 months, 43 members of staff have raised concerns either individually or as a group. There is a wide cross-section of the Trust workforce that have contacted the Guardian and these have included, clinical development leads, junior doctor, practice development team, matrons, nurses, administrators, health care support workers, student nurses, practitioners and other Allied Health Professionals

13. The majority initially requested that their issue be dealt with confidentially however with support and reassurance many have felt confident to be identified and further-more discuss issues openly with their senior managers and Human Resource business partners.

Summary of the concerns raised in detail below: previous data provided for comparison

Month	No. of Contacts	Internal	FTSU	External	Anonymous
January	7	6	6	1	1
February	8	7	7	1	1
March	10	10	9	0	1
April	7	6	6	1	1
May	5	5	5	0	0
June	6	5	5	1	1
TOTAL	**43**	**39**	**38**	**4**	**5**

Service Area	July 18 – Dec 18	Jan 19 – June 19
AMH/LD	4	16
CHS	16	11
Enabling	4	6
FYPC	11	10
Hosted	0	0

Themes *	July 18 – Dec 18	Jan 19 – June 19
Patient Safety	18	13
Staff Safety	18	9
Attitudes & Behaviours	21	19
Bullying/Harassment	9	2
System/Process	24	21
Infrastructure/Environment	1	1
Cultural	9	10
Leadership	5	1
Senior Management Issue	8	1
Middle Management Issue	24	13

Concerns often contain multiple themes

Discussion of Themes

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

Patient safety

15. The speaking up in relation to patient safety have come from CHS and continues to highlight increasing numbers of referrals of more complex patients, increasing numbers on caseloads, skill mix within teams including roles and responsibilities. However, at recent drop-in visits to the city CHS nursing teams, positive comments were made in relation to case load management and best practice. The FTSU advised colleagues to identify what changes had been made and how these had positively impacted on their work and encouraged them to feed this back to their senior managers to ensure effective work models are maintained and learning shared across the teams.

16. Practitioners from CAMHs within FYPC have spoken up about waiting lists and case load management, transformation plans, commissioning, capacity and sustainability of services. These issues in practice are being addressed through specific CAMHs action plans. There has also been increased communications and raising awareness through staff engagement sessions, bulletins and team meetings.
17. In addition, a number of practitioners from the SALT team have spoken up about their concerns in terms of caseloads management (particularly the waiting time between 1st appointments to treatment/therapy), transformation planning, commissioning, service level agreements, capacity and sustainability. I understand that action plans have been shared at team meetings and there is focused work taking place around improving care pathways,

consistency of therapy provision, case load management/record keeping and data analysis.

18. A number of staff from the AMH LD inpatient teams (The Willows and Stuart House) raised concerns in relation to the impact of the smoking policy and potential safety issues for service users that left NHS premises to smoke particularly in residential areas. An incident had occurred at The Willows that necessitated formal Police action with a member of the public. This was discussed as part of the LPT policy review and there have been further communications to staff to ensure they are aware of current local guidance and support in relation to LPT policy and steps for reporting anti-social behaviour where appropriate.

Staff safety

19. Individual cases highlight that working with high caseloads lead to staff feeling they are not operating in a 'safe' environment and that their own health and wellbeing is not being considered. Staff have emphasised the need for robust mechanisms when communicating with colleagues and appropriate and visible line managers for professional and personal support.

20. A number of issues relating to the variable experience of wrap around support provided for newly qualified nurses during their preceptorship have been raised resulting in an LiA event and subsequent actions. However, similar issues have been raised by other newly qualified nurses and listening meetings have taken place to discuss individual personal experiences and support models of best practice and shared learning. This matter will be monitored going forward to identify common themes and make improvements as appropriate.

21. All themes in relation to patient and staff safety concerns have been reported to the appropriate Directorate Management Teams or delegated representatives and managed at a local level.

Attitudes and Behaviour/Bullying and Harassment

22. Staff have spoken up about situations where they feel that the Trust values are not being upheld during interactions. These instances are reported to have taken place during formal and informal team meetings, during individual interactions and across a broad range of the workforce.

23. These issues are difficult to manage due to the reluctance of staff to provide information to resolve matters either informally or formally. Staff often state that they are unhappy to take these issues forward due to perceived barriers for example, 'nothing changes', 'negative effect on career development', 'divisive impact on the team' and 'managers sticking together'.

24. To build trust and confidence in the role, the FTSU Guardian has actively supported a number of staff, in these situations, to consider options, to access other services as appropriate, and by personally supporting a listening meeting with managers and leaders. These meetings ensure the staff member is enabled to speak up about their experience and that having done so they know they have been listened to. These meetings have reportedly been very helpful and can have the effect of 'nipping issues in the bud'. Feedback about the experience of speaking up in these situations has been positive from all parties. Outcomes from these meetings may involve the recommendation to engage informal processes such as facilitated meetings and mediation. Often just having had the opportunity to share the concern or discuss an issue, a springboard is created, leading to more transparent and supportive staff engagement.

25. To further support individual emotional needs in all cases signposting to AMICA, staff-side or occupational health services is provided.

26. There have been a variety of individual issues raised by practitioners both openly and anonymously, within the Safeguarding team. Issues include negative attitudes and poor

behaviour being exhibited across the team, hostile challenges to change, limited access to ongoing psychological supervision to support mental health and appropriate breaks to support wellbeing at work. The senior management team is aware of the wider issues and is focusing on support and supervision.

27. The Guardian regularly attends the Anti Bullying and Harassment Service meetings to ensure information and themes are referenced to existing Human Resources reporting systems. There are ongoing discussions about the available support for staff and recently the Anti-Bullying poster has been amended, to include the FTSU Guardian contact details, on the advice of the CQC.

28. The FTSU Guardian attends the current BAME focus group and is networking with the Equality and Diversity team to share information and deliver joined up working and training when appropriate.

Systems and Processes

29. Issues have been raised in terms of administrative processes including service organisation, HR policies and procedures.

Reflection and Impact

30. A concern was raised in relation to internal transfers and the information that a manager had included as part of the reference procedures. As a result of this issue being raised the guidance for managers has been amended to ensure that internal references are accurate, fair and include 'no surprises' to the subject of the reference. This is a positive outcome and embeds the Trust values into practice.

31. Specific safeguarding guidance in relation to social media and file sharing has been published to ensure there is clarity and consistency in practice across LPT. This has been addressed as a direct result of a member of staff having tenacity to continue to speak up about her concerns over a period of time when faced with significant resistance.

Cultural

32. There appears to been an increase in the number of staff speaking up about a variety of issues that they have described as cultural. This may be anticipated as a result of the recent communications around 'Our Future, Our Way' – Leadership, Culture and Inclusion focus groups. It is expected that this will have a positive impact on staff engagement and will reinforce the FTSU message, creating a more open and transparent culture.

Staff Engagement and Raising Awareness of the FTSU role

33. The role continues to be publicised through a wide variety of media including dedicated space on eSource, articles and personalised blogs in the LPT eNewsletter, articles in bank staff and volunteer's newsletters, Twitter posts, posters and mobile banners and practical contributions at staff engagement events such as the Health and Wellbeing Day, and LiA events.

34. The Guardian attends all Corporate Induction workshops including separate sessions for medical trainees and student nurses; and continues to gain invites to talk at individual team meetings. The Guardian is also part of the equality network in the Trust and regularly attends the Trusts staff support groups.

35. The results from the annual FTSU (see Appendix A) survey identifies that there is still work to be done in raising awareness of the role and this will be a priority action for the coming year, involving a refreshed communications plan, further development of FTSU partners group and active recruitment of partners across the workforce offering this as a development of the Change Champion role.

National Staff Survey Results

36. The NSS 2018 results for LPT demonstrate improvements in Safety Culture and particularly in how staff perceives the organisation treats those involved in errors. This is also reflected nationally, however demonstrates that staff across this organisation feel more confident that they will be treated fairly.

37. The NGO is using this set of questions to measure improvement in the speaking up culture; whilst this is in its infancy and further developments are anticipated the Trust showed some positive improvements:

Question	LPT - 2017	LPT - 2018	National Benchmark
Know how to report unsafe clinical practice (Q18a)	**97.50%**	**96.88%**	**96.35%**
Feel secure raising concerns about unsafe clinical practice (Q18b)	**72.19%**	**75.87%**	**73.30%**
Organisation treats staff involved in errors fairly (Q17a)	**52.95%**	**58.26%**	**57.68%**
Organisation encourages reporting errors (Q17b)	**87.63%**	**88.55%**	**89.32%**
% of staff reporting the most recent error they witnessed (Q16c)	**95.92%**	**95.92%**	**96.01%**

National Guardians Office (NGO) – Updates

38. It is a requirement from the National Guardians Office (NGO) for local FTSU Guardians to ask for feedback after each case has been closed and supply data in terms of the following question 'Given your experience, would you speak up again'. This information is being used to assess culture. There has been one 'no' response.

39. In June 2019 the National Guardian's Office published the speaking up review for Brighton and Sussex University Hospital NHS Trust. The report consists of 2 main parts :
    - Speaking up and equality and diversity in the trust
    - Overall speaking up culture in the trust.

40. As a result of the report, the National Guardian has made a number of recommendations for the individual trust and encouraged all other organisations to reflect on these and apply the learning to their own cultures and processes. This will be taken to the BAME focus group in July to review the content and recommendations with reference to current speaking up messages and mechanisms in LPT.

41. The Freedom to Speak up Guardian will use the published recommendations to inform case progression, highlight and challenge current processes, identify best practice and support future action planning. Case studies are disseminated to the appropriate directorate or team to ensure information is shared and recommendations considered with reference to LPT practice.

Next steps

- Develop and refresh communications plan in consultation with communications team to include ideas for FTSU month in October.
- Continue to use all means to promote; staff engagement and trust, awareness of the role of FTSU, and reinforcing the vision; *to create an open and transparent culture where colleagues*

feel safe to speak up and raise concerns in the knowledge that they will be listened to without prejudice.

- Focus awareness raising in community hospitals through working alongside staff utilising a shadow shift approach across all shifts (days, nights and weekends)
- To further develop the network of Freedom to Speak up Partners and increase number across the trust to improve the reach and consistently embed FTSU – develop a proactive recruitment programme.
- Increase the number of ways staff can speak up in the organisation (direct electronic reporting method on staff intranet)
- Continue to be an active member of working group to address issues relating to attitudes and behaviours/bullying and harassment within the organisation highlighting best practice from other organisations.
- Develop focussed work stream with Organisational Development(OD) and Human Resources teams to support leadership programmes to encourage being open, how to handle concerns to get the best possible outcome to continually improve patient safety and support best practice using the 5 step model.
- Actively engage with OD team to understand the outcomes of the 'Our Future, Our Way' programme and utilise the skills and expertise of the Change Champions.
- Revisit FTSU self-review.
- Engage in regular scheduled meetings/data sharing with other services including patient safety improvement and governance and risk teams.
- Continue to engage in regional and national FTSU meetings and conferences thereby using updates, information and recommendations to inform practice.

Conclusion

42. The Freedom to Speak Up agenda is building an environment where staff know their concerns, feedback and commentary are taken seriously and welcomed as an opportunity to guide service improvement and transformation.

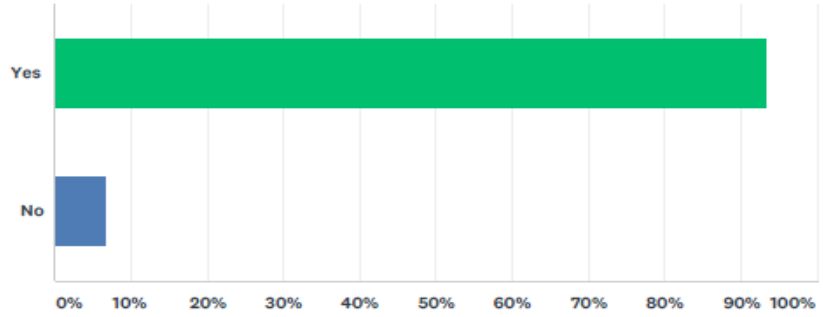
43. Feeling free to speak up is a significant culture change across the NHS. Success is not only the responsibility of those in the guardian role. It is vital the Trust learn from concerns that staff raise and ensure changes or actions are implemented, otherwise there will be no value in the process and we would be missing out on some of the most valuable information that comes from these reports.

Presenting Director: Angela Hillery
Author(s): Pauline Lewitt

Appendix A

Q1 Do you know how to raise a concern at work?

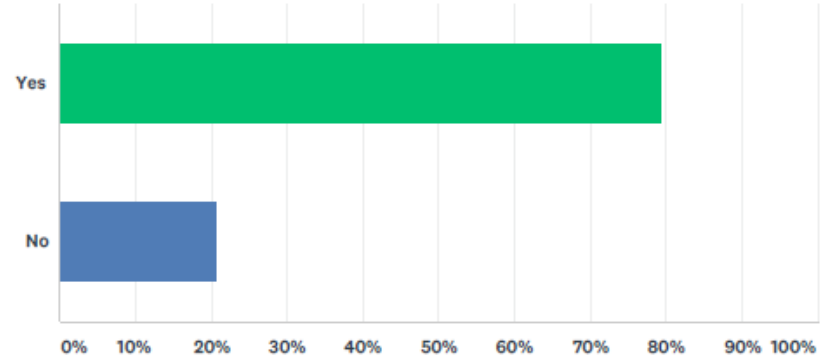
Answered: 704 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	93.32%	657
No	6.68%	47
TOTAL		704

Q2 Do you know that LPT has a Freedom to Speak Up Guardian?

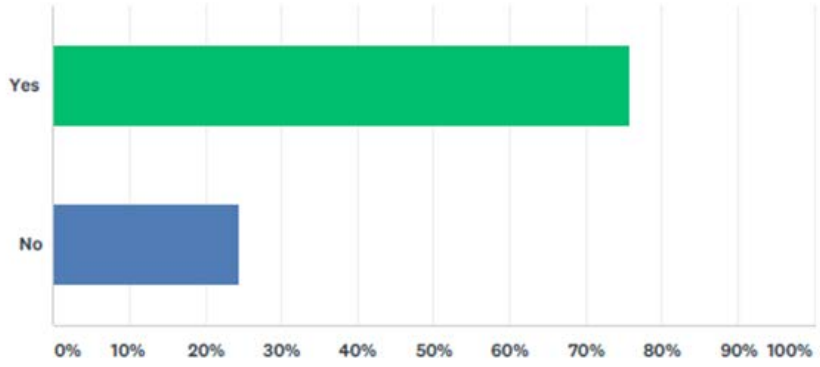
Answered: 703 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	79.37%	558
No	20.63%	145
TOTAL		703

Q3 Do you know how to contact the Freedom to Speak Up Guardian?

Answered: 548 Skipped: 156



ANSWER CHOICES	RESPONSES	
Yes	75.73%	415
No	24.27%	133
TOTAL		548

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board – 25 July 2019
Paper number	U

Name of Report - Annual Report on Consultant Appraisal and Revalidation

For approval	x	For assurance		For information	

Presented by	Dr Sue Elcock, Medical Director	Author (s)	Angela Salmen, Medical Staffing & Revalidation Manager

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe	x	Safe	x	S – High Standards	x
Effective		Staff	x	T - Transformation	
Caring	x	Partnerships		E – Environments	
Responsive		Sustainability		P – Patient Involvement	
Well-Led				G – Well-Governed	
				R – Single Patient Record	
				E – Equality, Leadership, Culture	
				A – Access to Services	
				T – Trustwide Quality improvement	x
Any equality impact (Y/N)		No equality impact implications have been identified			

Report previously reviewed by	
Committee / Group	Date
Not previously discussed in a committee	

Assurance : What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers
The report assures that the Trust is meeting The Medical Profession (Responsible Officers) Regulations 2010 and the GMC (Licence to Practice and Revalidation) Regulations 2012.	7d

Recommendations of the report
The Board is asked to approve this report (noting that it will be shared with the higher level Responsible Officer) and to sign the “statement of compliance” (Section 7) confirming that the organization, as a designated body, is in compliance with the regulations.

Leicestershire Partnership NHS Trust

Annual Report on Consultant Appraisal and Revalidation

1. Introduction/Background

Leicestershire Partnership NHS Trust has a prescribed connection to 142 doctors, for the purpose of Medical Revalidation, with the General Medical Council (as at 30th June 2019). There have been 140 doctors appraised in the appraisal year. The appraisal compliance rate is therefore 99%.

This Annual Report should be taken in conjunction with the previous Annual Report, in July 2018.

The figures contained within this report are correct as at 30th June 2019. Numbers refer only to those doctors who have a prescribed connection with the Trust. Medical Trainees on the approved training programme are excluded as they are connected to Health Education East Midlands.

2. Aim

The aim of this paper is to provide an annual report to the Trust on progress in implementing and managing appraisal and revalidation for doctors that have a prescribed connection to the Trust. It provides an overview of the elements defined in the Responsible Officer regulations.

3. Framework for Quality Assurance of Appraisal and Revalidation

The following report reflects the template prescribed by NHS England and NHS Improvement to assure the Trust and higher-level Responsible Officer of the effectiveness in supporting medical governance in keeping with the GMC's requirements.

3.1 The Annual Organisational Audit (AOA) for this year has been submitted.

Date of AOA submission:	16/05/2019
Action from last year:	Improve the quality and availability of information about doctor's activity
Comments:	The outstanding action has been on the programme of work by the IM&T team for some time.
Action for next year:	Continue to work with IM&T to ensure activity data is provided to doctors and in a meaningful format for appraisers.

3.2 An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year:	None
Comments:	Change in RO to Dr Susan Elcock on 01/10/2019
Action for next year: None	

3.3 The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes	
Action from last year:	None
Comments:	There is an Associate Medical Director in post responsible for Medical Governance. Operational Management is provided by the Medical Staffing & Revalidation Support Manager.
Action for next year:	None

3.4 An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year:	None
Comments:	The Medical Staffing & Revalidation Support Manager ensures the list of prescribed connections is updated on a monthly basis.
Action for next year:	None

3.5 All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year:	None
Comments:	Medical Appraisal and Revalidation Policy and Procedure updated in November 2017. Remediation Policy and Procedure updated in September 2017 Managing Concerns about Medical Staff implemented in February 2018
Action for next year:	Remediation Policy due for review September 2019 Appraisal Policy due for review November 2020

3.6 A peer review has been undertaken of this organisation's appraisal and revalidation processes.

Action from last year:	None
Comments:	Review by 360 Assurance conducted in 2015
Action for next year:	Arrange peer review for 2019/20

3.7 A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year:	None
Comments:	Locums responsible to LPT as the Designated Body are provided with the same appraisal/revalidation process as for substantive doctors. We do not provide appraisals for Agency Locums as they receive this through their agencies and have an external RO.
Action for next year:	None

Section 2 – Effective Appraisal

3.8 All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Action from last year:	None
Comments:	Information about the whole scope of practice is recorded in the e-appraisal system (SARD) and appraised by the appraiser.
Action for next year:	None

3.9 Where in Question 4.8 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year:	None
Comments:	n/a
Action for next year:	None

3.10 There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year:	None
Comments:	Medical Appraisal and Revalidation Policy and Procedure updated in November 2017.
Action for next year:	Policy is due for review in November 2020

3.11 The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year:	None
Comments:	There are 34 appraisers trained to provide revalidation ready appraisals.
Action for next year:	2 appraisers are leaving LPT in 2019. We will seek replacements to ensure

3.12 Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year:	None
Comments:	In-house development sessions are provided for appraisers twice yearly. Refresher training by an external organisation is planned for September 2019. Some appraisers have attended regional network events.
Action for next year:	Arrange training for new appraisers as required.

3.13 The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year:	None
Comments:	There is a quality assurance lead for appraisals that reviews completed appraisals against the ASPAT methodology (Appraisal Summary and PDP Audit Tool).
Action for next year:	Ensure findings are reported to the Strategic Workforce Group

Section 3 – Recommendations to the GMC

3.14 Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year:	None
Comments:	All recommendations with the last 12 months have been submitted on time. There has been 37 positive recommendations made in the last 12 months (no deferrals)
Action for next year:	None.

3.15 Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year:	None
Comments:	All doctors are advised of the recommendation prior to submission on GMC Connect. Any deferral recommendations would be discussed with the doctor beforehand.
Action for next year:	None

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Section 4 – Medical governance

3.16 This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year:	None
Comments:	There is an Associate Medical Director in post responsible for Medical Governance. The role encompasses appraisal and revalidation, job planning and the management of concerns.
Action for next year:	None

3.17 Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year:	None
Comments:	There is an automated system in place whereby reports on complaints, compliments and Sis is provided to all doctors for recording in their appraisal record.
Action for next year:	None

3.18 There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year:	None
Comments:	Managing Concerns about Medical Staffing policy and procedure implemented in February 2018
Action for next year:	None

3.19 The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].

Action from last year:	None
Comments:	All concerns are reported to the Strategic Workforce Group as part of a HR report
Action for next year: None	

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

3.20 There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].

Action from last year:	None
Comments:	The Trust uses the MPIT (Medical Practice Information Template) for this purpose.
Action for next year:	None

3.21 Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year:	None
Comments:	There is a Trust policy on managing concerns about medical staff. The policy is intended to protect employees from unfair treatment regardless of their background.
Action for next year:	None

Section 5 – Employment Checks

3.22 A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year:	None
Comments:	Pre-employment checks are carried out on all doctors, including locums and short-term doctors by the Medical Staffing Department.
Action for next year:	None

Section 6 – Summary of comments, and overall conclusion

One action remains outstanding from last year which is to provide meaningful and accurate data to doctors on their activity. This has been on the programme of work by the IM&T team for some time. We understand that an activity dashboard is due to be rolled out in Adult Mental Health for trail in the coming months.

Two appraisers are due to leave LPT in the next three months and replacements will be needed to ensure the workload for appraisers can continue to be managed with SPA (Supporting Professional Activity) time.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

The last audit/review of the appraisal and revalidation system and process was undertaken in 2015. An updated peer review will be sought in the coming 12 months.

The Remediation policy is due for review in September 2019.

Overall conclusion:

Medical appraisal and revalidation systems and processes are well established in LPT. There is an established team of appraisers providing quality appraisals as evidenced in audits and feedback.

Section 7 – Statement of Compliance:

The executive management team of Leicestershire Partnership NHS Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

(Chief executive or chairman)

Official name of designated body: Leicestershire Partnership NHS Trust

Name: …… Signed: ……

Role: ……

Date: ……

Leicestershire Partnership NHS Trust

Meeting Name and date	Trust Board 25 July 2019
Paper number	V

Board Committees' annual reports 2018-19

For approval	✓	For assurance		For information	

Presented by	Frank Lusk, Trust Secretary	Author (s)	Frank Lusk, Trust Secretary/ Anna Pridmore. Interim Associate Director of Corporate Goverance

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe	✓	Safe	✓	S – High Standards	✓
Effective	✓	Staff	✓	T - Transformation	✓
Caring		Partnerships	✓	E – Environments	✓
Responsive	✓	Sustainability	✓	P – Patient Involvement	✓
Well-Led	✓			G – Well-Governed	✓
				R – Single Patient Record	✓
				E – Equality, Leadership, Culture	✓
				A – Access to Services	✓
				T – Trustwide Quality improvement	✓
Any equality impact (Y/N)		No			

Report previously reviewed by	
Committee / Group	Date
Draft annual reports were reviewed at each committee and then presented to the May and July 2019 Audit and Assurance committees.	

Assurance : What assurance does this report provide in respect of the Board Assurance Framework Risks?	Links to BAF risk numbers

Recommendations of the report
To review and approve the Annual Committee Reviews including proposed changes of reference for committees. Following the Well-Led review outcome from the CQC inspection in 2018 there has been a series of reviews of the LPT governance arrangements. The reports by committees in this Paper reflect the 2018-19 look back "as was" and forward plans as known at the time of authorship of the papers. A Board development session on 30 August 2019 will have presented to it the outcome of a current review of the approach to Quality Governance by the Director of Nursing and Chief Executive. This will strengthen the committee structure reporting into the Quality Assurance

committee.

Leicestershire Partnership NHS Trust

ANNUAL REPORT
Year 2018-19

Committee/Group	Charitable Funds Committee
Date	5th March 2019
Chair of Committee	Cathy Ellis

Section A – Fulfilling Terms of Reference

1. Review of Terms of Reference (ToR)
   - Were all duties of the ToR covered through the work plan and agendas during this year? If there were gaps, how were these addressed?

The Terms of Reference are attached as appendix 1. The agendas for the committee set out standard items for discussion such as bids for the committee's approval and the finance report. These items ensure that the committee is able to manage the funds on behalf of the Trust Board and verify that the administration of the funds is in accordance with the Trust's Standing Financial Instructions.

- Has the membership been reviewed, and is it considered sufficient to enable all duties to be carried out and fulfil quoracy ie minimum attendance expected at meeting?

The core membership is two Non-Executive Directors and two Senior Managers (as nominated by the Director of Finance). Other senior managers from across the Trust are invited to present specific bids. Service areas have all introduced their own approval processes for bids, so the committee has assurance that the services have reviewed and approved all bids that come to committee for final approval.

- Are all of the Groups or functions that report to the Committee identified, and their ToR regularly reviewed?

There are no groups or sub-committees that report to the Charitable Funds Committee.

- Did the Committee cover its areas of responsibility for assurance on delivery of the Strategic Objectives?

The charity's objective is: The Trustees shall hold the trust fund upon trust to apply the income, and at their discretion, so far as may be permissible, the capital, for any charitable purpose or purposes relating to the National Health Service.
The Committee's agenda is aligned to this objective and governance arrangements are in place to ensure this is delivered.

- Please comment on the adequacy of the ToRs, mentioning any 'gaps' or 'overlaps' with other groups perceived

The committee don't consider that there are any overlaps with any other groups, or gaps in the Terms of Reference.

- Please inform of any agreed changes to ToRs (subject to Parent Committee adoption)

Section/Term	Current wording	Proposed revised wording
10.4	Ensure that the scheme of delegation within the Trust's Standing Orders and Standing Financial Instructions for expenditure of charitable funds is followed.	Ensure that the Trust's Standing Financial Instructions for funds held on trust are followed. The discharge of the Trust's corporate trustee financial responsibilities may not necessarily be discharged in the same manner as the Trust's financial responsibilities are, but there will still be adherence to the overriding general principles of financial regularity, prudence and propriety. Any departure from the Trust's SFIs will be clearly articulated in a separate document and approved by the committee each year
4.1	Membership will consist of two Non-Executive Directors and two Senior Managers (as nominated by the Director of Finance)	Membership will consist of two Non-Executive Directors, one of which will be the Trust Chair, and two Senior Managers (as nominated by the Director of Finance) one of which will be a senior finance manager
N/A	N/A	10.6 approve expenditure, subject to agreed raising health procedures being followed, and on receipt of a completed bid form which has been approved by local fund managers and has received appropriate health & safety and estates advice

This section will be completed following the Committee's review of the terms of reference.

2. <u>Assurance</u>
   - Please comment upon the robustness of assurances received

In the main, assurance provided to the committee is of a good standard and can be backed by evidence. However, on the occasions where the committee feel that appropriate assurance has not been provided then an action will be agreed and recorded in the action log. These actions are reviewed at every committee meeting and, in the majority of cases, the actions are cleared by the next meeting (unless longer timescales are agreed).

- Were there any sources of external assurance during this period? Were there any concerns raised and addressed?
    - o External Audit of the annual accounts
    - o Internal Audit review

The 2017/18 internal audit report received significant assurance, and the external auditors review of the 2017/18 accounts delivered a clean opinion.

- Has the committee considered all possible sources of assurance?

Charity commission guidance is followed e.g. Charity fundraising: a guide to trustee duties. Department of Health charitable funds guidance is also followed. Applicable IFRS accounting standards are used in the preparation of the in-year and annual accounts.

3. Analysis of Risks
   - What is the frequency of risk review by the Committee?

The Committee reviews the risk register at the start and end of each meeting with amendments and further considerations recorded as part of the minutes.

- Commentary on risks reviewed, and ease of process

All risks are reviewed on a quarterly basis with amendments undertaken by the Financial Controller to ensure changes are reflected in future reports. From the committee's perspective, the system for reviewing and amending the risk register is efficient and effective.

4. Work plan
   - Does the work-plan evidence the discharging of the ToR? (Please attach the 2018/19 workplan).

The 2018/19 work plan, shown at appendix 2, evidences the discharging of the terms of reference.

- Is the work plan then used to inform agendas?

All areas in the work plan have been covered in year. Agenda planning has sometimes meant that the timing of items is slightly different from that planned at the start of the year
   - Has the committee reviewed progress in-year against its annual work plan to see if is achieving objectives?

The work plan is reviewed at the end of each meeting.

- Please comment on any elements of the work plan that are not fulfilled

None have been identified.

Section B – Reflection upon Working Practices

5. Effectiveness of Committee discussion
   a. How effectively is the Group Chaired?
      - Keeping to time/controlling discussion

The agenda is well managed and the use of a timed agenda ensures timeliness of discussions.

- Confirming action to be taken, and recorded in minutes, when a declaration of interest is made

Declarations of interest are a standing item on the agenda, and when declarations are made, they are recorded in the minutes.

- Confirming that the meeting is quorate

All meetings have been quorate, as reflected in the attendance log shown below.

- Effectiveness in dealing with Matters Arising

Clear actions are agreed during the summing up of each discussion point by the Chair and these are captured in the actions log, and reviewed as part of the following meeting's agenda.

- Ensuring that all are 'heard'/have a chance to contribute

The inclusive style of chairing allows contributions from all members and attendees at the meetings.

- Summarising of discussion and clarity of agreed outcome/action

Clear actions are agreed during the summing up of each discussion point by the Chair.

   b. Do all members contribute?
      - Is an Attendance log maintained, and attendance levels of 75% achieved by all formal members of committees?

An attendance log is shown below:

Trustee	March	June	September	December
Cathy Ellis (Chair)	✓	✓	✓	✓
Geoff Rowbotham	X	✓	✓	X
Frank Lusk	✓	✓	✓	X
Sharon Murphy	✓	✓	✓	✓

Attendance by Percentage:

Cathy Ellis	100%
Geoff Rowbotham	50%
Frank Lusk	75%
Sharon Murphy	100%

- Are formal members recorded as such and others as attendees?

Trustees are listed as members and others are listed as attendees.

- Are members sufficiently prepared for meetings?

Members are sufficiently prepared for meetings and the Chair states the expectations at the start of each meeting that all papers are assumed as read in advance of the meeting.

- Is there sufficient challenge, and input to agenda items by members?

The minutes of the meetings demonstrate the good level of challenge posed by members on agenda items. Where challenge is not met with sufficient assurance or evidence then an action is recorded for follow up.

6. Communication channels
   a. Communications to and from members
      - Are draft agendas sent early enough to maximise time to prepare papers?

The draft agenda is sent at least 2 weeks before the paper deadline.

- Are papers submitted in good time? Are they disseminated in good time?

The bid paper deadline is 2 weeks before the paper dissemination date. All other papers must be submitted 1 week before the paper dissemination date. All papers are distributed 1 week before the committee meeting.
The chair has reiterated that timely submission of papers is important to the smooth running of the committee, and that late papers will only be accepted by exception. This rarely happens in practice.

- Is the Highlight report produced and shared within 5 working days?

The draft highlight report is shared with the Chair and Executive Lead within the appropriate timescales.

   b. Quality of papers
      - Are papers of a good standard?

Papers are generally of a high standard.

- Are papers usually presented by either their author, or an informed substitute?

Papers are normally presented by the author or an informed nominated representative.

- Is there a need to offer report writing skills?

None identified to date.

c. Quality of minutes
   - Is there evidence of challenge and assurance, where available, included in minutes?

The challenging nature of discussions, and assurance received, is recorded in the minutes.

- Are the recommendations/actions that the papers request of the Group reflected in the minutes?

The minutes accurately record all actions and recommendations made by the Committee

- Are the matters arising captured in an action log retaining the original implementation date?

Clear actions are agreed during the summing up of each discussion point by the Chair and these are captured in the actions log, include the implementation date, and are reviewed as part of the following meeting's agenda.

d. Information flows with Parent Committee
   - Does the 'parent' committee receive regular Overview/Highlight reports?

A highlight report is produced after each committee meeting by the Chair and Executive Lead for submission to the Trust Board.

- Is there sufficient feedback from the Parent Committee to the Sub-Group?

Feedback from the Trust Board comes in various forms; annual committee review undertaken by the Audit and Assurance Committee on behalf of the Board; Board delegation of duties to Charitable Funds Committee; Chief Executive to Trustee feedback; highlight report discussions and general discussion and reference to work undertaken by the committee.

7. <u>Achievements and Barriers</u>
   - Please list top three achievements or successes

The committee has continued to support services with funding for:

- Diana service 20th Anniversary vest appeal (focus of the general appeal for 2018)
- Stewart House Road to Recovery Appeal
- NHS 70 celebrations
- Enhancing the ward environment at the Evington Centre to be more sensitive to dementia patients' needs
- Music sessions and drama workshops on wards
- Arts projects which involve patients on our Community Hospital wards, Bradgate Unit and Westcotes House
- Whizzybug mobility aid for use in therapy sessions for children

LPT staff are keen to take part in fundraising events at work, and there has been a shift away from these events only being for the larger charities to being for Raising Health. Staff have taken part in challenge events such as walks, runs, cycling and swimming for Raising Health

appeals where they would have previously only thought it was possible to do this for other charities.

The charity has used mass participation challenges, use of social media platforms and local media coverage (radio, television and print) to boost brand awareness in external audiences, whilst recognising there is still a way to go to be a household name.

Grant funding from the Carlton Hayes Charity has steadily increased year on year with new and innovative grant requests being made from different areas of LPT who provide mental health care. Carlton Hayes trustees have agreed to make an annual grant to Raising Health, which the charity will administer. This shows a significant level of trust between the charities. Through the fundraising manager, applications to grant making trusts have increased and successes have been seen in this area for the first time.

- Please list the key issues considered during 2018/19.

The committee has worked hard to manage commitments and service expectations due to the level of cash funding available in 2018/19. The charity withdrew £150k from the capital investment in year to support cash flow management.

The committee continues to strive to reduce the overhead costs of the charity to ensure that as much funding as possible is used to fund bids.

- Were there any barriers perceived to the work of the Committee?

No barriers are perceived to the work of the committee.

- Please identify actions that will be taken (with timescales) to address any issues recognised as outcomes of this annual review process

No issues have been identified as part of the annual review process.

8. Future Plans
   - Please append Annual Work-plan for 2019/20

The 2019/20 workplan is included at appendix 3.

- What are the Committee's key priorities/focus/planned developments for next year?

Focus	Detail	Fundraising Strategy reference	Lead	Timescale
Marketing				
	Enhance the charity's brand visibility on LPT sites	7.1	Fundraising Manager	June 2019
	Ensure greater Raising Health presence at staff and public events	7.3	Fundraising Manager	For duration of strategy
	Legacy promotion	7.5	Fundraising Manager	June 2019
	Continued support of staff to look for charitable funding for projects	7.7	Fundraising Manager	For duration of strategy
Financial sustainability				
	Continued focus on the long term sustainability of		Committee	On going

	the charity and its capital investment.			
	Review Income & expenditure run rate to assist in forecasting and management of financial risk		Financial controller	June 2019
	The charity will undertake a procurement process to appoint new investment managers by the required date of 30 June 2019.		Committee	June 2019
	Focus on the charity's procedures, including SFIs, to ensure that they are clear and enhance efficiency and effectiveness		Financial controller	June 2019

Leicestershire Partnership NHS Trust

Charitable Funds Committee
Terms of Reference

References to "the Committee" shall mean the Charitable Funds Committee

1.0 Purpose of Committee

1.1 Leicestershire Partnership NHS Trust (LPT) was appointed as a corporate trustee of charitable funds received under a Transfer Order from NHS Leicestershire County and Rutland Primary Care Trust on 22 December 2011.

1.2 The Trust Board will act on behalf of the corporate trustee in the administration of the charitable funds.

1.3 The purpose of the Committee is to manage, on behalf of the Trust Board, and in accordance with Standing Orders, charitable funds held and provide assurance to the Trust Board on the effective management thereof.

2.0 Status and Indemnity of Trustees

2.1 Where a NHS Trust is the sole corporate trustee of a charity, the individual persons who, from time to time, are responsible for the management of the corporate body, i.e. the members of the trust or other officers, are not themselves trustees of the charity. The duties, responsibilities and liabilities of trusteeship lie with the body corporate.

2.2 As LPT is the corporate trustee it will appoint/nominate appropriate representation from the Board to act as Corporate Trustees on its behalf on the Charitable Funds Committee.

3.0 Authority

3.1 The Committee is authorised by the Trust Board to conduct its activities in accordance with these terms of reference, and in statutory compliance with the Charity Commission regulations and charity law.

3.2 The Committee is authorised by the Trust Board to seek any information it requires from any employee of the Trust in order to perform its duties.

4.0 Membership

~~4.1~~ Membership will consist of two Non-Executive Directors, one of which will be the Trust Chair, and two Senior Managers (as nominated by the Director of Finance) one of which will be a senior finance manager. ~~Membership will consist of two Non-Executive Directors and two Senior Managers (as nominated by the Director of Finance).~~

4.24.1 The Chair of the Committee will be the Chairman of the Trust. In the Chair's absence the chairing of the Committee will be undertaken by another Non-Executive Director.

4.34.2 The Committee may require the attendance for advice, support, and information routinely at meetings from Trust staff and external advisors.

5.0 Secretary

5.1 The Executive PA of the Chair shall act as secretary.

6.0 Quorum

6.1 The Committee quorum is one Non-Executive Director and one Senior Manager (as nominated by the Director of Finance).

7.0 Frequency of Meetings

7.1 The Committee shall normally meet at least quarterly but not less than twice a year and at such other times as the Chairman of the Committee shall require at the exigency of the business.

7.2 Members will be expected to attend at least three-quarters (75%) of all meetings.

8.0 Agenda/Notice of Meetings

8.1 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, and any other person required to attend, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to Committee members, and to other attendees as appropriate, at the same time.

8.2 The agenda for each meeting will include an item "Declarations of interest in respect of items on the agenda".

9.0 Minutes of Meetings

9.1 Draft minutes of each meeting will be circulated promptly to the Chairman for review

10.0 Role/ Duties

The Committee is authorised to:

10.1 ensure that the income and property of the Charity are applied for the purpose set out in the governing document and for no other purpose.

10.2 have a general duty of protecting the property of the Charity and use the charitable monies proactively – i.e. for the benefit for which they were given.

10.3 ensure that the Trust's policies and procedures for charitable funds investments are followed.

~~10.3~~10.4

~~10.4~~ ensure that the Trust's Standing Financial Instructions for funds held on trust are followed. The discharge of the Trust's corporate trustee financial responsibilities may not necessarily be discharged in the same manner as the Trust's financial responsibilities are, but there will still be adherence to the overriding general principles of financial regularity, prudence and propriety. Any departure from the Trust's SFIs will be clearly articulated in a separate document and approved by the committee each year. ~~.~~

10.5 manage the investments of the charitable funds pursuant to section 11 of the Trustee Act 2000 and, if necessary, appoint, as required, investment advisors. Day to day management on some or all of its investments to the investment advisors may be delegated with periodic reviews of the performance of the investment advisors.

~~10.5~~10.6 approve expenditure, subject to agreed raising health procedures being followed, and on receipt of a completed bid form which has been approved by local fund managers and has received appropriate health & safety and estates advice.

~~10.6~~10.7 ensure that the banking arrangements for the charitable funds are kept entirely distinct from the Trust's NHS funds.

~~10.7~~10.8 receive any audit reports from internal or external Audit which relate to Charitable Funds.

~~10.8~~10.9 receive the annual accounts of the Charity along with the Annual Trustees Report for the Charity Commission within the agreed timescales.

~~10.9~~10.10 ensure that the Committee membership is reviewed after 2 years and refreshed every 3 years.

~~10.10 Permanent trustees of the charity have been agreed as the Trust chair and a senior finance manager (as nominated by the Director of Finance).~~

~~10.11~~

~~10.12~~10.11 provide guidelines with respect to donations, legacies and bequests, fundraising and trading income.

11.0 Reporting Responsibilities:

11.1 The Committee shall make whatever recommendations to the Trust Board it deems appropriate on any area within its remit where action or improvement is needed.

11.2 The Committee shall produce for the Trust Board an annual report on the work it has undertaken, and its performance, during the course of the year.

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12.0 Date of Review

12.1 These Terms of Reference will be reviewed at least annually and where circumstances change in law and any significant changes take place in terms of scope or value of the funds.

13.0 Risk Responsibility

13.1 The risk areas the Committee has special responsibility for will be those that fall within the remit of this Committee.

Charitable Funds Committee - Annual Work Plan 2018/2019

	June 2018	Sept 2018	Dec 2018	Mar 2019
Standing Items				
Review of CF Risk Register	X	X	X	X
Strategy				
Review of draft fundraising strategy Approval of fundraising strategy	X	 X		
Approval of Investment Strategy		X		
Performance				
Annual review of the effectiveness of the Committee, review of the Terms of Reference, approval of the 2019/20 work plan and review of Committee membership for submission to AAC				X
Promoting Charitable Funds & delivering the strategy - Fundraising Managers' report	X	X	X	X
Investment Managers attend meeting for performance review	X			
Annual review of performance of Investment Advisors				X
Benefits realisation – assessing VFM	X			
Quarterly Finance Report including Pipeline Report & investment performance	X	X	X	X
Annual Accounts and Annual Trustees Report for submission to the Charities Commission • Timetable • Draft report		X	 X	
Procurement of Investment Managers	X	X	X	
Appointment of Investment Managers				X
Budget setting for running of Charity				X
Raising Health Overhead Costs Review				X
Assurance / Governance				
Review of Internal Audit Report			X	
Review SFIs and SORD				X
Annual Assurance and Review of Policies and Procedures				X
Bids				
Updates on Previous Bids	X	X	X	X
New Bids	X	X	X	X
Items for Information				
Charitable Funds Work Plan	X	X	X	X

Charitable Funds Committee - Annual Work Plan 2019

	March 2019	June 2019	Sept 2019	Dec 2019
Standing Items				
Review of CF Risk Register	X	X	X	X
Strategy				
Refresh of fundraising strategy				X
Approval of Investment Strategy		X		
Performance				
Annual review of the effectiveness of the Committee, review of the Terms of Reference, approval of the 2019/20 work plan and review of Committee membership for submission to AAC				X
Promoting Charitable Funds & delivering the strategy - Fundraising Managers' report	X	X	X	X
Investment Managers attend meeting for performance review	X			
Annual review of performance of Investment Advisors		x		
Benefits realisation – assessing VFM Long term projects		X		
Quarterly Finance Report including Pipeline Report,investment performance & legacies	X	X	X	X
Annual Accounts and Annual Trustees Report for submission to the Charities Commission • Timetable • Draft report		X	 X	
Procurement of Investment Managers	X	X		
Appointment of Investment Managers		X		
Budget setting for running of Charity		X 19/20		X 20/21
Raising Health Overhead Costs Review		X 19/20		X 20/21
Assurance / Governance				
Review of Internal Audit Report			X	
Review SFIs and SORD				X
Annual Assurance and Review of Policies and Procedures				X
Bids				
Updates on Previous Bids	X	X	X	X
New Bids	X	X	X	X
Items for Information				
Charitable Funds Work Plan	X	X	X	X
Next year's dates for agreement		X		

Draft Workplan 2019

Leicestershire Partnership NHS Trust

Meeting	Audit and Assurance Committee Trust Board
Date of meeting	05/07/2019
Paper number	V

Name of Report
Audit and Assurance Committee Review 2018-19

For approval	X	For assurance		For information	

Presented by the Accountable Director	Chair, Darren Hickman	Author (s)	Frank Lusk Darren Hickman

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe		Safe		S – High Standards	X
Effective		Staff		T - Transformation	
Caring		Partnerships	X	E – Environments	
Responsive	X	Sustainability	X	P – Patient Involvement	
Well-Led	X			G – Well-Governed	X
				R – Single Patient Record	
				E – Equality, Leadership, Culture	
				A – Access to Services	
				T – Trustwide Quality improvement	

Report previously reviewed by		
Committee / Group	Date	Assurance obtained (Significant/Limited/None)

Assurance : What level of assurance does this report provide in respect of the Board Assurance Framework Risks? (Significant / Limited / No Assurance)	Links to BAF risk numbers
Significant	7d

Recommendations of the report
The Committee is asked to review, comment and approve the Annual Review Look Back report ahead of submission to the 30 July 2019 Trust Board.

ANNUAL REPORT

Committee/Group	Audit and Assurance Committee
Date	July 2019
Chair of Committee	Darren Hickman

Section A – Fulfilling Terms of Reference

1. Review of Terms of Reference (ToR)
   - Were all duties of the ToR covered through the work plan and agendas during this year? If there were gaps, how were these addressed?
     Yes all TORs covered as committee workplan designed to do so. However some items not considered in sufficient depth as seen in External Governance review feedback and the committee's survey findings.

   - Was the membership sufficient to enable all duties to be carried out and fulfil quoracy ie minimum attendance expected at meeting?
     Yes

   - Are all of the Groups or functions that report to the Committee identified, and their ToR regularly reviewed?
     Not applicable

   - Did the Committee cover its areas of responsibility for assurance on delivery of the Strategic Objectives?
     Needs strengthening

2. Assurance
   - Please comment upon the robustness of assurances received
     The Survey findings (Appendix) of committee attendees give feedback on assurances in the round. Key points from the survey were:

     - Some concern over how committee integrates with other committees within LPT, and integrating with wider performance and standards compliance.
     - Strong support to quality of information received at committee, the level of information being appropriate, timeliness of papers, along with sufficient time to discuss items at the meetings assisted by effective Chairing.
     - Appropriate staff were at the meetings to support discussion and good discussion seen.
     - Some strengthening of assurances to committee was felt needed.
     - Good relationship with external audit
     - Unanimous strong support to unfettered role of Internal Audit work.
     - Committee seen as robust in closing down agreed actions in a timely way.
     - Weakness in reviewing information and assurances for CQC registration.
     - Some concerns on the balance of the agenda for financial, quality and performance issues (is being picked up by the External Governance report recommendations).
     - How the BAF is reviewed at the committee, and risk oversight in general, were seen as weak (CQC well-led findings and External Governance Review support these views).

- Were there any sources of external assurance during this period? Were there any concerns raised and addressed
  Yes – key sources were external and internal audit reports and benchmarking surveys.

- Has the committee considered all possible sources of assurance?
  This was felt to be the case and benchmarking with other Audit Committees had not shown any gaps/omissions.

3. Analysis of Risks
   - What is the frequency of risk review by the Committee?
     Every meeting.

   - Commentary on risks reviewed, and ease of process
     BAF/CRR risk register is considered at the end of each meeting for general commentary and specifically if it is felt that any risks have been mitigated or escalated as a result of discussion. Referral back to the oversight committee for risks is considered if needed and was done so.

4. Work plan
   - Did the work plan inform agendas?
     Yes – it sets initial agenda prior to Chair's review.

   - Did the committee review progress in-year against its annual work plan to see if is achieving objectives?
     Yes and mid-year for progress against future objectives set 2018-19.

   - Please comment on any elements of the work plan that were not fulfilled.
     All items covered.

Section B – Reflection upon Working Practices

5. Effectiveness of Committee discussion
   a. How effectively is the Group Chaired?
      - Keeping to time/controlling discussion
      - Confirming action to be taken, and recorded in minutes, when a declaration of interest is made
      - Confirming that the meeting is quorate
      - Effectiveness in dealing with Matters Arising
      - Ensuring that all are 'heard'/have a chance to contribute
      - Summarising of discussion and clarity of agreed outcome/action

      Survey findings very supportive of how effectively the committee is chaired with no issues such as those described above raised.

   b. Do all members contribute?
      - Is an Attendance log maintained, and attendance levels of 75% achieved by all formal members of committees?
        Yes and attendances in table below. 3 Members for full attendance. Geoff Rowbotham replaced Ruth Marchington at the October 18 meeting. Ruth Marchington substituted for Liz Rowbotham at the March 19 meeting.

Board Member	May 18	July 18	Oct 18	Dec 18	Mar 19

Darren Hickman	YES	YES	YES	YES	YES
Ruth Marchington	YES	NO			YES
Geoff Rowbotham			YES	YES	YES
Liz Rowbotham	NO	YES	YES	YES	

- Are formal members recorded as such and others as attendees?
  Yes

- Are members sufficiently prepared for meetings?
  Yes

- Is there sufficient challenge, and input to agenda items by members?
  Yes

6. Communication channels

a. Communications to and from members

- Are draft agendas sent early enough to maximise time to prepare papers?
  Yes

- Are papers submitted in good time? Are they disseminated in good time?
  Yes

- Is the Highlight report produced and shared within 5 working days?
  Yes

b. Quality of papers

- Are papers of a good standard?
  Yes

- Are papers usually presented by either their author, or an informed substitute?
  Yes

- Is there a need to offer report writing skills?
  No – many papers are sourced from external agencies with their own standards for reporting eg KPMG, 360 Assurance.

c. Quality of minutes

- Is there evidence of challenge and assurance, where available, included in minutes?
  Yes
- Are the recommendations/actions that the papers request of the Group reflected in the minutes?
  Yes

- Are the matters arising captured in an action log retaining the original implementation date?
  Yes – actions not completed are rolled forward in same Log item so original date/minute retained.

d. Information flows with Parent Committee

- Does the ‘parent’ committee receive regular Overview/Highlight reports?

Yes – Highlight reports to Board.

- Is there sufficient feedback from the Parent Committee to the Sub-Group?
  Not applicable as no reporting in groups.

7. Achievements and Barriers
   - Please list top three achievements or successes
     Successful oversight of governance arrangements for 2018/19 year end including in-depth review of Quality and Financial Accounts at the preparation stage.

     Networking of Chair and Finance Director at external Audit committees seminars to bring back best practice and re-validate current processes.

     Major reduction of volume and value of Chief Executive waivers during 2018/19.

   - Please list the key issues considered during 2018/19.
     Deep dives covering "Governance and Assurance working for Transformation Programmes" and "Risk Management Strategy and Framework."

     Early and ongoing oversight and support to risks related to Payroll provider.

     Critical and constructive review of Internal Audit report follow-ups with re-engagement with Service Senior teams/Executive team and changes to processes. Significant Assurance achieved in Head of Internal Audit Opinion Report 2018/19 for Follow-ups.

   - Were there any barriers perceived to the work of the Committee?
     None.

   - Please identify actions that will be taken (with timescales) to address any issues recognised as outcomes of this annual review report.
   -
     Moving forwarded the role of the Committee for oversight of risk and regulatory reporting items is being reviewed as part of a wider governance review arising from CQC inadequate Well-Led determination February 2019. As such the Terms of Reference are being reviewed by the Associate Director of Corporate Governance working the Chair and outcomes will be set-out in a "look forward" separate report.

Leicestershire Partnership NHS Trust

Meeting	Audit Committee Trust Board
Date of meeting	5 July 2019 25 July 2019
Paper number	

Name of Report Annual Report and governance arrangements for the Committee

For approval	X	For assurance		For information	

Presented by the Accountable Director	Anna Pridmore Interim Associate Director of Corporate Governance	Author (s)	Anna Pridmore Interim Associate Director of Corporate Governance

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe		Safe		S – High Standards	
Effective		Staff		T – Transformation	
Caring		Partnerships		E – Environments	
Responsive		Sustainability	x	P – Patient Involvement	
Well-Led	X			G – Well-Governed	x
				R – Single Patient Record	
				E – Equality, Leadership, Culture	
				A – Access to Services	
				T – Trustwide Quality improvement	

Report previously reviewed by		
Committee / Group	Date	Assurance obtained (Significant/Limited/None)
Audit Committee	5 July 2019	
Trust Board	25 July 2019	

Assurance : What level of assurance does this report provide in respect of the Board Assurance Framework Risks? (Significant / Limited / No Assurance)	Links to BAF risk numbers

Leicestershire Partnership NHS Trust

Governance arrangements for the Audit and Assurance Committee

July 2019

Contents

1 Terms of Reference

Audit and Assurance Committee

Terms of Reference

References to "the Committee" shall mean the Audit and Assurance Committee

1.0 Constitution

The Trust Board has established a committee known as the Audit and Assurance Committee (the Committee) reporting to the Trust Board, in accordance with standing order 4.

The Committee shall have terms of reference and powers and be subject to conditions, such as reporting back to the Trust Board, as the Trust Board shall decide and shall act in accordance with any legislation and regulation or direction issued by the regulator.

The Committee shall be a Non-executive Director led Committee of the Trust Board comprised of independent Non-executive Directors and Executive Directors with portfolio lead for the finance and performance agenda. The Committee has no executive powers, other than those specifically delegated in these terms of reference.

2.0 Purpose of Committee

The purpose of the Committee is to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's strategic objectives and statutory requirements

To recommend to the Trust Board from its Auditor Panel the appointment of external auditors.

3.0 Authority

The Committee is a Non-Executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

The Committee is authorised by Trust Board to investigate any activity within its terms of reference.

The Committee is authorised by Trust Board to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain, at the Trust's expense, any outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience or expertise, if it considers this to be necessary.

4.0 Membership

The Committee shall be comprised of three Non-executive Directors. A number of officers including the Finance Director and Trust Secretary will attend meetings of the Audit and Assurance Committee.

The membership will include:

- Three independent Non-executive Directors.

In attendance there will be the following officers from the Trust:

- Finance Director will hold executive responsibility for the meeting
- Trust Secretary
- Head of Assurance

Other in attendance will include:

- Director 360 Assurance (Internal Audit)
- Client Manager 360 Assurance (Internal Audit)
- Principal Anti-crime specialist 360 Assurance (Counter Fraud)
- Partner KPMG (External Audit)

The Chair of the Committee shall be one of the independent Non-executive Directors selected by the Trust Board. In their absence their place shall normally be taken by another independent Non-executive Director.

Membership of the Committee will be reviewed and agreed annually by the Board.

In the situation of a prolonged absence of the Chair or a member of the Committee, the Trust Board will determine a replacement Chair. The Chair of the Trust Board will determine replacement of independent Non-executive Director membership.

The Chief Executive Officer, other executive directors and accountable managers may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that director or manager.

The Chief Executive Officer will be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

Other staff of the Trust will be invited to attend for all or part of the meeting.

5.0 Administration

The Committee shall be supported administratively by The Personal Assistant to the Director of Finance.

The agenda will be agreed with the Chair following consultation with the Director of Finance in consultation with the Chair of the meeting.

The Personal Assistant to the Director of Finance will support the production of the Committee pack and ensure the pack is circulated within the required timeline of five working days prior to the meeting, attend the meetings to take the minutes, keep a record of matters arsing and issues to be carried forward and generally provide support to the Chair and members of the Committee. .

6.0 Quorum

The quorum shall be two members of the Committee A duly convened meeting of the Committee which is quorate shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

7.0 Attendance at meetings

Only members of the Committee have a right to attend the Committee; however other officers of the Trust may be invited to attend the Committee either for specific discussion items or for the whole meeting as required by the Committee.

Other Non-executive Directors have an open invitation to attend the Committee as felt appropriate after advising the Chair of the Committee of their attendance.

Any independent Non-executive Director or officer of the Trust who is not part of the normal membership of the Committee will be in attendance at the meeting.

8.0 Frequency of Meetings

The Committee shall meet no less than five times a year and at such other times as the Chairman of the Committee shall require at the exigency of the business.

Members will be expected to attend at least three-quarters (75%) of all meetings.

9.0 Agenda/Notice of Meetings

Unless otherwise agreed, notice of each Audit and Assurance Committee meeting will confirm the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

The agenda for each meeting will include an item “Declarations of interest in respect of items on the agenda”.

10.0 Minutes of Meetings

Minutes of Committee meetings shall be circulated promptly to all members of the Committee and, once agreed, to the secretary of the Trust Board. The Committee’s minutes will be open to scrutiny by the Trust’s auditors.

The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

11.0 Duties

Governance, Risk Management and Internal Control

To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation’s activities (both clinical and non-clinical) that supports the achievement of the organisation’s objectives.

To review the Risk Management Strategy and receive a quarterly update report on the systems for updating and managing the Board Assurance Framework and Risk Management.

To review the adequacy of all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality

Commission), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

To review the adequacy of the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.To review the adequacy of Trust policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements. To review the adequacy of the policy system as a key internal control mechanism. To review the code of business conduct policy.

To review the adequacy of Trust policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service.

To be responsible for reviewing the adequacy of Standing Orders, Standing Financial Instructions, and any suspension of the constitutional documents. To ensure there is an appropriate Scheme of Delegation and associated financial limits and to ensure that this is subject to regular review.

To review the quarterly report on losses and special payments

Receive information on the system used to manage any CQC recommendations or internal control mechanisms that are set up

To undertake on behalf of Trust Board an independent annual review of the Board Committees. This would be combined with the Committees' Annual Review for greater effectiveness. All Chairs of Board Committees attend either the May or July A&AC meetings to present their annual reviews.

In carrying out the duties listed above the Committee will primarily utilise the work of Internal Audit, External Audit, Counter Fraud Services and other assurance functions, but will not be limited to these audit functions. The Committee will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.

This will be achieved by:

(a) consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;
(b) review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
(c) consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources;
(d) ensuring that the Internal Audit function is adequately resourced and has appropriate

standing within the organisation;
(e) annual review of the effectiveness of internal audit.

External Audit

The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

(a) consideration of the performance of the External Auditor;
(b) discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy;
(c) discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;
(d) review all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation including Counter Fraud Services, and consider the implications to the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Resolution, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

In addition, the Committee will review the work of other Board committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work.

In reviewing the work of the Quality and Assurance committee, and issues around clinical risk management, the Committee will wish to satisfy themselves on the assurance that can be gained from the clinical audit function.

Whistleblowing

The Committee will review the effectiveness of the arrangements in place for allowing staff to raise, in confidence concerns about possible improprieties in financial, clinical and safety matters and ensure that any such concerns are investigated proportionately and independently.

Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

The Committee will receive third party assurance reports on an annual basis from organisations that provide services to the Trust. These would include, but are not limited to:

Internal Audit

Payroll Management

Financial Reporting

The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance.

The Committee should ensure that the systems for financial reporting to the Trust Board including those of budgetary control are subject to review as to the completeness and accuracy of the information provided.

The Committee shall review the Annual Report and Accounts before submission to the Board, focusing particularly on:

(a) the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
(b) changes in, and compliance with, accounting policies and practices;
(c) unadjusted mis-statements in the financial statements;
(d) major judgemental areas;
(e) significant adjustments resulting from the audit.

Auditor Panel

Panel membership comprises two Non-Executive members and the Director of Finance. A nominated Non-Executive is to act as Chair of the Audit Panel.

The Deputy Director of Finance shall normally attend the meetings.

One Non-Executive Director and the Director of Finance need to attend for quoracy.

The Panel is to conduct an appropriate LPT procurement process, as outlined in section 9 of the Trust's Standing Financial Instructions (SFIs) for the appointment of external auditors.

The Panel is to recommend to the Trust Board the appointment of external auditors.

The Panel is to ensure:

(a) Contract arrangements (i.e. procurement and the selection of external auditors) are appropriate.
(b) The relationship and communications with the external auditors are professional
(c) Conflicts of interest are effectively dealt with.
(d) It is also important that the Auditor Panel is alert to the possibility of conflicts of interest – for example, if non-audit services work is awarded to the external audit provider, how will the Auditor Panel ensure that the auditors' independence is maintained?

If the Trust Board asks the Panel it must advise on any proposal to enter into a liability limitation agreement with audit firms (this would be considered as part of the procurement process).

The Trust Board can determine to remove any member of the Auditor Panel including the Chair. The Chair of the Trust Board would need to re-consider the membership of the Committee in the case of a Non-executive Panel member being removed.

The Panel shall provide update reports to the Committee and to the Trust Board.

12.0 Reporting Responsibilities:

The Committee shall make whatever recommendations to the Trust Board it deems appropriate on any area within its remit where action or improvement is needed.

The Committee shall produce for the Trust Board an annual report on the work it has undertaken during the course of the year.

The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on:

(a) the fitness for purpose of the Assurance Framework;
(b) the completeness, and the extent to which risk management is embedded in the organisation;
(c) the integration of governance arrangements;

The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

13.0 Annual Review

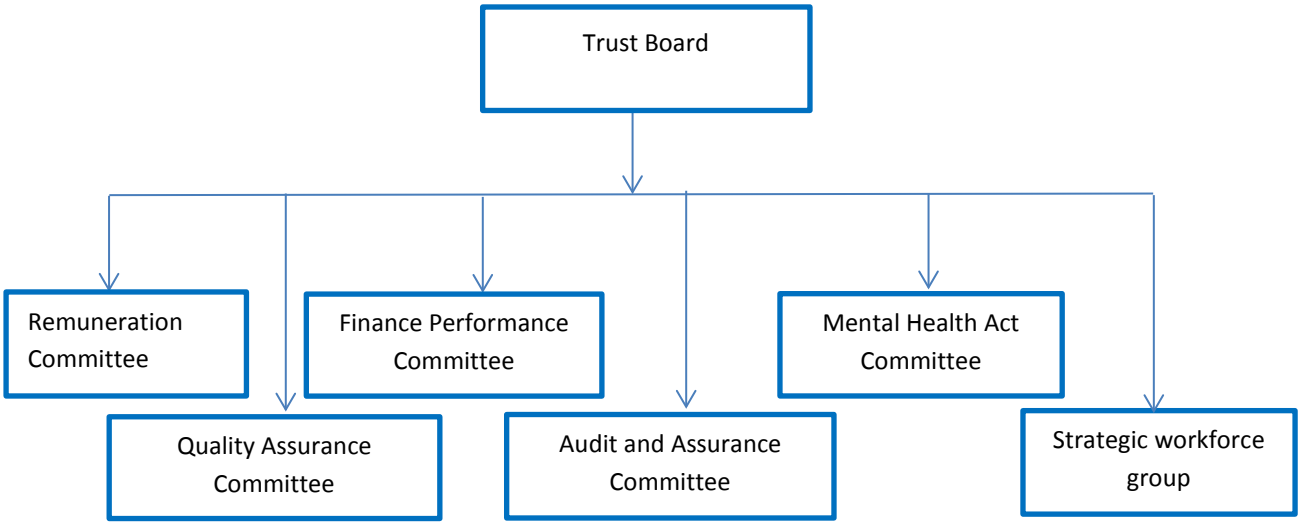
The Committee shall, at least once a year, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Trust Board for approval.

14.0 Risk Responsibility

The risk areas the Committee has special responsibility for will be those that fall within the remit of this Committee.

Author	Interim Associate Director of Corporate Governance
Owner	Audit and Assurance Committee
Date of Issue	August 2019
Version #	
Approved by	Trust Board
Review date	April 2020

2 Governance Structure



3 Membership and details of officers attending

	Audit and Assurance Committee
Membership	• NED **(chair)** • NED x 2
In attendance	• Director of Finance **(Executive Lead)** • Deputy Director of Finance • Head of Assurance • Trust Secretary • Other managers will be invited to attend as and when required
Frequency	Not less than four times per 12 months

4 Work programme

Meeting 1 – May (year-end) Private meeting with members of the Audit Committee and Internal and External Audit Annual Report Annual Accounts Financial statements ISA 260 Quality Account Going concern statement Annual Governance Statement Counter Fraud Annual Report Head of Internal Audit Opinion (incl. Annual Internal Audit Report) Board Committee review	**Meeting 2 – July** Board Assurance Framework and Risk Management Review of policy systems and key policies Internal Audit progress report Internal Audit Recommendations External Audit Progress Report Annual Audit Letter Counter Fraud progress report Report on policy system Review of Standing Orders, Standing Financial Instructions and Scheme of Delegation Board Committee review Third party reports that are available Losses and special payment report
Meeting 3 – October Board Assurance Framework and Risk Management Review of policy systems and key policies Internal Audit progress report Internal Audit Recommendations External Audit Progress Report Whistle blowing arrangements Losses and Special Payments Counter Fraud progress report Clinical Audit Annual Review Report on policy system Code of Business Conduct review Code of Conduct assurance report Third party reports that are available Losses and special payment report Cyber security	**Meeting 4 – December** Board Assurance Framework and Risk Management Review of policy systems and key policies Internal Audit progress report Internal Audit Recommendations External Audit Progress Report Draft Audit Plan Counter Fraud Policy Annual Report and Accounts timetable and progress plan Committee Annual report Terms of Reference review incl. work programme Report on policy system Third party reports that are available Losses and special payment report
Meeting 5 – March Internal Audit Plan Board Assurance Framework and Risk Management Review of policy systems and key policies Internal Audit progress report Internal Audit Recommendations External Audit Progress Report Third party assurance reports Counter Fraud Strategy and Plan Counter Fraud Progress report Counter Fraud Survey Annual Report and Accounts timetable and progress plan Report on policy system Third party reports that are available Losses and special payment report	

Auditor panel report as required during the appointment of External Audit.

The document provides details of the governance arrangements for the functioning of the Board Committee. The paper supports the well led requirements for the Trust and links into the well governed Trust priority. The documents provide significant assurance on the constitution of the Committee.	Priority 7

Recommendations of the report
The Committee is asked to consider the annual report and associated Terms of Reference and recommend approval of the Terms of Reference by the Trust Board. The Committee is also asked to recommend to the Audit Committee that the Terms of Reference provide the oversight the Committee is required to provide and supports the internal control mechanisms of the Trust

Leicestershire Partnership NHS Trust

Report to the Audit Committee

Annual Report and governance arrangements for the Committee

1. Introduction/Background

The Committee aims to follow good governance practice and has written an annual report as part of a review of the governance of the meeting. Additionally, following the receipt of a number of reports and a review by Internal Audit, the Trust has reviewed all the Terms of Reference for the Board Committees.

2. Aim

The aim of this paper is to present the annual report, outline the key changes made to the Terms of Reference for the Quality Assurance Committee following a full review and to outline the timeline for the introduction of the new working arrangements.

3. Annual Report

The Committee is required to write an annual report as part of the year end process. The annual report is attached at appendix 1 to this report. The key highlights from the report are:

4. Terms of Reference

Each year the Trust undertakes a review of the Terms of Reference of all Board Committees. This year a more detailed review has been undertaken following some criticism from regulators and external governance reports. The Terms of Reference have been redesigned to ensure that all formal Board Committees have consistent Terms of Reference that follow the same format. All Board Committee Terms of Reference provide clarity within the document about the governance structures and detail the work programme so on a quarterly basis the information that should have been considered by the Board Committee.

The significant changes made to the Terms of Reference are as follows:

- The inclusion of risk management
- Code of business conduct
- Annual Accounts
- Losses and special payments
- Scheme of delegation

As part of the development of the revised Terms of Reference the Chair and lead Director have been involved and had an opportunity to consider the revised arrangements in advance of the document being presented to the Finance and Performance Committee. The revised Terms of Reference are attached at appendix 2.

5. Timetable

The timetable for the introduction of the revised arrangements is as follows:

Receipt and review of the draft Terms of Reference by the Audit Committee	5 July 2019
Receipt and approval of the draft Terms of Reference by the Trust Board	July 2019
Introduction of the new working arrangements by the Committee	August 2019

5. Conclusion

As part of a review of governance arrangements across the Trust, the Board Committee constitutional documents have been reviewed. The review has ensured that there is consistency where ever possible between the committees and that the totality of the business being discussed at each of the Committees addresses the full agenda of the priorities of the Trust and the Board Assurance Framework.

6. Recommendations

The Committee is asked to consider the paper and associated Terms of Reference and recommend approval of the Terms of Reference by the Trust Board.
The Committee is also asked to recommend to the Audit Committee that the Terms of Reference provide the oversight the Committee is required to provide and supports the internal control mechanisms of the Trust

Leicestershire Partnership NHS Trust

Meeting	Finance and Performance Committee Audit and Assurance Committee Trust Board
Date of meeting	18 June 2019 5 July 2019 30 July 2019
Paper number	V

Name of Report **Annual Effectiveness Review and Governance arrangements for the Committee**

For approval	x	For assurance		For information	X

Presented by the Accountable Director	Danielle Cecchini Director of Finance	Author (s)	Danielle Cecchini Director of Finance Anna Pridmore Interim Associate Director of Corporate Governance

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe		Safe		S – High Standards	
Effective		Staff		T - Transformation	
Caring		Partnerships		E – Environments	
Responsive		Sustainability	x	P – Patient Involvement	
Well-Led	x			G – Well-Governed	x
				R – Single Patient Record	
				E – Equality, Leadership, Culture	
				A – Access to Services	
				T – Trustwide Quality improvement	

Report previously reviewed by		
Committee / Group	Date	Assurance obtained (Significant/Limited/None)
Finance and Performance Committee	18 June 2019	

Audit Committee	5 July 2019	
Trust Board	30 July 2019	

Assurance : What level of assurance does this report provide in respect of the Board Assurance Framework Risks? (Significant / Limited / No Assurance)	Links to BAF risk numbers
The document provides details of the work of the Committee during 2018/19 and summarises the successes and challenges. The document also provides details of the governance arrangements for the functioning of the Board Committee following a review. The paper supports the well led requirements for the Trust and links into the well governed Trust priority. The documents provide significant assurance on the constitution of the Committee.	7e

Recommendations of the report
The Committee is asked to consider the annual effectiveness review paper and the revised Terms of Reference and recommend approval of the Terms of Reference by the Trust Board. The Committee is also asked to recommend to the Audit Committee that the Terms of Reference provide the oversight the Committee is required to provide and supports the internal control mechanisms of the Trust

Report to the Finance and Performance Committee

Annual Effectiveness Review and Governance arrangements for the Committee

1. Introduction/Background

Following the receipt of a number of reports and a review by Internal Audit, the Trust has reviewed all the Terms of Reference for the Board Committees. This paper outlines the timeline for the introduction of the changed working arrangements for the Committees, specifically the Finance and Performance Committee, Quality Assurance Committee.

2. Aim

This paper is in two parts, the first section relates to the effectiveness review of the committee for 2018/19 including Terms of Reference, attendance and work programme. The second part the report presents the draft terms of reference for the committee or use from August 2019.

The aim of this paper is to outline the key changes made to the Terms of Reference for the Finance and Performance Committee and to outline the timeline for the introduction of the new working arrangements.

3. Annual effectiveness Review

The report outlines the work the committee has undertaken during the year. It highlights the successes and challenges and describes some of the changes that have been discussed with members that will be put in place during 2019/20. The review includes the current Terms of Reference, the attendance record during the year and the work programme for 2018/19.

4. Terms of Reference

Each year the Trust undertakes a review of the Terms of Reference of all Board Committees. This year a more detailed review has been undertaken following some criticism from regulators and external governance reports. The Terms of Reference have been redesigned to ensure that all formal Board Committees have consistent terms of reference that follow the same format. All Board Committee Terms of Reference provide clarity within the document about the governance structures and detail the work programme so that it can be seen on a quarterly basis what information should have been considered by the Board Committee.

A number of items have been moved from the Finance and Performance Committee to the Audit and Assurance Committee as they are part of the system of internal control and core responsibility of the Audit and Assurance Committee. These include:

- Review of the Code of Business Conduct
- Review of the Annual Accounts
- Review of losses and special payments
- Review of Scheme of Delegation

The Trust has introduced joint meeting where the Finance and Performance Committee and the Quality Assurance Committee meet on a quarterly basis. The principle behind this meeting is that the Finance and Performance Committee and the Quality Assurance Committee have shared agenda items which need to be discussed in a shared forum.

As part of the development of the revised terms of reference the chair and lead Director have been involved and had an opportunity to consider the revised arrangements in advance of the document being presented to the Finance and Performance Committee. The revised Terms of Reference are attached at appendix 4.

The Committee will meet not less than six times a year; previously the Terms of Reference had required the Committee to meet 10 times as a year. There was a discussion at the Finance and Performance Committee which recognised the ambition would be to move to six. The Committee decided that it would like to put not less than six times in the terms of reference with the option of being able to add additional meetings as was felt appropriate. It was agreed in the discussions that the meetings currently in the diary for the year would remain included in the diary system.

5. Timetable

The timetable for the introduction of the revised arrangements is as follows:

First joint meeting of the Finance and Performance Committee and Quality Assurance Committee	June 2019
Receipt and review of the draft Terms of Reference by the Committee	June 2019
Receipt and review of the draft Terms of Reference by the Audit Committee	5 July 2019
Receipt and approval of the draft Terms of Reference by the Trust Board	July 2019
Introduction of the new working arrangements by the Committee	August 2019

6. Conclusion

As part of a review of all the governance arrangements across the Trust, the Board Committee constitutional documents have been reviewed. The review has ensured

that there is consistency where ever possible between the committees and that the totality of the business being discussed at each of the Committees addresses the full agenda of the priorities of the Trust and the Board Assurance Framework.

7. Recommendations

The Committee is asked to consider the paper and associated Terms of Reference and recommend approval of the Terms of Reference by the Trust Board.
The Committee is also asked to recommend to the Audit Committee that the Terms of Reference provide the oversight the Committee is required to provide and supports the internal control mechanisms of the Trust

Committee/Group	Finance & Performance Committee
Date	18 June 2019
Chair of Committee	Geoff Rowbotham

This review of the effectiveness of the Finance and Performance Committee has been informed by the following:

- The mid-year review undertaken in October 2018
- Interviews with all members of the committee
- Questionnaires completed by regular attendees of the committee
- The outcome of the External Governance Review
- Review of the committee agenda and papers

Section A – Fulfilling Terms of Reference

1. Review of Terms of Reference (ToR)

- *Were all duties of the ToR covered through the work plan and agendas during this year? If there were gaps, how were these addressed?*

The Terms of Reference for the committee are included as *Appendix 1* and the tracking of agenda items and areas for discussion through the completed work plan in *Appendix 2* demonstrates that the committee has appropriately discharged its duties.

- *Has the membership been reviewed, and is it considered sufficient to enable all duties to be carried out and fulfil quoracy?*

The current membership consists of two Non-Executive Directors, Director of Finance, Medical Director, Chief Nurse and a Service Director.

In discussion with members it was suggested that the membership be amended to include both service directors and require that only one of either the medical director or Chief Nurse attend.

In addition, other managers and Non-executive directors, including the Trust chair, attend meetings to ensure expert views are received on appropriate items but also to support the development of managers in gaining exposure to Board committees and the wider strategic context. Regular attendees include the Deputy Director of Finance and Procurement, Associate Director of Business Development and Contracting, Associate Director of Strategic Planning, Associate Director of Estates and Head of Information.

It is proposed that other non-executive directors continue to be invited to attend the committee, but that other attendees come to committee to present or give expert views as required and for specific agenda items.

- *Are all of the Groups or functions that report to the Committee identified, and their ToR regularly reviewed?*

There are no groups or sub-committees that formally report in to the Finance and Performance Committee.

- *Did the Committee cover its areas of responsibility for assurance on delivery of the Strategic Objectives?*

Whilst the Committee contributes to all strategic objectives, it has particular focus on the strategic objective of "ensuring sustainability". The committee has appropriately discharged its duties including reviewing the progress against the IM&T strategy, Estates Strategy, contributing and challenging the development of the Finance Strategy, reviewing and approving the operational plan, monitoring the business development pipeline and maintaining in-year performance and planning oversight on the Trust's finances.

Specific areas of drill-down include scrutiny and monitoring of the Data Quality Improvement Programme (DQIP), Clinical Services' financial position and waiting times performance. The committee has also received updates on key developments such as the IM&T, Estates and Procurement Strategies and the NHSI/E planning guidance.

The Committee also has the overview role on behalf of the Trust Board for the monitoring of progress against the Strategic Objectives and Initiatives. This is monitored on a quarterly basis.

- *Please comment on the adequacy of the ToRs, mentioning any 'gaps' or 'overlaps' with other groups perceived*

Whilst the Terms of Reference do not appear to overlap with other groups or committees, the Committee, through the Chief Nurse, ensures that there is adequate communication with the Quality Assurance Committee (QAC). This allows for greater continuity in debate and discussion and helps the committee manage any overlap between the two committees, particularly in relation to the scrutiny of the Integrated Quality and Performance Report (IQPR) and the review of risks.

The Committee Chair and Executive Lead continue to liaise to ensure that the executive responsibilities and the committee's governance role do not conflict or provide excessive overlap.

Through the review process, it has become clear that both committees will be seeking assurances on similar topics but through a different "lens". To support a more integrated and triangulated discussion it is proposed that, on a quarterly basis, the Quality Assurance Committee and the Finance and Performance Committee hold a joint meeting to receive joint assurances were these are appropriate.

- *Please inform of any agreed changes to ToRs (subject to Parent Committee adoption)*

A number of items are proposed to be moved from the Finance and Performance Committee to the Audit and Assurance Committee as they are part of the system of internal control and core responsibility of the Audit and Assurance Committee. These include:

Review of the Code of Business Conduct
Review of the Annual Accounts
Review of losses and special payments
Review of Scheme of Delegation

2. Assurance

- *Please comment upon the robustness of assurances received*

There was a mixed view in the responses to this specific question and external reviewers also highlighted areas for improvement in this area.

In the main, assurance provided to the committee is of a good standard and can be backed by evidence. However, on the occasions where the committee feel that appropriate assurance has not been provided then an action will be agreed and recorded in the action log. These actions are reviewed at every committee meeting and, in the majority of cases; the actions are cleared by the next monthly meeting (unless longer timescales are agreed).

Following its mid-year review, the committee has begun to receive assurances in a much more targeted way, with the development of a dashboard approach to reporting progress and performance.

- *Were there any sources of external assurance during this period? Were there any concerns raised and addressed?*

Key areas of external assurance that have been utilised during the year include:

- External benchmarking including reference costs and service-specific benchmarking within the IQPR
- External Audit e.g. annual accounts
- NHS Improvement feedback in relation to financial and service performance
- Formal and informal commissioner feedback
- Feedback from NHS Improvement on the operational plans for 2019/20
- Lord Carter's Review of procurement and comparison against current practices
- CQC assessment of core services

Specific areas of concern that were raised through these sources of assurance included:

- Data quality
- Waiting times
- Ongoing financial challenges across the NHS and within the Trust
- Patient waiting times
- Safety and quality of our estate
- Overall governance arrangements

- *Has the committee considered all possible sources of assurance?*

The HFMA Audit Committee Handbook states examples of possible sources of assurance to be utilised by committees in undertaking their duties. By utilising this table and identifying the relevant sources of assurance for FPC demonstrates the breadth of sources used throughout the 2018/19 financial year.

3. Analysis of Risks

- *What is the frequency of risk review by the Committee?*

The Committee reviews the risk register at each monthly meeting with amendments and further considerations recorded as part of the minutes.

The Committee also receives feedback from QAC, as the main risk committee, on all aspects of risk including the rolling programme of risk review that is undertaken at QAC.

- *Commentary on risks reviewed, and ease of process*

All risks are reviewed on a monthly basis with the consideration of amendments undertaken by the Head of Corporate Finance and the Director of Finance to ensure changes are reflected in future reports. A full review of the risk register has been undertaken this year to simplify and update it.

From the committee's perspective, the system for reviewing and amending the risk register continues to be efficient and effective.

4. Work plan

- *Does the work-plan evidence the discharging of the ToR? (Please attach the latest 2018/19 work plan).*

The work-plan in *Appendix 2* demonstrates that all duties within the Terms of Reference have been covered.

- *Is the work plan then used to inform agendas?*

The work plan is the source document for agenda setting and this is combined with the action log for any additional items to be included on the agenda. Deviations from the work plan are only accepted by the Chair with a clear rationale and an indication of the revised timings. This is captured in the minutes.

- *Has the committee reviewed progress in-year against its annual work plan to see if it is achieving objectives?*

The Committee reviews the work plan each month as part of the agenda and any issues highlighted during the meeting are reflected in amendments to the work plan, where appropriate.

- *Please comment on any elements of the work plan that are not fulfilled*

The role and duties have been fulfilled.

Section B – Reflection upon Working Practices

5. Effectiveness of Committee discussion

   a. How effectively is the Group Chaired?

- *Keeping to time/controlling discussion*

Feedback has indicated that the agenda is well managed and the use of a timed agenda ensures timeliness of discussions. To accommodate thorough discussions of agenda items, the meeting time has, on occasion, been extended in advance of the meeting. In some instances, the meeting has overrun indicating that potentially the agenda is too full or that in-depth discussion is undertaken in an area where further assurances are required. It has been indicated that there may be a tendency in the meeting to try to resolve issues rather than refer matters back to the Executive Team.

- *Confirming action to be taken, and recorded in minutes, when a declaration of interest is made*

Declarations of interest are a standing item on the agenda, and when declarations are made, they are recorded in the minutes..

- *Confirming that the meeting is quorate*

The quoracy is confirmed at the start of the meeting.

- *Effectiveness in dealing with Matters Arising*

Matters Arising are efficiently and effectively dealt with in the meeting. Generally, the majority of actions and updates are pre-populated in the action log prior to the meeting. During the year, the action log was moved to the end of the agenda, which meant that items on the agenda, dealing with the matter arising, were appropriately discussed in the relevant agenda slot.

- *Ensuring that all are 'heard'/have a chance to contribute*

The inclusive style of chairing allows contributions from members and attendees at the session and as well as capturing the wider views, this provides opportunities for non-Board members to contribute to the committee's agenda.

Feedback received has highlighted that some members will speak to their paper only and that the conversation can be dominated by one or two individuals.

- *Summarising of discussion and clarity of agreed outcome/action*

Actions are agreed during the summing up of each discussion point by the Chair and these are captured in the actions log. One reviewer did indicate that the actions sometimes were not clear – this is potentially as a result of moving towards a more assurance based report.

b. Do all members contribute?

- *Is an Attendance log maintained, and attendance levels of 75% achieved by all members?*

The attendance log is shown at appendix 3.

- *Are members sufficiently prepared for meetings?*

Members are sufficiently prepared for meetings and the Chair states the expectations at the start of each meeting that all papers are assumed as read in advance of the meeting. The level and detail of questioning suggests that committee members are well-prepared for the meetings.

- *Is there sufficient challenge, and input to agenda items by members?*

The minutes of the meetings demonstrate the good level of challenge posed by members on agenda items. Where challenge is not met with sufficient assurance or evidence then an action is recorded for follow up.

6. Communication channels

a. Communications to and from members

- *Are draft agendas sent early enough to maximise time to prepare papers?*

The draft agenda is usually sent to authors between one and two weeks prior to the paper submission deadline.

- *Are papers submitted in good time? Are they disseminated in good time?*

Generally, papers are submitted in good time. On occasions, with the Chair's approval and depending on the timing of the meeting, some papers have been submitted later than the paper deadline or tabled at the meeting. This is usually due to the monthly cycle of information that drives the availability of reports e.g. waiting times. The Chair considers that a delay is justified in some instances in order to achieve more accurate / validated information.

- *Is Highlight report produced and shared within 5 working days?*

The Highlight Report is normally produced on the same working day as the Committee meeting and, following Chair and Executive Lead sign off, submitted to the Trust Board on the following working day.

b. Quality of papers

- *Are papers of a good standard?*

Papers are generally of a good standard.

- *Are papers usually presented by either their author, or an informed substitute?*

Papers are normally presented by the author or the nominated presenting director. In order to enable an informed and meaningful discussion within the time constraints of the meeting agenda, and ensure presenters feel their work and contribution is valued, report authors have been asked to:

- Be clear on the reasons that a paper is being brought to the committee and ensure this is reflected in the recommendations

- Be prepared to outline the key messages when introducing the report and not provide a full summary of the written paper.

c. Quality of minutes

- *Is there evidence of challenge and assurance, where available, included in minutes?*

The minutes are expertly and efficiently produced by the Director of Finance's P.A. As stated above, the challenging nature of discussions is recorded in minutes.

- *Are the recommendations/actions that the papers request of the Group reflected in the minutes?*

The minutes record all actions and recommendations made by the Committee.

- *Are the matters arising captured in an action log with the original implementation date?*

The action log captures matters arising and the expected implementation date. Improvements have been made over the year to ensure all actions have an implementation date.

d. Information flows with Parent Committee

- *Does the 'parent' committee receive regular Overview/Highlight reports?*

A monthly highlight report is produced by the Chair and Executive Lead for submission to the Trust Board. This is submitted routinely on a monthly basis whether there is a formal Board meeting in the month or not.

- *Is there sufficient feedback from the Parent Committee to the Sub-Group?*

Feedback from the Trust Board comes in various forms; annual committee review undertaken by the Audit and Assurance Committee on behalf of the Board; Board delegation of duties to FPC; Board members sit on the committee; Chief Executive to Director of Finance feedback; highlight report discussions and general discussion and reference to work undertaken by the committee.

7. Achievements and Barriers

- *Please list top three achievements or successes*

The committee has a broad range of duties, however, particular successes this year include:

- Maintaining the overview and scrutiny of the financial position, risks, pressures and mitigations and supporting the continued achievement of a surplus position within a very challenging financial climate. This includes greater drill-down of directorate financial positions with focus on variances and monthly run-rates and providing an advisory role to the Board on in-year risks to statutory and primary financial duties.

- Maintaining the focus on data quality across the Trust through the drill down, detailed scrutiny and monitoring of the Data Quality Improvement Programme. This remains work in progress and will continue to be a part of the committee's focus.

- The ongoing development of the waiting times report, ensuring that reporting is clear, accurate and that the committee is sighted on real waits. The waiting times report is significantly improved and enables a more appropriate discussion on performance and assurances required and received.

- *Were there any barriers perceived to the work of the Committee?*

Whilst noticeable improvements are being made, data quality remains the biggest underlying barrier to the Committee's work programme and one of the highest risks to the Trust achieving its strategic objectives.

- *Please identify actions that will be taken (with timescales) to address any issues recognised in this annual review process*

The mid-year review and the annual review process have identified the following actions to be taken.

a. Review of the membership to confirm that membership should include both divisional directors and that clinical representation could be limited to one of either the medical director or Chief Nurse (Director of Nursing AHPs and Quality). Confirm that attendees are required for their items only. (July 2019)

b. Review of the terms of reference to remove duties more appropriately attributed to the Audit Committee. (July 2019)

c. Ensure the agenda and the papers fully reflect the oversight requirements of the committee against the Step up to Great Priorities. This will be through the revised BAF as well as the introduction of a committee front sheet which reflects the Trust wide requirements. (July 2019)

d. Review the work programme so that in alternate months the committee can(July 2019):

   i. Consider its regular performance and oversight reports
   ii. Take a focussed approach on two or three subject areas for a more in depth discussion, consideration of assurances and any remedial actions required.

e. Develop and implement a programme of training and development for members, attendees and report writers. (August 2019 for delivery in year)

8. Future Plans

The 2018/19 work plan is shown at *appendix 2.*

- *What are the Committee's key priorities/focus/planned developments for next year?*

The committee's key priorities for the 2019/20 financial year will be directly linked to our Step up to Great priorities. Specifically these are:

- Transformation – Overview of impact of service transformation programmes in AMH/LD and CHS in particular drilling down on financial and performance areas
- Environment – Focus on a Safe, clean and welcoming estate by overseeing the development of clear governance arrangements for reporting performance and progress in facilities management. Includes oversight of the development of the Mental Health Inpatient Business Case and delivery of the CAMHs new unit.
- Governance – Oversight of the implementation of the Trust's revised performance monitoring and management arrangements.
- Record – Oversight of delivery of the single electronic patient record.
- Access – Continued focus on delivery of improvement in our waiting times.

In addition, the committee will continue to focus on:

- Continued improvement of data quality and monitoring the next stages of the DQIP
- Financial sustainability to achieve statutory and planned financial targets
- Review approach to the Enterprise Strategy to link with understanding and approach to service line sustainability.
- Maintain focus and scrutiny on the business development pipeline, IQPR, waiting times and finance report

Danielle Cecchini
Geoff Rowbotham
18 June 2019

Appendix 1

Finance & Performance Committee

Terms of Reference

References to "the Committee" shall mean the Finance and Performance Committee

1.0 Purpose of Committee

1.1 The purpose of the Committee is to provide the Trust Board with assurance on the development and delivery of financial strategies and achievement of key financial indicators; to review and provide assurance on business development and investment; and to ensure the delivery of key performance indicators, including contractual performance targets.

2.0 Clinical Focus and Engagement

2.1 The Trust considers clinical engagement and involvement in Board decisions to be an essential element of its governance arrangements and as such the Trust's integrated governance approach aims to mainstream clinical governance into all planning, decision-making and monitoring activity undertaken by the Board.

2.2 The Committee will therefore ensure appropriate clinical attendance at its meetings.

3.0 Authority

3.1 The Committee is authorised by the Trust Board to conduct its activities in accordance with its terms of reference.

3.2 The Committee is authorised by the Trust Board to seek any information it requires from any employee of the Trust in order to perform its duties.

3.3 The Committee is authorised by the Trust Board to obtain, at the Trust's expense, any outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

4.0 Membership

4.1 The membership of the Committee is approved by the Board, and

comprises: two Non-Executive Directors; Director of Finance, (Executive Lead); Medical Director; Chief Nurse and an Executive Service Director.

4.2 Only members of the Committee have the right to attend Committee meetings. However, other individuals and officers of the Trust may be invited to attend for all or part of any meeting as deemed appropriate

4.3 Membership of the Committee will be reviewed and agreed annually by the Board.

4.4 Chairmanship of the Committee will be a Non-Executive Director. In the event of the Chair not being available, either non-executive member present shall chair the meeting.

4.5 In the situation of a prolonged absence of a member of the committee, the Chairman of the Trust and the Chief Executive for Executive Directors, have the authority to nominate a replacement committee member.

4.6 The Chair of the Trust's Audit Committee shall not be a member of the Committee.

5.0 Secretary

5.1 The Personal Assistant to the Director of Finance will act as secretary of the Committee.

6.0 Quorum

6.1 The quorum necessary for the transaction of business shall be four, and must include a Non-Executive Director. A duly convened meeting of the Committee which is quorate shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

7.0 Frequency of Meetings

7.1 The Committee shall normally meet monthly but not less than 10 times a year and at such other times as the Chairman of the Committee shall require at the exigency of the business.

7.2 Members will be expected to attend at least three-quarters (75%) of all meetings.

8.0 Agenda/Notice of Meetings

8.1 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be

discussed, shall be forwarded to each member of the Committee, and any other person required to attend, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

8.2 The agenda for each meeting will include an item "Declarations of interest in respect of items on the agenda".

9.0 Minutes of Meetings

9.1 The secretary shall minute the proceedings and resolutions of all Committee meetings, including the names of those present and in attendance.

9.2 Minutes of Committee meetings shall be circulated promptly to all members of the Committee and, once agreed, to the secretary of the Trust Board. The Committee's minutes will be open to scrutiny by the Trust's auditors.

9.3 The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

10.0 Duties

10.1 To be the lead committee for responsibility for scrutiny of financial and business performance and developments.

Finance

10.2 To review and make recommendations to Board on budgets, strategic plans and long-term investment strategy. This review will include reviewing the Long Term Financial Model (or equivalent planning model) and associated strategies; Cost Improvement Programmes; Capital Programmes; activity and capacity plans, and Annual Business Plan, and any financial/budgetary arrangements with partners.

10.3 To review and monitor performance against all statutory and organisational financial targets including Financial Risk.

10.4 To review and make recommendations to Board on all significant investment and divestment proposals under the Trust's Scheme of Reservation and Delegation, and in line with best practice investment appraisal techniques, the five-year Long Term Financial Model and agreed strategies; and to approve any financing or use of financial instruments within its delegation.

10.5 To ensure there are robust arrangements for overview and scrutiny of the estates and IT strategies, and their delivery.

10.6 To ensure there are robust arrangements for overview and scrutiny of the Treasury Management function, and to regularly review the operation of those arrangements.

10.7 To ensure there are robust arrangements in place for the identification and management of financial risk, and to undertake a regular review of the financial risk register.

10.8 To ensure there is an appropriate Scheme of Delegation and associated financial limits and to ensure that this is subject to regular review.

10.9 To approve the accounting policies and treasury management policy

Business Development and Contracting

10.10 To ensure an appropriate and robust Business Development framework is in place and to regularly review its operation.

10.11 To scrutinise new business opportunities and tender proposals and to provide assurance to the Trust Board.

10.12 To ensure an appropriate and robust response is in place for contracting, and that the Trust has timely and accurate costing and activity information to support the process.

Performance

10.13 To scrutinise the performance of Operational and Enabling Services in their contribution to the achievement of strategic objectives, KPIs and contractual targets.

10.14 To ensure that an effective performance management and data quality system is in place.

10.15 To ensure that there are effective Emergency and Business Continuity arrangements in place for the Trust.

10.16 To ensure alignment to, and utilisation of, the Performance and Accountability Framework for each service based on established performance measures.

10.17 To ensure the arrangements and performance of the shared facilities management services are adequate and monitored regularly throughout the financial year.

10.18 To review the performance, business plans and value added contribution from hosted services on a regular basis.

10.19 To oversee the assessment of benefits realisation and achievement of value for money for areas of delegated responsibility.

General

10.20 To be empowered to delegate its authority to the Chairman or the Chief Executive Officer within the limits contained in the Trust's Scheme of Reservation and Delegation. The Board delegates responsibility for analysing and evaluating contract awards over £500k to FPC. After such consideration, FPC will make a recommendation to the Board for contracts where approval and award of the contract is proposed.

10.21 To receive on behalf of Trust Board the following:-

- Information Governance Toolkit Declaration
- Annual Accounts (draft)
- Annual Business Plan (draft)
- Emergency and Business Continuity Annual Report
- LPT Major incident plan
- LLR Operating Plan
- Losses and special payments report
- Reference costs

11.0 Reporting Responsibilities:

11.1 The Committee shall make whatever recommendations to the Trust Board it deems appropriate on any area within its remit where action or improvement is needed.

12.0 Annual Review

12.1 The Committee shall, at least once a year, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Trust Board for approval.

13.0 Risk Responsibility

13.1 The risk areas the Committee has special responsibility for will be those that fall within the remit of this Committee.

Appendix 2

Finance and Performance Committee Annual Work Programme 2018/19

	April 17th	May 15th	June 19th	July 17th	Aug 21st	Sept 18th	Oct 16th	Nov 20th	Dec 11th	Jan 15th	Feb 19th	Mar 19th
Standing Items												
DoF's Update Report including Strategic Initiatives summary report	X	X	X	X	X	X	X	X	X	X	X	X
Strategy and Planning												
Five Year Plan – Refresh summer 2019												~~X~~
Operational Plans												
Annual Financial Plan for 2018/19 including Revenue, Capital, CIP and Cash	X											
Integrated Operational Plan 2019/20								X	X	X	X	X

	April 17th	May 15th	June 19th	July 17th	Aug 21st	Sept 18th	Oct 16th	Nov 20th	Dec 11th	Jan 15th	Feb 19th	Mar 19th
Annual Financial Plan for 2019/20 including Revenue, Capital, CIP and Cash								X	X	X	X	X
Contract Negotiations 2019/20 *(if required)*									X	X	X	X
LPT Major Incident Plan		X										
Winter Plan						X						
Pandemic Flu Plan												X
Shared Services – Facilities Management												
Hosted Services – LHIS Business Plan												
Hosted Services – 360 Business Plan												
Underpinning Strategies												

	April 17th	May 15th	June 19th	July 17th	Aug 21st	Sept 18th	Oct 16th	Nov 20th	Dec 11th	Jan 15th	Feb 19th	Mar 19th
Estates Strategy – due 2022/23												
IM&T Strategy – due 2019/20								X				
Finance Strategy – due 2019/20						X						
Procurement Strategy – due tbc												
Efficiency and Productivity strategy												
Innovation Strategy – due 2019/20			X									
Quality Improvement												
Data Quality Improvement Plan – progress update	X	X	X	X	X	X	X	X	X	X	X	X
Response to CQC actions	X	X	X	X	X	X	X					
Waiting times improvement – Action Plan								X			X	
PLICS development			X					X				

	April 17th	May 15th	June 19th	July 17th	Aug 21st	Sept 18th	Oct 16th	Nov 20th	Dec 11th	Jan 15th	Feb 19th	Mar 19th
Governance												
Review of Risk Register	X	X	X	X	X	X	X	X	X	X	X	X
Information Governance six monthly review					X							X
GDPR monitoring		X			X			X				X
Information Governance Toolkit Declaration												X
Annual/Mid-Year Review of Committee's effectiveness and Terms of Reference						X						X
Risk and Assurance Deep Dives												
Financial Plan/Cash/CIPs (2651, 2130, 2134)									X			
Estates (2135)										X		
Data Quality/Information Capacity										X		

	April 17th	May 15th	June 19th	July 17th	Aug 21st	Sept 18th	Oct 16th	Nov 20th	Dec 11th	Jan 15th	Feb 19th	Mar 19th
(1119, 729)												
GDPR (2235)											X	
Loss of Business income / CSR decommissioning (3135, 2131)												X
Unfunded growth and cost pressures (2132)												X
DTOC (April 2019) (2403)												
Assurance and Performance												
Finance												
Finance Report including revenue, CIP, capital, contract monitoring & cash	X	X	X	X	X	X	X	X	X	X	X	X
Quarterly CIP progress report	X	X			X			X			X	
Reference Costs					X							X
Losses & Special Payments												X

	April 17th	May 15th	June 19th	July 17th	Aug 21st	Sept 18th	Oct 16th	Nov 20th	Dec 11th	Jan 15th	Feb 19th	Mar 19th
Operational Delivery												
IQPR Scrutiny and Approval including waiting times	X	X	X	X	X	X	X	X	X	X	X	X
Business Pipeline		X			X				X			
Alliance Contract update			X			X						
Business continuity including progress update, annual review / EPRR quarterly report		X			X			X				X
EPRR Core Standards Review						X						
Hosted Services - Health Informatics Services (HIS) – six monthly review		X						X				
Hosted Services - 360 Assurance six monthly review					X						X	
Strategies												
IM&T / EPR Strategies six monthly		X						X				

	April 17th	May 15th	June 19th	July 17th	Aug 21st	Sept 18th	Oct 16th	Nov 20th	Dec 11th	Jan 15th	Feb 19th	Mar 19th
update (EPR to be quarterly update)		X			X (EPR)			X			X (EPR)	
Estates and Facilities Management six monthly update (incl CQC actions & Shared Service update)				X						X		
Premises Assurance Model											X	
Procurement Service six monthly update									X			
Strategic Programme Progress Report		X		X			X			X		
Annual summary of Innovation Strategy: Commercialisation Projects			X									
Framework and Policy												
Performance and Accountability Framework – annual review												X

	April 17th	May 15th	June 19th	July 17th	Aug 21st	Sept 18th	Oct 16th	Nov 20th	Dec 11th	Jan 15th	Feb 19th	Mar 19th
Enterprise/Business development Framework												X
Code of Business Conduct Policy						X						
Approve Accounting Policies for 2018/19											X	
Review update of Treasury Management Policy											X	
SFI's / SO's / Scheme of Delegation – review and approval											X	
EPRR Policy Review (Every 3 Years – due 2021)												
Business Case and Procurement Scrutiny												
Business Case approval as required												
For information – questions to be raised under AOB if required												
FPC work programme	X	X	X	X	X	X	X	X	X	X	X	X

	April 17th	May 15th	June 19th	July 17th	Aug 21st	Sept 18th	Oct 16th	Nov 20th	Dec 11th	Jan 15th	Feb 19th	Mar 19th
No. of agenda items	8	15	10	8	14	12	7	16	10	10	16	18
No. of 'for information' items	1	1	1	1	1	1	1	1	1	1	1	1

Appendix 3

2017/18 Attendance log

Member	Attended %	Deputy %	Total Coverage %
Ruth Marchington (up to August 2018)	100	0	100
Geoff Rowbotham (from September 2018)	100	0	100
Faisal Hussain	92	0	92
Dani Cecchini (from June 2018)	90	10	100
Sharon Murphy (up to May 2018)	100	0	100
Adrian Childs (up to December 2018)	92	8	100
Anne Scott (from January 2019)	67	0	67
Satheesh Kumar (April 2018)	100	0	100
Saquib Muhammad (May to September2018)	100	0	100
Sue Elcock (from October 2018)	100	0	100
Rachel Bilsborough	75	25	100
Helen Thompson	83	17	100

Appendix 4

Leicestershire Partnership NHS Trust

Governance arrangements for the Finance and Performance Committee

July 2019

Contents

Finance and Performance Committee

Terms of Reference

1.0 Constitution

The Trust Board has established a committee known as the Finance and Performance Committee (the Committee) reporting to the Trust Board, in accordance with standing order 4.

The Committee shall have terms of reference and powers and be subject to conditions, such as reporting back to the Trust Board, as the Trust Board shall decide and shall act in accordance with any legislation and regulation or direction issued by the regulator.

The Committee shall be a Non-executive Director led Committee of the Trust Board comprised of independent Non-executive Directors and Executive Directors with portfolio lead for the finance and performance agenda. The Committee has no executive powers, other than those specifically delegated in these terms of reference.

2.0 Purpose of Committee

The role of the Committee is to provide assurance to the Trust Board, that the Trust is properly governed and well managed across the full range of activities within the scope of the terms of reference and to seek internal and external assurance relating to the delivery of key financial strategies, key financial indicators, business development and investment and performance management, estate management and IT management.

The Trust considers clinical engagement and involvement in Trust Board decisions to be an essential element of its governance arrangements and as such the Trust's integrated governance approach aims to mainstream clinical governance into all planning, decision-making and monitoring activity undertaken by the Board.

3.0 Authority

The Committee is authorised by Trust Board to investigate any activities within its terms of reference.

The Committee is authorised by Trust Board to seek any information it requires from any employee of the Trust in order to perform its duties. All employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain, at the Trust's expense, any outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience or expertise, if it considers this to be necessary.

4.0 Membership

The Committee shall be comprised of Non-executive Directors and Directors with finance and performance portfolios.

The membership will include:

- Two independent Non-executive Directors.
- The Director of Finance who will hold executive responsibility for the Committee
- Two Service Directors
- The Medical Director or Director of Nursing

The Chair of the Committee shall be one of the independent Non-executive Directors selected by the Trust Board. In their absence their place shall normally be taken by another independent Non-executive Director.

Membership of the Committee will be reviewed and agreed annually by the Board.

In the situation of a prolonged absence of the Chair or a member of the Committee, the Trust Board will determine a replacement Chair. The Chair of the Trust Board will determine replacement of independent Non-executive Director membership and the Chief Executive in consultation with the Chair of the Trust will determine replacement Directors. All replacement members will hold full membership authority unless otherwise agreed. .

5.0 Administration

The Committee shall be supported administratively by The Personal Assistant to the Director of Finance.

The agenda will be agreed with the Chair following consultation with the Director of Finance.

The Personal Assistant to the Director of Finance will support the production of the Committee pack and ensure the pack is circulated within the required timeline of five working days prior to the meeting, attend the meetings to take the minutes, keep a record of matters arsing and issues to be carried forward and generally provide support to the Chair and members of the Committee. .

6.0 Quorum

The quorum shall be three members of the Committee and must include one independent Non-executive Directors and one Director. A duly convened meeting of the Committee which is quorate shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

Attendance at meetings

Only members of the Committee have a right to attend the Committee; however other officers of the Trust may be invited to attend the Committee either for specific discussion items or for the whole meeting as required by the Committee.

Other Non-executive Directors have an open invitation to attend the Committee as felt appropriate after advising the Chair of the Committee of their attendance.

Any independent Non-executive Director or officer of the Trust who is not part of the normal membership of the Committee will be in attendance at the meeting.

7.0 Frequency of Meetings

The Committee shall meet not less than 6 times a year and at such other times as the Chairman of the Committee shall require at the exigency of the business.

The Finance and Performance Committee and the Quality Assurance Committee will additionally hold quarterly joint meetings to discuss key joint agenda issues and report jointly to the Board. Separate governance arrangements are in place for the management of the joint meeting.

Members will be expected to attend at least three-quarters (75%) of all meetings.

8.0 Agenda/Notice of Meetings

Unless otherwise agreed, notice of each Finance and Performance Committee meeting will confirm the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

The agenda for each meeting will include an item “Declarations of interest in respect of items on the agenda”.

9.0 Minutes of Meetings

Minutes of Committee meetings shall be circulated promptly to all members of the Committee and, once agreed, to the secretary of the Trust Board. The Committee’s minutes will be open to scrutiny by the Trust’s auditors.

The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

10.0 Duties

The Finance and Performance Committee supports the work of the Trust Board in ensuring a balanced and integrated approach to

- clinical focus, engagement and governance; Clinical Audit
- patient/stakeholder involvement
- performance management
- financial oversight
- strategic management
- business management

- Estates management
- IT management

The Committee is responsible for providing assurance to the Trust Board, on the effectiveness of the Trust's arrangements for finance, business and performance, ensuring there is a consistent approach throughout the Trust, specifically in the areas of financial management, business management, performance management and contract management, the Committee will review the adequacy and effectiveness of:

The underlying assurance processes that support achievement of the corporate objectives and the management of principle risks specific to finance, business and performance including:

- Assurance Framework

- Aspects of the Annual Governance Statement related to finance, business and performance

- Financial risks assigned to the Committee in line with the Risk Management Strategy

The Committee will seek assurance and undertake the following actions:

Finance

- To review and make recommendations to Board on budgets, strategic plans and long-term investment strategy. This review will include reviewing the Long Term Financial Model (or equivalent planning model) and associated strategies; Cost Improvement Programmes; Capital Programmes; activity and capacity plans, and Annual Business Plan, and any financial/budgetary arrangements with partners.

- To review and monitor performance against all statutory and organisational financial targets including Financial Risk.

- To review and make recommendations to Board on all significant investment and divestment proposals under the Trust's Scheme of Reservation and Delegation, and in line with best practice investment appraisal techniques, the five-year Long Term Financial Model and agreed strategies; and to approve any financing or use of financial instruments within its delegation.

- To ensure there are robust arrangements for overview and scrutiny of the estates and IT strategies, and their delivery.

- To ensure there are robust arrangements for overview and scrutiny of the Treasury Management function, and to regularly review the operation of those arrangements.

- To ensure there are robust arrangements in place for the identification and

management of financial risk, and to undertake a regular review of the financial risk register.

- To approve the accounting policies and treasury management policy.

- To review the reference costs on an annual basis.

Business Development and Contracting

- To ensure an appropriate and robust Business Development framework is in place and to regularly review its operation.

- To scrutinise new business opportunities and tender proposals and to provide assurance to the Trust Board.

- To ensure an appropriate and robust response is in place for contracting, and that the Trust has timely and accurate costing and activity information to support the process.

Performance

- To scrutinise the performance of Operational and Corporate Services in their contribution to the achievement of strategic objectives, KPIs and contractual targets.

- To ensure that an effective performance management and data quality system is in place.

- To ensure that there are effective Emergency and Business Continuity arrangements in place for the Trust.

- To ensure alignment to and utilisation of, the Performance and Accountability Framework for each service based on established performance measures.

- To ensure the arrangements and performance of the shared facilities management services are adequate and monitored regularly throughout the financial year.

- To review the performance, business plans and value added contribution from hosted services on a regular basis.

- To oversee the assessment of benefits realisation and achievement of value for money for areas of delegated responsibility.

General

- To be empowered to delegate its authority to the Chairman or the Chief Executive Officer within the limits contained in the Trust's Scheme of Reservation and Delegation. The Board delegates responsibility for analysing and evaluating contract awards over £500k to FPC. After such consideration,

FPC will make a recommendation to the Board for contracts where approval and award of the contract is proposed.

- To receive on behalf of Trust Board and provide the Trust Board with assurance on the following:-
  - Information Governance Toolkit Declaration
  - Annual Business Plan (draft)
  - Emergency and Business Continuity Annual Report
  - LPT Major incident plan
  - LLR Operating Plan

To receive exception reports of outcomes of **external** reviews, inquiries, surveys and investigations, with assurance that any lessons learnt have been implemented to ensure delivery of the highest quality of services, and to capture any risks to finance, business or performance.

To receive exception reports of outcomes of **internal** activity, e.g. from internal audit, site visits and other activities, and to capture any risks to finance, business or performance outcomes.

To receive assurance of compliance with agreed best practice, e.g. national guidance, and to ensure the capture of any risks to finance, business and performance.

11.0 Reporting Responsibilities:

The Committee shall make whatever recommendations to the Trust Board that it deems appropriate on any area within its remit where action or improvement is needed.

The Committee shall produce for the Trust Board an annual report on the work it has undertaken during the course of the year.

12.0 Annual Review

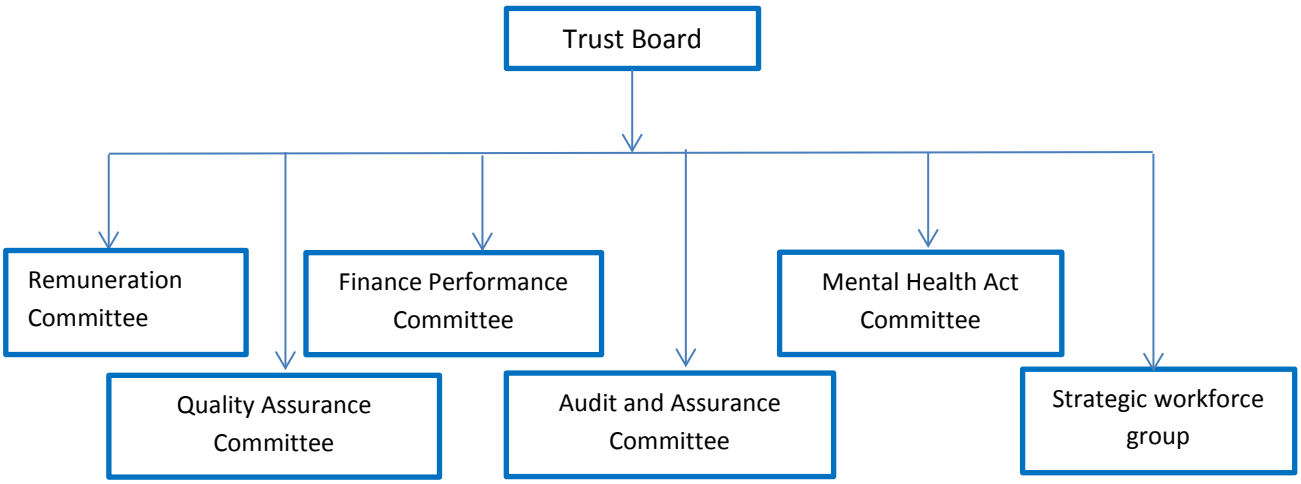
The Committee shall, at least once a year, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Trust Board for approval.

13.0 Risk Responsibility

The risk areas the Committee has special responsibility for will be those that fall within the remit of this Committee.

Author	Interim Associate Director of Corporate Governance
Owner	Finance and Performance Committee
Date of Issue	August 2019
Version #	
Approved by	Trust Board
Review date	April 2020

2 Governance structure



3. Membership- details of officers attending

	Finance and Performance Committee
Membership	• NED **(chair)** • NED x 1 • Director of Finance **(Executive Lead)** • Medical Director or Director of Nursing • Service Director x 2
In attendance	• Head of Assurance • Head of Estates • Deputy Director of Finance • Other managers will be invited to attend as and when required
Frequency	Not less than 11 times per 12 months
Day and times	XX on Tuesday of third week

4. Work programme

Quarter 1	**Meeting 1 – April** **Standing items** • Annual Review of Governance structure for the Committee • Annual Report • Annual Governance Statement • Annual financial plan including revenue, capital, CIP and cash • Health informatics service report **Quarterly reports** • Business pipeline and contracting report • Quarterly CIP report • CQC actions update • Strategic Programme progress report **Monthly reports** • Director of Finance update report including strategic initiative summary report • Review of Corporate Risk Register • Business cases as required • IQPR report • Data Quality Improvement plan • FPC work programme • Assurance Framework • Risk Register	**Meeting 2 – May** **Standing items** • Six month IMT Strategy • Approval of LPT major incident Plan • PLICS development **Quarterly reports** • Business continuity plan including progress update, annual review and EPRR quarterly report **Monthly reports** • Director of Finance update report including strategic initiative summary report • Review of Corporate Risk Register • Business cases as required • IQPR report • Data Quality Improvement plan • FPC work programme • Assurance Framework • Risk Register	**Meeting 3 - June** Quarterly joint meeting with Quality Assurance Committee **Standing items** • Six month Estate Strategy and Facilities Management Report • Annual Effectiveness of Committee and review of ToRs **Quarterly items** • Alliance contract update **Monthly items** • Director of Finance update report including strategic initiative summary report • Review of Corporate Risk Register • Business cases as required • IQPR report • Data Quality Improvement plan • FPC work programme • Assurance Framework • Risk Register

Quarter 2	**<u>Meeting 4 – July</u>** **Standing items** • Information Governance update **Quarterly report** • Business pipeline and contracting report • Quarterly CIP report • CQC actions update • Strategic Programme progress report **Monthly report** • Director of Finance update report including strategic initiative summary report • Review of Corporate Risk Register • Business cases as required • IQPR report • Data Quality Improvement plan • FPC work programme • Assurance Framework • Risk Register	**<u>Meeting 5- August</u>** **Standing items** **Quarterly items** • Business continuity plan including progress update, annual review and EPRR quarterly report **Monthly items** • Director of Finance update report including strategic initiative summary report • Review of Corporate Risk Register • Business cases as required • IQPR report • Data Quality Improvement plan • FPC work programme • Assurance Framework • Risk Register	**<u>Meeting 6- September</u>** Quarterly joint meeting with Quality Assurance Committee **Standing items** • Six month UHL Procurement Service report • Winter Plan • Code of Business Conduct Policy **(DN why not AC)** **Quarterly reports** • Alliance contract update **Monthly reports** • Director of Finance update report including strategic initiative summary report • Review of Corporate Risk Register • Business cases as required • IQPR report • Data Quality Improvement plan • FPC work programme • Assurance Framework • Risk Register

Quarter 3	**Meeting 7 – October** **Standing items** • Five year plan – strategic indicators • Health informatics service report **Quarterly reports** • Business pipeline and contracting report • Quarterly CIP report • CQC actions update • Strategic Programme progress report **Monthly reports** • Director of Finance update report including strategic initiative summary report • Review of Corporate Risk Register • Business cases as required • IQPR report • Data Quality Improvement plan • FPC work programme • Assurance Framework • Risk Register	**Meeting 8 – November** **Standing items** • Performance and Accountability Framework • Six month Estate Strategy and Facilities Management Report • Six month IMT Strategy • PLICS update **Quarterly reports** • Business continuity plan including progress update, annual review and EPRR quarterly report **Monthly reports** • Director of Finance update report including strategic initiative summary report • Review of Corporate Risk Register • Business cases as required • IQPR report • Data Quality Improvement plan • FPC work programme • Assurance Framework • Risk Register	**December – No meeting**

Quarter 4	**Meeting 9 – January** Quarterly joint meeting with the Quality Assurance Committee **Standing items** • Five year plan – strategic indicators • Information Governance update **Quarterly reports** • Business pipeline and contracting report • Quarterly CIP report • CQC actions update • Strategic Programme progress report **Monthly reports** • Contract negotiation update • Director of Finance update report including strategic initiative summary report • Review of Corporate Risk Register • Business cases as required • IQPR report • Data Quality Improvement plan • FPC work programme • Assurance Framework • Risk Register	**Meeting 10 – February** **Standard report** • Approval of Accounting Policies **(DN why not AC)** • Review of Treasury Management Policy **(DN why not AC)** • SFI/SOs/SoD review **(DN why not AC)** • Premises Assurance Model **Quarterly Report** • Business continuity plan including progress update, annual review and EPRR quarterly report **Monthly report** • Contract negotiation update • Director of Finance update report including strategic initiative summary report • Review of Corporate Risk Register • Business cases as required • IQPR report • Data Quality Improvement plan • FPC work programme • Assurance Framework • Risk Register	**Meeting 11 – March** Quarterly joint meeting with the Quality Assurance Committee **Standing items** • Six month UHL Procurement Service report • Pandemic Flu • Losses and special payments **(DN why not AC)** • IG toolkit declaration **Quarterly items** • Alliance contract update **Monthly items** • Contract negotiation update • Director of Finance update report including strategic initiative summary report • Review of Corporate Risk Register • Business cases as required • IQPR report • Data Quality Improvement plan • FPC work programme • Assurance Framework • Risk Register

Leicestershire Partnership NHS Trust

Meeting	Quality Assurance Committee Audit and Assurance Committee Trust Board
Date of meeting	17 June 2019 5 July 2019 30 July 2019
Paper number	V

Name of Report Annual Report and governance arrangements for the Committee

For approval	X	For assurance		For information	

Presented by the Accountable Director	Liz Rowbotham Chair of the QAC and Non-executive Director	Author (s)	Liz Rowbotham Chair of the QAC and Non-executive Director Anna Pridmore Interim Associate Director of Corporate Governance

Alignment to CQC domains:		Alignment to the LPT strategic objectives:		Alignment to LPT priorities for 2019/20 (STEP up to GREAT):	
Safe		Safe		S – High Standards	
Effective		Staff		T – Transformation	
Caring		Partnerships		E – Environments	
Responsive		Sustainability	x	P – Patient Involvement	
Well-Led	X			G – Well-Governed	x
				R – Single Patient Record	
				E – Equality, Leadership, Culture	
				A – Access to Services	
				T – Trustwide Quality improvement	

Report previously reviewed by		
Committee / Group	Date	Assurance obtained (Significant/Limited/None)
Quality Assurance Committee	17 June 2019	
Audit Committee	5 July 2019	
Trust Board		

Assurance : What level of assurance does this report provide in respect of the Board Assurance Framework Risks? (Significant / Limited / No Assurance)	Links to BAF risk numbers
The document provides details of the governance arrangements for the functioning of the Board Committee. The paper supports the well led requirements for the Trust and links into the well governed Trust priority. The documents provide significant assurance on the constitution of the Committee.	Priority 7

Recommendations of the report
The Committee is asked to consider the annual report and associated Terms of Reference and recommend approval of the Terms of Reference by the Trust Board. The Committee is also asked to recommend to the Audit Committee that the Terms of Reference provide the oversight the Committee is required to provide and supports the internal control mechanisms of the Trust

Leicestershire Partnership NHS Trust

Report to the Quality Assurance Committee

Annual Report and governance arrangements for the Committee

1. Introduction/Background

The Committee aims to follow good governance practice and has written an annual report as part of a review of the governance of the meeting. Additionally, following the receipt of a number of reports and a review by Internal Audit, the Trust has reviewed all the Terms of Reference for the Board Committees. This paper outlines the timeline for the introduction of the changed working arrangements for the Committees, specifically the Quality Assurance Committee and Finance and Performance Committee.

2. Aim

The aim of this paper is to present the annual report, outline the key changes made to the Terms of Reference for the Quality Assurance Committee following a full review and to outline the timeline for the introduction of the new working arrangements.

3. Annual Report

The Committee is required to write an annual report as part of the year end process. The annual report is attached at appendix 1 to this report. The key highlights from the report are:

4. Terms of Reference

Each year the Trust undertakes a review of the Terms of Reference of all Board Committees. This year a more detailed review has been undertaken following some criticism from regulators and external governance reports. The Terms of Reference have been redesigned to ensure that all formal Board Committees have consistent Terms of Reference that follow the same format. All Board Committee Terms of Reference provide clarity within the document about the governance structures and detail the work programme so on a quarterly basis the information that should have been considered by the Board Committee.

The significant changes made to the Terms of Reference are as follows:

- Responsibility for some duties has moved from the Quality Assurance Committee to Audit Committee, the most notable change is the management of risk system.

- The Committee will meet no less than 6 times a year; previously the Terms of Reference had required the Committee to only meet nine times as a minimum.

- The introduction of the joint committee meeting between the Finance and Performance Committee and the Quality Assurance Committee. The principle behind this meeting is that the Finance and Performance Committee and the Quality Assurance Committee have shared agenda items which need to be discussed in a shared forum.

The Chair and lead Director for the Committee have been involved in the development of the revised Terms of Reference and have had an opportunity to consider the revised arrangements in advance of the document being presented to the Quality Assurance Committee. The revised Terms of Reference are attached at appendix 2.

5. Timetable

The timetable for the introduction of the revised arrangements is as follows:

First joint meeting of the Finance and Performance Committee and Quality Assurance Committee	June 2019
Receipt and review of the draft Terms of Reference by the Committee	June 2019
Receipt and review of the draft Terms of Reference by the Audit Committee	5 July 2019
Receipt and approval of the draft Terms of Reference by the Trust Board	July 2019
Introduction of the new working arrangements by the Committee	August 2019

6. Conclusion

The Committee has reviewed its work of the past year and summarised it in an annual report. This report will be received by the Audit Committee and Trust Board As part of a review of governance arrangements across the Trust, the Board Committee constitutional documents have been reviewed. The review has ensured that there is consistency where ever possible between the committees and that the totality of the business being discussed at each of the Committees addresses the full agenda of the priorities of the Trust and the Board Assurance Framework.

7. Recommendations

The Committee is asked to consider the paper and associated Terms of Reference and recommend approval of the Terms of Reference by the Trust Board.

The Committee is also asked to recommend to the Audit Committee that the Terms of Reference provide the oversight the Committee is required to provide and supports the internal control mechanisms of the Trust

Appendix 1 Annual Report

Leicestershire Partnership NHS Trust

ANNUAL REPORT
Year 2018-19

Committee/Group	Quality Assurance Committee
Date	June 2019
Chair of Committee	Liz Rowbotham

The annual review of the Quality Assurance Committee (QAC) was led by the committee chair, Liz Rowbotham, Non-Executive Director, and the Executive lead, Anne Scott, Interim Chief Nurse with contributions from other committee members. All groups reporting to QAC have been required to produce an annual review and these have been considered in producing this review. The review was considered by QAC at the meeting in June 2019.
The review has also taken into account the outcomes of the external governance review commissioned in early 2019

Section A – Fulfilling Terms of Reference

1. Review of Terms of Reference (ToR)
   - All duties identified within the Terms of Reference (ToR) were executed throughout the year. The 2018/19 work plan is included
   - The membership of the committee is considered appropriate with support from clinical representative of the directorates and other officers as necessary. The meetings were always quorate.
   - All groups reporting to QAC have undertaken an annual review (including their terms of reference) and these have been considered as part of QAC's annual review. Individual groups has produced recommendations for improvement which will be monitored
   - There are significant amendments to the QAC terms of reference particularly those related to the responsibilities for oversight of risk. A new set of terms of reference has been produced. These have been developed to ensure the recommendations of the external review of governance can be implemented in accordance with the governance action plan.
   - The committee has received at each of its meeting an update on the progress of the CQC action plan.
   - The committee has received the following annual reports:-
     The whole family safeguarding report
     The sexual safety annual report
     The complaints annual report
     The clinical audit annual report
     The infection, prevention and control annual report

2. Assurance

- The committee has increased the emphasis on assurance and outcomes and the majority of assurance received comes through exception reporting from its sub groups. In order to enhance this it has undertaken a number of 'deep dives' throughout the year, these include:-
  - Thematic review of MHA commissioner visits
  - Serious incidents in AMHLD
  - AIMS accreditation of MHSOP wards
  - Risk related to bed flow and capacity

- The committee received external assurance from a number of sources
- 360 Assurance reports or follow ups have been received related to :-
  - Self-regulation
  - GDPR
  - Mortality surveillance
- The committee received monthly reports related to the CQC , these reports described the status of the "must do" actions and the level of assurance as assessed by other committees of the evidence such as SWG and FPC
- Updates were received from the visits by local commissioners and others
- The PLACE assessment was received and followed up in year
- Throughout the year the outcomes of the board walk programme undertaken by NEDs and Executive directors was reported
- The committee used multiple other sources of internal assurance and these included IQPR, risk registers, action log, 'deep dive' reports and investigations, reports from the Clinical Effectiveness group, clinical audit and other groups.
- The committee received the reports and recommendations from investigations in other trusts. These included the Liverpool community trust and the Gosport enquiry. The committee also received follow up on any action to be taken in response to these findings
- 'Soft intelligence' is actively sought from committee members and information is triangulated.
- The report to the board each month gives a level of assurance which is RAG rated in line with agreed definitions of assurance
- The committee will explore how to gain further positive assurance throughout the coming year including a greater use of triangulated data and statistical process control.

3. Analysis of Risks

- The committee functioned as the risk committee for the Trust in 2018/19 and as such it had a work programme that reviewed all risks within the Board Assurance Framework and Corporate Risk Register, risks were reviewed at every meeting of the committee. The committee received a report of the top organisational risks and the top risks from each of the clinical directorates. It provided feedback to the risk owners, ensured they were followed up and amendments made.
- The committee oversaw the development of the risk management systems, processes and strategy, including the annual review of the risk management

strategy. During the year it will implemented the risk appetite process agreed by the Board in March 2018.

- During the year an increasing amount of time has been spent on the clinical/quality risks. This has included a number of deep dives and a greater emphasis on the clinical risks with the CRR

4. Work plan
   - The work-plan is evidence of the discharging of the ToR for the committee and has been used in conjunction with the action log to inform agendas. The work plan has been used flexibly to ensure urgent or pressing issues were considered in a timely way as well as allowing essential planned business to take place.

Section B – Reflection upon Working Practices

5. Effectiveness of Committee discussion
   a. How effectively is the Group Chaired?

   The committee is chaired by a Non-Executive Director. The agendas are frequently long although progress has been made throughout the year to reduce the length of the agenda and of the papers. The agendas are well managed and all attendees are encouraged to participate. The meeting occasionally overruns but only by approx. 10 mins

   Minutes of the meeting are comprehensive, checked by the Chair and Lead Executive and distributed to members prior to the next meeting. Alongside the minutes is an action log to ensure all issues are followed up within a timely manner.

   Agendas have been reorganised to ensure an appropriate flow of discussion and triangulation of information and reflection time is incorporated to enable any further risks or actions to be agreed and to ensure there is clarity of action and the required outcome has been accurately recorded.

   The agenda now increases the emphasis on quality improvement activities

b. Do all members contribute?

- Is an Attendance log maintained, and attendance levels of 75% achieved by all members?
-

Board Member	Number of meetings attended	Percentage attendance
Chair Liz Rowbotham	11/12	92%
Non-Executive Director Geoff Rowbotham (until August 2018) Ruth Marchington (from September 2018)	5/5 7/7	100%
Non-Executive Director Claire Gibson (until 31st July) Prof Kevin Harris (since 1st October)	1/4 3/6	40%
Chief Nurse Prof Adrian Childs Dr Anne Scott	8/9 1/3	84%
Medical Director Dr Satheesh Kumar Dr Saquib Muhammad Dr Sue Elcock	1/1 5/5 6/6	100%
Director Rachel Bilsborough	9/12	75%

Members are sufficiently prepared for the meeting and are able to contribute to discussions. Papers are circulated five days prior to the meeting to give members the opportunity to review them.

Commissioners attended the committee throughout the year ensuring transparency and reducing duplication

6. <u>Communication channels</u>

a. Communications to and from members

- Papers are generally submitted within a timely manner, a standard for timeliness and distribution is monitored by the lead director. This has required specific actions at times during the year but has improved again
- A RAG rated highlight report is usually prepared within 2 working days of the meeting as it is required to meet the timeline for the Board agenda.

b. Quality of papers
- Work has been undertaken during the year to reduce the length of the papers but ensure that they still provide the level of assurance required. This has been achieved by reviewing what is required in the different reports. Papers are mainly of a good standard and now reducing in length. Further work needs to be undertaken this year to maintain progress and further reduce the length of reports
- All papers are presented by the author or an informed deputy. On rare occasions when this has not been able to take place the paper is placed on another agenda to ensure it is appropriately and fully considered.

c. Quality of minutes
- The minutes are comprehensive and maintained on a database and clearly document the challenge, levels of assurance received and the outcomes of the discussions.
- The recommendations to the committee are reviewed at the end of the discussion about the paper, recorded within the minutes and added to the action log and forward work plan as required.

d. Information flows with Parent Committee
- The committee receives regular highlight reports from all its groups. During the year this was amended utilising verbal updates and quarterly reports. This was evaluated mid-year by a process of conversations between the chair of QAC and the chairs of the subgroups. Whilst the administrative burden has been reduced the efficacy of sub groups reporting has been mixed and the individual sub group reviews have reflected this.
- Where the committee requires further assurance it requests it from the reporting group or considers undertaking a 'deep dive' and this is reported back to the groups.

7. <u>Achievements and Barriers</u>

a) General
- Full review of the committee undertaken to improve assurance and manage workload more effectively resulted in a recommendation to change risk responsibilities
- Review of agenda to reflect the strategic priorities , requirements for assurance related to Quality improvement and the standards related to quality of care
- The committee continues to have a high workload that does have an impact on the length of time that can be spent considering a single area. The implementation of the governance review will assist in streamlining the process ensuring assurance is provided and discussion enabled.
- Development of the proposed joint working model between FPC and QAC has been supported to ensure that there is less duplication and a greater assurance on the balance between finance and quality.

b) CQC compliance

The CQC inspected the trust in November 2018 and published its report in January 2019

The system of scrutiny of the CQC action plans was inadequate for the previous inspection resulting in deterioration in the CQC assessment of the trust services. This has resulted in a significant change in the monitoring in 19/20 with operational responsibilities moving to the Executive committee and assurance on progress directly to QAC.

To support the assurance model the programme of board walks has been refocused on the areas where improvement is required.

c) Sub committees

- The Safeguarding committee has strengthened the learning from SCR/SAR/DHR and how it is disseminated to the directorates; strengthened the information used for assurance and all members of the committee have demonstrated commitment and passion for the work.
- The clinical effectiveness group have undergone significant changes of membership during the year. It has streamlined the reporting arrangements and reduced the administrative burden
- The health and safety committee has undertaken significant pieces of collaborative work with other specialist teams and the directorates such as lone working arrangements, standardisation of hoists, fire regulations and emergency preparedness
- The infection prevention and control committee has strengthened the collaborative work with the directorates in areas such as the hygiene code, development of the urinary catheter passport and has review of IPC training
- The patient and carer experience group has held successful events for service users and carers to share views to inform future plans; supported the introduction of a new patient experience survey for community mental health teams and reinvigorated the "always events" programme
- The patients safety improvement group has introduced new directorate reports; improved challenge and feedback on audit actions and increased the focus on available harm

8. <u>Future Plans</u>

a) QAC

- The 2019/20 work plan is appended. We endeavour to make it as flexible as possible to ensure emerging business throughout the year can be accommodated.
- For 2019/20 the committee aims to embed the governance and SI review recommendations, increase the patient and users view to inform our work and ensure a greater emphasis is placed on quality improvement.
- Consideration will be given as to whether Healthwatch or users/carers can be involved directly in the committee

- A medicines oversight group will be established by July 2019
- Individual sub group recommendations will be reviewed mid-year to ensure progress.
- A review of the sub group structure will be undertaken during the year
- The agenda will continue to be focused on the “Step up to Great” priorities associated with the remit of the committee
- A specific agenda item will be introduce for the lead executive to keep the committee briefed on emerging issues both local and national from July 2019

b) Sub groups

- The safeguarding committee will focus on embedding the assurance process; undertake a review of capacity to address current risk and consider creating safeguarding champions in the trust
- The clinical effectiveness group will focus on its sub groups particularly CPA and smoke free as well as clinical outcomes and protected characteristics. . previous report related to drug usage will report to the newly formed medicines oversight committee
- The infection and prevention and control committee will continue its focus from last year which includes the flu vaccine uptake. A member of the CCG has been invited to attend
- The patient and carer experience group will focus on trust wide patient involvement including direct involvement with the group itself, oversee the mixed sex accommodation policy implementation and monitoring, review the FFT systems ensuing compliance with the new national guidance.
- The health and safety committee will continue to focus on its annual work plan and will improve reporting of operational issues to the executive teams
- The patients safety improvement group will focus on the assurance role of its subgroups, improve how data is presented for assurance purposes and improve the management of policies within the remit of the group. The medicines management group will report to the new oversight group

Work programme for 2018/19

QAC Workplan 2018-19

Delegated by TB to QAC

	Contact	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Integrated Corporate Risk register and BAF risk report	KD	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Full CRR and BAF to be considered (quarterly)	KD			**X**					**X**			**X**	**X**
Annual review of the board assurance and escalation framework (prior to Trust Board in February 2019)	KD											**X**	
Risk Appetite quarterly	KD			**XQ4**			**XQ1**			**Q2**			**XQ3**
Monthly Serious Incidents report	KD	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Learning from serious incidents Quarterly report	KD		**X Q4**			**X Q1**			**X Q2**			**X Q3**	

Integrated Quality and Performance Report - Quality Overview	LH	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Complaints Monthly Report	AS (JS to present)	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Complaints Annual Report	AS (JS to present)					**X**							
Patient and Carer Experience and Involvement and Complaints Quarterly (and quarterly progress from PCEG)	AS (JS to present)		**X Q4**			**X Q1**			**X Q2**			**X Q3**	
PLACE	AS (Helen Walton)						**X**					**X**	
Combined learning from Complaints, Concerns and Incidents Quarterly report	AS			**Q4**			**Q1**			**Q2**			**Q3**
Accessible Information Standard Report	SKi	**X**						**X**					
Changes to Data Protection Law (GDPR)	SKi		**X**			**X**			**X**			**X**	
Single EPR quarterly update	David Bell			**X**						**X**			

Caldicott Annual Report	SKi		X										
Monthly review of CQC action plan	KD	X	X	X	X	X	X	X	X	X	X	X	X
Sign Up to Safety (for review)	KD												
Positive and Safe and Seclusion Report Quarterly	MC		X Q4			X	X		X			X	
Draft LPT Quality Accounts 2018-19	AS	X	X	X ?						X	X	X	X
Quality Strategy QIP Update	AS		X						X			X	
Quality Schedule and CQUINS update	AS	X			X			X			X		
Internal Audit tracker	KD				X			X					
Community MH service user survey report 2018	AS										X		
Medicines Optimisation Strategy	AO		X										
Risk Management Strategy(and reviews)	KD							X					
Review of QAC ToRs (at least annually)	AC/SL												X

Mid year review of QAC objectives and on track with workplan	AC/LR							**or X**		**X**		**X**	
QAC Annual Report	LR/AC/SL	**X**											
QAC work-plan	LR/AC/SL	**X**											
R&D Quarterly Awareness Performance Report	SC	**X**			**X**			**X**			**X**		
Clinical Audit Annual Report	Medical Director (CEG Chair)						**X**	**X**					
Declaration of Single Sex Accommodation	LB	**X**											
Sexual Safety Annual report 2017-18	KD				**X**					**X**	**X**	**X**	**X**
Self-regulation quarterly report	KD	**X**	**X**			**X**	**X**		**X**	**X**	**X**		
Sub group Annual review (all groups)	Chairs	**X**											
Clinical Effectiveness Group-verbal as required	Medical Director												

Quarterly Overview Report	Medical Director	**X**			**X**		**X**			**X**	**X**		
future plans for clinical audit	Medical Director (via CEG)								**X**				
Clinical Outcomes	Medical Director								**X**				
Patient Safety Group-verbal as required	AH										**X**	**X**	
Quarterly Overview Report							**X**			**X**			**X**
Patient and Carer Experience Group-verbal as required and quarterly via patient experience report	AS												
Health & Safety Committee-verbal as required	BK												
Quarterly Overview Report				**X Q3**		**X Q4**		**X Q1**				**X Q2**	
Infection Control-	EW												
Quarterly Overview Report				**XQ4**			**XQ1**			**XQ2**			**XQ3**
Flu vaccination update	EW									**X**	**X**	**X**	**X**

Mortality & Morbidity Surveillance Group- quarterly report	Medical Director		X			X			X			X	
Safeguarding Committee-monthly report	AS (MC to present)	X	X	X	X	X	X	X	X	X	X	X	X
Safeguarding Annual Report	AS				X								
Policies - Board Adoption Template	FL	X	X	X	X	X	X	X	X	X	X	X	X
External visits	FL	X	X	X	X	X	X	X	X	X	X	X	X
Mental Health Act reviewer six monthly analysis	KD			X						X			
Clinical Excellence Awards	Angela Salmen												
Anti microbial Stewardship Annual review (via IPCC)	Tejas Khatau			X			X						

Appendix 2 Terms of Reference

Leicestershire Partnership NHS Trust

Governance arrangements for the Quality Assurance Committee

July 2019

Contents

1 Terms of Reference

Quality Assurance Committee

Terms of Reference

1.0 Constitution

The Trust Board has established a committee known as the Quality Assurance Committee (the Committee) reporting to the Trust Board, in accordance with standing order 4.

The Committee shall have terms of reference and powers and be subject to conditions, such as reporting back to the Trust Board, as the Trust Board shall decide and shall act in accordance with any legislation and regulation or direction issued by the regulator.

The Committee shall be a Non-executive Director led Committee of the Trust Board comprised of independent Non-executive Directors and Executive Directors with portfolio lead for the Quality and Safety agenda. The Committee has no executive powers, other than those specifically delegated in these terms of reference.

2.0 Purpose of Committee

The role of the Committee is to provide assurance to the Trust Board, that the Trust is properly governed and well managed across the full range of activities and to provide internal and external assurance relating to quality.

The Trust considers clinical engagement and involvement in Trust Board decisions to be an essential element of its governance arrangements and as such the Trust's integrated governance approach aims to mainstream clinical governance into all planning, decision-making and monitoring activity undertaken by the Board.

3.0 Authority

The Committee is authorised by Trust Board to investigate any activities within its terms of reference.

The Committee is authorised by Trust Board to seek any information it requires from any employee of the Trust in order to perform its duties. All employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain, at the Trust's expense, any outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience or expertise, if it considers this to be necessary.

4.0 Membership

The Committee shall be comprised of Non-executive Directors and Directors with quality and safety portfolios.

The membership will include:

- Three independent Non-executive Directors.
- The Director of Nursing who will hold executive responsibility for the Committee
- The Medical Director
- A Service Director

The Chair of the Committee shall be one of the independent Non-executive Directors selected by the Trust Board. In their absence their place shall normally be taken by another independent Non-executive Director.

Membership of the Committee will be reviewed and agreed annually by the Board.

In the situation of a prolonged absence of the Chair or a member of the Committee, the Trust Board will determine a replacement Chair. The Chair of the Trust Board will determine replacement independent Non-executive Director membership and the Chief Executive in consultation with the Chair of the Trust will determine replacement Directors. All replacement members will hold full membership authority unless otherwise agreed. .

5.0 Administration

The Committee shall be supported administratively by The Personal Assistant to the Director of Nursing.

The agenda will be agreed with the Chair following consultation with the Director of Nursing.

The Personal Assistant to the Director of Nursing will support the production of the Committee pack and ensure the pack is circulated within the required timeline of 7 days prior to the meeting, attend the meetings to take the minutes, keep a record of matters arsing and issues to be carried forward and generally provide support to the Chair and members of the Committee. .

6.0 Quorum

The quorum shall be three members of the Committee and must include one independent Non-executive Directors and one Director. A duly convened meeting of the Committee which is quorate shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

Attendance at meetings

Only members of the Committee have a right to attend the Committee; however other officers of the Trust may be invited to attend the Committee either for specific discussion items or for the whole meeting as required by the Committee.

Other Non-executive Directors have an open invitation to attend the Committee as felt appropriate after advising the Chair of the Committee of their attendance.

Any independent Non-executive Director or officer of the Trust who is not part of the normal membership of the Committee will be in attendance at the meeting.

7.0 Frequency of Meetings

The Committee shall meet a minimum of 6 times a year and at such other times as the Chairman of the Committee shall require at the exigency of the business.

The Quality Assurance Committee and the Finance and Performance Committee will additionally hold quarterly joint meetings to discuss key joint agenda issues and report jointly to the Board. Separate governance arrangements are in place for the management of the joint meeting.

Members will be expected to attend at least three-quarters (75%) of all meetings.

8.0 Agenda/Notice of Meetings

Unless otherwise agreed, notice of each Quality Assurance Committee meeting will confirm the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

The agenda for each meeting will include an item “Declarations of interest in respect of items on the agenda”.

9.0 Minutes of Meetings

Minutes of Committee meetings shall be circulated promptly to all members of the Committee and, once agreed, to the secretary of the Trust Board. The Committee’s minutes will be open to scrutiny by the Trust’s auditors.

The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

10.0 Duties

The Quality Assurance Committee supports the work of the Trust Board in ensuring a balanced and integrated approach to

- clinical focus, engagement and governance; Clinical Audit
- patient/stakeholder involvement
- performance management
- strategy management

The Committee is responsible for providing assurance to the Trust Board, on the effectiveness of the Trust’s arrangements for quality, ensuring there is a consistent

approach throughout the Trust, specifically in the areas of quality, effectiveness, patient experience and clinical & research governance, the Committee will review the adequacy and effectiveness of:

The underlying assurance processes that support achievement of the corporate objectives and the management of clinical principle risks specific to quality including:

- Assurance Framework
- Aspects of the Annual Governance Statement related to quality
- Clinical risks assigned to the Committee in line with the Risk Management Strategy
- Clinical audit programme
- Policies and procedures related to quality
- Quality Improvement Strategy
- Complaints report
- Pressure ulcer/infection control reports
- Privacy and Dignity Annual Declaration
- Safeguarding report
- Research and Development quarterly performance report
- Professional Revalidation reviews
- Clinical Excellence Awards

Compliance with all applicable legal and regulatory requirements in particular those of the CQC and NHS Improvement, and including:

- Patient involvement and information (including complaints, compliments and claims)
- Personalised care, treatment and support
- Safeguarding and safety (including infection control)
- Quality management (including SIs, notifications, complaints and records
- Statutory reports (including Quality Account)
- Compliance with quality national and local mandatory targets
- All other aspects of patient experience, safety and effectiveness including waiting times and outcomes

Ensure cost improvement programmes have had a quality impact assessment.

Ensure there is an understanding of the key issues being identified by internal audit reports associated to work of the Committee.

In carrying out this work the Committee will seek reports and assurance from Directors and Managers as appropriate, concentrating on the over-arching systems of quality governance and clinical risk management together with indicators of their effectiveness.

To scrutinise the Services on their performance against Quality Indicators that includes the relevant strategic objectives and the priorities set out in the Quality Account, and to monitor the key performance indicators relevant to all areas of quality.
To review reports from such bodies as Internal Audit, Audit Commission, National Confidential Inquiries, etc., to assure itself and the Trust Board that the necessary

steps are being taken to deal with any issues raised and that action plans are being implemented and reviewed.

To initiate and monitor investigation of areas of serious concern as necessary, and policies to be developed, and ensure resulting action plans are implemented.

To receive exception reports of outcomes of **external** reviews, inquiries, surveys and investigations, with assurance that any lessons learnt have been implemented to ensure delivery of the highest quality of services, and to capture any risks to Patient Safety and Care outcomes.

To receive exception reports of outcomes of **internal** activity, e.g. from clinical audits, site visits and other clinical governance activities, and to capture any risks to Patient Safety and Care outcomes. To provide assurance and challenge of clinical audits across the organisation.

To receive assurance of compliance with agreed best practice, e.g. NICE guidance, guidance that emerges from national confidential enquiries, high level enquiries and other nationally agreed guidance, and to ensure the capture of any risks to Patient Safety and Care outcomes. To ensure appropriate performance and focus of its sub-groups and to receive an annual report from each.

11.0 Reporting Responsibilities:

The Committee shall make whatever recommendations to the Trust Board that it deems appropriate on any area within its remit where action or improvement is needed.

The Committee shall produce for the Trust Board an annual report on the work it has undertaken during the course of the year.

12.0 Annual Review

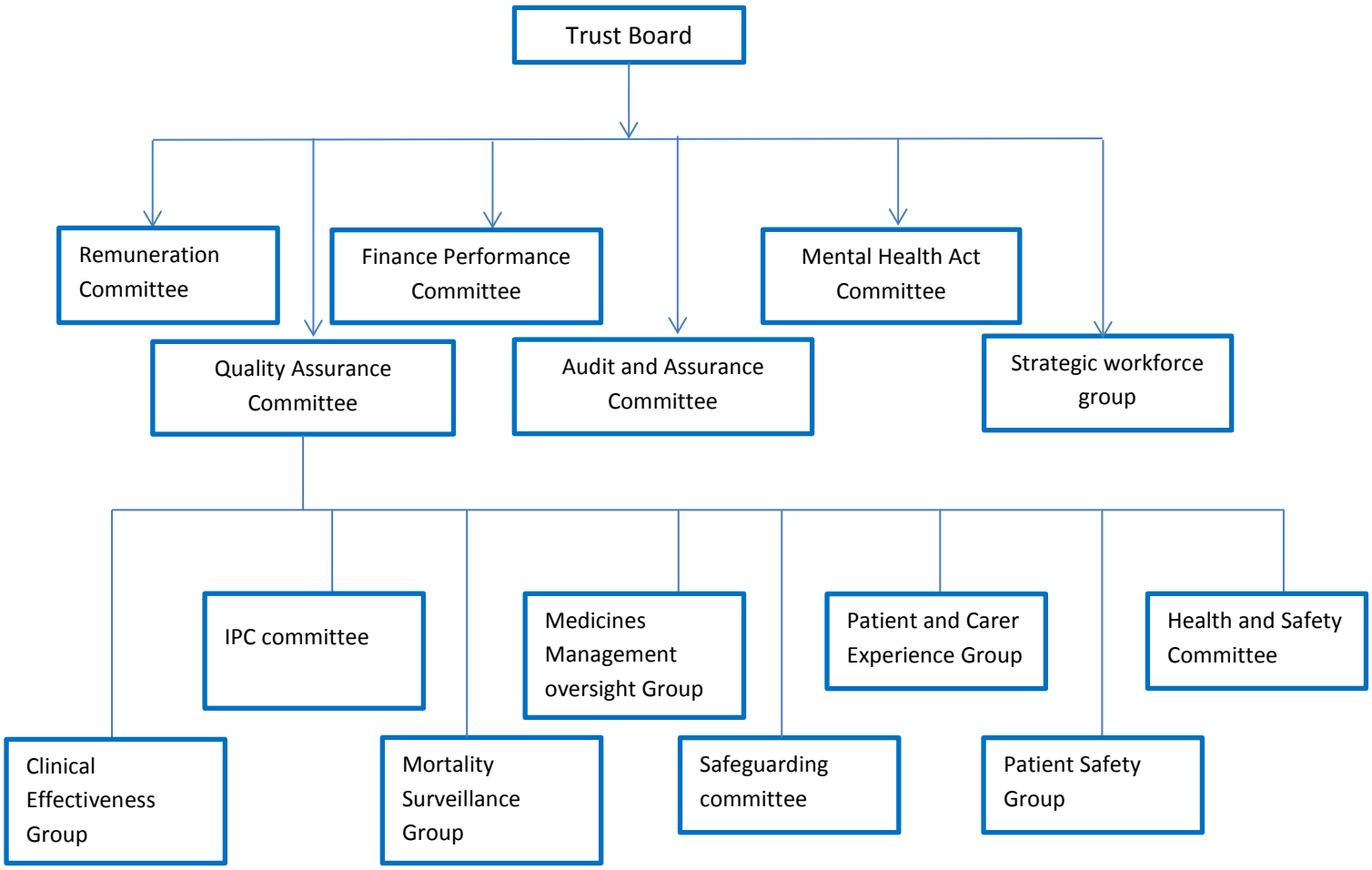
The Committee shall, at least once a year, review its own performance, constitution and Terms of Reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Trust Board for approval.

13.0 Risk Responsibility

The risk areas the Committee has special responsibility for will be those that fall within the remit of this Committee.

Author	Interim Associate Director of Corporate Governance
Owner	Quality Assurance Committee
Date of Issue	August 2019
Version #	
Approved by	Trust Board
Review date	July 2020

2 Governance structure



3. Membership- details of officers attending

	Quality Assurance Committee
Membership	• NED **(chair)** • NED x 2 • Director of Nursing **(Executive Lead)** • Medical Director • Service Director
In attendance	• Deputy Director of Nursing • Director of Human Resources & OD • Head of Assurance • Commissioner Representative • Head of Pharmacy • Clinical Director (Adult Mental Health and Learning Disabilities Service) • Clinical Director (Community Health Services) • Clinical Director (Family, Young People, and Children's' Services) • (Service CDs may appoint a designated representative, e.g. a Specialist Clinical Director) • Other managers will be invited to attend as and when required
Frequency	Not less than 6 times per 12 months
Day and times	9.00 am on Tuesday of third week

4. Work programme

Quarter 1	**Meeting 1 – April** **Standing items** • Annual Review of Governance structure for the Committee • Annual Report • Declaration of single sex accommodation • Annual Governance Statement • Accessible information standards (six month report) **Quarterly reports** • Quality Account • CQUIN report • Patient and Carers Experience and Involvement report • Combined learning from complaints, concerns, incidents and claims report • Positive and safe and seclusion report • R&D performance report • Clinical Effectiveness Group report **Monthly reports** • SI report • Complaints report • Assurance Framework • Corporate Risk Register • Integrated Quality and Performance report • CQC compliance report	**Meeting 2 – May** **Standing items** • Caldicott guardian report • Medicines Optimisation Strategy • Sub-group Annual Review • Draft Quality Account **Quarterly reports** • Overview report • Mortality and Morbidity Surveillance report • Health and Safety • Clinical Audit report • Internal Audit report • Self-regulation quarterly report • Patient Safety report • Positive and Safe Seclusion report • Quality strategy QIP update including CQUINS **Monthly reports** • SI report • Complaints report • Assurance Framework • Corporate Risk Register • CQC compliance report • Safeguarding report • Policy report • Integrated Quality and Performance report	**Meeting 3 - June** Quarterly joint meeting with Finance and Performance Committee **Standing items** • Quality Improvement Committee • External agencies report **Quarterly items** • Clinical Effectiveness Group • Infection prevention control (Inc. Flu vaccination campaign) • Cost improvement programme • Quality strategy QIP update including CQUINS **Monthly items** • SI report • Complaints report • Assurance Framework • Corporate Risk Register • CQC compliance report • Safeguarding report • Policy report • Integrated Quality and Performance report • Patient safety improvement group report

	• Safeguarding report • Policy report • Patient safety improvement group report • External visits • Directorate highlight reports	• Patient safety improvement group report • External visits • Directorate highlight reports	• External visits • Directorate highlight reports

Quarter 2	**Meeting 4 – July** **Standing items** • Annual Safeguarding report **Quarterly report** • Quality Account • CQUIN report • R&D awareness performance report • Learning from serious incidents • Patient and Carers Experience and Involvement Report • Combined learning from complaints, concerns, incidents and claims report • Positive and safe and seclusion report • R&D performance report • Safeguarding annual report • Clinical Effectiveness Group report **Monthly report** • SI report • Complaints report • Assurance Framework • Corporate Risk Register • CQC compliance report • Safeguarding report • Policy report • Integrated Quality and Performance report • Patient safety improvement group report • External visits • Directorate highlight reports	**Meeting 5- August** **Standing items** **Quarterly items** • Overview report • Mortality and Morbidity Surveillance report • Health and Safety • Internal Audit reports • Self-regulation quarterly report • Patient Safety report • Positive and safe seclusion report • Patient and Carers Experience and Involvement Report • Quality strategy QIP update including CQUINS **Monthly items** • SI report • Complaints report • Assurance Framework • Corporate Risk Register • CQC compliance report • Safeguarding report • Clinical Audit report • Policy report • Integrated Quality and Performance report • Patient safety improvement group report • External visits	**Meeting 6- September** Quarterly joint meeting with Finance and Performance Committee **Standing items** • Clinical annual audit report • Sexual safety annual report • PLACE update (six monthly) • Mid-year review **Quarterly reports** • Clinical Effectiveness Group • Infection prevention control (Inc. Flu vaccination campaign) • Cost improvement programme **Monthly reports** • SI report • Complaints report • Assurance Framework • Corporate Risk Register • CQC compliance report • Safeguarding report • Policy report • Integrated Quality and Performance report • Patient safety improvement group report • External visits • Directorate highlight reports

		• Directorate highlight reports	
Quarter 3	**Meeting 7 – October** **Standing items** • Accessible information standards (six month report) **Quarterly reports** • Quality Account • CQUIN report • R&D awareness performance report • Patient and Carers Experience and Involvement report • Combined learning from complaints, concerns, incidents and claims report • Positive and safe and seclusion report • R&D performance report • Clinical Effectiveness Group report **Monthly reports** • SI report • Complaints report • Assurance Framework • Corporate Risk Register • CQC compliance report • Integrated Quality and Performance report • Patient safety improvement group report • External visits • Directorate highlight reports	**Meeting 8 – November** **Standing items** • External agencies report **Quarterly reports** • Overview report • Mortality and Morbidity Surveillance report • Health and Safety • Internal Audit reports • Self-regulation quarterly report • Patient Safety report • Positive and safe seclusion report • Patient and Carers Experience and Involvement Report • Quality strategy QIP update including CQUINS **Monthly reports** • SI report • Complaints report • Assurance Framework • Corporate Risk Register • CQC compliance report • Clinical Audit report • Integrated Quality and Performance report • Patient safety improvement group report • External visits	**<u>December – No meeting</u>**

		• Directorate highlight reports	

Quarter 4	**Meeting 9 – January** Quarterly joint meeting with the Finance and Performance Committee **Standing items** • Information for the next Quality Account • Community MH Service User report • Clinical Effectiveness Group report • Infection prevention control **Quarterly reports** • Quality Account • CQUIN report • R&D awareness performance report • Learning from serious incidents • Patient and Carers Experience and Involvement Report • Combined learning from complaints, concerns, incidents and claims report • Positive and safe and seclusion report • R&D performance report • Clinical Effectiveness Group **Monthly reports** • SI report • Complaints report • Assurance Framework • Corporate Risk Register	**Meeting 10 – February** **Standard report** • Inpatient MH Survey • PLACE update (six monthly) **Quarterly Report** • Overview report • Mortality and Morbidity Surveillance report • Health and Safety • Internal Audit reports • Self-regulation quarterly report • Patient Safety report • Patient and Carers Experience and Involvement Report • Quality strategy QIP update including CQUINS **Monthly report** • SI report • Complaints report • Assurance Framework • Corporate Risk Register • CQC compliance report • Safeguarding report • Policy report • Integrated Quality and Performance	**Meeting 11 – March** Quarterly joint meeting with the Finance and Performance Committee **Standing items** • Year-end Quality Account **Quarterly items** • Clinical Effectiveness Group • Infection prevention control (Inc. Flu vaccination campaign) **Monthly items** • SI report • Complaints report • Assurance Framework • Corporate Risk Register • CQC compliance report • Safeguarding report • Policy report • Integrated Quality and Performance report • Patient safety improvement group report • External visits • Directorate highlight reports

	• CQC compliance report • Safeguarding report • Policy report • Integrated Quality and Performance report • Patient safety improvement group report • External visits • Directorate highlight reports	report • Patient safety improvement group report • External visits • Directorate highlight reports	

Leicestershire Partnership NHS Trust

Mental Health Act Assurance Committee (MHAAC)

ANNUAL REPORT
Year 2018-2019

Chair of Committee: **Faisal Hussain, Non-Executive Director**

Section A – Fulfilling Terms of Reference

1. Review of Terms of Reference (ToR)

- All duties identified within the approved Terms of Reference (ToR) were executed appropriately during the year.
- The MHAAC members are revising the ToR for 2019-2020, (to ensure outcomes of the governance review are reflected going forward).
- Faisal Hussain, Non–Executive Director continues as permanent Chair for the MHAAC.
- Over the last year each meeting of the MHAAC was quorate (two members are required to attend). Quoracy to be minuted at each meeting.

2. Assurance

- The committee has maintained the robustness of the assurance it requires. The evidence reviewed regularly at the MHAAC includes: the MHA Dashboard which monitors activity and outcome data; the MHA Audit; the MHA Census programme which tests outcomes at the point of care which has been subject to ongoing review in-year; mandatory training compliance for trained nurses and medics; highlight reports from services and emerging risks
- Where assurance is not considered robust further assurance is sought and captured in an action log until the committee is assured.
- The Chair re-visits actions to be entered on the action log at the end of each meeting.
- MHAAC has requested further analysis on recurring issues and themes which get picked up by CQC and others to satisfy we are getting proper assurance and to ensure measures are in place to remedy these.

3. Analysis of Risks

- The committee considers and reviews risks for escalation at every meeting; the Trust Board receives risks in the form of the Board Highlight report.

4. Work plan

- The work plan is evidence of the discharging of the ToR for the committee. The work plan is used in conjunction with the action log to inform setting the agenda for each meeting.
- The Service highlight reports provide flexibility where services can raise any emerging issues or risks outside of the agreed work plan.

Section B – Reflection upon Working Practices

5. Effectiveness of Committee discussion

a) How effectively is the Group Chaired?

- Chair arrangements have been highlighted in Section A above. The meeting agendas are distributed in a timely manner allowing for members to read prior to the meetings. The agenda is well managed and relevant to the work of the committee. On occasion the meeting has

exceeded its two hour time slot but members felt that this is for a justified reason as discussion is well controlled by the Chair. MHAAC is considering extending its meeting time to 2.5 hours, subject to agreement.

- An action log is maintained to monitor unresolved issues. Actions within the action plans should be SMART with a specific date for completion.
- All members are provided the opportunity to contribute and participate in discussions. Staff in regular attendance are invited to present a Service highlight report to the committee at each meeting, to share good practice.
- The minutes of the meeting are produced by the Quality Support Officer and reviewed prior to circulation to members to ensure that issues have been appropriately summarised and outcomes made clear. Challenge at the meeting to be clearly documented in the minutes.
- A meeting is held between the Committee Chair, Medical Director and the Regulation and Assurance Lead to set the agenda in line with the work plan, although this has been a challenge due to changing members of the Assurance Team.
- MHAAC will continue to develop based on the recommendations from the governance review.

b) Do all members contribute?

- An attendance log is maintained for each meeting with attendance by members recorded by the Quality Support Officer. Other staff in regular attendance enables effective communication and contribution to the agenda at each meeting.
- Members are fully prepared when attending meetings and are able to contribute to discussion, challenge, analysis and outcomes for each meeting.
- Challenge within the meeting enables further examination of issues and Committee, rather than individual, decision making to take place.
- Through the maintenance of an action log members can shape the meeting agenda. All members are offered an opportunity to raise any other business at every meeting.
- Members are able to add matters arising to the Agenda.

6. Communication channels

a) Communication to and from members

- Draft agendas are circulated to members two weeks prior to the meeting to enable members to prepare papers in a timely way. Each member has a copy of the agreed work plan.
- Papers are generally submitted within the required timeframe, but on occasion some papers are submitted and subsequently distributed less than the required five working days. Where this happens, late papers will not be included at the meeting unless prior authorisation is obtained from the Medical Director or Chair.
- A Highlight report to the Board is prepared after each MHAAC meeting which includes those issues requiring escalation to the Trust Board.

b) Quality of papers

- Papers do not always have a front sheet but are on the whole at an acceptable standard however, going forward there will be greater emphasis on the purpose, focus and recommendation of the reports.
- Future papers will be required to be focused containing clear details of requirements of the MHAAC and how this will influence sustainable change.
- Papers are presented by their author but on occasion a Deputy is nominated and accepted for attendance by the Chair.
- Papers will need to reflect how they support the implementation of the Trusts strategic priorities and values.

c) Quality of minutes

- The minutes reflect the discussion and agreed outcomes and there are rarely amendments to be made during the draft minute approval process.
- Effort is required to ensure that the narrative is comprehensive.

d) Information flows with Parent Committee

- The MHAAC receives highlight reports from the Quality Improvement Collaborative (QIC) and Panel Members Group (PMG) on a planned basis.
- The Chair/management leads of the QIC/PMG are regular members of the MHAAC which ensures efficient feedback between these groups and the MHAAC.

7. Key Achievements and Barriers

- Multi-agency working around the MHA has been strengthened.
- Embedding the census into practice
- Deep dive work has been commissioned into Section 17 leave and the use of CTO's (this work is ongoing, due to be completed summer 2019).
- Improvements in training and support for all staff in the use of the Act.
- Provided a forum for continued discussion and review.
- The use of the large Committee Room can feel intimidating.
- A change of personnel can lead to actions being delayed as there is a lack of resource to support the ongoing work.

8. Future Plans

- Priorities identified by the MHAAC for 2019-20 have been agreed as -
    1. To further strengthen systems and assurances associated with the use of Community Treatment Orders in community based mental health services including application and testing of Section 132 and subsequently the MHA training programme delivered to community nurses
    2. Stronger consideration of lessons learnt from MHA reviewer visits and escalation of issues identified. Committee to decide where findings are repetitive whether a 'deep dive' is justified.
    3. Standard item of CQC action / sustainable evidence to be added to the Agenda.
    4. A focus on the transition to a single EPR
    5. A focus on Quality Improvement methodology to further improve our census results
    6. A focus on improving bank staff training
    7. Drive the focus on continuous quality improvement.
    8. Medical staff and key leads to drive the focus and support the delivery of the Trust's strategic priorities.

- Appended are the approved Work plan for 2019-20 and a Draft ToR (subject to Board approval)

Revised Version 4, 24/04/19

Leicestershire Partnership NHS Trust

Mental Health Act Assurance Committee

Terms of Reference

References to "the Committee" shall mean the MHA Assurance Committee

1.0 Purpose of Committee

1.1 The Mental Health Act Assurance Committee is responsible for providing assurance to the Board of the organisations compliance with its delegated statutory and regulatory responsibilities in accordance with the requirements of the Mental Health Act 1983, (as amended in 2007) ("the Act") and associated Code of Practice.

2.0 Clinical Focus and Engagement

2.1 The Trust considers clinical engagement and involvement in Board decisions to be an essential element of its governance arrangements and as such the Trust's integrated governance approach aims to mainstream clinical governance into all planning, decision-making and monitoring activity undertaken by the Board.

3.0 Authority

3.1 The Committee is authorised by Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee who are directed to co-operate with any request made by the Committee.

3.2 The Committee is also authorised by Trust Board to obtain outside legal or other independent professional advice and to secure the attendance of external people with relevant experience and expertise if it considers this necessary.

4.0 Membe[illegible]

4.1 Membership of th[illegible]
A Non-Executive Director
Chief Nurse or Medical Director (subject to approval from Tru[illegible]retary)

4.2 The Chair of the Committee is the Non Executive Director.

4.3 In the event of the absence of the Non Executive Director the meeting shall be chaired by the Trust Chair.

In the absence of both the Non Executive Director and Trust Chair, either the Medical Director or Chief Nurse will deputise as Chair

4.4 Attendance

Only members of the Committee have the right to attend Committee meetings. However, other individuals and officers of the Trust may be invited to attend for all or part of any meeting as deemed appropriate. Officers of the Trust in regular attendance include:

Regulation and Assurance Lead
Senior Mental Health Act Administrator

Service MHA Leads – a nurse and medic representing each Directorate

Deputy Medical Director
Clinical Audit team representative

External representatives i.e. Local Authorities/Clinical Commissioning Groups may be invited to attend meetings as necessary.

5.0 Secretary

The Quality Support Officer will act as secretary of the Committee.

6.0 Quorum

6.1 The quorum necessary for the transaction of business shall be two members. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

7.0 Frequency of Meetings

7.1 The Committee shall meet on a bi-monthly basis.

7.2 Members will be expected to attend at least three-quarters (75%) of all meetings.

8.0 Agenda/Notice of Meetings

8.1 Notice of meeting dates, venues and times shall be sent to all members at the beginning of every year.

8.2 Further confirmation shall be sent to members, and any identified persons attending, together with an Agenda no less than 5 working days before the meeting.

8.3 Supporting papers for the meeting should be submitted to the Secretary no less than 10 working days prior to the date of the meeting for distribution with the Agenda.

8.4 The Mental Health Act Lead Officer will have responsibility for obtaining information and ensuring that it is sent to [illegible] Support Officer and circulated as appropriate.

8.5 The agenda for each meeting will include an item "Declarations of interest in respect of items on the agenda".

9.0 Minutes of Meetings

9.1 The secretary shall minute the proceedings and resolutions of all Committee meetings, including whether the meeting was quorate, the names of those present and in attendance.

9.2 Minutes of Committee meetings shall be circulated promptly to all members of the Committee and, once agreed, to the secretary of the Trust Board. The Committee's minutes will be open to scrutiny by the Trust's auditors.

10.0 Duties

The Committee shall:

10.1 Monitor compliance of key MHA policies and procedures and the effectiveness of the Trust's implementation, and compliance with current mental health legislation and the Code of Practice. .

10.2 To approve policies in relation to the Mental Health Act and scrutinise the application of the policies throughout the Trust (commensurate with Appendix 1) to this Terms of Reference. The Senior Mental Health Act Administrator is responsible for managing the database of MHAAC policies and procedures and will advise the committee which policies are current and when they require to be updated. The Senior MHA Administrator may offer advice to policy authors responsible for other Trust Policies that impact on the MHA and Code of Practice.

10.3 To consider the implication of any changes to legislation and regulations within a local context.

10.4 To benchmark and commission improvement initiatives for MHA legislative compliance informed by outcomes indicated on the MHA Dashboard/other as necessary.

10.5 To receive Highlight reports as necessary from Managers Panel Members in undertaking their delegated duties under section 23 of the Act.

10.6 To receive assurance that there is an appropriate number of Hospital Managers in place with the appropriate skills and experience to fulfil their role.

10.7 To address training issues in terms of delegation of responsibilities under the Mental Health Act 1983.

10.8 To manage risks identified and delegated by Trust Board and to identify and report to Trust Board any new risks that require escalation.

10.9 To receive reports following Care Quality Commission visits for information and comment and ensure appropriate action is agreed and implemented within the organisation.

10.10 To seek assurance on the development and delivery of action plans from services, following MHA Commissioner Inspection reports.

10.11 To receive assurance that MHA training is carried out and that accurate records are maintained including an annualised summary of training course evaluations.

10.12 To be aware of the work of multiagency partners for MHA legislative compliance to ensure system–wide effectiveness for compliance.

10.13 To receive a Highlight report following each meeting of the Quality Improvement Collaborative in undertaking their duties as agreed through their Terms of Reference.

10.14 To receive a Highlight report from each Directorate to communicate any emerging risks or compliance issues with mental health legislation/Code of practice requirements.

10.15 To request specific reports relevant to the application of the Mental Health Act, as necessary.

11.0 Reporting Responsibilities:

11.1 The Committee shall make whatever recommendations to the Trust Board it deems appropriate on any area within its remit where action or improvement is needed.

11.2 The Trust Board will receive the Highlight Report of the Committee at the next Trust Board meeting following each Committee meeting.

11.3 The Committee shall produce for the Trust Board an annual report on the work it has undertaken during the course of the year.

12.0 Annual Review

12.1 The Committee shall, at least once a year, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Trust Board through its annual report.

13.0 Risk Responsibility

13.1 The risk areas the Committee has special responsibility for will be those that fall within the remit of this Committee.

Appendix 1 – MHAAC list of policies/procedures (currently under review).

Leicestershire Partnership NHS Trust

Strategic Workforce Group

ANNUAL REPORT
Year 2018/2019

Chair of Committee: Dr Peter Miller - CEO

Section A – Fulfilling Terms of Reference

1. Review of Terms of Reference

- All duties identified within the Terms of Reference (ToR) were executed appropriately during the year.
- The membership of the committee remained appropriate throughout the year enabling the committee to address all areas of business.
- The Committee receives regular reports from the reporting committees and groups .Their ToR and annual reviews are considered by the Committee on an annual basis.
- The committee covered all areas it is responsible for in relation to the strategic objectives and reviewed all the associated risks on a regular basis.
- The committee has an annual work plan that enables it to consider workforce risks on the Board Assurance Framework and Corporate Risk Register in detail, and this was executed during 2018– 2019.
- The ToR have been amended as part of this annual review in line with changes to the organisation.

Section/Term	Current Wording	Proposed Revised Wording
10.4	Review and develop the leadership and talent management approach.	Review and develop the culture and leadership and talent management approach.
10.15	To receive on behalf of Trust Board the following:- • Consultant appraisals and revalidation annual report • Revalidation for Nurses and Allied Health Professionals (update on progress and annual report) • Recruitment Strategy – update • Equality Delivery System 2.	To receive on behalf of Trust Board the following:- • Consultant appraisals and revalidation annual report • Revalidation for Nurses and Allied Health Professionals (update on progress and annual report) • Recruitment Strategy – update • Equality Delivery System 2. WRES, WDES, Gender Pay Gap • Clinical Supervision Reports

2. Assurance

- The committee has maintained the robustness of the assurance it requires and requests that evidence is provided to the committee to complement the assurance provided. This has been in the form of audits, minutes of meetings and evidence of changing practice also monthly divisional workforce highlight reports. Where assurance is not considered robust enough further assurance is sought until the committee is content with the evidence provided. Specific areas for detailed assurance have included mandatory training, bank and junior doctor compliance, recruitment and retention, agency usage sickness absence and assurance regarding the CQC action plan.

- The Committee uses all available sources of assurance including the IQPR, risk registers, action log, in depth reports on specific issues, internal audit reports and external reviews.

3. Analysis of Risks

- The committee reviews all workforce risks on the BAF in every committee requesting appropriate updates on controls assurances and actions as appropriate.

4. Work Plan

- The work plan is evidence of the discharging of the Terms of Reference for the Committee.
- The work plan is used in conjunction with the action log to inform agendas for the Committee.
- The work plan enables flexibility to ensure any urgent or pressing issues can be considered in a timely way.

Section B – Reflection upon Working Practices

5. Effectiveness of Committee discussion

a. How effectively is the Group Chaired?

- The Group is chaired by the CEO (occasionally by Director of HR and OD). The agendas are long due to the number of issues that the committee is required to consider. The agenda is managed well and the committee always ensures it deals with essential business. The committee is inclusive and all attendees have the opportunity to contribute. On occasion the meeting exceeds its time allotment but not usually by more than 15-30 minutes.
- The action log has been developed. Actions are followed up by the administrator of the Committee and action owners are prompted to provide timely updates to the Committee.
- All members are provided the opportunity to contribute and participate in discussions.
- The minutes of the committee are comprehensive and reviewed by the chair and lead director prior to being circulated. There is also opportunity in the meeting where issues are clarified along with actions; this includes identifying issues for the highlight report to Trust Board.
- The chair summarises discussions and actions.

- The work plan is reviewed on a monthly basis by the Committee Chair and executive lead to ensure all aspects are covered therefore no elements of it have not been fulfilled.
- The committee asked its members to review effectiveness of the committee there was reference to the time allocation of the meeting however not requirement to amend it.

b. Do all members contribute?

- Attendance in line with the ToR.

Board Member	May 2018	July 2018	Sept 2018	Nov 2018	Jan 2019
Rachel Bilsborough, Director of Community Health Services	YES	NO	NO*	NO**	NO***
Adrian Childs, Chief Nurse/Anne Scott Acting Chief Nurse	YES	YES	YES	YES	NO
Ruth Marchington, Non-Executive Director			YES	NO	YES
Pete Miller, Chief Executive Officer	YES	YES	YES	YES	YES
Saquib Muhammad, Interim Medical Director/Sue Elcock Medical Director	YES	YES	YES	NO	NO
Geoff Rowbotham, Non-Executive Director*	YES	YES	NO	YES	NO
Helen Thompson, Director of FYPC Services	YES	YES	YES	YES	NO***
Sarah Willis, Director of HR & OD	YES	YES	YES	YES	YES

**Deanne Rennie, Speech and Language Therapy Clinical Lead for Speech Language and Communication Needs Acting AHP Lad/Jude Smith, Head of Nursing in attendance*

***Jude Smith, Head of Nursing in attendance*

****Jules Galbraith/head of Services CRR/LD & Jude Smith Head of Nursing in attendance/Mark Roberts Assistant Director FYPC in attendance*

In relation to the percentage of attendance for those meetings, it is as follows;	
Rachel Bilsborough, Director of Community Health Services	100%
Adrian Childs, Chief Nurse/Anne Scott Acting Chief Nurse	80%
Ruth Marchington, Non-Executive Director/ Geoff Rowbotham, Non-Executive Director	100%
Pete Miller, Chief Executive Officer	100%
Saquib Muhammad, Interim Medical Director/ Sue Elcock Medical Director	60%
Helen Thompson, Director of FYPC Services	100%
Sarah Willis, Director of HR & OD	100%

- An attendance list is maintained for the committee and members achieve good attendance. Where members are not able to attend they are encouraged to ensure a deputy is in attendance to maintain effective communication and contribution throughout the organisation. All meetings have met the ToR quoracy.
- Members are fully prepared when attending meetings.
- Challenge is present across the full agenda, enabling further examination of issues and ensuring full comprehension.

6. Communication Channels

a. Communications to and from members

- Draft agendas are circulated to members within ten days of the previous meeting thus enabling members to prepare papers in a timely way.
- Most papers are submitted within good time, a standard for timeliness and distribution of the full agenda has been set, although occasional papers have been late. We do not use standard front sheets.
- The agenda is prepared by the Director of HR and OD in conjunction with the chair paying reference to the action log, previous discussions and the work plan also current organisational workforce issues to ensure pace on response to issues.
- Draft minutes are produced as soon as is possible, however this is not always within five working days of the meeting taking place.

b. Quality of papers

- Papers are of a good standard, progress has been made on ensuring that the papers are more focussed on the strategic approach and assurance on delivery (or risks of non-delivery).
- The majority of papers are presented by their author, on occasion the committee will invite paper authors to attend if they do not normally attend. If the Committees needs have not been met, it has rescheduled the paper to ask the author to attend to clarify issues and enable further challenge.

c. Quality of minutes

- The minutes are comprehensive, maintained on a database and document challenge and levels of assurance where possible.
- The recommendations to the Committee are reviewed at the end of a discussion on a paper and are recorded within the minutes with any further action required.

d. Information flows with Parent Committee

- The group receives timely feedback by way of highlight reports from the relevant reporting subcommittees, and reports regularly to the board

7. Achievements and Barriers

The top noted achievements of the committee are:

- Growing our own, recruitment and retention
- Reduction in Agency spend and reduction in use of off framework workforce
- Focus on WRES
- Increasing response rate to staff survey
- Improving performance on appraisals
- Improving performance on clinical supervision
- Reduction in time to recruit
- Retention actions linked to NHSI programme
- Increase in staff survey response rate
- Clear offer with regards leadership and management support

The volume of work coming to the committee is large however this is balanced with more detailed work going to the Executive team allowing for the committee to focus on the strategic approach and assurance as to whether the approach is working.

8. Future Plans

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- Focus on the Culture and Leadership programme and the design and implementation phase which will inform the future Workforce Strategy.
- Focus on the Workforce Race Equality agenda – equality diversity and inclusion.
- Appended are the Annual Work-plans for and 2019/20 and the Terms of Reference
- Be responsive to the STP / ICS and system workforce challenges/ NHS long term plan.
- Continue to develop and assure the response to the staff survey.
- Reviewing the Trust wide progress against recruitment and retention.
- Focus on Career development pathways and grow own workforce models and plans.
- Ensuring we meet the requirements of developing workforce safeguards.
- Supporting alignment of workforce transformation with quality improvement
- Supporting workforce Transformation programmes.

Dr Peter Miller
CEO –
Sarah Willis Director of HR & OD

March 2019

Leicestershire Partnership NHS Trust

Strategic Workforce Group
Terms of Reference
References to "the Group" shall mean the Strategic Workforce Group

1.0 Purpose of Group

1.1 The purpose of the Group is to provide Board level focus and engagement with the strategic objective of "Staff will be proud to work here and we will attract and retain the best people"

2.0 Clinical Focus and Engagement

2.1 The Trust considers clinical engagement and involvement in strategic and operational decisions to be an essential element of its governance arrangements and as such the Trust's integrated governance approach aims to mainstream clinical governance into all planning, decision-making and monitoring of activity undertaken.

2.2 Strategies and plans will follow standard consultation channels where applicable.

3.0 Authority

3.1 The Group will advise the Trust Board and Executive Team on matters within its duties.

4.0 Membership

4.1 Chair of the Group will be the Chief Executive. Other members are the Director of HR & OD, Medical Director, Chief Nurse, an Executive Service Director, and a Non-Executive Director. Other staff will be invited to attend as required to support the work of the Group including Heads of Service and Head of Communications

5.0 Secretary

5.1 Secretarial support will be provided from Directorate of HR & OD.

6.0 Quorum

6.1 The quorum necessary for the transaction of business shall be three members. A duly convened meeting of the Group which is quorate shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

7.0 Frequency of Meetings

7.1 The Group shall normally meet bi-monthly and at such other times as the Chair shall require at the exigency of the business.

7.2 Members will be expected to attend at least 75% of all meetings.

8.0 Agenda/Notice of Meetings

8.1 Notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed shall be forwarded to each member of the Group, and any other person required to attend.

8.2 Papers must be received at least five days in advance of the meeting and will be issued 5 working days prior to the meeting.

8.3 The agenda for each meeting will include an item “Declarations of interest in respect of items on the agenda”.

9.0 Minutes of Meetings

9.1 Formal meeting minutes will be taken. Summary meeting notes will consist of actions, decisions and identified risks. An action log will be maintained.

10.0 Duties

The Group’s duties are to:

Strategic:

10.1 Review and develop the HR and Organisational Development strategies and plans for fit for purpose to support the requirements of both the Trust and the wider health economy.

10.2 Review and develop the strategic approach to workforce recruitment, retention and productivity.

10.3 Review and develop the strategic approach to Equalities.

10.4 Review and develop the culture and leadership and talent management approach.

10.5 Review and develop the approach to staff engagement and recognition.

10.6 Review and give response to workforce related organisational change initiatives by exception only.

10.7 Review directorate workforce highlight reports ensure appropriate strategic related work is directed to those groups.

Assurances:

10.8 Receive assurance on the HR aspects of any external/internal compliance reviews that have raised concerns at Board and/or Executive Team.

10.9 Consider whistleblowing efficacy and receive assurance on how workforce concerns raised are being dealt with.

10.10 Review the Board Assurance Framework/Corporate Risk Register high scoring risks for assurance on traction of actions, and adequacy of controls and assurances taken eg mandatory training.

10.11 Consider the results of the annual staff survey and local staff polling and if the overall Trust approach to staff engagement addresses the issues raised. Also receive assurances on the evaluation of the impact of the actions taken.

10.12 Review the programme of action associated with the well-being and healthy workplace agenda.

10.13 Receive assurance on HR & OD policies with adoption of such policies on behalf of the Trust Board.

10.14 Receive assurance on Trust wide use of bank and agency and off payroll engagements.

10.15 To receive on behalf of Trust Board the following:-

- Consultant appraisals and revalidation annual report
- Revalidation for Nurses and Allied Health Professionals (update on progress and annual report)
- Recruitment Strategy – update
- Equality Delivery System 2. WRES, WDES, Gender Pay Gap
- Clinical Supervision Reports

11.0 Reporting Responsibilities:

11.1 The Group shall make whatever recommendations to the Trust Board as it deems appropriate on any area within its remit where action or improvement is needed.

11.2 A highlight report with outputs of each meeting will be provided to the Trust Board for risk escalation, decision making or progress reporting (where requested).

12.0 Committee Review

12.1 The Group shall, at least once a year, review its own performance and terms of reference (including membership) to ensure it is operating at maximum effectiveness.

Strategic Workforce Group (SWG) WORKPLAN Financial Year 19/20 (Version 2 DRAFT)

	Agenda Item	Lead	May 19	July 19	Sept 19	Nov 19	Jan 20	Mar 20
1.0	Performance							
1.1	Workforce Risks	Director of HR & OD	X	X	X	X	X	X
1.2	Review workforce performance data within the IQPR	Head of Workforce Support	X	X	X	X	X	X
1.3	Review agency use against national indicators & targets	Head of ES	X	X	X	X	X	X
1.4	Review mandatory training performance (exceptional areas only)	Head of Education Training and Development	X		X		X	
	Review clinical supervision compliance dashboard	Head of Education Training and Development	x	x	x	x	x	x
1.5	Mandatory training performance (for information section)	Head of Education Training and Development		X		X		X
1.7	Divisional directorate workforce highlight Reports	Deputy Director of HR & OD	X	X	X	X	X	X
2.0	Strategic							
2.1	Review the delivery of the people strategy	Director of HR & OD/ Head of Organisational Development				X		
2.2	Review progress against developing workforce safeguards	Director HR OD / Head of workforce support Head of Education Training and Development		x				
2.4	Review the strategic approach to equality diversity and inclusion agenda (WRES WDES)	Equalities Lead		X		x		
2.5	Equality Action Plan Update (6 monthly)	Head of ES					X	
2.6	Review progress of the culture and leadership programme	Head of OD		x		x		x
2.7	Review approach to staff engagement	Deputy Director of HR & OD/Head of OD						
	Review approach to Career Development (Talent management and Career Pathways	Head of Education Training and Development/ Head of OD			x			
2.8	Annual learning & development plan to be agreed	Head of Education Training and Development	X					
2.9	Review progress of the LPT workforce plan 2018/19	Head of Workforce Support			X			
2.10	Review progress and any implications of STP workforce strategy	Chair	X					
2.11	Agree draft 2018/19 workforce plan	Head of Workforce Support					X	
3.0	Assurances							
3.1	Receive assurance on the HR aspects of any external/internal compliance reviews that have raised concerns at trust board and/or executive team ***(as required)***	Director of HR & OD						
3.2	Review the results of the annual staff survey & local surveys and agree actions	Deputy Director of HR & OD						X
3.3	Annual staff survey & local surveys - review progress and identification of further actions – substantive and bank	Deputy Director of HR & OD				X		
3.4	Review the programme of actions associated with the well-being and healthy workforce agenda	Deputy Director of HR & OD			X			
3.5	Receive assurance of HR & OD policies with adoption of such policies on behalf of the trust board ***(as required)***	Deputy Director of HR & OD						
3.6	Receive assurance on the organisational recruitment & vacancy , and retention plans (dashboards)	Head of ES	X	X	X	X	X	X

	Agenda Item	Lead	May 19	July 19	Sept 19	Nov 19	Jan 20	Mar 20
3.7	Receive assurance on bank and agency position and actions (dashboards)	Head of ES	X	X	X	X	X	X
3.8	Receive assurance on off-payroll use and IR35	Head of ES/Finance	X					
3.9	Receive midyear assurance on the delivery of the learning & development Plan	Head of Education Training and Development				X		
3.10	Review SWG terms of reference and receive annual Committee review	Director of HR & OD/Chair	X					
3.11	Review assurance consultant appraisal and revalidation – Annual Compliance Statement	Medical Director		X				
3.12	CQC action plan assurance ***(as required)***	Director of HR & OD						
3.13	Medical Revalidation 6 Month Report 6 month	Medical Staffing & Revalidation Support Manager	X				X	
3.14	AHP and Nursing Revalidation Report	Head of Professional Practice and Professional Education	X			X		

Leicestershire Partnership NHS Trust

ANNUAL REPORT
Year 2018/19

Committee/Group	Remuneration Committee
Date	April 2019
Chair of Committee	Ruth Marchington, Non Executive Director

Section A – Fulfilling Terms of Reference

1. Review of Terms of Reference (ToR)

The ToR for the committee are included as *Appendix 1* and the tracking of agenda items and areas for discussion through the completed work plan.

The current membership is deemed to be correct and sufficient and has been successful in carrying out the committee's duties. In addition, other Directors from the Trust attend meetings to ensure expert views are received on appropriate items.

No amendments to the terms of reference are proposed.

2. Assurance

For any identified issues, robust assurance has been received and where this has not been the case, clear follow up actions have been raised to receive that further assurance. These actions are recorded in the action log and followed up at the next meeting.

- *Were there any sources of external assurance during this period? Were there any concerns raised and addressed?*

Any external assurance has been through regional or national benchmarking data, as in the case of reviewing executive remuneration.

3. Analysis of Risks

There are no formal BAF or CRR risks that are reviewed at this committee. However if necessary, any identified risks are transferred to the appropriate board committee, where it does not fall within the remit of the Remuneration Committee.

4. Work plan

- *Does the work-plan evidence the discharging of the terms of reference?*

The work-plan is reviewed at the start of each calendar year to reflect the terms of reference. The latest version of the 2018 work plan is shown at *Appendix 2*

- *Is the work plan then used to inform agendas?*

The work plan has regularly been used to inform the development of the agenda and adequately reflects the duties outlined within the terms of reference.

- *Please comment on any elements of the work plan that are not fulfilled*

None, all items have been covered.

Section B – Reflection upon Working Practices

5. Effectiveness of Committee discussion

a. How effectively is the Group Chaired?

The meetings are well chaired with good time keeping. Actions and outcomes are agreed, and summarised for clarity. The chair always confirms that the meeting is quorate. On some occasions it would be helpful to ensure that the committee understand the purpose of the item to ensure the discussion does not wander into areas that are not the scope of the committee. Strong discussion and challenge is encouraged. On some occasions the time available following the Trust Board meeting is limited. A virtual agenda for certain items has been a good innovation.

b. Do all members contribute?

All members contribute.

In 2018/19, 8 meetings took place and of those 5 were virtual meetings conducted by email. The attendees and apologies (and those who did not contribute to the virtual meetings) are shown in the table below:

Date	Attendees	Apologies
17 April 2018 (virtual)	Ms R Marchington (Chair) Dr C Gibson Mr G Rowbotham Mrs E Rowbotham Mr F Hussain Mrs C Ellis	None
28 June 2018	Ms R Marchington (Chair) Mr G Rowbotham Mr F Hussain Mrs C Ellis	Dr C Gibson Mrs E Rowbotham

Date	Attendees	Apologies
10 July 2018 (virtual)	Ms R Marchington (Chair) Dr C Gibson Mr G Rowbotham Mrs E Rowbotham Mr F Hussain Mrs C Ellis	None
1 October 2018 (virtual)	Ms R Marchington (Chair) Mr F Hussain Mr G Rowbotham Mrs L Rowbotham Mrs C Ellis	None
25 October 2018	Dr K Harris Mr F Hussain Mr G Rowbotham Mrs L Rowbotham (Chair)	Ms R Marchington Mrs C Ellis
20 December 2018	Ms R Marchington (Chair) Dr K Harris Mr F Hussain Mr G Rowbotham Mrs L Rowbotham Mrs C Ellis	None
14 January 2019 (virtual)	Ms R Marchington (Chair) Dr K Harris Mr F Hussain Mr G Rowbotham Mrs L Rowbotham Mrs C Ellis	None
17 January 2019 (virtual)	Ms R Marchington (Chair) Dr K Harris Mr F Hussain Mr G Rowbotham Mrs L Rowbotham Mrs C Ellis	None

All members achieved 75% or over attendance as follows:

- Ruth Marchington 7/8
- Liz Rowbotham 7/8
- Geoff Rowbotham 8/8
- Faisal Hussain 8/8
- Cathy Ellis 7/8
- Claire Gibson 2/3
- Kevin Harris 4/4

- *Are members sufficiently prepared for meetings?*

  Members are suitably prepared for meetings and there is sufficient challenge.

- *Is there sufficient challenge, and input to agenda items by members?*

  The minutes of the meetings demonstrate the good level of challenge posed by members on agenda items. Where challenge is not met with sufficient assurance or evidence then an action is recorded for follow up.

6. Communication channels

a. Communications to and from members

Most papers are now submitted in good time and it is rare for papers to be either submitted late or tabled on the day of the meeting.

b. Quality of papers

The quality of papers is good, and they are generally presented by the author.

c. Quality of minutes

There is always challenge within the meetings and this is always fully reflected within the minutes. Matters arising are captured in an action log with the original implementation date.

d. Information flows with Parent Committee

The committee does not have any sub committees linked, however, where appropriate there are clearly identified information flows to other board committees.

The Chair presents a highlight report to the Trust Board.

7. Achievements and Barriers

- Streamlined the workplan
- Consolidated papers into a HR Director report

8. Future Plans

For 2019/20, the focus for the committee will be on the following areas:

- As per the 2019 work plan (*appendix 3*)
- Further refinement of the HR Director's report following information from NHSI on the Very Senior Managers' (VSM) pay framework.

Appendix 1

Leicestershire Partnership NHS Trust

Remuneration Committee

Terms of Reference

References to "the Committee" shall mean the Remuneration Committee

1.0 Purpose of Committee

1.1 The purpose of the Committee is to ensure there is a fair and transparent procedure for developing and maintaining policy on executive remuneration and terms and conditions, and for fixing the remuneration packages of individual directors.

2.0 Clinical Focus and Engagement

2.1 The Trust considers clinical engagement and involvement in Board decisions to be an essential element of its governance arrangements and as such the Trust's integrated governance approach aims to mainstream clinical governance into all planning, decision-making and monitoring activity undertaken by the Board.

3.0 Authority

3.1 The Committee is authorised by the Board to conduct its activities in accordance with its terms of reference.

3.2 The Committee is authorised by the Board to seek any information it requires from any employee of the Trust in order to perform its duties.

3.3 In connection with its duties the Committee is authorised by the Board to obtain, at the Trust's expense, any outside legal or other professional advice as is deemed necessary, following agreed Trust procedures.

4.0 Membership

4.1 Members of the Committee shall be appointed by the Board, in consultation with the Chair of the Remuneration Committee.

4.2 The Committee shall be made up of at least 3 members who are non-executive directors and the Chair of the Board, but shall not include the Chair of the Audit Committee.

4.3 The Chair of the Committee shall be appointed by the Chair of the Board of Directors and will be a non-executive director.

4.4 Only members of the Committee have the right to attend Committee meetings. However, other individuals such as the Chief Executive, the Director of HR and OD or external advisers may be invited to attend for all or part of any meeting as and when appropriate.

4.5 The Chief Executive or other directors shall not attend meetings where their remuneration is under consideration.

4.6 Appointments to the Committee shall be for a period of up to three years, which may be extended.

4.7 In the absence of the Committee Chair and an appointed deputy, the remaining members present shall elect one of themselves to chair the meeting.

4.8 In the situation of a prolonged absence of a member of the committee, the Chair for Non-Executive Directors, and the Chief Executive for Executive Directors, have the authority to nominate a replacement committee member.

5.0 Secretary

5.1 The Trust Secretary's nominee shall act as Secretary of the Committee.

6.0 Quorum

6.1 The quorum necessary for the transaction of business shall be 2 members. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

7.0 Frequency of Meetings

The Committee shall meet not less than twice a year and at such other times as the Chair of the Committee shall require at the exigency of the business.

7.1 Members will be expected to attend at least three-quarters (75%) of all meetings.

8.0 Agenda/Notice of Meetings

8.1 Meetings of the Committee shall be summoned by the Secretary of the Committee at the request of its members in consultation with the Chair of the Committee.

8.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, any other person required to attend and all other non-executive directors, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

8.3 The agenda for each meeting will include an item “Declarations of interest in respect of items on the agenda”.

9.0 Minutes of Meetings

9.1 The secretary shall minute the proceedings and resolutions of all Committee meetings, including the names of those present and in attendance.

9.2 Minutes of Committee meetings shall be circulated promptly to all members of the Committee and the Chair of the Trust Board once agreed. The Committee’s minutes will be open to scrutiny by the Trust’s auditors.

10.0 Duties

The Committee shall:

10.1 Determine and agree with the Board the framework or broad policy for the remuneration of the Trust’s Chief Executive, executive directors and any such other members of the executive management as it is designated to consider. This will include the individual starting salary and conditions of newly appointed Directors, as well as any annual salary uplift for existing directors. Determine any payment of management allowances for the Trust’s Medical Director and Associate Medical Directors. No director or manager shall be involved in any decisions as to their own remuneration. To ensure the work of the Committee is seen as fair and transparent Directors will be able to make submissions to the Committee and seek feedback from the Chair on the decisions of the Committee.

10.2 Policy will be in line with the NHSI Very Senior Manager Pay Framework.

10.3 Review the delivery of the Chief Executive’s performance objectives, and receive a review from the Chief Executive on the executive director performance objectives.

10.4 Review the ongoing appropriateness and relevance of the remuneration policy in line with the very senior manager pay framework.

10.5 Approve the design of, and determine targets for, any performance related pay schemes operated by the Trust and approve the total annual payments made under such schemes.

10.6 Determine the policy for, and scope of, pension arrangements for each executive director.

10.7 Ensure that contractual terms on termination, and any payments made, are fair to the individual and the Trust, that failure is not rewarded and the duty to mitigate loss is fully recognised.

10.8 Within the terms of the agreed policy and in consultation with the Chair and/or Chief Executive as appropriate determine the total individual remuneration

package of each executive director and other designated senior managers including any incentive payments.

10.9 In determining such packages and arrangements, give due regard to any relevant legal requirements and to compliance with Department of Health/NHS England/NHS Improvement guidance.

10.10 Be exclusively responsible for establishing the selection criteria, selecting, appointing and setting the terms of reference for any remuneration consultants who may be required to advise the committee. The Committee shall have full authority to commission any reports or surveys which it deems necessary to help it fulfil its obligations.

10.11 Will receive a business case for consideration where a member of staff may receive a redundancy/ or other severance payment, in excess of their statutory and contractual entitlements, and/or in excess of £100k. The Committee will make its recommendation prior to submission to the NHS Improvement Remuneration Committee. A quarterly report providing an overview of all redundancies (including those under £100k) will also be received by the Committee for information.

10.12 Ensure that board/executive level succession plans are maintained and reviewed.

11.0 Reporting Responsibilities:

11.1 Where no individual personal information or conflict of interest arises, the Committee Chair shall report formally to the Board, meeting in private session, on its proceedings after each meeting on all matters within its duties and responsibilities.

11.2 The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed.

11.3 The Committee shall review the Trust's remuneration policy and practices, which may form part of the Trust's Annual Report, approved at the Trust's Annual General Meeting. To assist the Committee the Director of HR & OD will annually provide comparative data on director pay and conditions.

11.4 The Chair of the Committee shall attend the Trust's Annual General Meeting prepared to respond to any stakeholder questions on the Committee's activities.

12.0 Annual Review

12.1 The Committee shall, at least once a year, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.

13.0 Risk Responsibility

13.1 The risk areas the Committee has special responsibility for will be those that fall within the remit of this Committee.

Appendix 2

Ref	Duties	2018											
		Jan	Feb	Mar 29	Apr	May	June 28	Jul	Aug	Sept	Oct 25	Nov	Dec
1	**PERFORMANCE** Review achievement of last year's objectives for CEO and Exec. Receive and note new objectives					x →							
2	Receive CEO / Exec performance objectives mid year reviews.										x		
3	**REMUNERATION** HR Report to include: • Remuneration trends • NHSI pay framework updates • Gender pay gap					x →							
4	Review executive pay					x →							
5	Consider annual inflationary uplift (note as and when recommendation is made by NHSI).												
6	Review succession plans			x							x		
7	Review the terms of reference			x									
8	Review the cycle of business/work plan for the year			x									
9	Review of Committee (ahead of Audit Committee in ?**May**)			x									
10	Receive business case for redundancy above £100k for recommendation to NSHI (as and when decision will be time limited) By email												
11	Quarterly redundancy report – FOR INFORMATION ONLY	x			x			x			x		
12	Matters arising action 111 – demonstration of uLearn appraisal process										?		

Note - Shaded areas indicate potential months for committee meetings (not less than twice a year)

Appendix 3

Ref	Duties	2019											
		Jan	Feb	Mar 28	Apr	May 23	June 27	Jul	Aug	Sept	Oct 31	Nov	Dec
1	**PERFORMANCE** Review achievement of last year's objectives for CEO and Exec. Receive and note new objectives					x →							
2	Receive CEO / Exec performance objectives mid year reviews.										x		
3	**REMUNERATION** HR Report to include: • Remuneration trends • NHSI pay framework updates • Gender pay gap					x →							
4	Review executive pay					x →							
5	Consider annual inflationary uplift (note as and when recommendation is made by NHSI).												
6	Review succession plans			x							x		
7	Review the terms of reference			x									
8	Review the cycle of business/work plan for the year			x									
9	Review of Committee (ahead of Audit Committee in July)			x									
10	Receive business case for redundancy above £100k for recommendation to NSHI (as and when decision will be time limited) By email												
11	Quarterly redundancy report – FOR INFORMATION ONLY	x			x			x			x		
12	Matters arising action 111 – demonstration of uLearn appraisal process			?									
13	6 monthly report on 360 Assurance VSM Bank						x						

Note - Shaded areas indicate potential months for committee meetings