Leicestershire Partnership NHS Trust

Public Meeting of the Trust Board
26th July 2022 9.30am
Microsoft Teams Live Stream

Agenda				
Time	Item		Paper	Lead
9.30	1.	Apologies for absence and welcome to meeting • The Trust Board Members	A	Chair
9.35	2.	Patient Voice Film – Directorate of Mental Health	verbal	Fiona Myers
9.45	3.	Staff Voice - Directorate of Mental Health	verbal	Fiona Myers
10.05	4.	Declarations of Interest in Respect of Items on the Agenda	verbal	Chair
	5.	Minutes of the Previous Public Meeting 31st May 2022	B	Chair
	6.	Matters Arising	C	Chair
	7.	Chair's Report	D	Chair
	8.	Chief Executive's Report	E	Mark Powell
Governance and Risk				
10.15	9.	Organisational Risk Register	F	Kate Dyer
Strategy and System Working				
10.25	10.	Service Presentation – Directorate of Mental Health • Step Up to Great Mental Health Implementation Plan - Getting help in Neighbourhoods video	verbal	Fiona Myers
10.50	11.	Healthwatch Report – LPT Response • LPT Response to Healthwatch paper: Accessing mental health services during crisis • LPT response to Healthwatch paper: Male Suicide - Turning the Tide: raising awareness to reduce death by suicide	 Gi Gii	Fiona Myers
10.55	12.	Break		
11.05	13.	Step Up to Great Q1 Progress Report	H	Alison Gilmour
11.10	14.	Clinical Plan	I	Avinash Hiremath
11.15	15.	Research and Development Plan	J	Avinash Hiremath
11.20	16.	Group Highlight Report 5th July 2022	K	Kate Dyer
Quality Improvement and Compliance				
11.25	17.	Quality Assurance Committee Highlight Report – 28th June 2022	L	Moira Ingham
11.30	18.	Care Quality Commission (CQC) Update Including Registration	M	Anne Scott
11.35	19.	Ockenden Report	N	Anne Scott
11.40	20.	Safe Staffing Monthly Reports	Oi Oii	Anne Scott

11.45	21.	Patient Safety Incident and Serious Incident Learning Assurance Report	P	Anne Scott
11.50	22.	Infection Prevention and Control 6 Monthly Report	Q	Anne Scott
11.55	23.	Privacy and Dignity and Single Sex Accommodation Annual Declaration 2021-22	R	Anne Scott
12.00	24.	Ligature Risks Annual Report 2021-22	S	Anne Scott
12.05	25.	Guardian of Safe Working Hours Annual Report 2021-22	T	Avinash Hiremath
12.10	26.	Freedom To Speak Up (FTSU) Guardian Annual Review 2021-22	U	Pauline Lewitt
Performance and Assurance				
12.15	27.	Finance and Performance Committee Highlight Report – 28th June 2022	V	Faisal Hussan
12.20	28.	Finance Monthly Report – Month 3	W	Sharon Murphy
12.25	29.	Standing Orders, Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation (SORD)	X	Sharon Murphy
12.30	30.	Performance Report – Month 3	Y	Sharon Murphy
12.40	31.	Charitable Funds Committee Highlight Report – 6th June 2022	Z	Cathy Ellis
12.45	32.	Audit and Assurance Committee Highlight Report – 10th June 2022	AAA	Hetal Parmar
12.50	33.	Review of risk – any further risks as a result of board discussion?	verbal	Chair
	34.	Any other urgent business	verbal	Chair
	35.	Papers/updates not received in line with the work plan	verbal	Chair
12.55	36.	Public questions on agenda items	verbal	Chair
1.00	37.	**Date of next public meeting: 27th September 2022**		

A

Our Trust Board

As of July 2022

NHS
Leicestershire Partnership
NHS Trust

*Indicates joint role with Northamptonshire Healthcare NHS Foundation Trust (NHFT) as part of group model arrangement

Cathy Ellis
Chair

Angela Hillery
Chief executive

Mark Powell
Deputy chief executive/managing director

Faisal Hussain
Non-executive director and deputy chair

Moira Ingham
Non-executive director

Hetal Parmar
Non-executive director

Prof. Kevin Paterson
Non-executive director

Ruth Marchington
Non-executive director and senior independent director

Alexander Carpenter
Non-executive director

Paul Sheldon
Chief finance officer*

Sharon Murphy
Executive director of finance

Samantha Leak
Executive director of community health services

Fiona Myers
Interim executive director of adult mental health

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

Sarah Willis
Executive director of human resources and organisational development

Chris Oakes
Executive director of corporate governance and risk*

David Williams
Executive director of strategy and partnerships*

Dr. Avinash Hiremath
Executive medical director

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

B

Leicestershire Partnership NHS Trust

Minutes of the Public Meeting of the Trust Board
31st May 2022 - Microsoft Teams Live Stream

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

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

TB/22/060	**Apologies for absence:** Mark Powell Deputy Chief Executive David Williams Director of Strategy and Partnerships (Sam Wood Head of Strategy presenting paper K) Paul Sheldon Chief Finance Officer **Welcome to meeting:** **Staff Voice & Service Presentation:** Emma Hughes Health Care Support Worker Ben Birch Crisis Plus Practitioner Astyn Tinkler Clinical Team Lead Ian Harratt Service Group Manager William Burdett Derby Service Manager, Leicester Children's Hospital UHL Paul Williams Head of Service Group 1 Services FYPC **Observers:** Ed Melia Head of Communications Danielle Mantel Nursing Fellow Eva Kwarteng Nursing Fellow Faith Tipper Nursing Fellow Amanda Hemsley IPC Lead Jessica Ryan Student Hari Subramanian Consultant Psychologist Rob Simpson Alex Carpenter For the Trust Board Members – refer to Paper A

TB/22/061	Patient Voice Film – Families Young People & Children's (FYPC) Services focusing on Children's & Adolescents Mental Health Services (CAMHS) A film was shared describing the experience of a service user who accessed the CAMHS Crisis Team services. The experience was positive and supportive, enabling coping techniques to manage difficult periods. Continuity of service was highlighted as an issue for improvement.
TB/22/062	Staff Voice – FYPC CAMHS Helen Thompson introduced the Crisis and Crisis Plus Teams (listed above) who introduced themselves to the Board. The team began in 2017 and has grown in size and structure including the introduction of the 24x7 mental health hub in the Bradgate Unit during the pandemic in 2020 and the development of the Central Access Point (CAP) offering 24 hour help and access. The team described the offer including home treatment for up to 6 weeks, immediate crisis and wrap around support for young people aged up to 18 years. The growth in the offer has made a real difference to Leicester, Leicestershire & Rutland (LLR) with teams across the system collaborating and working together to support young people in the best way. A Standard Operating Procedure (SOP) has been designed and further transformational work is underway with a delivery group focusing on pathway design between providers. The staff work in a multi-disciplinary team (MDT) which ensures that the patient voice is reflected in their care plan. It will include a safety plan, goal setting and techniques for self-management. Reflecting on the patient film, continuity of care is assessed as part of this. The Chair asked the team how they look after their own health and well-being and the team confirmed regular annual leave and time away through shift work was used to refresh staff; team building both in and out of work served to increase staff morale. The team described a bonded team with an open door policy meaning staff can always raise issued with their managers supporting good wellbeing. Darren Hickman asked how an early help offer could be promoted – offering pre crisis support. Ian Harratt confirmed that there are a range of services offered supporting early interventions – that the offer outside of crisis is extensive both within LPT and across the system. The CAP offers advice and support, signposting and referral not just in crisis. Angela Hillery thanked the team for their collective leadership and speed and responsiveness throughout the pandemic and requested that if any organisational barriers are encountered these should be escalated so resolution can be sought. Angela Hillery asked for feedback on the recent CAMHS recruitment initiative and the team confirmed that this was a success with almost 400 attendees and feedback that it was well organised and well received. There were less nurses attending than hoped and so thought is going into what can be done differently to attract nurses to the recruitment initiatives. Ruth Marchington asked what the team are doing to consider health inequalities and ensuring services are accessible to all. Ian Harratt confirmed that a focus group is looking at the development of the offer to ensure a greater reach is achieved and this is being supported by the Mental Health Investment Standard monies. The team advised that appointments will be offered at a place most suited to the young person to ensure accessibility. Helen Thompson confirmed that analysis of the data that underpins the service offer is being undertaken which will inform this work. The CQC feedback on this service is detailed in Paper O on today's agenda.
TB/22/063	Declarations of Interest in Respect of Items on the Agenda No declarations were received.
TB/22/064	Minutes of the Previous Public Meeting: 29th March 2022 – Paper B **Resolved:** The minutes were approved as an accurate record of the meeting.
TB/22/065	Matters Arising – Paper C There is one amber item on the action log – not due until the July Trust Board

	meeting where an update will be provided. Avinash Hiremath confirmed that the consultant caseload size in LPT is above the benchmarked average and there is work ongoing around this as part of the Step Up To Great (SUTG) mental health work which supports a more patient centered approach which will reduced caseloads – a further update will be given at the July Trust Board as this item remains open on the action log. **Resolved:** The Trust Board agreed the action log actions closed and outstanding.
TB/22/066	Chair's Report – Paper D The Chair presented the paper confirming that recent board walks and visits had evidenced high quality compassionate care. The UNICEF baby friendly assessment feedback has been positive with compliments from mums and the final outcome was awaited. The University of Leicester's recent research results have been fantastic with 89% of their research assessed as world leading and LPT are proud to be their research partners. It was noted that clinical medicine and sports science are both rated as 2nd in the country. **Resolved:** The Board received the report for information
TB/22/067	Chief Executive's Report – Paper E Angela Hillery presented the report confirming the de-escalation from a level 4 to a level 3 incident. Although the level is now different which is welcomed, staff remain challenged in terms of demand and we continue to work to manage this as we move into reset and rebuild. The Health & Care Act 2022 is a legislative change and an increased focus on Integrated Care System (ICS) finance is expected. This will need to be managed together as a system and increased rigour in terms of achieving a break-even budget is expected. Thanks were offered to all staff who have supported the acute mental health core service inspection which resulted in increased Care Quality commission (CQC) ratings. The recent Health Service Journal (HSJ) partnership award is validation and recognition of our work in this area. **Resolved:** The Board received the report for information
TB/22/068	Organisational Risk Register – Paper F Chris Oakes presented the paper confirming that there are 25 risks on the register. The proposal today is to close risk 63 – the winter and covid impact risk with the mandatory training element picked up in risk 61. Risk 79 & 80 have been added to the register as agreed by the Finance and Performance Committee (FPC) and the Quality Assurance Committee (QAC) at their April meetings. There are two new risks in draft – one around financial control and one around the loss of the 11 plus Healthy Together contract. Ruth Marchington asked what had caused the facilities management increased residual risk (12 to 16) position in risk 65 – requesting more detail around this risk and the implications of the lack of data on our safe systems. More detail was needed so we could be clear where the risk lies. Darren Hickman noted that with regard to the staff risks 60 & 61; the risks seem to be increasing including a 12.3% vacancy rate, increased staff turnover, inflation impacts on agency costs and suggestions of increased recruitment and growth within LPT – should this not be reflected in a higher risk and risk score? It was agreed that this would be considered at the end of the meeting in light of the information presented throughout the agenda. Sarah Willis confirmed that we were living in an uncertain climate around workforce challenges and that local plans were in place including the international nurses recruitment 5 year plan; the transitional programme of over recruitment and growth of health care support workers; new roles and service redesign to mitigate against these risks. It was confirmed that the risk score remained under review and adjustments will begin to be reflected. It was suggested that a future Board development session could consider discussion around workforce development in light of the ICS.

	The Chair asked if both risk 71 & 81 were needed for finance and Sharon Murphy confirmed that these were both under review – that 71 relates to the planning risk and may evolve into the ICS capital strategy delivery risk and that 81 relates to the revenue plan delivery risk. These will remain under review. **Action:** Paul Sheldon - further description to be added to risk 65 so it is clear where the risk lies and why the residual risk has increased. **Action:** Kate Dyer – include workforce development in light of the ICS at a future Board development session. **Resolved:** The Board approved the new draft risks 81 and 82 and approved the closure of risk 63.
TB/22/069	Governance Arrangements – Paper G Chris Oakes presented the paper which is a response to the de-escalation from level 4 to level 3. Full agendas are to be reinstated in level 1 & 2 meetings and level 3 meetings are to stand back up. This remains under review should the situation change. **Resolved:** The Board received the paper and supported of the recommendations within it.
TB/22/070	Documents Signed Under Seal Quarter 4 Report – Paper H Chris Oakes presented the paper for information. **Resolved:** The Board received the paper for information.
TB/22/071	NHS Provider Licence Self Certification (G6 and FT4) – Paper I Chris Oakes presented the paper confirming that following a self-assessment, LPT are compliant with G6 and compliant under FT4 and this is recommended for adoption by the Board. **Resolved:** The Trust Board received the report and confirmed the compliance
TB/22/072	AGM Date to be agreed – 5th September 2022 – confirmed the meeting will be held online.
TB/22/073	Non-Executive Directors (NED) Responsibilities – Paper J The Chair presented the paper which reflected handovers and responsibilities - confirming that two new Non-Executive Directors joined LPT on 1st June 2022 – Alex Carpenter and Hetal Parmar. Thanks were offered to Darren Hickman who begins a new role as the audit chair for the ICS. **Resolve:** The Trust Board received and approved the paper
TB/22/074	Service Presentation – FYPC CAMHS Paul Williams presented the PowerPoint presentation contained within the combined paper pack – talking through the detail contained within each slide including the roadmap of the CAMHS services; the increased number of complex referrals; the increased investment; increased workforce challenges; early intervention work; links to the SUTG mental health programme; work with Northamptonshire Healthcare Foundation Trust (NHFT) and the improved system working supported by the new model employed allowing the opportunity to do things differently. Staff are working collaboratively as part of the ICS to find solutions to service problems. Ruth Marchington suggested that the Beacon Quality Improvement (QI) plan and reduction in incidents data will be useful to see once ready at QAC and it was confirmed that this will be included in the new quality dashboard that is planned. Ruth Marchington also suggested that physical care data would be useful to see alongside the mental health data and Paul Williams confirmed that physical health forms part of the QI plan, there has been investment in the physical healthcare pathway. Kevin Paterson asked if the pandemic has contributed to the increase in complex referrals and Paul Williams confirmed that whilst this time of year always sees an increase in referrals the impact of covid is evident with lockdowns, school closures and exams having a negative impact on young people's mental health. This impact is expected for the next 2-3 years.

	Angela Hillery asked what more we can do to support the workforce challenge particularly in the inpatient provision and Paul Williams suggested improved links with educational institutions could support this. Paul Williams also noted that the inpatient post structure offers less development opportunities. Helen Thompson confirmed that there is a workforce plan in the directorate which links with colleges and universities offering good clinical placements and improvements which is within our gift to deliver. This includes the 0% health care support worker vacancy ambition, creating a peripatetic team and filling all administration vacancies. Avinash Hiremath asked what the teams are doing to support staff wellbeing and Paul Williams described supervision, engagement events, listening events and improved staff rest areas along with the Trust -wide initiatives including the golden ticket initiative, and access to the health and well-being hub. Visible leadership supports staff although there remains a challenge in creating reflective time due to staffing levels however the staff survey results suggest improvement and a sense of hope and optimism within the team.
TB/22/075	Step Up To Great Strategic Delivery Plan – Paper K Sam Wood presented the paper confirming that a number of delivery plans sit behind each brick within the annual strategic delivery plan and that this plan follows a robust process and has oversight at the Transformation Committee. This plan will be presented to Trust Board throughout the year to demonstrate the progress made towards the strategic objectives. **Resolved:** The Trust Board approved the Step Up To Great Strategic Delivery Plan
TB/22/076	Joint Working Group Highlight Report – 3rd May 2022 – Paper L Chris Oakes presented the paper detailing the real opportunity for learning within the group. The joint roles have been supported by the committee. **Resolved:** The Trust Board approved the highlight report and the MOU for submission to the Remuneration Committee.
TB/22/077	Quality Assurance Committee Highlight Report – 26th April 2022 – Paper M Moira Ingham presented the report confirming that the second report on the Ockenden Review will be received by QAC at their June meeting before coming to Trust Board in July. The areas where QAC received medium assurance were the Performance Report which highlighted concerns around mandatory training compliance. The Pressure Ulcer Update where a focused improvement plan is in place but numbers remain higher than desired and serious incident investigations where a quality summit has taken place and actions are being examined. The quality dashboard is under development and will further allow QAC to monitor these areas. Mental Health Act compliance data is being provided to QAC from the Legislative Committee highlight reports and there is a continued focus on improving the data. **Resolved:** The Trust Board received the report for assurance.
TB/22/078	CQC Update – Paper N Anne Scott presented the paper confirming that the re-inspection report from May 2022 has a positive outcome with improvements to two ratings and has generated 3 new must do actions. There is more to do but improvement is acknowledged. There has been positive informal feedback from the CQC visit to the mental health Liaison Service at the Leicester Royal Infirmary in April 2022. The CQC Mental Health Act visits continue across the Trust. **Resolved:** The Trust Board received the report and note the oversight of the CQC action plan.
TB/22/079	LPT Urgent & Emergency Care LLR System Inspection feedback (Psychiatric Liaison Service at LRI) – Paper O Angela Hillery presented the paper detailing the system review inspection of LLR which LPT as a partner are part of. The visit to the Psychiatric Liaison Service at the Leicester Royal Infirmary is detailed within the paper with positive feedback

	received. Angela Hillery thanked all staff involved and noted the areas to note including system wide wait times detailed in the report. **Resolved:** The Trust Board received the report for information and noted the feedback and actions required with partners on wait times.
TB/22/080	Safe Staffing - Monthly Report – Paper P Anne Scott presented the papers which cover February and March 2022. Safety huddles were increased to daily during the February school half term and the same approach is taking place in this May half term. There is increased temporary and agency staff utilisation over both months and mitigation remains in place to support the areas of note in the inpatient and community teams. Training compliance continues to be monitored as the revert back to the pre covid compliance framework has had an impact on training compliance. Rates are increasing for substantive staff but remain low for bank staff and plans are in place to improve this. The staffing position remains challenged and there is emerging evidence that controls do not always mitigate. The Chair asked how the staffing issues on the Diana and Looked After Children's Teams are being managed as this has limited the service provision and Anne Scott confirmed that work was underway looking at recruitment plans, what can be done differently, skills mixes across teams and that teams continue to feel supported and supervised including psychological and safeguarding supervision. Darren Hickman commented that there is a high bank and agency utilisation but when you consider the fill rates – they are mostly achieved – with night shifts filled more than day shifts. Anne Scott confirmed that night shifts are easier to fill and that work is ongoing around offering contracts for nights only shifts. Darren Hickman asked if the move towards virtual wards will impact on the safer staffing and Anne Scott confirmed that there is a pathway management board looking at the planning of staffing on virtual wards. Sam Leak added that the virtual wards are a great opportunity, are clinically led and there is capacity for each of the pathways. We will work together to consider safer staffing. Faisal Hussain asked what measures were being taken to prevent harm considering the high rate of temporary/agency usage and Anne Scott confirmed that this risk is managed and mitigated everyday by ensuring there are substantive staff on shift, clinical leads are overseeing and supervising and regular safety huddles are held. Faisal Hussain asked how the mandatory training rates will be improved for bank staff and Sarah Willis confirmed that work was ongoing around this including block booking training for bank staff and considering preventing non-compliant bank staff taking shifts. This risk needs to be balanced to support safe staffing levels. Bank and agency are often block booked, they are a regular workforce and are not always new staff, they are part of the team who work in a flexible way. Ruth Marchington commented that on a recent visit to the Diana Team two new team members felt very supported and the clinical and psychological supervision was impressive. The focus on agency staff and the tension between agency staff and the finance driver will be discussed further at the QAC & FPC joint meeting due to be held on 7th June 2022. Anne Scott added that quality and safety of patient care will always be the top priority. **Resolved:** The Trust Board received assurance from the report.
TB/22/081	Patient Safety Incident and Serious Incident Learning Assurance Report – Paper Q Anne Scott presented the paper confirming challenges remain as the recovery from the backlog position through the pandemic continues. A quality summit has taken place and a collaborative plan for improvements drafted – all directorates now have QI plans in place and improvements are evident with national key learning being applied. A follow up quality summit is planned for June. The work around pressure ulcers is ongoing with QI initiatives in place. Sam Leak confirmed that LPT are

	benchmarked at average with the grade 2 pressure ulcers and there is improvement in the grade 4 numbers towards the ambition of zero. The number of self harm reports continues to be high and patient stories to share learning are included within the report. The Chair asked if the directorates are on track with their trajectories for backlog clearance and Annes Scott confirmed that each directorate has a plan in place and are making great progress. Kevin Paterson asked for further explanation on the targets within the statistical process control (SPC) graphs contained within the report and Anne Scott confirmed that the Head of Patient Safety would be able to explain this detail outside of today's meeting. The Chair asked if the increasing incidents evident on some of the graphs are related to staffing pressures and Anne Scott confirmed that at the moment there is no evidence to suggest this, but monitoring continues. **Resolved:** The Trust Board received assurance from the report.
TB/22/082	Patient and Carer Experience and Involvement and Complaints Quarter 4 Report – Paper R Anne Scott presented the paper confirming that work was ongoing to address breaches in the 45 day timeframe for complaints and improvement was evident. There has been a review of the complaints themes and a deep dive undertaken on communications. The carer and service user networks continue to grow and the development of the proposed lived experience representative continues. The People's Council continue their focus on the outcomes of their independent review work. The Community Mental Health survey results are detailed in the report and these downward trend results are being used to inform QI work. Angela Hillery confirmed that it has been challenging throughout the pandemic to be as responsive as we would have like to have been and the patient leadership work is a significant shift towards collaborative working. Faisal Hussain asked if the recruitment of "listen and talk" volunteers would be extended if successful and Anne Scott confirmed that this would be the plan. **Resolved:** The Trust Board received the report for assurance.
TB/22/083	Learning From Deaths Quarter 4 Report – Paper S Avinash Hiremath presented the paper confirming that there had been no change in the reported numbers. A structured approach to analysing deaths and learning is evident across the trust and evidence indicated that there are no problems associated with care. The National Medical Examiner system went live for Community Health Services (CHS) in April. Improvements within reporting are ongoing in particular in relation to demographics to support health inequality work. Faisal Hussain commented that a more coordinated approach to demographic data would be required across the system. Avinash Hiremath confirmed that forums across the system discuss health inequalities and there is an active ongoing project around reducing inequalities in accessing heath at Accident & Emergency in UHL and for mental health in LPT.. **Resolved:** The Trust Board received the report for assurance.
TB/22/084	Annual Staff Survey & Action Plan – Paper T Sarah Willis presented the staff survey action plan which includes feedback including workforce race equality and disability data indicating positive improvements – work is ongoing around this. Sarah Willis outlined the main areas of focus moving forward. Reset and Rebuild, which includes getting the basics right, health and wellbeing initiatives and strengthening the blended working approach. Reducing inequalities looking at staff experience and engagement. The People Promise Exemplar is a detailed programme of work which is currently underway and will bring about change. Financial and mental health and well being are being considered. Workforce capacity and demand is an area of focus including transforming recruitment and new initiatives including fayres and

	campaigns. Local interventions are planned with targeted programmes of work to support teams and team peer to peer support planned. There is a focus on segmenting teams according to their staff survey results, providing in reach support to lower performing teams. Ruth Marchington asked if the cost of living pressures and financial wellbeing were being considered particularly in light of mileage rates. Sarah Willis confirmed that there is a local arrangement in place for high level community staff mileage which are over a set threshold where a supplementary payment is being offered to support. Work is ongoing with both UHL & NHFT building a detailed financial health and wellbeing plan. Faisal Hussain commented that there had been positive feedback from the staff support networks around events that have been held but a concern that these events may not be reaching all directorates in the same way. Sarah Willis confirmed that lower performing teams are being targeted and the Change Champions will update on progress at a future board meeting. **Resolved:** The Board received the report and noted the actions in place.
TB/22/085	Equality Diversity & Inclusion (EDI) Plan Refresh – Paper U Sarah Willis presented the plan confirming that it had been supported by QAC at their April meeting. **Resolved:** The Trust Board supported and approved the plan and actions detailed within the plan.
TB/22/086	Finance and Performance Committee Highlight Report – 26th April 2022 – Paper V Faisal Hussain presented the report confirming that the business pipeline work over the last 2 years had been great and thanked the team. The performance assurance had been split as the performance framework was embedded and working well, offering high assurance but there were areas where performance and data collections were not so strong and this offered low assurance, however, plans and trajectories were in place. The Improving Access committee report also was given split assurance with low assurance due to the waiting times backlog – a matter that will be discussed further in the joint QAC & FPC workshop planned for the 7th June. **Resolved:** The report was received for assurance.
TB/22/087	Finance Monthly Report – Month 1 – Paper W Sharon Murphy presented the paper confirming that there is a £688,000 overspend in month 1 with £512,000 within the directorate of mental health. This has been offset against central reserves so the planned £497,000 deficit has been reported. There is a finance improvement plan within mental health and we are assured that the actions will deliver. Agency costs continue to accelerate with £2.9m reported in April 2022. Nationally this will need to reduce to comply with the NHSI ceiling which is anticipated to come back into force with a likely ban on the use of non-clinical agency. There is an operational group meeting every 2 weeks to discuss agency usage and a directorate level oversight group which meets monthly. The cash and Better Payments Practice Code (BPPC) both show good performance. Capital spend to date has been £33,000 and it is too early in the financial year to review this performance. The Chair commented that the agency efficiency scheme is a big opportunity and month 2 should indicate more trends on run rates.**Resolved:** The Trust Board received the report for assurance.
TB/22/088	Performance Report – Month 1 – Paper X Sharon Murphy presented the paper detailing new items which include the mental health core data pack (NHSE) which shows the system performance and LPT's contribution to it – this is important moving forward as how we do as a trust impacts on the system and region as a whole. CQUINs (Commissioning for Quality and Innovation) framework targets will be included once the information is available. The single oversight framework metrics – some are included and some

	still require work to clarify what needs to be reported. The waiting times picture is mixed, full details are within the report with each directorate having some improved and some deteriorated services. The month 1 performance reviews confirmed that all services have improvement plans in place and this offers assurance for improvement – services are clear where they are off target and clear around their plans to address this. The transfer of care delays have increased to 6.4%, the extended criteria for patients in a CHS bed whilst waiting for a package of care may have had an impact on this. The push on IG mandatory training continues, to ensure the 95% target is met. Fiona Myers confirmed that a deep dive into data discrepancies on 72 hour mental health follow up has been completed. Angela Hillery commented that a recent regional deep dive into mental health metrics confirmed that LPT's data around zero out of area placements is one of the best in the country. Sharon Murphy confirmed that the performance report continues to evolve and changes will be seen to content over the coming months. **Resolved:** The Trust Board approved the report and noted the new metrics
TB/22/089	Operational and Financial Plan 2022-23 – Paper Y Sharon Murphy presented the summary of the plan which was submitted to NHSI on 28th April 2022. Priorities for the year include growing the workforce including the facilities management transfer in of staff. The financial plan is predicting a £1.4m deficit for the year which is due to inflationary pressures. The ICS is predicting a deficit plan too. Since the plan's submission there have been further meetings with the national NHSI team and further funding has been released to reduce inflation pressures, so a revised plan is being worked on for submission on 20th June 2022. Board will be further updatedin advance of the plan being submitted . **Resolved:** The Trust Board received and approved the Operational and Financial Plan 2022-23
TB/22/090	Review of risk – any further risks as a result of board discussion? The staffing risk may need a further review due to increased pressure within the system. The Facilities Management transfer needs further review so that there is a batter understanding of where the risk lies. CAMHS workforce and bed closures remains a risk and this should be considered further.
TB/22/091	Any other urgent business A late paper was received for discussion under AOB. The Charitable funds Bank Account – a new savings account was being opened for the Trust's Charity Raising Health. **Resolved:** The Trust Board approved the plans in the paper.
TB/22/092	Papers/updates not received in line with the work plan - NA
TB/22/093	Public questions on agenda items: **Question:** On-line meetings are a really helpful way to enable public engagement, however using Microsoft Teams requires compatible ('up-to-date') technology and a Microsoft license. In practice this means a laptop or desktop computer and a Microsoft Office subscription, items which many families cannot afford and many people (particularly older people) cannot use. Whereas Zoom has a free license option, is compatible with most smartphones (as well as laptops and desktops) and only requires people to click on one link. So in using Microsoft Teams the board is limiting who can participate to only the computer literate, affluent and middle income groups in what might be considered a discriminatory move. Is there a good reason why this meeting cannot be held on Zoom and would the board consider taking steps to overcome these obstacles in order to open the meetings up to a wider audience?

	Response: We would like to thank you for raising your concern. Throughout the pandemic we have been using as many interactive ways as possible to reach out to our audiences. MS Teams is easy to access for our staff and for the public. You do not need a license or app to access the platform as it is also available via your website's browser, meaning it is just as accessible as Zoom. Until recently our information governance policy has not allowed us to use Zoom due to security reasons, although we are currently reviewing this again in light of new improved data security information and will be looking to diversify where we see this as appropriate.

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Leicestershire Partnership NHS Trust

TRUST BOARD 26th July 2022

MATTERS ARISING FROM THE PUBLICTRUST BOARD MEETINGS

All actions raised at the Trust Board will be included on this Matters Arising action log. This will be kept and updated by the Corporate Affairs Manager. Items will remain on the list until the action is complete and there is evidence to demonstrate it. Each month a list of matters arising will be provided with the Board papers, for report under this item. The list will not include where evidence has been provided (and therefore can be closed). Red = incomplete, amber = in progress, green = complete

Action No	Meeting date and minute ref	Action/issue	Lead	Due date	Outcome/evidence actions are not considered complete without evidence)
949	TB/22/049 29.3.22	To bring assurance & information around caseloads and staffing capacity for medical staff to the board meeting.	Avinash Hiremath	18.7.22	Complete - Paper presented at Strategic Executive Board July 22 outlining challenges with regards to consultant caseloads and specific measures needing to be undertaken to mitigate risks as a result of high caseloads. Measures have been approved and are being translated into actions within Directorate. Follow-up on implementation will be presented at Operational Executive Board for oversight and monitoring.
952	TB/22/068 31.5.22	Further description to be added to risk 65 so it is clear where the risk lies and why the residual risk has increased.	Paul Sheldon	18.7.22	Complete - Risk narrative updated to reflect latest position. Risk score had increased due to lack of an agreed date for the transfer of services. Date now agreed so score has fallen again.
953	TB/22/068 31.5.22	Include workforce development in light of the ICS at a future Board development session.	Kate Dyer	18.7.22	Complete – added to 23rd August 2022 development agenda
954					

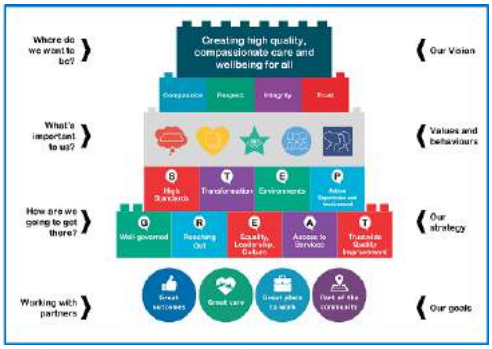
D

Leicestershire Partnership NHS Trust

Trust Board – 26 July 2022 - Chairs report

Purpose of the report

Chairs report for information and accountability, summarising activities, and key events
From 31 May 2022 to 26 July 2022.



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

Hearing the patient and staff voice	• The Chair and Non-Executive Directors have been on Boardwalks to meet staff and patients in frontline services. We have visited the following areas: ○ Hinckley & Bosworth Community Hospital ○ North West Leicestershire Community Mental Health Team ○ North West Leicestershire Health Visiting team ○ Pulmonary Rehab service ○ Children's Speech and Language Therapy ○ Cognitive Behavioural Therapy ○ Podiatry
Connecting for Quality Improvement	• As the UNICEF Baby Friendly Guardian for infant feeding, I participated in the accreditation assessment, which also included interviews with health visiting staff and mums about the quality of care they received. We are pleased that our re-accreditation has been confirmed, subject to implementing 3 actions. • Participated in the July CQC engagement meeting. The LPT team gave an update on recent successes, staffing, quality, well led- and risk. • Joined the judging panel for LPT's Let's Get Gardening competition which is run annually for mental health inpatient wards. Some impressive gardens which highlighted our patient participation in gardening and the hard work of our staff. Thank you to all the wards who took part and improved their outdoor space for patients.
Promoting Equality Leadership & Culture	• Attended the LPT/NHFT Group "Inclusive Leadership" masterclass • Joined the South Asian Heritage Month staff event jointly hosted by the BAME networks in LPT and NHFT • Participated in the shortlisting panel for LPT's staff Celebrating Excellence Awards

Building strong Stakeholder relationships	• Attended LLR Integrated Care Board (ICB) meetings which covered the current operational, financial, and quality priorities for the Integrated Care System (ICS) • Attended the ICS Health & Wellbeing Partnership Board development workshop which focused on health inequalities and the priorities in LLR. • Chaired the monthly LLR ICS Finance Committee meetings focusing on 2022/23 plan approval, revenue spend, capital programme, transformation, and key risks. • Attended the Homelessness Charter Group meeting for Leicester City • 1:1 stakeholder meetings with John MacDonald Chair of UHL, David Sissling Chair of LLR ICS, Paula Clark Chair of LLR Patient Care Locally • Attended the University of Leicester Centenary Graduation event in my capacity as lay member of the University Council
Good Governance	• An Extraordinary Board meeting was held 10 June to approve the year accounts and associated documents. A further meeting was held on 15 June to approve the LPT 2022/23 financial and operational plan submission. • LPT Board development session held on 21 June which focused on health inequalities and the impact that LPT can have to reduce inequality for LLR patients; an update on the clinical plan and the estate plan; a review of committee governance. • Chaired the Joint Working Group for LPT & NHFT where we considered the process for an annual review of the Group Model and Memorandum of Understanding; the Rest and Rebuild programmes; the strategic framework and our 8 strategic priorities. • Interviewed for the Group Chief Financial Officer for LPT & NHFT • Interviewed for the ICS Interim Director of Finance • Interviewed for a Non-Executive Director in Coventry & Warwickshire Partnership Trust
Raising Health LPT's Charity	• Chaired the Charitable Funds Committee which included approving new bids to support staff networks and a review of the research and development projects funded by the charity. • In 2021 and 2022 Raising Health has focused on improving staff rooms for better wellbeing and upgrading outdoor spaces for patients and staff • The charity is hosting some roadshows at LPT sites to increase its visibility to patients and staff. • Our current fundraising appeals are detailed on our website https://www.raisinghealth.org.uk/

Governance table

For Board and Board Committees:	Trust Board 26 July 2022	
Paper sponsored by:	Cathy Ellis	
Paper authored by:	Cathy Ellis	
Date submitted:	18 July 2022	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	N/A	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	N/A	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Reported every public board meeting	
STEP up to GREAT strategic alignment*:	High **S**tandards	X
	Transformation	X
	Environments	
	Patient Involvement	X
	Well **G**overned	X
	Reaching out	X
	Equality, Leadership, Culture	X
	Access to Services	
	Trust Wide Quality Improvement	X
Organisational Risk Register considerations:	List risk number and title of risk	N/A
Is the decision required consistent with LPT's risk appetite:	N/A	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:	Yes reflects the role of our staff networks and personal commitment to inclusion	

Leicestershire Partnership NHS Trust

E

Trust Board of Directors – 26 July 2022

Chief Executive's Report

Purpose of the report

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

Analysis of the issue

National Developments

Coronavirus COVID-19

Since my last report, we have seen a continued increase in COVID-19 prevalence and a corresponding increase in pressure on our services through increased demand and staff absence. Whilst well-rehearsed, I do not underestimate the effect that responding to these pressures (both the heatwave and the pandemic) is having and want to thank staff in particular for their work during this period.

As at week ending 6 July 2022, the percentage of people testing positive for Coronavirus COVID-19 continued to increase across the UK with an estimated 2.9m people testing positive for the virus, some 5.27% of the population (roughly 1 in 19 people). The Office for National Statistics (ONS) estimates the incidence within the East Midlands region to be around 5.1%. The increase in infections is being seen across all age groups to varying degrees.

On 15 July 2022, the Government announced that certain people will be eligible for autumn COVID-19 booster and flu vaccinations. Based on independent advice from the Joint Committee on Vaccination and Immunisation (JCVI), this includes all people aged 50 and over, residents and staff in care homes for older adults, frontline health and social care workers, unpaid carers, individuals aged 5 to 49 in clinical risk groups and household contacts of those who are immunosuppressed. Details of how the autumn booster vaccination programme will be implemented will be set out nearer the start of the programme.

For more information on the autumn booster programme, please see the government website: https://www.gov.uk/government/news/health-and-social-care-secretary-accepts-jcvi-advice-on-autumn-booster-programme.

Public inquiry

On 28 June 2022, the Prime Minister confirmed the Terms of Reference for the UK COVID-19 Inquiry, which will be chaired by the Rt. Hon. Baroness Heather Hallett DBE. Approval of the Terms of Reference enables the Inquiry to officially begin its work.

The aims of the Inquiry (in summary) are to:

1. Examine the COVID-19 response and the impact of the pandemic in England, Wales, Scotland and Northern Ireland, and produce a factual narrative account, including:
    a. The public health response across the whole of the UK
    b. The response of the health and care sector across the UK
    c. The economic response to the pandemic and its impact, including governmental interventions
2. Identify the lessons to be learned from the above, to inform preparations for future pandemics across the UK.

Whilst the terms of reference serve as a framework, the Inquiry Chair has the discretion to explore issues in more depth as part of the Inquiry's scope. Public evidentiary hearings are expected to start in 2023, preceded by a 'listening exercise' in the autumn to enable people who wish to share their experience with the Inquiry to do so.

For more information on the Public Inquiry, including a copy of the full terms of reference, please visit the dedicated website: https://covid19.public-inquiry.uk/.

Monkeypox

Cases of monkeypox infection were confirmed in England from 6 May 2022. Monkeypox is a zoonotic infection, caused by the monkeypox virus, that occurs mostly in West and Central Africa. Previous cases in the UK had been either imported from countries where monkeypox is endemic or contacts with documented epidemiological links to imported cases. The outbreak has mainly been in gay, bisexual, and men who have sex with men without documented history of travel to endemic countries. As of 14 July 2022, there were 1,856 confirmed cases in the UK. Of these, 1,778 are in England and the highest proportion were London residents (c. 75% of English cases). By contrast, there were 20 confirmed cases in the East Midlands region. NHFT is working in partnership with other local health and care agencies under national guidance on how to respond to the monkeypox outbreak.

For more information on Monkeypox please see the UK Health Security Agency's website: https://www.gov.uk/government/news/monkeypox-cases-confirmed-in-england-latest-updates

Health and Care Act 2022

1 July 2022 is a major milestone for the new legislation, which amongst other things sees the formal establishment of Integrated Care Boards (ICBs) and the merger of NHS England and Improvement. ICBs replace Clinical Commissioning Groups (CCGs), taking on most of their functions and some of the commissioning functions of NHS England.

NHS Providers has produced a guide to the health and care act 2022, which is available on the organisation's website: https://nhsproviders.org/a-guide-to-the-health-and-care-act-2022.

NHS England and Integrated Care Systems

On 1 July 2022, together with 41 other areas across England, Leicester, Leicestershire and Rutland's Integrated Care Board (ICB) and Integrated Care Partnership (ICP) became legal entities as part of the county's Integrated Care System (ICS). ICS' are formed to drive the delivery of better, more efficient and joined-up care for patients, improvements in physical and mental health, and reductions in inequalities among the communities they serve.

At the same time as these changes to ICS', NHS England and NHS Improvement formally merged and became NHS England. Speaking at the annual NHS Confederation exposition, NHS England Chief Executive Amanda Pritchard set out four challenges for the NHS in the coming years:

- **Recovery** – ensure that people who need care, tests, and treatment can get it as quickly as possible;
- **Reform** – make the most of the opportunities presented by system working, and technology and data, to provide more effective, more convenient and more preventative services;
- **Resilient** – build capacity and capability to withstand the shocks of the future, including working to ensure we have the right numbers of staff, the right physical and community capacity, and the right approach to urgent and emergency care in particular, and;
- **Respect** – look after our staff, providing the best possible value for taxpayers, and ensuring that all patients are treated as equal partners in their care, and their needs and opinions are central to how we plan, deliver and improve services.

New Government Ministers

Following the resignation of Rt. Hon. Sajid Javid, MP, Rt. Hon. Steve Barclay was appointed to the role of Secretary of State for Health and Social Care on 5 July 2022. Mr Barclay oversees a team of five other ministers: Gillian Keegan MP, Minister of State for Care and Mental Health; Maria Caulfield MP, Minister of State; Maggie Throup MP, Minister for Vaccines and Public Health; James Morris MP, Minister for Patient Safety and Primary Care; and Lord Kamall, Minister for Technology, Innovation and Life Sciences.

NHS England consultation on governance

On 27 May 2022, to support NHS Trusts and Foundation Trusts to work effectively within systems, NHS England launched consultations on a revised Code of Governance for NHS provider Trusts, a draft Addendum to 'Your Statutory Duties – a reference guide for NHS Foundation Trust Governors' and draft guidance on good governance and collaboration under the NHS provider licence.

Code of Governance - for the first time, the Code of Governance applies both to NHS Foundation Trusts and to Trusts. It brings together the latest best practices of the NHS and private sector to set out a common overarching framework for the corporate governance of trusts that complements statutory and regulatory obligations.

Good governance and collaboration – the draft guidance on good governance and collaboration sets clear high-level expectations of collaboration in three key areas; engaging consistently in shared planning and decision making; consistently take collective responsibility with partners for delivery of services across various footprints including system and place; and consistently taking responsibility for delivery of agreed system improvements and decisions.

Experiences from health and social care: the treatment of lower-paid ethnic minority workers

During 2020, the Equality and Human Rights Commission (EHRC) carried out an inquiry to assess the treatment and experiences of lower-paid (agenda for change band 1 to 3) ethnic minority workers in health and social care, particularly during the COVID-19 pandemic. According to data within the report, ethnic minorities represent 17.8% of the lower-paid workforce across health and social care in England.

EHRC made a number of recommendations for the government, regulators, NHS Trusts/Foundation Trusts, Local Authorities and Integrated Care Systems, for more information and to access a copy of the report please visit the website: https://equalityhumanrights.com/en/publication-download/experiences-health-and-social-care-treatment-lower-paid-ethnic-minority-workers

Care Quality Commission Strategy – one year on

In 2021, the CQC set 'a new strategy for the changing world of health and social care' through which it sought to strengthen its commitment to ensure health and care services provide people with safe, effective, compassionate, high-quality care and to encourage those services to improve. Comprised of four themes (people and communities, smarter regulation, safety through learning and accelerating improvement), the strategy aimed to assess local systems and tackle inequalities in health and care.

A year on from the launch of the strategy, in a recent blog post, the CQC's Chief Executive notes that during the pandemic the CQC adapted its approach to maintain a view of quality. While some of our routine inspection work was paused, the CQC developed a way of having structured conversations with providers and used monthly reviews gave assurance to people about the quality of care.

The CQC developed a new single assessment framework following extensive engagement and believes that it will help the organisation to understand how people experience care across a geographical area as well as in an individual service. For more information on the single assessment framework, please visit the CQC's website: https://www.cqc.org.uk/about-us/how-we-will-regulate.

The Health and Care Act 2022 has given the CQC a new role in looking at systems. This includes a role reviewing and assessing integrated care systems (ICSs) as well as new powers to look at how local authorities meet their social care duties. Feedback from the CQC on the outcomes of its series of coproduction sessions on system regulation is available via the organisation's YouTube channel: https://youtu.be/cRty0l29xHY

Interacting with people with a learning disability

From 1 July 2022, the Health and Care Act 2022 introduced a new requirement for providers registered with the CQC to ensure that their staff receive training in how to interact appropriately with people with a learning disability and autistic people, at a level appropriate to their role. Pending the outcomes of the anticipated consultation on a Code of Practice, the CQC has updated its statutory guidance for Regulation 18 to explicitly include the requirement concerning training and supervision of those working with people with a learning disability and/or autistic people.

The CQC has signalled that during inspections it will be checking whether providers are training their staff in how to interact appropriately with people with a learning disability and autistic people, at a level appropriate to their role. The CQC will also look at whether providers have assessed the competencies of their staff following the training.

For more information on the updated regulations please visit the CQC's website: https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-18-staffing.

Building the Right Support Action Plan

On 14 July 2022, the Government published the Building the Right Support Action Plan, which brings together in one place commitments from across government and public services to ensure there is suitable community support available for people with a learning disability and autistic people. This supports government plans to reduce reliance on mental health inpatient care. It aims to ensure that people are treated with dignity and respect; experience personalised care and treatment; and can live an ordinary, independent life in their own home as part of the community.

Within the plan are measures to speed up discharge for people with a learning disability and autistic people, limit the scope under which people with a learning disability and autistic people can be detained and build on specialist training for health and care staff to ensure they have the skills to better care for people with a learning disability and autistic people.

For more information on the plan, please visit the Government's website:
https://www.gov.uk/government/news/better-care-for-people-with-a-learning-disability-and-people-with-autism

Update to the Duty of Candour Regulation

The CQC has recently updated its guidance on the Duty of Candour to clarify how the term 'unexpected or unintended' should be applied when trying to define whether or not something qualifies as a notifiable safety incident. The updated guidance clarifies that providers should "interpret "unexpected or unintended " in relation to an incident which arises in the course of the regulated activity, not to the outcome of the incident… So, if the treatment or care provided went as intended, and as expected, an incident may not qualify as a Notifiable Safety Incident, even if harm occurred.". To access a copy of the guidance in full, please visit the CQC website: https://www.cqc.org.uk/guidance-providers/all-services/duty-candour-notifiable-safety-incidents.

Draft Mental Health Bill 2022

On 27 June, the government published the draft Mental Health Bill following its White Paper 'reforming the Mental Health Act' and an independent review undertaken by Sir Simon Wessely (in 2018). The Bill is currently in a period of pre-legislative scrutiny before it eventually becomes law. It addresses many of the proposals in the White Papers, including the introduction of four guiding principles, increasing the frequency of automatic referrals to the mental health tribunal and the creation of a statutory nominated person role.

The four new guiding principles are:

- Choice and autonomy – ensuring service users' views and choices are respected;
- Least restriction – ensuring the MHA powers are used in the least restrictive way;
- Therapeutic benefit – ensuring patients are supported to get better, so they can be discharged from the MHA;
- Person as an individual – ensuring patients are viewed and treated as individuals

It is expected that the Bill will pass through parliament early next year before receiving royal assent later in 2023/24 at the earliest. An implementation period of up to ten years is anticipated owing to the lead time for training additional clinical and judicial staff.

A copy of the draft Mental Health Bill can be found on the government's website: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1085870/draft-mental-health-bill-print-ready.pdf.

NHS England system oversight framework for 2022/23

On 27 June 2022, NHS England published the NHS Oversight Framework through which it confirms NHS England's approach to oversight for the 2022/23 financial year in line with both the priorities set out in national planning guidance and the legislative changes made by the Health and Care Act 2022. The new framework reinforces system-led delivery of integrated care in line with the NHS Long Term Plan; Integrating Care Next steps to building strong and effective integrated care systems across England, and the Integration White Paper. The new framework took effect from 1 July 2022 and is available on the NHS England website: https://www.england.nhs.uk/publication/nhs-oversight-framework-22-23/

Leadership for a collaborative and inclusive future

On 8 June 2022, General Sir Gordon Messenger and Dame Linda Pollard published the final report following their review of leadership and management in the NHS and social care sector. Recommendations within the report are grouped under seven headings covering areas including collaborative leadership; equality, diversity and inclusion; accredited training; a standard appraisal system; career and talent management; recruitment and development of Non-Executive Directors; and encouraging top talent into challenged parts of the system.

To access a copy of the report please visit the government's website: https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future/leadership-for-a-collaborative-and-inclusive-future

Next Steps for integration primary care: Fuller Stocktake report

On 26 May 2022, NHS England published Dr Claire Fuller's report assessing how newly formed Integrated Care systems and primary care could work together to improve care for patients. Her report sets a new vision for integrating primary care, improving the access, experience and outcomes for communities, which centres on three essential offers:

- **streamlining access to care and advice** for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it
- **providing more proactive, personalised care with support from a multidisciplinary team of professionals** to people with more complex needs, including, but not limited to, those with multiple long-term conditions
- **helping people to stay well for longer** as part of a more ambitious and joined-up approach to prevention.

Within the report, Dr Fuller recommends that systems focus on developing integrated neighbourhood 'teams of teams' out of Primary Care Networks (PCNs), bringing together previously siloed teams and professionals to do things differently to improve care for the whole population. For more information and to access a copy of the report

please visit the NHS England website: https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf.

Women's Health Ambassador

In June 2022, Dame Lesley Regan, Professor of Obstetrics and Gynaecology at Imperial College London St Mary's Hospital, was appointed Women's Health Ambassador to support the implementation of the upcoming women's health strategy for England. The strategy will ensure that all women feel comfortable talking about their health, can access services that meeting their needs, have access to high quality information and education, and feel supported and can reach their full potential in the workplace. It will embed routine collection of demographic data as part of research trials to make sure that research reflects the society served.

For more information on Dame Lesley's appointment please see the government website: https://www.gov.uk/government/news/dame-lesley-regan-appointed-womens-health-ambassador

A plan for digital health and social care

On 29 June 2022, the Department of Health and Social Care published a plan for digital health and social care, setting out a vision for a digital future for leaders with a plan to effect a digital transformation of health and social care.

Designed for leaders within the sector, the publication confirms that digital transformation of health and social care is a top priority for the Department of Health and Social Care (DHSC) and NHS England (NHSE). It sets out a single action plan to achieve the four goals of reform identified by the Secretary of State will be approached, through which the system will be equipped to:

- prevent people's health and social care needs from escalating
- personalise health and social care and reduce health disparities
- improve the experience and impact of people providing services
- transform performance

Please visit the government website to access a copy of the plan: https://www.gov.uk/government/publications/a-plan-for-digital-health-and-social-care/a-plan-for-digital-health-and-social-care

Data saves lives: reshaping health and social care with data

In June 2022, the Department of Health and Social Care published the latest version of its data strategy in which it describes how the NHS will embrace the digital revolution and the opportunities that data-driven technologies provide. It responds to recent reviews by Professor Ben Goldacre, 'better, broader, safe: using health data for research and analysis', and Laura Wade-Gery, 'putting data, digital and tech at the heart of transforming the NHS', and centres on seven areas:

1. Improving trust in the health and care system's use of data
2. Giving health and care professionals the information they need to provide the best possible care
3. Improving data for adult social care
4. Supporting local and national decision-makers with data
5. Empowering researchers with the data they need to develop life-changing treatments, diagnostics, models of care and insights
6. Working with partners to develop innovations that improve health and care
7. Developing the right technical infrastructure

Since the latest strategy refreshes an earlier draft version, much of the work envisaged is already now underway. The publication sets out the progress so far before making commitments for the future. As with any national strategy, this data strategy will frame our local plans in our local health economy.

To access the strategy please visit the government's website: https://www.gov.uk/government/publications/data-saves-lives-reshaping-health-and-social-care-with-data/data-saves-lives-reshaping-health-and-social-care-with-data

Healthy Foundations: integrating housing as part of the mental health pathway

On 20 May 2022, the NHS Confederation published a report setting out what should be done at the policy and practice levels to achieve a more integrated and strategic approach between health, housing and social care. It makes seven recommendations asserting that now is an opportune time to invest in and make explicit the relationship between mental health and housing.

For more information on the report and its findings, please visit the NHS Confederation website: https://www.nhsconfed.org/publications/healthy-foundations-integrating-housing-part-mental-health-pathway

Local Developments

Major expansion of mental health crisis support as new crisis cafes start to open across Leicester, Leicestershire and Rutland

The Leicester, Leicestershire and Rutland Clinical Commissioning Groups (LLR CCGs) and Leicestershire Partnership NHS Trust (LPT), in partnership with Voluntary Action LeicesterShire (VAL) are expanding the number of crisis cafés as they announce the next 11 cafes that are set to open.

The first of 11 new Crisis Cafes was launched in Coalville, North-West Leicestershire, at the Marlene Reid Centre (MRC). More than 40 local people and some of the organisations who will work with the centre, came to hear from the café owners, the NHS and a number of the people who currently use MRC.

Recruitment event for community health and mental health services

Offering a wide range of opportunities to join LPT in clinical and administrative roles in our community health and mental health services, at an event at Leicester Tigers on Thurs 7 July 2022.

Rescue dogs help veterans improve their mental wellbeing through therapeutic open water swim sessions this summer

Over this summer, a number of ex-service personal will take part in a series of unique NHS-supported open water swimming sessions with award winning rescue dogs, to help them with post-traumatic stress disorder (PTSD).

The four-hour sessions will take place at Stanton Lakes in Stoney Stanton, following a successful pilot held in September 2020. The veterans taking part will don wetsuits and take part in a series of relaxing floating and towing experiences in the water with the specially trained Newfoundland dogs, as part of the mental health support they are receiving from Leicestershire Partnership NHS Trust's Armed Forces service.

Celebrating Excellence 2022

Our annual Celebrating Excellence Awards recognise our exceptional individuals and teams for their dedication and commitment to our vision: 'creating high quality, compassionate care and wellbeing for all' and our values of compassion, respect, integrity and trust.

We're excited to announce this year's awards ceremony will be back to face-to-face on the evening of Thursday 13 October 2022 (subject to any relevant Covid restrictions and infection prevention and control guidelines).

The awards are a superb opportunity to celebrate the significant contribution of Leicestershire Partnership NHS Trust (LPT) staff and volunteers, and to share their achievements for the wider benefit of patients, service users and staff.

LPT launches new online healthy recipes for little and big tummies to coincide with Dietitians and British Nutrition Foundation's Healthy Eating Weeks

Having fun and getting involved in the kitchen at an early age is the aim of Leicestershire Partnership NHS Trust's (LPT) early years nutrition and dietetics public health team, who have launched a new online resource to help get families cooking together. A range of step-by-step, budget friendly, yummy, easy to prepare and nutritionally balanced recipes are now available on the Health For Under 5s website for free, complete with easy to follow guides and videos.

South Asian Heritage Month 2022

The Black, Asian and Minority Ethnic (BAME) staff support networks from Leicestershire Partnership NHS Trust and Northamptonshire Healthcare NHS Foundation Trust are collaborating for the third year running to celebrate South Asian Heritage Month 2022 (Monday 18 July – Wednesday 17 August 2022). All staff are invited to take part in the events lined up, with the aim of learning from and sharing in the celebrations.

Queen's Jubilee/NHS Big Tea – July 2022

This year, to say thank you for all your hard work and also celebrate the Queen's Jubilee and the NHS' Birthday, we once again took part in the NHS Big Tea. Our charity Raising Health organised for each team/area at LPT to have a Big Tea with the help of funding from NHS Charities Together.

Volunteers' week – 1-7 June 2022

Volunteers play such an important role in supporting the Trust. Without them our services would not be as enriched as they are. The last year has been exceptionally challenging, and we would like to thank all our volunteers, including those who are waiting patiently to return to their roles, for their time and commitment.

Relevant External Meetings attended since last Trust Board meeting

June 2022	July 2022
LLR NHS CEO's meeting	LLR Inaugural ICB Board
Regional Mental Health Trusts CEO Meeting	Midlands regional roadshow
Vice Chancellor DMU	LLR NHS CEO meeting
LLR ICB Board	National Mental Health Trusts CEO meeting
LLR System flow partnership meeting	NHS providers Board Meeting
LLR System Executive meeting	LLR Systems Flow Partnership Meeting
Midlands Regional MH Deep Dive	LLR System Executive group
LLR UEC CQC Feedback system review	UHL COO introduction meeting
ICB CEO designate	Inclusive Leadership masterclass with NHFT
National CEO working group (MH)	LLR ICB meeting
MP Briefing	UHL COO meeting
LLR NHS CEO Meeting	*South Asian Heritage month
NHS providers finance committee	*CQC engagement
Lead Connect and Learn festival LLR	*LLR System Flow Partnership Meeting
Rutland County Council	* LLR System Executive group
LLR System discussion re G&A capacity modelling	
HSJ roundtable	
DMU Centre for Excellence in Empathic Healthcare	
HWB – ICB session	

Proposal

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

Decision required

None.

Governance table

For Board and Board Committees:	Trust Board 26 July 2022	
Paper sponsored by:	Angela Hillery, Chief Executive	
Paper authored by:	Kate Dyer, Deputy Director of Governance and Risk	
Date submitted:	18 July 2022	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	None	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	n/a	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Routine board report	
STEP up to GREAT strategic alignment*:	High **S**tandards	
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	Yes
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trust wide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	none
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed	
Equality considerations:	None	

Leicestershire Partnership NHS Trust

F

Trust Board – 26 July 2022

Organisational Risk Register

Purpose of the report

The Organisational Risk Register (ORR) contains strategic risks that may prevent us from achieving our objectives. It is presented as part of a continuing risk review process.

Analysis of the issue

There are currently 23 risks on the ORR, of which, one is presented for closure. Of the 23 risks, eight (35%) have a high current risk score.

ORR risks (July 2022)

No.	Title	SU2G	Initial risk	Current risk	Residual Risk	Tolerance
57	The lack of an embedded clinical and quality governance infrastructure may result in insufficient or inconsistent application of systems and processes, resulting in poor quality care and patient harm.	High Standards	12	8	8	16-20
58	Insufficient Safeguarding competency may result in limitations on service provision, which may result in poor quality care and patient harm.	High Standards	12	12	8	16-20
59	Lack of staff capacity in causing delays in the incident management process, including the review and closure of a backlog of reported incidents, the investigation and report writing of SIs and the closure of resulting actions. This will result in delays in learning and could lead to poor quality care and patient harm as well as reputational damage.	High Standards	12	16	12	16-20
60	A high vacancy rate for registered nurses, AHPs, HCSWs and medical staff, is leading to high agency staff usage, which may result in poor quality care and patient harm.	High Standards	16	20	16	16-20
61	A lack of staff with appropriate skills will not be able to safely meet patient care needs, which may lead to poor patient outcomes and experience.	High Standards	16	16	12	16-20
62	Insufficient understanding and oversight of regulatory standards and key lines of enquiry may result in non-compliance and/or insufficient improvement in priority areas, leading to sub-standard care.	High Standards	12	12	8	9-11
64	If we do not retain existing and/or develop new business opportunities, we will have less financial sustainability and infrastructure resulting in a loss of income and influence within the LLR system.	Transformation	12	12	9	9-11
65	The present FM provision does not meet our quality standards or requirements, leading to the inability to provide the full hard and soft Facilities Management and maintenance service within LPT. This impacts compliance, timeliness of maintenance responses and quality of services for patients, staff and visitors.	Environments	16	16	12	16-20
66	The lack of detail around accommodation requirements in strategic business planning, means that the Estates Strategy cannot adequately plan for potential building solutions, leading to an estate configuration which is not fit to deliver high quality healthcare.	Environments	12	12	8	16-20
67	The Trust does not have a Green Plan or identified resource for the green agenda, leading to non-compliance with the NHS commitment to NHS Carbon Zero.	Environments	12	12	9	9-11
68	A lack of accessibility and reliability of data reporting and analysis	Well Governed	16	16	8	9-11

	will impact on the Trust's ability to use information for decision making, which may impact on the quality of care provided.					
69	If we do not appropriately manage performance, it will impact on the Trust's ability to effectively deliver services, which could lead to poor quality care and poor patient experience.	Well Governed	8	8	4	9-11
71	*If we do not have a sufficiently detailed financial plan for 2022/23, the Trust will not have clarity over the actions required to deliver the plan, resulting in a plan which is not fit for purpose for the Trust or LLR.*	*Well Governed*	*15*	*10*	*10*	*9-11*
72	If we do not have the capacity and commitment to proactively reach out, we will not fully address health inequalities which will impact on outcomes within our community.	Reaching Out	16	12	8	16-20
73	If we don't create an inclusive culture, it will affect staff and patient experience, which may lead to poorer quality and safety outcomes.	Equality, Leadership and Culture	12	12	9	16-20
74	As a result of covid 19, winter pressure, service recovery and workforce restoration there is a risk that our staff's health and wellbeing will be compromised, leading to increased sickness levels.	Equality, Leadership and Culture	9	9	6	16-20
75	Increasing numbers of patients on waiting lists and increasing lengths of delay in accessing services will mean that patients may not be able to access the right care at the right time and may lead to poor experience and harm.	Access to Services	16	16	8	16-20
77	Without the appropriate level of focus, resource and preparation, the Trust cannot adequately support the National Public Inquiry into the Covid Pandemic, leading to a lack of lessons learned, inability to respond effectively to future situations and major incidents, a failure to comply with the Public Inquiry statute and reputational damage.	Well Governed	12	12	8	9-11
78	Inability to sustain the level of cleanliness required within the National Cleanliness Standards and Hygiene Code	Environment / High Standards	12	12	8	9-11
79	The Cyber threat landscape is currently considered significant due to the geopolitical conflicts, high prevalence of cyber-attack vectors, increase in published vulnerabilities, etc which could lead to a significant impact on IT systems that support patient services and potential data breaches	Well Governed	16	12	8	16-20
80	If staff are not vaccinated against influenza, they pose a risk to the health and wellbeing of themselves, colleagues, patients and the wider community. This would adversely impact on Public Health, potentially leading to increased hospitalisation, increased staff sickness levels and staffing challenges and a risk to those who are vulnerable.	High Standards / Equality, Leadership and Culture	20	12	8	16-20
81	Inadequate control, reporting and management of the Trust's 2022/23 financial position could mean we are unable to deliver our financial plan and adequately contribute to the LLR system plan, resulting in a breach of LPT's statutory duties and financial strategy (including LLR strategy)	Well Governed	15	15	10	9-11
82	The loss of the 11+ healthy together contract will mean a change in delivery for this service from LPT to the LA, impacting on Trust staff and income, and continuity of care for secondary school aged children.	High Standards	16	16	12	16-20

Proposal

Closures

- **Risk 71** If we do not have a sufficiently detailed financial plan for 2022/23, the Trust will not have clarity over the actions required to deliver the plan, resulting in a plan which is not fit for purpose for the Trust or LLR.

  We are proposing the closure of this risk now that the final financial plan has been submitted. The one outstanding action around ICS capital strategy development is incorporated into the delivery of the in-year plan (Risk 81).

Decision required

- Closure of risk 71

Governance Table

For Board and Board Committees:	Trust Board 26 July 2022	
Paper sponsored by:	Chris Oakes, Director of Governance and Risk	
Paper authored by:	Kate Dyer, Deputy Director of Governance and Risk	
Date submitted:	18 July 2022	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	None	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Regular	
STEP up to GREAT strategic alignment*:	High **S**tandards	Yes
	Transformation	Yes
	Environments	Yes
	Patient Involvement	Yes
	Well **G**overned	Yes
	Reaching Out	Yes
	Equality, Leadership, Culture	Yes
	Access to Services	Yes
	Trust wide Quality Improvement	Yes
Organisational Risk Register considerations:	All	Yes
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed	
Equality considerations:	None	

Risk No: 57	Date included	29 November 2021	Date revised	15/07/2022
Objective: S	High Standards			
Risk Title:	The lack of an embedded clinical and quality governance infrastructure may result in insufficient or inconsistent application of systems and processes, resulting in poor quality care and patient harm.			
Risk owner:	Exec: Director of Nursing, AHPs and Quality and Medical Director	Local: Associate Director of AHPs and Quality		
Governance:	Quality Forum, QAC / Board - monthly review			

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

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

Controls	Description:	• Policies and procedures in place for delivery against all CQC Registration and Health and Social Care act requirements (i.e. core standards) • Clinical and quality governance model - systems and processes • Corporate Governance structures (3-tiered model) • Clinical quality teams in place to support delivery against core standards – corporate and directorate • Quality Schedule • Revised clinical and quality governance infrastructure – recruitment complete
	Gaps:	• Embeddedness of the infrastructure consistently across all Directorates

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

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

Status: Green

Risk No: 58	Date included	29 November 2021	Date revised	18/07/2022		Consequence	Likelihood	Combined
Objective: S	High Standards				Current Risk	4	3	12
Risk Title:	Insufficient Safeguarding competency may result in limitations on service provision, which may result in poor quality care and patient harm.				Residual Risk	4	2	8
Risk owner:	Exec: Director of Nursing, AHPs and Quality		Local: Head of Safeguarding		Tolerance level Significant 16-20 (Appetite Quality-Seek)			
Governance:	Safeguarding Committee / QAC / Board - Monthly Review							

Controls	Description	• Identified Safeguarding Lead Nurses & Practitioners -Child Lead, Adult Lead) and named Doctor for safeguarding children. • Member of local Safeguarding Boards, two Community Safety Partnerships and the Safeguarding Vulnerabilities group. • Adult and Children's Safeguarding Team • Advice line and use of incident reporting system to raise high priority safeguarding issues for specialist oversight by safeguarding team. • Policies and procedures in place		
	Gaps:	• The safeguarding training offer is not fully compliant with national standards and guidelines. • Implementation and embeddedness of the recommendations from the external review and quality improvement plan • Staff skill and knowledge re MCA including Liberty Protection Safeguards • Poor uptake of Bank Staff attending safeguarding suite of training provides a risk of poor quality of care and safety to the patients requiring safeguarding.		
Assurances	Internal:	Source: • Legislative Committee and Safeguarding Committee • Collaborative Safeguarding Report • Mandatory Training Compliance Report • Safeguarding Team training needs analysis • Safeguarding, Public Protection & MCA Report – April 2022	Evidence:	Assurance Rating Amber
	External:	Source: • Internal Audit – Liberty Protection Safeguards (Advisory 2022/23) • External review by quarterly SCAT return to the CCG • CQC Inspection 2021 • CQC inspections (contribution to CCG Safeguarding Inspections /direct LPT CQC Inspection) • Commissioner meetings, including quarterly safeguarding assurance template (SCAT) Membership of four Local Safeguarding Boards, including the Boards' respective sub-committees ,	Evidence: • CQC identified no major safeguarding concerns feedback from the CQC report published 10th November 2021. • Local Safeguarding Board reports and minutes	Assurance Rating Green
	Gaps:			

Actions	Date:	• Actions:	Action Owner:	Progress:	Status
	July 22	• Safeguarding adult training compliance with national standards	All - Safeguarding Dept		Amber
	July 22	• Quality Improvement Plan			
	July 22	• Implement and embed recommendations from the external review.			
	July 22	• Accuracy of training programme			
	July 22	• Training programme to be delivered from June 22			
	Aug 22	• Board Safeguarding training			

Risk No: 59	Date included	29 November 2021	Date revised	15/07/2022		Consequence	Likelihood	Combined
Objective: S	High Standards				Current Risk	4	4	16
Risk Title:	Lack of staff capacity is causing delays in the incident management process, including the review and closure of a backlog of reported incidents, the investigation and report writing of SIs and the closure of resulting actions. This will result in delays in learning and could lead to poor quality care and patient harm as well as reputational damage.				Residual Risk	4	3	12
Risk owner:	Exec: Director of Nursing, AHPs and Quality and Operational Executive Directors		Local: Head of Patient Safety		Tolerance level Significant 16-20 (Appetite Quality-Seek)			
Governance:	IOG, Quality Forum, QAC / Board - Monthly Review							

Controls	Description:	• Centralised SI reporting and oversight process • Incident reporting policy • Additional SI investigators recruited for newly reported SI's • Governance arrangements for escalation • Incident investigation training monthly rolling programme		
	Gaps:	• Directorate staff capacity for reviewing reported incidents and undertaking SI investigations from the backlog. See staffing vacancies risk 60 and the impact of covid on staffing risk 74. • Implementation of identified actions resulting from SI investigations		
Assurances	Internal:	Source • Oversight of performance • Reports/ minutes from Incident Oversight Group and Quality Forum • Quality Summit March 2022 • Monthly Quality Monitoring Report – Patient Safety Incident Investigation Report	Evidence • Directorate improvement plans - monitored via IOG and through to QF	Assurance Rating Red
	External:	Source: • Internal Audit – Patient Safety Incident Response Framework and Plan due Q3 2022/23 • CQC Inspection 2021 • CCG sign off and feedback for SI reporting	Evidence: • CQC feedback The trust must ensure that managers review incident in a timely way, in line with trust policy. (Reg17 (1)) • CCG – number of reports signed off / number returned for additional work	Assurance Rating Amber
	Gaps:	• Internal assurance / evidence to demonstrate learning		

Actions	Date: July 2022	Actions: Delivery of Directorate improvement plans for Incident and SI's	Owner: FM/SL/HT	Progress: ongoing	Status: Amber

Risk No: 60	Date included	29 November 2021	Date revised	18/07/2022
Objective: S	High Standards			
Risk Title:	A high vacancy rate for registered nurses, AHPs, HCSWs and medical staff, is leading to high agency staff usage, which may result in poor quality care and patient harm.			
Risk owner:	Exec: Director of Nursing, AHPs and Quality and Director of HR & OD		Local: Associate Director of Nursing and Professional Practice	
Governance:	Quality Forum, SWC/QAC /Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	5	20
Residual Risk	4	4	16

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

Controls

Description:

LPT Controls

- NHS Developing Workforce Safeguards standards incorporated into monthly staffing reviews
- Directorate safe staffing SOPs in place for business continuity, escalation and management Dedicated workforce and safe staffing matron and an international recruitment matron
- Trust retention and attraction schemes
- LLR System and LWAB working together on system initiatives
- Flexible working guidance launched
- Home first - Aging well started / Community Service Redesign Aging well recruitment
- International recruitment programme
- eRoster – 6 week planning and roster sign off
- Trust wide Safe Staffing policy
- New to healthcare induction programme

System controls

- Each organisation has risk assessed staffing
- Implemented escalation & mitigation plans
- NHSE&I – winter assurance plans completed
- Origination Accountable Officers Letter – about positive risk taking
- Workforce Sharing Agreement
- System escalation for Clinical Executive
- System discussion and joint decision making prior to significant derogation from NQB staffing levels/ skill mix

Gaps:

- National workforce shortages – particularly in LD, mental health and community nursing.
- Workforce Planning capacity / Medical Consultant capacity in AMH/CAMHS
- Resource capacity to respond fully to system wide urgent and emergency bed pressures

Assurances

Internal:

Source:
Incident Review Meeting
Daily safe staffing huddle, Winter Preparedness 2021 Nursing Safer Staffing BAF November 2021, National safe staffing return
6 monthly establishment reviews and monthly safe staffing reports to QAC/Trust Board
Trust wide local induction checklist for bank and agency staff
Safe staffing

Evidence:

- Self-assessment complete 4 key themes to enhance assurance, action plan developed
- Weekly situational and forecast staffing meeting

Assurance Rating Amber

External:

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

Assurance Rating Green

Gaps:

Actions

Date:	Actions:	Action Owner:	Progress:	Status
Jul 22	• MH Recruitment plan against 22/23 investment	John Edwards		Amber
Mar 23	• Recruit additional 44 international nurses	Asha Day	Second cohort of nurses are in post – on track	
Aug 24	• Develop a volunteer to career framework	Minaxi Patel	Framework in place to support volunteers – to be expanded	
Sept 22	• Recruit trainees to the HEE new roles training programme	SW / Louise Evans	Submitted a bid, meeting to review new roles governance framework June 2022	
Sept 22	• Increase our nursing associate recruitment for the Sept 22 cohort	Emma Wallis	Workforce planning session July 2022	
July 22	• PMO workstream to reduce reliance on agency spend project	PMO coordinator-ToD	Met in June 2022, ongoing project scoping with timescales	
August 22	• Task and Finish Group to review MH therapeutic and safe observations	Michelle Churchard	Established with ongoing meetings	
Oct 22	• HCSW Zero vacancy tasks and finish group	Jay Patel	Ongoing programme	

Risk No: 61	Date included	29 November 2021	Date revised	18/07/2022		Consequence	Likelihood	Combined
Objective: S	High Standards and Equality, Leadership, Culture				Current Risk	4	4	16
Risk Title:	A lack of staff with appropriate skills will not be able to safely meet patient care needs, which may lead to poor patient outcomes and experience.				Residual Risk	4	3	12
Risk owner:	Exec: Director of Nursing, AHPs and Quality and Director of HR & OD		Local: Head of Education, Training and Development		Tolerance level Significant 16-20 (Appetite Quality-Seek)			
Governance:	SWC, QAC / Board - Monthly Review							

Controls	Description:	• Mandatory and Role Essential Training Policy, Study Leave Policy • National and local People Plan • Safer staffing policies and guidance • MHOST tool for review of patient acuity and dependency measurement • E rostering in place across inpatient services and community • Auto planner within CHS / E rostering in place across inpatient services and community • On-going recruitment programme • Recovery of Mandatory Training compliance action log reported to Training Education and Development Group monthly		
	Gaps:	• National tools to measure therapy staffing for patient acuity and dependency • Low compliance to ILS and BLS mandatory training		
Assurances	Internal:	Source: • SWC , Directorate Workforce groups , retention working group • Quarterly workforce triangulation to ops exec - hotspots and action • Workforce and Wellbeing Board • Transformation committee • Hotspots identified on Directorate Risk Registers • Weekly safe staffing meeting **KPIs** • Core Mandatory Training Compliance for substantive staff - Target is >=85% (Feb 22 = 90%)	Evidence: • Mandatory Training and Role Essential Training Flash Report (December) • Noc trust board and SEB deep dive • Directorate risk registers received at DMTs • Quarterly triangulation document to Exec Team with action plan. • Month 12 performance report (March 2022)	Assurance Rating Green
	External:	• NHS retention support and benchmarking data		Assurance Rating Green
	Gaps:			

	Date:	Actions:	Owner:	Progress	Status
Actions	Jul 22	• New process for amending compliance requirements to position numbers	AOD / Helen Briggs	Progress ongoing, deadline moved to July 22	Amber
	Jul 22	• Manager compliance and DNA reports live on ulearn	AOD / Helen Briggs		
	Sept 22	• Pilot safe care and review establishment	Amrik Singh	Imperial Innovations and Allocate (system suppliers) have agreed that evidence based tools can be used in SafeCare however the license for each tool has to be purchased. Paper will be sent to Execs for approval.	
	Sep 22	• Deteriorating Workforce and Sepsis Group to progress and review training and compliance for ILS and BLS	Margot Emery	Ongoing	
	Sep 22	• STAR days	AOD / Helen Briggs	Promotion material sent out	

Risk No: 62	Date included	29 November 2021	Date revised	11/07/2022
Objective: S	High Standards			
Risk Title:	Insufficient understanding and oversight of regulatory standards and key lines of enquiry may result in non-compliance and/or insufficient improvement in priority areas, leading to sub-standard care.			
Risk owner:	Exec: Director of Nursing, AHPs and Quality	Local: Lead for Quality, Compliance and Regulation		
Governance:	Foundation for GPC, Quality Forum, QAC / Board - Monthly Review			

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

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

Controls0	Description:	• Quality Improvement work programme / Quality accreditation • Foundation for Great Patient Care with KLOEs driving the agenda • Quality Surveillance Tracker • Core standards training / 3 phased methodology • Trust self-assessment for KLOE/Well Led framework • CQC inspection preparation checklist • Procedure for responding to a CQC Inspection • Time to Shine Booklet and Training • Well Led information pack • Work programme in place for Foundation for Great Patient Care to ensure cross Trust learning.
	Gaps:	• Implementation of the Foundations 4 High Standards programme • Staff capacity to support implementation of the programme and delivering on the improvement actions. (see risk 59 for mitigations)

Assurances	Internal:	• Quality surveillance tracker • CQC action plan • Weekly CQC action plan assurance meeting • Foundation for great patient care / Quality forum / QAC / Trust Board • 15 Steps • Feedback from Focus Groups • Patient feedback	Evidence: • CQC must do action plan - complete • Mental Health Act inspection action plans in progress • CQC Re-inspection action plan devised	Assurance Rating Green
	External:	Source: • CQC Inspection 2021 / re-inspection report – published 5 May 2022 • Mental Health Act inspections • Urgent and Emergency Care system wide inspection – April 2022 • External Audit value for money conclusion 2021/22 (awaiting)	Evidence:	Assurance Rating Green
	Gaps:			

Actions	Date: Ongoing	Actions: Implementation of the Foundations 4 High Standards programme	Action Owner: Deanne Rennie/Jane Gourley	Progress: Programme in its infancy, pillar leads identified, plans on a page developed and monthly programme meetings in place. No end date for programme

Status
Amber

Risk No: 64	Date included	29 November 2021	Date revised	18/07/2022
Objective: T	Transformation			
Risk Title:	If we do not retain existing and/or develop new business opportunities, we will have less financial sustainability and infrastructure resulting in a loss of income and influence within the LLR system.			
Risk owner:	Exec: Director of Strategy and Business Development		Local: Head of Strategy	
Governance:	Transformation Committee / FPC / Board - Monthly Review			

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

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

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

Actions	Date: Ongoing July 22	Actions: Regular attendance at ICS Board meetings, transition and steering groups Development of robust business development road map for bid development	Owner: Chair & CEO Executive Director of Strategy & Partnerships	Progress: Achieving (this action will be on-going) Complete	Status Green

Risk No: 65	Date included	29 November 2021	Date revised	13/07/2022		Consequence	Likelihood	Combined
Objective: E	Environments				Current Risk	4	4	16
Risk Title:	The present FM provision does not meet our quality standards or requirements, leading to the inability to provide effective hard and soft Facilities Management and maintenance services. This impacts compliance, timeliness of maintenance responses and quality of estates provision for patients, staff and visitors.				Residual Risk	4	3	12
Risk owner:	Exec: Chief Finance Officer		Local: Associate Director Estates & Facilities		Tolerance Level Significant 16-20 (Appetite Quality-Seek)			
Governance:	Estates Committee, FPC / Board - Monthly Review							

Controls	Description:	• FM Business Case approved by the Board • Legal Exit Agreement in progress • FM Transformation Programme compliance and business case capacity through external contract • Relentless focus on driving up standards, with governance through EMEC • Increased property manager capacity to work with Operational teams on estates management • Compliance manager in post to oversee the data provided by contractors and escalate high risk areas requiring maintenance		
	Gaps:	• Exit legal agreement and staff engagement sessions via UHL as employer • Data on compliance has been very slow to be provided through our contract • Lack of supplier ownership and proactive management of estates risks • Poor KPIs performance with maintenance and repairs are not always undertaken in a timely manner		
Assurances	Internal:	Source: FM Oversight Group FM Transformation Board Estates and Medical Equipment Committee FPC Estates risk register	Evidence: • Provider service review meetings • Ongoing review of audit actions • Monthly estates updates including health and safety reviews • FPC estates updates	Assurance Rating Green
	External:	Source: • CQC inspection 2021	Evidence: • CQC report	Assurance Rating Amber
	Gaps:	• Lack of information available from UHL including asset information, job plans and TUPE information		

	Date:	Actions:	Action Owner:	Progress:	Status
Actions	Oct 22	• Staff engagement/ TUPE sessions jointly planned for Sept/Oct.	CFO	Date agreed with UHL for FM transformation for 1 November 2022	Amber
	August 22	• LPT Workstreams in progress including; Comms; Operational readiness; People; FM delivery model; Supple Chain; CAFM; Finance; Operational Plans; IT; Assets	CFO	• All workstreams have project plan reported monthly	
	Sept 22	• Creating asset information and job plans	CFO/Estates Team	• New Computer Aided Facilities Management purchased	

Risk No: 66	Date included	29 November 2021	Date revised	13/07/2022		Consequence	Likelihood	Combined
Objective: E	Environments				Current Risk	4	3	12
Risk Title:	The lack of detail around accommodation requirements in strategic business planning, means that the Estates Strategy cannot adequately plan for potential building solutions, leading to an estate configuration which is not fit to deliver high quality healthcare.				Residual Risk	4	2	8
Risk owner:	Exec: Chief Finance Officer		Local: Associate Director Estates & Facilities		**Tolerance** level Significant 16-20 (Appetite Quality-Seek)			
Governance:	Estates Committee, FPC / Board - Monthly Review							

Controls	Description:	• Approved Strategic plan for the elimination of dormitory accommodation • New Hospitals Programme (NHP) Expression of Interest submitted • Refresh of Mental Health inpatient Strategic Outline Case and bed modelling • Tripe R outputs • Estates Strategy refresh in progress • Capital resource prioritisation framework • Refreshed SUTG strategy 2021
	Gaps:	• Finalise ward moves to confirm phasing order for dormitories. Works continue on programme. • Directorate and enabling business plans to support wider Estate Strategy development

Assurances	Internal:	Source: • Strategic Property Group • Estates and Medical Equipment Committee • Finance and Performance Committee • Health and Safety Committee. Directorate Health and Safety Action Groups	Evidence: • Reports to EMEC • Consideration of estates strategy with directorates • Monthly report to FPC on progress against the Estate Strategy • Health and Safety Reports and confirmation of compliance	Assurance Rating Amber
	External:	Source: • CQC Inspection 2021, 2022 • Consideration of NHP expression of interest submitted 2022.	Evidence: • CQC report • NHSEI updated monthly on track.	Assurance Rating Amber
	Gaps:			

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

Risk No: 67	Date included	29 November 2021	Date revised	18/07/22	
Objective: E	Environments				
Risk Title:	The Trust does not have a Green Plan or identified resource for the green agenda, leading to non-compliance with the NHS commitment to NHS Carbon Zero.				
Risk owner:	Exec: Chief Finance Officer		Local: Chief Finance Officer		
Governance:	Estates Committee, FPC / Board - Monthly Review				

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

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

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

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

	Date:	Actions:	Owner:	Progress:	Status
Actions	Jun 22 Oct 22	Funding approval for sustainability posts Outline chapters drafted and shared with provisional chapter leads	CFO CFO	Awaiting confirmation CFO taking the lead on research to support draft chapters and working with System partners - deadline Oct 22	Amber

Risk No: 68	Date included	29 November 2021	Date revised	13/07/22		Consequence	Likelihood	Combined
Objective: G	Well Governed				Current Risk	4	4	16
Risk Title:	A lack of accessibility and reliability of data reporting and analysis will impact on the Trust's ability to use information for decision making, which may impact on the quality of care provided.				Residual Risk	4	2	8
Risk owner:	Exec: Director of Finance & Performance		Local: Head of Information		Tolerance Level Moderate 9-11 (Appetite Regulatory-Cautious)			
Governance:	Data Privacy Committee; FPC / Board - Monthly Review							

Controls

Description:
- Executive senior information risk officer (SIRO) sponsorship
- Information asset owners in place
- Clinical system training in place
- Performance management framework (which includes the 6 dimensions of data quality)
- Data quality policy and procedure
- Data Quality Kitemark & Framework approved by DQC, will be implemented for 22/23 reporting.

Gaps:
- Incomplete data quality reports for local and national data sets
- Insufficient monitoring of data quality incidents does not allow for learning opportunities
- Configuration of systems to support requirements of information standards and NHS data models
- Robust technical infrastructure to support timely and accessible use of data
- Ownership of data quality across the Trust – being picked up with support of Change Champion attendance at Data Quality Committee
- Capacity of the information team due to demands from national sitrep reporting
- Accessible data for front line clinical teams

Assurances

	Source:	Evidence:	
Internal:	• Performance review meetings include Directorate level metrics • FPC / Trust Board • Clinical audit • Annual record keeping audit • Data security and protection toolkit self assessment • Regular oversight reports from the IM&T Committee • Data quality committee • Local Risk register	• DSPT 'standards met' annual submission made in June 2022 • Data quality actions reported to FPC via Data Privacy Committee highlight report – assurance rating Green (June) - Local risks reviewed in Data Privacy Committee - Delivery of phase 1 21/22 data quality work plan	Assurance Rating Green
External:	Source: • Annual benchmark reporting against peers • Internal audit programme for data quality and reporting • Internal audit review of our data security and protection toolkit (DSPT) • Commissioner scrutiny	Evidence: • Data quality framework 21/22 audit – significant assurance • DSPT 21/22 360 assurance audit – Significant assurance	Assurance Rating Green

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

Actions

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

Risk No: 69	Date included	29 November 2021	Date revised	13/07/22
Objective: G	Well Governed			
Risk Title:	If we do not appropriately manage performance, it will impact on the Trust's ability to effectively deliver services, which could lead to poor quality care and poor patient experience.			
Risk owner:	Exec: Director of Finance & Performance		Local: Director of Finance & Performance	
Governance:	FPC / Board - Monthly Review			

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

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

Controls	Description:	• Board approved Performance management framework • Board level performance dashboard • Revised governance framework • SUTG plan • SOP in place • New automated report in place for 22/23 reporting		
	Gaps:	• Capacity of the information team due to demands from national sitrep reporting • Level 2 committee dashboards – implementation delayed due to COVID • Investment in information team capacity and a new performance team for the Trust supported by March 22 OEB, but funding in 22/23 not approved		
Assurances	Internal:	Source: • FPC / QAC / Trust Board reports • Bi monthly Performance review meetings • Simplified, directorate owned, board reporting and an agreed set of 2022/23 KPIs for the Board • Review of Information Team capacity & delivery model	Evidence: • Routine performance reporting with committee dashboards to FPC / QAC /Board – assurance rating green (April 2022) • Escalated items from performance reviews reported to OEB. • Performance reports narrative updated by Directorate Business Managers prior to release.	Assurance Rating Amber
	External:	Source: • CQC inspection 2021 • External and internal audit	Evidence: • Internal audit review of performance framework 21/22 – significant assurance	Assurance Rating Green
	Gaps:	• Fully embedded system (demonstrated once level 2 dashboards are fully implemented) • Trust wide approach to reporting planned post covid performance & capacity		

Actions	Date: Sept 22 Dec 22	Actions: • Restructure of information team • Phase 2 review of information team, including approach to performance framework management	Action Owner: SM SM	Progress: In Progress In Progress	Status Amber

Risk No: 71	Date included	29 November 2021	Date revised	13/07/22		Consequence	Likelihood	Combined
Objective: G	Well Governed				Current Risk	5	2	10
Risk Title:	If we do not have a sufficiently detailed financial plan for 2022/23, the Trust will not have clarity over the actions required to deliver the plan, resulting in a plan which is not fit for purpose for the Trust or LLR.				Residual Risk	5	2	10
Risk owner:	Exec: Director of Finance & Performance		Local: Deputy Director of Finance		Tolerance Level Moderate 9-11 (Appetite Financial-Cautious)			
Governance:	FPC / Board monthly							

Controls	Description:	• LPT & LLR system 4-year financial strategy defines plan deliverables • LPT Financial & Operational Planning process supports plan development • H1 & H2 financial plan delivered a breakeven position for LPT system, ensuring solid foundations for 22/23 planning • Agreed prioritisation criteria for internal investments • LLR Triple lock process for system funded investments • Transformation Committee oversight of efficiency plan development • Capital Management Committee develops the capital plan with input from key estates & I, M & T leads & prioritises schemes against agreed criteria • Standing Financial instructions underpin planning approach		
	Gaps:	• System wide approach to financial planning & in year management is new & untested • Trust's transformation & value approach to identifying efficiencies is new • LLR Design groups ability to identify & deliver sufficient savings • Culture change required across system partners • LLR capital strategy not yet defined • LPT & LLR ICS April plan submissions show a combined deficit of £49m		
Assurances	Internal:	Source: • Plan reports for committees includes I & E, cash, efficiency & capital plans to deliver against NHSI guidance , statutory requirements and the LPT & LLR financial strategy • Board approval of final 2022/23 plans • Submitted LPT finance, activity, workforce & performance plans to ICS/NHSI	Evidence: • Draft plans presented to OEB, SEB, FPC & Trust Board December – April • Efficiency plan delivery presented to Transformation Committee • Draft 22/23 operational & finance plans submitted 17/03/22 • Final Trust board plan sign off of April plan 28/04/22 • Revised June plan board sign off before submission on 20/06/22	Assurance Rating Green
	External:	Source: • ICS Finance committee with Executive & Non-Executive leads from each NHS LLR organisation • ICB sign off of ICS financial plan • NHSI acceptance of submitted plan	Evidence: Highlight report presented to ICB Minutes of meeting	Assurance Green
	Gaps:			

	Date:	Actions:	Action Owner:	Progress:	Status
Actions	Jun 22	Respond to & manage actions required as a result of any NHSI escalation & plan resubmission requirements	SM	LPT plan submitted on 20/06/22	Green
	Dec 22	LLR ICS capital & financial strategy development	SM	Action captured within the in-year plan delivery in Risk 81	

Risk No: 72	Date included	29 November 2021	Date revised	18/07/2022
Objective: R	Reaching Out			
Risk Title:	If we do not have the capacity and commitment to proactively reach out, we will not fully address health inequalities which will impact on outcomes within our community.			
Risk owner:	Exec: Director of Strategy and Business Development		Local: Head of Strategy	
Governance:	Transformation Committee / FPC bi-monthly / Board Quarterly			

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

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

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

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

	Date:	Actions:	Owner:	Progress:	Status
Actions	July 22	Reaching out delivery plan as part of the Step Up to Great (SUTG) strategy and plan	David Williams	Revised timescales – end July 2022	Amber
	Aug 22	Social value framework co-produced	David Williams	Discussions with HACT Re framework and tool taking place and proposal received.	
	July 22	Further agreement on our approach and calculating impact and value	David Williams	To be developed once the SUTG delivery plan completed – as above revised timescales end of July 2022	
	July 22	Development of inequalities data in an accessible format	Information Team		

Risk No: 73	Date included	29 November 2021	Date revised	18/07/2022
Objective: E	Equality, Leadership, Culture			
Risk Title:	If we don't create an inclusive culture, it will affect staff and patient experience, which may lead to poorer quality and safety outcomes.			
Risk owner:	Exec: Director of HR & OD		Local: Head of Equality, Diversity and Inclusion	
Governance:	SWC, QAC / Board - Monthly Review			

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

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

Controls

Description:

- Our Future Our Way / Leadership behaviours (which includes an EDI specific behaviour)
- 6 high impact action submission has been signed off by EDI Workforce Group
- Anti – Racism strategy co production with NHFT part of group model
- EDI Taskforce - 10 action areas agreed.
- 8th We Nurture OD targeted sessions for BAME staff delivered
- Reverse mentoring. Second cohort completed and third cohort launched.
- National and LPT People Plan priorities being addressed.
- WRES and WDES action plans revised annually and being implemented.

Gaps:

- Improved delivery against outcome measures / WRES and diversity metrics
- Embeddedness of WRES/ WDES/ Together Against Racism action plan/ NHSEI high impact actions (Inclusive talent management implementation)

Assurances

Internal:	• Diversity workforce dashboard reported to SWC • Regular reporting of equalities progress against measures to level 2 and 1 committees • Annual Equalities Action Plans revised and produced for WRES, WDES and GPG • Staff survey results inform action planning	• EDI annual report to EDI committee / EDI group • WRES/WDES DATA published action plan to QAC/SWC – highlight report that include assurance ratings. • Staff survey report Trust Board – results	Assurance Rating Green
External:	Source: • System wide EDI Taskforce established and identified seven priority areas for implementation	Evidence: • EDI Taskforce – highlight report assurance rating • CQC feedback • EDI projects and programmes being resourced and delivered across the system and internally • WRES and WDES metrics have improved in most areas.	Assurance Rating Green
Gaps:			

Actions

Date:	Actions:	Owner:	Progress:	Status
Aug 22	Revision of WRES and WDES action plans and six high impact Race	Haseeb Ahmed		Green
Aug 22	Equality Actions following analysis of latest data.	HA/ Kamy Basra		
Oct 22	Launch of refreshed Zero Tolerance Campaign and guidance	HA (with Bina Kotecha)		
Sept 22	Delivery of Cultural Competency Programme	HA		
Sept 22	Establishing Equality Objectives within staff appraisals	HA		

Risk No: 74	Date included	29 November 2021	Date revised	18/07/2022		Consequence	Likelihood	Combined
Objective: E	Equality, Leadership, Culture				Current Risk	3	3	9
Risk Title:	As a result of covid 19, service recovery and workforce restoration there is a risk that our staff's health and wellbeing will be compromised, leading to increased sickness levels.				Residual Risk	3	2	6
Risk owner:	Exec: Director of HR & OD		Local: Deputy Director of HR and OD		Tolerance Level Significant 16-20 (Appetite People - Seek)			
Governance:	SWC, QAC / Board - Monthly Review							

Controls	Description:	• Wellbeing, sickness management policy • Counselling service • Anti bullying harassment and advice service • Staff Physiotherapy scheme • Health and wellbeing champions • Leadership Behaviours Framework • NHS People Plan national support • Staff risk assessments / stress indicator • System mental health HWB hub • Mental health and Wellbeing Hub • Occupational health service wellbeing strategy and implementation plan • Occupational health department / Staff reps / Amica • Health and Wellbeing Lead / People Promise Manager (starting May 22)		
	Gaps:	- Impact of financial pressures on health and wellbeing – task and finish group to review cost of living in place		
Assurances	Internal:	• Financial HWB support task and finish group • Daily Sickness absence monitoring • Sickness and workforce reports to SWC / QAC • Sickness reviews within divisions • Staff side – monthly meetings • Referrals to OH and Amica	Evidence: • Sickness absence rate LPT target 4.5% - current performance (March 22) 5.2% • Staff side – feedback • Action plan reporting through SG AND ICC	Assurance Rating Amber
	External	Source: • Be well midlands staff engagement process by NHSEI • NHSI reporting • LLR workforce group • Health and wellbeing taskforce group	Evidence: • NHSI benchmarking reports • Attendance at external NHSI wellbeing workshops • MHWB hub data	Assurance Rating Green
	Gaps:			

Actions	Date: Oct 22 Nov 22	Actions: • Delivery of the Health and Wellbeing Action Plan • Codesign review of the anti bullying and harassment policy	Action Owner: Amy Huckle Claire Taylor	Progress: Reviewing HWB framework to identify gaps Progressing	Status Amber

Risk No: 75	Date included	29 November 2021	Date revised	18/07/2022		Consequence	Likelihood	Combined
Objective: A	Access to Services				Current Risk	4	4	16
Risk Title:	Increasing numbers of patients on waiting lists and increasing lengths of delay in accessing services will mean that patients may not be able to access the right care at the right time and may lead to poor experience and harm.				Residual Risk	4	2	8
Risk owner:	Exec: Medical Director		Local: Operational Executive Directors		**Tolerance Level** Significant 16-20 (Appetite Quality-Seek)			
Governance:	Waiting List and Harm Prevention Committee, FPC and QAC / Board - Monthly Review							

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

Assurances	Internal:	Source: • Strategic waiting times and harm review committee • Directorate level performance and accountability reviews • Waiting time performance reported to Finance and Performance Committee • Spot checks of safety of patients waiting • Directorate risks including risk 4677 for CYP ED • Agreed joint working approach between LLR and Northants system to undertake demand and capacity modelling	Evidence: • Performance dashboards and reporting to DMTs , OEB and Trusts Board • Trajectory for improvement and measurement against trajectory • Transformation plans • Report to triangulate evidence of harm with Trust wide data from Patient Safety and Patient Experience	Assurance Rating Green
	External:	Source: • Internal Audit – Remote Consultations due Q1 2022/23 • Internal Audit – Patient Experience due Q1 2022/23 • CQC inspection 2021 • System performance monitoring • NHSI Regional Escalation oversight • National benchmarking data • Quality / Contract Monitoring with CCG & Specialised Commissioning with escalation route	Evidence: • CQC inspection 2021 action plan – reinspection report awaited for April 2022	Assurance Rating Amber
	Gaps:			

	Date:	Actions:	Owner:	Progress:	Status
Actions	July 22	Understanding the outputs of the demand and capacity modelling and feeding into the transformation programme	Director of MH AS/AvH		Amber
	July 22	Consideration of avoidable harm measures including impact of partial or full COVID related closures			

Risk No: 77	Date included	1 December 2021	Date revised	18/07/2022
Objective: G	Well Governed			
Risk Title:	Without the appropriate level of focus, resource and preparation, the Trust cannot adequately support the National Public Inquiry into the Covid Pandemic, leading to a lack of lessons learned, inability to respond effectively to future situations and major incidents, a failure to comply with the Public Inquiry statute and reputational damage.			
Risk owner:	Exec: Deputy Chief Executive		Local: Deputy Director of Governance and Risk	
Governance:	Public Inquiry Programme Board / SEB / Trust Board - monthly review			

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

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

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

Actions	Date: July 22	Actions: Ongoing collation of evidence	Action Owner: Clare Lacey	Progress: In progress and on track

Status
Amber

Risk No: 78	Environment / High Standards	Date reviewed:	18/07/2022		Consequence	Likelihood	Combined
Risk Title:	If levels of cleanliness are not sustained, the Trust will not comply with the requirements of the National Cleanliness Standards and Hygiene Code which may impact on patient safety and experience.			Current Risk	4	3	12
Director risk owner:	Director of Nursing, AHP's and Quality and Chief Finance Officer			Residual Risk	4	2	8
Governance / Review:	IPCC, QAC and FPC / Board - Monthly Review			**Tolerance** level Moderate 9-11 (Appetite Reputational–Cautious)			

Controls	Description:	• Contract management with NHSPS for provision of soft facilities management (including cleaning standards) • Collaborative agreement in place with UHL for provision of soft facilities management (including cleaning standards) • Use of the Hygiene standards • LPT estates rep sits on/reports into IPC Group (cleaning/water/waste/decontamination) • Infection control team / IPC quarterly report and annual report / • SOPs in place to describe key responsibilities • Audit programme includes Cleaners rooms and trolleys / Clear and agreed reporting mechanism against the Hygiene code • 21/22 FM SLA and performance KPIs • Revised cleaning spec/scope (zoned wards) and allocation of cleaning responsibilities (FM staff/Ward staff) • On outbreak wards staff aligned to task for whole shift. System in operation and working. • Additional rapid response staff • LPT participation in NHSEI cleaning with confidence (CwC) campaign – training programme added to Ulearn • Service spec updated to introduce a third daily clean to IP areas • Inpatient ward matron cleaning roles and responsibility meetings with the Director for Infection, Prevention and Control • IPC operational meeting		
	Gaps:	Progress with the FM transformation including; • Progress with sustained implementation of the turnaround plan • Appropriately trained estates team in place • UHL / NHSPS representation at LPT IPC Group and Cleaning Forum • Inconsistent reporting with cleaning scores • Number of audits completed KPI not being met		
Assurances	Internal:	Source: • Implemented the National Standards of Healthcare Cleanliness 2021 • Align pandemic cleaning routine to the National Standards of Healthcare Cleanliness • Cleaning report to the Estates Committee • Finance and Performance Committee • IPC Group to QAC • Bi-monthly contractual cleaning forum (estates/IPC/NHS PS/UHL) - this goes to estates committee and FPC. • Regular cleaning audits and KPI score monitoring • IPC Bi-Annual report to Trust Board	• DMTs • Monthly reports to FPC (Estates) and QAC - (IPC) • Environmental audit • Contractual cleaning audit findings • Regular performance reports against hygiene standards and regular review at IPC	Assurance Rating Amber
	External:	Source: • NHSI IPC audit • CQC inspections	Evidence: • National Guidance on cleaning for COVID-19 • CQC IPC summary inspection report	Assurance Rating Green
	Gaps:	UHL Facilities Cleaning Turnaround plan - plan received 4.10.21 - nothing further to IPC Group.		

Actions	Date: Ongoing	Actions: Implementation of the cleaning turnaround plan with evidence	Action Owner: UHL – oversight R. Brown	Progress All actions are on-going	Status: Amber

Risk No: 79	Date included	29.03.22	Date revised	13/07/22
Objective: G	Well Governed			
Risk Title:	The Cyber threat landscape is currently considered significant due to the geopolitical conflicts, high prevalence of cyber-attack vectors, increase in published vulnerabilities, etc which could lead to a significant impact on IT systems that support patient services and potential data breaches			
Risk owner:	Exec: Director of Finance & Performance/SIRO		Local: Head of Data Privacy	
Governance:	Data Privacy Committee, FPC/Bi-Monthly Review			

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

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

Controls

Description:

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

Gaps:

- Authentication of identity at service desk contact – implementation of multifactor authentication at all levels of the organisation
- New digital posts required such as CIO
- Phishing simulations delayed due to covid

Assurances

	Source:	Evidence:	
Internal:	Bi-Monthly report to Data Privacy Committee LHIS re-accreditation of secure email system [ISO27000] and Cyber Essentials Consultancy Review and testing of disaster recovery and business continuity processes in response to real world testing Cyber metrics reported through DPC Dashboard Reporting of incidents	Accreditation reports Output reports and remediation plans Dashboard for Committee meeting Data breach reports to Data Privacy Committee	Assurance Rating Green
External:	LHIS ISO Audit KPMG Understanding IT 21/22 Audit 360 Assurance DSPT Audit 21/22 DSPT submission – standards met 21/22	Accreditation report Audit report Audit Report – substantial assurance NHS Digital submission	Assurance Rating Green
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Aug 22	Board Development session re: Cyber Threat	Chris Biddle	Board Development Session 23 August 2022	Green
Sept 22	Cyber Threat update report to Audit Committee	Chris Biddle	Audit Committee Agenda item	
June 22	DSPT submission	Hannah Plowright	Completed 30 June	

Risk No: 80	Date included	29 March 2022	Date revised	18/07/22
Objective:	High Standards / Equality, Leadership and Culture			
Risk Title:	If staff are not vaccinated against influenza, they pose a risk to the health and wellbeing of themselves, colleagues, patients and the wider community. This would adversely impact on Public Health, potentially leading to increased hospitalisation, increased staff sickness levels and staffing challenges and a risk to those who are vulnerable.			
Risk owner:	Exec: Director of Nursing AHPs and Quality		Local: Trust clinical lead for staff flu vaccinations	
Governance:	Trust Strategic Flu and Covid-19 Group / Quality Forum / QAC / Board - monthly review			

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

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

Controls

Description:	• Strategic Flu and Covid-19 Group and staff vaccination workforce group • NIVS system for uptake reporting – weekly SITREP and use of QR code to record staff who have been vaccinated outside of LPT. • Flu vaccine order placed mid March 2022 . Sufficient for all frontline healthcare workers • Mixed delivery model of roving vaccinators, peer vaccinators in clinical areas and co-delivery of Flu and COVID vaccinations if advised by JCVI • Implementation of the national best practice vaccination programme principles including flexible access, board endorsement, publicity and comms and staff incentives • Communications plan weekly for clinic availibity with dedicated Comms support • High level action plan which aligns with national and LLR plans and uptake ambitions • Clinical peer vaccinators to support teams on site and during the shift • Focused work through Trust CQUIN group • Vaccine confidence training for all peer vaccinators • Supportive focused clinics for supporting colleagues with needle phobia • Flu group with Directorate champions
Gaps:	• No vegan or vegetarian vaccine available • Considerable vaccine reluctance amongst LPT staff for additional vaccination after Covid vaccination x3 in previous 12 months • Low levels of circulating flu in the wider community has been interpreted as flu vaccination not being required • Flu vaccination uptake correlates with increasing age – younger staff do not see Flu as a health concern for their age group

Assurances

Internal:	Source Monthly review at the Strategic Flu and Covid-19 Group and staff vaccination workforce group with reporting to level 1 and 2 committees Update reporting from NIVS and weekly SITREP CQUIN reports CQUIN action to deliver 70% staff vaccinated	Evidence: Papers to SEB / QF and QAC Data uptake and analysis presented to Strategic Flu and Covid-19 Group Update in highlight report to the Quality Forum Weekly LPT SITREP for flu uptake	Assurance Rating Green
External:	Source LPT reports into the situation reports for the LLR Flu and Covid-19 Board	Evidence: SITREP	Assurance Rating Amber
Gaps:	• Number of staff affected by vaccine reluctance and lack of vegetarian / vegan vaccine is not known • Staff having flu vaccination outside of LPT requires individual staff to confirm this as access through NIMS is no longer available		

Actions

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

Risk No: 81	Date included	29 April 2022	Date revised	13/07/22
Objective: G	Well Governed			
Risk Title:	Inadequate control, reporting and management of the Trust's 2022/23 financial position could mean we are unable to deliver our financial plan and adequately contribute to the LLR system plan, resulting in a breach of LPT's statutory duties and financial strategy (including LLR strategy).			
Risk owner:	Exec: Director of Finance & Performance		Local: Deputy Director of Finance	
Governance:	FPC / Board monthly			

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

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

Controls	Description:	• National planning guidance followed in preparation of the plan • LPT Financial & Operational Plan triangulated with workforce plan • Standing Financial Instructions support control environment • Treasury management policy , cash flow forecasting ensure robust cash management • Capital Financing strategy & plan in place • LPT draft medium term financial strategy in place & presented to Trust Board April 2022
	Gaps:	• Culture change required across system partners • LLR ICS medium term capital strategy not yet in place • LLR ICS medium term revenue strategy not yet in place • LPT 22/23 April plan delivered a £1.4m deficit- revised breakeven, best endeavours plan submitted 20/06/22 • ICS Risk/gain share could adversely impact on LPT's financial position

Assurances	Internal:	Source: • Audit Committee • Operational oversight & management of cost forecasts through Directorate Management Teams • Capital Management Committee's oversight of capital delivery and agreed governance processes; • Finance and Performance Committee report includes I & E, cash & capital reporting • LLR ICS Finance committee oversight	Evidence: • Reports & updates from Internal & external auditors • Monthly Director of Finance report to FPC / Trust Board – highlight report assurance rating Red (June 2022) • Ongoing oversight and management of all aspects of financial position against plans • Monthly reports to OEB/SEB/FPC/Board/ICS finance committee on all aspects of delivery against plan • Mitigation plans for capital and revenue to ensure plans are delivered
	External:	Source: • KPMG audit of 2021/22 annual accounts and value for money conclusion • Internal Audit Report 2021/22: Key financial systems • Internal Audit Report 2021/22: Integrity of the general ledger and financial reporting • Internal Audit Report 2021/22: Capital expenditure processes	Evidence: • 2021/22 annual accounts unqualified opinion • Significant assurance • Significant assurance • significant assurance
	Gaps:	• ICS financial risk needs to feed into LPT financial risk	

Assurance Rating Amber

Assurance Rating Green

Actions	Date:	Actions:	Action Owner:	Progress:
	Mar23	Continued monitoring and management of all aspects of the Trust's delivery of the financial plan	SM	
	Jul 22	Add in relevant ICS Financial risk content to LPT risk	SM	ICS risks drafted – presented to June ICS finance committee; more work required
	Dec 22	Contribute to LLR ICS capital & financial strategy development	SM	CFOs have discussed approach
	Dec 22	Revise LPT medium term capital & financial strategy to ensure alignment with ICS strategy	SM	

Status: Green

Risk No: 82	Date included	10 May 2022	Date revised	8 July 22
Objective: G	High Standards			
Risk Title:	The loss of the 11+ healthy together contract will mean a change in delivery for this service from LPT to the LA, impacting on Trust staff and income, and continuity of care for secondary school aged children.			
Risk owner:	Exec Lead: FYPCLD Director / Director of Strategy and Partnerships	Local: Janet Harrison		
Governance:	FYPC DMT / Ops Exec Board / Board monthly			

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

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

Controls

Description:

- LA mobilisation plan
- Service specifications
- National Healthy Child Programme
- LPT policies and procedures / standard operating guidance / competency frameworks
- TUPE arrangements confirmed as not applicable due to fragmentation of service; this secures professional supervision and training
- Clarity over framework requirements for SCPHNs, supervision and training resolved through retention of staff ; LA policies and procedures/ SOPs and competency frameworks not relevant now TUPE does not apply
- LSCB / LPT Safeguarding practice and guidance

Gaps:

- Appropriate representation from health partners at Safeguarding strategy calls and conferences
- Ability of the new provider to access the historical electronic clinical record
- Data sharing to provide system partnership alerts e.g. primary care and UHL Emergency Department
- Active caseload handover
- Continuity of single EPR
- Communication with families regarding new provider arrangements
- Suitable alternative employment for all staff involved in the 11-19 service
- Income shortfall and overhead contributions

Assurances

Internal:	Source: • Mobilisation group for 0-11 plus transition to LA 11+ offer • Directorate Management Team • Ops Exec Board • MoC for 5-19 staff	Evidence: Teams project plan Minutes of meetings DMT minutes / De-mobilisation assurance document / financial plan OEB Minutes SOG for caseload handover 1:1's with FSM and HR	Assurance Rating Amber
External:	Source: • Director of Public Health and Commissioners • LCC Integrated Project Meeting 11+ - with 5 workstream groups; Comms; IT; Information Governance; Rutland; Safeguarding Plus operational group	Evidence: ToR and Workstream groups established Operational group established to work through caseload handover	Assurance Rating Red
Gaps:	Health representation for safeguarding from 1 September		

Actions

Date:	Actions:	Action Owner	Progress:	Status
Jun 22	• Raised as a risk to Leicestershire County Council and CCG	D Williams	Raised and actions below confirmed	Amber
8 Jul 22	• Raised with System Executive as a system risk	D Williams		
26 Jul	• System meeting between ICB senior nurse leaders to identify solutions for health representation for safeguarding	C Trevithick		
12 Aug	• Options and recommendations to System Executive	C Trevithick		
31 Aug	• Complete 1:1's with all 5-19 staff as part of MoC	J Harrison		

Leicestershire Partnership NHS Trust

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26th July 2022 Public Trust Board

Response to Healthwatch paper: Accessing mental health services during crisis – May 2021

Purpose of the report

To provide a brief overview of the Healthwatch paper that was published in May 2021 including its limitations. To receive a response to each of the recommendations described in the paper.

Background

The healthwatch paper was received in various committees within Leicestershire Partnership NHS Trust after its May publication. The Trust discussed with Healthwatch that it would not immediately respond to the recommendations due to its plans to commence a large public consultation that included proposals with urgent care and crisis services.

The consultation concluded with over 6,500 contributors and over 70% agreement on all of the questions posed in the consultation including the changes to urgent mental health care.

Each recommendation from the healthwatch paper was explored in turn, in the context of the learning from the consultation. The full paper can be found in Appendix A. The remainder of this paper outlines the proposed actions in response to the paper's recommendations.

Healthwatch report

The Leicester and Leicestershire Healthwatch undertook a survey and focus-group based exploration of people's experiences with:

- Accessing support services
- Using urgent support services (i.e. LPT Referral service)
- Discharge from support services
- Highlight good practice and positive patient experience
- Highlight common patient experience themes
- Highlight evidenced recommendations

The recommendations and findings were drawn from a small sample size of 27 people in 2020. This segmented down further to a smaller number of people that described themselves as having direct experience of the different services that were the subject to the review. The responses that Healthwatch received was mixed across the different questions but overall weighted towards a greater degree of negative experiences and views. The presentation of information was predominantly in percentages and therefore difficult to see how many people represented positive or negative positions against each question. The overall small sample size is unlikely to represent the diversity views of the populations that use or need urgent mental health support. Those limitations aside, the overall 'sense' from

the feedback and recommendations that Healthwatch derived from their analysis does resonate with the insights from the events and direct feedback acquired in the larger consultation.

Actions in relation to the Healthwatch paper

There were eight recommendations in the paper. The following describes actions being undertaken by the Trust in conjunction with system partners.

1. ***There needs to be additional training on mental health and triage for GP surgery administrative staff.***

The Trust are working with partners to look at how we can roll out mental health skills training for wide range of staff including primary care known as 'decider' skills. This both provides better awareness and understanding of mental health needs but also skills that the whole continuum, of administrative to clinical staff, can use.

2. ***Leicestershire Partnership NHS Trust (LPT) needs to explore ways to improve its triage service and not leave patient on hold on the phone for a long period of time.***

The public consultation supported the intent to ensure that the central access point offer was reliable and responsive. This will be part of the implementation plan from the consultation.

3. ***LPT needs to address the inconsistencies in the Central Access Point (CAP) Service response for patients.***

There was not strong feedback in the consultation on inconsistency of support from Central Access Point however we recognise that a good service should be both individualised and not inappropriately inconsistent. This will again be part of the quality improvement and development of the Central Access Point.

4. ***LPT needs to explore interim support for patients who are waiting for mental health services to respond.***

In 2022/23 we will be looking at ways that we can strengthen the interim support that can be offered to people. This includes investment in voluntary sector provision, crisis cafes and recovery services. Our ultimate goal is to significantly reduce the time that people wait for support and this is a key focus of our transformation plans. However, we recognise that there is a period where people have and, for the immediate future, will continue to have long waits. We ensure there is a clear understanding with patients waiting what they can currently expect in terms of waits and provide different places that they can seek support, including the 24/7 central access point, if their needs escalate. Targeted additional interim support is also offered to individuals based on their presenting risks. Nevertheless, we recognise that we can strengthen the support provided to people as they wait.

5. ***There needs to be improved advertising of local urgent mental health services to all communities and age groups, including the support Social Services can provide to support those with mental ill health.***

This was also strong finding from the consultation, that promotion and education around the services available to support people's mental health had not been good enough. Improving this was a recommendation agreed from the consultation and is being taken forward through the transformation plans. Advertisement around the central access point has already commenced. There is also now a self-guidance and support function being trialled on the LPT website

6. ***Urgent access to Mental Health Services needs to be made more accessible, especially for those that are deaf or hard of hearing.***

There were various communities, engaged as part of the consultation, that felt that access to direct contact points was limited including the deaf community. This again featured as a recommendation from the consultation to be addressed as part of the transformation plan. We are working with service users and partners to make sure that our materials are fully accessible, for example the deaf community and those with hearing impairments, an audience that was flagged in the report.

7. ***Ensure that the patient mental health record is shared with relevant providers at the point of crisis so that patients do not have to keep repeating their story to different service providers.***

The local system is moving towards advanced shared care plan approach which will allow an increased level of sharing between system partners this is expected to be in place by the end of 22/23 (with partial use by the summer of 2022).

8. ***Feed this information gathered from this review into the forthcoming combined Clinical Commissioning Group review into getting help in neighbourhoods.***

The development of the getting help in neighbourhoods (development of VCS and integrated services around local patches within Leicester, Leicestershire and Rutland) is going to be accelerated in 2022/23 as part of the system MH commissioning plan. The findings from this report will be made available as part of that process.

Recommendations

LPT Trust Board are asked to:

- note the findings and recommendations undertaken by Healthwatch in relation to crisis and urgent mental health care in LLR and its limitations
- Support the actions being undertaken in response to the recommendations

Governance table

For Board and Board Committees:	Trust Board 26 July 2022
Paper sponsored by:	Fiona Myers, Interim Director for Mental Health
Paper authored by:	John Edwards, Associate Director for Transformation
Date submitted:	19.7.22

State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Directorate Management meeting 30th March 2022 Strategic Executive Board 1st April 2022	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	**Assured**	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	**One off report**	
STEP up to GREAT strategic alignment*:	High **S**tandards	X
	Transformation	X
	Environments	
	Patient Involvement	
	Well **G**overned	
	Reaching out	
	Equality, Leadership, Culture	X
	Access to Services	X
	Trust Wide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	
Is the decision required consistent with LPT's risk appetite:	NA	
False and misleading information (FOMI) considerations:	Nil	
Positive confirmation that the content does not risk the safety of patients or the public	It does not risk safety of patients and public	
Equality considerations:	Equality Impact assessment undertaken as a component of the public consultation (related to the recommendations from the Healthwatch Board). Ensuring inclusivity of access (particularly for deaf community) is a component of recommendations.	

Gii

Leicestershire Partnership NHS Trust

Trust Board 26th July 2022

Response to Healthwatch paper: Male Suicide - Turning the Tide: raising awareness to reduce death by suicide (February 2022)

Purpose of the report

To provide a brief overview of the Healthwatch paper that was published in February 2022 and the Trust key areas for response and action. To receive a response to each of the recommendations described in the paper.

Introduction

Male Suicide - Turning the Tide: raising awareness to reduce death by suicide was published in February 2022 by Healthwatch. Healthwatch Leicester and Healthwatch Leicestershire is the independent voice of the public in health and social care services. They collect feedback from the public about their experiences of using health and social care services and use that feedback to work with service providers and commissioners to find ways to improve services. One of the ways that they collect feedback is by carrying out focused projects as part of their annual workplan. The male suicide report is a 37-page document with 13 recommendations.

This report pulls some key messages from the Report, outlines a brief Trust response against each of the recommendations – the responses are part of work already in progress and illustrate an ongoing commitment to our system-wide approach to suicide prevention. LPT is an active partner in the Leicester, Leicestershire and Rutland (LLR) Suicide and Audit Prevention Group and provided initial support and sector knowledge to the project.

Healthwatch reviewed a range of national research evidence and spoke with local organisations, individuals and carers who have accessed the whole range of services with an interest in suicide prevention. The Report largely concentrates on the voices of men interviewed and some of those have been quoted in this paper. The recommendations are consistent with transformation plans to strengthen pathways between services, develop ongoing support in primary care/mental health interface following self-harm and suicide attempts and to target priority groups to access specific support for mental health before a crisis.

Further resources in support of the wider national context of men and suicide is contained in detail in a specific 'men and suicide' section within the new LPT Staff Resource for Self-Harm and Suicide Prevention.

Suicide in Men in Leicester, Leicestershire and Rutland

The aims and objectives of the project Healthwatch reported on were:

- To understand the purpose of the LLR Suicide Awareness and Prevention Group and its role in the prevention of suicide across Leicester and Leicestershire, identifying any gaps in the prevention pathway
- To identify and contact suicide prevention services across the city and county and identify any gaps in service provision
- Give a voice to people who have used or attempted to use services to tell us of their experiences
- Identify any potential barriers that prevent men from coming forward to access services
- Explore ways to raise awareness of services and suggest appropriate tools to promote services

455 deaths have been recorded since January 2015 and 353 of these were males. This represents 75.1% of all deaths and nationally, 45–49-year-old men have the highest age-specific suicide rate, but the risk for LLR is nearly equal from 25 years through to 54 years.

Since the first version of the Healthwatch Report, we have also become aware through local intelligence that Melton has the second highest incidence of male suicide per % of population in the country – work is proceeding to verify, clarify and explore that through Leicestershire Police who lead the surveillance for LLR.

Key Findings Relevant to LPT **(Pages 18-23 of the Healthwatch Report)**

Men who had no diagnosed mental health condition or any long-term mental health issues were the ones who were more likely to fall through the net. There was a distinct lack of knowledge amongst participants on what help was available or where they could go for help. They were also the ones who were reluctant to access formal services not wanting to be seen as a 'patient' receiving counselling or psychiatric care.

Page 18 specifically related to the urgent care pathway: *It was not possible to get figures prior to meeting of the number of people who had attended ED subsequently having taken their own life. It is known however that 40% of male suicides in Leicester and Leicestershire over the past 5 years were known to mental health services. It has not been possible however to find out how many of these were in touch with mental health services at the time of their suicide, or whether they had been previously in touch or had been assessed for support from the mental health team but had not met the criteria for a service.*

The Report highlights the need for better access to services for individuals from diverse communities - with a recurring theme that people do not find existing services relatable or safe.

The report particularly highlighted the lack of ED and mental health team support for men who had presented to UHL with self-harm:

> *"I have attended A&E countless times from the age of 18 until the last time at Christmas 2020. I have taken around 17 overdoses and cut my wrists countless times. I have been dealt with in A&E and discharged but never had any follow up"*

There is limited evidence however of how ED link into the broader suicide prevention strategy. There is no sharing of information protocol in terms of the numbers of people attending ED who have attempted suicide or self-harmed so there is no opportunity to consider who may be at high risk who could be targeted for community-based prevention services. This we were told is being developed currently. We received feedback from both mental health service users and bereaved relatives of people who have died by suicide and most of this feedback indicated negative experiences and gaps in services. We interviewed eight men who were long term mental health service users many of whom were or had been regular attenders at ED for self-harming behaviours[1]

And men who do not make contact with services:

> *"I didn't want to worry my family and friends and didn't want them getting all upset and phoning the doctor and people like that. Once you are in the system that's it for life. You will be labelled mentally ill and I didn't want that."*

Healthwatch Recommendations and LPT Responses

Healthwatch Recommendations		Suggested LPT Response[2]
1.	A review and strengthening of Pathways between NHS Trusts, GP's, ED and SAPG to improve coordination of services for those who self-harm or attempt suicide and present to GPs or ED. There is an important role in prevention particularly for primary care, ED, and mental health services. SAPG should focus on how these services can improve the recognition of risk and respond to men's needs, and how services might work better together.	Alignment with NICE Consultation due July 2022 Align with findings of NCISH Annual Report 2021 Ongoing work across the Urgent Care Pathway to develop and include aligned processes and skills for effective alcohol and substance misuse services
2.	ED and mental health services to develop a system to follow up people admitted or assessed by mental health services following a suicide attempt and to ensure they have information about ongoing support	Ensure that clinical practices are supported to deliver and support effective personal safety planning and follow-up calls.

[1] Page 23 incorrectly states: *The Mental Health team will carry out a rapid review led by the Medical Director and consider any immediate learning from an incident.* Rapid Clinical Reviews – a process introduced by the Lead Nurse Suicide Prevention is now facilitated by the Deputy Head of Nursing for Urgent Care.

[2] It has not been possible to get any feedback about ongoing discussions to inform these suggested responses – hence the recommendation.

	services. ED and mental health services to develop a system to follow up people admitted or assessed by mental health services following a suicide attempt and to ensure they have information about ongoing support services.	Align also with improved provision of sign-posting, managed referrals and specific & supportive follow-up
3.	Mental health services to provide information about ongoing support when discharging patients and hand over care following a suicide attempt or self-harm so that people have options for support should this be required.	Need to develop pathway outlining informed criteria for referral into secondary services Develop interface with new MHPs and PCNs. Would that be a useful part of the prevention and follow-up pathway.
4.	Information on where men can get help quickly and easily to be made available in an accessible way on the internet with a media campaign on how this can be accessed. Also consider information packs to be available in key places such as Libraries and Job Centres etc	Need to consider how to actively contribute to this via the Mental Health Facilitators and GHiN?
5.	A campaign to raise awareness of men's mental health and suicide prevention targeted at men who do not access mental health services either through choice or who don't meet the criteria for mental health support. This should be in partnership with organisations and businesses whose demographic is largely men such as sporting activities, pubs and clubs, where men can receive information on help available discreetly. (A campaign is planned to take place in January in partnership with Everards's brewery and Leicester United sporting clubs to raise awareness amongst men but there may be other opportunities to be explored with other business, community organisations in Leicester and Leicestershire.) Get the Ball Rolling	To consider active involvement in this campaign and others – also ensuring that any work is diverse and inclusive, built on a range of private and public social spaces that men across the life span inhabit. Also need to target older men as per NCISH data through covid at higher risk >65
6.	Information to be available to GP's, ED and mental health services that can be given to men who present with self-harm or suicide ideation but who do not need admission or mental health input so that men are not discharged without access to ongoing support.	Need to link across to current NICE consultation Self harm: assessment, management and preventing recurrence In development [GID-NG10148] as there are fuller details about the role

		of GPS/ED – although the evidence base is low Need to continue promoting info@harmless.org.uk, 01158 800280. A referral can be made via self-referral or professional referral and the online referral form is available at: harmless.org.uk/referring-partners-self-harm-form-leicestershire/ We have disseminated information for Mensoar – Men's Peer Support Groups via DMH S-H & SPG www.mensoar.co.uk/
7.	Development of a poster giving information to men on how they can access help either through use of a QR code or something discreet that is available in public place that men are likely to access including places like job centres.	Need to consider a response as system partner – likely to be a specific piece of Public Health work
8.	Consideration of more awareness raising activities targeted at younger men in schools, colleges, youth clubs etc, providing information on where men can go to access help or information and raising the profile of #StartAConverstation.	Need to consider a response as system partner – likely to be a specific piece of Public Health work
9.	Evidence of access to suicide prevention and support by the BAME and LGBT community is that the numbers are low. Consideration to be given by commissioners to allocating a specific budget to specialist providers of services to BAME groups and LGBT communities to develop these services to ensure that these groups have equal access to support to services that are relevant to their needs.	Needs a specific LPT programme of work to be considered at the Trust Suicide Prevention Group
10.	Further work to be considered looking at the myths and realities of the perceived low uptake of engagement of BAME and LGBT communities in suicide prevention initiatives.	Need to consider a response as system partner – recommended to be a specific piece of Public Health work.
11.	Information sharing protocols around ED attendances and admissions should be	Part of the work in support of Recommendation 1, 2, 3 & 6

	agreed as a priority in order to accurately identify high risk groups and ensure resources are targeted at these groups and appropriate follow up support provided.	
12.	Public health to collect demographic data on the number of self-harm cases in order to assist with targeting of services and to analyse any demographic connection between those that self-harm and those that go on to take their own lives. This will assist with identifying and targeting those at high risk of suicide.	There is no consistent LLR robust process for collecting actual numbers, theming and developing This is being followed up for investment in data analysis across the system at the LLR group.
13.	Ensure that men identified as being at risk of suicide have access to Improving Access to Psychological Therapies (IAPT) where appropriate.	Development of an option to manage a referral process rather than rely on individuals seen in MHCUH/ED/CMHTs to self-refer?

1. Recommendations for the Trust Suicide Prevention Group

Establish a sub-group or use the DMH Self-Harm & Suicide Prevention Group to bring specific focus to support clinical and service developments, with an action plan, with the following considerations:

- Recommendations 1, 2, 3, 6, 9, 10, 11 and 13 all relate to the development of a revised clinical pathway between ED and LPT
- Use the feedback from local men interviewed to inform all services – involve Experts by Experience in the design & leadership of the work
- Align suicide prevention activities with the interface between MHPs, PCNs and SPAG to make the most of the strategic objective to support primary care
- Improve LPT data management to focus service design and partnership work especially with key groups e.g., LGBT, BAME communities and all other protected groups; and that LPT ensures that diverse communities ***inform*** service redesign and support provision of specialist services
- Ensure that the Trust suicide prevention group informs service design and priority actions are additionally informed by NCISH as outlined in **Appendix One** and **Two**
- Maintain the focus and resource requirements for veterans, who are predominantly men and as previously reported the east midlands has a higher % of regiments who were active in Afghanistan and Iraq tours – also note the very recent Office for

Veteran's Affairs Veterans Strategy Action Plan 2022-2024 with particular regard to a new method for recording and reporting veteran suicide, reporting from 2023. In the interim a 10-year lookback on veteran deaths through suicide, alcohol misuse and drug abuse is due to be reported in 2022.

- Not a specific recommendation – the Report highlights the lack of consistent sign-posting and referral from services to the Tomorrow Project for suicide bereavement support.

- Not a specific recommendation – develop a focus on different services to be available for males across age ranges, particularly as in LLR we have a lower age group vulnerable to suicide and NCISH have recently reported the increased risks post-covid for older men over the age of 65

Recommendations For Trust Board

LPT Trust Board are asked to:

- note the findings and to be taken forward at the Trust Suicide Prevention Group.
- Support the actions being undertaken in response to the recommendations

Appendix One

Appendix Two

Key messages

1. Middle-aged men are the group at highest risk of dying by suicide; the reasons for this are complex, and include a combination of longstanding and recent risks. We should avoid attributing these suicide deaths to single causes, as this will make prevention less effective;

2. Rates of contact with services among middle-aged men were higher than expected; almost all had been in contact with a front-line service or agency at some time. It is therefore too simplistic to say that men do not seek help;

3. There is a vital role in prevention particularly for primary care, A&E, the justice system, and mental health services. We should focus on how these services can improve the recognition of risk and respond to men's needs, and how services might work better together;

4. We have confirmed that economic adversity, alcohol and drug misuse, and relationship stresses are common antecedents of suicide in men in mid-life. Prevention requires a range of public health, clinical and socio-economic interventions;

5. More than half of the middle-aged men who died had a physical health condition; over a third of those who were prescribed medication for their physical health were prescribed opiates. Physical ill-health is an important factor in suicide risk and help-seeking for physical health problems may be an opportunity for prevention. Opiate analgesics appear to add to risk, particularly in individuals with physical ill-health, and safe prescribing is vital and in accordance with national guidelines on the management of chronic pain;

6. Middle-aged men who seek help for their mental health sometimes remain untreated. In particular, psychological therapies suited to their needs should be offered;

7. Around half of the men who died were known to have self-harmed. Recognition of risk by services after self-harm is vital, as further self-harm may involve a method of greater lethality such as hanging;

Key messages (continued)

8. Many of the men in our study appear to have been affected by bereavement. There is a need to ensure bereavement support is available in a way that addresses the needs of men;

9. We found information on suicide methods was often obtained via the internet: online safety should be part of any prevention plan for men at risk of suicide. The current online harms initiative by the Law Commission is an opportunity to consider this aspect of suicide risk;

10. There is also a small group of suicidal men who appear to be out of contact with any supports. There are several examples of local and national third sector initiatives aiming to reach this group and these should be supported and adopted more widely.

Governance table

For Board and Board Committees:	Trust Board 26.7.22	
Paper sponsored by:	Fiona Myers, Director of Mental Health Services	
Paper authored by:	Michelle Churchard-Smith, Interim Deputy Director of Nursing/ Jackson, Suicide Prevention Lead DMH.C/LD	
Date submitted:	19.07.22	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	DMH Quality and Safety DMT, DMH Suicide Prevention Group Trust Suicide Awareness and Prevention Suicide Group.	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	N/A	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	This is a one off report.	
STEP up to GREAT strategic alignment*:	High **S**tandards	Yes

	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	Yes
	Reaching Out	
	Equality, Leadership, Culture	Yes
	Access to Services	
	Trustwide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	
Is the decision required consistent with LPT's risk appetite:	N/A	
False and misleading information (FOMI) considerations:	N/A	
Positive confirmation that the content does not risk the safety of patients or the public	This supports the safety of the patients and public	
Equality considerations:		

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Leicestershire Partnership NHS Trust

Trust Board – 26th July 2022

Q1 2022/23 Step Up to Great Delivery (SUTG) Plan Report

Purpose of the report

To provide an update for the Board, on the progress with the delivery of SUTG for the first quarter of this financial year (2022/23).

Proposal

Oversight of SUTG delivery is through monthly reporting to LPT Transformation Committee supported by regular SRO/workstream support meetings with the PMO. A quarterly report will be provided to the Board.

Decision required

The board are asked to support the progress and implementation of SUTG delivery, whilst at the same time noting the resurgence of COVID-19.

Governance table

For Board and Board Committees:	Trust Board 26th July 2022	
Paper sponsored by:	David Williams, Group Director of Strategy & Partnerships Leicestershire Partnership NHS Trust & Northamptonshire Healthcare NHS Foundation Trust	
Paper authored by:	Tim O'Donovan Deputy Director of Transformation	
Date submitted:	15th July 2022	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	SUTG Delivery Plan Approved by Trust Board May 2022	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	SUTG Q2 2022/23 report due November 2022	
STEP up to GREAT strategic alignment*:	High **S**tandards	X
	Transformation	X
	Environments	X
	Patient Involvement	X
	Well **G**overned	X
	Reaching Out	X
	Equality, Leadership, Culture	X
	Access to Services	X

	Trustwide Quality Improvement	X
Organisational Risk Register considerations:	List risk number and title of risk	64,72
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	Nothing identified	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed	
Equality considerations:	This will support all bricks within the Trust strategy	

LPT Q1 2022/23 SUTG Delivery Plan

Theme	Focus	Outcomes	SUTG Q1 22/23 Latest Delivery Update
	We will build on the learning from Covid and will deliver safe care and reduce harm.	We will demonstrably improve compliance against Health and Social care core standards and Care Quality Commission (CQC) registration requirements.	1. We have developed our Foundations 4 High Standards approach working with NHFT to enable us to consistently be ready for inspections or regulations. This programme is underway. 2. We have achieved all our CQC must do actions and should do actions within timescales and have no warning notices in place and have improved inspection ratings for the acute services revisited. 3. We have supported the Urgent and Emergency Care system inspection. a positive report from the CQC for the Mental Health Liaison Team
	We will build on the learning from Covid and will deliver safe care and reduce harm.	Development of an implementation plan for the local National Patient Safety Strategy- includes pressure ulcers, deteriorating patient, self-harm, Infection, Prevention and Control (IPC), suicide prevention and least restrictive practice.	1. The plan for implementation of the Patient Safety Strategy is being held within the Foundations 4 High Standards Programme with leadership from the Head of Patient Safety. 2. Patient partners roles are being developed to support the role out of the strategy. 3. The PSIRF framework publication is delayed nationally but preparation is underway within the patient safety team in readiness for this.
	We will transform our patients' experience of care - making no decision about them, without them.	Implementation of the Shared Decision-Making Framework.	The shared decision making framework has been approved by the executive team and implementation has commenced.
	Progress our Ageing Well accelerator work.	Quicker response, earlier clinical intervention and decreasing urgent care attendances by target population.	1. We are now achieving the national 2hr urgent response national target 2. We have worked with the national team to test data reporting methodology to support other Trusts 3. We are part of the urgent community response team which is having positive results in decreasing hospital attendance and admissions 4. We have decreased falls in the community and care homes 5. We have funding and are in the planning phase for frailty virtual wards

Transformation	Address our waiting lists, particularly in relation to continence and Neuro.	Reduced waiting times.	1. We have transformational programs of improvement in place, we are currently finalizing this year's trajectory for improvement & we are seeing a reduction in our longest waits. Our Finance and Performance Committee are providing additional assurance and oversight of our progress. 2. Actions are in place and within our Neuro Developmental programme we are establishing a new Access Team to triage referrals & re-direct to most appropriate health professionals to avoid delays, new primary care assessment forms that will streamline the referral process (and avoid families repeating their experience). 3. Working with YAB on a referral form that can capture the voice of the CYP at the outset. The LD Service Implemented a new single point of access service in January 2022. 4.Transforming the process of referral to assessment within all disciplines and supporting the wider implementation of the pathway process, which is fully mobilised on SystmOne. Improvement trajectories in place or under development for services to March 2023.
Transformation	Work in partnership to develop and deliver a strategic plan to ensure the Best Start for Life and the importance of the 1001 first critical days.	Continue to participate in the system-wide coalition of organisations to agree and deliver a strategic plan for the first 1001 days.	We continue to work closely with the LLR CYP partnership on priorities for CYP as we move towards a future CYP collaborative. Healthy Together Project Manager is post to mobilise the HT 0-11 service and 11+ transition.
Transformation	Increase the focus on Learning Disability.	People with a learning disability are better supported to live fulfilling lives in the community and have quicker access to services when they need it.	The LLR LD&A Collaborative is expected to commence in September 2022 with the collaborative's baseline operating model, governance framework, MoU and partnership agreement prepared for the partnership. The Collaborative Maturity Framework 2022/23 will be further developed and is due to commence in September 2022 following sign-off by all ICS partners. First year end report and second year plan submitted to NHSEI (for the 3 year LD roadmap).
Transformation	Establish Neurodevelopmental Transformation Programme and Leicester, Leicestershire and Rutland (LLR) Autism service (children, young people and adults).	Our service users with Autism will wait less time to receive care when they need it and will be supported to stay out of hospital as much as possible.	The clinical process is drafted and to be confirmed by our task and finish group by the 8th July. New assessment forms will be piloted and then evaluated/signed-off in November 2022. Work continues on the accessible digital platform for families. Business Case development is underway. Training framework and associated competency framework (inter-disciplinary and inter-organisational) is under development. A pilot of Chat Autism to expand the age range for the 0-14 to provide timely support and prevent escalation and admission. Project is on-track for all key milestone for 2022/23.

	Respond to the outcome of the public consultation on mental health services and support.	Develop a clear Step Up To Great Mental Health Delivery Plan building on the outcome and learning from the consultation.	Workshops for Mental Health (MH) Practitioners in primary care are happening in July and August with recruitment from September. Targeted MH access work continues in neighbourhoods that have historic low access rates to services. Preparedness for the Mental Health Support Teams in Schools Wave 7 to commence in September 2022. Co-production of digital information on access to services in progress Focus on improving demographic data collection to improve our ability to address inequalities and improve performance.
	Lead a clear digital plan that makes sure digital transformation is owned by the Trust.	Refresh the Trust Digital Information Management & Technology plan in line with key national initiatives.	We have a digital strategyfrom 2020-2024. We are working through refreshing and updating this, in line with the new ICS digital strategy.
	Make the Trust a better place to work by ensuring staff are safe and healthy, physically and mentally well and able to work flexibly.	Delivery of the objectives for this year of our Trust's People Plan.	This is ongoing and we are now including actions from staff survey and the people promise exemplar programme.
	Take action to ensure our Trust engages staff well.	Improving our culture, leadership and inclusion with the Our Future Our Way programme, and embedding our Leadership Behaviours for All staff.	Continue to meet with change champions and planning to increase change champions numbers through a recruitment drive
	Take action to ensure our Trust engages staff well.	Roll out of our Reset & Rebuild Programme of Big Conversations and resulting actions.	Health & well-being priorities and blended working principle being rolled out

	Recruiting and retaining our people.	Improving employment and development opportunities for our Black, Asian and Minority Ethnic people.	We are running interview skills training and career development programmes for our BAME workforce. Active bystander master class delivered at system and group level, Compassionate and inclusive leadership program developed and implement this has been shared at group level. Our model employer target indicator has improved.
	Recruiting and retaining our people.	Further develop and support the Trust's staff support networks.	Ongoing support and development of networks additional funding for networks to use approved and supported by charitable funds.
	To capture and use the learning from patient feedback and engagement to inform and influence how the Trust delivers and designs its services, including Implementation of the new Friends and Family Test system across the organization.	We will make it easy and straight forward for people to share their experiences.	1. Staff offer underway to include FFT analysis, understanding touch points and creating QI, ENVOY, patient stories is being built into staff & patient exp. 2. Work commenced on 15 steps, PLACE cohort of patient reviewers, and A&C staff offer 3. All work on target for the qtr 4. Establishing re starting carers task and finish group will commence in Q2. 5. Work to understand trust activity and position has been undertaken during Q1 including liaising with other trusts/buddy trust. Q2 aim to strengthen progress
	To capture and use the learning from patient feedback and engagement to inform and influence how the Trust delivers and designs its services, including Implementation of the new Friends and Family Test system across the organization.	We will increase the numbers of people who are positively participating in their care and service improvement.	Further work on Friends and family Test and use of QR code roll-outs being completed
	Deliver continuous development of patient/carer participation and involvement.	We will improve the experience of people who use or who are impacted by our services.	1. Involvement network continues to grow with increased collaborative working, and the development of a QI share and learn space for service users and carers, with regular attendance. 2. Involvement cafes currently being reviewed. 3. Review of training and resources for staff offer, identifying gaps and conversations with key staff, staff groups. All Q1 targets met 4. Youth Advisory Board ongoing leadership and support established. Continuous engagement with services to co-produce/engage ongoing.

	Providing leadership for ongoing improvement across our Well Led framework, informed by learning from others.	Improvement against the well-led Key Lines of Inquiries.	1. Internal Audit annual report and Head Of Internal Audit Opinion Significant Assurance 2. Provider Licence - compliant 3. Draft framework of potential well led system inspection regime in anticipation of CQC next steps 4. CQC reinspection feedback 5. Showcase presentation at NHS Providers Governance Conference with excellent feedback. Video to remain on NHS Providers website as a resource.
	Contributing to the development of ICS governance and risk systems.	To have effective governance and risk systems in place with system partners to input into the Integrated Care System (ICS).	1. ICB nomination submitted within timescales.Revised governance structure and assurance flow. 2. Paper received at SEB May 2022 and Trust Board development workshop 21 June 2022. Further paper taken to SEB July 2022. On track for delivery in September 2022 to include revised SEB and Executive Management Board arrangements. 3. Attendance at the company secretary network with workshop by the Good Governance Institute for ICB governance development
	Invest in our resources to deliver optimal health outcomes.	Good financial plans and delivery of plans, aligned to investment in key areas will support the Trust's ability to deliver against the vision of improving health and wellbeing.	Financial approval levels process re-worked and approved within both trusts (December 2021)
	We have a clear data quality framework and plan that guides our delivery of great data quality.	Review data quality policy, develop data quality improvement plan and submit data privacy and security toolkit.	Review in progress, further update in Q2
	Support a sustainable local community in Leicester, Leicestershire and Rutland.	Review the current work with other NHS partners, local authorities and other stakeholders and identify areas of work where the Trust can work with others to support our sustainable communities.	Individual Directors are attending local authority health and well-being board meetings, support the development of strategic plans across LLR, these are exploring how the public sector can support our communities further.

	Positively support environmental, economic & regeneration improvements, policies and practices in LLR.	To have an agreed set of principles that set out our commitments to this aim, agreed through our Trust public board meetings.	These will be developed during this financial year and come to board approval later in the year.
	Supporting our most vulnerable in society; raising health equity across Leicester, Leicestershire and Rutland.	We will be a member of the local authority and NHS group to reduce health inequalities in Leicester, Leicestershire and Rutland and play a full role in agreeing a plan and implementing that plan to improve equity.	We are a member of this group, we are actively supporting system plans to reduce inequalities. In June 2022 LLR system colleagues attended an LPT Board workshop to support our work on tackling inequalities. LPT has shared our work to reduce inequalities for people with a learning disability and or neurodevelopmental needs with other colleagues across the Midlands.
	Therapeutic environments that improve outcomes for people using services by supporting safe, joined up, person-centered care.	Eradication of dormitory accommodation	1. Phase one work at Bradgate site – Bosworth ward completed July 2021 and Thornton completed October 2021. 2. Phase two commenced in November 2021 at Ashby ward completed February 2022. Aston ward due for completion in July 2022. The new Safehinge doors will be incorporated onto Aston ward as they have been on Ashby ward. **3. This will see all 4 shared sleeping wards identified by CQC in report from October 2021 eradicated.** 4. Further work at Evington ward is planned for completion in February 2023. Work on Bennion ward is planned for completion in May 2023.
	A positive and effective working environment for all staff building on the learning from post Covid 'reset and rebuild' work.	Implement facilities management business case to deliver the capacity and capability for high quality estates.	Health & well-being priorities and blended working principle is rolling out across our estate. We have implemented a range of cost of living support Facilities Management services transferring to LPT 1st November 2022 as per the business case
	Greener NHS buildings and identifying our route to net zero.	Develop and deliver a green action plan for the Trust.	LPT have produced Green Plan which sets out how the Trust will support the transition to a Net Zero NHS and help achieve the ambitious Net Zero targets. The Trust has recognised the importance of environmental sustainability and the role it must play in reducing the impacts of climate change. Development of data to support the plan is one key aspect as currently limited historic data is available. The Green Plan lays out the Trust's nine areas of focus. Each sub-section details the purpose and proposed actions for the Trust to reduce carbon emissions.

	Improve access in a prompt responsive and suitable manner.	Support the implementation of the policy framework - improving Access policy implementation across all 3 directorates.	We are using a Quality Imporvement approach to waiting list management, focused currently on our high priority services we are working in partnership across LLR to achieve this more effectively. This includes clear access/referral criteria for all services, response to referrer standards; Governance via "deep dive" sessions, reported through to monthly meetings and then to LPT Access Committee.
	Ensure that the Standard Operating Procedures governing access are being adhered to consistently across all areas.	Ensure all services have a Standard Operating Process for access.	All service Standard Operating Procedures are either in final drafting or have been updated to reflect the current Access Policy. Preliminary discussions are now taking place about Equity of Access to services.
	Improving data quality and performance monitoring in relation to access.	Quality Improvement focused approach to waiting list management including implementation of validation and Patient Tracking Lists.	Service PTL processes are established, supported through our Quality Imporvement Approach. Improvement trajectories established and reported at deep dive sessions.
	We will proactively work with Northamptonshire Healthcare Foundation Trust (NHFT) on a single approach for both Trusts, optimising the shared learning approach, building on the learning from post Covid 'reset and rebuild' work.	Develop joint Quality Improvement strategy with NHFT.	Single approach to QI in place within LPT and an opportunity to refresh at a strategic level is being revisited as part of reset and rebuild. The potential to align transformation and trust wide QI is being explored and the implementation of the QI methodology for the trust is being revisited.
	We will set clear priorities for Quality Improvement initiatives.	Develop and implement the Trust's priorities for Quality Improvement.	The Trust Head of Quality, clinical governance and QI has reviewed the projects on Life QI and is working to align with the Trust strategic priorities. QI is being realigned with the Trust transformation programme to share resource, capacity and expertise and ensure quality is at the centre of transformation.

Trustwide Quality Improvement	Widening the opportunities for more people to participate in research to inform future health and social care.	Strengthening research projects across a wider range of partnerships crossing organisational boundaries.	LPT and NHFT are Category A Partner organisations of the Clinical Research Network, with separate research delivery contracts. The current Senior Research Nurse at NHFT has met with the R&D Lead at LPT, to discuss opportunities where both Trusts can deliver the same Portfolio study and learn from each other. Developing areas of clinical and service priority of joint concern, and therefore develop potential locally-led research projects from this, with suitable leadership and resource.

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Leicestershire Partnership NHS Trust

Public Trust Board 26th July 2022

Clinical Plan

Purpose of the report

- To present the final version of the Clinical Plan 2022 to 2023, appended to this report

Analysis of the issue

- LPT undertook to refresh the previous version of the Clinical Strategy 2014 to 2019, extended to 2021.
- The current version was named as the Clinical Plan; describing the fundamental philosophy and approach to modelling, implementing and improving delivery of clinical services in line with the Step Up to Great Strategy
- The fundamental approach is based on Value Based Health Care; underlining high quality outcomes at sustainable costs. This is in line with the LLR ICS philosophy of a population health focussed strategy.
- The Plan was co-produced following campaigns and conversations with service user groups, clinical leadership, Directorate management groups and staff in LPT.
- The Plan has been discussed and approved at SEB, May 22 and presented and discussed at the Trust Board Development Session in June 2022.

Proposal

- That the Trust Board approve the Clinical Plan for implementation
- That the support, oversight and implementation is governed through the appropriate governance fora; and progress reports presented at Operational Executive Board and also at Trust Board as and when indicated.

Decision required – Please indicate:

Briefing – no decision required	☐
Discussion – no decision required	☐
Decision required – detail below	☒

- To approve the final version of the Clinical Plan for implementation.

Governance table

For Board and Board Committees:	Public Trust Board 26th July 2022	
Paper sponsored by:	Dr Avinash Hiremath	
Paper authored by:	Dr Girish Kunigiri Samantha Wood	
Date submitted:	18th July 2022	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Strategic Executive Board	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning		
STEP up to GREAT strategic alignment*:	High **S**tandards	x
	Transformation	x
	Environments	
	Patient Involvement	x
	Well **G**overned	
	Reaching Out	
	Equality, Leadership, Culture	x
	Access to Services	x
	Trustwide Quality Improvement	x
Organisational Risk Register considerations:	List risk number and title of risk	
Is the decision required consistent with LPT's risk appetite:	yes	
False and misleading information (FOMI) considerations:	n/a	
Positive confirmation that the content does not risk the safety of patients or the public	yes	
Equality considerations:		

WeAreLPT
compassion respect
integrity trust

NHS
Leicestershire Partnership
NHS Trust

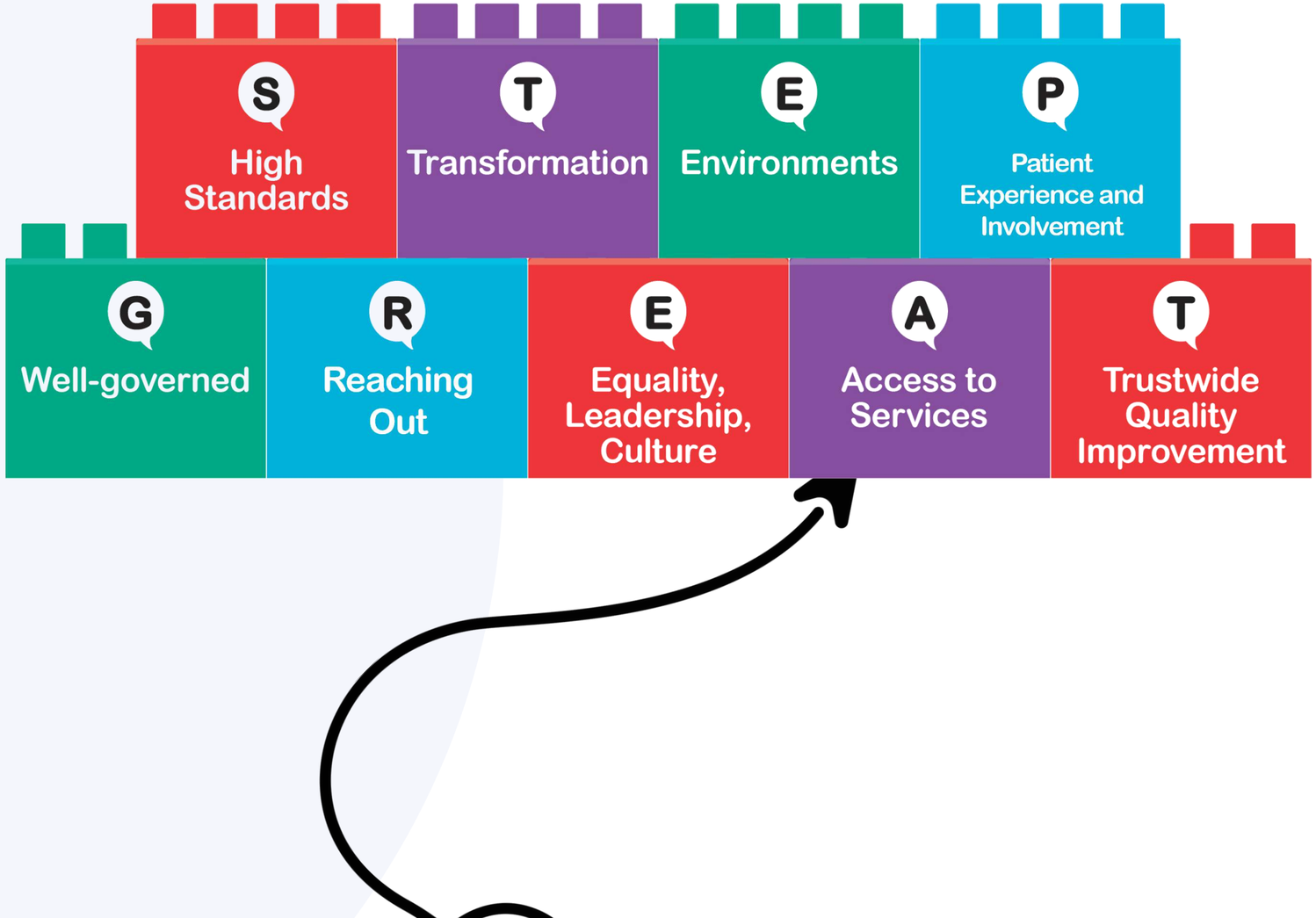
2022/23

Our Clinical Plan

Creating high quality, compassionate care and wellbeing for all

www.leicspart.nhs.uk

Contents



Foreword

We are pleased to present our clinical plan for the Leicestershire Partnership NHS Trust. It has been developed within the context of the area we serve in Leicester, Leicestershire and Rutland and the new Integrated Care Partnership. The plan will continue to evolve in light of the ongoing development of these partnership strategies and further engagement with stakeholders, although the broad direction of travel outlined in this plan is not expected to change. Our plan has been developed at this time to reflect the publication of the Trust's refreshed strategy and the reflection we have undertaken to rebuild following the Covid-19 pandemic.

Our plan has been developed through a comprehensive programme of engagement with our staff and stakeholders, commencing in Autumn 2021 and we would like to thank everyone involved for their valuable input and support. Oversight has been provided through a combination of the Clinical Leadership Team and Strategy and Partnerships function with leadership from our Medical Director.

This is an exciting time for the Trust and a great opportunity to deliver real benefits for our patients, citizens and our staff and we look forward to continuing to work with all our stakeholders to support this.

Angela Hillery
Chief executive

Cathy Ellis
Chair

About our Trust

We work alongside schools, local hospitals, GP practices, social services and other local authority departments such as housing and education, as well as working with voluntary organisations and local community groups, in order to achieve our goals and to ensure that anyone we care for is treated to the highest possible standard.

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

We are committed to ensuring we have joined up services within LPT and between us and other organisations, to create high quality, compassionate care and wellbeing for all. There will be a system wide plan (called an Integrated Care System or ICS) that we are contributing to and developing with others. To aid our thinking about our wider role in the system and within our communities and to be clear about how this connects to our Step Up To Great Strategy we have described 4 goals (Great outcomes, Great care, Great place to work and Part of the community) that support us to achieve our vision and strategy in partnership with these wider stakeholders.

LPT in numbers

6.8k
staff
(including bank staff)

216,657
active caseload

1.2m
community contacts

100+
premises

300
active
volunteers

163k
bed days

82%
positive FFT ratings

£356m
income

2469
members representing
the population we serve

Services

We provide care and support in three key areas of focus:

Mental Health Services

Our services work to deliver high quality care for adults with acute and enduring mental health conditions across Leicester, Leicestershire and Rutland. Services range from acute inpatient care, acute assessment and home treatment, mental health services for older people, day care, psychological therapies, community-based mental health care and assertive outreach, day care and prison healthcare. We are also a teaching trust, which means we conduct research and provide training and education for medical, psychology, nursing and therapy students.

Families, Young People and Children's Services and Learning Disability Services

We provide universal and specialist support including child and adolescent mental health services, complex learning difficulties, health visiting and school nursing, paediatric medicine, nutrition and dietetics services, eating disorder services, speech and language therapy, occupational therapy and physiotherapy. This is along with locality-based learning disability teams, short break homes, specialist inpatient care, autism and outreach services. Our learning disability teams also offer specialist advice and support to others involved in caring for someone with a learning disability.

Community Health Services

Community health services includes adult nursing and therapy services. We deliver services in inpatient wards, in clinics, and in patients' own homes.

Our services include general and stroke rehabilitation, end of life care, physiotherapy, occupational therapy, speech and language therapy, podiatry and falls prevention.

Performance and challenges

We are a Trust which is working hard to make improvements in our CQC ratings and credit goes to all our staff on the ground together with our leadership in making significant improvements in the quality of our care and services. We know we have more to do but we are confident in the progress we've made and the plans we have in place to address our challenges.

Staff engagement is also an improving picture. Our staff survey response rate is the highest we've had in five years, and is higher than the national average of 49%. The results are an important way for us to hear staff views on how it feels to work in LPT, what they think works well and what they think needs to improve. We are pleased that compared to last year, staff have reported a more positive experience of working in LPT across all the indicators, with significant improvements in staff engagement, morale and safety culture.

We are committed to partnership working and we are a leading partner in establishing the East Midlands Mental Health Alliance, which has enhanced our work around provider collaboratives. Notably, we are the regional lead for the adult eating disorders provider collaborative. We have also been successful in receiving funding for enhanced perinatal mental health services, and have launched our CAMHS Beacon Unit – ensuring care is provided closer to home for our young people. Our out of area placements for adult mental health services has reduced to being consistently at zero - a great success story we are proud of and very much aligned to what we are stating in this plan as mattering most to patients and staff.

The last year has been one of the most challenging years in the NHS' history, however, we are proud of our staff and the way they have continually stepped up to great in achieving our Trust's vision throughout the pandemic: "creating high quality, compassionate care and wellbeing for all."

Strategic context

Our population and their healthcare needs

The county of Leicestershire faces the challenge of an ageing population. The population in Leicestershire is expected to grow by 20.3% between 2020 and 2043 with the biggest increase expected in the 60+ age group. With our ageing population we need to consider what plans that need to be put in place to manage future health and care needs and demands in the longer term, with a focus on preventable ill health, particularly in working age adults. Leicester is the ninth largest city in England and the most populous urban centre in the East Midlands. Leicester's population is relatively young compared with England; a third of all city households include dependent children, 20% of Leicester's population (72,600) are aged 20-29 years old (13% in England) and 12% of the population (42,300) are aged over 65 (18% in England). The large proportion of younger people in Leicester reflects the student population attending Leicester's two universities and inward migration to the city.

Leicestershire is home to a diverse range of faiths and communities and residents come from over 50 different countries. Leicester is also a National Asylum Seeker Service (NASS) designated dispersal city. A quarter of Leicester households in which at least one person has a long-term health problem or disability. Leicester also has a high level of deprivation compared to England.

Our clinical plan

Our staff and the people who access our services tell us that our clinical plan needs to support our wider Trust strategy by focussing on providing value-based care. Through our engagement with staff and review of patients' experiences, we have identified a number of key themes that the clinical plan needs to incorporate;

Value-based care requires the clinician and those who support them to consider:

1. Person centred care (including experience and outcome)
2. Clinical effectiveness (evidence-based practice and captures quality and high standards)
3. Sustainability
4. Multi-professional and Triumvirate Leadership

Our clinical plan explained

Patient experience and outcomes

Patient experience and their satisfaction encompasses the range of interactions that patients have with the health and care system, the care they received, and the challenges they had during their interactions. Health outcomes may reflect a number of areas such as function, pain, and quality of life and are captured in many ways. Health outcomes are often influenced by factors outside of the treatment provided, including…

One of our Trust goals is to be ‘part of our community’ and that is because we know that patients who report good experience with their care also have better short and long-term outcomes. The Marmot review, published in 2010, raised the profile of wider determinants of health by emphasising the strong and persistent link between social inequalities and disparities in health outcomes. Variation in the experience of wider determinants (i.e. social inequalities) is considered the fundamental cause of health outcomes, and as such health inequalities are likely to persist through changes in disease patterns and behavioural risks so long as social inequalities persist.

LPT will work with partner organisations in developing outcomes that are codesigned, shared and meaningful to the patient. The outcome will form the basis for further changes and/or redesign of services.

We are also committed to improving access to our services and we will utilise technology to enhance the positive experience of patients and carers where appropriate in areas such as for improved and easy access to services, digital consultations, leaflets that will aid in self-monitoring and aid in recovery and prevention.

Our clinical plan explained

Person-centred Care

Person-centred care is one of the ways in which we ensure we are delivering our goal of ‘great care’ by providing care and services for patients (and their families) in ways that are respectful of, and responsive to, individual patient preferences, beliefs, needs and values. It also ensures that patient values guide clinical decisions. Person-centred care is framed around the moral obligation to care for patients in their social and environmental context, while meeting their needs. Person-centred care goes beyond the clinician-patient encounter and is designed to promote collaborative/shared decision-making.

Clinical effectiveness

One of our goals as a Trust is to ensure patients have great outcomes. Evidence based practice and clinical guidelines are recommended interventions developed over the years through evaluations, clinical trials and research. They aim to reduce clinical care variability and improve the likelihood that the patient receives a treatment that has a measurable clinical effect and ultimately a better patient experience.

Care provided will be of high standards and based on QI philosophy to continuously improve the services based on co-production and continuous feedback from patients/cares, ensuring that patients have great care.

Our clinical plan explained

Sustainability

Being part of our community means that we must be sustainable over time. We define sustainability as our capacity to deliver healthcare, with consideration to future generations. Sustainability can be considered as a domain of quality in ¬healthcare because the aim is to extend the responsibility of health services to patients not just today but also to our patients of the future. We need to have a longer-term perspective because we know that we have an impact on our healthcare system and on our environment and the communities we serve.

We have a responsibility to consider the wider population health. A sustainable approach to our clinical interventions will therefore enable us to expand the healthcare definition of value to measure health outcomes against environmental and social impacts alongside financial costs. We will set out to develop a practical framework for including these new dimensions in our value-based healthcare framework. We believe that the goals of meeting immediate healthcare needs, conserving resources and promoting wider wellbeing are not at all in tension but may be mutually reinforcing of our wider Trust Strategy.

We already know from learning of what is happening in other areas that there are some ways of achieving improved sustainability such as;

- integrated care
- appropriate use of technology
- co-working teams and rationalised estate
- improved skills mix and developing the workforce
- avoid duplication by working better with our partners
- lean methodology in terms of our systems and processes and QI principles
- tackle health inequalities through the provision of services that are appropriate to the needs of different groups of the community
- active participation on health promotion and prevention
- Making Every Count Contact (MECC) to bring parity among mental health and physical health patients

Our clinical plan explained

Triumvirate/ Multi-professional Leadership accountability

The definition of triumvirate is “a group of three people who are in control of an activity or organisation.” The triumvirate model of nurse, operations manager and senior clinician exist in most NHS provider organisations, who work together to deliver services to patients. This model does offer challenges but has been shown to be effective and productive for service lines. The reasons why it is so challenging to work as a trio are a mixture of clarity, personality, relationships, power, capabilities and ownership of resources. Every triumvirate will be different, however there are ways to help deliver to allow them to work effectively. The core values are set below:

- Define the unique reason to exist
- Set expectations
- Challenge performance
- Be human
- Manage the tri-brand
- Take time out together

Strategic context

Our approach

Focus #1 Patient Experience & Involvement : Incorporating person-centred strategies of care

This involves focusing on patient and carers needs, understanding the resources they have for continued self-management and matching their care preferences. In situations involving indecision, patient-decision making support tools should be used to allow the patient and the clinician to negotiate a treatment approach which they each finds valuable. The aim is to empower the patient towards taking responsibility and self-management of their condition.

Focus #2 Access to Services & High Standards : Improving processes of care

If the right providers give the right care at the right time, outcomes are improved and it will also reduce future costs that occur when the condition is less able to be managed conservatively .

Add in something here about reducing duplication and false barriers to pathways.

Focus #3 Reaching out : Work in partnership and reaching out

We must consider whether we are the best service for that patient. Placing the patients' needs first will always drive value-based care. This might mean that we need to bring other partners into the patient's care plan or may even mean that we need to introduce them to another care area. We can only achieve this through better partnership working and engagement with local communities.

Next steps

Our clinical plan will focus initially on the coming year in order to get the fundamentals in place and create an environment for success. Conversations with our staff and feedback from our patients and carers demonstrates what we need to focus on first and how we must continually involve people in our plan as it develops. Our first year will focus on 3 key deliverables;

1a) Develop a shared understanding of value-based care.

- Set up working groups which are representative of our professional and service areas as well as patients, carers and the people who use our services to develop an agreed description of what is meant by value-based care at LPT.

By end of Quarter 3 of 2022/23

- Develop a core triumvirate group structure across all service lines

By end of Quarter 4 of 2022/23

1b) Co-produce a value-based care framework

- We will create a framework (structure) intended to serve as a support or guide for services and the people working within them to identify ways in which they can evolve to provide greater value-based care.

By end of Quarter 3 of 2022/23

Next steps

Our clinical plan will focus initially on the coming year in order to get the fundamentals in place and create an environment for success. Conversations with our staff and feedback from our patients demonstrates what we need to focus on first and how we must continually involve people in our plan as it develops. Our first year will focus on 3 key deliverables;

2) Co-produce a **value-based care assessment tool**

- An assessment tool will be created which will include the following components:
  - the context and conditions for the assessment
  - the tasks to be administered
  - an outline of the evidence to be gathered
  - the evidence criteria used to judge the quality of performance

By end of Quarter 3 of 2022/23

Next steps

Our clinical plan will focus initially on the coming year in order to get the fundamentals in place and create an environment for success. Conversations with our staff and feedback from our patients demonstrates what we need to focus on first and how we must continually involve people in our plan as it develops. Our first year will focus on 3 key deliverables;

3a) Conduct baseline assessments

- Services will conduct baseline assessment in order to provide information on the situation in relation to value-based care. It will provide a critical reference point for assessing changes and impact, as it establishes a basis for comparing the situation before and after an intervention, and for making inferences as to the effectiveness of the change

By end of Quarter 4 of 2022/23

3b) Review assessments and make recommendations

- There will be a review of all assessments undertaken and the working group will make recommendations for priority improvements

By end of Quarter 4 of 2022/23

Summary

A clinical plan is important for Leicestershire Partnership NHS Trust that will be fundamental to STUG strategy. Leicester, Leicestershire and Rutland has a growing and aging population and the communities we serve are diverse and have a number of needs which require innovative and well planned approaches. Health inequalities disproportionately impact the populations we serve, leading to high numbers of emergency admissions and un-planned care.

It is estimated that 1 in 6 people in the past week experienced a common mental health problem and 1 in 4 people will experience a mental health problem of some kind each year in England. The overall number of people reporting mental health problems has been going up in recent years making it even more important that the care we provide is collaborative, person-centred, effective and accessible.

Our clinical plan will ensure the delivery of effective patient-centred care through supporting the delivery of our goals of delivering great care, great outcomes, creating a great place to work and reaching out. We have developed a new Clinical Plan to re-set our clinical vision following learning from the COVID-19 pandemic, taking into account the NHS Long Term Plan, and building on the strategic vision and goals set out by our refreshed strategy STEP up to GREAT.

Our Trust developed the clinical themes in this strategy following extensive engagement with clinical teams and departments, listening to staff, patients and carers, and it will continue to evolve in light of the ongoing development of the Leicester, Leicestershire and Rutland system-wide clinical strategy, and further engagement with stakeholders.

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Leicestershire Partnership NHS Trust

Public Trust Board 26th July 2022

Research and Development Plan

Purpose of the report

- To describe the drivers for Research and Development (R&D)
- To describe the R&D establishment and plans
- To seek Trust Board approval for the implementation of measures described in the R&D plan appended to this report

Analysis of the issue

- LPT has a thriving R&D department collaborating with various partners for portfolio and collaborative research, and supporting the development of Research designed within LPT.
- The R&D plan outlines the drivers at the national and local level; that influence the proposed R&D plan.
- The plan considers its partnerships and relationships with various stakeholders, to maximise research productivity in LPT; described through its 7 pillar paradigm.
- The plan outlines measures that could be considered for exploration; to enhance the R&D establishment and operations.

Proposal

- The Trust Board are requested to consider the narrative forming the R&D plan and approve it in principle for progress and implementation as appropriate and feasible.

Decision required – Please indicate:

Briefing – no decision required	☐
Discussion – no decision required	☐
Decision required – detail below	☒

- To receive and approve the broad approach, aims and principles outlined in the R&D plan.
- To support exploring recommendations proposed within the plan in terms of strengthening R&D infrastructure, collaborations and governance.
- To accept information on progress through the Quarterly R&D reports through the established Governance fora and routes.

Governance table

For Board and Board Committees:	Public Trust Board 26th July 2022	
Paper sponsored by:	Dr Avinash Hiremath	
Paper authored by:	Dave Clarke Karishma Joshi Prof Sudip Ghosh	
Date submitted:	18th July 2022	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):		
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Updates via Quarterly Reports through QAC/ OEB	
STEP up to GREAT strategic alignment*:	High **S**tandards	x
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	x
	Reaching Out	
	Equality, Leadership, Culture	x
	Access to Services	
	Trustwide Quality Improvement	x
Organisational Risk Register considerations:	List risk number and title of risk	
Is the decision required consistent with LPT's risk appetite:	yes	
False and misleading information (FOMI) considerations:	n/a	
Positive confirmation that the content does not risk the safety of patients or the public	yes	
Equality considerations:		

PAPER J APPENDIX 1

Research & Development PLAN

Dave Clarke & Karishma Joshi

Context

On 23rd March 2021, the DHSC published "Saving and improving lives: the future of UK clinical research delivery" (https://www.gov.uk/government/publications/the-future-of-uk-clinical-research-delivery/saving-and-improving-lives-the-future-of-uk-clinical-research-delivery) setting out the key principles for health research going forward. This was followed in June 2021 by the first iteration of the implementation plan (https://www.gov.uk/government/publications/the-future-of-uk-clinical-research-delivery-2021-to-2022-implementation-plan)

The March 2021 Strategy included three key aims:

A. Strengthen the UK's renowned research expertise as a world-leader in designing and delivering research
B. Ambitious vision to unlock the true potential of research putting patients and NHS at its heart
C. Using the lessons from COVID-19 to build back better, the government will create a patient-centred, pro-innovation and a digitally-enabled research environment.

In detail, this included 5 key themes:

1. Clinical research delivery embedded in the NHS – supporting all in the NHS in research delivery
2. Patient centred research
3. Streamlined, efficient and innovative clinical research- lessons learned from covid
4. research delivery enabled by data and digital tools – developing a future-ready clinical research environment
5. sustainable and supported research delivery workforce – making research in the NHS more resilient (commercially and non-commercially, supporting the development of research skills in HCPs

At the heart of this is the drive to realise the oft-stated ambition to embed clinical research and innovation at the heart of everyday patient care, to move research from being "somebody else's business" to being something that everyone, not just clinical academics, feel empowered to support and participate in. The vision also includes empowering research delivery through leveraging the power of data, and through expanding current platforms to further accelerate clinical developments.

The June 2021 document reinforced this stating that:

> *"Our aim is to create a step change in the delivery of clinical research in the NHS, so that research is increasingly seen as an essential part of healthcare. Making research an intrinsic part of clinical care means that patients and service users can expect to have access to the most cutting-edge treatments and technologies."*

These plans are likely to trigger and additional £300m of funding into research delivery, over the life-course of the strategy.

In England, the main vehicle through which clinical research is delivered, is through the NIHR (National Institute for Health and Care Research) and more specifically the Clinical Research Network, and this infrastructure will continue to be at the core of delivery going forward.

Within the UK Policy Framework for Research in Health & Social Care, and the Health Research Authority, there is a mandatory requirement for research active organisations to have a "research office" (these vary hugely in resources across the UK). Collectively, these drivers will be congruent with "Step Up to Great" and can help drive elements of the "rest and rebuild" transformation process.

Context within Leicestershire Partnership NHS Trust

Since "Best Research for Best Health (2003)" and the creation of the NIHR, the core NHS R&D Strategy has been to empower support for larger, more powerful multi-centre research through the adoption of studies onto the NIHR "portfolio". This recognised that most local research, based around local priorities was not of a scale required to provide robust evidence, and to promote real, evidence-based, change in practice, and whilst not actively discouraged there would no longer be central funding available for this, such that local "priorities and needs" research would have to be resourced by the NHS Provider itself. Much, if not all, of this activity is more properly categorised as "service evaluation" or "quality improvement" and not requiring of the

same level of review,assurance and governance (through the HRA) as formal research. This distinction is critically important, if not always absolute, and the involvement of R&D Staff in WeImproveQ helps to clarify any issues.

LPT is a "Category A" partner organisation of UKCRN (United Kingdom Clinical Research Network), and since the appointment of the first Mental Health Research Network Clinical Studies Officers in 2006, has forged an excellent reputation for the ability to assess, set-up, and deliver NIHR "Portfolio" research over 15 years, the studies which feed into NICE etc. The key "missing element" within LPT, is the lack of a core of research leaders, with or without an academic post of some kind, able to generate ideas of sufficient merit to bring in additional funding, for locally led, portfolio research.

Based now at Swithland House, the flexible research delivery team (funded by the East Midlands CRN) is co-located with and managed by the lean "R&D Office" based at Swithland House (founded and headed by the Interim R&D Lead), but also through the involvement of a significant number of clinical and non-clinical staff across the Trust.

Appendix A deals with immediate options within the LPT Office and Delivery Team.

Context within Northamptonshire Healthcare NHS Foundation Trust

Historically (in part thanks to past LPT/ University of Leicester Infrastructure), NHFT have had a somewhat smaller research profile than LPT (roughly 50% of the level of infrastructure funding from CRN), but are also a Category A Partner Organisation of the CRN. This department is known as "Research & Innovation" with a smaller team of CRN-funded delivery staff (full and part-time) in post. The "Head of R&I" post in NHFT has been vacant due to the retirement of the post-holder, and this is impacting performance and progress.

There are some differences in service profile between the organisations, for example, in NHFT, sexual health services are part of their profile, and these are often the domain of intermittent levels of research. Similarly, through past association with DeNDRON, NHFT have a track record of commercial trial activity, primarily in Dementia and Neurodegeneration with one outstanding PI (Paul Koranteng).

Whilst there is scope for greater cross-Trust collaboration, this should be led from identifying common local priorities, given that "Portfolio" studies have a long lead-in time, and where the allocation of "sites" is competitive and at the discretion of the Lead, or Sponsor site. Wherever possible, such studies can occur in both LPT and NHFT, subject to Sponsor agreement.

Local Context: The Integrated Care System

In April 2022, the LLR ICS published Version 5 of its' strategy "Embedding Research into Practice", with the following extract especially pertinent:

> "Our mission is to maximise the benefits of research in improving patient outcomes, attracting and retaining a high-quality workforce and increasing efficiencies and investment into our region. We will embed research at the core of our ICS.
>
> The ICS recognises that investing in local research facilitates our patient population to access the latest medical advances at the earliest opportunity. Creating an inclusive approach to research can help address the needs of underserved communities and reduce health inequalities in the provision of care. We will ensure that there is diverse and inclusive participation in our research meaning that the findings are generalizable and applicable to our local populations.
>
> The ICS will endeavour to understand the unique character of its population and the specific health challenges and these should actively inform local research priorities to continue to increase understanding of our local population needs.
>
> Research is most efficiently done when embedded into clinical practice and through harnessing research networks. Collaborative working can help create important frameworks for implementation of clinical research and ensuring this informs local clinical practice."

The ICS strategy document also references the infrastructure outlined in this Draft "Plan", so that both are in alignment. It is not yet clear if the Northamptonshire ICS will take a similar view, which may affect the direction of travel for NHFT (although a close academic relationship in the acute sector between UHL, Kettering and Northampton General Hospitals is developing).

Elements of the R&D Plan

This plan is based around seven cross-cutting key "pillars" that will underpin further developments, with potential commonalities across organisations, and to demonstrate that "research impact", is more than simply numbers in trials or the generation of additional income but is of a very real value in empowering positive changes in health care provision.

Pillar 1: Workforce & Personnel

"Saving & Improving lives" aims to develop a "sustainable, supported research delivery workforce" – offering rewarding opportunities for all healthcare staff and exciting careers for those from all professional backgrounds who lead research.

A similar model is necessary for LPT, wherein, as part of "talent management" new role descriptions are developed to allow clinical staff across LPT to see research as a supported part of their ongoing career. This may result in building upon existing schemes in LPT, such as the Research Envoy Scheme, The Director of Nursing Fellowships and so forth to support staff development and engagement with research

This is based around the working title of "LPT DARES" in terms of the research workforce, whatever the level of contribution (everything from Chief Investigator to Consumer). "Supporting" research can embrace leading, facilitating, utilising/implementing, conducting with all contributions having an intrinsic value, to an organisation that dares to challenge itself, and enquire why we do what we do, and how we can improve.

Staff and patients are at the centre of all that we do as a Trust, and without a core of Investigators at various stages of development, and staff empowered to undertake the role of PI, research will remain a limited activity, and not be "embedded" as is desired by the national strategy.

- **D**evelop
  - Ensuring that there are supported pathways for staff to consider seeing research as a key part of their career development, through internal and external training opportunities.
  - Inclusion of research as an element in Trust induction.
  - Enhance and embrace the Clinical Academic Career Pathway
  - Develop more joint posts with academic/commercial partner organisations
  - Skills development to critically appraise research (and other forms of enquiry) etc.
  - ICH-GCP Introduction to be part of mandatory training
- **A**ttract
  - Ensuring that the Trust is a place where talent knows they will be supported.
  - Creating research substantive roles in alliance with partners (academic and otherwise) linked to clinical and business strategy (research as core business)
- **R**etain
  - Creating opportunities for staff to make use of skills developed in training (especially research-specific awards) through modifying clinical roles to ensure that research remains a component of their career.
  - Seeking "critical mass" of research groups to reduce isolation
  - Ensuring "glass ceilings" can be addressed to improve retention.
  - Research is an element in every staff member's job plan/description and contribution reviewed at PDR
- **E**mpower
  - Seeking to include "research" as a key element within the Job Description of all staff, from all professional, clinical and non-clinical disciplines, and at all bandings and seeing this as part of every PDR, around three tiers:
    - Implementing Research
    - Facilitating/Supporting Research
    - Leading Research
  - Ensuring decisions and initiatives can be taken from the most junior levels, to the most senior to encourage ideas to flourish. In LPT WeImproveQ is an example of this.
  - Establishing key contacts within every clinical team
  - Top-level affirmation that research is part of what we do.
- **S**upport
  - Ensuring researchers and support staff have the resources and time they need to deliver quality research, feeding into clinical change.

- Link with internal and external support structures for training and grant development
- Enhance in-house support available through targeted investment in roles and facilities
- Modifying job descriptions to enshrine research as an element in staff progressing through the pathway

There is scope, as part of the LLR ICS, and the LPT/NHFT Group to develop shared Principal/Chief Investigator roles, together with a mentoring network, that, to an extent, already exist in LPT as part of the Leadership Framework. This can also link to the "Associate Principal Investigator scheme launched during COVID-19, as a pathway into quality clinical research. The workforce planning across the organisation should encompass "flex" to allow people to move into research roles, or hybrid research/clinical/academic roles without affecting career progression or increments.

Pillar 2: Facilities, Digital Innovation & Infrastructure

Both LPT and NHFT have limited facilities to support research, with an R&I "wing" at Berrywood Hospital, and in LPT the rooms and offices at Swithland house, the latter equipped with -20^{o} and -80^{o} Freezers, 12-lead ECG, Blood Pressure Monitor, Centrifuge, Defibrillator etc. resourced from past research income.

"Saving & Improving lives" talks about the development of "world-class" facilities, with science and research being a cornerstone of health provision going forward. These manifest in Biomedical Research Units and Centres funded by NIHR (and partners) across the UK, with an expectation that the wider healthcare system will support these key Units. NIHR also have established five "Participant Recruitment Centres" (PRCs) to focus on Phase III Commercial Trials. One of these is in LLR (at Leicester General Hospital) and offers resource to partners to help deliver such trials, with the assistance of satellite sites across the region. For commercial trials, the standards of staff training, experience and facilities are very demanding, such that a significant growth in income derived from such is limited by the scope of the facilities available (and the number of suitably qualified investigators). At a local level, more can be done as part of the LLR Community and as the Healthcare Clinical Group. This could include:

- Further investment in a small estates development, short of an acutal "clinical research facility" to enable a wider range of commercial trials to be conducted safely and effectively (contingent upon staffing) within the Trust.
    - Staffing to include methodological expertise, information & analytics, statistical support (some of this can be leveraged from the RDS)
    - Software (e.g., SPSS site license) and Hardware resources
        - Analysis software is especially important to support local level, pre-protocol evaluation work, that itself leads to more robust, and potentially fundable, research questions.
        - Many staff in the Trust have trained on SPSS during their studies, and this skill set should be maintained.
- Investment in a Clinical Trials Pharmacy Facility/Pharmacist capacity to support commercial research (self-sustaining with a growth in trial activity)
- Encouraging staff from all disciplines to get experience of trial delivery, and potentially involvement in the "Associate PI" scheme.
- Identify "ad hoc" facilities within existing estate to be used as a research space to make study delivery possible
    - Include research capacity within future estate planning
- Digital strategy to make the best use of data, and safe-haven processing facility.
    - Build on the "Research Delivery Service" S1 Unit
    - Developing an association with a "data aggregation and query" system (Such as TriNetX), with parallel improvements in overall Trust data quality, to power study feasibility, attract new research opportunities, and an aid to business information.
    - Integration of Business Analytics and Data Queries within the R&D Pathway.
- Reinforcing "research beacons" (e.g. Huntington's Disease, Enhanced Mental Health Rehabilitation and Intellectual Disability in LPT, and Dementia in NHFT) with supporting facilities adapted to need.
- Agile staff deployment options where research demands require such, and where they are resourced (zero-sum for services)
- Mobile Clinical Trial Laboratory/Research Space to take research to where facilities are non-existent and to increase access to potential research participants
- Aligning information systems optimised for the setting.

Pillar 3: Finance & Contracting

Managing resources appropriately is a key element of service and financial sustainability. The Trust "Research Office" is the key element of this (as is expected by the definition within the UK Policy Framework), supported by central Finance, Costing and Contracting staff where needed. The key dimensions here are:

- A "Protected Income" Cost Centre (PICC) recognising that research is not geared to financial year end
    - Project/Programme Specific Cost codes to ensure financial probity (managed by R&D but linked to the generators of income (PIs or Grant Holders))
    - This structure enables end of year reporting to NIHR CCF or equivalent
    - Research Capability Funding to be part of the PICC
    - Enables individual study/project management, analogous to an academic project grant mode of operation.
- Continued implementation of a transparent Income Distribution Model for research grants and commercial income linked to the PICC.
- Compliance with the NIHR CRN Financial Health Check
    - Managing CRN funding ring-fenced from other Trust budgets
    - Ability to reimburse where CRN resource has been used to support commercial work
- A clear mechanism for accessing Excess Treatment Cost resource where required up to the value of the Trust-specific annual threshold (now 0.01% of operating costs).
- Establishing a Core Trust Research Budget for addressing unmet service support costs, and as a pump-priming or matched-funding mechanism to build infrastructure for locally led, pre-portfolio research activity and integration with QI initiatives.
- The core budget would be directed by the new R&D Committee, with oversight from FPC, building upon lessons learned from the successful use of Trust Charitable Funds to increase the pace and scale of new, local research
- Ensuring finance and contracting procedures are optimised within the mandatory "Assess, Arrange, Confirm" process encapsulated within ORCA (Organisational Research Capacity Assessment).
- Trust Finance to provide dedicated rapid costing support for grant submissions, identifying NHS Costs within research as separate from academic costs.
    - System-compliant with NHS Guidance on cost attribution
- Rapid Contract and legal review where a proposed contract is outside of the national templates
    - Includes non-disclosure agreements

Pillar 4: Patient & Public Engagement

"Saving & Improving Lives" reinforces the overriding aim of putting patients at the centre of all we do, and additionally targets reducing health inequalities as one of the elements that research should address. Therefore:

- Build upon the existing "Research Partners Collaborative" as a means of co-production and involvement/leadership in the development of:
    - Specific Research Projects & Programmes
    - Identifying key research priorities
    - Improve resourcing of PPIE activity
- Compliance with the "transparency" agenda by ensuring that all results from Trust-sponsored research are fully shared with participants, and so far as it is possible, disseminating the results of national research of local impact.
- Liaison with HealthWatch and similar organisations.
- Continued recognition and development of cultural and ethnic awareness and competency
- Revise procedures to consider withholding Trust Sponsorship for research that does not adequately meet minimum standards of PPIE (this is contingent on building the PPIE Resource).
- Potentially establish "Consent to Contact" Register as part of public dissemination and patient contact process.
- Ensuring PPI is embedded within LPT Research "Beacons".

Pillar 5: Partnerships & Networks

5.1 National Institute for Health Research.

One of the key drivers in "Saving & Improving Lives" is that research is not a parochial activity, but is ideally undertaken in partnership, and this builds on the "Best Research for Best Health" agenda that established the NIHR. The premise of NIHR is that larger, multi-centre studies (the "portfolio") produce more robust results, and therefore evidence to improve care. The

NIHR also fund infrastructure such as the AHSN, ARC and BRCs, as well as the Career Development Pathway opportunities: NIHR therefore is a key partner. Without engagement in "portfolio" research, income would drop significantly, and the existence of the research delivery team would be threatened. Therefore:

- NIHR Clinical Research Network (the "delivery arm" of NHS Research)
    - Build upon the LPT Status as a Category A Partner of the NIHR CRN
        - Be represented at CRN Partnership Board at Executive Level
        - Increase service involvement with portfolio research
        - Offer opportunities for clinical staff to become PIs or collaborators and role models
        - Underwrite the cost of the research delivery team resources by the CRN
- Applied Health Research Collaborative (NIHR ARC)
    - Engage with all aspects of the ARC Programmes
        - Applied Research (health inequalities, mental health etc.)
        - Staff Development Opportunities
- Academic Health Science Network (NIHR AHSN)
    - Engage with the AHSN for bringing innovative developments to the NHS

5.2 Exploring & Renewing Academic Partnerships

It needs to be understood, that through the NIHR CRN, LPT (and NHFT) operates in partnership, both short-term and long-term with a wide range of academic institutions. With excellent delivery performance this leads to "repeat business" with these institutions, and the opportunity for LPT patients to be offered the chance of participation in research and treatments (and/or training for staff) not otherwise available.

Although LPT has a long history of association with a major University Medical School (University of Leicester), there is considerable scope for improvement, and re-basing this relationship for mutual benefit, including the development of academic/clinical leadership roles to develop the research programmes of the future. Only through increasing capacity in-house (which requires strategic, long-term, goal-focused investment), will LPT be able to consider becoming a BRC in partnership with academia and other institutions. Future "clinical academic" appointments should be aligned as much with Trust Clinical Priorities, as academic independence by seeking a balance, rather than a tension between the two.

It is proposed that with each partner University, an additional "clinical academic" role is created annually, over a five-year rolling programme, with a specific clinical base, but able to fully exploit the academic element of the role, to the agreed benefit of the partnership.

The need for academic partnership is also exemplified by the evidence that research-led services provide generally better outcomes for patients. The development of the Leicester Academic Health Partnership (LAHP) referenced in the ICS Strategy, can be the vehicle for such development, alongside other components such as LCMHR (Leicester Centre for Mental Health Research).

Critically, "University Partnership" is not limited to University of Leicester, DeMontfort, and Loughborough. We have a burgeoning relationship with Lancaster in HD Psychology, and Warwick in terms of Autism and Intellectual Disability. In short, a "University Collaboration" should be on the basis of congruence of expertise with clinical need, as opposed to geography.

Across the NIHR and partners, there are significant funding streams available, from training awards to multi-million-pound programmes. Through long-term investment in academic leadership, LPT accessibility to such funding would be enhanced, although this is hugely competitive, and would require full engagement with the Research Design Service.

5.2 Developing Commercial Partnerships

Commercial research, and the "capacity building" elements of Clinical Trial income, is one way to:

- Provide access to new treatments for patients
- Provide an environment for the training of investigators
- Provide income to clinical and support services

To achieve this, facilities and infrastructure need to be in place in order to maximise the chances of "site selection". Increasing the number of clinical trials attracted to LPT would be facilitated by:

- Seeking long-term development pathway agreements with pharmaceutical and medical device providers.
- Developing staff as potential Principal Investigators, without which, the conduct of significantly more income-generating trials and access to new treatments, will not be attractive to industry sponsors.
- Seeking blanket CDAs with Industry to facilitate rapid review on feasibility and co-production
- Utilise the existence of the NIHR PRC at LGH to increase the number of Phase III Studies involving LPT, and associated income.

5.3 Cross-sector Support

It is central to the national strategy, and to that of the Clinical Research Networks and the ICS, that more and more research is done collaboratively. This builds upon the existing large-scale, multi-centre studies to embrace sites working in partnership, particularly with regard to the patient journey. There is no reason why the best research should not embrace identification in primary care, into tertiary or acute care or vice versa, delivered by a flexible workforce. LPT already operates this sort of model, happy to work in or in partnership with Care Homes, Primary care and wider.

One step would be to establish formal partnerships with new Primary Care Networks, offering the opportunity for people under the care of a PCN, access to trials that may occur, in partnership with a BRU, or the PRC, and the Trust Delivery Team.

The EM@CRN is establishing a "Direct Delivery Team" to work in this space, with the NIHR rebranded as National Institute for Health & Social Care Research: this will enhance the cross-regional capability to support more diverse, and cross-sectoral research, and the needs of "under-served" communities.

Pillar 6: Communications, Governance & Management

Communications: Too often, research is seen by staff as "something for scientists", rather than core to everyday clinical practice. This can be partly addressed by communication and training, but also by modifying career pathways. The DHSC and NIHR have national level campaigns including "Be Part of Research", "It's OK to Ask" and "Your Path in Research" which help to address this. In addition, this needs to be reinforced through for example:

- Further develop the "Be Part of Research" newsletter and web presence for LPT
- Consider the development of the "LPT Institute" – in-house publication (occasional papers and monographs etc.)
- Investment in expertise to accommodate changes to information governance and use of data.
- Board-level confirmation of ambitions to be a more research-active Trust
- Engage key contacts in Clinical Teams with "It's Ok to Ask" principles.

Governance: Research needs to be embedded within the Assurance and Escalation reporting structures of the Trust, and for this assurance to be evidenced that the Trust is compliant with the principles contained in the UK Policy Framework for Health & Social Care Research (UKPF). Much of this will be embedded within the workings of the central "Research Office", the capacity of which (together with other enabling functions) determines the ability of the Trust to act as a Research Sponsor (as defined in the UKPF). This includes mandatory reporting elements such as:

- Quarterly Clinical Trials Performance via the CTP Portal
- Data *must* be reported at Board level.
- Quality Account
- Delegated accountability and leadership within Clinical Divisions

If there is a SLA in place with a clinical or academic partner, then there is nothing in principle against over time the "Research Office" being a cross-organisation function. A "joint research office" exists elsewhere, Newcastle, and Imperial (London) being notable examples.

Management: Research is still by and large, an activity regarded as for "specialists", or is perceived to be. In terms of clinical and service management across the Trust, there needs to be an increase in the number of roles aware of, and responsible for leading or including research in their agenda. This has to be mirrored by service and clinical management seeing research as something they *can* do, as part of everyday business. This is further explored in the LPT Specifics Appendix.

Pillar 7: Dimensions of NHFT/LPT Collaboration

As indicated earlier, collaboration is very much at the heart of quality research, with powered, multi-centre studies at the heart of the Portfolio. This is likely to inform the development of the NIHR CRN, which is being asked to cover wider aspects of health and social care. “Partnership”, is also at the heart of the ICS and PCN developments. There is likely to be some degree of divergence between LPT and NHFT, given that the Trust are in separate ICS areas, with the Northamptonshire ICS already developing a research & innovation sub-group, involving NHFT.

There are four key levels in which collaboration with in the LPT/NHFT could develop.

1. Project Level (already occurring)
    a. Non-portfolio – joint local studies of mutual priority
    b. Portfolio – sharing resources or plans to deliver the same study where both Trusts are “sites”.
2. Programme Development
    a. Exploring developing cross-Trust research leadership roles
    b. Aligning clinical and research priorities in areas of joint provision
3. Alignment of Governance Processes
    a. Potential for single Research Office
4. Over-arching Research Committee
    a. Merged research delivery & support infrastructure

Summary: research collaboration beyond the project level should be born out of long-term clinical partnership, where areas of joint concern prompt the allocation of resources into developing research ideas to address them. It must also be recognised that high quality research is costly, and designing and securing the funding for such activity is only possible with long-term investment.

Appendix A

Leicestershire Partnership NHS Trust Specifics

The proposed "roadmap" for R&D to be developed over the next 9-12 months, will be founded on five key principles:

1. The sustainability of the service model.
2. Quality standards throughout (strengthening the R&D Office and Governance)
3. Best use of resources
4. Enabling all staff to achieve
5. Working in suitable and safe environments.

This document outlines some of the initial ideas, prior to more widespread consultation with Directorates and Partners. These would include:

1. Identifying Directorate "Research Advocates" to provide focus, leadership and capacity coordination within and across individual Directorates in terms of priorities and objectives, as well as linkage between innovation, improvement and research.
    a. Advocates to be part of the overarching Trust R&D Committee (which can include similar representatives in partner organisations inside and outside the NHS)
    b. Supplementing the "R&D Office" and Delivery Team activity in governance assessment for the hosting of any research, and the support available in grant development.
2. Workforce planning to enable research-active staff to apply for hybrid roles, rather than returning to "work as usual", and to encourage research participation.
3. Identifying "research space" within existing environments
4. Delegating to the lowest possible unit of activity (i.e. the most junior of staff), the power and right to innovate, propose ideas and enact the process of enquiry.
5. Establishing within each clinical team, a single point of contact to be conduit for all matters pertaining to research within that team, including:
    a. That research is included on every team meeting (even if not discussed)
    b. Liaising with R&D central functions on research opportunities (portfolio or otherwise)

Where we are

As a first step, the proposal is to create within LPT, Directorate Level Research Advocates roles (with an assumed role status equivalent to 8a), supported by nominated research contacts within each clinical team within the Directorate, and with a place on the Senior Clinical Team or appropriate body in the Directorate. These roles (which could form part of the responsibilities of existing roles) would have delegated responsibility to identify priorities, develop ideas and channel them to the most appropriate support and direction, act as a focus within the Directorate regarding research priorities, performance, and contribute to the overarching R&D Committee. Each Research Advocate would work with one or more of the core research delivery staff and service users to ensure a positive contribution to the Assess, Arrange, Confirm process if needed, and that we maintain our hard-won reputation for both flexibility, but also a robust feasibility for all research such that we deliver what we promise.

Overall Leadership

The R&D Committee would be chaired by an Executive portfolio holder for research (or delegate, such as a Non-Executive Director), a role that would allow for performance reporting and advocacy at Trust Board level, as is required in the UK Policy Framework and Partner Organisation Agreement. This is one of the key characteristics of a truly research active Trust. There is in principle no reason why such a committee could not be enacted between multiple organisations, led by a joint Research Director.

Research Delivery Team & Research Office

The UK Policy Framework for Health & Social Care Research and the HRA set out the key role and responsibility of the "Research Office". These vary significantly in size across different organisations, but are viewed as key "gatekeepers", acting in a proportionate and pragmatic way with the HRA and other regulators. This office could potentially be shared, cross-organisational function (with NHFT for example) whilst retaining Trust independence through the

"Champions" roles. The Research Office role is (amongst many others), that for each research study that the NHS organisation hosts to:

a. Ensure that the NHS organisation has the both the capability and capacity to undertake the study – that is, bearing in mind the inclusion and exclusion criteria and the resources required, will it be possible to recruit the required number of participants within the timescale of the study delivery period?
b. Managing the resources required to deliver the study both at study set up and throughout the study life cycle.
c. Undertaking an early assessment of operational risks to the delivery of the study and to the organisation and ensuring there are proportionate systems in place to manage those risks to effectively deliver the study through its life cycle.
d. Negotiating contracts/agreements and costs for the delivery of the study (sometimes with support from the Finance or Legal Departments within the NHS organisation).
e. Gaining assurance that research applications comply with the law and that, where required, there is sufficient insurance in place.
f. Formally giving permission, or not, for the study to take place within the NHS organisation.
g. Ensuring that the study is delivered "to time and to target" – i.e., the site recruits the number of participants stated in the original application (or a revised target) within the timeline agreed with the sponsor to the study protocol.
h. Processes amendment information and makes any necessary arrangements to continue NHS permission or, very occasionally, withdraws NHS permission if the amendment reduces the capacity and capability of the organisation to deliver the research to the new protocol.

Specific Plans with Regard to Existing Staffing (Research Office & Delivery Team)

The Trust already has a "research office", working closely with and uniquely, directly managing the CRN-funded research delivery staff to enable and support participation in portfolio research across the organisation. The latter team are limited in size by the infrastructure budget available from CRN, such that only by increasing portfolio participation can this be enhanced. The proposed central and dispersed R&D Office structure, funded by the Trust should be:

- (B8c) Head of Research Operations/Interim Lead for R&D *(Dr Dave Clarke)*
- (B7) R&D Business Manager (Jo Edgar) *(a CRN-funded post, but should be Trust-funded, at least to 50%)*
- Directorate Lead/Research Fellow (CHS) *(Dr Sarah Baillon) – effectively, the CHS Research "Advocate"*
- *Vacant (MH Directorate Lead)*
- *Vacant (FYPC Directorate Lead)*
- (B6) Research Support Officer *(Dr Karishma Joshi)*[1]
- (B6) Statistical Support Officer (new Post)
- (B4/5/6) Research Compliance, Sponsorship and Governance Facilitator/Administrator (New Post)
- Further admin team support from Enabling Service pool

These would be supplemented by dedicated time from staff in Communications, Finance etc.

Delivery Team

To further develop roles within the delivery team to offer scope for progression beyond the CRN "glass ceiling" at Band 6. This may include Team Leader roles for example.

Moving the role of "business manager" to a primarily Trust-funded role allows for additional posts purely for "delivery" to be resourced within the funding envelope.

The current delivery team is limited only by the "cap and collar" approach of the budget provided by EM CRN, in supporting studies across the Trust. Enhancing home-grown research to portfolio status would enable the team to grow. The "flat" budget approach in reality means a year-on-year resource reduction.

[1] Should the idea of a Compliance and Governance role be supported, and the roles of Directorate Leads, the role of RSO should be upgraded to Band 7 to recognises the extra responsibility, and for the purposes of succession planning.

The restrictions imposed by the EM:CRN in terms of staff deployment, and limits on progression, is a very real threat in terms of supporting “in-house” research to achieve portfolio status, and also long-terms skilled staff retention, as to progress to higher bandings, it can be necessary to move on.

Research Beacons

The vision over time would be to identify and build upon areas of existing high research activity (e.g. Huntingdon’s Disease) in both Trusts, and in further partnerships.

The expired R&D Strategy identified the key components of a Research Beacon, and through a targeted rolling programme of investment, and smart recruitment into clinical/research leadership posts in partnership with a wide range of academic partners, these existing Beacons can be enhanced, and new ones established.

The HD Research Beacon already has a national and international reach, through long-term collaboration with the CHDI Foundation and EHDN, which is now attracting a wave of new clinical trials (some commercial, bringing in additional income). This has now also developed an academic partnership with Lancaster University, from a psychological perspective, sourcing a grant from the Gossweiler Trust.

Intellectual Disability and Autism has seen a growth in the number of portfolio trials and studies, and also secured major NIHR funding in partnership with Loughborough University. A partnership is developing with University of Warwick through Peter Langdon.

A model for exploiting this would be to ensure that the clinical leaders for the Beacons (Reza Kiani and Maria Dale for HD: Satheesh Kumar, Sam Tromans etc. for IDA), can, should they choose negotiate a changed status or work pattern to further protect and develop this.

The next beacons are likely to be Eating Disorders, and Mental Health Enhanced Recover (Kelly Fenton, Sandeep Singh, and Kat Kidd). In addition, by linking in with Professor Julian Barwell, there is the possibility of a collaborative centre of excellence being establish in Fragile-X, involving University of Leicester, UHL, LPT (FYPC and DMH).

This Plan proposes that any nascent Beacon can apply for central Trust “Seedcorn” funding, in order to take them on to the next level of growth.

Leicestershire Partnership and
Northamptonshire Healthcare Group

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Trust Board 26th July 2022
Leicestershire Partnership & Northamptonshire Healthcare Group
Chairs' Joint Highlight Report

Purpose of the report

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

Analysis of the issue

- The governance arrangements and mobilisation of Joint Roles are complete. The Committees in Common will receive a Joint Roles Employment Register as a Standing Item from September 2022.
- A review of the Group Terms of Reference and Memorandum of Understanding, together with and Effectiveness Review is to be undertaken during August and submitted to the Committees in Common in September 2022.
- Proposals for an over-arching Group strategic framework continue to be developed.
- Some early work benchmarking and comparing each Trust's Financial plans has highlighted some differences regarding agency spend, capital and more work is planned to explore opportunities in relation to these. This will be received by the Committees in Common in September 2022.

Proposal

- This LPT-NHFT Committees in Common Highlight report (Appendix A) from the Joint Working Group meeting is offered to each Trust Board to reflect the achievements and direction of travel for the Group model.

Decision required

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

Leicestershire Partnership and Northamptonshire Healthcare Group

Appendix A - LPT-NHFT Committees in Common (CiC) Joint Working Group (JWG) HIGHLIGHT REPORT 5th July 2022

Purpose of Report

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

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

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

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

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

Report	Assurance level	Committee escalation	ORR Risk Reference
1. Attendance & Apologies	N/A	Listed in the CiC meeting notes	N/A
2. Action Tracker	High	The 5th July 2022 meeting of the CiCs noted all actions as closed.	N/A
3. Group Risk Register Update	High	The updated risk register, following the Strategic Priorities year one review was received, and the overall level of risk considered low. It was noted that the risk log would continue to be refreshed and updated as part of the Strategic priorities year two planning and presented in September.	N/A
4. Annual Review of Group Model and MoU	High	The July 2022 meeting of the CiCs received and supported a proposal and suggested timeline for a review of the Group Model and MoU. This will include a review of effectiveness of the JWG, based on existing committee review format to incorporate the following; • Terms of Reference • Membership • Attendance	N/A

Report	Assurance level	Committee escalation	ORR Risk Reference
		• Feedback on effectiveness including a survey to both sets of Trust Board members around benefits, barriers and priorities. It will also include an annual review of the MoU, including deliverables from 2021/22 and priority workstreams, group remit and recommendations for 2022/23 The August 2022 JWG will review the draft output and consideration of priorities for 2022/23 including the following; • Proposal for the JWG to be manged by the corporate governance teams dependent on resource. • Explore the impact of the emerging joint management structures The September 2022 Trust Boards will receive an output from the review.	
5. Strategic Framework Proposal	Amber	The July meeting received a paper outlining a potential Group strategic framework which identified themes common to both Trusts. This paper built on the comparison of each Trust strategy (Step up to Great and DIGBQ) received earlier this year. The framework was supported in principle and some refinement and consideration of additional programmes of work (such as Recruitment and Retention and collaborative learning) were agreed.	N/A
6. Living and Working with Covid-19 / Reset and Rebuild, and review of the combined plans to identify any missed opportunities	High	The 5th July meeting received a report on Living with Covid, highlighting commonalities and lessons learnt from each Trust on the recovery work. Noted importance of focusing on business as usual, benefits of cross-organisational discussion and learning, and positive impact on staff health and well-being of decompression. Segmenting and RAG rating teams using both qualitative and quantitative data has been beneficial in understanding where the pressure points are.	N/A
7. Strategic Priorities Programme Year-End Review	High	A Programme Highlight report was received and supported at the July meeting following year-end reviews with leads for each of the 8 strategic priorities. Some amendments have been made to the original plans based on learning or shifting landscape. Strong support in the Group was given for the direction of travel and it was agreed that year two deliverables will be the focus at the September meeting. Next steps agreed were to start to build in the themes identified as part of the Strategic Framework Proposal.	N/A

Report	Assurance level	Committee escalation	ORR Risk Reference
8. Joint Roles Employment Register	High	The 5th July meeting received a register of all current employed Joint Roles. This is to be updated as new roles are appointed to and will be a standing agenda item at each meeting.	N/A

Leicestershire Partnership and Northamptonshire Healthcare Group

LPT Trust Governance Table

For Board and Board Committees:	26th July Trust Bloard	
Paper sponsored by:	LPT Trust Chair, Cathy Ellis, NHFT Trust Chair, Crishni Waring	
Paper authored by:	Lisa Hall, Amanda Johnston	
Date submitted: **State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):**	8th July 2022 LPT-NHFT CiC JWG 5th July 2022	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured: **State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning**	Assured Next update to Trust Board September 2022	
STEP up to GREAT strategic alignment*:	High **S**tandards	x
	Transformation	x
	Environments	x
	Patient Involvement	
	Well **G**overned	X
	Reaching Out	
	Equality, Leadership, Culture	X
	Access to Services	
	Trustwide Quality Improvement	X
Organisational Risk Register considerations:	List risk number and title of risk	
Is the decision required consistent with LPT's risk appetite: **False and misleading information (FOMI) considerations:**	yes None identified	
Positive confirmation that the content does not risk the safety of patients or the public	None identified	
Equality considerations:	Outcome will apply equally to all staff in LPT	

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Leicestershire Partnership NHS Trust

QAC 28th June 2022 9.00-12.00

Highlight Report

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

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
Director of Nursing, AHPs & Quality Report – Paper C	NA	This was the last DON report submitted to QAC due to the new process planned. There was a focus on IPC and development of the Quality Dashboard. The interpretation of performancedata which is supported by this report will be covered within the performance report agenda item moving forward.	
Medical Director Update – Paper D	NA	This was the last Medical Director report submitted to QAC due to the new process planned. There was a focus on medical workforce issues and suicide prevention. In future, items covered within this report can be raised by exception and assurance will be gained from Level 2 committee highlight reports.	
Director of HR Update – Paper E	NA	This was the last Director of HR report submitted to QAC due to the new process planned. Activity around recruitment and health and wellbeing of staff continues within the trust. In future this will be reported through specific agenda items and Strategic Workforce Committee for assurance.	
CQC Action Plan Assurance Report – Paper F	High	Additional must dos have been added from the recent re-inspection which had a positive report describing significant progress. All actions are on track and weekly monitoring continues. Since this report was written the Mental Health Liaison Team at UHL have received a very positive (not rated) narrative report following their inspection. Learning is shared in the Foundation For Great Patient Care forum and at the Quality Surveillance Tracker Meetings across directorates..	57, 62, 66

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
Performance Report - Quality and Workforce Measures – Paper G	Medium	The current vacancy rate is 14% and the Strategic Workforce Committee are monitoring this and looking at the way vacancies are reported with real time reporting being employed moving forward. Improvements in mandatory training and clinical supervision are evident. A working group is now looking at agency spend in detail with more rigorous controls and more senior oversight for authorisation planned. Different models of care and support are also being considered and a robust plan of reduction is being drafted with safe staffing being considered at every stage. An agreed set of plans with actions will be drafted and presented to QAC for assurance.	60, 74, 75
Provider Collaborative Performance - CAMHS Quality Summit – Paper H	High	It had been a successful year as the lead provider for AED. Feedback from patients and carers was positive and included within the report. An underspend is being carried forward to be used for frontline operational services including a virtual day care service offer. The average length of stay has reduced; occupancy levels remain static and there have been no serious incidents. The CAMHS Quality Summit was well attended and follow-on work is underway. Further information will be provided to QAC in August.	57
Safeguarding Quarter 4 Report – Paper I	L M	The Mental Capacity Act and Deprivation of Liberty work has moved from the Legislative Committee to the Safeguarding Committee from June 2022 - the safeguarding team have been leading on MCA & DOLS for many years so this is better aligned. The full guidance on LPSis currently out for consultation. The new version of safeguarding training has been delayed but will start in July 2022 and the ORR 58 has been updated to reflect this. QAC received split assurance from the report – low assurance around the safeguarding training due to the delays and medium assurance for the rest of the report.	57, 58, 61
Ockendon Report – Paper J	High	Triangulation against the report continues across the Trust including within directorates. Learning will be discussed at the Quality Forum and will feed up to QAC through the highlight report.	57, 61, 62, 73
Ligature Risks Quarter 4 Report – Paper K	High	There is a comprehensive fixed ligature workplan working on hinged doors and window replacements. Non-fixed ligatures have a small	58, 62

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
		working group set up to discuss plans as these remain a complexissue.	
Falls Prevention Annual Report – Paper L	High	The group continued to meet through the pandemic and have focussed on developing a learning culture and taking ownership at ward level with the use of huddles with a QI focus. Monthly monitoring continues and the levels of harm remain unchanged from previous years. Falls are multifactorial and theming remains important. Priorities have been set for the group moving forward.	57, 58, 59, 61
Nurses and AHPs Revalidation Annual Report – Paper M	High	The report which is an annual outline of processes, systems and controls within the Trust. Details of revalidations are contained within the report for information.	61
Medical Revalidation Annual Report – Paper N	High	The process and governance is detailed within the paper and there are no concerns or issues to highlight.	61
MHA Annual Report including Hospital Managers' Panel Annual Report – Paper O	Low	The report details all activity pertaining to the Mental Health Act within the Trust. Mental Health Act activity has reduced – the details are within the paper including details of reduction in use of sections. There were highlighted issues around rights under Section 32 & Section 17 leave records storage,being picked up in the IM&T Delivery Group. Themes and learning from the MHA focused visits are captured and will be in the next LEG highlight report. These are also logged by the Compliance Team on the Quality Surveillance Tracker (QST) and shared in the QST meetings for immediate learning. QAC considered that the report does not offer assurance and that a clear plan is required to improve compliance against these targets. Until this is provided QAC agreed low assurance was received.	57, 61, 62
Research and Development Annual Report – Paper P	High	Covid themed research was now slowing down. Intellectual disabilities & LD collaboration with Loughborough University has attracted a large grant and the work 'breaking the barriers' has attracted funding from CRN colleagues and is now extending into ethnic minorities. Work is ongoing in the team to promote how all staff can become involved in research, making research relevant.	73
Guardian for Safer Working Quarterly	High	There have been 2 exception reports this quarter with no trend evident.	61

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
Report – Paper Q			
Staff Side Facilities Statement Annual Report – Paper R	High	The report was presented to QAC for information.	
ORR – Paper S	High	The register had undergone an executive review and this has resulted in some amendments to risk scores which are detailed within the report. All risks have been updated and risk 80 has now been removed. Residual risks remained low in risks 61, 62 & 75 as the team have a confidence level around the impact of the actions detailed. This will be monitored monthly.	57, 62
Strategic Workforce Committee Highlight Report 16th March & 18th May 2022 – Papers Ti & Tii	Medium	Assurance levels have been reconsidered and previously green assurance had been allocated to a number of areas due to there being plans in place, however on reflection this should have been amber and has now been amended. The People Promise Exemplar programme is a 12 month programme of improvement with work around retention and strategies with an action plan being drafted following diagnostics. The People Promise Manager is now in post and working on these issues.	60, 61, 73, 74
Policy Committee Highlight Report 27th April 2022 – Paper U	Medium	The number of out of date policies had now reduced and good progress had been. A remapping process is ongoing and a Ulysses module for automated tracking will ensure this situation does not occur in the future.	57, 62
Health and Safety Highlight Report 5th May 2022 – Paper V	High	The amber rating in the report was around fire safety at 2 sites and these were housekeeping risks rather than environmental issues and these have now been addressed. A group had been set up to support smoking cessation and the incidents referenced in the report were monitored and managed well at operational level, the smoking policy is due to be renewed.	57, 59, 61
Legislative Committee Highlight Report 18th May 2022 – Paper W	Low	The Legislative Committee is focused on the Mental Health Act now and will be renamed accordingly with revised TOR and a new Chair. Issues remain around training, Section 132 rights and Section 17 leave forms. Action plans and the success of these is being discussed and the challenges are around pace and sustaining improvements with workforce and culture impacting compliance. QAC requested an urgent committee review.	57, 58, 61, 62
Safeguarding Committee	Medium	It was confirmed that there is currently a pressure point around LAC involvement in terms	58, 61

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
Highlight Report 13th April 2022 – Paper X		of the system team and resolution is being sought.	
Quality Forum Highlight Report 12th May & 9th June 2022 – Paper Yi & Yii	H L	Assurance on SIs remain low due to plans and trajectory progress not being on target, new plans and trajectories will be reviewed by the Incident Oversight Group (IOG) and the next Quality Forum meeting will receive and report on this. The positive and safe training compliance was red and some issues relating to this were due to staff sickness. An issue of unassigned tasks on SystmOne was highlighted is being investigated. There is a learning from deaths backlog in 2 directorates and an urgent QI programme and Quality Summit are planned to support with interim measures in place. Robust discussions around these issues will continue in the Quality Forum. QAC received a split assurance from the report – high assurance for the grip being applied and low for the issues of concern highlighted.	57, 59, 61, 62

Chair of Committee:	Moira Ingham

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Leicestershire Partnership NHS Trust

Trust Board – 26th July 2022

Care Quality Commission Update

Purpose of the report

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

The CQC assurance action plan accompanies this report, to accurately reflect the achievements to date against the 'must do' actions. The action plan includes the 3 new must do actions following the reinspection in February 2022.

Analysis of the issue

CQC Inspection Activity

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

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

Key inspection activity within LPT relates to:

1. Responding to the May/June/July 2021 inspection to ensure improvement actions are taken, embedded and learning is shared trust wide.
2. Progressing actions in relation to the reinspection of the acute adult mental health wards in February 2022 (report published 5th May 2022).
3. Progressing the should do action following the urgent and emergency care system wide inspection April 2022 (report published 23rd June).
4. Participation in CQC Mental Health Act inspections.
5. Participation in Provider Collaborative visits

Scrutiny and Governance

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

- Ongoing weekly meetings with key nominated leads from the directorates and the Quality Compliance and Regulation team, to update and examine evidence on the must and should do actions. This includes evidence of embeddedness and sustained governance and oversight.
- The Quality Compliance and Regulation team have built a repository of evidence for each action.
- Progress is reported to the Executive Board meetings for oversight and scrutiny.
- Progress against the actions is being provided to the CQC on a monthly basis, as agreed with the CQC.

Action Plan Summary

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

Urgent and Emergency Care Inspection

The trust has participated in a system wide CQC urgent and emergency care inspection which encompassed services across Leicester, Leicestershire, and Rutland, including primary care. The inspection took place in April 2022. As part of this inspection the CQC inspected LPT's Mental Health Liaison Service which received positive informal feedback. The final report was published on the 23rd June 2022 and highlighted many aspects of good practice, adherence to standards and multi professional working.

The report contained one should do action which the Service is working collaboratively with the University Hospitals of Leicester NHS Trust to address:

The trust should ensure that they address the referral process to ensure waiting times are not hindered by 'bulk' referrals.

Mental Health Act Inspections

To date, this year, there have been six Mental Health Act inspections carried out on:

- Beaumont Ward
- Aston Ward
- Watermead Ward
- Heather ward
- Welford ward
- The Willows

Following receipt of the reports the wards have individual action plans to address areas of concern. The trust has now received all reports for the inspections including Welford ward and the Willows and actions plans are being developed by the wards.

Provider Collaborative Visits

A Provider Collaborative visit was carried out on Langley ward on the 24th June 2022, the trust is waiting for the final report.

Potential Risks

1. The trust is required to clearly articulate its commitment to addressing the concerns raised within the CQC inspection report and demonstrate progress against the required actions.

Decision required

Trust Board is asked to note the oversight of the progress against the action plan alongside the updated position following the reinspection of the acute mental health wards.

Governance table

For Board and Board Committees:	Public Trust Board 26th July 2022	
Paper sponsored by:	Anne Scott, Director of Nursing, AHP's and Quality	
Paper authored by:	Jane Gourley Head of Quality, Compliance and Regulation	
Date submitted:	14th July 2022	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Strategic Executive Board 1st July 2022	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Assured	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Twice monthly reports to Board	
STEP up to GREAT strategic alignment*:	High **S**tandards	Yes
	Transformation	Yes
	Environments	Yes
	Patient Involvement	Yes
	Well **G**overned	Yes
	Reaching Out	Yes
	Equality, Leadership, Culture	Yes
	Access to Services	Yes
	Trustwide Quality Improvement	Yes
Organisational Risk Register considerations:	List risk number and title of risk	Risk 62
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed	
Equality considerations:	Yes	

CQC Action Plan

Ref No:	Must Do Actions	Theme	Service	Improvement / Objective	Update following inspection	Actions Required	Lead (Executive & Local)	Deadline	Action Status / RAG Rating	Governance/ Approving Committee	Updates	Action Closed
MD1 - Page 8, 51 MD 11- Page 9	The trust must ensure it immediately reviews arrangements of dormitory accommodation with a view to eliminating this in line with national guidance. (Regulation 10(1)	Dormitories - Estates	Trust wide (Well Led)	The Trust will eliminate all dormitory accommodation in line with National guidance	Update: -The Trust reviewed its dormitory accommodation reprovision plan immediately post inspection. There is no potential for acceleration of the existing planned timescale. Agreed timeline for the programme of works is to be concluded by 2023. There is a clear governance process in place to ensure the progress of the plan is kept under review at the Estates and Medical Equipment Committee (EMEC) and any risks are escalated through to the Finance and Performance Committee (FPC). Post inspection an action plan was developed and shared with the CQC with further updates sent on the 25/11/21. This plan detailed actions taken to improve the dignity and privacy of patients, improve storage and laundry facilities. The two remaining actions from the Dormitory action plan on implementation of laundry facilities for Aston and Ashby Ward and permanent storage for the Bradgate Mental Health Unit and Willows are aligned to the delivery of the dormitory reprovision accommodation plan.	1. Review of dormitory accommodation reprovision plan to establish if timescales can be brought forward.	Richard Wheeler/Richard Brown	12/08/2021		Estates and Medical Equipment Committee, DMH DMT and Executive Boards.	12/08/21 Single dormitory programme has been reviewed - there is no potential for acceleration of the existing planned timescale. Agreed timeline for the programme of works progressing to ensure single dormitory provision is concluded by 2023. Actions taken to improve privacy and dignity and storage are detailed in MD7 and MD12.The estates programme is kept under review through monthly reporting to the Estates and Medical Equipment Committee (EMEC). The latest meeting on the 15/12/21 reported the dormitory reprovision programme continues to be on track for completion by 2023. The route of escalation for any ongoing concerns is to the Finance and performance Committee and Trust Board should any delays occur.	Closed
MD2 - Page 8 MD14 - Page 9	The trust must ensure that patients are able to summon for staff assistance effectively in all wards, to include communal areas and dormitories. (Regulation 12(1)).	Call Systems - Estates	Trust wide (Well Led)	The Trust will ensure that patients have access to call alarms to summon for staff assistance	Update: -We immediately reviewed the current usage and access of personal safety call alarms across all acute wards against the CQC Brief Guide on 'Call systems in mental health inpatient services for patients/service users and visitors' (July 2020). -We have a communication plan in place for ensuring ward staff are aware of process of utilising existing wrist pits and Standard Operating Procedure. -we have strengthened risk assessment processes. -An action plan was developed immediately and shared with the CQC post inspection with updates provided tot he CQC on the 25/11/21. -We have purchased additional wrist pits to strengthen accessibility for all patients on every ward to summon assistance. -we reviewed current usage and access of personal safety call alarms across all wards for visitors. - we have commissioned surveys on our estates to ensure alarms can be used and identify where upgrades are required.	1. Installation of new receivers 2. Implementation of newly purchased wrist pits to strengthen accessibility for all patients on every ward to summon assistance if they are alone temporarily on the ward based on individual clinical risk assessment. This gives full capacity for 100% usage if required.	Richard Wheeler/ Richard Brown	31/01/2022	Closed	Estates and Medical Equipment Committee, Directorate Management Team Meetings and Executive Boards.	A detailed action plan was developed immediately post inspection outlining immediate actions taken: **Risk assessment and wrist pits** 1. Established and confirmed that all acute wards have access to call bell alarm systems for patients and visitors and identified areas for further action. DMT sign off on 11/08/21 where further actions were agreed and guidelines were developed and put in place. 2. Risk assessment processes were strengthened. MDT Workshop held 17/08/21 to ensure oversight and co-ordination of delivery plan. Outputs of workshop were a) triangulation of patient safety data which showed no patient safety issues related to access to call bell alarm systems over past two years including via SIs and complaints. b) MDT clinical decision related to risk assessments of appropriate call alarm systems which was mobile -v- fixed. It was agreed to continue with mobile wrist based call alarm systems within Acute and Stewart House and Mill Lodge, as these are on a different alarm system. Guidelines and patient risk assessments were put in place by the 23/08/21 and this was confirmed 31/08/21 19/08/21 Additional wrist bands ordered - actions progressed: 1. Continued clinical risk management in line with Observation Policy and guidelines whilst wrist bands are on order. 2. Individual patient risk assessment developed with guidance for staff before provision of individual wrist pit. 27/09/21 - Half of the wrist pit order has been delivered. Awaiting the other half within the next 2 weeks. 06/10/21 - Outstanding wrist pits delivered. **Estates and survey** Estates arranged for a new site survey to be carried out by the provider. 19/08/21 - The Trust has placed a Purchase Order for the survey work at Bradgate / Bennion, requested for w/c 23/08/21. Pinpoint have confirmed that all other sites apart from Bradgate/Bennion have aerials/receivers which are compatible with new wrist fobs. 19/08/21 - Request made to confirm whether current systems are able to accommodate additional pit alarms at Belvoir ward and Herschel Prins 20/08/21 Confirmation received that neither the SAS or Guardian systems require any additional surveys as further pits can be added. As above, additional wrist pits ordered and received.	Closed
MD3 - Page 8	The trust must ensure environmental risks are identified and mitigated against including checks of the communal garden at Stewart House. (Regulation 15(1)(2)(a)(b)).	Environmental Risks / Estates	Rehabilitation	The Trust will have environmental risk assessments in place which includes communal garden areas.	Update: -The systematic checking of the garden was placed on the daily Ward Environmental Checklist. - A weekly check of compliance is carried out by the Ward Sister / Charge Nurse. - Work immediately undertaken to tidy the area and the Trust estates gardening team continue to maintain the horticulture.	1. A new 6 weekly Quality Round will be undertaken by Ward Sister / Charge Nurse and Matron.	Fiona Myers / Helen Perfect	31/01/2022	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards	14/06/2021 – Site visit from gardeners and trimmed all bushes and shrubbery 09/07/21 Environmental checklist amended to include garden areas and communication shared with staff. 16/12/21 The quality tracker tool to be used on Step up to Great Quality Checks has been submitted to Quality and Safe meeting for sign off 16/12/21. All wards will have completed the first cycle of checks by end of January 2022 23/12/21 Quality and Safety Meeting cancelled due to response to Covid -19 pandemic Level 4. Email sent to the inpatient matrons with final version of the quality check attached. This included a reminder that each ward will have completed cycle 1 of the quality checks by end of January 2022. 07/01/22 Two non clinical staff identifed to commence audit work as Matrons now clinical in response to covid 19 pressures on ward staffing. Results will be monitored at Service line Quality and Safe meetings. 13/01/22 Audits have commenced. Two completed for Aston and Heather wards. On track for completing audits . 20/01/22 Additional staff identified to undertake the Quality Checks as the Matrons are supporting ward staffing due to escalation of Omnicron COVID-19 pressure. Plans received to demonstrate the checks will be complete by the deadline. 27/01/22 All wards have now participated in the 6 weekly step up to great quality round. Results will be collated and items not being delivered on are being escalated to Directorate Management Team meetings for ongoing assurance 31/01/22 Monitoring of ongoing compliance will form part of directorate level governance.	Closed
MD4 - Page 8	The trust must ensure there are effective systems and processes in place to audit risk assessments across the service and action taken to address short falls in clinical documentation. (Regulation 17(1)(2)(a))	Auditing system - Risk Assessments	Rehabilitation	The Trust will have an effective system in place where risk assessments are audited and actioned to improve clinical documentation	Update: - A review of the current systems and processes has been completed using the PDSA approach as a quality improvement project 7th June 2021 - There is a process in place to review risk assessments and care plans, the PDSA identified further actions to achieve continued improvement re: risk assessment and care plans being updated following an incident.	1. The peer review audit tool will be amended to include questions on risk assessments. 2. Monthly audits will be carried out and the results entered onto AMaT. 3. Results will be monitored at the service line Quality and Safe Meeting.	Fiona Myers / Helen Perfect	31/01/2022	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards	07/06/21 Review of PDSA cycle to improve risk assessment completed. Actions developed and embedded as part of QI work. There is a process in place to review risk assessments and care plans, the PDSA identified further actions to achieve continued improvement re: risk assessment and care plans being updated following an incident. 23/12/21 Action on track. Questions have been added onto the tool in AMAT and ready for implementation in January 2022. 29/12/21 WeimproveQ Team emailed for screen shot evidence of questions added to the audit tool. 07/01/22 Ward audit results are now available on AMaT which will be monitored at Service line Quality and Safe meetings. 13/01/22 Audits are on track for completion by 31/01/22. 20/01/22 Wards have started to use the revised audit tool, all wards will have completed an audit by the end of January 2022 and based on outcomes a quality improvement plan will be developed to ensure full compliance. 31/01/22 Confirmation received all wards have completed an audit. Monitoring of ongoing compliance will form part of directorate level governance.	Closed

MD5 - Page 8	The trust must ensure there are effective systems and processes in place to audit care plans across the service and action taken to address short falls in clinical documentation. (Regulation 17(1)(2)(a)).	Auditing system - Care Plans	Rehabilitation	The Trust will have an effective system in place where care plans are audited and actioned to improve clinical documentation	Update: - A review of the current systems and processes has been completed using the PDSA approach as a quality improvement project 7th June 2021 - There is a process in place to review risk assessments and care plans, the PDSA identified further actions to achieve continued improvement re: risk assessment and care plans being updated following an incident.	1.A peer review care plan audit will be carried out monthly. 2. The results will be entered onto AMaT. 3. Results will be monitored at the service line Quality and Safe meeting.	Fiona Myers / Helen Perfect	31/01/2022	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards	07/06/21 Review of PDSA cycle to improve risk assessment completed. Actions developed and embedded as part of QI work. There is a process in place to review risk assessments and care plans, the PDSA identified further actions to achieve continued improvement re: risk assessment and care plans being updated following an incident. 30/11/21 The PDSA cycle now includes a process to monitor that risk assessments are being updated post incident. This is reviewed at the Risk Assessment Group. Awaiting evidence of results from audit cycle. 23/12/21 Action is on track questions have been added onto the tool in AMAT and ready for implementation for January 2022. 29/12/21 WeimproveQ Team emailed for screen shot evidence of questions added to the audit tool. 07/01/22 Ward audit results are now available on AMaT which will be monitored at Service line Quality and Safe meetings. 13/01/22 Audits are on track for completion by 31/01/22. 20/01/22 All wards will have completed an audit by the end of January 2022 and based on outcomes a quality improvement plan will be developed to ensure full compliance. 31/01/22 Confirmationn received that all wards have now completed a monthly audit. Monitoring of ongoing audits will form part of directorate level governance.	Closed
MD6 - Page 8	The trust must ensure at the Willows staff consistently apply and record appropriate contemporaneous records for seclusion. (Regulation 17(1)(2)(c)).	Seclusion Records	Rehabilitation	Documentation at the Willows will demonstrate high standards of record keeping in relation to seclusion	Update: - All staff have been identified who have not received local training on the seclusion policy and they have been scheduled for training. - the seclusion audit on AMAT is completed by the Matron following every seclusion incident to monitor the quality of care and record keeping.	1. All staff who have not previously received the local training will be trained by 31st January 2022	Fiona Myers / Helen Perfect	~~31/01/2022~~ revised date 28/2/22 due to the impact of Omicron Covid	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards	17/06/21 Doctors were reminded of their roles and responsibilities for seclusion reviews. 23/06/21 Individual reflection session with practitioner held regarding use of appropriate language. 25/06/21 CDM's were reminded that out of hours they have an oversight and coordination role for seclusion as per Seclusion Policy. 01/09/21 – Bite size training in relation to language used by staff has now been developed and rolled out. 02/11/21 – The audit was discussed at the Positive and Safe meeting 25/10/21. A meeting is planned to complete the update of AMAT questions, and a revised version will be taken to the November Positive and safe meeting for sign off. Local training planned for staff who have not had previous training on the policy for completion by end of January 2022. 23/12/21 Meeting has taken place with team leaders at The Willows and 4 dates have been agreed to complete training. 29/12/21 Need training dates as evidence and minutes of Rehab Positive and Safe meeting in November 07/01/22 November 2021 Positive and safe meeting minutes received 13/01/22 Training booked as planned. One date was cancelled due to the impact of Omicron Covid 19 and the focus on providing safe patient care. The AMAT tool has been revised. 20/01/22 Delivered 1 session as planned, one session missed due to technical difficulties with IT - session re-booked. No further episodes of seclusion since inspection to be able to reaudit. 27/01/22 Awaiting confirmation that all staff trained following additional training being delivered 31/01/22 Currently 8 out of 18 staff have received update training, 7 members of staff are unavailable due to long term sick. Further training sessions had been arranged but as this is enhanced training and not mandatory the service has had to prioritise the safety of patient care. The wards have been adversely affected with staffing shortages due to a direct impact of Omicron Covid-19 sickness as discussed with the CQC within engagement meetings. ORR risk number 63. 03/02/22 List of outstanding staff requring training has been reviewed. Training recommenced 22/02/22 All available staff have now completed this training. This leaves only the staff currently on sick leave absence, and there is a plan for them to be trained on their return to work.	Closed
MD7 - Page 8	The trust must ensure that the privacy and dignity is protected around the respectful storage of patient's clothes; (Regulation 10(1)).	Storage - Privacy & Dignity	Rehabilitation	The Trust will have safe and respectful storage facilities for patients clothes	Update: - A review of all inpatient storage facilities was undertaken - The Trust invested in improving permanent storage facilities for patients personal belongings on the Rehabilitation wards, now completed on Acacia and Sycamore. -Access to plastic storage boxes/cupboards and laundry bins made available. - Patient lockers have been provided for personal items that need to be stored securely and items that may be considered a risk.	1. Storage cupboards work to start on Cedar Ward in December 2021	Fiona Myers / Helen Perfect	28/02/2022	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards	Immediate review of storage and additional temporary storage boxes arranged. Workshop held to review improvements required. 17/08/21 - Outputs of workshop were a) Confirmed that there is adequate storage on Ashby ward dormitories, as each bed space has access to a wall mounted wardrobe with four shelves. b) On Aston Ward we have identified an additional room for the storage of larger items for the 12 patients in the 3 dormitories to have access. Ongoing co-production through ward community meetings of patient property management and storage. The additional storage identified at the Willows has already been scoped and awaiting confirmation of the dates for works to commence. 31/08/21- Aston ward - additional storage facilities now in place in a designated room on the ward. 03/09/21- . Bosworth ward received new furniture in one bedroom. This was used as a pilot for all other wards. 06/09/21 The shelving for Sycamore ward at the Willows commenced installation 13/09/21 - Bedroom furniture evaluated by staff and patients, positive feedback received and agreement to cascade the furniture out to all the new bedrooms in line with dormitory works 13/09/21 The shelving for Acacia ward at the Willows commenced installation 21/09/21 - Acacia ward and Sycamore ward shelving complete 27/09/21- Directorate now scoping additional furniture for all rooms. 05/10/21 - Thornton ward and Bosworth ward furniture being manufactured and to inform plans for other wards (Ashby and Aston to commence in line with dormitory reprovision works). 14 week turnaround timescale. 11/10/21 - Furniture installation now extended to include all appropriate rooms – approved by Directorate of Mental Health and Anne Scott (Executive Director of Nursing/AHP's & Quality). The additional furniture has been manufactured and is currently being installed in Thornton ward. Bosworth ward to be installed at completion of Thornton ward during 2 week decant period commencing 29/10. 01/11/21 -Tilbury Douglas have started the works as planned, completing one room at a time. Timescales + 8 weeks to complete 08/11/21 - Thornton ward furniture upgrade complete. 15/11/21 - Bosworth ward furniture upgrade complete.	Closed
MD8 - Page 8	The trust must ensure protected characteristic needs are identified, care planned and actioned. (Regulation 10(1)).	EDI - Protected Characteristics	Rehabilitation	Trust records will document / action and care plan patients needs around protected characteristics.	Update: -The patients individual care plan was reviewed and revised to encompass all of their individual needs. - The Rehabilitation wards welcome pack was reviewed by the Trust Equality, Diversity and inclusion group to include how the unit meets patients protected characteristic needs. - The Matron has worked with the lead at the Community Knowledge Framework for LGBTQ to acquire materials and signposting information to local networks for inclusion in patient resources at Stewart House.	1. The peer care plan audit tool within the AMaT is currently under review as part of the PDSA work. This will also include questions on recognising and meeting the equality and diversity needs of all patients. The tool will be updated by 31st December 2021	Fiona Myers / Helen Perfect	31/03/2022	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards	08/06/2021 MDT review of individuals care plan undertaken Additional review completed 22/06/2021 Review of welcome packs undertaken by Equality and Diversity and Inclusion Lead and ward provided with the most up to date version. 30/11/21 The Amat Tool has been changed to identify the frequency of expected audits reflecting the nature of the patient group. 16/12/21 narrative sent to WeimproveQ to be add to collaborative care planning review tool which will be completed and started to be used by 01/01/22 29/12/21 Email sent to WeimproveQ team for screen shot evidence of AMaT tool including audit questions on equality and diversity needs. 04/01/22 Screen shots of amended AMaT tool received. 07/01/22 Willows welcome pack now in use, audits using new tool to commence which will be monitored at Service line Quality and Safe meetings. 13/01/22 AMAT tool amended and audits underway 20/01/22 The questions are on AMAT and wards have started to use the revised audit tool, all wards will have completed an audit by the end of January 2022 and based on outcomes a quality improvement plan will be developed to ensure full compliance. 31/01/22 Confirmation received that all wards have completed the monthly care plan audit. Ongoing monitoring of audits to be part of directorate governance oversight. 03/03/22 - second round of 6 weekly checks due by 18/03/22 and to provide updated results by end of March. 17/03/22 - Awaiting AMAT report to review question regarding protected characteristics. One round already completed and outputs from 2nd round of 6 weekly checks to be provided as evidence by end of March. 24/03/22 A further round of care plan audits have been completed using the amended AMAT audit tool which includes questions of meeting the equality and diversity needs of patients. Learning from this has also involved revising the guidance for staff on how to complete the audits more effectively.	Closed

MD9 - Page 9	The trust must use patient feedback to make improvements of the quality and variety of food available. (Regulation 17(1)(2)(a)(e)).	Food quality	Rehabilitation / Estates	The Trust will improve (according to patients) the quality and variety of food choices on the menus offered.	Update: -Estates and Facilities are reviewing the process for managing patients feedback on meals and menus more productively. - A trends and themes report is being submitted to the LPT Nutrition group meeting to allow for discussion and monitoring of the quality and choice of the food provided to wards which is being included at the shared service meeting with the external catering provider to identify trends and themes of feedback and improve the quality of service received from the provider. - the Rehabilitation wards have monthly patient community meetings facilitating feedback. the agenda has been amended to include you said / we did responses. - Updated posters, co-produced with service users, have been developed to display on the ward.	1. Across the Directorate the Matrons will collate feedback from all wards patient community meetings regarding quality and choice of food to the Trust Nutrition Group Meeting to enhance availability of quality food choices with the external provider	Fiona Myers / Helen Perfect / Richard Brown	28/02/2022	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards Quality Forum	20/10/21 Estates and Facilities are reviewing the process for managing patients feedback on meals and menus more productively. - A trends and themes report is being submitted to the LPT Nutrition group meeting to allow for discussion and monitoring of the quality and choice of the food provided to wards, which is being included at the shared service meeting with the external catering provider to identify trends and themes of feedback and improve the quality of service received from the provider. - The Rehabilitation wards have monthly patient community meetings facilitating feedback. The agenda has been amended to include you said / we did responses. - Updated posters, co-produced with service users, have been developed to display on the ward. 10/11/21 Taste testing sessions took place at the Beacon Unit. 10/12/21 Minutes from the Nutrition Group are required detailing steps taken to evidence progress on this action. 16/12/21 Nutrition group meeting 16/12/21 received up to date patient feedback. Nutrition Group meetings have increased to monthly from quarterly. Amended feedback form is now discussed directly with clinical team for immediate actions to be taken. SOP to be devised to address how to escalate concerns in and out of hours to Catering. Independent Food review of our menus will be undertaken by the end of March 2022 with gaps identified and capital bids submitted to address the gaps. 23/12/21 Colin Bourne attended the Nutrition Group Meeting on 16/12/21 and provided feedback from mental health rehabilitation in-patients to the group. Colin will continue to attend and to provide feedback and link to ward. 29/12/21 Rehab food tasting sessions planned- Stewart House 25/01/22, Willows 26/01/22 06/01/22 Confirmed taste testing sessions will be prioritised to go ahead. 13/01/22 Food tasting sessions to continue as planned. Helen Walton will escalate any delays 19/01/22- Willows taster session has had to be postponed due to an outbreak of Covid 19 on the ward. The session will be re-arranged. 24/02/22 Taste testing exercises have been completed at Stewart House and the Beacon Unit to date with	Closed
MD10 - Page 9	The trust must ensure staff are up to date with mandatory training including Mental Health Act training. (Regulation 18(1)).	Mandatory Training - MHA	Rehabilitation	The Trust will achieve mandatory training compliance of above 85% in the number of staff trained in the Mental Health Act	Update: - The Rehabilitation wards have reviewed mandatory training to support recovery of compliance since Covid-19 - The number and frequency of scheduled MHA training dates has been examined to ensure that they meet the requirements of the number of staff requiring training and additional sessions can be provided.	1. Ward sisters/Charge Nurses are implementing a plan to ensure staff that are out of date for all mandatory training including MHA training are scheduled protected time to undertake mandatory and clinical training on the next ward roster in Jan 2022	Fiona Myers / Helen Perfect	~~31/01/2022~~ revised date 28/2/22 due to impact of Omicron Covid	Closed	Monthly rehabilitation Quality and Safety meeting, DMT, Executive Boards	Ward sisters/Charge Nurses have been implementing a plan to ensure staff that are out of date for all mandatory training including MHA training are scheduled protected time to undertake mandatory and clinical training on the next ward roster in January 2022. 16/12/21 staff training needs mapped out. MHA -Stewart House 73%, Acacia 59%. MCA - Stewart House 84%, Acacia 83%, Maple 83% 23/12/21. All staff reminded to complete all mandatory training including MHA 29/12/21 Evidence received all staff have been reminded to undertake training. 06/01/22 Training figures to be provided with comparison of ratio from July 2021 and current. 13/01/22 Evidence shows varying degrees of compliance. Discussed at DMH DMT and decision made to prioritise new starters. Mandatory training will continue to be available and staff booked on. In light of current staffing challenges and risk to patient safety due to the impact of Omicron Covid, some mandatory training for staff may be delayed. 20/01/22 Agreed this will be placed on Risk Register re: ability to meet the action deadline due to the inability to release staff. Wards will prioritise providing safe patient care. 27/01/22 Await an update on current position as this action is at risk of not achieving the deadline. Training compliance report for the 1st February 2022 required. 31/1/22 The service has had to prioritise the safety of patient care as the wards experienced staffing shortages due to impact of Omnicron Covid-19 sickness discussed with the CQC within engagement meetings. ORR risk number 63.New deadline proposed to executive board for approval 03/02/22 Workforce agreed to revert to providing the bespoke training reports for the next 6 months whilst training compliance is addressed and improving. The reports will also detail staff non-attendance. DMH to roster staff on to attend training as part of roster planning. 04/02/22 - Executive Board approved new deadline of 28/02/22. From 7/02/22 there awill be twice weekly training huddles to review planned training for staff on each ward. Ability to release staff for training or non-attendance will be checked at the daily safer staffing huddles. 23/02/22 All remaining available staff have completed their MHA training. There are 2 members of staff who are currently not available due to being on Maternity or long term sick leave, who will complete the training on their return	Closed
MD12 - Page 9	The trust must ensure that the privacy and dignity of patients is always maintained. (Regulation 10(2)).	Privacy & Dignity	Acute / PICU	The Trust will maintain the privacy and dignity of all patients	Update: - Estates and Facilities have implemented a new system whereby the replacement/ hanging of curtains is prioritised as soon as the wards report an issue. - A daily environmental checklist is carried out on the wards which includes all curtains, window and bed spaces, and the ward sisters oversee the checking for compliance. Any concerns are escalated to the Team manager / Matron. - Spot checks are routinely undertaken. - All wards display temporary laminated signs on patient bedrooms to remind staff to knock. - A more permanent solution is in development.	1. Permanent signage on bedroom doors will be co-designed with service user feedback and is in development. Permanent signage will be in place by 28th February 2022.	Fiona Myers / Michelle Churchard Smith	28/02/2022	Closed	Acute and PICU Quality and Safety meeting, DMT, Executive Boards	17/08/21 Outcome of the MDT Workshop held : soundproofing including physical partitioning considered, it was confirmed that soundproofed curtains and physical partitioning would not meet the Fire, IPC and ligature risk requirements. Patients have access to lockable personal storage. We have also reviewed the safety risk assessments to ensure choice is included as a consideration and where personal care/physical care is required. Daily Environmental Checklist completed. Revised Privacy and Dignity Audit confirmed on 19/08/21. Monthly spot check audit commenced. Progress is being made to improve response timeframes. Communication sent to all staff regarding update on privacy and dignity and their responsibilities w/c 23/08/21 31/08/2021- Ward sister DMH meeting- new process in place that privacy and dignity issues are being prioritised by facilities team. They will prioritise hanging curtains if the wards highlight it is a privacy and dignity issue. 14/10/21 Completed privacy and dignity audits paper presented at Quality Forum. 08/11/21 Privacy doors between male and female place at Stewart House are in place. **Signage** 3/12/21 Patient Experience, and carer lead to ask the patients by experience group to consider wording for the signs. 7/12/21 Email sent to MH Ward Sisters and Charge Nurses to ask them to consult current inpatients on wards about the privacy and dignity signs for bedrooms/ curtains - email evidence attached. Feedback to be received by 21/12/21 for discussion and decision on wording at the Lead Nurses meeting on 22nd December 21. **Laundry** Initial review of laundry facilities completed, further scoping to determine extra capacity required. 23/08/21 - Review delayed by a week by external contractor 31/08/21- Scoping exercise complete 10/09/21 - Works end date requested from Tilbury Douglas 05/10/21 - Confirmation received that expected timescale of works is 8 weeks for both to be completed . 11/10/21 - Following Fire Officer review, this initial scope has been enhanced and 2 laundry rooms are now being upgraded. Surveys have been completed, scope and design agreed, Major works required to strip	Closed
MD13 - Page 9	Staff must ensure they routinely explain rights to informal patients, offer written information and record this. (Regulation 11(1)).	Patient Rights	Acute / PICU	Informal patients will be given information on their rights and that this will be clearly documented in the patients records	Update: - A new Bradgate Unit Welcome Pack, co-produced with patients, available on all wards which includes information for patients wanting to leave the ward. - Whilst the wards await full information packs to be distributed, leaflets regarding informal rights are available for patients on admission.	1. Immediately following inspection wards were supplied with information leaflets for informal patients as an interim measure until each ward is issued with the new information pack, including leaflets and posters, to be available by 31st December 2021. Ward Sisters / Charge Nurses will sign to confirm receipt of the information pack on distribution to the ward. 2. Offering informal patients a rights leaflet will be added to the admission check list, to confirm it has been provided to the patient and enabling auditing of the process. The first audit will be completed by January 2022	Fiona Myers / Michelle Churchard Smith	31/01/2022	Closed	Acute and PICU Quality and Safety meeting, DMT, Executive Boards	Immediately following inspection wards were supplied with information leaflets for informal patients as an interim measure until each ward is issued with the new information pack, including leaflets and posters, to be available by 31st December 2021. 07/12/21 The admission checklist has been amended and sent to the inpatient Matrons. The updated form will be taken to the next quality and safety meeting on 21 December 2021 for sign off. 07/12/21 Ward booklets issued and will be updated due to NHS.net migration. 10/12/21 Evidence of the admission checklist audit required in January 2022 16/12/21 Checklist amended and provided as evidence, to be submitted to Quality and Safe meeting for sign off 21/12/21 23/12/21 Quality and Safe meeting cancelled due to Level 4 response to Covid -19 pandemic. Checklist approved by Chair outside of meeting and to be circulated. Information for informal patients has been sent to all Matrons. Communications and engagement officer will be completing a review of all patient facing leaflets. Agreed that an audit will be completed by Carol Scarborough and Apexa Patel in January 2022. 06/01/22 Audits to commence week commencing 10/01/22 20/01/22 Spot check tool has been developed to check leaflets are offered on admission. 31/1/22 Spot checks results for January 2022 received. Monitoring of ongoing compliance will form part of directorate level governance.	Closed

MD15- Page 9	The trust must ensure that all wards are properly maintained with requests being attended to in a timely way. (Regulation 15(1)).	Maintenance- Estates	Acute / PICU	The trust will have an effective system in place where wards report maintenance issues and Facilities attend to the repairs in a timely manner	Update: -A new environmental checklist has been developed which is being used by ward teams to identify repairs / maintenance requests in a timely manner. - The Ward sisters / charge nurses are maintaining a spreadsheet of all maintenance requests detailing job numbers for action with the estates and Facilities team. - A monthly estate meeting is now in place with site facilities coordinator, manager and estates link to review and escalate any outstanding works to the Business and Performance Meeting and Health and Safety Action group. - Trust Board have approved a business case and are investing in a facilities Management Transformation Programme.	1. The 6 weekly Matron / manager quality assurance audit tool will include questions on checking that the environment all checklists have been completed fully and relevant actions addressed. The first cycle will be completed by Jan 2022	Fiona Myers / Michelle Churchard Smith / Richard Brown	31/01/2022	Closed	Acute and PICU Quality and Safety meeting, DMT, Executive Boards	29/06/21 1 Ward sisters/charge nurse check each week any works required to Ward are logged on the ward spreadsheet and any outside the timescales (as specified in the estates flowchart) are escalated to Dave Wright, Acting Site Manager and the spreadsheet is updated with details of escalation. 13/07/21 – Spreadsheet has been tidied up and ward sisters/ charge nurses have been contacted to discuss individual wards and setting up meetings to review outstanding jobs. Thornton jobs have been reviewed and a meeting is scheduled with Heather on 19/07/21. 21/09/21 Work is cotinuing with the wards to update logs and escalate all jobs over the 21-day SLA to estates. 05/10/21 – The number of outstanding jobs has reduced significantly. A meeting took place 04.10.21 to discuss outstanding issues. 23/11/21 First draft of Step up to Great Quality Checks sent to Head of Nursing for sign off. This quality check has had a question added about garden/courtyard spaces as follows: •Has the ward environmental checklist been completed? •Were any identified issues from the checklist escalated/managed appropriately? •Has the environmental checklist been signed off by the Ward Sister/Charge Nurse? 07/12/21 This Quality check will go to the next Directorate Quality and Safety Meeting on 16th December, with roll out from 20th December, all wards will have been completed by end January 2022. 23/12/21 Quality and Safe Meeting cancelled due to Level 4 response to the Covid -19 pandemic. Email sent to the inpatient Matrons with final version of the quality check attached, with a reminder for each ward to have completed cycle 1 of the quality checks by end of January 2021 04/01/22 Email received confirming that there is a process in place whereby centralised spreadsheets are reviewed weekly, the process is effective as the majority of maintenance requests are now up to date. 06/01/22 Two non clinical staff identifed to commence audit work as Matrons providing clinical support to the wards in response to covid 19 pressures on ward staffing. 13/01/22 Audits have commenced. 20/01/22 Plans received to demonstrate the checks will be complete by the end of Jan 2022. 27/01/22 All wards have now participated in the 6 weekly step up to great quality round. 31/01/22 Monitoring of ongoing compliance will form part of directorate level governance.	Closed
MD16 - Page 9	The trust must ensure that managers review incidents in a timely way, in line with trust policy. (Regulation 17(1)).	Incident Review	Acute / PICU	Incidents will be reviewed as per Trust Policy	Update: - The sign off of all incidents, to ensure closure is undertaken within required timescales, is an agenda item at the weekly directorate incident review meeting and reviewed at the Incident Oversight Group. - The format of the AFPICU Incident Review Meeting has been amended. - A highlight report is to be presented at the Directorate Quality and Safety meeting in January 2022.	1.All outstanding incidents for Acute and PICU Services will be reviewed and will be signed off by the 31st Jan 2022 2. Incident management update training will be provided to all ward sisters / charge nurses and deputies to be completed by the 31st Jan 2022.	Fiona Myers / Michelle Churchard Smith	~~31/01/2022~~ revised date 28/2/22 due to impact of Omicron Covid	Closed	Acute and PICU Quality and Safety meeting, DMT, Executive Boards	**1. Incidents**Directorate plan is in place for all outstanding incidents for Acute and PICU Services are being reviewed and will be signed off by the 31/01/22 07/12/21 Significant work has been undertaken to reduce the backlog such that only Beaumont and Watermead have historic EIRF's open that need actioning. The team manager and band 6s are allocating time to close outstanding EIRF's. A EIRF completion guide has been developed by the team manager to support the process and prevent any incidents exceeding 15 days without sign off for sustainability. 23/12/21 Bradgate mental health wards have progressed historical eirfs with a small number outstanding. Currently on track. Eirf system being used and monitored by team manager to highlight areas of concern each week to prioritise resources when close to breaching 15 day sign off target. 31/12/21 Need evidence from Directorate or IOG that outstanding incidents are decreasing. 06/01/22 DMH incident report submitted to the Incident Oversight group received. 13/01/22 Reviewing of timely incidents. Reduction in backlog of incidents, awaiting data for evidence. 19/01/22 Currently 137 incidents awaiting closure for PICU and acute wards. Plan in place to address these and developing sustainability plan to ensure processes are in place for timely closure going forward. 27/01/22 Confirmation received from Incidents Team only 2 incidents requiring sign off. 28/1/22 Confirmation received that the 2 outstanding incidents are closed **Action 1 closed and Green** **2. Training** Incident management update training is being provided to all ward sisters / charge nurses and deputies to be completed by the 31st Jan 2022. Session delivered ot Foundations for Great Patient Care on incident closure cross trust 24/11/21 16/12/21 Incident review training cancelled by CPST, training to be re-arranged Training booked in for 28/12/21 06/01/22 Additional training dates for band 6 and 7 ward staff arranged. 19/01/22 Further training session to be arranged for remaining charge nurses and deputies. Thornton, Belvoir, Ashby, Aston attended training. Awaiting potential dates from patient safety team for week commencing 24.01.22	Closed
MD17 - Page 9	The trust must ensure the acute and psychiatric intensive care wards have consistent and effective management of contraband items – to include lighters. (Regulation 17(1)(2)).	Checks Policy	Acute / PICU	The acute wards for adults of working age and psychiatric intensive care units will have an effective process in place in relation to managing items of contraband, including lighters	Update: - We have improved compliance with checking and searching training. - The Quality Improvement project that focuses on checking and searching patients has commenced. - A new checklist has been developed for the wards to use which logs patients lighter use. - The quality improvement starter has been approved and the first audit on the use of patients lighters is to be disseminated in December 2021. - Spot checks have been undertaken to ensure compliance with Policy.	1. The 6 weekly Matron/ Manager quality assurance audit tool will include questions on checking that patients who smoke have a care plan in place, log the equipment used for smoking and that the lighter checklist is in use. The first cycle will be completed by January 2022	Fiona Myers / Michelle Churchard Smith	31/01/2022	Closed	Acute and PICU Quality and Safety meeting, DMT, Executive Boards	16/06/21 Ward sisters/ Charge Nurses reminded of the expectations of checking and searching when patients are returning from leave: 08/06/21 Training figures sent to ward sisters charge sisters on asking them improve compliance over the next few months. 02/1/21 – Improved compliance highlighted in the draft Nov 2021 training report however Ashby and Watermead remain under 85% compliance. Staff members have been contacted individually; some have now completed however team manager is collecting evidence as to why this is not reflected on the report. Ongoing compliance to be monitored. 03/11/21 Spot checks have been carried out over the past 3 months. Recent check indicated only 1 patient did not have a have a care plan. To move into 6 weekly Matron quality checks for sustainability. 23/11/21 First draft of Step up to Great Quality Checks sent to Head of Nursing for sign off. This quality check has had a question added about garden/courtyard spaces as follows: •Patients who smoke or secrete contra-band have a care plan detailing the checking and searching requirements •The wards are using the lighter checklist 07/12/21 This Quality check will go to the next Directorate Quality and Safety Meeting on 16th December 2021, with the plan to roll out from 20th December 2021, so all wards will have been completed by end January 2022 23/12/21 Quality and Safe Meeting cancelled due to Level 4 response to the Covid -19 pandemic. Email sent to the inpatient Matrons with final version of the quality check attached, with a reminder for each ward to have completed cycle 1 of the quality checks by end of January 2022 06/01/22 Two non clinical staff identifed to commence audit work as Matrons clinical supporting the wards in response to covid 19 pressures. 13/01/22 Audits have commenced. 20/01/22 Additional staff identified to undertake the Quality Checks due to the capacity of the Matrons with support regarding situation in relation to COVID-19. Plans received to demonstrate the checks will be complete by the end of Jan 2022. 27/01/22 All wards have now participated in the 6 weekly step up to great quality round.	Closed

MD18 - Page 9	The trust must ensure that all patients have appropriate access to a range of psychological therapies. (Regulation 18(1)).	Psychology Access	Acute / PICU	Psychological therapy will be available to patients who require it as part of their treatment	Update: - Since inspection a series of recruitment exercises to therapy posts have been undertaken. - The vacancies in OT Support Worker posts have been successfully recruited to, recruitment will continue to support turnover. - Recruitment to bank OT has been successful and will be ongoing. - The Band 8c lead psychology post has been recruited into.	1. Following successful recruitment to the lead post the remaining psychology posts and vacancies will be advertised by the end of December 2021 2. Any vacant occupational therapy posts will be re-advertised by the end of December 2021.	Fiona Myers / Michelle Churchard Smith	28/02/2022	Closed	Acute and PICU Operational Management meeting, mental health Directorate Workforce group, DMT, Executive Boards	23/07/21 Lead psychologist post interviewed and appointed. Once in post recruitment to wider team to be completed. Since the CQC visited staffing has increased by 4.0wte (8c lead and 3 Band 4 Assistant Psychologists) 01/09/21 – both band 3's and 5 appointed to and in post. Further recruitment will be ongoing due to staffing changes. 3/12/21 Request made for additional agency cover for 2 wte Band 8a psychologists. 09/12/21 - Inpatient OT vacancies for Band 3, 5 and 6 have been advertised with interviews on 9/12/21. Any posts not filled will be re-advertised by the end of December 2021. 5 of the 8 B3 OTA posts have been recruited to. Rehabilitation - The CERT B6 and B3 posts have now been successfully recruited to. 09/12/21 Recruitment plan for psychology posts updated with further adverts to go out . 10/12/21 Evidence required that recruitment continues through December 2021 16/12/21 No applicants as yet for advertised posts. Posts to be re-advertised week commencing 20/12/21. Chief Psychological Officer job description submitted for Agenda for Change. This will strengthen future recruitment. OT posts currently out to advert. 23/12/21 Re-advertised B8a vacancies - evidence received (link to job advert) 13/01/22 Recruitment to Psychology Post unsuccessful therefore readvertising. OT posts recruited to successfully. 20/01/22 Recruitment underway for both Psychological Therapies staff and OT 27/01/22 All OT posts recruited to remaining Psychology posts out to advert 03/02/22 All Psychology and OT posts have been recruited to and are in the onboarding stage 17/02/22 All posts recruited to, accepted and awaiting start dates	Closed
MD19 - Page 9	The trust must ensure that all clinical staff receive training in the Mental Health Act which is updated regularly. (Regulation 18(2)).	Mandatory Training - MHA	Acute / PICU	The acute wards for adults of working age and psychiatric intensive care units will achieve compliance of 85% or above of staff trained in the Mental Health Act	Update: - Since inspection the Acute and PICU wards have reviewed mandatory training to support recovery of compliance since Covid-19. - The number and frequency of scheduled MHA training dates has been examined to ensure that they meet the requirements of the number of outstanding staff requiring training.	1. Ward Sisters / Charge Nurses will implement a plan to ensure staff out of date for all mandatory training including MHA/MCA and life support training will be scheduled protected time to undertake mandatory and clinical training on the next ward roster in January 2022	Fiona Myers / Michelle Churchard Smith	~~31/01/2022~~ revised deadline 28/2/22 due to impact of Omicron Covid	Closed	Acute and PICU Operational Management meeting, mental health Directorate Workforce group, DMT, Executive Boards	Ward Sisters / Charge Nurses have been implementing a plan to ensure staff that are out of date for all mandatory training including MHA/MCA and life support training are scheduled protected time to undertake mandatory and clinical training on the next ward roster in January 2022. 16/12/21 Ward Sisters / Charge Nurses now have access to book staff onto training. 06/01/22 Head of nursing reviewing all training data with comparison of compliance from inspection to current figures. Impact of current pressures on ward staffing in light of emerging increasing incidence of Covid and required Trust response to Level 4 actions acknowledged. 13/01/22 Evidence shows varying degrees of compliance. Discussed at DMH DMT and decision made to prioritise new starters. Mandatory training will continue to be available and staff booked on. In light of current staffing challenges due to Covid and risk to patient safety some mandatory training for staff may be delayed. 20/01/22 Agreed that this will be put on Risk Register for meeting the deadline to complete training due to being able to release staff. 27/01/22 Await an update on current position. 1st February 2022 compliance report needed 31/01/22 The service has had to prioritise the safety of patient care. The wards have been adversely affected with staffing shortages due to impact of covid-19 sickness. ORR risk number 63. New deadline proposed to executive board for approval. 04/02/22 - Executive Board approved new deadline of 28/02/22 - as discussed with the CQC within engagement meetings. 7/02/22 Twice weekly training huddles have been implemented to review planned training for staff on each ward. Ability to release staff for training or non-attendance will be checked at the daily safer staffing huddles 23/02/22 All available Acute and PICU staff are compliant or booked on to mandatory training including MHA. All unavailable staff due to maternity or long term sick leave will complete the training on their return to work.	Closed
MD20 - Page 9	The trust must ensure that all clinical staff receive training in the Mental Capacity Act which is updated regularly. (Regulation 18 (2)).	Mandatory Training - MCA	Acute / PICU	The acute wards for adults of working age and psychiatric intensive care units will achieve compliance of 85% or above of staff trained in the Mental Capacity Act	Update: - Since inspection the Acute and PICU wards have reviewed mandatory training to support recovery of compliance since Covid-19. - The number and frequency of scheduled MHA training dates has been examined to ensure that they meet the requirements of the number of outstanding staff requiring training. - MCA training is available on U Learn.	1. Ward Sisters / Charge Nurses will implement a plan to ensure staff that are out of date for all mandatory training including MHA/MCA and life support training are scheduled protected time to undertake mandatory and clinical training on the next ward roster in January 2022	Fiona Myers / Michelle Churchard Smith	~~31/01/2022~~ revised deadline 28/2/22 due to impact of Omicron Covid	Closed	Acute and PICU Operational Management meeting, mental health Directorate Workforce group, DMT, Executive Boards	Ward Sisters / Charge Nurses have been implementing a plan to ensure staff that are out of date for all mandatory training including MHA/MCA and life support training are scheduled protected time to undertake mandatory and clinical training on the next ward roster in January 2022. 16/12/21 Ward Sisters / Charge Nurses now have access to book staff onto training. 23/12/21 - Charge nurses booking staff on training; training is future dated so returns not immediately available. Wards have been requested for updates in terms of numbers booked and several wards have booked all outstanding staff on future training already. Training compliance is closely monitored bi-weekly to track progress against each ward. Progress from 1st Dec – 15 Dec is minimal, this should improve over the weeks following staff attendance. 06/01/22 Head of nursing reviewing all training data with comparison of compliance from inspection to current figures. Impact of current pressures on ward staffing in light of emerging increasing incidence of Omicron covid and required Trust response to Level 4 actions acknowledged. 13/01/22 Evidence shows varying degrees of compliance. Discussed at DMH DMT and decision made to prioritise new starters. Mandatory training will continue to be available for booking. In light of current staffing challenges and risk to patient safety some mandatory training for staff may be delayed. 20/01/22 Agreed that this will be put on Risk Register for meeting the deadline to complete training due to being able to release staff. 27/01/22 Await an update on current position. 31/01/22 The service has had to prioritise the safety of patient care. The wards have been adversely affected with staffing shortages due to impact of covid-19 sickness. ORR risk number 63. New deadline proposed to executive board for approval. 04/02/22 - Executive Board approved new deadline of 28/02/22 - as discussed with CQC during engagement meetings. 7/02/22 twice weekly training huddles implemented to review planned training for staff on each ward that week. Ability to release staff for training or non-attendance will be checked at the daily safer staffing huddles 24/02/22 All available staff have completed or are booked on to MCA training.	Closed
MD21 - Page 9	The trust must ensure that all clinical staff are trained in basic life support, and qualified nurses undertake intermediate life support training. (Regulation 18(2)).	Mandatory Training	Acute / PICU	The acute wards for adults of working age and psychiatric intensive care units will achieve compliance of 85 % or above for clinical staff in BLS and 85% or above for Qualified Nurses in ILS	Update: - Since inspection the Acute and PICU wards have reviewed mandatory training to support recovery of compliance since Covid-19. - The number and frequency of scheduled MHA training dates has been examined to ensure that they meet the requirements of the number of outstanding staff requiring training. - Basic and ILS training within Covid secure guidelines has been restored.	1. Ward Sisters / Charge Nurses will implement a plan to ensure staff that are out of date for all mandatory training including MHA/MCA and life support training are scheduled protected time to undertake mandatory and clinical training on the next ward roster in January 2022	Fiona Myers / Michelle Churchard Smith	~~31/01/2022~~ revised deadline 28/2/22 due to impact of Omicron Covid	Closed	Acute and PICU Operational Management meeting, mental health Directorate Workforce group, DMT, Executive Boards	Ward Sisters / Charge Nurses have been implementing a plan to ensure staff that are out of date for all mandatory training including MHA/MCA and life support training are scheduled protected time to undertake mandatory and clinical training on the next ward roster in January 2022 16/12/21 Ward Sisters / Charge Nurses now have access to book staff onto training. 23/12/21 - Charge nurses booking staff on training; training is future dated so returns not immediately available. Wards have been requested for updates in terms of numbers booked and several wards have booked all outstanding staff on future trainings already. Training compliance is closely monitored bi-weekly to track progress against each ward. Progress from 1st Dec – 15 Dec is minimal, this should improve over the weeks following staff attendance. 06/01/22 Head of nursing reviewing all training data with comparison of compliance from inspection to current figures. Impact of current pressures on ward staffing in light of emerging increasing incidence of Omicron covid and required Trust response to Level 4 actions acknowledged. 13/01/22 Evidence shows varying degrees of compliance. Discussed at DMH DMT and decision made to prirority ise new starters. Mandatory training will continue to be available and staff booked. In light of current staffing challenges as a direct impact of Covid and risk to patient safety some mandatory training for staff may be delayed. 20/01/22 Agreed that this will be put on Risk Register for meeting the deadline to complete training due to being able to release staff. 27/01/22 Await an update on current position 31/01/22 The service has had to prioritise the safety of patient care. The wards have been adversely affected with staffing shortages due to impact of covid-19, sickness. ORR risk number 63.New deadline proposed to executive board for approval. 04/02/22 - Executive Board approved new deadline of 28/02/22 - as discussed with the CQC during engagement meetings. 7/02/22 twice weekly training huddles implemented to review planned training for staff on each ward . Ability to release staff for training or non-attendance will be checked at the daily safer staffing huddles 24/02/22 All available staff have completed or are booked on to BLS and ILS training.	Closed

MD22 - Page 9	The trust must ensure that all staff follow NICE guidance regarding the use of rapid tranquilisation and monitor side effects and the service user's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status. To protect patients from the risks of over sedation and possible loss of consciousness. (Regulation 12(2)(f)).	Rapid Tranquilisation - NICE guidance	Learning Disabilities	The Trust will adhere to NICE guidance in monitoring the physical health of each patient receiving rapid tranquilisation.	Update: - Records demonstrate compliance in training, 100% of all available Registered Nurses have completed the ulearn training on rapid tranquilisation. - 5 episodes of rapid tranquilisation were reviewed by the ward manager and unit matron. Documented care provided evidenced all care had been delivered as per the policy and NICE guidance. - Guidance on how to monitor side effects and complete the template on SystmOne has been implemented and shared with the team and a laminated flow chart is on display. - There are clear systems in place for monitoring and reviewing records. - There is a clear system in place to identify clinical staff who require an update on their return to work. - Pharmacy are providing a daily and weekly summary report to the Charge Nurse on the use of rapid tranquilisation, which is reviewed by the Matron. - Following each administration the Charge Nurse and Matron are reviewing practice and documentation of the event. 04.04.22- Rapid tranq : 86.20% (13/15) 2 staff unavailable	1. All remaining clinical staff who require an update on the use of rapid tranquilisation will complete the ulearn module on their return to work.	Helen Thompson / Zayad Saumtally / Francine Bailey	31/01/2022	Closed	Service line weekly meetings, monthly DMT and reporting to Executive Boards	Records demonstrate compliance in training, 100% of all available Registered Nurses have completed the ulearn training on rapid tranquilisation. - 5 episodes of rapid tranquilisation were reviewed by the ward manager and unit matron. Documented care provided evidenced all care had been delivered as per the policy and NICE guidance. - Guidance on how to monitor side effects and complete the template on SystmOne has been implemented and shared with the team and a laminated flow chart is on display. - There are clear systems in place for monitoring and reviewing records. - There is a clear system in place to identify clinical staff who require an update on their return to work. - Pharmacy are providing a daily and weekly summary report to the Charge Nurse on the use of rapid tranquilisation, which is reviewed by the Matron. - Following each administration the Charge Nurse and Matron are reviewing practice and documentation of the event. For sustainability training and rapid tranquilisation are discussed at unit meetings. 16/12/21 All available staff have undertaken training. 23/12/21 One new starter in progress of completing rapid tranquilisation training. Audits completed -on physical health checks. 31/12/21 Rapid tranquilisation training - 87% 06/01/22 No episodes of rapid tranquilisation used in December 2021, only Preceptee staff remaining to complete training. 13/01/22 Waiting for one member of staff to complete. Two staff members not available. 20/01/22 Confirmation received that final available staff member has completed RT training. RT audit received 17.1.22 27/01/22 Evidence received that all available staff have completed training 31/01/22 Monitoring of ongoing compliance will form part of directorate level governance. 13/03/22 No incidents of rapid tranquilisation throughout February. Rapid Tranquilisation:86.7% 13/15 staff members (2 staff members completed but not showing on system, ward manager has emailed L&D asking to reflect in uLearn)	Closed
MD23 - Page 9	The Trust must ensure that all staff are trained in basic life support and intermediate life support. (Regulation1 8(2)(a)).	Mandatory Training	Learning Disabilities	The wards for people with learning disability or autism will achieve compliance of 85% or above for clinical staff in BLS and trained nurses in ILS	Update: - Since inspection, the Unit has reviewed mandatory training to support recovery of compliance since Covid-19 by means of a designated member of staff who monitors staff training. - Monthly training compliance reports are being reviewed by the Team Manager and Charge Nurse and immediate actions being taken to ensure improved compliance. - There is now a process in place for the Charge Nurse and staff member designated to focus on training, are notifying staff when their training is due and supporting them to ensure they are booked on and compliant.	1. The outstanding members of available staff will be booked onto Immediate Life Support training, this is in progress with a completion date by the end of December 2021. 2. 3 available staff members will be booked onto Basic Life support training and will be completed by end of December 2021	Helen Thompson / Zayad Saumtally / Francine Bailey	31/01/2022	Closed	Service line weekly meetings, monthly DMT and reporting to Executive Boards	25/11/21 All available remaining staff are booked onto life support training. 09/12/21 - ILS 66.7% on Trust compliance report. 10 out of 11 currently available staff are trained. Further support has been put in place for one staff member to help them achieve their competencies. BLS - 72.5% on Trust compliance report - 30 ot 40 staff complete all other available staff are booked on. 16/12/21 Positive trends in training - need evidence 23/12/21 Update: ILS 10/15 (2 booked and 3 unavailable). BLS - issue with non-attendance / sickness. 31/12/21 ILS - 67% (maximum that can be achieved is 80% due to staff not available) BLS - 75% (anomolies identified with reporting) actual figure 83% 06/01/22 BLS training now 80.5%, ILS 71% of available staff showing steady improvement. 13/01/22 - ILS 9 out of 12 staff are compliant (2 unavailable) one member of staff has failed 3 tims and due to resit on 17/01. BLS remains at 80.5%. 7 staff remain non-compliant, one on long term sick. 4 staff booked on this morning (one DNA'd) and need confirmation of other 3 booked on in January. 14/01/22 3 remaining staff to complete BLS, 1 booked for 17th Jan and 2 are not available 20/01/22 ILS - no change, one person still to complete. BLS - Remaining available staff now completed therefore full compliance of available staff 27/01/22 BLS now at 92% all available staff have completed the training. ILS now at 85% which equates to 12 out of 14 staff in data with remaining 2 staff currently unavailable to complete training due to absence. Therefore all available staff have completed training. 31/01/22 Monitoring of ongoing compliance will form part of directorate level governance. 13/03/22 ILS training compliance for February: 80%- 13 out of 15 staff members have completed the training (this is all available staff, 1 completed 7th March and 2 staff members are off sick). BLS training compliance for February: 92.1%, Staff member booked for 29th March. New starter- started 7th March, booked 25th march. 1 x staff member was sick, rebooked 22nd April 04/04/22- BLS- 92.10% and ILS 80% (12/15) 2 staff unavailable, 1 booked 22nd April and 1 new starter. Actual = 93.33% Rapid tranq : 86.20% (13/15) 2 staff unavailable	Closed
MD24 - Page 9	The trust must ensure there are effective systems and processes to monitor the quality of clinical records, in particular seclusion records, physical health monitoring post rapid tranquilisation (Regulation 17(2)(b)).	Clinical Record keeping audits	Learning Disabilities	The wards for people with learning disability or autism will have an effective system in place where clinical records are audited and actioned to improve the quality of clinical documentation.	Update: - Following each episode of rapid tranquilisation use, care records are being reviewed by the Charge Nurse. - In addition the Unit Matron is carrying out monthly reviews of all episodes of rapid tranquilisation administration and seclusion to quality check practice, documentation and adherence to policy and NICE guidance.	1. Monthly auditing of individualised patient records will be carried out to review all care, including physical health monitoring, and will be reviewed at service meetings to ensure sustained compliance	Helen Thompson / Zayad Saumtally / Francine Bailey	31/01/2022	Closed		Guidance on how to monitor side effects and complete the template on SystmOne has been implemented and shared with the team. 25/06/21 A laminated flow chart is on display in relevant clinical areas. 09/12/21 - 3 Rapid Tranquilisation's in November 2021 all of which have been audited and care in line with NICE guidance. 16/12/21 To be discussed in Directorate Operational Meeting 21/12/21 23/12/21 Discussed in Operational Meeting and DMT minutes will be provided. Since update on Audit of records in November 2021, no further episodes of seclusion. 31/12/21 Evidence of completed audits received 06/01/22 No episodes of rapid tranquilisation during December 2021. 13/01/22 Still no episodes of rapid tranquilisation. One episode of seclusion. 20/01/22 90.7% compliance with seclusion audit Jan 2022 27/01/22 Evidence received - Rapid Tranquilisation audit form 17.01.22 31/01/22 Monitoring of ongoing compliance will form part of directorate level governance.	Closed
MD25 - reinspection Feb 2022	The Trust must ensure that staff carry out regular testing of patient wrist worn alarms and fixed room alarms and that this is recorded as per Trust policy. Regulation 12(1)(2).	Testing of patient alarms	Acute / PICU	The testing of patient wrist worn alarms will be completed and recorded daily as per the Patient and Visitor Safety Alarm Guidelines. Fixed room alarms will be tested and recorded daily as per the Patient and Visitor Safety Alarm Guidelines.	Update: - The Nurse in Charge allocates a responsible member of staff on a daily basis to complete the daily environmental checklist which includes the checking of patient wrist worn alarms.	1. The Patient and Visitor Safety Alarm Guidelines will be reviewed and updated by 30/05/22. 2. The core daily environmental checklist will be amended by the 30/06/22 to include the testing of fixed and personal safety alarms. 3. All wards will map fixed alarm points and display by 30/05/22. 4. The patient safety alarm Learning Board will be updated and disseminated to wards by 30/06/22.	Fiona Myers / Michelle Churchard Smith Jane Martin	30/05/22 30/06/22 30/05/22 30/06/22	Closed		26/05/22 First draft of the Acute wards amended Guidelines has gone out for comment and to be taken to DMT 01/06/22. A quality tool has been devised to check the use and documentation of fixed, patient and visitor safety alarms. 09/06/22 Action 1 complete as the Patient and Visitor Safety Alarm Guidelines have been reviewed, updated and disseminated. Action 3 complete as wards have mapped and are displaying posters of their fixed alarm points position. 16/06/22 A trial started on the 13/06/22 for 4 weeks of the Core and Directorate daily environmental checklist, which Thornton, Watermead and Stewart House are trialling. In the interim until the pilot finishes the additional questions will be added to the daily and weekly checks to ensure testing takes place. The Learning Board has been updated and is out for comment.	Closed
MD26 - reinspection Feb 2022	The Trust must ensure that risk assessments for wrist worn alarms are uploaded into the electronic patient care record as per Trust policy. Regulation 12(1)(2).	Risk assessments for patient alarms	Acute / PICU	Completed patient risk assessments for the use of wrist worn alarms will be uploaded onto SystmOne as per trust Policy.		1. The risk assessment template will be available on SystmOne to document directly into by 30/09/22 2. In the interim the paper risk assessment tool will be amended by the 30/06/22 to document a weekly update. 3. The Patient and Visitor Safety Alarm Guidelines will reflect that in the interim the paper risk assessments will be located in the 'patient handover information folder' and uploaded onto SystmOne on discharge 30/06/22	Fiona Myers / Michelle Churchard Smith Jane Martin	30/09/22 30/06/22 30/06/22			26/05/22 The process has been established and commenced in requesting that the risk assessment template be built into SystmOne. 09/06/22 The required SystmOne change request form has been submitted as the first part of the process in building the risk assessment template into SystmOne. Action 2 complete as the paper risk assessment tool has been amended to document a weekly update. Action 3 complete as the Patient and Visitor Safety Alarm Guidelines have been amended to reflect that the paper risk assessments will be located in the patient information folder and be uploaded onto SystmOne on discharge until the risk assessment is available on systmOne.	
MD27 - reinspection Feb 2022	The Trust must ensure that for each patient who wears a wrist worn alarm a care plan is in place for its' use in the electronic patient record, as per Trust policy. Regulation 12(1)(2).	Care Plans for patient alarms	Acute / PICU	SystmOne will document an up to date care plan for each patient risk assessed for the use of a wrist worn alarm.		1. The Patient and Visitor Safety Alarm Guidelines will be amended to reflect for patients needing a personal safety alarm their care needs will be documented in the collaborative care plan 30/06/22. 2. Ward Sisters will communicate via the updated learning Board to all Qualified Nursing staff that it is their responsibility to document within the collaborative care plan if a patient has a personal safety alarm 08/07/22	Fiona Myers / Michelle Churchard Smith Jane Martin	30/06/22 08/07/22	Closed		09/06/22 Action 1 complete as the Patient and Visitor safety Alarm Guidelines have been amended to reflect that for patients requiring a personal safety alarm their care needs will be documented in the collaborative care plan. 16/06/22 To new posters have been designed for patients and staff regarding the use of personal safety alarms. These will also be included in the July Bradgate Newsletter for wider dissemination. 23/06/22 - Action 1 complete. Action 2 Final version of Learning board received as well as table confirming wards that the new Learning Board has replaced the old version and confirmation of communication sent to each ward detailing changes. 07/07/22 Action 2 complete	Closed

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Leicestershire Partnership NHS Trust

Trust Board – July 26 2022

LPT's Response to the Ockenden review of maternity care following the Final Report Published 31st March 2022

Purpose of the report

To update and assure Trust Board on LPT's response so far and the transferrable learning to date and actions recommended. This report summarises the two previous reports and is prepared following the publication of the final Ockenden review of maternity care at Shrewsbury and Telford NHS Trust published March 2022. This paper has also been presented to the Quality Assurance Committee.

Background

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

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

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

In January 2022, all Chief Executives received a letter from NHSE/I, requesting that one year on from the Ockenden report publication, all Trusts reviewed and discussed any progress with learning before the end of March 2022. A report was also presented to Trust board outlining the transferrable learning identified via our learning Community of Practice and actions to be taken. This paper was approved at Board and then shared via the Patient Safety Improvement Group in April 2022 for dissemination via governance teams for actions within Directorate.

The Ockenden final report was published at the end of March 2022 and as part of this a series of recommendations have been made that are applicable to all Trusts and this report will consider those in addition to those we have already identified.

Whilst this report has distilled and shared the transferrable learning, it is strongly recommended that all senior leaders within all NHS organisations consider learning from the report. The stories contained in the report provide the context to support the culture changes needed. The failings are twofold, babies and their mothers were harmed. The response/lack of response to the harm has caused further harm.

'To err is Human, to cover up is unforgivable and to fail to learn is inexcusable' (Sir Liam Donaldson 2010)

Analysis of the issue

The report defined final findings under four Key areas: Staffing, Training, Listening and Learning. Below our previous transferrable learning is listed under headings and expanded to include additional areas described in the final report. These have been considered and distilled into the below accumulative plan

Staffing

The report identifies a number of staffing areas to be addressed primarily the need for increased numbers which is being addressed in other workstreams within LPT. Culture is another staffing area of focus including the stability of teams.

The report details that constant changes within the executive team did not provide stability to the oversight of what was happening. The findings also support the need to consider where there is high usage of temporary staffing practices need to flex to account for this. The report concluded that the consideration of staffing numbers alone is not sufficient for the safe and effective working of teams

Management of locums

The transferrable learning is that there must be a robust process for the induction and supervision of Locum staff. Local processes need to be robust and clear to support Locum Colleagues to quickly integrate into teams. Concerns with practice of Locums needs to be addressed promptly in a supportive way to achieve improvements. We must think as a system and the practice of simply not booking Locums whose practice is not up to standard is not an appropriate response

Clinicians with responsibility for Governance

To support the above, the report advises that clinicians who have responsibility for governance must have sufficient time in their job plans to undertake this essential role, in addition to the training and support part of this role is to ensure there are suitable guidance and oversight of Dr's in the training grades as well as Locums. This includes the supervision of their work and clear routes to seek support.

Actions

- The induction of Locums should be reviewed to ensure that it is robust
- The Clinicians with responsibility for governance should have their job plans reviewed to ensure there is sufficient time to undertake this piece of important work.
- The process for managing performance of locum staff should be considered to ensure all possible support is provided and where there remain concerns this is managed and shared with the Locum agency

Training

'Working together'

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

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

The CPST are working with the Medical Directors deputies in DMH to strengthen the input to investigations from medical staff. LPT still could improve this opportunity of promoting shared learning amongst medical staff.

Actions

- Medical representative for PSIG
- Review all training and consider where this can be delivered to teams rather than separate staff groups
- Compliance with training to be prioritised and considered a measure of safety culture.

Listening

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

The report identifies that women and their families were not listened to. It also identifies that staff were not listened to. As we have seen in other high-profile reports if this continues staff stop speaking up. NHSE/I are currently refreshing the guidance around freedom to speak up. Freedom to speak up was introduced post the findings of the Francis review in 2014 and it is disappointing that we are still identifying this as a key contribution after all this time.

The Freedom to Speak process is a workaround in response to the symptoms of the problem and is not the solution to the problem. Organisational culture needs to create the conditions where staff opinion is invited and welcomed and responded to. Staff contribution to organisational change is integral to the processes of the organisation. Where changes are implemented, staff have been involved in the planning of the change and as part of the project there should always a feedback loop that invites feedback on how it is progressing and ideas for improvement.

In addition there is a need for informed consent and shared decision making-This is not new *'nothing about me without me'* (DH 2012) and more recently Cumbeledge *'first do no harm'* (2020)

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

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

Actions in progress

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

Actions to be taken

- DMH to strengthen personal safety planning (identified in SI's)
- DMH to strengthen the identification of a Next of Kin/Significant person and ensure this is recorded and conversations are had with patients around involving them in their care as appropriate.
- CHS to further embed motivational interviewing and the training of DN's in assessing mental capacity to support good quality decision making (identified in SI's)
- Medical staff to strengthen the documentation of shared decision making and information used to make decisions including risks as well as uncertainties.
- All levels of the organisation to consider how staff can easily feedback

Leadership and poor workplace culture- this is key across the whole of the NHS. We need to create the conditions and leadership behaviors that create the conditions that allow staff to contribute and be heard. This spans the headings of Listening and Learning

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

Actions already in place

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

Actions

- Directorate leadership teams to support and promote this culture of Leadership for Safety
- High visibility of leaders in the clinical workplace promoting high standards
- Using all available data (thinking about outcomes)
- All projects that introduce change should have feedback loops built in to listen to staff and make changes in a timely way
- Consider all anonymous reporting as a red flag and not only respond to the content of the report but what led up to it
- The work to develop a clear process for de brief for staff post incident should be prioritised.

Learning

'Always learning and improving'.

This is essentially about visibility/transparency and oversight of incidents. The implementation of robust actions

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

This is also improving the culture of learning conversations and the meeting is valued as a learning opportunity. Immediate actions are identified, and areas of immediate concern are escalated as appropriate.

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

Actions in progress

- Trial of learning patient stories from SI's to share across the organisation.
- Improving the quality of Executive summaries for SI's so they can be shared and more readily accessible (to Board and the wider organisation).
- We have identified a Patient Safety champion NED on the Board.
- The CPST are working towards accreditation for the SI process with the Royal College of Psychiatrists (this supports family engagement and the use of appropriate language)

- Complaints that describe harm/potential harm are shared with patient safety and considered at IRM if appropriate – If a patient safety incident requiring a higher level of investigation is identified – the complainant is informed, and the complaint put on hold

Actions

- Strengthen the process for agreeing SMART actions and the timely implementation (within 6 months of identifying) using a QI approach to the implementation of these. This should include the post implementation audit for embeddedness
- Include in action plans the sharing of the learning with subject matter experts to ensure that the learning is included in training
- Improved theming and trending of complaints and triangulate with other information
- CPST to develop guidance for staff to support meaningful engagement with patients and families through the investigation process

Decision required

- Trust Board to be assured that the findings of the Ockenden review have been considered for transferrable learning and actions taken.

Governance table

For Board and Board Committees:	Trust Board 26th July	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Tracy Ward- (Patient Safety Specialist)	
Date submitted:	15th May 2022	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	QAC May 2022	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	This report combines the 1 year on report and the final report– the work from this and the previous report should become BAU in Directorates	
STEP up to GREAT strategic alignment*:	High **S**tandards	Yes
	Transformation	
	Environments	
	Patient Involvement	Yes
	Well **G**overned	Yes
	Reaching Out	
	Equality, Leadership, Culture	Yes
	Access to Services	
	Trustwide Quality Improvement	Yes
Organisational Risk Register considerations:	List risk number and title of risk	ORR 59 -management of the whole incident management process
Is the decision required consistent with LPT's risk appetite:		
False and misleading information (FOMI) considerations:		
Positive confirmation that the content does not risk the safety of patients or the public	This supports the safety of the public	
Equality considerations:	This is promoting equality	

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Leicestershire Partnership NHS Trust

Public Trust Board – 26th July 2022

Safe Staffing Review - April 2022

Purpose of the report

This report provides a full overview of nursing safe staffing during the month of April 2022, including a summary of staffing areas to note, updates in response to Covid- 19, potential risks, and actions to mitigate the risks to ensure that safety and care quality are maintained.

This report triangulates workforce metrics; fill rates, Care Hours Per Patient Day (CHPPD), quality and outcomes linked to Nurse Sensitive Indicators (NSI's) and patient experience feedback. A summary is available in Annex 1; scorecard, with a detailed overview and exception report narrative by in patient area and service in annexe 2.

Analysis of the issue

Right Staff

- Temporary worker utilisation rate decreased this month; 0.58% reported at 45.08% overall and Trust wide agency usage slightly increased this month by 0.75% to 23.49% overall.
- In April 2022; 29 inpatient wards/units utilised above 6% agency staff to meet safe staffing levels, this equates to 90.62% of our inpatient Wards and Units, changes from last month include Thornton ward
- Areas to note are identified either by the Head/Deputy Head of Nursing due to; high percentage of temporary worker/agency utilisation or concerns relating to; increased acuity, high risk patients, staff sickness, ability to fill additional shifts and the impact to safe and effective care.
- The key in-patient areas to note regarding current staffing challenges with high risk and potential impact to quality and safety; Beacon unit, Agnes unit, Mill Lodge, Griffin, Coleman, Welford, Rutland and Swithland wards, St Luke's ward 1.

- The community team 'areas to note', Healthy Together City, County, notably Blaby team, Looked After Children Team, Diana team, City Community Nursing, CRISIS Resolution and Home Treatment team, Criminal Justice, Liaison & Diversion team, Melton, Charnwood, South Leicestershire Community Mental Health Teams, Assertive outreach, ADHD, Unscheduled Care team and the memory service.

Right Skills

- . Correct to 1 April 2022 Trust wide substantive staff.
    - Appraisal at 76.8% compliance AMBER
    - Clinical supervision at 77.7% compliance AMBER
    - All core mandatory training compliance is GREEN except for Information Governance AMBER at 77.0 % and Fire Safety Awareness RED at 74.7%
- Clinical mandatory training compliance for substantive staff, to note.
    - BLS increased compliance by 2.3 % to 66.6%compliance RED
    - ILS increased compliance by 1.3% to 67.2% compliance RED
- Clinical mandatory training compliance for bank only workforce remains low.
    - BLS 54.5% at RED compliance
    - ILS 50.0% at RED compliance

During the pandemic a temporary extension of 6 months was added to each training topic compliance period. On the 1st of March 2022 the 6-month extension was removed for clinical face to face training, with all other topics following suit on 1st April 2022. This has impacted on our compliance figures together with challenging staffing levels experienced during the omicron variant and ability to release staff to attend training. Significant activity is underway to ensure training compliance improves across the trust. The Training Education and Development group are exploring implementing Supervision, Training, Appraisals and Reflection Days (STAR days) which will mean a day out of clinical areas for teams. This is currently being worked through with directorate leads. More specific actions are being taken to support Bank and medical trainees' compliance.

Right Place

- The Covid-19 risk managed wards are North and Sycamore. Risk managed is to mean that the ward is caring for patients on the emergency admission Covid-19 high and

medium risk pathways, as per the national safe staffing descriptors and IPC care pathways, maintaining separation between possible and confirmed COVID-19 patients and supporting staff cohorting.

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

- The total Trust CHPPD average (including ward based AHPs) is reported at 18.50 CHPPD in April 2022, with a range between 4.4 (Stewart House) and 64.1 (Agnes Unit) CHPPD. General variation reflects the diversity of services, complex and specialist care provided across the Trust. Analysis has not identified significant variation at service level; indicating that staff are being deployed productively across services.

Staff absence data- updated

Absence by directorate	Sickness absence	Self-Isolation - Working from home	Self-Isolation - Unable to work from home	Total
Community Health Services	4.4%	0.1%	0.4%	4.8%
Enabling Services	3.3%	0.5%	0.5%	4.4%
FYPC	4.4%	0.3%	0.5%	5.1%
Hosted Service	0.0%	0.0%	0.0%	0.0%
Mental Health Services	4.3%	0.1%	0.6%	5.0%
LPT Total	**4.1%**	**0.2%**	**0.5%**	**4.7%**

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

In comparison to the previous month total absence has decreased by 1.8% associated with a decrease in general absence overall.

In-patient Staffing

Summary of inpatient staffing areas to note.

Wards	February 22	March 22	April 22
Hinckley and Bosworth East Ward	x	x	x
Hinckley and Bosworth North Ward	x	x	x

Wards	February 22	March 22	April 22
St Luke's Ward 1	x	x	x
St Luke's Ward 3	x	x	x
Beechwood	x	x	x
Clarendon	x	x	x
Coalville Ward 1	x	x	x
Coalville Ward 2	x	x	x
Rutland	x	x	x
Dalgleish	x	x	x
Swithland	x	x	x
Coleman	x	x	x
Kirby	x	x	x
Welford	x	x	x
Wakerley	x	x	x
Aston	x	x	x
Ashby	x	x	x
Beaumont	x	x	x
Belvoir	x	x	x
Griffin	x	x	x
Phoenix	x	x	x
Heather	x	x	x
Watermead	x	x	x
Mill Lodge	x	x	x
Agnes Unit	x	x	x
Langley	x	x	x
Beacon (CAMHS)	x	x	x
Thornton	x	x	x
Stewart House	x	x	x

Table 2 – In-patient staffing areas to note

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

Covid-19 risk managed wards are also identified as areas to note, North Ward and Sycamore ward (The Willows). Risk managed is to mean that the ward is caring for patients on the emergency admission COVID pathway as per the national safe staffing descriptors and IPC care pathways medium and high.

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

FYPC/LD

Beacon Unit (CAMHS) due to high levels of bank and agency staff to meet planned safe staffing and increased staffing to support increased patient acuity. Due to decreased substantive staff numbers, the Beacon unit has capacity to safely staff 6 beds, this is under daily review and has been agreed with commissioners. Daily directorate prioritisation of services and business continuity plans enacted in addition to existing actions currently in place; for example, single ward sites to have additional RN and HCSW staff to support. Staff in non -patient facing roles with a clinical qualification are currently working within the staffing establishment to support continuity of care. Block booking of bank and agency continues to support planning for safer staffing levels. Throughout April 2022 the Beacon unit have been using two separate teams of Prometheus staff to support the complex needs of two of the patients who require care in medium secure units. They are supporting with 24-hour care.

Patient acuity on the Agnes Unit remains high and staffing is reviewed and increased to meet patient care needs, this is reflected in high utilisation of temporary workforce staff deployed against planned levels and high CHPPD. Agnes Unit continue to focus recruitment to Registered Nurse and HCSW vacancies.

CHS

All in-patient wards in Community Hospitals reported operating at an amber risk overall, due to increased patient acuity and dependency, patients requiring enhanced observations due to one-to-one care, annual leave, vacancies, maternity leave, sickness, additional beds that have been opened due to LLR wide system request and impact of COVID 19 related isolation requirements. Key areas to note are Rutland, Snibston, St Luke's Ward 1, East Ward, North Ward and Swithland. Temporary workforce usage continues to remain high across nine of the wards.

Daily safe staffing reviews and substantive staff movement across the service to ensure substantive RN cover and block booking of temporary workers is in place. Sixteen international nurses recruited to a number of wards and now registered with the NMC.

DMH

Mill Lodge continues as a key area to note with high utilisation of temporary workforce impacting continuity of care. It is noted that the Ward regularly runs with one RN at night for 14 patients, supported by staff from Stewart House. Daily directorate review continues with a number of actions in place in terms of redeployment and recruitment to support

continuity of staffing across the unit with consideration to new/alternative roles. A peripatetic model has been introduced between Stewart House and Mill Lodge to provide staffing for short falls/last minute sickness. This has increased the use of bank and agency staff being requested and booked onto their rotas on alternative months.

The Ward is supporting recruitment of two International Nurses now registered with the NMC and a Medicines Administration Technician and a newly registered band 5 RN who started in April 2022. The annual safe staffing establishment review is progressing, and a quality summit improvement plan continues to progress focusing on leadership, culture, and staffing with oversight to QAC. The Willows use of temporary staffing remains higher due to the opening of the additional ward as a surge ward to aid bed flow across the inpatient pathway with fluctuations in use of the bank and agency depending on its occupancy.

In patient wards across DMH reported increased acuity and dependency, complexity, vacancies, sickness, increasing staff absence and additional increased staff movement following promotions to urgent care pathway roles and step up to great mental health transformation. Key areas to note, Griffin, Aston, Beaumont, Heather, Coleman, and Welford wards. With a Covid outbreak on Welford ward on the 11th of April 2022. Staff Movement across the wards to ensure substantive RN cover and flexible workers (booked in addition to block booking of temporary workforce) to cover last minute sickness/shortfalls. Number of occupied beds, temporary workforce percentage together with the NSIs that capture outcomes most affected by nurse staffing levels is presented in the tables per in-patient area by service and directorate in Annex 2.

Community Teams

Summary of community 'areas to note'.

Community team	February 2022	March 2022	April 2022
City East Hub- Community Nursing	x	x	x
City West Hub- Community Nursing	x	x	x
East Central	x	x	x
Hinckley	x	x	x
Healthy Together – City (School Nursing only)	x	x	x
Healthy Together County	x	x	x
Looked After Children	x	x	x

Community team	February 2022	March 2022	April 2022
Diana team	x	x	x
Children's Phlebotomy team	x		
LD Community	x	x	x
LD Therapy	x	x	x
CAMHS Crisis team (on call rota)	x	x	
South Leicestershire CMHT			x
Melton CMHT	x	x	x
Charnwood CMHT	x	x	x
Memory service	x	x	x
Unscheduled Care			x
Assertive outreach	x	x	x
ADHD service	x	x	x
Crisis Resolution and Home team	x	x	x
Criminal Justice & Liaison Team			x
Central Access Point (CAP)	x	x	

Table 3 – Community areas to note

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

FYPC/LD Community

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

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

LD Psychology continues with on-going recruitment challenges, active recruitment, and utilisation of agency staff to meet staffing shortfalls. Waiting lists are frequently reviewed and improving.

LD community is improving with long standing vacancies being recruited to and new starters commencing within the teams. High acuity, caseloads and referrals within LD nursing and outreach teams require significant input from the service in order to mitigate any risks. Therapy teams are also reporting high referral levels and long-standing vacancies in the LD physio team. Waiting lists are frequently reviewed and avoidable harm risk mitigation processes in place.

The Diana team/service is an ongoing area to note due to staff absence and HCSW vacancies. Due to the specific staff skills and knowledge required to deliver care and family support the service is not able to utilise temporary/agency workers to meet demand and planned staffing. As a result of staff absence there is currently reduced care hours and respite offer, and no new referrals are being taken as a control measure. The service is reviewing recruitment to explore Band 4 posts.

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

CHS Community

Throughout April 2022, Community Nursing has been reporting operating at OPEL level 3 working to level 4 actions. The patient acuity levels during this time have been very challenging across all community nursing teams. Bank nurse shift fill for county teams has remained low with no improvement in agency shift fill within the city. Essential visits were maintained by staff working increased hours, additional shifts and paying overtime. Daily review of all non-essential activities across the service line as per Level 4 OPEL actions and a daily review of all leadership managerial days to support the clinical offer continues.

Increasing staff absence due to COVID related sickness absence remained a challenge. There continues to be staff working from home due to symptomatic/COVID positive household members and pregnancy related risk assessments, which further reduced clinical capacity

across service provision with the highest risk being in the City community nursing hub, with key areas to note, City, East Central and Hinckley.

Business continuity plans continue including patient assessments and clinic appointments being reprioritised and rescheduled in line with available staff capacity. The reprioritised assessments include wound and holistic assessments. Additional support from specialist teams including Continence and Podiatry services have been requested to provide ongoing support throughout the month of April 2022, this has impacted on the recovery and waiting list position for these services. Hub leadership teams have been mobilised clinically which has impacted on the operational management of hubs including training, supervision, and appraisals.

All planned and essential care has continued to be carried out within agreed timescales for all community patients.

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

- Ensuring staff across all CHS community staff have completed the required Medi quip training

- Identifying strategies to meet the 2-hour response targets as these are at risk due to reduced responding capacity.

- To continue to work with staff to support health and wellbeing, sharing the actions that are being taken to provide daily support and improve the situation long term, including the recent CHS Quality & Safety Summit actions.

- Continued work with the Workforce Supply group to attempt to maximise fill rates for planned and last-minute staffing gaps, including continuous review of recruitment and retention premia and bonus payments as appropriate, to make additional shifts attractive.

- Review ways of working, looking at options for new geographical boundary working. There is focussed work taking place to support effective triage, self-care options and pressure ulcers as per the quality improvement action plans.

- Ongoing targeted recruitment campaign to band 5 RNs, Health Care Support Workers, assistant practitioner, and nursing associates continues. This month the focus continues with advertising on face book and on the back of 15 buses. A Registered Nurse advert is open until June 2022. Seven successful RN vacancies have been filled across the County teams, with adverts open again.

- A quality improvement plan and actions continue focusing on workforce, learning from serious incident investigation, a pressure ulcer QI programme and staff engagement and communication with oversight to QAC.

MH Community

The Crisis Team continue to experience high levels of routine referrals. The Crisis Resolution and Home Treatment Team continues as an area to note due to existing vacancies (40%) along with recruitment and retention challenges. Bank and agency staff are block booked where possible to ensure continuity of care and safe service provision where possible.

The Criminal Justice & Liaison & Diversion service is having similar challenges with the requirement for all staff who work in the service to be police vetted, which makes the use of bank and agency staff more difficult.

The number of vacancies across community MH services generally remains challenging and gaps are filled with bank and agency wherever possible; community mental health teams find it difficult to recruit agency workers for the block booking commitment required, recruitment continues.

On-going key areas to note are Melton CMHT, Charnwood CMHT, South Leicestershire CMHT, the ADHD Service, Assertive Outreach, Unscheduled Care Team, and Memory service.

Melton CMHT is an area to note, additional clinical support from another team has been requested whilst recruitment takes place, and a plan developed to support the team to

deliver safe care to its patients. The plan includes cover for depot clinics, admin support, the duty rota and waiting list management process. Medical presence in the team is to be increased.

The Unscheduled Care team reported similar challenges due to high sickness and vacancies, additional clinical support was provided from another team to maintain responsive services and deliver safe quality care.

A number of scheduled clinics were cancelled in the memory service due to short term sickness and vacancies. Mitigation is in place to ensure waiting times are monitored and compliance with the 'Keeping people safe whilst waiting process' is achieved.

Proposal

Considering the triangulated review of workforce metrics, nurse sensitive indicators, patient feedback and outcomes in April 2022 it is proposed that staffing challenges continue to increase and there is emerging evidence that current controls and implementing business continuity plans are not fully mitigating the impact to the quality and safety of patient care across all services, at all times.

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

Decision required

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

April 2022

Ward Group	Ward	Average no. of Beds on Ward	Average no. of Occupied Beds	Fill Rate Analysis (National Return) Actual Hours Worked divided by Planned Hours — Nurse Day (Early & Late Shift) Average % fill rate registered nurses	Nurse Day (Early & Late Shift) Average % fill rate care staff	Nurse Night Average % fill rate registered nurses	Nurse Night Average % fill rate care staff	AHP Day Average % fill rate registered AHP	AHP Day Average % fill rate non-registered AHP	% Temporary Workers (NURSING ONLY) Total	Bank	Agency	Overall CHPPD (Nursing And AHP)	Medication Errors	Falls	Complaints	PU Category 2 (Month in arrears)	PU Category 4 (Month in arrears)
				>=80%	>=80%	>=80%	>=80%	-	-	<20%								
AMH Bradgate	Ashby	14	21	101.0%	193.6%	101.2%	167.7%			35.3%	23.5%	11.8%	9.8	↑4	→0	→0		
	Aston	14	14	94.3%	291.4%	123.7%	255.7%			65.9%	15.7%	50.2%	12.9	↓0	↓0	↓0		
	Beaumont	21	22	94.5%	146.3%	102.2%	147.9%			65.9%	36.2%	29.8%	12.2	↑2	→2	↑2		
	Belvoir Unit	10	10	127.6%	173.8%	105.1%	165.3%			41.8%	27.2%	14.6%	18.8	→0	→0	→0		
	Heather	17	18	89.3%	180.8%	109.8%	152.6%			57.5%	28.6%	28.9%	7.4	→0	↓1	→0		
	Thornton	12	17	87.8%	175.2%	101.1%	119.8%			29.2%	23.6%	5.6%	9.7	→0	→0	→0		
	Watermead	19	20	112.4%	247.1%	125.5%	223.1%		100.0%	47.5%	18.4%	29.2%	9.0	→1	↓0	→0		
	Griffin - Herschel Prins	5	6	110.3%	298.0%	106.5%	754.0%			63.3%	34.8%	28.6%	43.2	→0	↑1	→0		
AMH Other	Phoenix - Herschel Prins	11	12	112.7%	183.7%	122.4%	164.9%		100.0%	46.3%	18.6%	27.6%	14.1	→0	→0	→0		
	Skye Wing - Stewart House	31	30	94.2%	95.9%	129.6%	139.8%			44.5%	38.0%	6.5%	4.4	→0	↑6	→0		
	Willows	7	9	159.1%	192.3%	139.3%	171.8%			62.3%	37.9%	24.4%	17.3	↑3	→0	↓0		
	Mill Lodge	12	14	178.6%	100.1%	202.7%	144.8%			60.9%	36.4%	24.5%	18.8	↑1	↓4	↓0		
CHS City	Kirby	12	23	76.6%	134.5%	126.9%	204.3%	100.0%	100.0%	45.0%	24.8%	20.2%	15.8	→0	→2	→0	→0	→0
	Welford	15	24	65.8%	126.1%	131.1%	237.8%			38.4%	19.9%	18.5%	10.4	↓0	↑9	→1	→0	→0
	Beechwood Ward - BC03	21	22	90.7%	99.6%	98.1%	98.8%	100.0%	100.0%	31.8%	9.3%	22.6%	8.2	↓1	↓1	→0	→0	→0
	Clarendon Ward - CW01	19	21	87.3%	103.2%	117.8%	99.7%	100.0%	100.0%	36.6%	10.1%	26.5%	9.4	↑2	↓0	↑1	↓1	→0
	Coleman	13	20	50.7%	212.9%	130.4%	506.6%	100.0%	100.0%	58.7%	33.3%	25.4%	21.1	→0	↑5	→0	→0	→0
	Wakerley (MHSOP)	13	20	93.6%	133.2%	136.0%	194.3%			47.6%	22.7%	24.9%	18.1	↓0	↓11	→0	→0	→0
CHS East	Dalgleish Ward - MMDW	15	17	106.7%	84.2%	110.2%	100.0%	100.0%	100.0%	25.4%	8.1%	17.2%	7.9	↑2	↑3	→0	↓0	→0
	Rutland Ward - RURW	16	16	92.9%	131.6%	98.4%	146.5%	100.0%	100.0%	43.2%	20.0%	23.3%	9.1	→1	↑5	↓0	↑1	→0
	Ward 1 - SL1	18	20	92.7%	104.0%	99.6%	134.5%	100.0%	100.0%	32.8%	11.9%	20.9%	9.4	↓0	↑6	→0	→0	→0
	Ward 3 - SL3	12	13	118.9%	82.3%	101.4%	95.0%	100.0%	100.0%	27.4%	11.2%	16.2%	9.6	→2	↓0	→0	→0	→0
CHS West	Ellistown Ward - CVEL	17	18	108.8%	105.4%	111.4%	97.6%	100.0%	100.0%	16.0%	5.5%	10.5%	8.7	↓0	↓1	↑1	↑1	→0
	Snibston Ward - CVSN	15	17	95.5%	102.8%	103.3%	167.9%	100.0%	100.0%	25.0%	9.4%	15.6%	11.6	↓0	→3	→0	↑2	→0
	East Ward - HSEW	22	23	107.5%	118.0%	111.4%	152.1%	100.0%	100.0%	33.7%	9.2%	24.5%	9.5	↑1	↓3	→0	↓0	→0
	North Ward - HSNW	17	19	102.7%	118.2%	106.1%	130.8%	100.0%	100.0%	38.7%	8.8%	29.9%	10.7	→2	↑4	0→0	↑2	→0
	Swithland Ward - LBSW	18	20	101.8%	95.4%	95.0%	142.5%	100.0%	100.0%	17.0%	10.0%	6.9%	8.7	→1	↑8	→0	→1	→0
FYPC	Langley	12	15	96.5%	104.8%	129.0%	146.7%	100.0%		49.5%	35.2%	14.3%	15.7	↓0	↓0	→0		
	CAMHS Beacon Ward - Inpatient Adolescent	6	17	117.5%	197.5%	169.9%	336.1%			68.8%	23.5%	45.3%	42.5	↑5	→0	→0		
LD	Agnes Unit	2	4	89.6%	86.5%	126.6%	115.2%			53.5%	20.5%	33.0%	64.1	→0	↓1	→0		
	Gillivers	1	5	86.6%	96.0%	106.7%	160.0%			2.6%	2.6%	0.0%	63.9	→0	→0	→0		
	1 The Grange	1	3	126.9%	76.9%	-	102.4%			17.7%	17.7%	0.0%	60.3	→0	→1	→0		

Annexe 2: Inpatient Ward triangulation staffing and NSIs.

Trust thresholds are indicated below.

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

Mental Health (MH)

Acute Inpatient Wards

Ward	Average no. of Occupied Beds	Average % fill rate registered nurses	Average % fill rate care staff	Average % fill rate registered nurses	Average % fill rate care staff	Total	Bank	Agency	CHPPD	Medication Errors	Falls	Complaints
		>=80%	>=80%	>=80%	>=80%	<20%						
Ashby	21	101.0%	193.6%	101.2%	167.7%	35.3%	23.5%	11.8%	9.8	↑4	→0	→0
Aston	14	94.3%	291.4%	123.7%	255.7%	65.9%	15.7%	50.2%	12.9	↓0	↓0	↓0
Beaumont	22	94.5%	146.3%	102.2%	147.9%	65.9%	36.2%	29.8%	12.2	↑2	→2	↑2
Belvoir Unit	10	127.6%	173.8%	105.1%	165.3%	41.8%	27.2%	14.6%	18.8	→0	→0	→0
Heather	18	89.3%	180.8%	109.8%	152.6%	57.5%	28.6%	28.9%	7.4	→0	↓1	→0
Thornton	17	87.8%	175.2%	101.1%	119.8%	29.2%	23.6%	5.6%	9.7	→0	→0	→0
Watermead	20	112.4%	247.1%	125.5%	223.1%	47.5%	18.4%	29.2%	9.0	→1	↓0	→0
Griffin - Herschel Prins	6	110.3%	298.0%	106.5%	754.0%	63.3%	34.8%	28.6%	43.2	→0	↑1	→0
Totals										↑7	↓4	→2

Table 4 - Acute inpatient ward safe staffing

All the wards have used a high percentage of temporary workforce throughout April 2022. This is due to high acuity /patient complexity and to meet planned staffing levels. Ashby have a patient on level 4 therapeutic observation with 2 staff and are reliant on agency staff as bank staff are declining to work on the ward due to the risk of allegation.

There were four reported falls reported during April 2022. This is a decrease in falls from nine reported in March 2022. Of the four reported falls, these were experienced by patients from two of the acute wards and one in female PICU. Three of these falls were first falls and one a repeat fall. All of the falls were unwitnessed, and the majority occurred in bedroom areas. One fall resulted in a patient attending UHL for assessment of his physical health. All

of the patients were supported with a medical review post fall. Analysis has shown that staffing was not a contributory factor.

There were seven medication errors reported in April 2022 which is an increase compared to three in March 2022. These were reported for four different acute wards. One incident was an Electronic Controlled Drug register discrepancy. Three incidents involved an extra dose of medication being given to the patient, linked to immediate changes made (PRN) and changes made via a stat dose. One incident reported was regarding medication being returned to pharmacy incorrectly. Two incidents reported on Ashby ward, had a theme regarding patients gaining access to medication. One patient had obtained medication from the person who accompanied them on admission. Staff were reminded about the principles of checking and searching and if the patient declined then to discuss with patients regarding any medication they may have brought in from home. The second incident related to a patient obtaining medication from the clinic room, whilst staff in the clinic room were distracted by two other patients. Staff were reminded of being vigilant when dispensing medication and managing the clinic room and footfall. All incidents were reviewed in line with the Trust medication error policy and individual review was completed with staff involved.

Low Secure Services – Herschel Prins

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints
HP Phoenix	12	112.7%	183.7%	122.4%	164.9%	46.3%	18.6%	27.6%	14.1	→0	→0	→0
Totals										→0	→0	→0

Table 5- Low secure safe staffing

Phoenix continues to use a high proportion of bank and agency staff to support planned staffing levels and to cover vacancies and levels of therapeutic observation. There were no medication errors or falls reported for Phoenix Ward for April 2022.

Rehabilitation Services

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers %	Bank %	Agency %	CHPPD	Medication	Falls	Complaints
Skye Wing	30	94.2%	95.9%	129.6%	139.8%	44.5%	38.0%	6.5%	4.4	→0	↑6	→0
Willows	9	159.1%	192.3%	139.3%	171.8%	62.3%	37.9%	24.4%	17.3	↑3	→0	↓0
Mill Lodge	14	178.6%	100.1%	202.7%	144.8%	60.9%	36.4%	24.5%	18.8	↑1	↓4	↓0
TOTALS										↑4	↑10	↓0

Table 6 - Rehabilitation service safe staffing

Mill Lodge continues to utilise a high percentage of temporary workforce to meet planned staffing levels due to vacancies and sickness. Two international nurses have registered with the Nursing Midwifery Council (NMC) and two additional development Band 6 nurses recruited to increase the Unit's regular nursing workforce. Two further international nurses are due to start at Mill Lodge and one international nurse due to start at Stewart House in June 2022.

Willows use of temporary staffing remains higher due to the opening of the additional ward as a surge ward to aid bed flow across the inpatient pathway with fluctuations in use of the bank and agency depending on its occupancy.

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

There were four reported medication incidents in April 2022, compared to zero in March 2022. Three at the Willows and one for Mill Lodge. Two incident forms were completed for the same incident (1 by pharmacy and 1 by the ward) regarding discharge medication not received on the ward. One incident was reported regarding breaking of a medication bottle. Another incident was regarding one extra dose being given over the prescribed course. All incidents were reviewed in line with the Trust medication error policy and individual review was completed with staff involved.

There were ten falls reported in April 2022, a slight increase from nine in March 2022. Of these ten falls, four related to Mill Lodge and six for Stewart House.

Six falls were reported at Stewart House, which is a higher amount than in previous months. These falls are experienced mostly by two patients who have a history of placing themselves on the floor, however as these falls are unwitnessed the staff responded as if the falls are significant and with head injuries to avoid any kind of complication being overlooked.

Both patients have been referred and reviewed by physiotherapy and have falls care plans and risk assessments up to date.

For the four falls reported at Mill Lodge; all were repeat falls, two were in the bedroom and were slides from bed to the tumble mat. One fall was experienced in the lounge area where a patient slid down their chair onto the wheelchair footplate. One patient fell in the garden linked to progression of their Huntington's Disease

Mental Health Services for Older People (MHSOP)

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints	PU Category 2	PU Category 4
Kirby	23	76.6%	134.5%	126.9%	204.3%	45.0%	24.8%	20.2%	15.8	→0	→2	→0	→0	→0
Welford	24	65.8%	126.1%	131.1%	237.8%	38.4%	19.9%	18.5%	10.4	↓0	↑9	→1	→0	→0
Coleman	20	50.7%	212.9%	130.4%	506.6%	58.7%	33.3%	25.4%	21.1	→0	↑5	→0	→0	→0
Wakerley	20	93.6%	133.2%	136.0%	194.3%	47.6%	22.7%	24.9%	18.1	↓0	↓11	→0	→0	→0
TOTALS										↓0	↑27	→1	→0	→0

Table 7 - Mental Health Services for Older People (MHSOP) safe staffing

The MHSOP wards did not meet planned fill rates on days for Registered Nurses (RNs) on Kirby, Welford and Coleman Wards. The staffing establishment on these wards consist of a Medication Administration Technician (MAT) and nursing associates. Kirby Ward has a Mental Health Practitioner (MHP), which does not fall within the registered nurse numbers.

The service continues to use temporary staff to support unfilled shifts due to vacancies, sickness and to support increased patient acuity and levels of observation. All the wards have vacancies for registered nurses, an advert is currently out for Registered Nurse recruitment.

Staffing continues to be risk assessed and managed across all MHSOP wards and staff moved to support safe staffing levels and skill mix whilst considering patient care needs/acuity and dependency. Acuity across all wards continued to increase during April 2022 which increased the need for additional temporary staffing. In addition, Welford ward had a covid 19 outbreak

affecting both patients and staff. Kirby ward and Welford ward have interviewed and recruited band 6 deputy charge nurses during this period and these are currently working through the recruitment process.

There are current plans for HCSW recruitment and band 5 nurse recruitment across existing vacancies across the wards.

There were no pressure ulcer incidents reported in April 2022 and Welford ward received one complaint that is currently being investigated by the service.

There have been no reported medication incidents during April 2022 across MHSOP inpatients.

A review of falls for MHSOP wards identified an increase in falls on both Welford ward and Coleman Ward where patients have been experiencing multiple falls during the month, with a number of patients experiencing multiple falls due to their clinical presentation.

Falls huddles were implemented to minimise risk of further falling. The falls process was followed in each case and physiotherapy involvement established prior to falls occurring in most cases. Falls analysis continues to show that patient demographic and acuity of patients is a factor with experiencing falls and repeat falls amongst specific patients. There was no theme identified to indicate staffing impacted or was a contributory factor.

Community Health Services (CHS)

Community Hospitals

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints	PU Category 2 (month in arrears)	PU Category 4 (month in arrears)
Dalgleish Ward - MMDW	17	106.7%	84.2%	110.2%	100.0%	25.4 %	8.1%	17.2 %	7.9	↑2	↑3	→0	↓0	→0
Rutland Ward - RURW	16	92.9%	131.6%	98.4%	146.5%	43.2 %	20.0 %	23.3 %	9.1	→1	↑5	↓0	↑1	→0
Ward 1 - SL1	20	92.7%	104.0%	99.6%	134.5%	32.8 %	11.9 %	20.9 %	9.4	↓0	↑6	→0	→0	→0
Ward 3 - SL3	13	118.9%	82.3%	101.4%	95.0%	27.4 %	11.2 %	16.2 %	9.6	→2	↓0	→0	→0	→0
Ellistown Ward - CVEL	18	108.8%	105.4%	111.4%	97.6%	16.0 %	5.5%	10.5 %	8.7	↓0	↓1	↑1	↑1	→0
Snibston Ward - CVSN	17	95.5%	102.8%	103.3%	167.9%	25.0 %	9.4%	15.6 %	11.6	↓0	→3	→0	↑2	→0

East Ward - HSEW	23	107.5%	118.0%	111.4%	152.1%	33.7 %	9.2%	24.5 %	9.5	↑1	↓3	→0	↓0	→0
North Ward - HSNW	19	102.7%	118.2%	106.1%	130.8%	38.7 %	8.8%	29.9 %	10.7	→2	↑4	0→0	↑2	→0
Swithland Ward - LBSW	20	101.8%	95.4%	95.0%	142.5%	17.0 %	10.0 %	6.9%	8.7	→1	↑8	→0	→1	→0
CB Beechwood	22	90.7%	99.6%	98.1%	98.8%	31.8 %	9.3%	22.6 %	8.2	↓1	↓1	→0	→0	→0
CB Clarendon	21	87.3%	103.2%	117.8%	99.7%	36.6 %	10.1 %	26.5 %	9.4	↑2	↓0	↑1	↓1	→0
TOTALS										↓12	↑34	↑2	↑8	→0

Table 08 – CHS in-patient wards safe staffing

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

The increased fill rate for HCA on night shifts for Rutland, Snibston Stroke Ward, St Luke's Ward 1, East Ward, North Ward and Swithland is due to increased acuity and dependency and patients requiring enhanced observations, one to one supervision and additional beds that have been opened due to LLR wide system request.

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

Care hours per patient day has decreased for Dalgleish Ward, further analysis is required in the strengthening and reporting of CHPPD data.

A review of the Nurse Sensitive Indicators (NSIs) for the community hospital wards has identified an increase in the number of falls incidents from twenty-six in March to thirty-four in April comprising of twenty-four first falls, eight repeat falls and two patients placed on the floor. Of the falls reported, 14 falls were witnessed with 4 of the falls being in relation to patients mobilising/standing or when being assisted to by staff or equipment. Ward areas to note are St Luke's Ward 1, Swithland and Rutland Ward. The wards continue to see an increase in patient dependency and acuity including delirium presentation of the patients. Review of the increased incidences has not identified any direct correlation between staffing and the impact to quality and safety of patient care/outcomes.

The number of medication incidents for the community hospital wards has decreased from sixteen in March 2022 to twelve in April 2022. The incidents reported were across nine of the eleven wards. The main causes of medication incidents related to prescribing, failure of staff to following medication procedure/policy/guidance, discrepancy in counted medicine and electronic controlled drug register issues.

There have been two complaints received during April 2022 which are being investigated, both complaints had no direct correlation with staffing.

The number of category 2 pressure ulcers developed in our care has increased to eight (7 in March 2022). The matron team are working with the ward sisters to review all pressure ulcers reported and reviewing training for both registered and non-registered staff, targeting prevention, repositioning, and management plans.

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

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints
Langley	15	96.5%	104.8%	129.0%	146.7%	49.5 %	35.2%	14.3%	15.7	↓0	↓0	→0
CAMHS	17	117.5%	197.5%	169.9%	336.1%	68.8 %	23.5%	45.3%	42.5	↑5	→0	→0
TOTALS										→5	↓0	→0

Table 09 – FYPC safe staffing

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

The Beacon Unit is facing challenges to recruit to a variety of positions. Recruitment remains a key focus and there has been success in appointing a band 2 HCSW however, the main concern is band 5 nurse vacancies.

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

Throughout April 2022 the Beacon have been using two separate teams of Prometheus staff to support the complex needs of two of the patients on the unit. They are supporting with 24-hour care and are not included in the above figures.

The five medication errors were all unrelated and identified different concerns. The first concern was a documentation error. When completing balance check/key handover for the control drugs, it was noted that there were discrepancies. The afternoon drugs were not signed for. Following analysis the Controlled Drugs (CD) register was adjusted to resolve the discrepancy.

The second medication error involved a patient who did not receive a medication prescribed for 20.00hours, as the nurses on shift were responding to an emergency with another patient. Medication was then attempted around 21:30hours, but the patient was heavily asleep.

The third medication error was an omission of a dose; as the staff member could not read the medication dosage from the strips as they had been cut into a smaller section.

The fourth medication error was whilst administering a controlled drug, the member of staff charted the same patient twice however the correct dose was administered to the correct patient.

The final Medication error related to administration of an incorrect dose to a patient. The patient was administered a lower dose of medication. Analysis has shown that the prescription was not clear on the system.

Learning Disabilities (LD) Services

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints
Agnes Unit	4	89.6%	86.5%	126.6%	115.2%	53.5%	20.5%	33.0%	64.1	→0	↓1	→0
Gillivers	5	86.6%	96.0%	106.7%	160.0%	2.6%	2.6%	0.0%	63.9	→0	→0	→0
1 The Grange	3	126.9%	76.9%	-	102.4%	17.7%	17.7%	0.0%	60.3	→0	→1	→0
TOTALS										→0	↓2	→0

Table 10 - Learning disabilities safe staffing

Patient acuity on the Agnes Unit remains high and staffing is reviewed and increased to meet patient care needs, this is reflected in high utilisation of temporary workforce staff deployed

against planned levels and high CHPPD. Agnes Unit continue to focus recruitment to Registered Nurse and HCSW vacancies.

There were no medication errors in April 2022. There were four falls reported for the Agnes unit however none of them were associated with staffing and patients sustained minor harm.

Short breaks (including Gillivers and the Grange) staffing includes both RNs and HCSWs due to the complex physical health needs. Staffing was managed well and adjusted to meet individual patient's care needs, and this is reflected in the fill rate. There was one fall reported for short breaks in April 2022. None of the incidents of falls are related to staffing & staffing fill rates.

Governance table

For Board and Board Committees:	Trust Board 26.7.22	
Paper sponsored by:	Anne Scott, Interim Executive Director of Nursing, AHPs and Quality	
Paper authored by:	Emma Wallis, Interim Deputy Director of Nursing and Quality and Elaine Curtin Workforce and Safe staffing Matron	
Date submitted:	26.07.2022	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):		
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Monthly report	
STEP up to GREAT strategic alignment*:	High **S**tandards	√
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	√
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trust wide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	1: Deliver Harm Free Care 4: Services unable to meet safe staffing requirements
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:		

Oii

Leicestershire Partnership NHS Trust

Public Trust Board – 26th July 2022

Safe Staffing- May 2022

Purpose of the report

This report provides a full overview of nursing safe staffing during the month of May 2022, including a summary of staffing areas to note, updates in response to Covid- 19, potential risks, and actions to mitigate the risks to ensure that safety and care quality are maintained.

This report triangulates workforce metrics; fill rates, Care Hours Per Patient Day (CHPPD), quality and outcomes linked to Nurse Sensitive Indicators (NSI's) and patient experience feedback. A summary is available in Annex 1; scorecard, with a detailed overview and exception report narrative by in patient area and service in annexe 2.

Analysis of the issue

Right Staff

- Temporary worker utilisation rate decreased this month; 2.68% reported at 42.40% overall and Trust wide agency usage slightly decreased this month by 1.65% to 21.84% overall. A Trust wide task and finish group has been set up to look at actions to reduce our reliance on agency usage.
- In May 2022; 30 inpatient wards/units utilised above 6% agency staff to meet safe staffing levels, this equates to 93.75% of our inpatient Wards and Units, changes from last month include Thornton ward.
- Areas to note are identified either by the Head/Deputy Head of Nursing due to; high percentage of temporary worker/agency utilisation or concerns relating to; increased acuity, high risk patients, staff sickness, ability to fill additional shifts and the impact to safe and effective care.
- The key in-patient areas to note regarding current staffing challenges with high risk and potential impact to quality and safety; Beacon unit, Agnes unit, Mill Lodge, Willows, Ashby, Aston, Beaumont, Griffin, Coleman, Wakerley, Rutland, Ward 3 St Luke's, Ellis town and Snibston Wards, Coalville.

- The community team 'areas to note', Healthy Together City, County, notably Blaby team, Looked After Children Team, Diana team, City Community Nursing, East Central, Hinckley, Crisis Resolution and Home Treatment team, Melton, Charnwood, South Leicestershire Community Mental Health Teams, Assertive outreach, ADHD, and the memory service.

Right Skills

- Correct to 1 May 2022 Trust wide substantive staff.
    - Appraisal at 79.1% compliance AMBER
    - Clinical supervision at 81.4% compliance AMBER
    - All core mandatory training compliance GREEN except for Information Governance AMBER at 89.2 % and Fire Safety Awareness AMBER at 83.3%
- Clinical mandatory training compliance for substantive staff, to note.
    - BLS increased compliance by 4.4 % to 71.0%compliance RED
    - ILS increased compliance by 1.2% to 68.4% compliance RED
- Clinical mandatory training compliance for bank only workforce remains low.
    - BLS 52.8% at RED compliance
    - ILS 68.4% at RED compliance

Right Place

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

- The total Trust CHPPD average (including ward based AHPs) is reported at 17.98CHPPD in May 2022, with a range between 6.0 (Stewart House) and 66.1 (The Grange) CHPPD. General variation reflects the diversity of services, complex and specialist care provided across the Trust. Analysis has not identified significant variation at service level; indicating that staff are being deployed productively across services.

Staff absence data

Absence by directorate	Sickness absence	Self-Isolation - Working from home	Self-Isolation - Unable to work from home	Total
Community Health Services	4.0%	0.1%	0.1%	4.1%
Enabling Services	2.9%	0.0%	0.0%	2.9%
FYPC	4.3%	0.1%	0.1%	4.5%
Hosted Service	1.4%	0.0%	0.0%	1.4%
Mental Health Services	5.0%	0.0%	0.1%	5.1%
LPT Total	**4.1%**	**0.1%**	**0.2%**	**4.4%**

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

In comparison to the previous month total absence has decreased by 0.3% associated with an increase in general absence overall.

In-patient Staffing

Summary of inpatient staffing areas to note.

Wards	March 2022	April 2022	May 2022
Hinckley and Bosworth East Ward	x	x	x
Hinckley and Bosworth North Ward	x	x	x
St Luke's Ward 1	x	x	x
St Luke's Ward 3	x	x	x
Beechwood	x	x	x
Clarendon	x	x	x
Coalville Ward 1	x	x	x
Coalville Ward 2	x	x	x
Rutland	x	x	x
Dalgleish	x	x	x
Swithland	x	x	x
Coleman	x	x	x
Kirby	x	x	x
Welford	x	x	x
Wakerley	x	x	x
Aston	x	x	x
Ashby	x	x	x
Beaumont	x	x	x
Belvoir	x	x	x

Wards	March 2022	April 2022	May 2022
Griffin	x	x	x
Phoenix	x	x	x
Heather	x	x	x
Watermead	x	x	x
Mill Lodge	x	x	x
Agnes Unit	x	x	x
Langley	x	x	x
Beacon (CAMHS)	x	x	x
Thornton	x	x	x
Stewart House	x	x	x

Table 2 – In-patient staffing areas to note

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

Number of occupied beds, temporary workforce percentage together with the NSIs that capture outcomes most affected by nurse staffing levels is presented in the tables per in-patient area by service and directorate in Annex 2.

Community Teams

Summary of community 'areas to note'.

Community team	March 2022	April 2022	May 2022
City East Hub- Community Nursing	x	x	x
City West Hub- Community Nursing	x	x	x
East Central	x	x	x
Hinckley	x	x	x
Healthy Together – City (School Nursing only)	x	x	x
Healthy Together County	x	x	x
Looked After Children	x	x	x
Diana team	x	x	x
Children's Phlebotomy team			
LD Community	x	x	x
LD Therapy	x	x	x
CAMHS Crisis team (on call rota)	x		
South Leicestershire CMHT		x	x
Melton CMHT	x	x	x
Charnwood CMHT	x	x	x
Memory service	x	x	x

Community team	March 2022	April 2022	May 2022
Unscheduled Care		x	x
Assertive outreach	x	x	x
ADHD service	x	x	x
Crisis Resolution and Home team	x	x	x
Criminal Justice & Liaison Team		x	x
Central Access Point (CAP)	x		

Table 3 – Community areas to note

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

FYPC/LD Community

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

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

The Diana team/service is an ongoing area to note due to staff absence and HCSW vacancies. Due to the specific staff skills and knowledge required to deliver care and family support the service is not able to utilise temporary/agency workers to meet demand and planned staffing. As a result of staff absence there is currently reduced care hours and respite offer, and no new referrals are being taken as a control measure. However,

the Dianna team are continuing to support high numbers of children requiring palliative and end of life care, with high emotional impact on the team.

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

CHS Community

Throughout May 2022, Community Nursing has been reporting operating at OPEL level 3 working to level 4 actions. The patient acuity levels during this time have been very challenging across all community nursing teams. Bank nurse shift fill for County teams has remained low with no improvement in agency shift fill within the city. Essential visits were maintained by staff working increased hours, additional shifts and paying overtime. Daily review of all non-essential activities across the service line as per Level 4 OPEL actions and a daily review of all leadership managerial days to support the clinical offer continues.

COVID related sickness absence remained a challenge. There continues to be staff working from home due to symptomatic/COVID positive household members and pregnancy related risk assessments, which further reduced clinical capacity across service provision with the highest risk being in the City community nursing hub, with key areas to note, City, East Central and Hinckley.

Business continuity plans continue including patient assessments and clinic appointments being reprioritised and rescheduled in line with available staff capacity. The reprioritised assessments include wound and holistic assessments. Additional support from specialist teams including Continence and Podiatry services have been requested to provide ongoing support throughout the month of May 2022, this has impacted on the recovery and waiting list position for these services. Hub leadership teams have been mobilised clinically which has impacted on the operational management of hubs including training, supervision, and appraisals.

MH Community

The Crisis Resolution and Home Treatment Team continues to be an area to note due to 40% vacancies along with recruitment and retention challenges. Bank and agency staff are being block booked where possible to try and ensure continuity of care and safe service provision where possible. A recent quality summit highlighted several actions to support recruitment and retention in the team and explore the possibility of new clinical roles.

The Criminal Justice & Liaison & Diversion service is having similar issues within the team, this is made more challenging with the requirement for all staff who work in the service to have been police vetted which makes the use of bank and agency staff more difficult. The team continues to work on recruitment, and have new starters set to join the team. There has been successful recruitment into Mental Health Practitioner vacancies for the Place of Safety Assessment Unit (PSAU).

On-going key areas to note are Melton CMHT, Charnwood CMHT, South Leicestershire CMHT, the ADHD Service, Assertive Outreach, Unscheduled Care Team and Memory service. The volume of referrals is proving challenging whilst recruitment is progressing, and gaps in medical cover are an increasing challenge. Melton CMHT continues as an area to note and additional clinical support from another team has been requested whilst recruitment takes place, and a plan developed to support the team to deliver safe care to its patients, including cover for depot clinics, admin support, the duty rota and waiting list management process.

Medical presence in the team is to be increased, however cover is further challenged with increased numbers of locums and substantive staff leaving. A risk has been placed onto the risk register. A non-medical prescriber (NMP) has been deployed to provide cover to a medication review clinic in one team. It is also noted that there are gaps in psychology and vacancies in occupational therapy, all of which is contributing to long waiting list times.

The Unscheduled Care team in MHSOP community services reported similar challenges due to high sickness and vacancies, additional clinical support was provided from another team to maintain responsive services and deliver safe quality care. Recruitment is progressing slowly.

A number of RN vacancies continue to impact on the memory service. Recruitment and retention continues to be challenging. A quality improvement cycle is in place focusing on patient waiting times. Waiting times are closely monitored to understand the impact on patients waiting to be seen for appointments and follow up visits. Following review there have been no staffing related incidents, with clear process in place to escalate concerns and mange essential visits across localities to support patient needs.

Proposal

Considering the triangulated review of workforce metrics, nurse sensitive indicators, patient feedback and outcomes in May 2022 staffing challenges continue to increase and there is emerging evidence that current controls and implementing business continuity plans are not fully mitigating the impact to the quality and safety of patient care across all services, at all times.

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

Decision required

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

May 2022

Ward Group	Ward	Average no. of Beds on Ward	Average no. of Occupied Beds	Fill Rate Analysis (National Return) Actual Hours Worked divided by Planned Hours — Nurse Day (Early & Late Shift) Average % fill rate registered nurses	Nurse Day (Early & Late Shift) Average % fill rate care staff	Nurse Night Average % fill rate registered nurses	Nurse Night Average % fill rate care staff	AHP Day Average % fill rate registered AHP	AHP Day Average % fill rate non-registered AHP	% Temporary Workers (NURSING ONLY) Total	% Temporary Workers (NURSING ONLY) Bank	% Temporary Workers (NURSING ONLY) Agency	Overall CHPPD (Nursing And AHP)	Medication Errors	Falls	Complaints	PU Category 2	PU Category 4
				>=80%	>=80%	>=80%	>=80%	-	-	<20%							(Month in arrears)	
AMH Bradgate	Ashby	15	21	105.8%	290.0%	131.5%	224.3%			56.3%	3.1%	53.1%	11.8	↓0	↑2	↑1		
	Aston	14	13	97.2%	231.9%	105.3%	193.0%			61.0%	9.5%	51.5%	11.1	→0	→0	→0		
	Beaumont	22	22	86.4%	106.3%	86.4%	102.8%			57.2%	31.9%	25.3%	8.8	↓0	↓0	↓1		
	Belvoir Unit	9	10	132.9%	173.1%	106.3%	180.3%			53.3%	29.0%	24.3%	20.1	→0	↑2	→0		
	Heather	18	18	90.7%	155.4%	103.0%	111.3%			45.9%	32.3%	13.5%	6.2	→0	↑2	↑1		
	Thornton	12	13	87.9%	204.4%	99.5%	129.7%			29.6%	21.5%	8.1%	10.3	→0	→0	→0		
	Watermead	19	20	118.4%	252.2%	112.0%	186.9%			50.6%	24.1%	26.5%	8.2	↑2	↑3	→0		
	Griffin - Herschel Prins	6	6	107.1%	250.0%	104.5%	626.4%			62.4%	35.4%	27.0%	33.0	↑2	↓0	→0		
AMH Other	Phoenix - Herschel Prins	11	12	106.7%	186.9%	105.4%	177.2%		100.0%	47.7%	16.2%	31.4%	14.2	→0	→0	→0		
	Skye Wing - Stewart House	30	30	130.1%	115.6%	213.7%	209.9%			45.8%	28.2%	17.6%	6.0	↑1	↓1	→0		
	Willows	8	9	194.5%	192.0%	140.4%	172.9%			56.1%	30.5%	25.6%	17.5	↓1	→0	→0		
	Mill Lodge	12	14	148.0%	100.8%	141.9%	99.8%			55.2%	37.6%	17.6%	15.0	↓0	↓3	→0		
CHS City	Kirby	16	23	70.4%	152.4%	131.7%	163.2%	100.0%	100.0%	45.4%	22.3%	23.1%	11.7	↑4	↑6	→0	→0	→0
	Welford	18	21	72.2%	139.1%	133.3%	268.7%			39.5%	19.6%	19.9%	9.1	↑2	↓4	↓0	→0	→0
	Beechwood Ward - BC03	22	23	106.0%	105.7%	102.6%	104.0%	100.0%	100.0%	32.3%	10.6%	21.7%	8.2	↑4	→1	→0	→0	→0
	Clarendon Ward - CW01	20	20	91.4%	120.7%	106.5%	111.0%	100.0%	100.0%	25.8%	8.7%	17.1%	9.6	↓1	↑2	↓0	→1	→0
	Coleman	12	20	51.4%	252.2%	125.4%	569.0%	100.0%	100.0%	65.9%	40.5%	25.4%	24.9	↑1	↑6	→0	→0	→0
	Wakerley (MHSOP)	12	20	92.3%	118.0%	133.4%	152.2%			39.5%	19.3%	20.2%	17.2	→0	↓6	↑1	→0	→0
CHS East	Dalgleish Ward - MMDW	16	17	107.5%	93.0%	100.1%	146.6%	100.0%	100.0%	22.1%	7.1%	14.9%	8.8	↓0	↓2	→0	→0	→0
	Rutland Ward - RURW	16	16	98.0%	153.9%	100.3%	170.9%	100.0%	100.0%	41.5%	17.3%	24.2%	10.2	↑2	↑6	→0	→1	→0
	Ward 1 - SL1	18	19	86.7%	123.8%	100.0%	171.8%	100.0%	100.0%	30.8%	14.9%	15.8%	10.5	↑1	↓3	→0	→0	→0
	Ward 3 - SL3	12	13	102.5%	96.4%	98.4%	101.3%	100.0%	100.0%	30.6%	14.3%	16.3%	9.7	→2	↑4	→0	→0	→0
CHS West	Ellistown Ward - CVEL	17	18	128.1%	103.3%	104.8%	119.2%	100.0%	100.0%	12.7%	5.0%	7.7%	9.2	↑2	↑5	↓0	↑5	→0
	Snibston Ward - CVSN	18	19	98.3%	112.5%	98.4%	154.9%	100.0%	100.0%	18.4%	7.7%	10.7%	10.1	↑1	↑4	→0	↓0	→0
	East Ward - HSEW	22	23	107.5%	143.2%	108.1%	163.8%	100.0%	100.0%	29.6%	7.5%	22.1%	10.6	↑2	↓0	→0	↑3	→0
	North Ward - HSNW	16	19	104.5%	111.0%	101.3%	117.2%	100.0%	100.0%	25.9%	9.1%	16.8%	11.1	→2	↓0	→0	↓0	→0
	Swithland Ward - LBSW	19	20	100.6%	96.5%	96.8%	152.5%	100.0%	100.0%	17.0%	6.8%	10.2%	8.6	→1	↓2	↑1	↑2	→0
FYPC	Langley	13	15	111.4%	108.5%	132.8%	146.2%	100.0%		49.4%	36.6%	12.8%	14.9	↑1	→0	→0		
	CAMHS Beacon Ward - Inpatient Adolescent	5	17	119.0%	166.7%	140.8%	295.8%	100.0%		72.4%	30.9%	41.5%	41.9	↓2	↑2	→0		
LD	Agnes Unit	2	3	82.5%	81.0%	100.8%	109.8%			49.3%	18.3%	31.0%	59.2	→0	↓1	→0		
	Gillivers	1	5	101.4%	86.8%	138.6%	133.3%			2.5%	2.5%	0.0%	61.6	↑1	→0	→0		
	1 The Grange	1	3	144.7%	83.4%	-	115.2%			16.8%	16.8%	0.0%	66.1	→0	↓0	→0		

Annexe 2: Inpatient Ward triangulation staffing and NSIs.

Trust thresholds are indicated below.

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

Mental Health (MH)

Acute Inpatient Wards

Ward	Average no. of Occupied Beds	Average % fill rate registered nurses	Average % fill rate care staff	Average % fill rate registered nurses	Average % fill rate care staff	Total	Bank	Agency	CHPPD	Medication Errors	Falls	Complaints
		>=80%	>=80%	>=80%	>=80%	<20%						
Ashby	21	105.8%	290.0%	131.5%	224.3%	56.3%	3.1%	53.1%	11.8	↓0	↑2	↑1
Aston	13	97.2%	231.9%	105.3%	193.0%	61.0%	9.5%	51.5%	11.1	→0	→0	→0
Beaumont	22	86.4%	106.3%	86.4%	102.8%	57.2%	31.9%	25.3%	8.8	↓0	↓0	↓1
Belvoir Unit	10	132.9%	173.1%	106.3%	180.3%	53.3%	29.0%	24.3%	20.1	→0	↑2	→0
Heather	18	90.7%	155.4%	103.0%	111.3%	45.9%	32.3%	13.5%	6.2	→0	↑2	↑1
Thornton	13	87.9%	204.4%	99.5%	129.7%	29.6%	21.5%	8.1%	10.3	→0	→0	→0
Watermead	20	118.4%	252.2%	112.0%	186.9%	50.6%	24.1%	26.5%	8.2	↑2	↑3	→0
Griffin - Herschel Prins	6	107.1%	250.0%	104.5%	626.4%	62.4%	35.4%	27.0%	33.0	↑2	↓0	→0
Totals										↓4	↑9	↑3

Table 4 - Acute inpatient ward safe staffing

All the wards have used a high percentage of temporary workforce throughout May 2022. This is due to high acuity /patient complexity and to meet planned staffing levels. Ashby have a patient on level 4 therapeutic observation with 2 staff and are reliant on Agency staff as bank staff are declining to work on the ward due to the risk of allegation. Actions are being taken to reduce the risk of allegations by strengthening the bank staff induction, providing a robust handover specific to the patients risks and need for observation and changing the way the patients level 4 observations are managed and instead of both staff starting and finishing observations at the same time they are staggered into half hour safety and finish times, with both staff observing the patient for 1 hour at a time.

There were nine falls reported across four wards during May 2022. This is an increase in falls from four reported in April 2022. There were six first falls and three repeat falls. Four falls happened during the night shift and two falls during the day shift. From the first falls all six were unwitnessed. There were one male first fall and five female first falls.

The same patient fell three times in May 2022, one witnessed and two unwitnessed. The patient had falls on two of the wards.

The main cause group for falls incidents related to the environment, whereby a patient experienced three falls out of bed, one feeling unwell and the other feeling dizzy in the shower, mechanical cause's such as tripping over a mattress (witnessed) and a trip (as stated) in the garden into a bush, a medication may have been a cause in one case along with reduced mobility, agitation, and aggression. All patients were reviewed medically, and treatment provided specifically for two patients with minor head and wound injuries. One patient who fell on Ashby ward was reviewed medically, transferred to UHL and treated for a fractured hip. A serious incident investigation is underway. Analysis of the falls has shown that staffing was not a contributory factor.

There were four medication errors reported in May 2022 which is a decrease compared to seven in April 2022. These were reported for one acute ward and one PICU ward. One incident was an Electronic Controlled Drug register discrepancy. Two incidents involved incorrect dose of medication being given to the patient, there was no harm to the patient as a result of the incorrect dose and one incident regarding mislaid medication management. All incidents were reviewed in line with the Trust medication error policy and individual review was completed with staff involved. Review of the incidences has not identified any direct correlation between staffing and the impact of quality and safety of the patient's care/outcomes.

Low Secure Services – Herschel Prins

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints

HP Phoenix	12	106.7%	186.9%	105.4%	177.2%	47.7%	16.2%	31.4%	14.2	→0	→0	→0
Totals										→0	→0	→0

Table 5- Low secure safe staffing

Phoenix continues to use a high proportion of bank and agency staff to support planned staffing levels and to cover vacancies and levels of therapeutic observation. There were no medication errors or falls reported for Phoenix Ward for May 2022.

Rehabilitation Services

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers %	Bank %	Agency %	CHPPD	Medication	Falls	Complaints
Skye Wing	30	130.1%	115.6%	213.7%	209.9%	45.8%	28.2%	17.6%	6.0	↑1	↓1	→0
Willows	9	194.5%	192.0%	140.4%	172.9%	56.1%	30.5%	25.6%	17.5	↓1	→0	→0
Mill Lodge	14	148.0%	100.8%	141.9%	99.8%	55.2%	37.6%	17.6%	15.0	↓0	↓3	→0
TOTALS										↓2	↓4	→0

Table 6 - Rehabilitation service safe staffing

Mill Lodge continues to utilise a high percentage of temporary workforce to meet planned staffing levels due to the amount of RN and HCSW vacancies. Willows use of temporary staffing remains higher due to the opening of the additional ward as a surge ward to aid bed flow across the inpatient pathway with fluctuations in use of the bank and agency depending on its occupancy. Stewart House and Mill Lodge continue with a peripatetic rota between them to provide staffing for short falls in staffing. This has increased the use of bank and agency staff being requested and booked on their rotas on alternative months.

There were two reported medication incidents in May 2022, compared to four in April 2022. One incident was inappropriate storage of medication and a second was the wrong medication being administered. There was no harm to the patient because of this. All incidents were reviewed in line with the Trust medication error policy and individual review was completed with staff involved.

There were four falls reported in May 2022, a decrease from ten in April 2022. Of these four falls, three related to Mill Lodge and one for Stewart House. At Stewart House, one fall experienced by a patient (with a history of falls) leant on a suitcase (in her bedroom) whilst getting dressed, the suitcase moved, and the patient fell. At Mill Lodge, three falls were

reported. Two of the falls were experienced by the same patient who rolls out of his bed and onto the crash mat by the side of the bed. The third fall involved a patient who fell onto his table (in his bedroom) linked to symptoms of Huntington's Disease. Following review staffing was not identified as a contributing factor.

Mental Health Services for Older People (MHSOP)

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints	PU Category 2	PU Category 4
Kirby	23	70.4%	152.4 %	131.7%	163.2%	45.4%	22.3%	23.1%	11.7	↑4	↑6	→0	→0	→0
Welford	21	72.2%	139.1 %	133.3%	268.7%	39.5%	19.6%	19.9%	9.1	↑2	↓4	↓0	→0	→0
Coleman	20	51.4%	252.2 %	125.4%	569.0%	65.9%	40.5%	25.4%	24.9	↑1	↑6	→0	→0	→0
Wakerley	20	92.3%	118.0 %	133.4%	152.2%	39.5%	19.3%	20.2%	17.2	→0	↓6	↑1	→0	→0
TOTALS										↑7	↓22	→1	→0	→0

Table 7 - Mental Health Services for Older People (MHSOP) safe staffing

The MHSOP wards did not meet planned fill rates on days for Registered Nurses (RNs) on Kirby, Welford, and Coleman Wards. The staffing establishment on these wards consist of a Medication Administration Technician (MAT) and nursing associates. There are a number of band 5 and 6 vacancies across the Wards.

The service continues to use temporary staff to support unfilled shifts due to vacancies, sickness and to support increased patient acuity and levels of observation.

Staffing continues to be risk assessed and managed across all MHSOP wards and staff moved to support safe staffing levels and skill mix whilst considering patient care needs/acuity and dependency. Acuity across all wards continued to increase during May 2022 which increased the need for additional temporary staffing. Kirby ward and Welford ward are awaiting start dates for band 6 deputy charge nurses, following recruitment to these posts

Coleman and Wakerley wards continue to have the greater acuity with increased average CHPPD on these wards. This is due to a combination of mental and physical health needs which require a higher ratio of nursing staff to maintain safety of patients and staff.

There are current plans for HCSW and band 5 nurse recruitment to existing vacancies across the wards. These vacancies will be promoted at the DMH recruitment event in July 2022.

There were no pressure ulcer incidents reported in May 2022. There has been an increase in reported medication incidents during May 2022 across MHSOP inpatients. Four incidents were recorded on Kirby Ward, three related to storage and dispensing of medication, and one related to the wrong medication being given to the wrong patient. The patient did not experience harm as a result of this. Welford ward reported two incidents of a reduced dose of medication being given, and one patient on Coleman ward who was prescribed medication despite having an allergy relating to that medication. The patient was monitored for any effects of this, and the patient did not experience harm because of this.

A review of falls for MHSOP wards identified a reduction on both Welford and Wakerley Wards, however, an increase was reported for Kirby and Coleman wards where patients have been experiencing multiple falls during the month, due to their clinical presentation. Falls huddles were implemented and risk assessments and care plans updated to reflect falls risks. There was no correlation between the number of falls experienced and staffing levels on duty.

Community Health Services (CHS)

Community Hospitals

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints	PU Category 2	PU Category 4
Dalgleish Ward - MMDW	17	107.5%	93.0%	100.1%	146.6%	22.1 %	7.1%	14.9 %	8.8	↓0	↓2	→0	→0	→0
Rutland Ward - RURW	16	98.0%	153.9%	100.3%	170.9%	41.5 %	17.3 %	24.2 %	10.2	↑2	↑6	→0	→1	→0
Ward 1 - SL1	19	86.7%	123.8%	100.0%	171.8%	30.8 %	14.9 %	15.8 %	10.5	↑1	↓3	→0	→0	→0
Ward 3 - SL3	13	102.5%	96.4%	98.4%	101.3%	30.6 %	14.3 %	16.3 %	9.7	→2	↑4	→0	→0	→0
Ellistown Ward - CVEL	18	128.1%	103.3%	104.8%	119.2%	12.7 %	5.0%	7.7%	9.2	↑2	↑5	↓0	↑5	→0
Snibston Ward - CVSN	19	98.3%	112.5%	98.4%	154.9%	18.4 %	7.7%	10.7 %	10.1	↑1	↑4	→0	↓0	→0
East Ward - HSEW	23	107.5%	143.2%	108.1%	163.8%	29.6 %	7.5%	22.1 %	10.6	↑2	↓0	→0	↑3	→0
North Ward - HSNW	19	104.5%	111.0%	101.3%	117.2%	25.9 %	9.1%	16.8 %	11.1	→2	↓0	→0	↓0	→0
Swithland Ward - LBSW	20	100.6%	96.5%	96.8%	152.5%	17.0 %	6.8%	10.2 %	8.6	→1	↓2	↑1	↑2	→0

Beechwood Ward - BC03	17	107.5%	93.0%	100.1%	146.6%	32.3 %	10.6 %	21.7 %	8.2	↑4	→1	→0	→0	→0
Clarendon Ward - CW01	16	98.0%	153.9%	100.3%	170.9%	25.8 %	8.7%	17.1 %	9.6	↓1	↑2	↓0	→1	→0
TOTALS										↑18	↓29	↓1	↑12	→0

Table 08 – CHS in-patient wards safe staffing

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

The increased fill rate for HCA on night shifts for all wards is due to increased acuity and dependency and patients requiring enhanced observations, one to one supervision and additional beds that have been opened due to LLR wide system request.

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

A particular area to note is Rutland ward at 41.5% temporary workforce, this is due to enhanced observations due to patient levels of acuity and requiring additional HCA support impacted by the environmental challenges of the layout of the ward itself.

A recruitment event is being arranged for the 7th of July 2022 with recruitment videos created to promote the nursing roles and career opportunities within community hospitals.

Care hours per patient day has improved from the previous month remaining stable across the eleven wards, the lowest reporting ward is Beechwood at 8.2 to the highest ward North ward at 11.1. Further analysis continues to strengthen reporting of CHPPD data.

A review of the Nurse Sensitive Indicators (NSIs) for the community hospital wards has identified a decrease in the number of falls incidents from thirty-four in April 2022 to twenty-nine in May 2022 comprising of nineteen first falls and ten repeat falls.

Of the falls reported eleven of these falls were witnessed with six of the falls being in relation to patients mobilising/standing or when being assisted to by staff or equipment. The remaining five witnessed falls were due to a fall from chair (3) and fall from bed (2). Ward

areas to note are Rutland Ward, Ward 3 St Luke's, Ellistown and Snibston Coalville. The wards continue to see an increase in patient dependency and acuity including patients presenting with delirium. Review of the increased incidences has not identified any direct correlation between staffing and the impact to quality and safety of patient care/outcomes.

The number of medication incidents for the community hospital wards has increased from twelve in April 2022 to eighteen in May 2022. The incidents reported were across nine of the eleven wards. The main cause group of medication incidents related to prescribing incidents, failure of staff in following medication procedure/policy/guidance, discrepancy in counted medicine and electronic controlled drug register issues. The Matron team are addressing the process issues and improvements through their clinical walk rounds.

The service received one multi agency complaint during May 2022 which is currently being investigated, initial findings indicate that it had no direct correlation with staffing.

The number of category 2 pressure ulcers developed in our care has increased to twelve (eight in April 2022). The matron team are working with the ward sisters to review all pressure ulcers reported and reviewing training for both registered and non-registered staff, targeting prevention, repositioning, and management plans. Specific review of pressure relieving cushions availability and process for use is being undertaken through June/July 2022.

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

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints
Langley	15	111.4%	108.5%	132.8%	146.2%	49.4 %	36.6%	12.8%	14.9	↓1	→0	→0
CAMHS	17	119.0%	166.7%	140.8%	295.8%	72.4 %	30.9%	41.5%	41.9	↓2	↑2	→0
TOTALS										↓3	↑2	→0

Table 09 – FYPC safe staffing

Inpatient areas continue to increase temporary worker utilisation for Langley and CAMHS to meet planned staffing levels due to vacancies and complex patient care needs associated with high levels of patient acuity. Recruitment remains a key focus and there has been success in appointing a band 2 HCSW however, the main concern is band 5 nurse vacancies. The Beacon

unit has six beds open and occupied. One patient is being nursed in Long Term Segregation and is being supported by a team of Prometheus staff.

There were two medication incidents reported in May 2022, one incident was a documentation error, the drug was recorded as administered when the patient refused. The second incident was in relation to controlled drugs (CD). The CD stock was incorrect, as two tablets were administered by temporary staff, and it was not recorded on the CD stock but was recorded on Wellsky. Staff recorded that they only gave one tablet but did administer 2. This was picked up on the CD drug check and rectified. It was a human error as 2 tablets were given but only charted 1 as given.

There were no falls reported for Langley in May 2022. There was one medication error which related to CD's. Two tablets were prescribed, and staff recorded that they administered one tablet, but did give the correct dose of two tablets on review.

Learning Disabilities (LD) Services

Ward	Occupied beds	Average % fill rate registered nurses Day	Average % fill rate care staff Day	Average % fill rate registered nurses Night	Average % fill rate care staff Night	Temp Workers%	Bank %	Agency %	CHPPD	Medication errors	Falls	Complaints
Agnes Unit	3	82.5%	81.0%	100.8%	109.8%	49.3%	18.3%	31.0%	59.2	→0	↓1	→0
Gillivers	5	101.4%	86.8%	138.6%	133.3%	2.5%	2.5%	0.0%	61.6	↑1	→0	→0
1 The Grange	3	144.7%	83.4%	-	115.2%	16.8%	16.8%	0.0%	66.1	→0	↓0	→0
TOTALS										↑1	↓1	→0

Table 10 - Learning disabilities safe staffing

Patient acuity on the Agnes Unit remains high and staffing is reviewed and increased to meet patient care needs, this is reflected in high utilisation of temporary workforce staff deployed against planned levels and high CHPPD. Agnes Unit continue to focus recruitment to Registered Nurse and HCSW vacancies.

There was one reported fall on Agnes which is related to a patient experiencing an epileptic seizure and was supported to the ground. This patient is a known epileptic and has an individual care plan to manage this.

Short breaks (including Gillivers and the Grange) the staffing includes both RNs and HCSWs due to the complex physical health needs. There were no medication errors or falls reported for the Grange.

Governance table

For Board and Board Committees:	Trust Board 26.7.22	
Paper sponsored by:	Anne Scott, Interim Executive Director of Nursing, AHPs and Quality	
Paper authored by:	Emma Wallis, Interim Deputy Director of Nursing and Quality and Elaine Curtin Workforce and Safe staffing Matron	
Date submitted:	26.07.2022	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):		
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Monthly report	
STEP up to GREAT strategic alignment*:	High **S**tandards	√
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	√
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trust wide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	1: Deliver Harm Free Care 4: Services unable to meet safe staffing requirements
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:		

P

Leicestershire Partnership NHS Trust

Trust Board - July 2022

Report title - Patient Safety Incident and Serious Incident Learning Assurance Report for Trust Board July 2022

Purpose of the report

This document is presented to the Trust Board bi-monthly for May and June 2022 to provide assurance of the efficacy of the overall incident management and Duty of Candour compliance processes. Incident reporting supporting this paper has been reviewed to assure that systems of control continue to be robust, effective, and reliable underlining our commitment to the continuous improvement of keeping patients and staff safe by incident and harm reduction.

The report also provides assurance around 'Being Open', numbers of serious incident (SI) investigations, the themes emerging from recently completed investigation action plans, a review of recent Ulysses incidents and associated lessons learned.

Analysis of the issue

We continue to work to support the governance of patient safety improvement and early recognition of trending incidents across the trust to offer early insight for leaders and working closely with staff within Directorates. The data presented in relation to incidents is considered in the specialist groups with the learning and actions required to improve patient care and staff engagement in the investigation process; these are owned and monitored through each directorate's governance route. This report will concentrate on the work in relation to the Patient Safety Strategy including the investigation of incidents. To accommodate this, less information has been included around individual incident categories.

Investigation compliance with timescales

There continues to be challenges in relation to compliance with serious incident and internal investigations timescales. The position has deteriorated during the COVID19 pandemic, due to staff being rediverted to clinical work or because of staff illness and operational staffing challenges.

Actions in place

- The Governance of the Incident Review Meeting (IRM) agreed to only escalate incidents if considered there is a real opportunity for learning identified (support of commissioners and regulators for this approach)
- Prompt allocation to either corporate investigators or Directorate Teams
- Regular 'check in' with investigators to support 'blockages' (time, confidence to access to information or the right people)
- Senior Directorate staff commitment and availability to support and provide leadership when required
- Report at the point of sign off to be of a good standard to allow focus on robust recommendations and for sharing with patients, families, and staff
- Continue to promote the timely completion of an improvement plan in response to well considered recommendations

- More robust actions should reduce repeated incidents with the promotion to link into quality improvement
- Monitoring the timeliness and quality of initial service managers reports and backlog ensures impact

Incident Oversight and action plans post investigation

The incident oversight group (IOG) continues to monitor the whole incident management process. From the local management of incidents, completion of patient safety incident investigation reports, and action plans. There continues to be challenges in relation to capacity of staff to undertake the improvement work in a timely way to manage action plans post incident investigation. However, all three directorates have plans in place and have been strengthening processes to robustly oversee the implementation of actions. These foundations are slowly starting to show some signs of improvement.
We have been using QI methodology to track and working towards Zero delayed reports by the end of June 2022; although we have not achieved (current position provided in appendices), the actions are managed via IOG and actions are described as part of the ORR.

Patient Safety Strategy

The implementation of the Patient Safety Strategy has been delayed nationally because of the Covid-19 pandemic. In relation to the management of incidents the Patient Safety Incident Response Framework (PSIRF) final publication nationally has also been delayed.
This PSIRF is a real shift in thinking and because of this has been trialled at earlier adopter sites. Their feedback has been evaluated by NHSE/I and changes made and we are expecting publication of the final PSIRF by the end of summer 2022. It is anticipated that organisations will take up to 12 months to transition to this model. The evidence from early adopters is that it is important that we do not try to slot this new process into 'old thinking'. Within the Trust, we continue to promote the foundations for this new model by implementing and developing IRM, moving away from Root Cause Analysis (RCA) and instead using human factors and system thinking as an investigation response. This approach is taught at our Patient Safety Incident Investigation Training which is delivered on a regular basis by the corporate patient safety team. The recruitment of independent incident investigators from a range of backgrounds is fundamental to the change in thinking and is a key strategy as part of PSIRF.

The success of this model relies on those responsible for commissioning and overseeing and receiving these investigations also having awareness of this new thinking. This was shared with Trust Board at their development session and there is commissioner facing link from the Lead Nurse in the corporate patient safety team.

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

Involving patients in patient safety

There are two areas to this:

Part A – involving patients in their own safety; this requires further consideration. However, for many clinicians this is often done without 'thinking' and is part of their holistic approach to caring. We need to build on this and learn from good practice and bespoke record keeping in relation to this.
Part B – to continue the journey for recruiting two Patient Safety Partners for two of our safety related committees. We are working with patient experience to recruit to these posts. It is essential that we ensure we have the culture, framework, training, and support structure in place for this to be successful. The time scales have been extended for our patient safety partners to be in place to the end of September 2022.

Patient Safety Training
The patient safety training level 1 and 2 has been published and the Patient safety team and Comms Team are working to develop the introduction of this to LPT staff. We are also working together to develop change leaders who will support and promote this

Summary
The implementation of the patient safety strategy (PSS) has been delayed across the NHS by the Covid-19 pandemic. We have, however, been working towards the principles and developing the right systems and processes and culture and thinking so we have not lost this time. The cultural foundations of 'just culture and learning' are key to the success of the rest of the strategy. We have work underway in various stages of maturity in all the areas required of the strategy. The key deadlines being recruitment of our patient safety partners by 2022, the embedding of the patient safety training level 1 + 2 as soon as possible with an ambition to adopt across all staff. The introduction of the PSIRF over the next 12 months working with system partners to achieve this. Our aim is to get to a 'place' where the PSS is part of our everyday business and considered in our clinical and operational decision making.

Analysis of Patient Safety Incidents reported

Appendix 1 contains all the Statistical Process Control (SPC) charts utilising the NHSI Toolkit that are shared to support the narrative and analysis below and local speciality incident information.
We have now included the overall position of all investigations and action plans previously unreported through the bi-monthly board report. **NB** the data is live and will therefore be subject to fluctuation as incidents are updated and validated (the PU data is trust wide so will be different to any other specific directorate reports)

All incidents reported across LPT

As previously reported, we continue to describe that incident reporting should not be seen as a good single indicator of safety in the clinical environments, however, these can provide an early indication of incident change in specialities or even across the trust or a wider healthcare system.

Work related to 'open incident backlogs' continues and is an improving picture with senior support and oversight. The position will have governance and oversight through IOG. The prompt oversight and management of incidents is part of a strong safety culture. We also have a robust 'safety net' system in place to regularly review and escalating any outstanding incidents still flagging at 'moderate harm and above' and encourage this review through the incident review process, or by checking and challenging harm levels not reviewed in conjunction with incident review and/or closure of incidents at directorate level.

Review of Patient Safety Related Incidents

The overall numbers of all reported incidents continue to be above the previous mean and can be seen in our accompanying appendices. Most of the increase continues to be related to staff reporting Covid-19 positive.

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

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

Areas of focus are

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

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

Falls

The falls group have developed a whole bed management policy to support staff to make informed decisions around keeping patients safe who may be at risk from falling from bed. While falls remain a consistent concern for clinical areas there has been a significant and sustained reduction from Feb 2022, and we have seen a reduction in falls with harm reported as serious incidents in Q1 for 2022-23.

Deteriorating Patients

This is the term used to describe a clinical physical deterioration in patients, often initially unrecognised in patients with complex co-morbidities. The numbers of incidents relating to this are not easy to quantify as they are often reported under different categories. The deteriorating patient group are working to develop a process so that they consider our recognition and response post any cardiac arrest, when patients are unexpectedly transferred back to the acute trust and from any relevant SI's. This focus is identifying some emerging themes around delayed escalation of patients who are deteriorating (particularly out of hours), the management of observations and management of fluids and we are working to support staff with a range of tools and competencies to deliver a higher level of care and escalate concerns earlier.

All Self-Harm including Patient Suicide

In May we saw steep increase in 'reported suicides', several being younger/middle-aged women. We continue to report and see a high numbers of self-harm incidents resulting in moderate harm, and above which has peeked in May 2022. The picture continues within the community mental health access services who report increasing numbers of patients in crisis who may have contacted CAP have self-harmed or are planning to. This continues to be distressing for patients, their families and the staff trying to offer support and share coping strategies.

Inpatient self-harm reporting across CAMHS has seen a dramatic fall in June influenced by individual patients either in recovering or transferred to more appropriate in-patient settings than our acute admission unit at the Beacon. In addition, there has been a continued focus on supporting our young people when they are distressed and equipping staff with better skills and support to do.

Self-harm behaviours continue to range from very low harm to multiple attempts by inpatients during individual shifts of head-banging, ingestion of foreign objects, cutting with any implement and ligature attempts being common themes.

Suicide Prevention

The suicide prevention lead has retired and DMH are recruiting to this role whilst reviewing suicide prevention models to consider best practices nationally. The suicide prevention group has re-established and is re looking at their work program and membership.

Violence, Assault and Aggression (VAA)

The trial of body worn cameras is in progress within DMH and continued feedback is positive. Funding has been secured to extend the scheme and purchase more to roll out in additional areas. This is a positive support for staff and can afford us learning and reflection when reviewing incidents involving violence and aggression in the clinical areas. Incidents of violence and aggression have seen a downward trend in both May and June 2022 overall.

Medication incidents

There has been an increase in the number of medication incidents reported. This is felt to be a result of a focus on medication incidents. There is a task and finish group for the management of controlled drugs in the community. Early review continues to suggest that this is a system error. There is now a pharmacist member of the IRM which is providing that important link and oversight. The medicines risk reduction group are working with directorates to consider the increase in medicines related incidents and having a particular focus on omitted doses. Patient safety are working with pharmacy to develop a case of need for a Medicines Safety Officer (MSO) which is a requirement of the patient safety strategy.

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

The CQC continues to receive 72hr reports for newly notified SI's, completed SI reports and action plans along with evidence. The CQC have not raised any concerns. We continue to work with our other commissioners to provide assurance around our improvement work and progress towards the implementation of the patient safety strategy

Learning from Deaths (LfD)

The LfD process is well supported by a Trust coordinator. We continue to have a backlog of learning from deaths yet to be reviewed and each directorate has a recovery plan to manage this.

Learning Lessons Exchange

Patient safety is working with the Comms team to re brand the learning lessons exchange into a group working to foster a 'learning culture' to ensure that staff have the skills to identify learning and implement necessary changes.

The next meeting will consider the learning from complaints/the complaints process

Sharing Learning and hearing the patient story from incidents

Through PSIG we are using patient stories to use within directorate and to share learning across directorate. These stories are discussed at PSIG to ensure we are really focussing on what the learning is. This is part of our culture and new way of thinking.

Decision required

- Review and confirm that the content and presentation of the report provides assurance around all levels and categories of incidents and proportionality of response.

- Be assured systems and processes are in place to ensure effective investigations are undertaken that identify appropriate learning.
- To enable sighting of the senior Trust team of emerging themes, concerns through incident reporting and management and patient safety improvements

Governance table

For Board and Board Committees:	Trust Board 26.7.22	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Tracy Ward (Head of Patient Safety) Sue Arnold (Lead Nurse / PSII Lead CPST)	
Date submitted:	17/07/2022	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	PSIG-Learning from deaths-Incident oversight	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Assurance of the individual work streams are monitored through the governance structure	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning		
STEP up to GREAT strategic alignment*:	High **S**tandards	X
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	X
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trust Wide Quality Improvement	X
Organisational Risk Register considerations:	List risk number and title of risk	1 – There is a risk that the Trust's systems and processes and management of patients may not be sufficiently effective and robust to provide harm free care on every occasion that the Trust provides care to a patient. 3-- There is a risk that the Trust does not demonstrate learning from incidents and events and does not effectively share that learning across the whole organisation.
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:		
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equaliy considerations:		

Appendix 1

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

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

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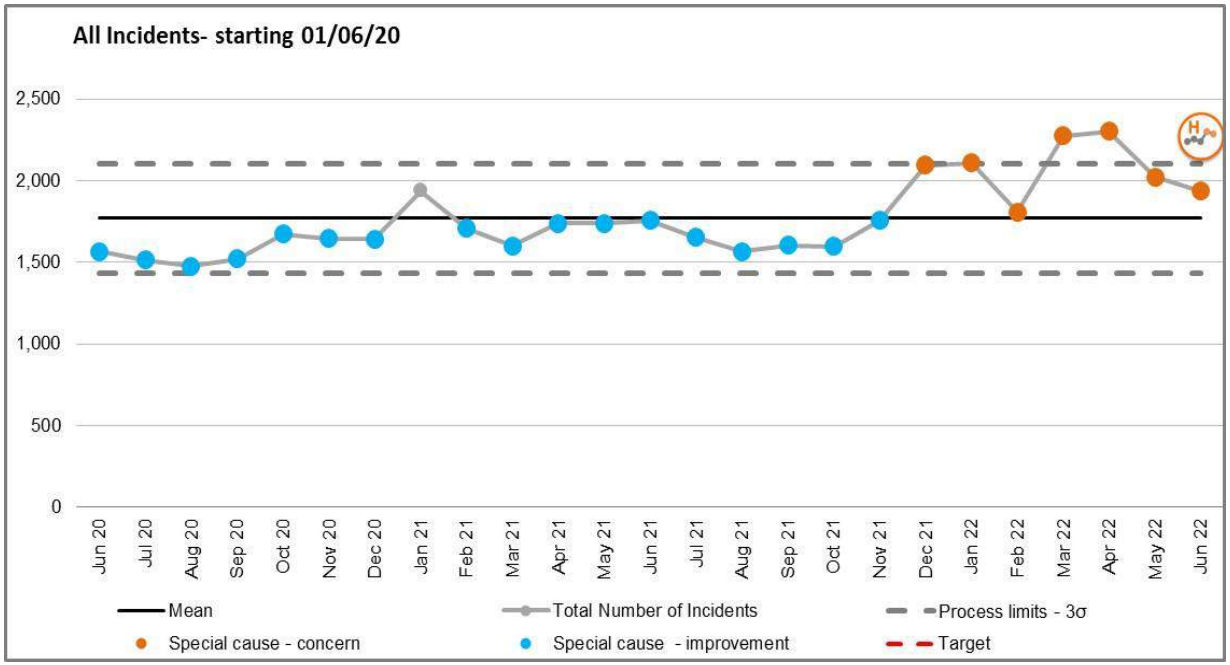
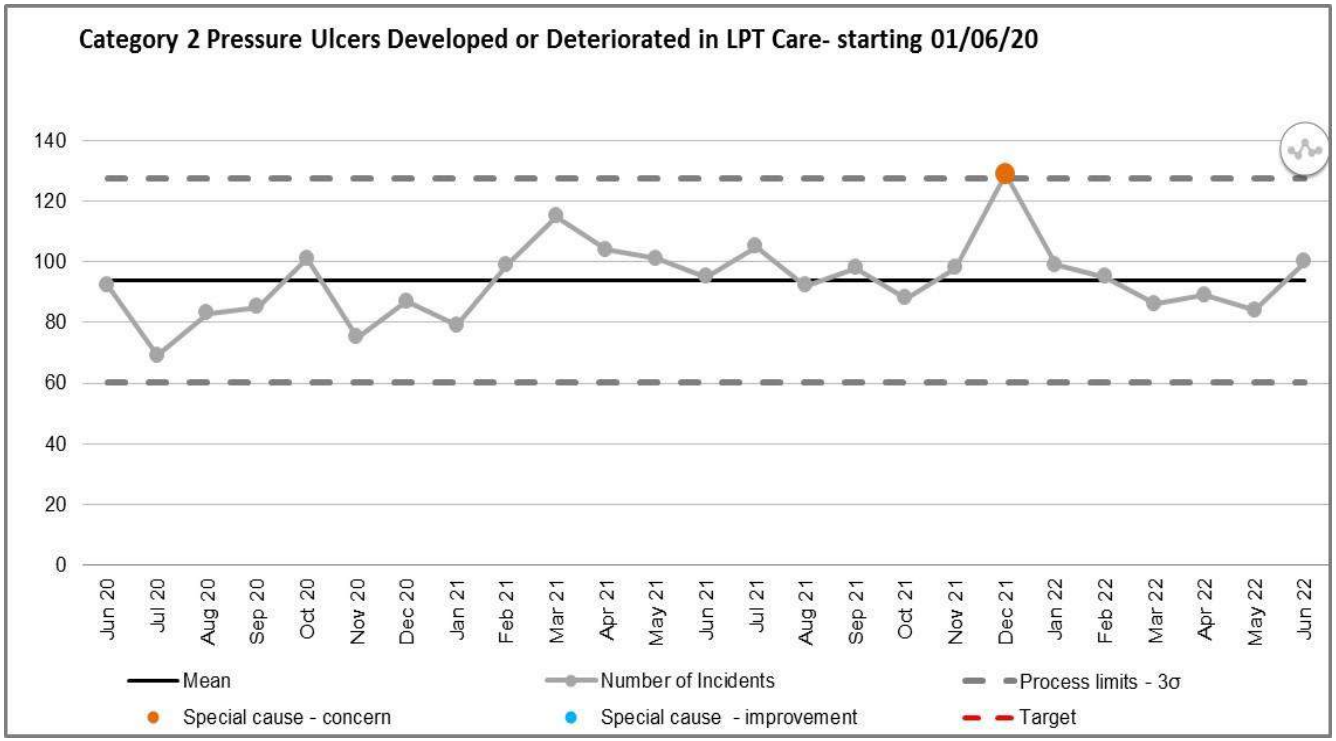
1. All incidents



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



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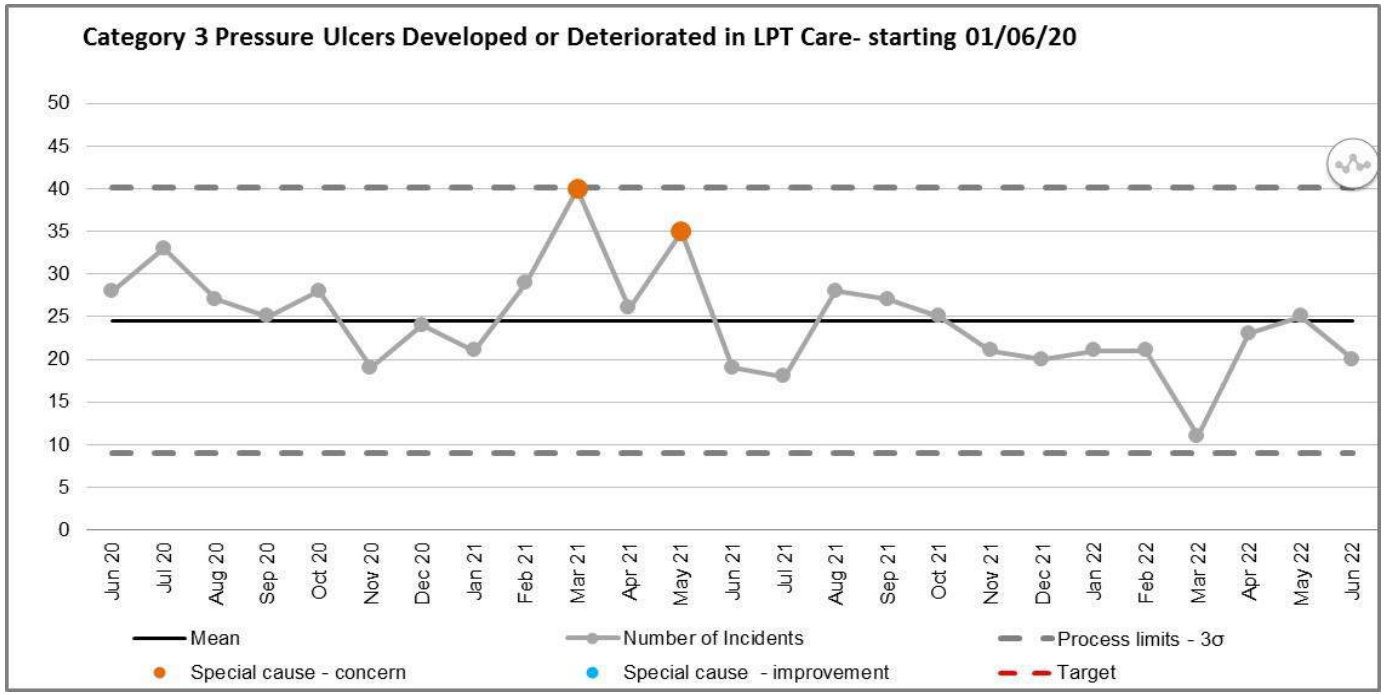
3. Category 3 Pressure Ulcers developed or deteriorated in LPT Care



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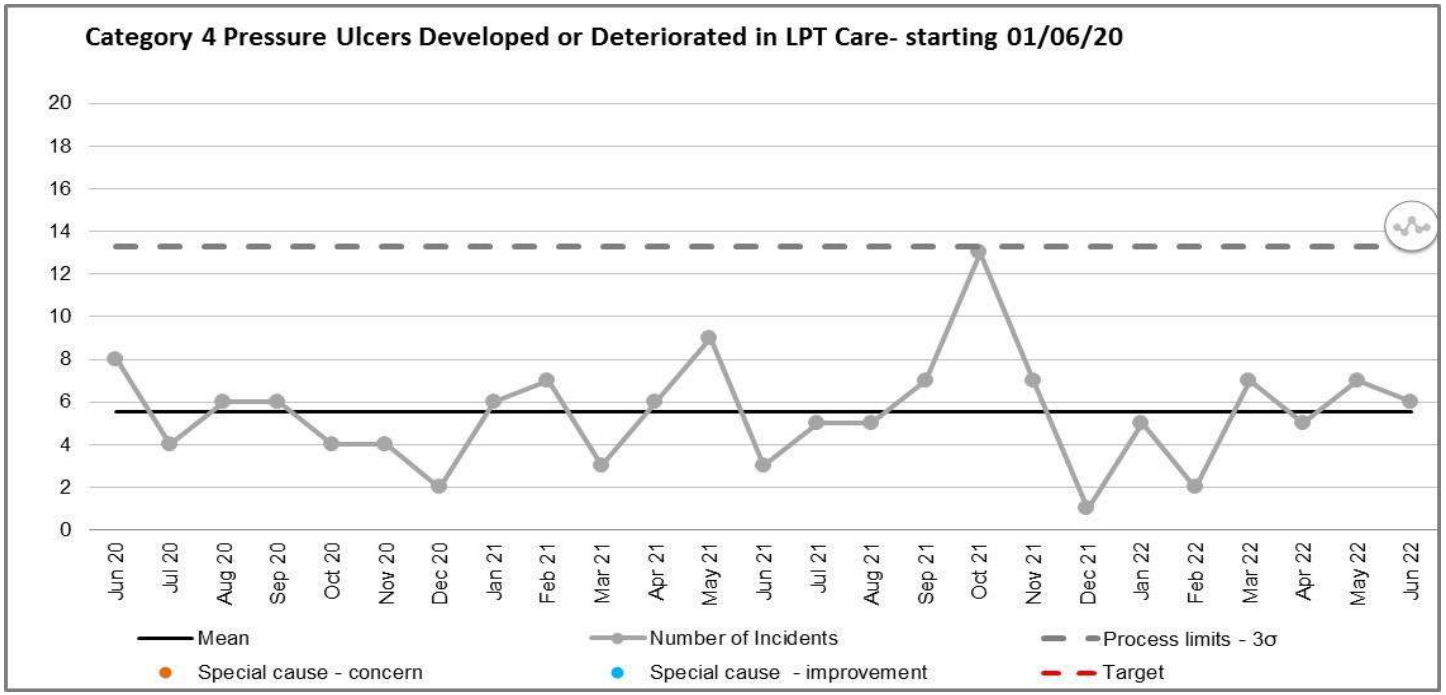
4. Category 4 Pressure Ulcers Developed or deteriorated in LPT Care



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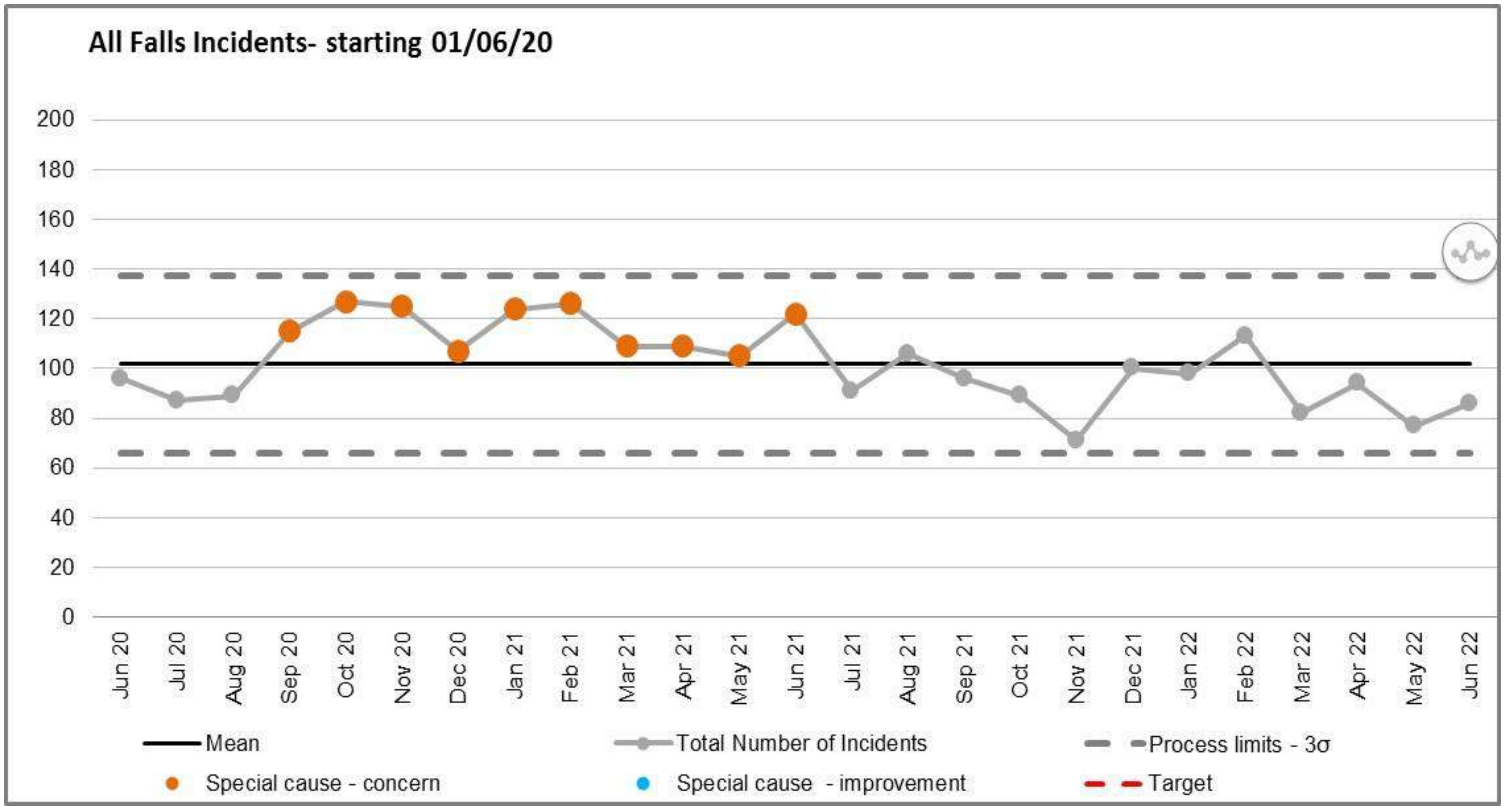
5. All falls incidents reported



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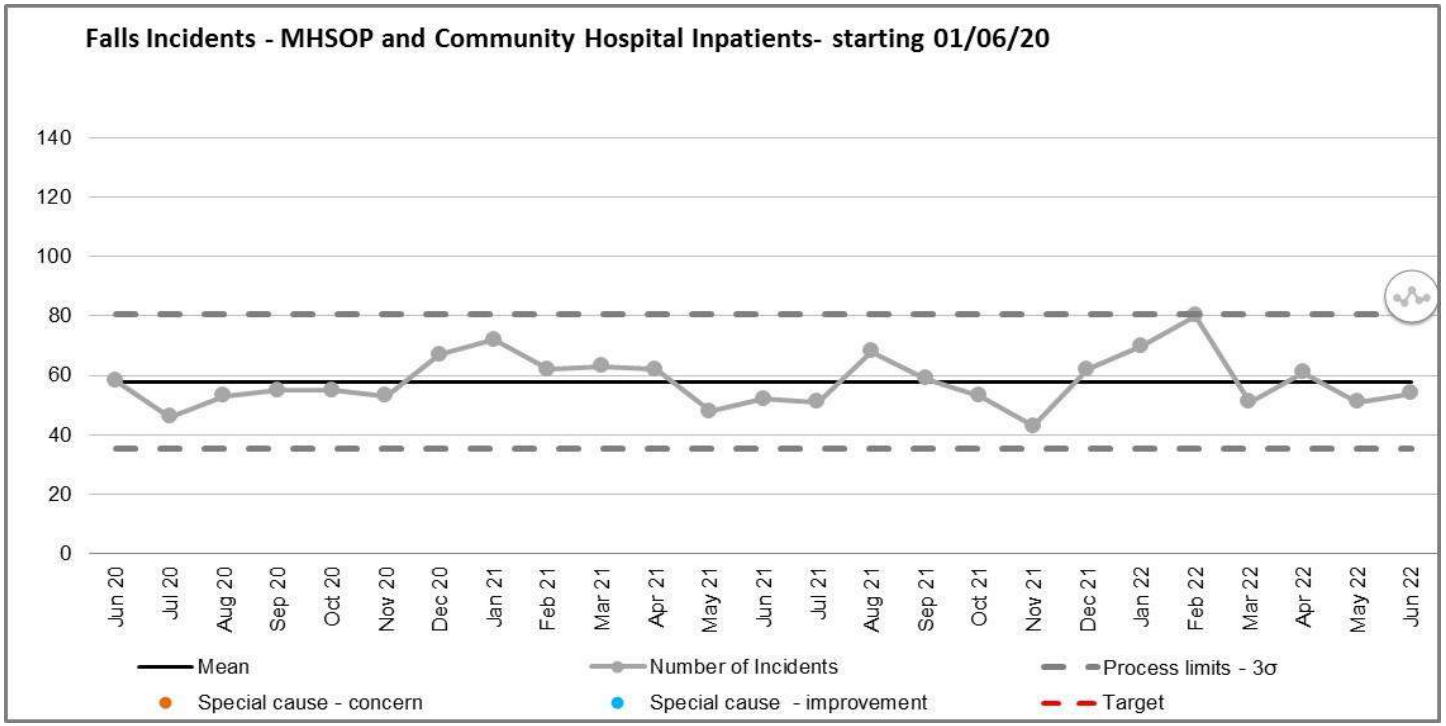
6. Falls incidents reported – MHSOP and Community Inpatients



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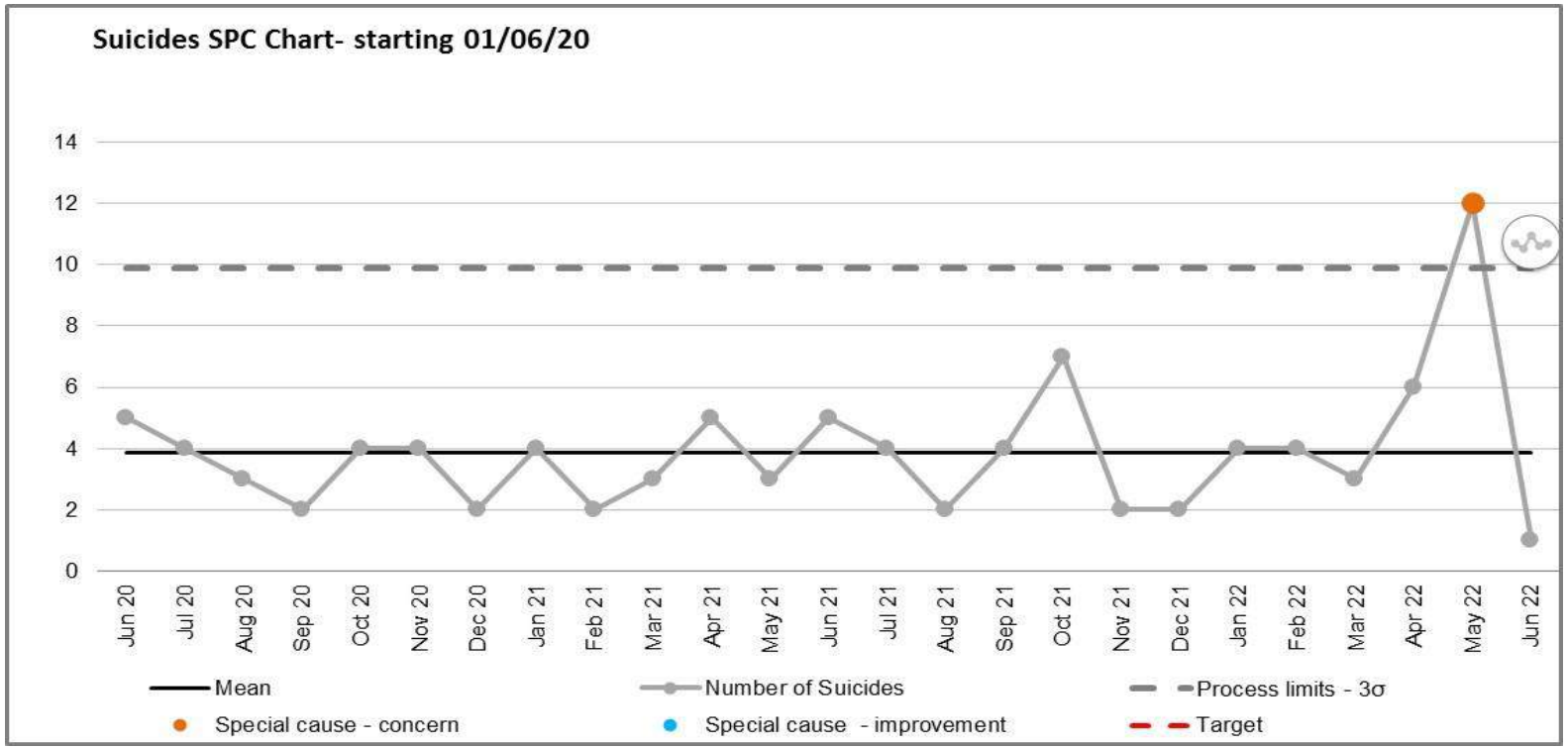
7. All reported Suicides



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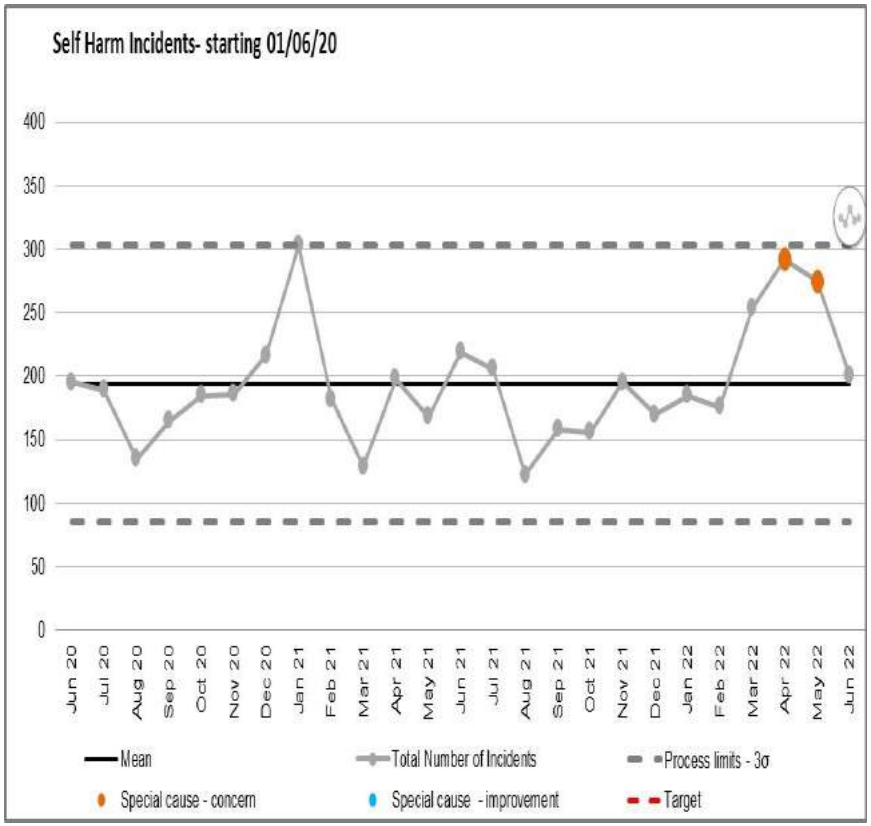
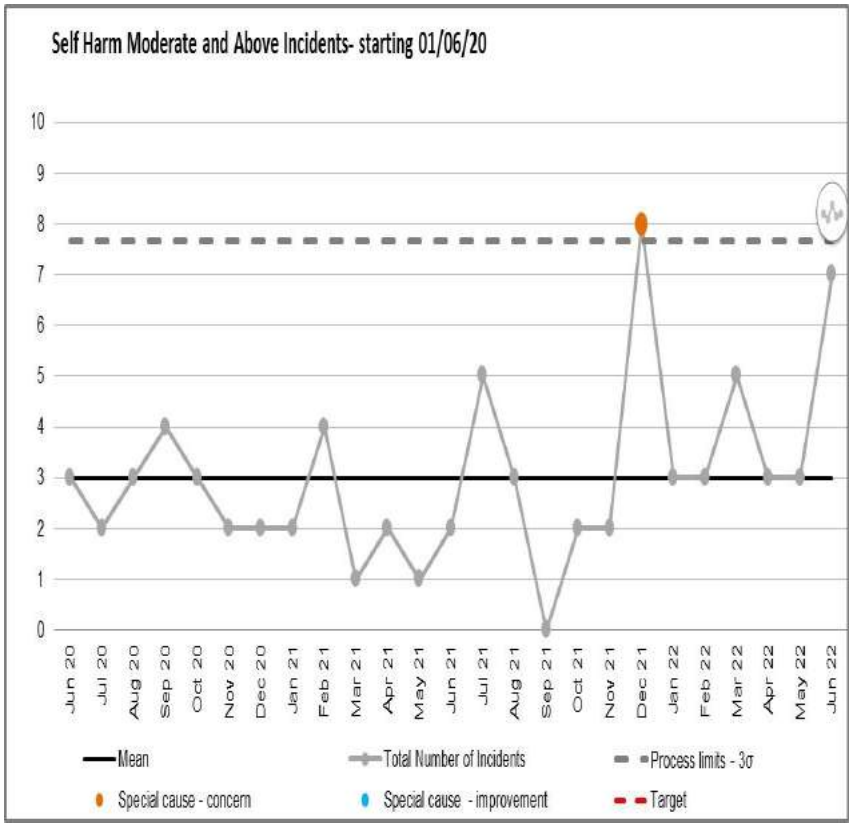
8. Self Harm reported Incidents





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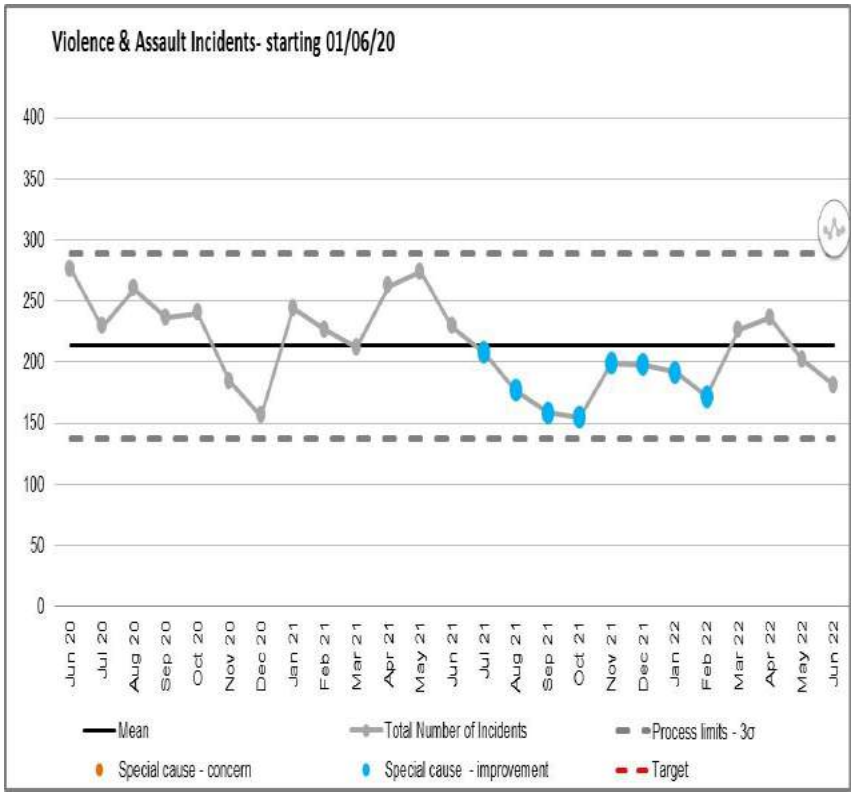
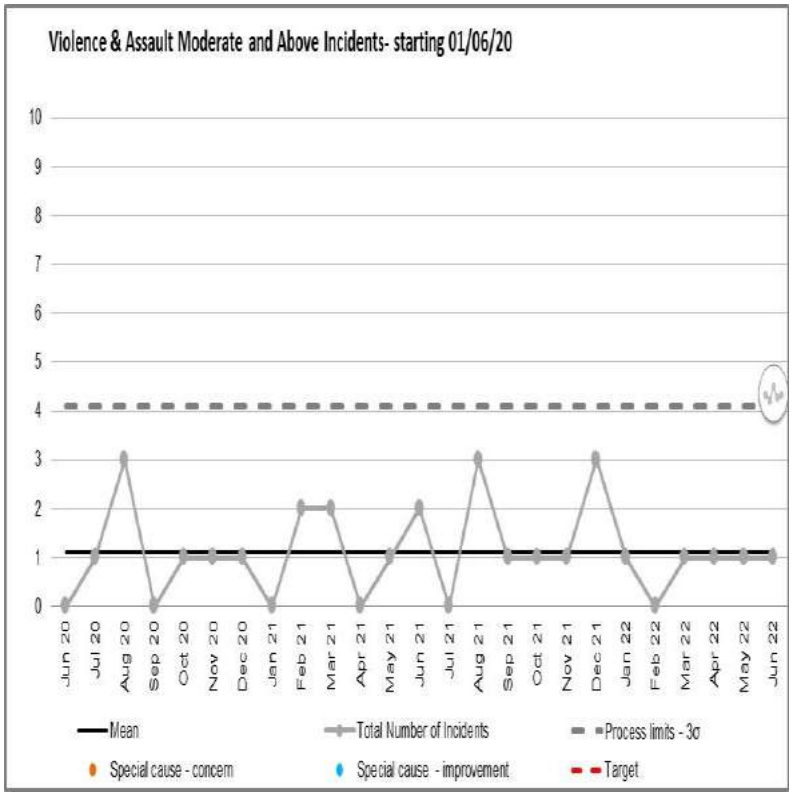
9. All Violence & Assaults reported Incidents





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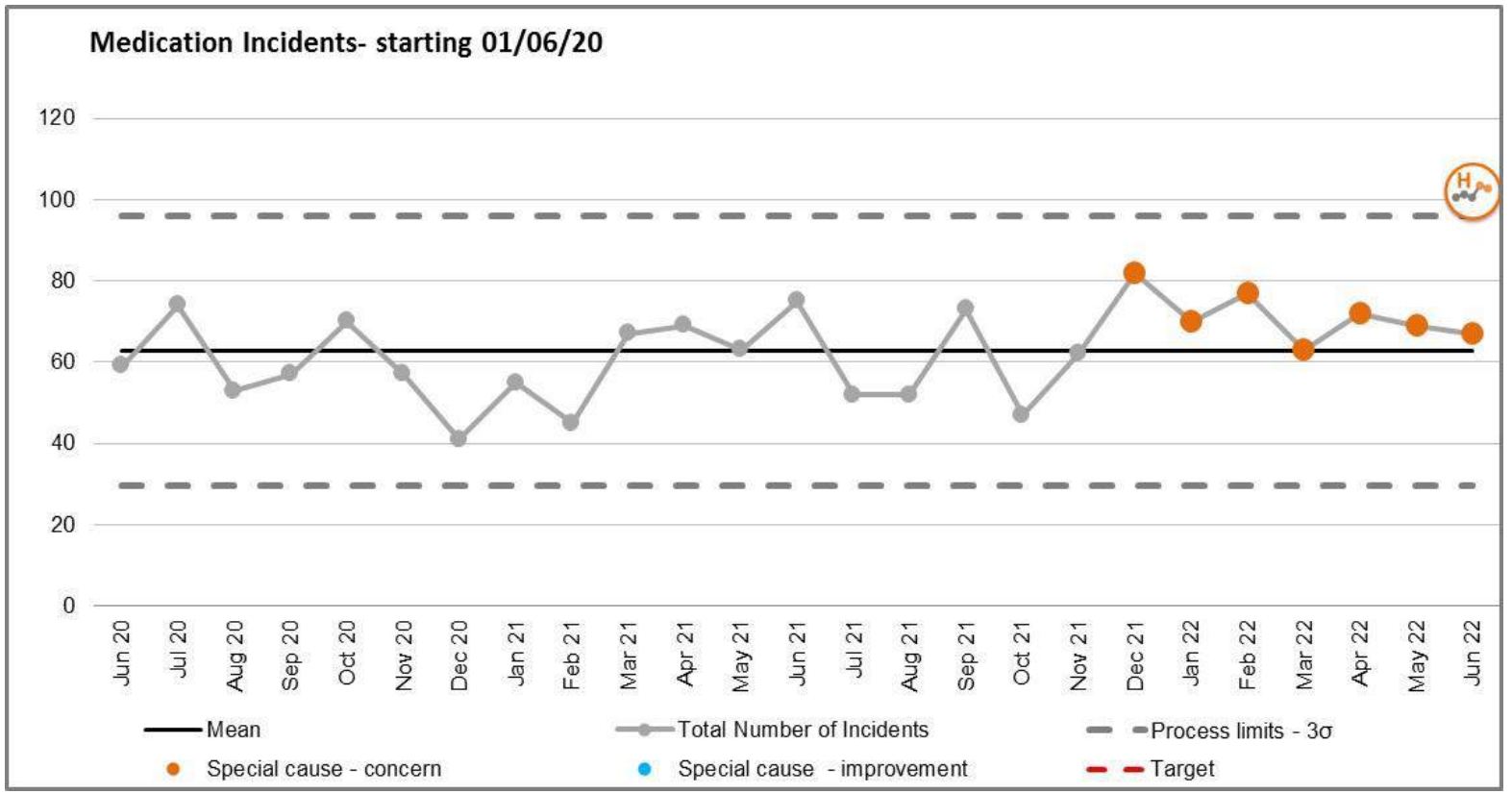
10. All Medication Incidents reported



12. Ongoing - StEIS Notifications for Serious Incidents

2022/2023 - STEIS Notifications and Internal Investigations									
		StEIS Notifications	SI INVESTIGATIONS				Internal Investigations		
		Downgrade & removal requests	SIs declared DMH	SIs declared FYPC/LD	SIs declared CHS	Signed off in month	DMH	FYPC/LD	CHS
2022/23 Q1	April	0	2	0	2	10	3	3	3
	May	0	3	0	0	12	5	0	4
	June	0	4	1	2	7	2	1	3
2022/23 Q2	July								
	August								
	September								
2022/23 Q3	October								
	November								
	December								
2022/23 Q4	January								
	February								
	March								
YTD			9	1	4	29	10	4	10

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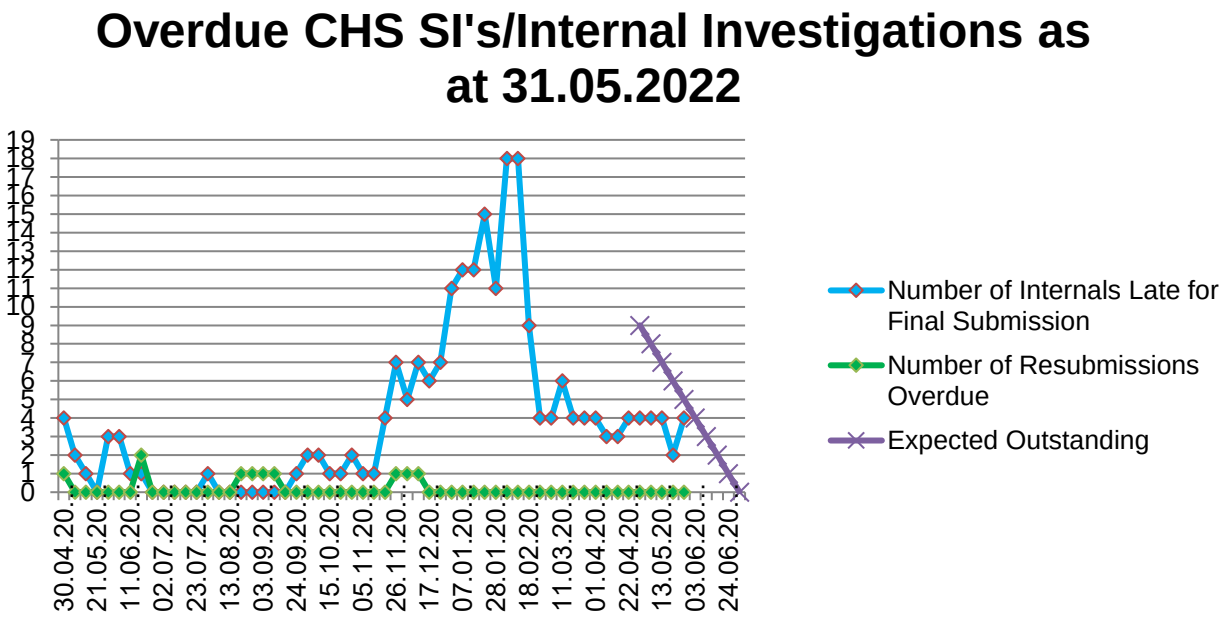
12a. Overdue Serious Incidents/Internal Investigation & CCG resubmissions(includes totals) - CHS



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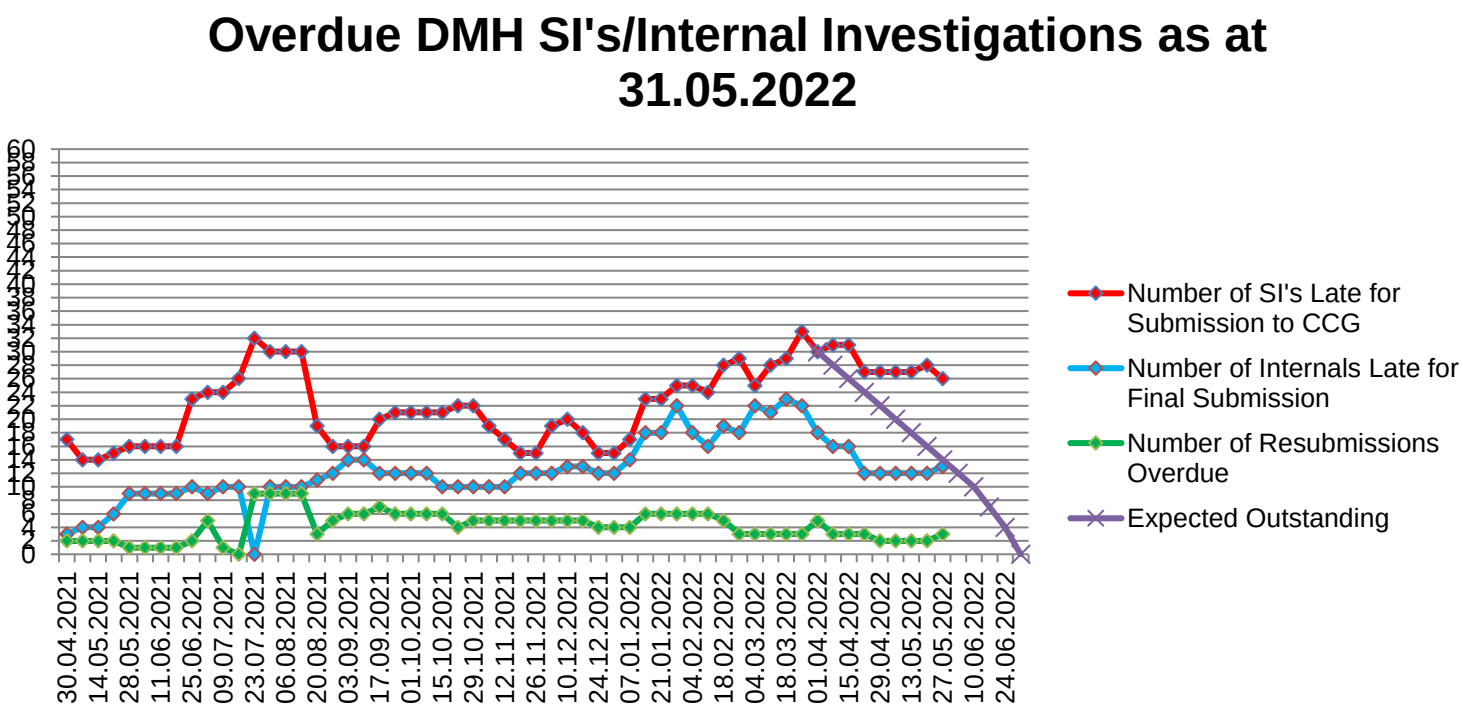
12a. Overdue Serious Incidents/Internal Investigation & CCG resubmissions (includes totals) - DMH



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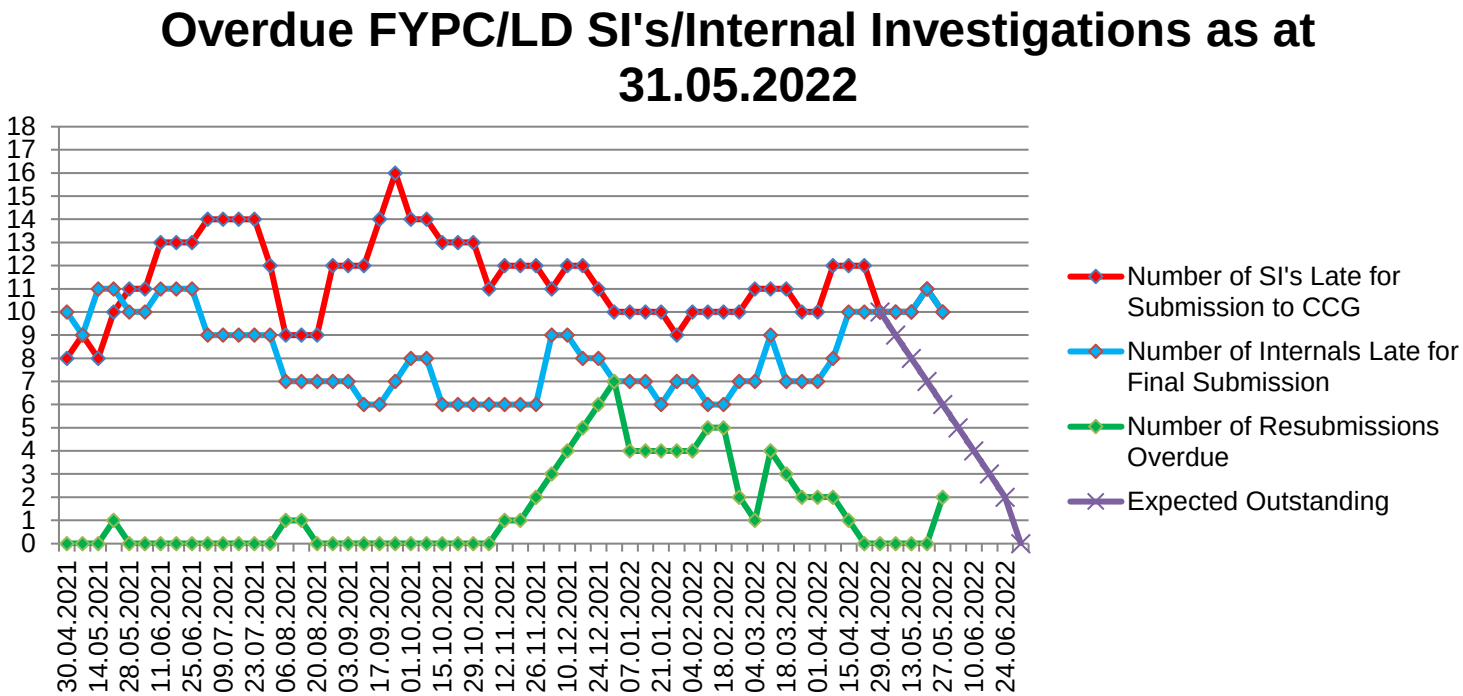
12a. Overdue Serious Incidents/Internal Investigations & CCG resubmissions (includes totals) - FYPCLD



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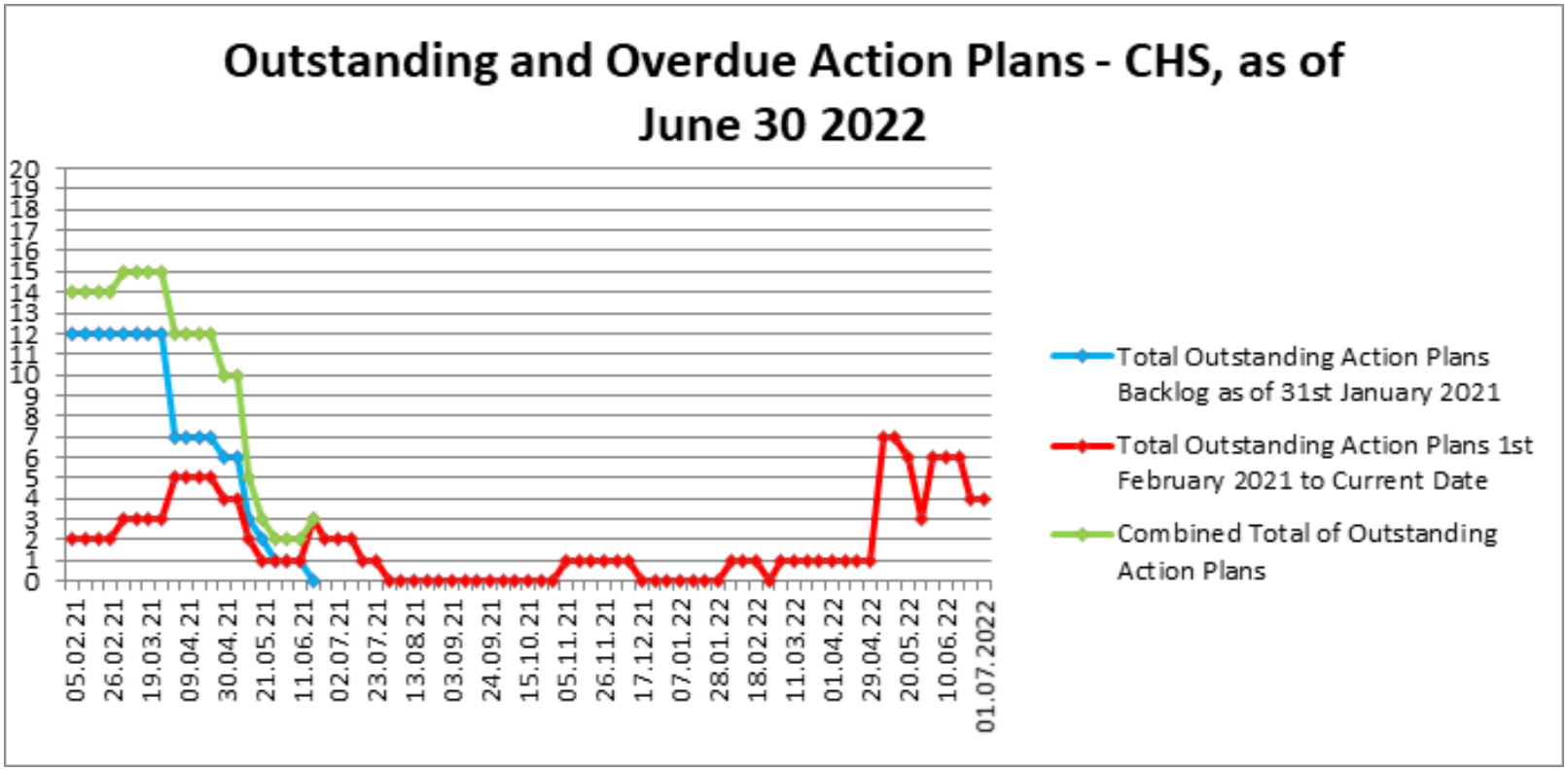
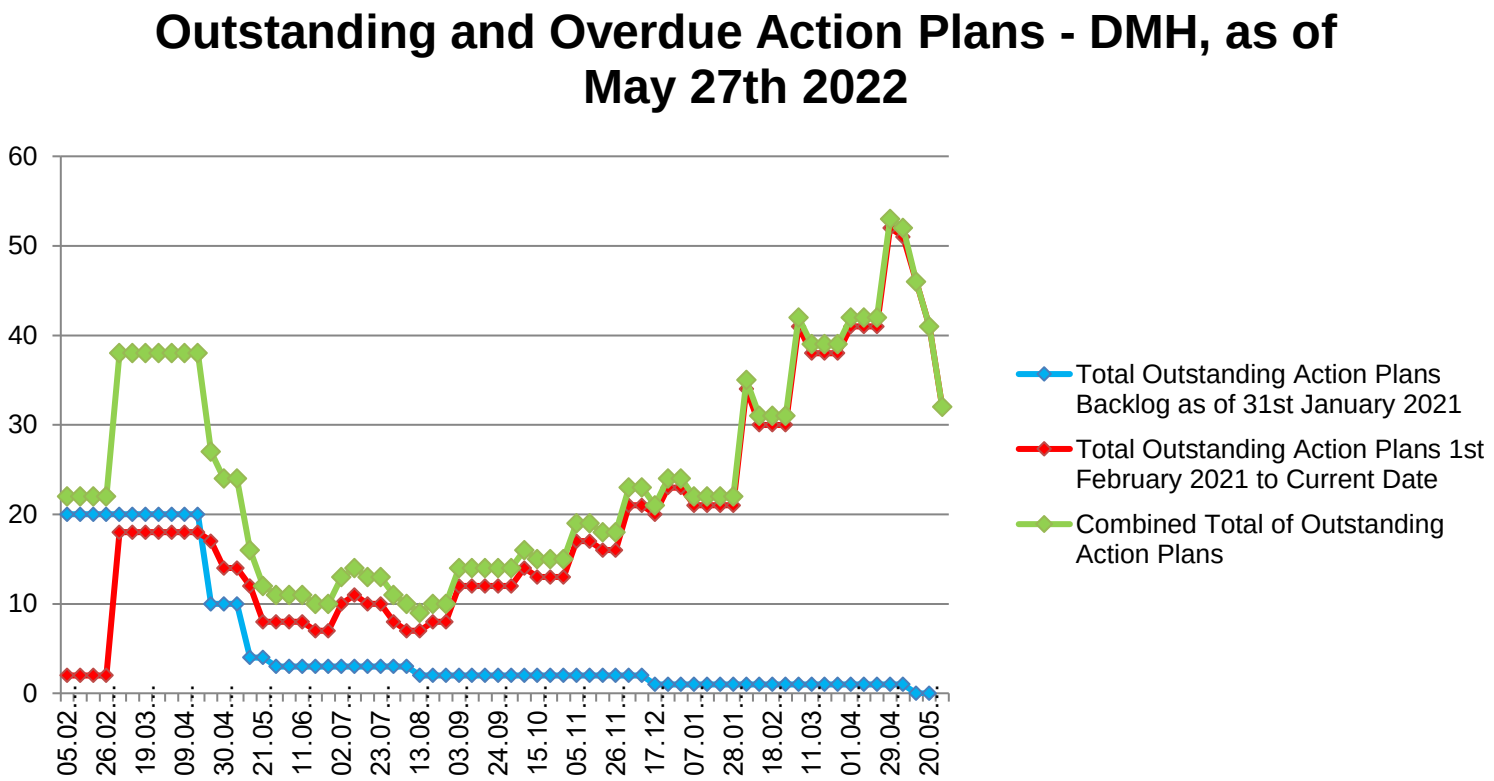
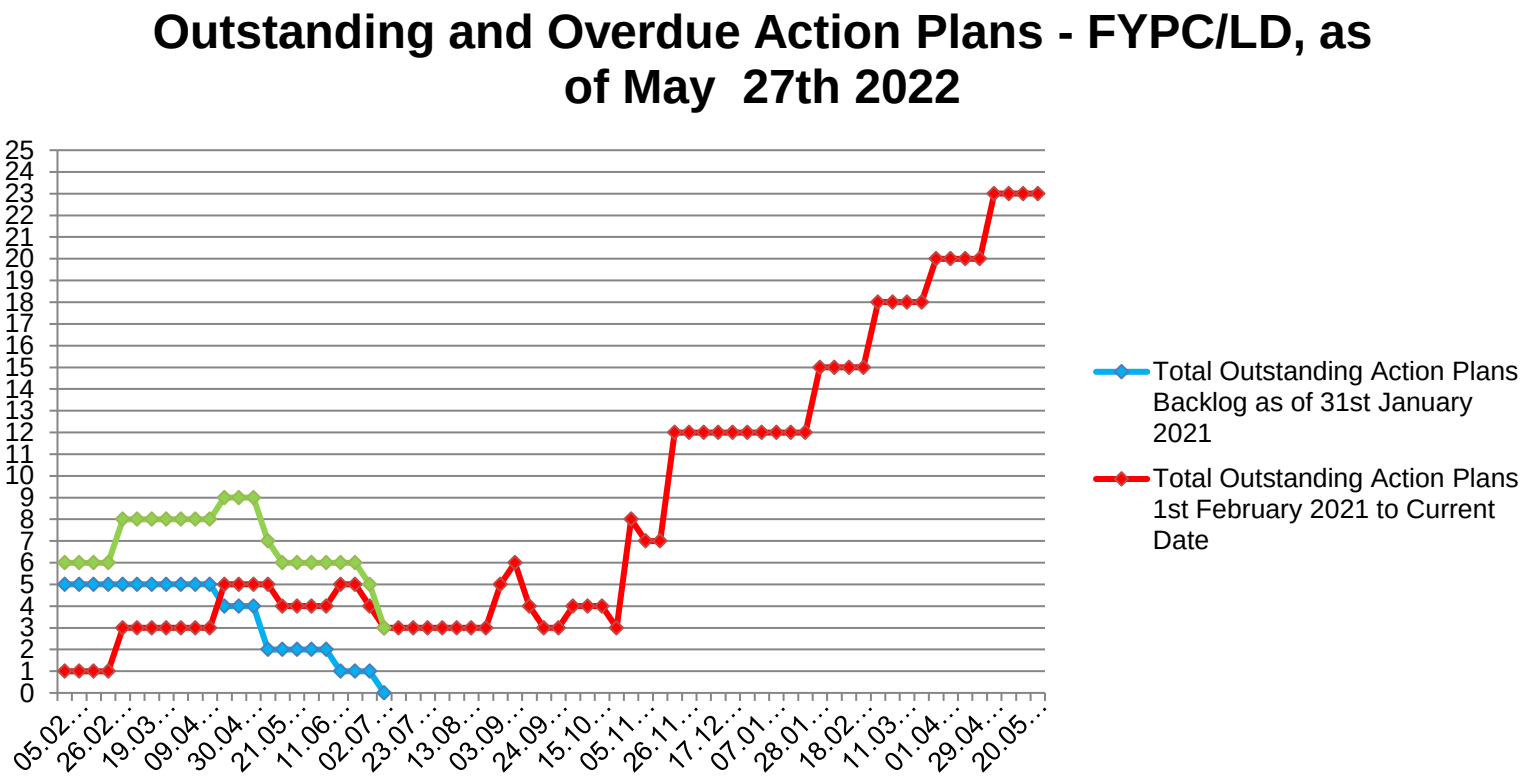
12.b Directorate SI Action Plan Compliance Status 2020/21 to date



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



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



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12. Learning

Serious & Internal Incidents Emerging & Recurring Themes

- Lack of communication or joined up approach between teams or sharing of information with other agencies. **Action:** FYPC/LD and DMH have a project group planned to agree how to make the sharing of information easy
- Mental Capacity Assessments & overall care plans and risk assessments not considered or completed – this remains a theme across all adult areas. **Action:** Planned Safeguarding Level 3 for roll out that will address the importance of using MCA's and increasing staff confidence.
- Management of fluid balance and recognising/ escalating dehydration. **Action:** Task and finish group to improve staff knowledge & tools to manage this in the clinical areas
- Management of the deteriorating patient **Action:** embedding the use of NEWS2 escalation and expansion of CHS readmission audit

Q

Leicestershire Partnership NHS Trust

Public Trust Board – 26 July 2022

Infection Prevention and Control Six-Monthly Report to Trust Board

Introduction

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

Background

The IPC team currently has 3.7 Whole Time Equivalent (WTE) Infection Prevention and Control Nurses and 1 WTE IPC administrator. The team is supported and managed by the Interim Deputy Director of Nursing and Quality/Deputy Director of Infection Prevention and Control (DDIPaC). Recruitment into the IPC team for vacancies due to retirement has proved challenging due to the specialist skills and knowledge required and national recruitment to enhance IPC teams throughout the pandemic. The team are looking at new ways to attract and develop secondment opportunities to support succession planning and sustainability.

The Infection Prevention and Control Board Assurance Framework (BAF) has been updated twice since December 2021, with a further 22 Key Lines of Enquiry (KLoEs). The BAF has been reviewed, and information and reports embedded within the self-assessment. The BAF self-assessments and subsequent updates have been shared with Trust and both NHS England & Improvement (NHSE & I) IPC leads, and Care Quality Commission (CQC) as detailed in previous Trust board 6-month IPC reports, all BAF actions are now completed and closed.

Purpose of the report

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

In addition the report provides updates on:

- Information, quality improvement learning and actions for compliance in regard to Covid-19 outbreaks and nosocomial Covid-19
- Podiatry decontamination update
- Monkeypox infection

Analysis of the issue

1. COVID-19 pandemic

1.1 The Covid-19 pandemic has been downgraded from level 4 to level 3. Management of patients with suspected or known Covid-19 continues both nationally and locally.

1.2 National guidelines and communications issued continue to be logged through the Trust Incident Control Centre and or Clinical Reference Group. Action cards for staff guidance are updated to ensure we have responded in an evidence-based way to maintain the safety of patients, staff, volunteers and contractors.

1.3 The UK Health Security Agency (UKHSA) updated its UK IPC guidance in May 2022 with new Covid-19 pathogen specific advice for health and care professionals aligned with the National Infection Prevention and Control Manual (NIPCM) for England. This applies to all NHS settings or settings where NHS services are delivered. It is acknowledged that organisations will require a period of transition to make changes and adapt operating procedures given local variation in infection levels and risk assessment of settings including ventilation, spacing and mask wearing.

1.4 To support this transition a 'living with Covid-19' risk assessment tool was adapted organisations local risk assessment to support local decision-making regarding mask use and spacing as part of the rest and rebuild programme. This helped the trust to transition back to pre-pandemic visiting and introduce safe visiting guidance. We also introduced a new triage and screening template on systmOne and have moved from three (low, medium, high) Covid-19 patient pathways to respiratory and non-respiratory pathways to guide patient placement, IPC precautions and Personal Protective Equipment (PPE) for contact.

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

1.6 A task and finish group with a pilot test was set up to introduce Lateral Flow Device (LFD) for patient testing in place of PCR testing. This is supported in the national guidance. As an LFD is considered a medical device, a point of care testing policy and competencies for staff has been developed to support the process and governance requirements.

1.7 Between 1st April 2021 and 31st January 2022, LPT recorded 18 COVID -19 outbreaks, including incidents that occurred in non- clinical areas affecting staff only. 8 of the outbreaks occurred in Community Health Services and 10 occurred in Directorates of Mental Health, Families and Young People and Learning Disabilities Services.

1.8 <u>COVID-19 figures from 1st April 2021 – 31st January 2022:</u>

Total number of COVID-19 patient cases = 148

- Total number of COVID-19 cases 0-2 days = 13
- Total number of COVID-19 cases 3-7 days = 20
- Total number of COVID-19 probable nosocomial cases = 18
- Total number of COVID-19 definite nosocomial cases = 97

1.9 33 of the COVID-19 cases were attributed to community onset, picked up by screening. The remaining 115 cases are nosocomial.

1.10 Total number of COVID-19 staff cases = 996. Not all staff cases have been associated with outbreaks within the inpatient or community services. However, the impact on the workforce and the management of patients is reflected in these figures.

1.11 Learning identified as part of the outbreak reviews (included in the second aggregated review appendix 1) a further learning board included:

- Mask wearing by patients not documented, compliance or offer
- Testing of symptomatic patients delayed
- Extremely hard for some client groups to comply to isolation i.e., dementia patients documented evidence of this very good
- Social distancing between patients often difficult to achieve but staff have tried and documented
- Equipment not dedicated to positive patients only when could have been
- Storage in ward areas often limited meaning some cross contamination may have occurred
- BBE breaches continue despite large amount of education around topic – further training and Hand Hygiene audits continue
- Outbreaks have sometimes identified broken equipment e.g., dish washer, macerator that have been reported
- Patient swabbing generally good but often delays in receiving or reporting results
- Access to lab results - common delay
- Large amounts of asymptomatic cases.
- Facilities and domestics responded quickly when asked for deep cleans and enhanced cleaning to outbreak area
- Lack of therapy staff attendance at outbreak meetings
- Staff break areas often shared between areas which can lead to cross contamination
- LPT has a large number of old buildings not ideal for up-to-date IPC recommendations
- Some equipment on ward leading to cross contamination - continue to work with therapist to help minimise risk.
- Care plan usage for positive patients very poorly used

Overall outbreak meetings have been very positively received and support the management in a difficult period, often result with positive outcome to support the ward area.

2. Decontamination

2.1 During a review of the risk register, it was identified within Community Health Services that the risk regarding decontamination for Podiatry services, had not been recently reviewed. Decontamination compliance was audited in 2016 and then the actions had not been progressed. This was reported as a Serious Incident (SI), with an investigation carried out. The full report was completed in May 2022.

2.2 The scope of the SI was to look at the processes, audits and governance for podiatry held autoclave and washer disinfector machines servicing regimes and statutory pressure system testing. The investigation process reviewed the potential impact to patients and staff from a patient safety and quality perspective and to identify contributory factors and learning to ensure robust oversight of servicing, testing and auditing.

2.3 A number of recommendations and actions have been completed to rectify this position and a full and concise report submitted to Directorate Governance groups and Executive Directors and Trust Board members. These actions are monitored and updated by the service, escalations to CHS DMT

and exception reporting through the Quality Assurance Forum and Trust Board meetings. A number of actions to address the gaps in assurance were undertaken, these included:

- Task and finish group with weekly meetings set up and led by the Director of the Service
- Equipment service history reviewed and services undertaken
- Single use equipment used where decontamination was halted
- Audits carried out to identify any risks associated with the delivery of podiatry services
- An authorised Engineer for Decontamination was appointed, and a review was undertaken of the processes for decontamination used in podiatry services
- Decontamination group with quarterly meetings set up
- Decontamination policy and terms of reference under review (completion date Aug22)

3. Monkey pox (MPX)

3.1 Monkeypox is a rare disease that is caused by the monkeypox virus. Monkeypox is most commonly seen in central and west Africa but there has been a recent increase in cases in the UK as well as other parts of the world where it has not been seen before.

3.2 Monkeypox usually causes a mild illness that resolves without treatment and most people recover within a few weeks. However, severe illness can occur in some people. It is possible that young children, pregnant women and immunocompromised people are more at risk of becoming severely unwell than others.

3.3 Infection mainly spreads between people through direct (skin to skin) contact, including sexual contact, or close contact via particles containing the monkeypox virus. Infection can also be spread via contaminated objects such as linen and soft furnishings. The chance of catching the infection increases when there is close contact with an infected person who has monkeypox symptoms.

3.4 Monkeypox infection usually starts with symptoms such as fever, headache, muscle aches, backache, chills or exhaustion. This is followed by a rash a few days later that may start on the face, groin or hands, before spreading to the rest of the body. It starts as raised spots, which turn into small blisters filled with fluid (lesions). These blisters eventually form scabs which later fall off.

3.5 An individual with monkeypox is considered infectious from when their symptoms start, until their lesions have scabbed over, all the scabs have fallen off and a fresh layer of skin has formed underneath. This may take several weeks.

3.6 A number of meetings and actions have occurred over the last few weeks since the emergence of monkeypox as an infection in the UK. The following information outlines updates as of 20 June 2022

3.7 LPT response

- Staff communications sent out as updates received
- Action log commenced to support governance process and channel appropriate information
- Action card developed for community/inpatient staff as guidance for actions to be taken if a suspected case presents
- Action card developed for attendees at hospitals and healthcare
- Domestic staff identified for FFP3 training and is currently being provided by LPT to support UHL capacity

3.8 Midlands region meeting (East and West)

- Nationally cases up to 1400 with approximately 40 cases within East and West Midlands Region
- Most patients self-referring, identified as infectious prior to the rash developing which manages symptoms earlier and prevents cross contamination
- Majority of patients within the London or Southeast region
- Majority of those affected are men, with some women now testing positive.
- Patients mainly well and able to isolate at home
- A weekly update provided from UHSHA
- Consideration given to rename the infection to remove stigma
- Minimal association of mortality at the present time with the infection

4. Seasonal Flu vaccination programme – updated with figures from 22 March 2022

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

4.2 The flu vaccination programme runs between October and February every year. Last year the flu vaccination programme ran alongside the Covid-19 vaccination and booster programme.

4.3 The figures below identify the final position of the Trust for the uptake of the staff flu vaccine Winter 2021 / 2022

		Accurate to 22 March 2022	
		Influenza	
All staff	**No. staff**	**1 dose**	**Vaccine Uptake (%)**
Total	7393	4421	**59.8%**
Of which LPT staff	*6768*	*4082*	*60.3%*
Of which Workforce Bureau staff	*625*	*339*	*54.2%*
Staff with direct patient contact	5839	3440	**58.9%**
Of which LPT staff	*5229*	*3101*	*59.3%*
Of which Workforce Bureau staff	*610*	*339*	*55.6%*
Staff without direct patient contact	1554	981	**63.1%**
Of which LPT staff	*1539*	*975*	*63.5%*
Of which Workforce Bureau staff	*15*	*6*	*40%*

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

		Influenza	
Staff with direct patient contact by staff group (inc WFB) As reported to Public Health England each month	**No. staff**	**1 dose**	**Vaccine Uptake (%)**
Doctors	216	141	65.3%
Qualified Nurses, midwives and health visitors	2098	1362	64.9%
All other professionally qualified clinical staff	948	648	68.4%
Support to Clinical Staff	2320	1162	50.1%
Staff with direct patient contact	**5582**	**3313**	**59.4%**

4.5 The national average percentage seasonal influenza vaccine uptake for frontline healthcare workers – all NHS England Trusts 2021 to 2021 was 60.5%.

4.6 The seasonal flu vaccine for staff has been delivered using a multi-pronged approach to support flexibility and access opportunities for staff. The roving vaccinator team has predominantly delivered the staff flu vaccination programme. These clinics were at delivered in clinical settings and non-clinal environments to maximise uptake and opportunity. This programme of delivery was supported by peer vaccinators. Nationally there was a requirement to move to National Immunisation Vaccination System (NIVS) as the recording process which does not have a booking element, so clinics were all 'walk-in'. The opportunity to have the flu vaccination and the Covid booster at the same time has also been provided through the LPT and UHL Hospital Hubs.

4.7 The table below outlines the FHCW uptake by directorate teams up the 22 March 2022.

By Directorate

		Influenza	
Directorate	**No. staff**	**1 dose**	**Vaccine Uptake (%)**
Bank	1077	491	45.6%
CHS	1713	1149	67.1%
Enabling Services	581	390	67.1%
FYPC.LD	1572	993	63.2%
Hosted Services	220	131	59.5%
Mental Health Services	1605	928	57.8%
Workforce Bureau	625	339	54.2%
TOTAL	**7393**	**4421**	**59.8%**

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

4.9 Reasons for higher vaccination uptake triangulated with national data include key influencers within teams, committed leadership to the flu programme, flexibility and availability of flu clinics across LPT sites and a strong roving and peer vaccinator team.

4.10 Analysis of the reasons for not having the flu vaccine reported by staff are: too many vaccines in the previous 12 months (many staff have had x3 COVID vaccinations), low levels of circulating flu in the community and therefore not seen as a personal risk, lack of availability of a vegetarian/ vegan flu vaccine, concerns about allergies and therefore reluctance to have another vaccine and that flu is seen as having more serious consequences for older people and this is reflected in the age correlation of the flu vaccine uptake (lowest in the age group 18 – 30 and highest in the 65+ age group).

5. Reporting and monitoring of HCAI Infections

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

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

5.2 MRSA Blood stream infection rates

The national trajectory is set at zero. The Trust performance for MRSA bacteraemia from April 2021 to March 2022 is zero.

5.3 Clostridium difficile infection (CDI) rates

The agreed trajectory for 2021/22 was 12 and is set internally by the Clinical Commissioning Group (CCG) (identified as EIA toxin positive CDI). There have been 11 cases of health care associated infection of CDI between April 2021 and March 2022. This slight increase reflects the national picture

- July 2021 – St Lukes, Ward 3
- September 2021 – Evington Centre, Beechwood Ward
  September 2021– Loughborough Hospital, Swithland Ward
- October2021 – Melton Hospital, Dalgleish Ward
- December 2021 – St Lukes, Ward 3
- December 2021 – Hinckley & Bosworth, North Ward
- January 2022 – Hinckley & Bosworth, East Ward
- February 2022 – Evington Centre, Clarendon Ward
- February 2022 – Evington Centre, Clarendon Ward
- February 2022 – Bennion Centre, Langley Ward
- March 2022 – Loughborough Hospital, Swithland Ward

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

5.5 **MSSA Blood stream infection rates**

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

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

In 2017 the Secretary of State for Health launched an important ambition to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021 and reduce inappropriate antimicrobial prescribing by 50% by 2021. Furthermore, the NHS Long Term Plan supports a 50% reduction in Gram-negative bloodstream infections (GNBSIs) by 2024/25. To help NHS systems achieve this, NHS England have developed a GNBSI reduction toolkit: a collection of guidance notes, actions and resources to support reducing GNBSI.

From April 2018 the Gram-Negative Bloodstream Infection rates include:

- E-Coli
- Klebsiella pneumonia
- Pseudomonas aeruginosa

5.7 There is no Trust trajectory for GNBSI, however monthly data for this infection rate is submitted to the Clinical Quality Report Group (CQRG) as part of the quality schedule reporting (Please note this captures E-Coli infection rates only).

5.8 Due to the pandemic a number of planned workstreams to look at improving the reduction in rates had halted, work is now underway to re-establish the working groups.

6. Ventilation

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

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

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

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

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

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

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

7. Water Management

7.1 The water safety group (WSG) continue to meet on a quarterly basis. The governance of the group is identified in the terms of reference, with an updated water safety group policy and water safety plan in place. The membership of the group has been independently confirmed by the Authorised Engineer for the trust (Hydrop).

7.2 Responsible person training identified within the water safety policy has been completed by the relevant staff employed within LPT and UHL. Further training is being undertaken by UHL estates staff and the water safety group have requested updates for each quarter.

7.3 Overall water compliance has steadily improved, but there remains a number of key areas the WSG continue to focus on with UHL required to rectify these issues. Those included with a level of improvement have been.

- work by the WSG and monthly Water meetings with UHL to improve the visibility of data, enabling the direction of tasks to be focused.
- Access to the system that holds the data for LPT has allowed scrutiny of Planned Preventative Maintenance (PPM) work, and therefore being able to identify. Overall data capture and compliance level is steadily improving.
- 99% of Trust water risk assessments are complete. Actions from the assessments are currently situated with UHL to complete.
- Coalville Community Hospital actions associated with the legionella outbreak have been completed with actions for the Bradgate Unit complete
- Monthly LPT/UHL Water Safety Action tracker meetings have created a report with clear responsibilities assigned to tasks, as they emerge, e.g., flushing, sampling, remedial actions to issues.

7.4 LPT has not undertaken water risk assessments previously. An action to survey all sites is near completion to support this further work. A task and finish group has been established and will focus on the prioritisation of the actions in the risk assessments, with an external company assigned to high-risk priorities.

8. Hand hygiene

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

8.2 Q3 returned an average total of 811 hand hygiene audits and Q4 increased to an average of 859. Therefore, audits being completed remain under the expected average. A possible factor of this may be an issue which arose with inputting audits onto the hand hygiene app and the delay in reporting. Analysis and feedback have also shown that completion of audits has been impacted by changes to link IPC staff, staff working from home and staffing challenges affecting time to audit and input.

8.3 The graph indicates that on average, the number of hand hygiene audits being completed is considerably below the expected target of 909. Taking into consideration the possible factors outlined above, work continues to try to improve the number of audits being completed. For any newly identified IPC links, a team's meeting is offered to provide support on how to complete and input audits onto the hand hygiene app.

8.4 Hand hygiene audit reports are accessible via Staffnet. These are updated and uploaded onto Staffnet weekly. A draft monthly report has also been created by the information team which is going to the IPC Assurance Group for sign off in June 2022. Moving forwards, this report will be circulated monthly to the team leads. These reports will enable directorates to address any areas of concern.

8.5 There has been sustained compliance performance in terms of practice and results of the audits during Q3 & Q4, showing an average of 99%.

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

9. Cleaning

9.1 Cleaning audit outcomes are reported monthly through the Trust IPC Group. Exceptions are highlighted with mitigation and actions to remedy included in the report. Work continues to ensure clinical leaders are present at the time of the audits to confirm and challenge. Cleaning

services have been identified as an organisational risk which is reviewed at every IPC group meeting. Remedial actions have been put into place with a detailed improvement plan.

9.2 In line with the national recommendations, during Covid-19 peaks, two hourly touch point cleaning was implemented within inpatient areas. This process supported the reduction in outbreaks of infection, with specific reference to Covid-19. This process has been documented and audited to provide assurance. This action has since been reduced and is applicable in outbreak areas only.

9.3 A business case was developed, and a rapid response cleaning team was operationalised for supporting the introduction of a third clean in inpatient areas as well as a quick response to outbreak/cleaning requirements.

9.4 Cleaners rooms and equipment are audited monthly as part of the management audit undertaken by the Soft FM team.

9.5 The Trust has a twelve-month rolling deep clean programme in place and progress is monitored at the IPC Group.

9.6 A monthly facilities forum in place.

9.7 The National Standards for Healthcare Cleanliness 2021 has been implemented. Charters signed by the CEO and Chair are currently being produced for display in all areas of the Trust.

10. Antimicrobial stewardship

10.1 'Antimicrobial stewardship remains a vital tool in the fight against resistance and preserving the usefulness of antimicrobials so that they benefit patients who really need them.

10.2 The lead pharmacist for antimicrobial stewardship continues to oversee the maintenance of the actions and controls within the trust policy. This includes careful consideration of stock lists for inpatient wards, bi-annual audit, education and training and prescribing protocols.

10.3 Antimicrobial surveillance is a useful tool to monitor consumption. A sophisticated dataset has been developed to monitor trends in consumption across inpatient areas, with quarterly reports being fed into Medicines Management Committee and [pls insert the IPC meeting name].

10.4 The lead pharmacist for antimicrobial stewardship also continues to represent LPT in Leicestershire-wide groups.'

Proposal

This report outlines assurance from the Trust DIPaC demonstrating compliance with the Health and Social Care Act 2008. The report also highlights the impact of the COVID-19 pandemic to the business as usual IPC work programme and quality improvement in response to NHSE & I IPC visits.

Decision required

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

Governance table

For Board and Board Committees:	Trust Board 26.7.22	
Paper sponsored by:	Anne Scott – Executive Director of Nursing, AHP and Quality	
Paper authored by:	Amanda Hemsley – Lead Infection Prevention and Control Nurse	
Date submitted:	9.12.21	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Direct to trust board	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	6 monthly reports	
STEP up to GREAT strategic alignment*:	High **S**tandards	x
	Transformation	
	Environments	x
	Patient Involvement	
	Well **G**overned	x
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trustwide Quality Improvement	x
Organisational Risk Register considerations:	List risk number and title of risk	5
Is the decision required consistent with LPT's risk appetite?	Yes	
False and misleading information (FOMI) considerations:	Yes	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:		

Paper Q – appendix 1

Leicestershire Partnership NHS Trust

Report to: Infection Prevention and Control Group

From:	Amanda Hemsley – Head of Infection Prevention and Control, Laura Brown Senior IPC Nurse, Clarissa Swann IPC Nurse, Claire King IPC Nurse, Eden Miller IPC Admin Assistant Emma Wallis AD Nursing / Deputy Director IPC Dr Anne Scott Executive Director of Nursing and Quality and DIPAC
Date:	27 April 2022
Subject:	Aggregated LPT SARS CoV-2 Outbreak Report

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1. INTRODUCTION

Guidance issued to all NHS Trusts from National Health Service England and Improvement (NHSE/I) on 9 June 2020 required all NHS organisations to instigate formal outbreak management processes where outbreaks of SARS-CoV-2 were identified.

In the event of a COVID-19 outbreak, NHS organisations were to follow existing Public Health England guidance on defining and managing communicable disease outbreaks https://www.gov.uk/government/publications/communicable-disease-outbreak-management- operational-guidance

The purpose of this report is to provide an aggregated review of outbreaks and nosocomial infections between 1st April 2021 and 31st January 2022 within Leicestershire Partnership NHS Trust (LPT). This has also supported interpretation of the data, lessons identified for learning across the Trust and maintaining patient safety.

2. LPT OUTBREAK MANAGEMENT PROCESS

UK Health Security Agency UK HAS (formally Public Health England) Guidance defines an outbreak as the following:
two or more cases in a single setting (for example, in a single ward or having shared a location) that have become symptomatic or detected on screening on or after day eight of hospital admission.

This report follows the same processes and references the following documents as previous document submissions:

- A comprehensive policy with guidance, process and systems for management and associated documents were developed by the Infection Prevention and Control Team (IPCT).
- A toolkit based on UKHSA guidance adapted by the IPCT.
- Senior Clinical Leadership presence at all outbreak meetings was provided by the Executive Director of Nursing, AHP's and Quality – Director for Infection Prevention and Control (DIPaC), Associate Director of Nursing and Professional Practice –

Deputy Director of Infection Prevention and Control or the Head of Infection Prevention and Control

- Meetings (Monday – Friday) were held for each directorate to review the outbreak, associated actions and items for escalation as required.
- A weekly meeting chaired by the DIPaC or DDIPaC took place, membership included colleagues from NHSEI, PHE and the CCG. The IIMarch sitrep was completed as per NHSE/I guidance.
- Minutes and action logs recorded.
- Development of learning boards to reflect the changes and learning from the outbreaks that incorporated local and national learning using a human factors approach. (Appendix 1).

3. MANAGING HEALTHCARE ASSOCIATED COVID-19 CASES

The Infection Prevention and Control Team created a reporting system that enabled a process by which COVID-19 patient infection numbers could be reviewed and analysed on a daily basis according to the nationally defined criteria.

The definitions of apportionment of COVID-19 in respect of patients diagnosed within hospitals are as follows (NHSEI CNO Letter (Ref No 001559) 19 May 2020):]

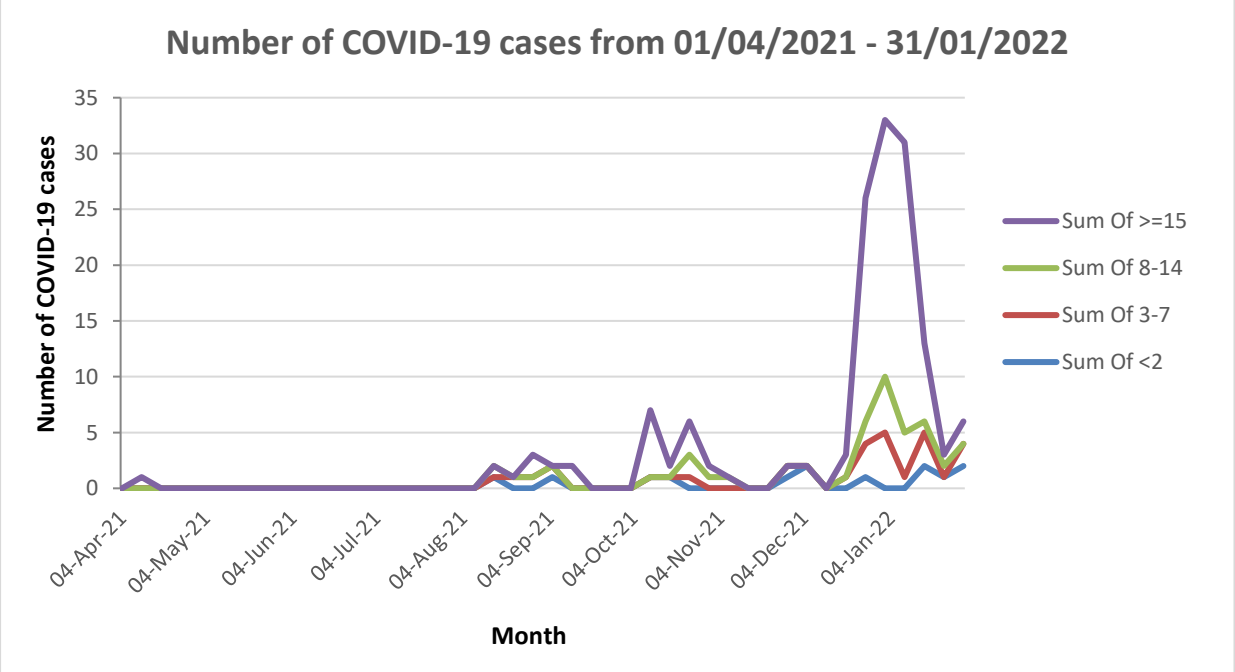
Community-Onset *(CO) - positive specimen date <=2 days after hospital admission or hospital attendance.*

Hospital-Onset Indeterminate Healthcare-Associated *(HO. iHA) - positive specimen date 3-7 days after hospital admission.*

Hospital-Onset Probable Healthcare-Associated *(HO. pHA) - positive specimen date 8-14 days after hospital admission.*

Hospital-Onset Definite Healthcare-Associated *(HO. dHA) - positive specimen date 15 or more days after hospital admission.*

The following chart identifies the number of cases in LPT inpatient services:



All Trusts were also requested to undertake root cause analyses (RCAs) for every 'definite' healthcare associated COVID-19 inpatient infection. LPT instigated a process and RCA tool the Infection Prevention and Control Team completed these to support the reporting process. Future reviews will require the support of the inpatient areas for completion.

Currently where enhanced surveillance reports are required for reviews into patient deaths associated with COVID-19, they form the starting point for further clinical and patient management investigation. A process map was developed to support this process. Appendix 2.

Across Leicester, Leicestershire and Rutland (LLR), all organisations providing NHS services met on a weekly basis to discuss the local infection status and share any key learning points. As of 1st March 2022, these meetings have been scheduled bi-weekly due to lower COVID-19 figures. During the end of March 2022, the infection rates for covid have increased significantly both in the wider community and within LPT inpatient areas. Outbreak meetings are held as required need which can result in daily meetings.

4. LPT OUTBREAKS

LPT provides a wide range of services across LLR which includes inpatient services for Adult Mental Health, Mental Health Services for Older People (MHSOP), Children and Adolescent Mental Health Services (CAMHS) and Community Health Services.

Between 1st April 2021 and 31st January 2022, LPT recorded 18 COVID -19 outbreaks, including incidents that occurred in non- clinical areas affecting staff only. 8 of the outbreaks occurred in Community Health Services and 10 occurred in the Mental Health Services.

<u>COVID-19 figures from 1st April 2021 – 31st January 2022:</u>

Total number of COVID-19 patient cases = 148

- Total number of COVID-19 cases 0-2 days = 13
- Total number of COVID-19 cases 3-7 days = 20
- Total number of COVID-19 probable nosocomial cases = 18
- Total number of COVID-19 definite nosocomial cases = 97

33 of the COVID-19 cases were attributed to community onset, picked up by screening. The remaining 115 cases are nosocomial.

Total number of COVID-19 staff cases = 996

Not all staff cases have been associated with outbreaks within the inpatient or community services. However, the impact on the workforce and the management of patients is reflected in these figures.

Community Health Services

Community Health Services reported 8 out of the 18 outbreaks identified, with reviews and learning identifying potential causes listed below:

- Lack of single rooms with ensuite facilities, resulting in cohorting patients.
- Patient placement – previous learning from the last aggregated review has

informed the process of admission and where patients are placed (i.e., where possible new admissions with potential infectious status unknown, would not be placed next to a patient who had been in the facility for a number of days, which supported the reduction in nosocomial reported infections,
- A number of the buildings are part of an old estate with fixtures and fittings that pre-date a number of the recent IPC requirements for a built environment in healthcare.
- PPE compliance with staff groups.
- Sharing break times and not adhering to social distancing.
- Delays in receiving patient swab results, either through delays from the laboratory or delays in staff reviewing results.
- Patients not being offered a Fluid Resistant Surgical Face Mask – not being documented within the patient record
- Staff socialising outside of work together over the Christmas period, which resulted in a significant outbreak on one ward, findings identified the Christmas party was the potential link.
- Admission swabbing protocol not being followed
- Lack of clear documentation of when patients are put into Source Isolation Precautions (SIPs)
- Lack of information around care planning for patients

Mental Health Services

Mental Health Services reported 10 of the 18 outbreaks identified, with reviews and learning identifying potential causes listed below:

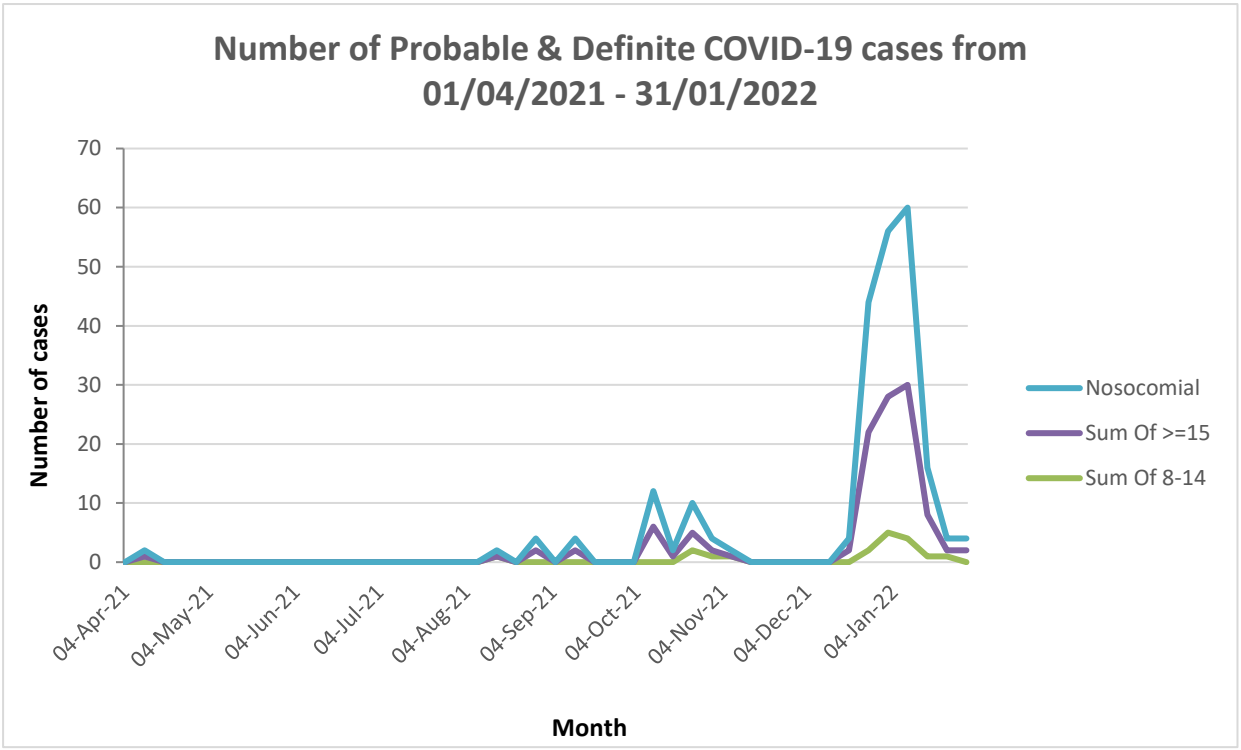
- Lack of single rooms for patients, noted significant number of dormitories with multi-occupancy room, and therefore socialising without the ability to distance was common.
- A number of the buildings are part of old estate with fixtures and fittings that pre-date a number of the recent IPC requirements for healthcare environments.
- A number of patients declined/refused to be swabbed for COVID-19 and also to isolate within their room.
- PPE compliance within some staff groups at various times.
- Sharing break times and not adhering to social distancing.
- Staff not being Bare Below the Elbows, which included the wearing or rings, watches, fitness trackers and long sleeves.
- Delays in receiving patient swab results.
- Staff not identifying patient swab results within a timely manner.
- Patients not being offered a Fluid Resistant Surgical Mask – not being documented within the patient record
- Staff not carrying out LFT prior to attending the workplace, with symptoms prior to starting work.
- Staff attending the workplace whilst awaiting a PCR result and did not inform their manager at the time.
- Development of new patient symptoms which were indicative of COVID-19 and not acted upon for a significant number of days i.e.) SIPs not put into place
- Decontamination of equipment not undertaken between patient use within a COVID red areas
- Admission swabbing protocol not being followed
- Lack of clear documentation of when patients are put into Source Isolation Precautions (SIPs)

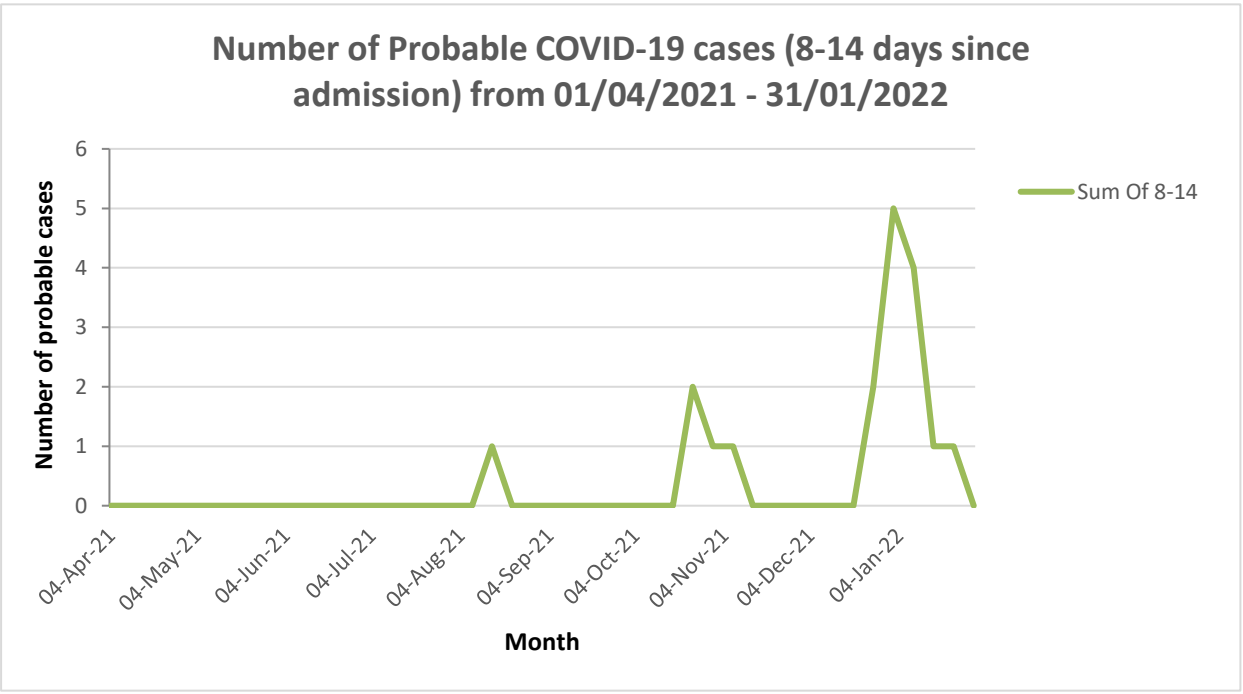
- Lack of information around care planning for patients
- Adherence to cleaning schedules and the appropriate documentation
- Large number of patients having unescorted leave – staff unable to know about PPE compliance

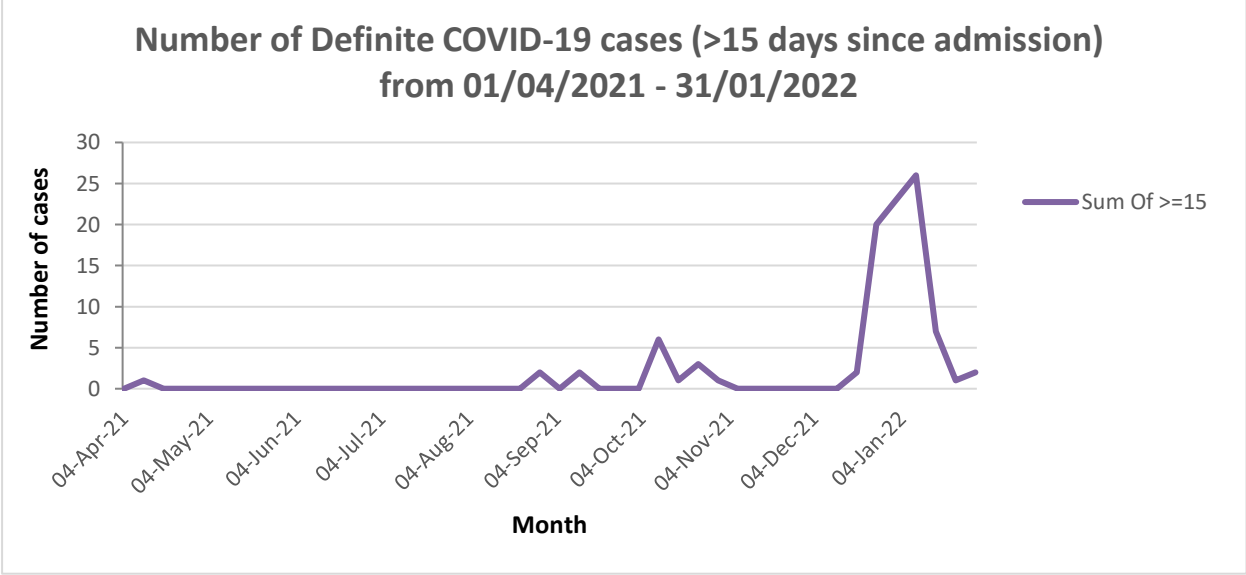
The following charts show the daily number of COVID-19 cases. Data was gathered for the earlier months using a look back exercise. The figures for the months of December, January and February reflect the second wave of COVID-19 infections and the cases of Covid-19 within the geographical areas across LLR. The majority of the nosocomial cases are linked to the increased incidences and outbreaks.

Generic learning across all areas

- Mask wearing by patients not documented, compliance or offer
- Testing of symptomatic patients delayed
- Extremely hard for some client groups to comply to isolation i.e., dementia patients documented evidence of this very good
- Social distancing between patients often difficult to achieve but staff have tried and documented this
- Equipment has not been dedicated to positive patients only when could have been
- Storage in ward areas often limited meaning some cross contamination may have occurred
- BBE breaches continue despite large amount of education around topic – further training to be ongoing Hand Hygiene audits continue
- Outbreaks have sometimes identified broken equipment e.g., dish washer, macerator that have been reported but long waits for repairs or replacement.
- Patient swabbing generally good but often delays in receiving or reporting results
- Access to lab results is a common delay
- Large amounts of asymptomatic cases.
- Facilities and domestics have responded quickly when asked for deep cleans and enhanced cleaning to outbreak area
- Therapy attendance at outbreak meetings has been low
- Staff break areas are often shared between areas which can lead to cross contamination
- LPT has a large number of old buildings not ideal for up-to-date IPC recommendations.
- A lot of therapy equipment is often around the ward leading to cross contamination. This includes activity IPC continue to work with therapist to help minimise risk.
- Care plan usage for positive patients very poorly used.
- Outbreak meetings have been very positively received and help to manage the areas through this stressful time, they have often sped up repairs and given the ward areas an area to ask for help.


Number of Probable & Definite COVID-19 cases from 01/04/2021 - 31/01/2022
Number of cases
70
60
50
40
30
20
10
0
04-Apr-21
04-May-21
04-Jun-21
04-Jul-21
04-Aug-21
04-Sep-21
04-Oct-21
04-Nov-21
04-Dec-21
04-Jan-22
Month
Nosocomial
Sum Of >=15
Sum Of 8-14


Number of Probable COVID-19 cases (8-14 days since admission) from 01/04/2021 - 31/01/2022
Number of probable cases
6
5
4
3
2
1
0
04-Apr-21
04-May-21
04-Jun-21
04-Jul-21
04-Aug-21
04-Sep-21
04-Oct-21
04-Nov-21
04-Dec-21
04-Jan-22
Month
Sum Of 8-14


Number of Definite COVID-19 cases (>15 days since admission) from 01/04/2021 - 31/01/2022
Number of cases
30
25
20
15
10
5
0
04-Apr-21
04-May-21
04-Jun-21
04-Jul-21
04-Aug-21
04-Sep-21
04-Oct-21
04-Nov-21
04-Dec-21
04-Jan-22
Month
Sum Of >=15

Asymptomatic carriage of COVID-19 continues to be a national priority to understand and investigate and the role this has for both patients and staff in the potential for cross infection. Where asymptomatic carriage was detected in either staff or patients in the identified outbreaks within LPT, immediate action was taken to either isolate patients and screen any contact patients or ensure staff did not come to work and isolated for the required time period. Where such instances were identified as part of an outbreak situation, this was documented, monitored and managed as part of the outbreak control process.

5. LEARNING FROM LPT OUTBREAKS

Aggregated learning from LPT outbreaks was disseminated across the Trust as part of shared learning using the platform of learning boards (Appendix 1 – Learning Board No 2 The key actions are set out below, listing both the concern and the advice from the Infection Prevention and Control team.

Action Cards have been reviewed as new guidance has been issued, with a governance process of agreement and sign off from the Clinical Reference Group (CRG), shared in the weekly Trust communications for all staff. A designated folder on the staff intranet was also developed for all COVID-19 processes and a sub-folder for action cards was included.

Car sharing

Concern: Car-sharing identified as potential risk for staff-to-staff transmission.

Findings – Staff had travelled together, who lived separately but were related. FRSM's not worn during the travel time

Administration/Office areas

Concern: Staff-to-staff transmission linked to close contact without PPE in non-clinical areas.

Findings

- The maximum occupancy posters developed as part of the covid secure risk assessment had been removed, and larger gatherings of staff occurred
- Staff were not following the COVID-19 secure risk assessments

Ventilation

Concern: The large majority of clinical areas in LPT rely on windows for ventilation, and in a number of areas, the use of fans for cooling of the environment. However, with a significant number of LPT services providing services for staff with mental health requirements as well as the national concerns raised by HSE prior to the pandemic around patient safety, window restrictors are in place throughout a number of the inpatient areas within LPT. This limits the volume of fresh air that can enter clinical areas and raises the concern that low numbers of air changes may lead to a build-up of infectious airborne viral load.

- The ventilation group has since been developed to identify any issues and actions within the trust

Response - If tolerated and safe to do so wards were asked to institute a programme of opening windows for short, sharp bursts of 10 to 15 minutes regularly throughout the day.

The SAGE - Environmental and Modelling Group describes that being in a room with fresh air can reduce the risk of infectionfrom COVID-19 particles by over 70%.

Work related group gatherings (including patient management reviews)
Concern: Some staff considered mask use to remove the need for social distancing. Staff attended a large Christmas celebration and gathering outside of work hours which was aligned to the cause of an outbreak

Response - Staff were reminded that breaches of social distancing during staff breaks and staff meetings have been linked to healthcare associated outbreaks and asked to reflect on practices to support future learning and understanding. Ensure distancing measures are maintained at all times as well as wearing a Fluid-Repellent (Type IIR) Surgical Mask (FRSM).

Breaks
Concern: Break times require staff to remove their mask in order to eat and drink. Break rooms are frequently small and limit options for social distancing.

Response - Advice was given to control access to break and rest rooms. Ensure robust hand hygiene pre and post access Ensure environmental cleaning is undertaken and a new Fluid-Repellent (Type IIR) Surgical Mask (FRSM) applied when break finished. Open windows for increased ventilation where possible.

Patient Screening
Concern – LPT policy is for all admissions to be screened for COVID-19 infection at or before admission and negative patients to be re-screened on days 0, 3, 5, 7, of admission and at 7-day intervals thereafter. Initially patients were not always screened in a timely manner to identify COVID-19, however through the course of the pandemic this improved significantly.

Response – An action card was developed and periodic reminders both at a local inpatient area level and via the trust communications process to carry out screening in line with policy were communicated.

Patient Placement
Concern – A review of the patients who developed Covid-19 a number of days after they had been admitted to an inpatient area identified a risk of cross contamination, from more recent admissions.

Response – A review of admissions and development of a safe operating procedure (SOP) was put into place to prevent new admissions (waiting for Covid-19 test results) being placed next to patients who have been an inpatient for a number of days. This was adhered to where possible, however bed capacity and a minimal number of single rooms to source isolate patients.

Compliance with national policy and guidelines
Concern – National policy and guidelines around infection prevention evolved during the pandemic and posed the risk that LPT was non-compliant.

Response – The LPT IPC team reviewed all national policy and guidance as soon as it was available and took all efforts to ensure LPT local guidance at last matched national guidancein terms of staff and patient safety. On many occasions, LPT practice exceeded national standards,for example, LPT supported and increased level of respiratory

protection (use of FFP3 respiratory face masks) for practices such as Nasogastric tube insertion and deep oral suctioning, supported by the specialist teams, but not advised within the national guidance at that beginning of the pandemic.

7. THE NATIONAL CONTEXT – underlying issues

The COVID-19 pandemic has been a challenge to infection prevention across the NHS. While there is still lack of clarity about the relative importance of droplet versus aerosol in thetransmission of SARS-CoV-2, it is clear that rapid identification and isolation of infectious patients is key to interrupting transmission in healthcare settings.

The problem faced by healthcare organisations was the lack of a plentiful supply of rapid, accurate diagnostic tests that could detect COVID-19 in emergency admission patients in Adult Mental Health Services and admissions within community services. The Cepheid SARS-CoV-2 polymerase chain reaction (PCR) test is the best test but was limited in the initial stages of the pandemic due to the provision of this service and limited number of tests across LLR.

If patients could be isolated in single rooms pending the results of investigations, longer turnaround time tests would have sufficed. However, the large majority of inpatient services in England do not have a sufficient number of single rooms in which to isolate patients, leading to the situation where patients with unknown Covid-19 status may be placed in a bay or open ward, leading to the significant risk of cross-infection.

Of the single occupancy rooms within LPT, very few have en-suite bathroom facilities. Some have a toilet and handwash basin but no shower. The impact of this is that patients who have been identified as being infectious have to leave their rooms to use communal toilet and shower facilities. During outbreaks, cleaning services did aim to provide a dedicated domestic to the ward each day to clean the communal shower and toilet facilities after each use. However, it was quickly identified that the Estates and Facilities Service was not resourced to enable this on all the wards at all required times

Single rooms within our Adult Mental Health Services in LPT are disproportionate, with the patient group potentially at significant associated risks of harm. The development of a high (red) pathway admission ward was implemented within the Mental Health Services for Adults, to try to reduce admissions to a large number of different areas (status unknown) and contain where possible the risk of cross contamination.

A further complication is the variable length of incubation time of Covid-19, ranging from 1- 14 days. This means that patients may be admitted with a non-Covid condition but be incubating infection that only emerges later on in the admission, again posing the risk of cross-infection. This was the reason for the repeated screening described above.

Concerns have been expressed nationally about the risk posed to patients by infected but asymptomatic staff. The level of risk posed by such staff is not known but is likely to be low, partly because few or no symptoms may correlate with a low viral load and infectivity and also because staff have been wearing respiratory protection that not only limits their infection risk but also acts as a barrier to transmission to patients. Additionally, LPT patient-facing staff are asked to carry out regular lateral flow testing in line with nationalguidance, thereby identifying infected staff with no or minimal symptoms.

8. CONCLUSION

LPT staff have followed and continue to practice well in order to maintain good Infection Prevention and Control practices.

Old retained estate can now be viewed as a potential factor in determining risk of cross infection for patients where a viral organism is the causative agent. Even when there are no lapses in care identified, it is impossible to prevent the spread of organisms in these types of environments.

Lack of sufficient numbers of accurate diagnostic tests contributed to the delays experiencedwith patient flow through the organisation.

Patient placement and the level of Covid-19 infection within the wider community were also thought to play a significant part in particularly in the 2nd wave of the spread of infection in the months of December 2020, January and February 2021.

Where there were compliance issues identified from a staff perspective with Covid-19 guidelines, senior leadership attention was paid to this via the Outbreak Committee at the planned meetings. Relevant communication was distributed across the organisation by the Communication Team at daily Covid-19 all staff briefings, Tactical and Strategic Command meetings and a weekly Infection Prevention and Control Outbreak meeting established as part of the Command-and-Control structure. All Clinical Management Groups were represented on the meetings.

NB: Data and graphs provided by Andy Knock – Infection Prevention and Control Nurse and Eden Miller – Infection Prevention and Control Administrator

Appendix 1

Learning from our Covid outbreaks

NHS
Leicestershire Partnership
NHS Trust

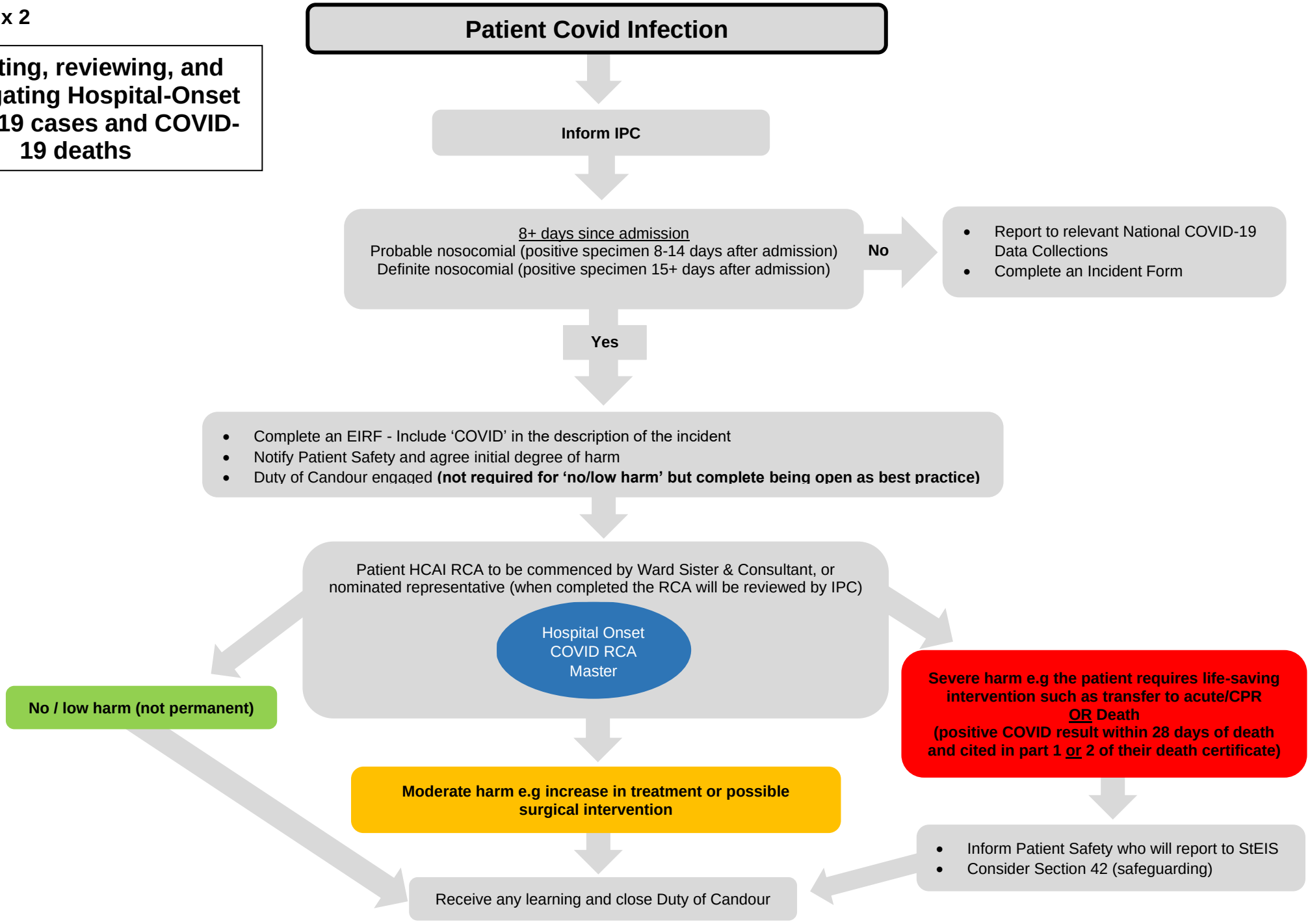
Covid StaffNet page: https://bit.ly/39A6O0W

Key learning findings	What we have done
Staff are not always maintaining social distancing of 2 metres during work time when able and appropriate to do so.	Development of a communications campaign linked with well known pop music including the messages don't stand so close to me.
Delays in accessing laboratory swabbing results has potentially increased the risk of patients becoming infected with Covid from another patient, due to the management of the infection being delayed.	Staff have been made aware of the importance of following up test results in a timely manner. Buddy systems developed with adjacent inpatient areas, to increase access to the laboratory system.
Patients are not always placed into source isolation in a timely manner, and thereby increases the potential risk of cross contamination and infection to others.	Patient placement and source isolation requirements were key agenda items on the daily outbreak meetings, and discussed as a learning action to promote Infection Prevention and Control requirements.
Reviewing potential causes of outbreaks has identified that a number of a number of staff had continued to take their breaks with staff from other ward areas. This included therapy staff. Learning from outbreaks is initially shared at the outbreak meetings, however it was noted that the meetings did not included attendance by a therapy lead or representative (to share that learning)	Therapy leads added to the membership of the outbreak meetings. This supported sharing of minutes, updates, and learning for the wider allied health professional teams. Designated break areas for staff working on a ward with an outbreak identified, to prevent shared areas with staff from non-outbreak wards.
On a number of occasions, the infection prevention and control team have not been informed of staff or patients who have tested positive for Covid as it occurred, and has been picked up once an apparent outbreak was being investigated.	Communications campaign included a number of ways in which staff could contact the Infection Prevention and Control team - Infection Prevention and Control generic email, telephone numbers, task allocation via SystmOne and incident reporting.
Through our audits and outbreak meetings we have learnt that assessment and documentation of patient mask use and risk is not consistently documented or embedded in practice.	Key processes included in the action card to support the process of providing and documenting masks for patient use. A poster for patient about wearing a mask. Communication campaign and auditing regularly, as well as a key indicator at every outbreak meeting.

Version 4 - 06.04.2022

Appendix 2

Reporting, reviewing, and investigating Hospital-Onset COVID-19 cases and COVID-19 deaths



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Leicestershire Partnership NHS Trust

Trust Board –26th July 2022

Same Sex Accommodation Annual report (including annual declaration of compliance)

Purpose of the report

The purpose of this report is to provide the Trust Board with a summary of the Trust position for the financial year 2021/2022, in regard to compliance with NHS England and Improvement (NHSE& I) requirements to eliminate Mixed Sex Accommodation (MSA) breaches within all inpatient areas; including compliance with national 'Delivering same-sex accommodation' guidance. The report sets out definitions for reporting a breach and in addition the impact of Covid-19 to national reporting and system requirements. The Trust has an annual requirement to declare and publish compliance with delivering same sex accommodation; this is included as an appendix to the report.

Background

Why is same sex accommodation important?

Every patient has the right to receive high quality care that is safe and effective and respects their privacy and dignity. Providers are expected to have a zero-tolerance approach to mixed-sex accommodation, except where it is in the overall best interest of all patients affected. A mixed-sex accommodation breach occurs at the point a patient is admitted to mixed-sex accommodation outside the guidance:

- Patients should not normally have to share sleeping accommodation with members of the opposite sex.
- Patients should not have to share toilet or bathroom facilities with members of the opposite sex.
- Patients should not have to walk through an area occupied by patients of the opposite sex to reach toilets or bathrooms; this excludes corridors.
- Women-only day rooms should be provided in mental health inpatient units.

Male and female corridors

Patients may on rare occasions be admitted into single, en suite bedrooms in areas occupied by the opposite sex when no bedroom is immediately available in the appropriate area. This will only be done following discussion with the patient and with safeguards in place, including 1:1 nursing care whilst a more appropriate bed is found. These incidents are reported internally as privacy and dignity breaches.

Reporting

There are times when the need to urgently admit and treat a patient can override the need for complete segregation of sexes with some clinical circumstances where mixing can be

justified. These are few, and mainly confined to patients who need highly specialised care, such as that delivered in critical care units. An unjustified breach is where mixing occurs that cannot be clinically justified. Local reporting should include:
• all toilet and bathroom breaches
• an additional requirement for mental health inpatient units in relation to the availability of same-sex day space for women who use services
• all cases of justified and unjustified breaches of sleeping accommodation in each 24-hour period, regardless of whether it is the same occurrence of mixing.

The Trust continued to review and report all incidents in line with national guidance throughout the pandemic and between April 2021 and March 2022. There was one reported justified breach in August 2021 in line with national guidance and definition:

The joint admission of couples or family groups may be a justifiable breach if it is in the overall best interest of the patient and the patients have expressed a preference for sharing and this consent is recorded.

A couple married for over sixty years requested to be able to share accommodation whilst both in-patients on East Ward Hinckley. Actions taken to support this request were:

- Patient request and decision documented clearly in clinical records, both patients had capacity to make this decision.
- Patient individual care plans updated to reflect wishes.
- Both patients were placed in a large room with en-suite facilities.
- There was no impact to other Ward patient's privacy and dignity or SSA.
- Escalated to the Executive team, compliance team and reported to the CCG and CQC.

Proposal

The guidance also includes information on same-sex accommodation in relation to individuals who identify as transgender. Individuals who are undergoing gender reassignment or who identify as transgendered are considered a protected characteristic under the Equality Act 2010. The guidance sets clarification on how transgendered patients should be supported including gender variant children and young people. The Trust policy is under review and will be updated to reflect the national guidance with patient involvement.

The justified mixed sex accommodation breach in 2021/2022 supports the annual declaration as outlined in appendix 1.

Decision required

Trust Board is asked to:

- be assured that internal processes are in place to monitor and report MSA breaches
- gain insight into the MSA guidance for individuals who identify as transgender and gender variant children and intended work to review the policy
- approve the declaration of commitment to deliver single sex accommodation

Appendix 1

Leicestershire Partnership NHS Trust

Declaration of Compliance – June 2022

Leicestershire Partnership NHS Trust is committed to providing every patient with same sex accommodation as it helps to safeguard their privacy and dignity when they are often at their most vulnerable. The only exception to this is when it is in the patients overall best interests or reflects their personal choice.

Why is same sex accommodation important?

Every patient has the right to receive high quality care that is safe and effective and respects their privacy and dignity. We are committed to ensuring that patients' privacy and dignity is maintained at Leicestershire Partnership Trust. The Trust continues to report all incidents in line with NHS England and NHS Improvements 'Delivering same-sex accommodation' guidance. The guidance states patients must not;

- Share sleeping accommodation with members of the opposite sex
- Share toilet or bathroom facilities with members of the opposite sex
- Walk through an area occupied by patients of the opposite sex to reach toilets or bathrooms; this excludes corridors
- In addition women-only day rooms should be provided in mental health inpatient Units

Reporting

Compliance of same sex accommodation is monitored and reported internally to the Trust Quality Forum and externally by our commissioners. In 2021/2022 there was one clinically justified mixed sex accommodation breach in line with the guidance.

We will continue to monitor our progress against information that is made available following CQC inspections and staff and patient feedback.

We want to know about your experiences. Please contact our Patient Advice and Liaison Service (PALS) on pals@leicspart.nhs.uk or Telephone on 0116 295 0830

Governance table

For Board and Board Committees:	Trust Board 26th July 2022	
Paper sponsored by:	Anne Scott, Executive Director of Nursing, AHPs and Quality	
Paper authored by:	Louise Evans, Interim Assistant Director of Nursing and Professional Practice	
Date submitted:	11.07.22	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Quality Forum 9.6.22	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Assured	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Annual report and declaration	
STEP up to GREAT strategic alignment*:	High **S**tandards	X
	Transformation	
	Environments	X
	Patient Involvement	X
	Well **G**overned	X
	Reaching Out	
	Equality, Leadership, Culture	X
	Access to Services	
	Trust wide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	
Is the decision required consistent with LPT's risk appetite:	y	
False and misleading information (FOMI) considerations:	n	
Positive confirmation that the content does not risk the safety of patients or the public	y	
Equality considerations:	Transgender and gender variant children and young people	

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Leicestershire Partnership NHS Trust

Public Trust Board 26th July 2022

Ligature Risks Annual Report

Purpose of the Report

This report presents of a summary of the ligature risks and improvement work within Leicestershire Partnership Trust (LPT). The report;

- Outlines the management and oversight of ligature risks including environmental fixed point ligatures for Leicestershire Partnership NHS Trust.
- Highlights where gaps in assurance have been identified and improvement action taken to address these.
- Provides an update on the prioritisation programme of work in respect of fixed point ligatures.
- Provides an update on the improvement priority relating to ligatures and self harm within the Quality Account 2021-2022 and outlines the programme of work within the quality account 2022-2023

Analysis of the issue

- In August 2020, Dr Kevin Cleary, Deputy Chief Inspector of Mental Health and Community Services wrote to all Mental Health Trusts setting out the concerns of the quality and safety of care in mental health units. More specifically, this letter highlighted the expectation for Trusts to address known environment fixed point ligatures through a prioritised capital programme of work.
- The trust Ligature Reduction Group was established in October 2020 to monitor the management of ligature risks trust wide. The terms of Reference for the group was reviewed and the purpose of the group is to monitor the management of Fixed and non fixed ligature risks trust wide.

Governance arrangements for the monitoring and management of environmental fixed point ligatures is through the operational Ligature Reduction Group reporting jointly into Patient Safety & Experience Group and the Health & Safety Committee for oversight

Overview of key findings of review, gap analysis and improvement actions

This section summarises the key information in regards to the review and gap analysis work in relation to both fixed and non fixed ligatures. Furthermore, it outlines improvement work underway or planned.

Environmental fixed point ligatures

Local assessments were carried out to identify the number of fixed point ligatures using the LPT Environmental Ligature Risk Tool.

The Ligature Reduction Group have prioritised the following 3 risks for capital expenditure to reduce risk:

(1) Door frame, hinge and door furniture. There are no retro fit of doors recommended to meet fire regulations available which also ensure vision panels are in line with CQC expectations and promote privacy and dignity.

(2) Window restrictions and window furniture.

(3) Bedside cabinets

- The ligature group continue to meet monthly and there is a key trajectory of work to and including policy review, training, recommendations to the capital programme, risk assessment review.
- The Ligature group has developed an annual work plan.
- An external audit was undertaken by 360 Assurance which had reviewed the management of fixed-point ligatures within the Trust and the management of care records
- The Management of Fixed-Point Ligature Policy was updated to reflect the findings and recommendations made from the from360 assurance audit report.
- Annual planned preventative maintenance (PPM) arrangements are established for testing anti-ligature items – for example, curtain rails
- Ligature reduction work continues to with the installation of safer radiator covers, fire detectors and safe hinge doors via the dormitory eradication programme.
- The safe hinge Primera (SHP) doors have been identified as the door of choice for LPT as this is a fully load alarmed system specifically for use in mental health Trusts where ligature is an identified risk; a trial of these doors has been undertaken on Ashby Ward and is in installation phase on Aston ward and Gwendolen ward (2 doors).
- The group reached the decision to remove ensuite doors in Acute Mental Health inpatient settings whilst maintaining privacy and dignity.
- Lesson plan agreed for Ligature Removal practical Staff working in Directorate of Mental Health, Directorate of Family Young Person Children and Learning Disability (FYPC/LD), and is incorporated in Safety Intervention 3-day / 5-day or annual refresher course
- Lesson plan agreed for staff working in Community Hospital and is incorporated as ‘observation’ within ILS and BLS course. A review will be undertaken in 6 months’ time.
- 3 Ligature cutters agreed for use within DMH, FYPC/LD, ordering and replacement process agreed. Roll out is expected towards mid-August. Community hospital will continue to use the current ligature cutter.
- The new At a glance information has been added to the policy. The At a glance poster was reviewed to include the new 1-5 scoring matrix. These are being disseminated to the inpatient wards in July 2022.
- The ligature reduction group has developed a ligature risk assessment schedule for both inpatient and community services which includes feedback and actions required following the sample audit.

- Health &Safety inspections is triangulated with fixed ligature point Risk Assessments and findings shared at the Ligature group.
- Directorates will bring both the Risk Assessment & Bid for Ligature Capital prioritisation to the ligature meetings and that this will be discussed and placed on the ligature priority list.
- Ligature cutter E-Learning package & Ligature awareness session developed by Health & Safety. Delayed in going live due to changes in policy and further enhancement to the E-learning package. Expected going live date is by end of July 2022.
- The group has agreed to window replacement programme for Gwendolen Ward.
- The Group will review the priority list after the 3 top priorities at the ligature group to re-affirm continued support for these to be the priorities.
- The work already undertaken has reduced fixed ligature risk and the group is focus on the continuous improvement of the environment to support reduced ligatures. We have introduced more effective early warning mechanisms e.g. doors and also preventative measures in the safe vent windows as these have no window restrictors.

Incident Analysis of reported ligature between April 2021 and June 2022

- Between January 2019 and March 2021, 77 incidents were recorded involving a fixed point ligature (1 was a duplicate incident). 37 were wrongly coded as fixed point and 6 of these 37 incidents involved fixed ligature points in the community. There were therefore 33 incidents that involved a fixed point item within inpatient settings.

Between April 2021 and June 2022, 54 incidents were recorded involving a fixed ligature point ligature. 38 were wrongly coded as fixed point ligature and 17 of these 38 incidents involved fixed ligature points in the community. There were therefore 16 incidents that involved a fixed point item within inpatient settings including the Place of Safety Assessment unit (PSAU).

Table 1 Incidents of fixed point ligatures

Ligature point	**Number of incidents**
Involving doors	5
Chair	3
Curtain poles/fittings	2
Toilet tissue holders	1
Radiator	1
Tap	1
Handles	1
Chairs	1
Fire alarms	1
‘Crutches’	1
Total	17

The Ligature Reduction Group continue to focus on the areas of improvement and has developed a work plan:

- Ligature related Alerts Shared through the group
- Progress against actions from the 360 Audits
- Audit of a number of fixed point risk assessments
- To receive and review any new legislation or briefing notes from CQC or other regulators
- Prioritisation of capital programme works for doors, widow fittings and bedside furniture, exploring new technology.
- Sharing learning from incidents and implementing change by developing a culture of learning through review of incidents, national guidance and alerts associated with fixed ligatures

Non Fixed ligatures

Non fixed ligature incidents make up the majority of ligature related incidents within Leicestershire Partnership Trust. Between April 2021 to June 2022, there were 816 incidents of non fixed ligature reported with 787 of those incidents taking place within inpatient areas. Therefore, ensuring we have a clear approach to prevent, reduce harm and support patients and staff with incidents involving non fixed ligatures is of significant importance. This improvement was identified as a key priority within the Quality Account 2021-22, (Priority One) which was greatly affected by Covid and again for 2022-20223 to further strengthen and build on the improvement made in the previous year. This aims to improve the quality of care to individuals at risk of self -harm in inpatient setting and build on the minimisation of non fixed ligature incidents. The Quality Account details the delivery expectations in each quarter and the programme of work which is running alongside the self harm non fixed ligature task and finish group.

Proposal

In summary the key ongoing priorities for quality improvement are:

- Ensuring organisation wide learning and further embed the work of the Ligature Reduction Group to reduce the number of ligature incidents across the Trust
- Promoting a safe and secure environment in which to treat our patients and improve their experience
- Reducing the number of environmental fixed point ligatures across the Trust through the capital work programme over a three to five year period.
- Delivering the work as outlined within the Quality Account 2022-2023

Decision required

This paper provides assurance on the identified risks and improvement work that is in progress to support the reduction and management of both fixed and non fixed ligatures trust wide. The Trust Board is asked to receive the report for information and assurance.

Governance table

For Board and Board Committees:	Public Trust Board 26th July 2022	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Zayad Saumtally, Michelle Churchard (Head of Nursing) & Bernadette Keavney (Head of Trust Health and Safety Compliance)	
Date submitted:	08/07/2022	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	N/A	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Assurance of the ligature improvement work is monitored through quality forum	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	One off	
STEP up to GREAT strategic alignment*:	High **S**tandards	x
	Transformation	
	Environments	x
	Patient Involvement	x
	Well **G**overned	x
	Reaching Out	
	Equality, Leadership, Culture	x
	Access to Services	
	Trust Wide Quality Improvement	x
Organisational Risk Register considerations:	List risk number and title of risk	1 and 3
Is the decision required consistent with LPT's risk appetite:	yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	yes	
Equality considerations:	yes	

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Leicestershire Partnership NHS Trust

Public Trust Board – 26th July 2022

Report title

- Guardian of Safe Working Hours – Annual Report (April 2021 – March 2022)

Purpose of the report

- Provide assurance to the Trust Board that doctors in training in LPT are safely rostered and have safe working hours that comply with the Terms and Conditions of Service
- Inform that 27 Exception Reports were raised in the period April 2021 – March 2022; indicating a variance from the agreed work schedule. This report highlights the actions taken to monitor and address such variances.

Analysis of the issue

Exception Reports

Exception reporting is the mechanism for all doctors employed on the 2016 Junior Doctors Contract to inform the Trust when their day to day work varies significantly and/or regularly from the agreed work schedule. The reports are raised electronically using the "Allocate" rostering system. All reports are received by the Medical Staffing team, the Guardian of Safe Working Hours and the Consultant supervisor for the individual trainee. Once received the Consultant supervisor discusses with the trainee to reach an agreed outcome which is subsequently logged on the Allocate system.

In 2021/22, 27 exception reports were logged. A breakdown is provided in Appendix 1.
This is a small increase on 24 exception reports logged in the previous 12 months 2020/21.

Bradgate Rota
Of the 27 Exception reports, 15 were related to two Doctors; 7 were raised by one GP trainee and were all related to working overtime during their regular working hours and were not related to on call issues. A further 8 Exception reports were raised by one FY1 trainee and were again related to working overtime, not achieving natural breaks and was due to high numbers of physically unwell patients on the Bradgate unit, Junior doctors isolating and absences due to annual leave.

Evington rota
There has been only 1 exception report in Jan 2022 relating to mandatory rest not being achieved as a patient was secluded which meant the doctor would have to review the patient every 4 hours as per the Trust Seclusion policy and this.

Higher Trainee rota
There were 3 exception reports due to busy shifts, but mitigations in place were accessed.

Measures in place to monitor and mitigate exceptions

The following measures have been implemented:

- Small working group to include the Director of Medical Education, Guardian of Safe Working Hours, Medical Staffing Manager and StR reps, continues to meet to agree practical solutions to address overnight work intensity. This working group reports into the Junior Doctors Forum for oversight and sign off.
- Next day compensatory rest or Time off in lieu continues to be provided to any trainee that is unable to take the required rest overnight.
- Hotel accommodation continues to be provided to any trainee that feels unsafe to travel home after an on call duty.

The risks if the above measures are not supported could include:

- Impact on the health, well-being and safety of the care giver i.e. medical trainee
- Risk of burn out to the affected medical trainees
- That the rota is not compliant with the Junior Doctors Terms and Conditions of Service. Compliance can prevent guardian fines being levied.

Decision required

- The Trust Board can be assured that the hours of work of medical trainees is monitored and causes are understood where breaches have occurred. Actions are taken to resolve the variance from the agreed work schedules.
- That there were no adverse clinical events as a result of Doctors on rotas not achieving expected rest provision.
- The Trust Board is requested to acknowledge and support the above ongoing measures.

Governance table

For Board and Board Committees:	Public Trust Board 26th July 2022	
Paper sponsored by:	Dr Avinash Hiremath, Medical Director	
Paper authored by:	Dr Shweta Gangavati, Consultant Psychiatrist and Guardian of Safe Working Hours	
Date submitted:	18/07/2022	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	None	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	n/a	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Annual report Next report will be in July 2023	
STEP up to GREAT strategic alignment*:	High **S**tandards	x
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	
	Reaching Out	
	Equality, Leadership, Culture	x
	Access to Services	x
	Trustwide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	4 – Service are unable to meet safe staffing requirements; 26 – Insufficient staffing levels to meet capacity and demand and provide quality services; 27 – The health and well-being of our staff is not maintained and improved 28 – Delayed access to assessment and treatment impacts on patient safety and outcomes.
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:	None	

Log of Exception reports – 1st April 2020 – 31st March 2021

Date of Issue	Rota	Trainee Level	Reason for Breach	Resolution
07.04.21	West ST Rota	ST4	Rest not achieved	Guardian fine (TBC)
28.05.21	ST Rota	ST4	Rest not achieved	Compensatory rest provided.Trainee contacted on call consultant and requested to cover shift
16.08.21	Evington	CT2	On call doctor for weekend was sick a and therefore was unable to relieve the night doctor	Medical staffing have identified that this was a human error
16.08.21	Bradgate A	ST2	Bradgate B doctor not available	TOIL offered
18.08.21	Bradgate A	ST2	Bradgate B doctor not available	TOIL offered
25.08.21	Bradgate wards	FY1	Overtime (stayed back after 5pm on 18.08.21)	TOIL offered and other steps taken such as starting ward rounds early, monitoring by Consultants etc
25.08.21	Bradgate wards	FY1	Overtime(stayed back after 5 pm on 19.08.21)	Same as above
25.08.21	Bradgate wards	FY1	Overtime(stayed back after 5pm on 20.08.21)	Same as above
01.09.21	Bradgate wards	FY1	Overtime(stayed back after 5 pm on 23.08.21)	Same as above
02.09.21	ST rota	ST5	Busy on call shift	Trainee discussed with Consultant on call who offered to step down
13.09.21	Bradgate Rota	FY2	Bradgate A doctor not available for on call	Outcome agreed but doctor left rotation in Dec
21.09.21	Bradgate wards	FY1	Overtime(stayed back after 5 pm on 15.09.21)	TOIL
21.09.21	Bradgate wards	FY1	Overtime (stayed back on 15.09.21)	TOIL
22.09.21	Bradgate wards	FY1	Overtime(stayed back after 5 pm on 17.09.21)	TOIL
24.09.21	Bradgate Wards	FY1	Overtime(stayed back after 5 pm on 24.09.21)	TOIL

28.09.21	**Bradgate wards**	**FY1**	**Overtime(stayed back after 5 pm on 28.09.21)**	**TOIL**
23.11.21	**Bradgate wards**	**ST2**	**Overtime**	**All reports below were raised by same trainee on 23rd Nov and the trainee left the Trust by 30.11.21 therefore Er's could not be discussed . GSWH however has highlighted to future trainees during induction that ER's have to be raised in a timely manner and if is for the same issue then discussing it with Clinical supervisor is vital.**
23.11.21	**Bradgate wards**	**ST2**	**Overtime**	
23.11.21	**Bradgate wards**	**ST2**	**Overtime**	
23.11.21	**Bradgate wards**	**ST2**	**Overtime**	
23.11.21	**Bradgate wards**	**ST2**	**Overtime**	
23.11.21	**Bradgate wards**	**ST2**	**Overtime**	
23.11.21	**Bradgate wards**	**ST2**	**Overtime**	
05.12.21	**Bradgate ward**	**FY2**	**Trainee did not have appropriate log ins for Ilab and System one**	**Medical staffing have resolved the issue by procuring the correct IT login**
16.12.21	**Bradgate Ward**	**ST1**	**Overtime due to trainee not being aware that the on call doctor had already arrived**	**Nil required**
04.01.22	**Evington Rota**	**CT3**	**Rest not achieved due to having to complete seclusion reviews**	**Agreed that it would be difficult to achieve 5 hours continuous rest if seclusion reviews occur.**
27.01.22	**Bradgate rota**	**CT**	**Bleep holder not available**	**Steps taken to involve the Rota co-ordinator to arrange cover**

Note 1 - Expected rest whilst on call is 8 hours per 24 hour period, of which at least 5 hours should be continuous and occur between 22.00 and 07.00. In highlighted cases 5 hour continuous rest has not occurred between 22.00 and 07.00

Abbreviations:

StR	Specialty Registrar
CT	Core Trainee
FY1	Foundation Year 1 Trainee
FY2	Foundation Year 2 Trainee

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Leicestershire Partnership NHS Trust

Trust Board – 26th July 2022

Freedom to Speak Up: half yearly report

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

Purpose

This paper is a half yearly report to the Trust Board of Directors. The report includes comparative data on numbers of cases per year over the period 2018 – 2022. In addition, there is a breakdown of the number of cases raised through the FTSU route during the periods Q4 20-22 and Q1 22-23. This provides a breakdown of concerns, along with analysis of themes or trends within the organisation and actions being taken.

In addition, the paper contains details of activities carried out in the Trust as part of the Freedom to Speak Up work stream updates and updates from the National Guardians Office (NGO).

Analysis of the Issue

FTSU Guardian Activity

Raising Awareness

In response to the national COVID guidelines, the FTSU Guardian continues to work from home linking in through virtual means and engaging with individual members of staff, teams and networks as appropriate. However, in response to changing guidance as we move to 'living with COVID-19' the FTSU guardian has planned drop-in sessions at all Community hospitals to connect directly with clinical colleagues. Face to face attendance at corporate induction sessions has been maintained to ensure that all new starters, returners, bank staff and aspirant nurses are aware of the role and have opportunity to meet the Guardian in person embedding key speaking up messages from the start of their career with LPT. Attendance at the training and development sessions for Medical Trainees, student nurses, healthcare support workers are nurses on preceptorship provides again provide opportunities to raise the profile of speaking up.

National Staff Survey Results 2021

There will be no Freedom to Speak Up Index published going forward as the original format is now redundant.

The high level analysis of the 2021 National Staff Survey results (shown below) indicate that Leicestershire Partnership NHS Trust is higher than the average across all questions under the People Promise element – '*We each have a voice that counts*'. This is very positive and suggests an embedding of the key Speak Up messages across the organisation and a culture where staff feel safe and able to speak up.

Question 17a - I would feel secure raising concerns about unsafe clinical practice

	2020	2021
Best	81.7%	86.1%
LPT	**75.5%**	**81.5%**
Average	75.6%	79.6%

Question 17b - I am confident that my organisation would address my concern

	2020	2021
Best	76.5%	74.4%
LPT	**62.0%**	**65.1%**
Average	63.1%	64.2%

Question 21e - I feel safe to speak up about anything that concerns me in this organisation

	2020	2021
Best	78.3%	78.7%
LPT	**68.0%**	**69.1%**
Average	68.3%	66.8%

Question 21f - If I spoke up about something that concerned me I am confident my organisation would address my concern – *no trend data are shown as this is a new question*

	2021
Best	71.3%
LPT	**56.8%**
Average	55.1%
Worst	34.3%

The FTSUG is working collaboratively with the People Promise Manager, Health and Wellbeing Lead, Organisational Development Lead and Staff Engagement Lead to underpin and embed the key FTSU messages within these work domains. The Model Health System supported by NHS England provides data sets and will be used to provide benchmarking data across the wider NHS peer group.

Freedom to Speak Up – Speak Up Month – October 2022

FTSU guardian is working with local communications team to identify and build on the opportunities to promote speaking up through October as part of National Speak Up Month. It is intended that members of staff across all levels of the workforce will be enabled to share speak up messages using refreshed resources, including, speech bubbles to make a personal pledge, photograph opportunities at roadshows and drop in events, articles through corporate and service bulletins and communications through social media platforms.

National Guardian Office (NGO) updates

Speak Up, Listen Up, Follow Up – new module added

Freedom to Speak Up in Healthcare in England
Speak Up, Listen Up, Follow Up

National Guardian
Freedom to Speak Up

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

Health Education England eLearning for healthcare (HEE elfh), in partnership with the National Guardian Office, has added a 3rd session to the Freedom to Speak Up in the Health Sector in England eLearning programme. The Follow Up module, is aimed at all senior leaders including executive board members (and equivalents), non-executive directors, and governors to help them understand their role in setting the tone for a good speaking up culture and how speaking up can promote organisational learning and improvement.

Freedom to Speak Up Guardian Survey - *Senior leaders' essential role in Freedom to Speak Up*.

In March 2022 the NGO published the FTSU Guardian survey - This included key findings and recommendations for organisations to support the development and embedding of a speaking up culture.

https://nationalguardian.org.uk/wp-content/uploads/2022/03/2021-FTSUGuardian-Survey-Report.pdf

Freedom to Speak Up: A guide for leaders in the NHS

The guide for leaders in the NHS and organisations delivering NHS services, provides comprehensive information, advice and resources to support leaders to provide the best possible working environment – one where speaking up is not only welcomed, but valued as an opportunity to learn and improve. It identifies 8 fundamental principles

1. Value speaking up.
2. Role-model speaking up and set a healthy Freedom to Speak Up culture.
3. Make sure workers know how to speak up and feel safe and encouraged to do so.
4. When someone speaks up, thank them, listen up and follow up.
5. Use speaking up as an opportunity to learn and improve.
6. Support Freedom to Speak Up guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements alike.
7. Identify and tackle barriers to speaking up.
8. Know the strengths and weaknesses of the organisation's speaking-up culture and take action to continually improve.

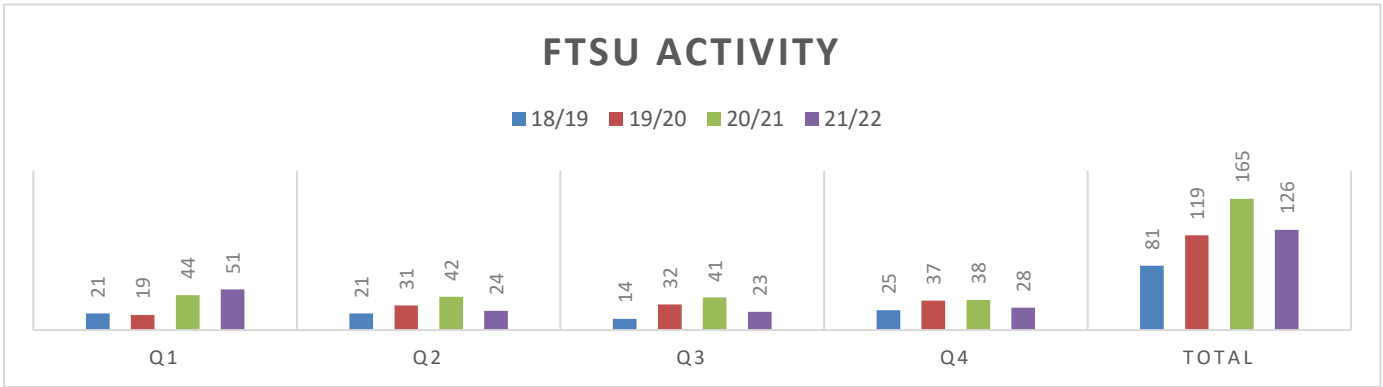
This document also provides advice on the structure of board reports and it is intended that future board reports will be presented as recommended in the guide.

Freedom to Speak Up: A reflection and planning tool

This tool recommends the senior lead for FTSU takes responsibility for completing the reflection tool and is designed to help identify strengths and any gaps that need work. It is intended to be used in conjunction with the guide for leaders in the NHS and organisations delivering NHS services

Utilisation of the FTSU Process

The chart below shows the number of concerns raised per quarter during the period 2018 -2022. Although, speak up contacts had progressively increased year on year initially, there is a comparative reduction in the number of contacts across the last 3 quarters of 2021-22 and Q1 0f 2022-23. There may be many reasons for this for example: reduced visibility of the FTSUG across the trust (due to working from home), the increase in confidence to speak up through alternate routes, individual time and capacity to speak up or other real or perceived barriers.



FTSU Guardian Activity and Speaking Up

As seen in the table below there are a relatively constant number of speaking up cases across the last 12 months with a slight increase in Q4 21/22.

Generally, colleagues request that their issue be dealt with confidentially however with support and reassurance many have felt confident to be identified and further-more discuss issues openly with their senior leaders or managers through an informal 'listening meetings'. These meetings create opportunities for staff to be listened to and to understand any future actions in response and/or achieve resolution. Feedback on this process has been positive and builds on the development of an open and transparent culture.

Comparative Summary of speaking up cases 2021 -2022

Service Area	Q2 21/22	Q3 21/22	Q4 21/22	Q1 22/23
DMH	7	12	17	14
CHS	5	5	4	1
Enabling	0	2	2	3
FYPC/LD	12	4	4	4
Hosted	0	0	1	0
TOTAL	**24**	**23**	**28**	**22**

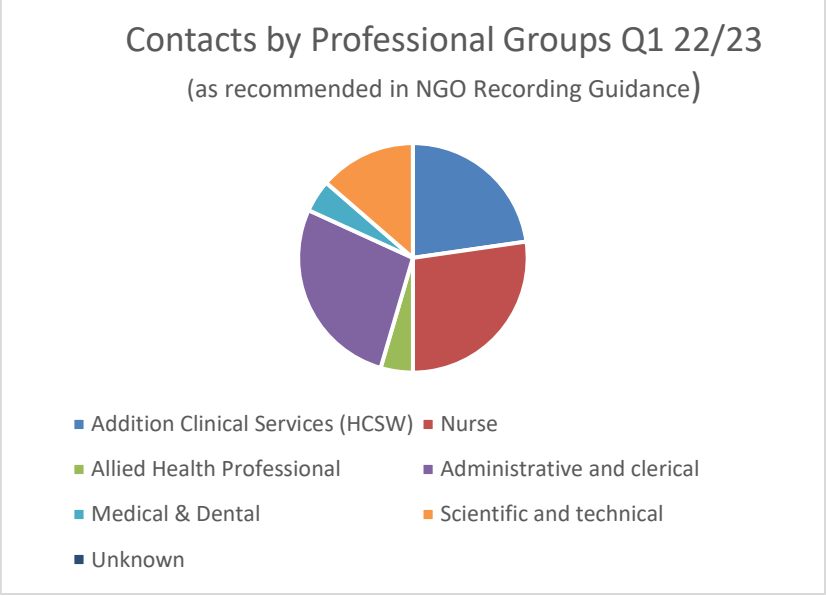
	No. of Contacts	Internal	External	Anonymous
Q4 21/22	28	25	3	3
Q1 22/23	21	21	0	0

Themes *	Q2 21/22	Q3 21/22	Q4 21/22	Q1 22/23
Patient Safety/quality	12	8	9	7
Staff Safety	12	12	21	9
Attitudes & Behaviours	9	18	15	8
Bullying/Harassment	3	5	5	5
System/Process	14	9	18	10
Infrastructure/Environment	5	2	2	1
Cultural	5	16	14	4
Leadership	15	18	21	10
Senior Management Issue	1	3	3	7
Middle Management Issue	11	10	14	7

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

Contacts by Professional Groups

There is a wide cross-section of the Trust workforce, that have contacted the FTSU guardian, from a variety of professional groups and levels of seniority. A comprehensive definition for professional groups forms part of the updated guidance Recording Cases and Reporting Data (NGO 2022)



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

Discussion of Themes

Staff Safety, Attitudes & Behaviours, Systems & Processes and leadership behaviours often relating to professional relationships and management issues were the highest categories of concern during Q4 21/22 and Q1 22/23. Issues relating to attitudes and behaviours, and more recently leadership behaviours have been consistently reported within each quarter and work is being undertaken to embed compassion and civility into the culture. In these cases, sign posting regularly includes recommendation to undertake Leadership Behaviours and Giving and Receiving Feedback training to support the development of an open, just and learning culture. In addition, staff are supported through coaching style conversations to manage expectations, explore options and agree future actions. Actions may include facilitated conversations, mediation or listening meetings. Where concerns relating to staff safety have been highlighted these have reflected how a member of staff is feeling within the team dynamic and does not directly relate to a specific risk. In these cases, feedback is provided to the individuals and learning shared within service areas when appropriate.

Issues identified as systems and processes mainly relate to interpretation and actions under policy and guidance procedures. Colleagues have been supported to explore these issues through the appropriate responsible team or department and where appropriate learning has been shared.

Learning and Actions

The FTSU guardian has been asked to provide specific information relating to the concerns raised across each directorate. This has been included as intelligence in the context of wider triangulation opportunities, as part of workforce listening events or discussed as part of the response, action plan and assurance from Quality Summits.

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

Decision required

- Trust Board is asked to note the activity and actions relating to FTSU workstream.
- Confirm assurance that issues of concern are being raised and dealt with in line with the Freedom to Speak Up: Raising Concerns (Whistleblowing) policy and that the Trust Board is aware of themes and trends emerging in the organisation.
- Confirm assurance that the Trust Board are proactive in supporting a speaking up culture in the Trust
- Acknowledge the national updates

Presenting Director: Angela Hillery

Author(s): Pauline Lewitt

15/07/22

Governance table

For Board and Board Committees:	Trust Board 26.7.22	
Paper sponsored by:	Angela Hillery, CEO	
Paper authored by:	Pauline Lewitt, Freedom to Speak Up Guardian	
Date submitted:	15/07/22	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	N/A	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	N/A	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	6 Monthly	
STEP up to GREAT strategic alignment*:	High **S**tandards	Yes
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	
	Reaching Out	
	Equality, Leadership, Culture	Yes
	Access to Services	
	Trustwide Quality Improvement	Yes
Organisational Risk Register considerations:	List risk number and title of risk	
Is the decision required consistent with LPT's risk appetite:		
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed	
Equality considerations:	None	

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Leicestershire Partnership NHS Trust

FPC – 28th June 2022 – 1:00 – 3:30pm

Highlight Report

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

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
Director of Finance Update – verbal	NA	The financial plan had now been resubmitted with the additional £1.4m funding included giving a break even plan position. This was a best-case basis submission.	71 81
CFO – Strategic Estates Update – Paper C	NA	The most recent FM Transformation Update had been given at the 21st June Trust Board meeting. The proposed date for transfer had been discussed and ageed. This will be approved by the executive directors and come back to FPC for assurance at the August meeting.	65 66 67
Director of Strategy and Partnerships Update – verbal	NA	The LLR system and LPT continue to work on how the collaboratives will operate, once drafted this will follow the governance route to the Trust Board Confidential meeting. The SystmOne workshops took place and feedback is being collated along with lessons learned.	64 72
Finance Report Month 2 – Paper D	Low	This month's report is still measuring against the £1.4m deficit plan – this will change for next month. Month 2 is on target to the year-to-date plan however expenditure runs rates are higher than expected and there is a material risk of not delivering the year-to-date plan by month 3. Agency costs are the main driver in this due to being higher than expected There will be a more detailed year end forecast from month 3. Directorate main areas of overspend are in patient units, community nursing and wards. Also overspend due to service provision growth in urgent and planned care. There are a number of workstreams looking at these issues with workplans to	71 81

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
		address this issue including the HCSW & admin zero vacancy scheme; retention schemes etc. A Trust wide plan in this area is being drafted to bring together the individual actions that are taking place. The plan and set of actions will be brought back to FPC for assurance. FPC received low assurance from the report due to the adverse position at month 2.	
Business Pipeline – Bids & Tenders Update – Paper E	High	FPC received the report for an update and received high assurance from the report.	64
Performance Report Month 2 – Finance and Performance Metrics - Paper F	Medium	Deteriorating areas have been escalated to the performance review meetings as have been off trajectory for 3 consecutive meetings. The 52 week waits remain stable; the vacancy rate is at 14% which is above the Trust's target; appraisal and clinical supervision compliance rates have increased. Perinatal has national and system oversight and they continue to work closely with NHSI and NHFT. The early intervention in psychosis plans are in place and have been reviewed. There is some ongoing mapping work with the community mental health teams and an increasing number of vacancies in the planned care teams is having an impact and being monitored. The continence backlog has improved but not the overall performance and CINSS longest waits are now reducing. There is ongoing work considering trajectories for the rest of the year. Workforce supply is the key issue affecting waits. A review of the Performance Management Framework was agreed.	68 69 75
Improving Access Report – Paper G including Improving Access Committee Highlight Report (Paper Ti & Tii)	M L	This report now contains numerical data, performance against targets and trajectories. The data indicates increase wait times, increased referrals into services and increased over 52-week waiters and a deterioration against targets. The main reason for these shifts is demand and capacity. Mitigations include waiting list validations, patient tracking list, demand/capacity reviews and transformation journeys within services for example structural changes. There remains an issue around flow – discharges need to balance with referrals, and this is complex to manage. Reducing the risk of harm whilst waiting continues to be monitored and triangulation	65 69 72 75

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
		takes place with the patient safety and patient experience teams. It is anticipated that the data will continue to look this way for some time, it is unlikely that dashboards and trajectories will improve in the next 6-9 months. FPC received split assurance from the report - medium assurance for the governance and plans in place and low assurance for the waiting times.	
CQC Action Plan Assurance Report – Paper H	High	3 of the 4 dormitory wards are now complete with the 4th due for completion at the end of July. Dates for completion will be added to the new actions for the next report.	All
Provider Collaborative Performance – Quarter 4 – Paper I	High	A surplus is being reinvested in plans to deliver more adult eating disorder services. There is a carry forward which will be invested into front line services including a virtual day service. There has been a reduction in the length of stay and occupancy levels have remained static.	64
Data Security and Protection Toolkit Annual Return – Paper J	High	The final submission is planned for 29th June the figure currently stands at 92.7% and new processes are planned for next year to ensure the target is met earlier on.	68 79
Caldicott Guardian Annual Report – Paper K	Medium	The data security & awareness training compliance issue was due to the extension to 18m and the back down to 12m meaning the figures reduced in March 2022. The issues with the subject access request are resolving and compliance is now increasing. This process is being streamlined. FPC received medium assurance from the report as there were measures in place, but outstanding issues remain.	68 79
Cyber Security Management – Paper L	High	The report was presented for information and FPC received high assurance from the report. There were no issues to escalate.	68 79
HIS Annual Report – Paper M	High	There has been a financial challenge this year. The SLA has been extended for a further 12 months due to the ICB changes and workforce remains a challenge. The risks highlighted in the report are being captured and held within the HIS service. Plans are in place to improve recruitment with a digital based recruitment fayre planned and an internal management development plan being drafted. FPC asked that consideration be given to the nature of the HIS risks and where they are held and to ensure this feeds into the strategic workforce plan.	69 79

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
PLACE Audit Update – verbal	NA	The PLACE audit has not yet taken place due to covid restrictions – the schedule will restart in the autumn and report to FPC in due course.	NA
ORR – Paper N	High	Risk 70 was proposed to be closed as it refers to the previous year, a new risk will be included for this financial year. Following a benchmarking exercise, the risk has been reduced for risks 72 & 79.	All
Estates and Medical Equipment Committee Highlight Report 20th April & 18th May 2022 – Paper Oi & Oii	High	The medical devices issues was discussed at the committee. The discipline of returning and getting checked has lapsed and a task and finish group has been set up to look at this issue with comms planned to support the initiative.	65 66
Transformation Committee Highlight Report 12th April & 10th May 2022 – Paper Pi & Pii	High	There are planned changes to the committee and the function of the group will change moving forward.	64
IM&T Committee Highlight Report 20th May 2022 – Paper Q	High	FPC received high assurance from the report there were no issues to escalate.	68 79
Data Privacy Committee Highlight Report 15th March 12th April & 10th May 2022 – Paper Ri, Rii & Riii	High	FPC received high assurance from the report there were no issues to escalate.	68
Capital Management Committee Highlight Report 11th May 2022 – Paper S	Medium	Amber items are largely linked with this year's capital plan. Tnhere were no other issues to escalate.	71 81
Improving Access Committee Highlight Report 5th April & 3rd May 2022 – Paper Ti & Ti	M L	FPC received split assurance from the report - medium assurance for the governance and plans in place and low assurance for the waiting times.	65 69 72 75
Chair of Committee:	Faisal Hussain		

Leicestershire Partnership NHS
NHS Trust

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Finance Report for the period ended
30 June 2022

For presentation at the
Trust Board meeting
26th July 2022

Contents

Executive Summary and overall performance against targets

1. This report presents the financial position for the period ended 30 June 2022 (Month 3). A net income and expenditure deficit of £1,208k is reported for the period. This is in line with the planned position for month 3 (forming part of the overall original planned deficit of £1.4m for the year).

2. Within the overall month 3 position, net operational budgets report a £1,961k overspend. Directorate overspends include DMH (£1,627k), CHS Services (£264k), FYPC (£184k) and LD (£180k). Hosted services are underspending by £168k, Estates by £75k and Enabling services by 51k.

3. Central reserves report a temporary surplus of £753k which partially offsets the net operational deficit, resulting in the net £1,208k deficit reported for the Trust.

4. The final Trust plan submission on 20th June showed an I&E break-even position for the year. This is following receipt of additional national funding to support non-pay inflation cost pressures. The previous plan position showed a year end deficit of £1.4m. The final plan submission (both at Trust and ICS level) was completed on a 'best endeavours' basis and acknowledges a high level of risk in terms of delivery.

5. Closing cash for June stood at £29.8m. This equates to 37.6 days' operating costs.

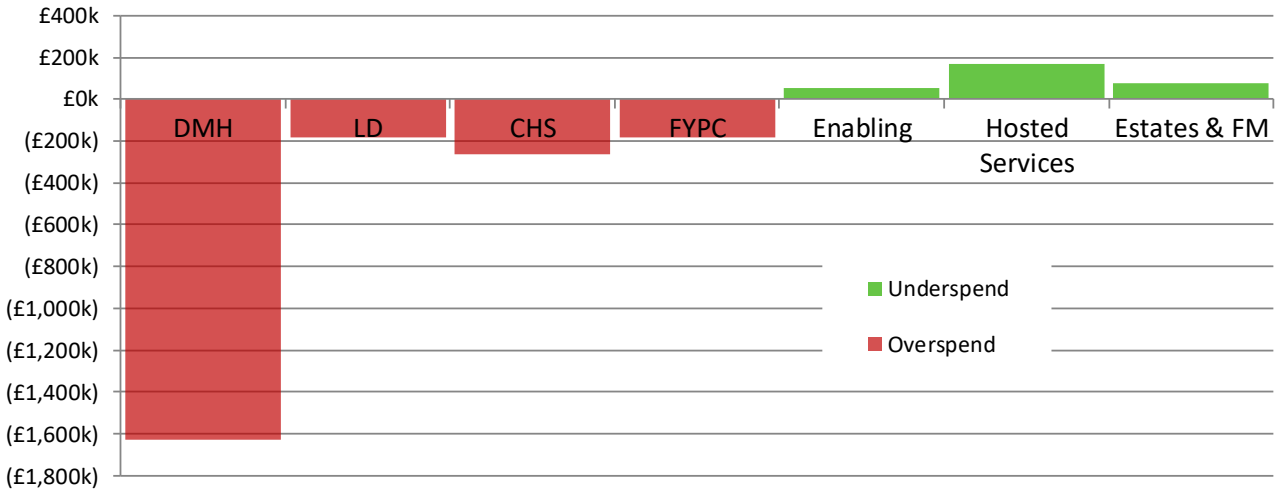
Performance against key targets and KPIs

NHS Trust Statutory Duties	Year to date	Year end f'cast	Comments
1. Income and Expenditure break-even.	R	A	The Trust is reporting a financial deficit position at the end of June 2022. **[see 'Service I&E position' and *Appendix A*]**. Year end plan delivery is rated 'amber' given the high level of risk acknowledged at plan stage, and the very high levels of expenditure in Q1.
2. Remain within Capital Resource Limit (CRL).	G	G	The capital spend for June is £3.2m, which is within limits. The likely year end forecast is also within the limits for the year.
3. Achieve the Capital Cost Absorption Duty (Return on Capital).	G	G	The dividend payable is based on the actual average relevant net assets; therefore, the capital cost absorption rate will automatically be 3.5%.
4. Remain within External Financing Limit (EFL).	n/a	G	The current cash level is £29.8m. The year-end forecast is £23m, in line with plan.

Secondary targets	Year to date	Year end f'cast	Comments
5. Comply with Better Payment Practice Code (BPPC).	G	G	The target is to pay 95% of invoices within 30 days. Cumulatively the Trust achieved all of the BPPC targets in June.
6. Achieve Efficiency Savings targets.	G	R	The efficiency savings target for month 3 has been met. However, the target increases across the year as additional schemes are planned to come on line. The current forecast assumes delivery of approximately 80% of the target for the year.
7. Deliver a financial surplus	n/a	n/a	NHS Financial planning currently assumes no requirement to deliver a financial surplus (only a break-even).
Internal targets	**Year to date**	**Year end f'cast**	**Comments**
8. Achieve a Financial & Use of Resources metric score of 2 (or better)	G	A	There is currently no formal requirement to be monitored against the Financial & Use of Resources metrics. An internal summary calculation is still conducted to measure progress internally, and this suggests that the Trust is currently still scoring a '2', despite the deficit position.
9. Achieve retained cash balances in line with plan	G	G	A cash balance of £29.8m was achieved at the end of June 2022. **[See 'cash and working capital']**
10. Deliver capital investment in line with plan (within +/- 15% YTD planned spend levels)	G	G	Capital expenditure totals £3.2m, 6% below planned level. This comprises of £2.25m property, plant and equipment, and £0.95m for a new property lease. **[See 'Capital Programme 2022/23'].**

Income and Expenditure position

The month 3 position shows a net operational overspend against year-to-date budgets, partially offset by an underspend within reserves, resulting in the net £1,208k I&E deficit Trust position (in line with the plan for month 3).



The Mental Health directorate is overspending by £1,627k at Month 3. This is largely due to continuing high levels of agency staff to cover vacancies and in response to high acuity and increased level 1 observations. Spend for agency was £1.4m for the month of June, compared to May (£1.2m). The average overall monthly expenditure run-rate for DMH increased in the second half of last year, correlating with the increase in agency spending. The DMH deficit also includes a continuation of the Covid bank incentive payments, which result in increased costs of c. £100k per month. There is a minor non-pay overspend mainly due to drugs costs, and an income under recovery is reported due to Out of area activity. Given the very high levels of overspend currently being reported, a significant amount of work is being undertaken within the directorate and in conjunction with finance leads in order to identify causes and also to identify urgent mitigations in order to halt and recover the overspend. A comprehensive recovery plan is being developed, that will set clear actions and lines of accountability. With reliance on agency staffing seen as a major cause of the financial pressure, actions within the directorate and also from the various workstreams now in place more widely across the Trust, will need to focus on reducing this reliance as an immediate priority.

The FYPC financial position at month 3 is an overspend of £184k. The rate of overspend has slowed since M2, although significant pressures still exist, especially within the two inpatient areas. The Beacon position also includes costs not supported by the CAMHS provider collaborative against an Extra Package of Care submitted for a patient. Despite the continuing issues, it should be noted that there was a reduction in agency usage in the month. The ward positions are currently off set by budget underspends within community services, in particular the Healthy Together budget. However this underspend is anticipated

to reduce once the new County contract begins in September. Emerging pressures are noted within the Diana medical equipment budget and pressures remain with Children's physical services budgets for which the Directorate has agreed additional non recurrent funding from internally generated funds to address wait times and recovery.

The LD financial position at month 3 reports an overspend of £180k. This is largely driven by costs within the Agnes Unit, which reported a £452k overspend at month 3. However, agency costs were lower than trend, and the financial position is expected to improve during quarter 2 due to the discharge of patients and the corresponding reduction in the number of pods in use. Community services remain underspent.

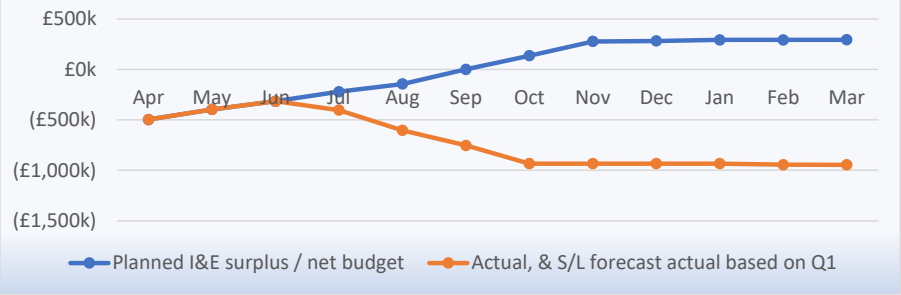
The CHS Service is reporting an overspend of £264k for the first 3 months of the year. Bank and agency expenditure spend is £3,270k, of which £176k is still attributed to Covid. At the end of Q1 last financial year, the bank and agency cost was £1,930k. Pressures within the inpatient service continue due to the increased number of acute patients that are being admitted along with cover for the high level of vacancies and staff sickness. These overspends are being partly offset by community nursing vacancies.

Enabling Services are underspent by £51k mainly due to vacancies within the Business Development team.

Forecast position

The Q1 position is a deficit of £1.2m, and this is in line with planning expectations. However, the plan assumed that the significantly increased levels of expenditure seen in Q4 last financial year (particularly within DMH) were a consequence of winter and Covid surge pressures (plus other non-recurrently funded issues). The plan therefore reflected a general reduction in costs, beginning in Q1 and a return to more normal levels into Q2 and across the remainder of the year. The forecast for the year was then based on a small monthly surplus being achieved across the second half of the year, to the extent that an I&E break-even position would be achieved for the year as a whole by 31st March 2023.

Based on the Q1 actual position, spending levels are actually increasing, and to deliver against plan in Q1, all non-recurrent contingencies and benefits from the previous financial year have already been utilised. The underlying deficit at the end of Q1 is therefore closer to £2.7m. If this level of spend is not addressed, even on a simple straight line forecast, the overspend for the year would be c. £10m. The chart below shows the original monthly I&E plan assumption (blue line), alongside the actual position and a simple extrapolation of current trend before any recovery actions (orange line). The gap between the two would represent the growing distance from target if spending levels do not reduce.



This report includes an additional appendix this month. ***Appendix F*** provides a Trust level view of the pressures and mitigations within the current position and how these might play out over the whole year. In addition, the level of further risk is shown. This analysis allows a range of possible scenarios to be presented at high level, and the appendix can be viewed in conjunction with the further explanations given below.

The best case assumption – to align with the best endeavours approach used in the national financial planning assumption – shows the planned break even position.

The worst case assumption also still aligns with the level of risk identified when the plan was finalised – which shows a £19.7m deficit by the year end. However, the make-up of individual risks has changed, with more of the pressure now crystalising within the DMH position.

The current likely risk-adjusted case assumes that a number of planned actions within DMH take place, including a return to agency levels more in line with those seen in 2021/22, plus a reduction in Covid costs and general recovery measures. The likely case also reflects the further impact of Trust wide efforts to reduce reliance on agency staffing (broadly bringing agency costs to the 22/23 planned levels of £23m), and assumes a recovery plan equal to just over 1% of Trust budgets. This would result in a deficit of £3.9m

A final scenario models a case where initial suggested DMH actions are taken, but shows no further improvement (i.e no additional agency reduction, and no further recovery plan implemented). This would realise a deficit of £9.5m, and broadly aligns with the simple forecast modelling in the chart above.

The outcome of this analysis shows that delivery of a break-even position is still seen only in the best case scenario. The worst case factors in £19.7m risk, of which elements are clearly already playing into the position.

Further work to support the month 4 financial position is expected to result in a more complete forecast next month, crucially with a better grasp of recovery actions and a clear plan for their delivery.

Decisive action, with over 8 months of the year still remaining can reduce the potential for a significant deficit, with a material reduction in agency cost being the single most significant and immediate opportunity to help achieve this.

Efficiency Savings

	Scheme Ref	Scheme name	Current Financial RAG	Annual plan £	YTD plan £	YTD actual £	YTD variance £
CHS	CHS 1	Travel		90,000	22,500	22,500	0
	CHS 2	Comm / Inpatient Management Non Pay savings		90,000	22,500	22,500	0
	CHS 6	Comm Nursing / Therapy - Service review of investments - estimated		253,000	63,250	63,250	0
	CHS 8	Virtual ward + Long COVID Rehab- Service review of investments		65,000	16,250	16,250	0
	CHS 9	LDU Review		90,000	22,500	22,500	0
	CHS 10	Procurement - contract reviews i.e taxis, continence supplies etc		149,000	37,250	37,250	0
	CHS 12	Other Non Pay savings - N/R		23,000	5,750	5,750	0
		CHS - total		**760,000**	**190,000**	**190,000**	**0**
LD	LD 3	Travel savings against baseline 2019/20 cost		23,000	5,750	5,751	1
	LD 4	Agency reduction Agnes in 22/23 against 21/22 out-turn		100,000	0	0	0
		LD - total		**123,000**	**5,750**	**5,751**	**1**
FYPC	FYPC1	Travel savings against baseline 2019/20 cost		100,000	25,000	24,999	-1
	FYPC2	Integrated Primary care offer (PMHW)		100,000	25,000	24,999	-1
	FYPC3	Agency reduction HUB & CAP in 22/23 against 21/22 out-turn		50,000	0	0	0
	FYPC4	Agency reduction Beacon & Langley in 22/23 against 21/22 out-turn		150,000	0	0	0
	FYPC5	Digital offer to reduce printing & postage costs		20,000	0	0	0
		FYPC - total		**420,000**	**50,000**	**49,999**	**-1**
DMH	DMH 1	Travel savings against baseline 2019/20 cost		50,000	12,501	12,501	0
	DMH 2	Volunteer Transport		75,000	18,750	0	-18,750
	DMH 3	Oxevision		20,000	0	0	0
	DMH 4	Agency reduction in spend for HCSW		300,000	0	0	0
	DMH 5	Agency reduction in spend for Admin		100,000	10,000	0	-10,000
	DMH 6	eRoster advance planning for 12 weeks		50,000	0	0	0
	DMH 7	Medical locums		50,000	5,000	0	-5,000
	DMH 8	Covid bank incentive payments		300,000	0	0	0
		DMH - total		**945,000**	**46,251**	**12,501**	**-33,750**
ENABLING	ENAB 1	Chief Exec		20,000	5,000	5,000	0
	ENAB 2	Quality		7,000	1,750	1,750	0
	ENAB 3	Medical		30,000	7,500	7,500	0
	ENAB 4	Finance Directorate (including Procurement, Info. Team & IG:		80,000	20,000	20,000	0
	ENAB 5	Human Resources (including education and training)		30,000	7,500	7,500	0
	ENAB 6	Business Development and Information Services		0	0	0	0
	ENAB 7	Enabling non-recurrent schemes		165,000	41,250	41,250	0
		ENABLING - total		**332,000**	**83,000**	**83,000**	**0**
TRUST WIDE	T1	Travel Savings		413,000	103,250	103,250	0
	T2	Corporate led agency reduction schemes		605,000	0	0	0
	T3	Mobile phone contract savings		125,000	31,250	31,250	0
	T5	Capital charges reduction		850,000	0	0	0
	T6	Balance sheet flexibility		1,027,000	256,750	290,501	33,751
		TRUSTWIDE - total		**3,020,000**	**391,250**	**425,001**	**33,751**
		GRAND TOTAL		**5,600,000**	**766,251**	**766,251**	**0**

Risk adjusted forecast:

High risk:	1,055,000	**-791,250**
Medium risk:	638,000	**-319,000**
Year end forecast:		**4,489,750**

As at the end of month 3, the year to date efficiency target of £766k is being met.

Further schemes are planned to come on line later in the year. Based on a current financial deliverability RAG rating of all schemes, the forecast year end position is delivery of £4.5m savings against the target of £5.6m (approximately 80% delivery).

Agency reduction schemes phased in later in the year are potentially flagged as the key reason for the shortfall. However the further work across the Trust to reduce agency reliance could improve this position.

Statement of Financial Position (SoFP)

PERIOD: June 2022	2021/22 31/03/22 Audited (Restated) £'000's	2022/23 30/06/22 June £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	192,037	191,899
Intangible assets	4,818	4,715
IFRS16 - Right of use (ROU) assets	45,430	46,389
Trade and other receivables	932	933
Total Non Current Assets	**243,217**	**243,936**
CURRENT ASSETS		
Inventories	418	381
Trade and other receivables	8,087	15,754
Cash and Cash Equivalents	31,991	29,835
Total Current Assets	**40,496**	**45,970**
Non current assets held for sale	**0**	**0**
TOTAL ASSETS	**283,713**	**289,906**
CURRENT LIABILITIES		
Trade and other payables	(28,460)	(35,203)
Borrowings	(285)	(285)
Borrowings - IFRS16 ROU assets	(3,390)	(3,490)
Capital Investment Loan - Current	(186)	(104)
Provisions	(3,588)	(3,368)
Total Current Liabilities	**(35,909)**	**(42,450)**
NET CURRENT ASSETS (LIABILITIES)	**4,587**	**3,520**
NON CURRENT LIABILITIES		
Borrowings	(7,177)	(7,178)
Borrowings - IFRS16 ROU assets	(42,040)	(42,899)
Capital Investment Loan - Non Current	(3,021)	(3,021)
Provisions	(1,256)	(1,256)
Total Non Current Liabilities	**(53,494)**	**(54,354)**
TOTAL ASSETS EMPLOYED	**194,310**	**193,102**
TAXPAYERS' EQUITY		
Public Dividend Capital	101,831	101,830
Retained Earnings	39,058	37,850
Revaluation reserve	53,421	53,422
TOTAL TAXPAYERS EQUITY	**194,310**	**193,102**

Non-current assets

Property, plant, and equipment (PPE) amounts to £191.9m. Depreciation charges more than offset capital additions of £3.2m.

Due to the adoption of IFRS-16 leases from 1st April 2022, non-current assets have increased by £45.4m, with a corresponding liability shown against current and non-current borrowings. The opening balance sheet has been restated to include the transition of lease balances for Right of Use assets.

The change of accounting treatment for IFRS-16 leases creates an additional 'cost' to the Trust's capital programme for any new leases (this replaces our previous revenue lease cost and so does not impact on our overall net cashflow). An equivalent increase to our capital resource limit (the total amount the Trust can spend on capital) is anticipated but the national approach has not yet been confirmed.

Current assets

Current assets of £46m include cash of £29.8m and receivables of £15.8m.

Current Liabilities

Current liabilities amount to £42.5m and mainly relate to payables of £35.2m.

Net current assets / (liabilities) show net assets of £3.5m.

Working capital

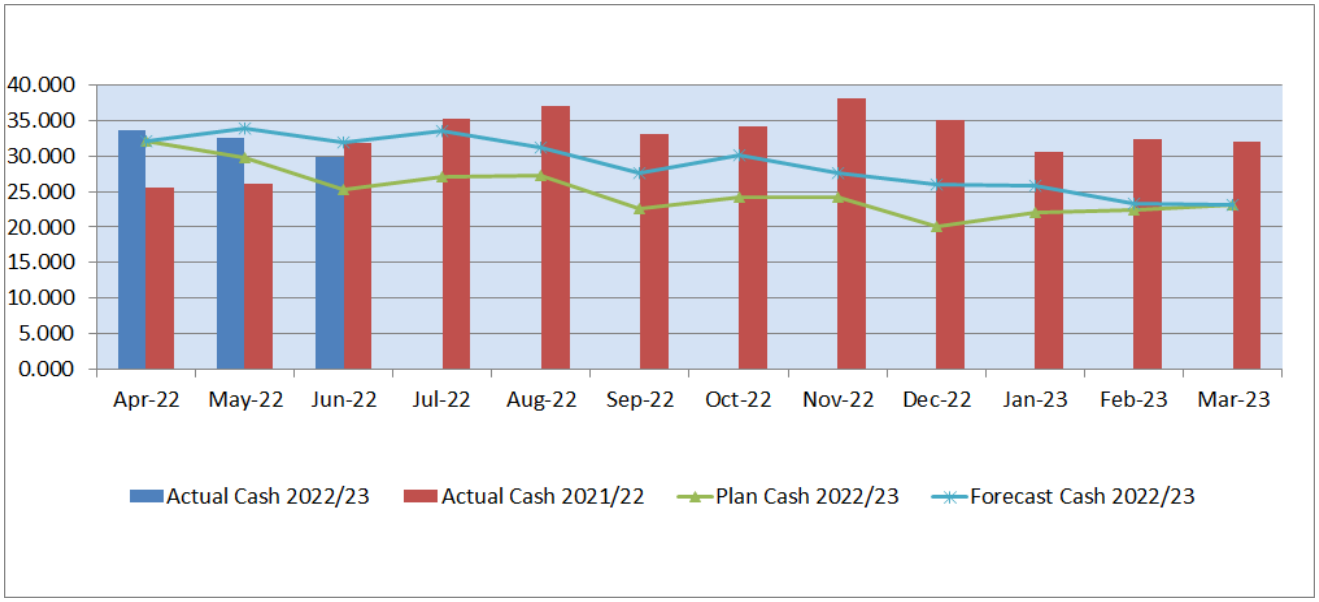
Cash and changes in working capital are reviewed on the following pages.

Taxpayers' Equity

June's deficit of £1,208k is reflected within retained earnings.

Cash and Working Capital

12 Months Cash Analysis Apr 22 to Mar 23



Cash – Key Points

The closing cash balance at the end of June was £29.8m, a reduction of £2.8m during the month.

The cash position remains high due to the inclusion of expenditure accruals (relating to outstanding supplier invoices) and the receipt of deferred income

The year end cash forecast is £23m, in line with plan.

A cash-flow forecast is included at ***Appendix D.***

Receivables

Current receivables (debtors) total £15.8m; an increase of £2.4m during the month.

Receivables	Current Month June 2022					
	NHS	Non NHS	Emp's	Total	% Total	% Sales Ledger
	£'000	£'000	£'000	£'000		
Sales Ledger						
30 days or less	1,189	3,072	3	**4,264**	**25.55%**	**71.5%**
31 - 60 days	338	254	9	**601**	**3.60%**	**10.1%**
61 - 90 days	273	3	2	**278**	**1.67%**	**4.7%**
Over 90 days	355	278	191	**824**	**4.94%**	**13.8%**
	2,155	3,607	205	**5,967**	**35.76%**	**100.0%**
Non sales ledger	4,551	5,236	0	**9,787**	**58.65%**	
Total receivables current	**6,706**	**8,843**	**205**	**15,754**	**94.41%**	
Total receivables non current		933		933	**5.59%**	
Total	**6,706**	**9,776**	**205**	**16,687**	**100.00%**	**0.0%**

Debt greater than 90 days increased by £116k since May and now stands at £824k. Receivables over 90 days should not account for more than 5% of the overall total receivables balance. The proportion at Month 3 is 4.94% (last month: 4.95%).

The non-current receivables balance stands at £933k. It comprises of a £249k long term debtor with NHSI to support the clinical pensions' tax provision and a £684k prepayment to cover PFI capital lifecycle costs.

There was no movement against the bad debt provision this month. The provision is currently £310k; this is a reduction of £10k since the start of the year and relates to the write-off of ex-employee debt. This follows advice from the Trust's debt recovery agency, after taking into consideration the value of the debt and the debt recovery activities undertaken.

Payables

The current payables position in Month 3 is £35.2m - an increase of £614k since the previous month and £6.7m since the start of the year. Expenditure accruals and deferred income liabilities continue to increase – these accruals are required to cover the receipt of goods and services where invoices have not yet been received, and to reduce income when cash has been received but relates to future periods.

Provisions

Trust provisions have reduced by £222km since the start of the year and now stand at £4.6m.

Better Payment Practice Code (BPPC)

The specific target is to pay 95% of invoices within 30 days. The Trust achieved all of the 4 BPPC targets in June. Further details are shown in ***Appendix B***.

Capital Programme 2022/23

Capital expenditure totals £3.2m for the first quarter of the year. This comprises of £2.25m relating to property, plant and equipment, and £0.95m for the commencement of a new property lease, required under IFRS16 rules to capitalise right-of-use assets. The new lease supports the accommodation requirements for the Estates and FM transformation programme. The current position against the original April 2022 plan is shown below:

	Annual Plan	June Actual	Year End Forecast	Revision to Plan
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**
Depreciation & technical adjustments	9,500	1,454	9,500	0
Dormitory elimination - Bradgate (PDC)	4,000	794	4,000	0
Agnes unit PFI lifecycle costs	100	0	100	0
Cash utilisation from previous years' surplus - LPT	3,633	0	3,633	0
Cash utilisation to support stroke ward reserve - ICS	1,000	0	1,000	0
Cash utilisation to support system resource reserve - ICS	1,532	0	1,532	0
IFRS-16 leases - borrowings	3,913	959	3,913	0
Total Capital funds	**23,678**	**3,207**	**23,678**	**0**
Application of Funds	**£'000**	**£'000**	**£'000**	**£'000**
Estates				
Estates Service Improvements	(6,395)	(1,059)	(6,395)	0
Estates backlog	(2,637)	(700)	(2,637)	0
Estates other rolling programmes	(1,090)	0	(1,090)	0
Estates Staffing	(431)	(111)	(431)	0
Estates & FM Transformation	(470)	(15)	(470)	0
Medical Devices	(200)	0	(200)	0
Estates Directorate bids	(2,847)	(10)	(2,847)	
	(14,070)	**(1,895)**	**(14,070)**	**0**
IT Programme				
IM&T Rolling Programmes	(1,705)	(214)	(1,705)	0
IM&T Directorate bids	(1,158)	9	(1,158)	0
	(2,863)	**(205)**	**(2,863)**	**0**
Other				
ICS limits allocation	**(2,532)**	**0**	**(2,532)**	**0**
Contingencies	**(300)**	**(148)**	**(300)**	**0**
IFRS16 Leases / ROU Assets	**(3,913)**	**(959)**	**(3,913)**	**0**
Total Capital Expenditure	**(23,678)**	**(3,207)**	**(23,678)**	**0**
(Over)/underspend	**(0)**	**0**	**(0)**	**0**
Total - excluding IFRS16 leases	**(19,765)**	**(2,248)**	**(19,765)**	**0**

A separate capital paper on the Trust Board meeting agenda outlines a number of changes to some of the assumptions underpinning this year's programme. Changes include funding requirements for those schemes not completed by 31st March 2022 (due to delays in materials, site access etc), schemes recognised in the opening plan that now require more funding, and new schemes not known at plan stage. The proposed revised plan balances these additional requirements with other mitigations in order to ensure that the wider programme can still be delivered against available funding. The capital paper includes full details of the proposals, alongside the original plan values, and is presented to the Board for formal approval.

The plan currently includes an additional system capital allocation - £1m was ringfenced for the Stroke ward and £1.5m is currently an un-allocated reserve. In the revised capital plan it is anticipated that the Stroke ward funding will now be used to support the Virtual Wards project. Plans to spend the unallocated system reserve, either by LPT or UHL still need to be determined. The system reserve would technically only be funded by slippage across the wider system, and so the funding is 'locked' until any additional slippage is realised / forecast.

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 30 June 2022	YTD Actual M3 £000	YTD Budget M3 £000	YTD Var. M3 £000
Revenue			
Total income	89,490	87,919	1,570
Operating expenses	(88,957)	(87,387)	(1,570)
Operating surplus (deficit)	**532**	**532**	**(0)**
Investment revenue	0	0	0
Other gains and (losses)	0	0	0
Finance costs	(357)	(357)	0
Surplus/(deficit) for the period	**175**	**175**	**(0)**
Public dividend capital dividends payable	(1,383)	(1,383)	0
I&E surplus/(deficit) for the period (before tech. adjs)	**(1,208)**	**(1,208)**	**(0)**
NHS Control Total performance adjustments			
Exclude gain on asset disposals	**0**	**0**	**0**
NHSE/I I&E control total surplus	**(1,208)**	**(1,208)**	**(0)**
Other comprehensive income (Exc. Technical Adjs)			
Impairments and reversals	0	0	0
Gains on revaluations	0	0	0
Total comprehensive income for the period:	**(1,208)**	**(1,208)**	**(0)**
Trust EBITDA £000	**3,985**	**3,985**	**(0)**
Trust EBITDA margin %	**4.5%**	**4.5%**	**-0.1%**

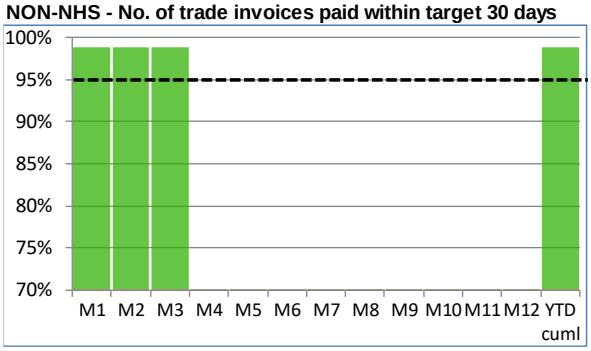
APPENDIX B – BPPC performance

Trust performance – current month (cumulative) v previous

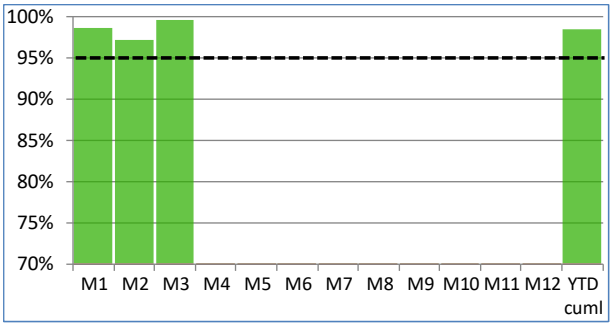
Better Payment Practice Code	June (Cumulative)		May (Cumulative)	
	Number	£000's	Number	£000's
Total Non-NHS trade invoices paid in the year	8,188	26,786	5,684	19,359
Total Non-NHS trade invoices paid within target	8,096	26,404	5,619	19,003
% of Non-NHS trade invoices paid within target	**98.9%**	**98.6%**	**98.9%**	**98.2%**
Total NHS trade invoices paid in the year	175	14,494	103	8,197
Total NHS trade invoices paid within target	173	14,435	102	8,197
% of NHS trade invoices paid within target	**98.9%**	**99.6%**	**99.0%**	**100.0%**
Grand total trade invoices paid in the year	8,363	41,280	5,787	27,556
Grand total trade invoices paid within target	8,269	40,839	5,721	27,200
% of total trade invoices paid within target	**98.9%**	**98.9%**	**98.9%**	**98.7%**

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

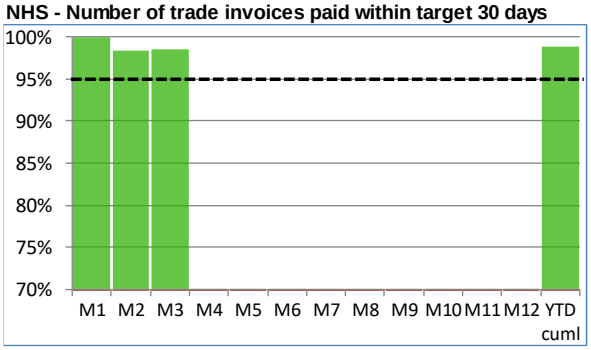
NON-NHS - No. of trade invoices paid within target 30 days



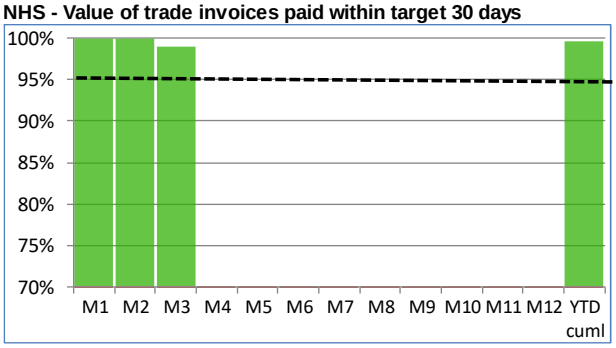
NON-NHS - Value of trade invoices paid within target 30 days



NHS - Number of trade invoices paid within target 30 days



NHS - Value of trade invoices paid within target 30 days



APPENDIX C – Agency staff expenditure

2022/23 Agency Expenditure	2021/22 Outturn £000s Actual	2021/22 Avg mth £000s Actual	2022/23 M1 £000s Actual	2022/23 M2 £000s Actual	2022/23 M3 £000s Actual	2022/23 M4 £000s	2022/23 M5 £000s	2022/23 M6 £000s	2022/23 M7 £000s	2022/23 M8 £000s	2022/23 M9 £000s	2022/23 M10 £000s	2022/23 M11 £000s	2022/23 M12 £000s	22/23 YTD £000s Actual	22/23 initial year end projection £000s (before recovery)
						Initial projections before further financial recovery actions										
DMH																
Agency Consultant Costs	-3,586	-299	-330	-217	-307	-292	-292	-292	-292	-280	-270	-250	-250	-250	-853	-3,319
Agency Nursing	-6,589	-549	-965	-959	-1,052	-975	-885	-803	-714	-591	-525	-572	-573	-527	-2,976	-9,141
Agency Scient, Therap. & Tech	-190	-16	-8	-24	-19	-15	-15	-15	-15	-15	-15	-15	-15	-15	-51	-186
Agency Other clinical staff costs	-12			-19	-4	-7	-7	-7	-7	-7	-7	-7	-7	-7	-23	-84
Agency Non clinical staff costs	-317	-26	-16	-6	-27	-20	-15	-8	-8	-8	-8	-8	-8	-8	-49	-140
Sub-total for Directorate - DMH	**-10,694**	**-890**	**-1,319**	**-1,225**	**-1,409**	**-1,309**	**-1,213**	**-1,124**	**-1,035**	**-901**	**-825**	**-852**	**-853**	**-807**	**-3,952**	**-12,871**
LEARNING DISABILITIES																
Agency Consultant Costs	-133	-11	-37	-13	-22	-21	-21	-21	-6	0	0	0	0	0	-72	-141
Agency Nursing	-2,418	-201	-200	-176	-153	-150	-130	-116	-92	-92	-92	-92	-92	-92	-529	-1,477
Agency Scient, Therap. & Tech	-25	-2	0	-15	-14	-5	0	0	0	0	0	0	0	0	-29	-34
Agency Other clinical staff costs	0														0	0
Agency Non clinical staff costs	-14	-1	-1	-6	-8	0	0	0	0	0	0	0	0	0	-15	-15
Sub-total for Directorate - LD	**-2,590**	**-215**	**-239**	**-209**	**-197**	**-176**	**-151**	**-137**	**-98**	**-92**	**-92**	**-92**	**-92**	**-92**	**-448**	**-1,667**
CHS																
Agency Consultant Costs	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Agency Nursing	-5,864	-489	-746	-683	-657	-630	-630	-560	-560	-560	-600	-600	-550	-550	-2,086	-7,326
Agency Scient, Therap. & Tech	-639	-53	-50	-53	-51	-40	-40	-40	-40	-40	-40	-40	-40	-40	-154	-514
Agency Other clinical staff costs	0														0	0
Agency Non clinical staff costs	-31	-3	0	-14	4	0	0	0	0	0	0	0	0	0	-10	-10
Sub-total for Directorate - CHS	**-6,534**	**-545**	**-796**	**-750**	**-705**	**-670**	**-670**	**-600**	**-600**	-600	**-640**	**-640**	**-590**	**-590**	**-2,251**	**-7,851**
FYPC																
Agency Consultant Costs	-754	-63	-82	-71	-60	-82	-71	-70	-60	-60	-60	-60	-60	-60	-212	-795
Agency Nursing	-4,172	-348	-391	-378	-469	-336	-300	-300	-220	-166	-160	-146	-125	-125	-1,238	-3,116
Agency Scient, Therap. & Tech	-48	-4	-2	-6	-9	0	0	0	0	0	0	0	0	0	-17	-17
Agency Other clinical staff costs	0			0	0	0	0	0	0	0	0	0	0	0	0	0
Agency Non clinical staff costs	-117	-10	-2	-6	-16	-2	-2	-2	0	0	0	0	0	0	-24	-30
Sub-total for Directorate - FYPC	**-5,091**	**-425**	**-476**	**-461**	**-554**	**-420**	**-373**	**-372**	**-280**	**-226**	**-220**	**-206**	**-185**	**-185**	**-1,491**	**-3,958**
Enabling, Hosted & reserves																
Agency Consultant Costs	-10	-1	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-2	-6	-25
Agency Nursing	-89	-7	0	90	0	0	0	0	0	0	0	0	0	0	90	90
Agency Scient, Therap. & Tech	-290	-24	-18	-3	-24	-15	-15	-15	-15	-15	-15	-15	-15	-15	-46	-181
Agency Other clinical staff costs	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Agency Non clinical staff costs	-1,592	-133	-99	-151	-112	-110	-110	-40	-30	-30	-30	-30	-30	-30	-362	-802
Sub-total for Directorate - Enab/Host	**-1,982**	**-165**	**-119**	**-67**	**-138**	**-127**	**-127**	**-57**	**-47**	**-47**	**-47**	**-47**	**-47**	**-47**	**-324**	**-918**
TOTAL TRUST																
Agency Consultant Costs	-4,483	-374	-450	-302	-391	-396	-386	-385	-360	-342	-332	-312	-312	-312	-1,144	-4,280
Agency Nursing	-19,132	-1,594	-2,302	-2,106	-2,331	-2,091	-1,945	-1,779	-1,586	-1,409	-1,377	-1,410	-1,340	-1,294	-6,739	-20,970
Agency Scient, Therap. & Tech	-1,192	-99	-79	-102	-117	-75	-70	-70	-70	-70	-70	-70	-70	-70	-297	-933
Agency Other clinical staff costs	-12			-19	-4	-7	-7	-7	-7	-7	-7	-7	-7	-7	-23	-84
Agency Non clinical staff costs	-2,072	-173	-118	-183	-158	-132	-127	-50	-38	-38	-38	-38	-38	-38	-460	-997
Total	**-26,891**	**-2,240**	**-2,949**	**-2,712**	**-3,002**	**-2,701**	**-2,534**	**-2,290**	**-2,060**	**-1,866**	**-1,824**	**-1,837**	**-1,767**	**-1,721**	**-8,663**	**-27,264**

Total agency costs for June are £3m.

This is the highest monthly cost ever recorded by the Trust,and is 3.5 times higher than the average monthly cost in 2019/20.

Initial projections for the year reflect the measures required within DMH to slow the overall rate of overspend. This is higher than the DMH projection included last month and so represents a more realistic target.

Based on these initial projections, costs for the year would be £27.3m. This is higher than 2021/22 costs whereas the financial plan assumed that agency costs would reduce from the (at the time) unprecedented 21/22 levels (22/23 planned costs are £23.1m).

Whilst the projections factor in the ambition to slow rates within DMH, the ambition must be that the wider focus on reducing reliance on agency staffing will result in a reduction in the forecast later in the year.

APPENDIX D – Cash flow forecast

2022/23 CASH-FLOW FORECAST	JUNE	JUNE	JUNE	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	YTD	21/22
	FORECAST	ACTUAL	VARIANCE	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	FORECAST	ACTUAL	FORECAST
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
OPENING BALANCE	**32,608**	**32,608**	**0**	**29,835**	**33,469**	**31,254**	**27,571**	**30,054**	**27,543**	**25,926**	**25,844**	**23,390**	**31,990**	**31,990**
INCOME														
Leicester & Leicesteshire CCG block contracts	23,278	23,697	**420**	23,278	23,278	23,278	23,278	23,278	23,278	23,278	23,278	23,278	70,252	279,750
Other CCG block contracts	651	477	**(174)**	477	300	300	300	300	300	300	300	300	723	3,600
East Midlands Provider Collaborative - CAMHS	129	129	**0**	129	129	129	129	129	129	129	129	129	387	1,548
Local Authorities block contracts	3,645	1,368	**(2,277)**	3,720	1,443	1,443	1,443	1,443	1,443	1,443	1,443	1,443	2,052	17,316
NHS England	680	680	**0**	1,930	680	680	1,930	680	680	680	680	680	2,040	10,660
UHL contract	474	0	**(474)**	717	243	243	243	243	243	243	243	243	0	2,661
MADEL	0	0	**0**	3,101	0	0	2,312	0	0	2,346	0	0	2,844	10,603
HIS income	100	111	**11**	100	100	100	100	100	100	100	100	255	156	1,211
360 Assurance income	200	8	**(192)**	200	200	200	300	300	300	300	300	397	11	2,508
UHL rental income	0	0	**0**	320	0	0	0	320	0	213	213	214	0	1,280
Previous year's income	500	114	**(386)**	0	0	0	0	0	0	0	0	0	2,644	2,644
VAT	549	549	**0**	520	250	250	250	250	250	250	250	250	1,905	4,425
Property sales	0	0	**0**	0	0	0	0	0	0	0	0	0	0	0
PDC for capital investment	0	0	**0**	0	0	2,000	0	0	0	0	0	2,000	0	4,000
Other income	1,058	660	**(398)**	1,094	1,020	970	2,408	970	970	1,020	1,020	1,616	1,670	12,758
Total Receipts	**31,264**	**27,793**	**(3,471)**	**35,586**	**27,643**	**29,593**	**32,693**	**28,013**	**27,693**	**30,302**	**27,956**	**30,805**	**84,684**	**354,964**
PAYMENTS														
Payroll	20,140	20,017	**(123)**	20,124	20,946	20,948	20,148	20,148	19,148	18,848	18,848	18,848	59,638	237,645
Capital	500	947	**447**	500	500	1,000	1,500	2,000	2,000	3,000	3,000	(77)	1,158	14,581
Non pay general expenditure	5,079	5,676	**597**	4,650	4,650	4,650	4,650	4,650	4,650	5,150	5,150	6,185	17,589	61,974
UHL - Estates & FM Services	2,901	967	**(1,934)**	2,901	967	967	967	967	967	967	967	967	967	11,604
UHL - Other contracts	456	0	**(456)**	608	152	152	152	152	152	152	152	152	0	1,824
NHS Property Services rents	700	605	**(95)**	445	350	600	600	300	300	300	300	300	605	4,100
Community Health Partnerships rents	137	137	**0**	126	126	126	126	126	126	126	126	126	376	1,510
Agency Nursing Costs	1,700	2,217	**517**	2,100	2,000	1,900	1,900	1,900	1,800	1,700	1,700	1,700	6,276	22,976
Out of Area (OOA) costs for patients placed in private hospitals	25	0	**(25)**	50	25	25	25	25	25	0	25	25	0	225
Turning Point	307	0	**(307)**	448	141	141	141	141	141	141	141	142	116	1,693
Public dividend capital payment (PDC)	0	0	**0**	0	0	2,766	0	0	0	0	0	2,766	0	5,532
Other finance costs (inc loan interest and principal repayments)	0	0	**0**	0	0	0	0	115	0	0	0	0	114	229
Total Payments	**31,945**	**30,566**	**(1,379)**	**31,952**	**29,857**	**33,275**	**30,209**	**30,524**	**29,309**	**30,384**	**30,409**	**31,134**	**86,839**	**363,893**
CLOSING CASH BOOK BALANCE	**31,927**	**29,835**	**(2,092)**	**33,469**	**31,254**	**27,571**	**30,054**	**27,543**	**25,926**	**25,844**	**23,390**	**23,061**	**29,835**	**23,061**

APPENDIX E – Covid-19 expenditure, June 2022

Cost of Covid response

CATEGORY	AMH	CHS	FYPC	LD	ESTS	ENAB	HOST	RSRVS	TOTAL
PAY	£000	£000	£000	£000	£000	£000	£000	£000	£000
Expand NHS Workforce - Medical / Nursing / AHPs / Hcare Scientists / Other									
Substantive	6	1	0	0	0	0	0	0	**7**
Bank	92	26	0	0	0	0	0	0	**118**
Agency	2	12	0	0	0	0	0	0	**14**
Existing workforce additional shifts									
Substantive	0	0	0	0	0	5	0	0	**5**
Bank	0	0	15	8	0	0	0	0	**23**
Agency	0	0	0	0	0	0	0	0	**0**
Backfill for higher sickness absence									
Substantive	0	0	0	0	0	0	0	0	**0**
Bank	0	0	0	0	0	0	0	0	**0**
Agency	0	0	0	0	0	0	0	0	**0**
Sick pay at full pay (all staff types)	0	0	0	0	0	0	0	0	**0**
NON-PAY	£000	£000	£000	£000	£000	£000	£000	£000	£000
NHS Staff Accommodation - if bought outside of national process	0	0	0	0	0	0	0	0	**0**
PPE - locally procured	0	0	0	0	0	0	0	0	**0**
PPE - other associated costs	0	0	0	0	0	0	0	0	**0**
Increase ITU capacity (incl hospital assisted respiratory / mech. ventilation)	0	0	0	0	0	0	0	0	**0**
Remote management of patients	0	0	0	0	0	0	0	0	**0**
Support for patient stay at home models	0	0	0	0	0	0	0	0	**0**
Segregation of patient pathways	0	0	0	0	0	0	0	0	**0**
Plans to release bed capacity	0	0	0	0	0	0	0	0	**0**
Decontamination	0	0	0	0	0	0	0	0	**0**
Additional Ambulance Capacity	0	0	0	0	0	0	0	0	**0**
Enhanced Patient Transport Service	1	0	0	0	0	0	0	0	**1**
NHS 111 additional capacity	0	0	0	0	0	0	0	0	**0**
After care and support costs (community, mental health, primary care)	0	0	0	0	15	0	0	0	**15**
Infection prevention and control training	0	0	0	0	0	0	0	0	**0**
Remote working for non patient activites:									
IT/Communication services and equipment	0	0	0	0	0	0	0	0	**0**
Furniture, fittings, office equip for staff home working	0	0	0	0	0	0	0	0	**0**
Internal and external communication costs	0	0	0	0	0	0	0	0	**0**
Covid Testing	0	0	0	0	0	0	0	0	**0**
Business Case (SDF) - Ageing Well - Urgent Response Accelerator	0	0	0	0	0	0	0	0	**0**
Direct Provision of Isolation Pod	0	0	0	0	0	0	0	0	**0**
PPN / support to suppliers (continuity of payments if service is disrupted)	0	0	0	0	0	0	0	0	**0**
TOTAL FOR MONTH 3:	**102**	**39**	**15**	**8**	**15**	**5**	**0**	**0**	**184**
TOTAL M1 - M2 COVID COSTS:	**216**	**142**	**27**	**17**	**24**	**16**	**0**	**0**	**442**
TOTAL YTD COVID COSTS:	**318**	**181**	**42**	**25**	**39**	**21**	**0**	**0**	**626**

The majority of residual Covid costs relate to the Covid bank staff incentive that continues to be paid.

Covid Vaccination costs

Covid vaccination costs continue to be incurred and these are fully underwritten by a NHSE reimbursement. Virtually all the costs relate to staffing, with some minor non-pay costs relating to security at Feilding Palmer and medical supplies.

APPENDIX F – Pressures, Mitigations and Risk analysis

The table below presents an analysis of pressures and mitigations reflected in current positions and likely to factor in a year end position. As such the figures represent annual assumptions. At this stage of the year it is always difficult to produce an accurate forecast, and this year in particular, as services continue to recover, the task is even harder. The scenarios below attempt to factor in current levels of risk in varying levels. Work to identify mitigations is expected to identify further opportunities to offset some of this risk

The risks are quantified and fully reflected in the 'worst case' position.

Likely Risk Scenario				Further Risk	Scenario Analysis			
Description	Pressure £000	Mitigation £000	Net Total £000	Risk, reflected in worst case scenario £000	1. 'Best endeavours' (DELIVERS PLAN) £000	2. Likely risk-adjusted estimate £000	3. Likely risk case, no Trust recovery plan or further agency reduction £000	4. Worst case £000
22/23 budget break-even assumption	-	-	**0**	-	**0**	**0**	**0**	**0**
Operational positions								
Mental Health Directorate	(13,088)	4,895	**(8,193)**	(4,895)	(5,000)	(8,193)	(8,193)	(13,088)
Learning Disabilities	(617)	175	**(442)**	(552)	(200)	(442)	(442)	(994)
Community Health Services	(835)	350	**(485)**	(515)		(485)	(485)	(1,000)
Families, Young People and Childrens Services	(900)	455	**(445)**	(1,026)	(186)	(445)	(445)	(1,471)
Enabling Services	(735)	735	**0**	(278)	250	0	0	(278)
Estates	(200)	200	**0**	(300)	300	0	0	(300)
Hosted Services	(700)	953	**253**	(438)	503	253	253	(185)
Operational Services - total	**(17,075)**	**7,763**	**(9,312)**	**(8,004)**	**(4,333)**	**(9,312)**	**(9,312)**	**(17,316)**
Trustwide/Corporate Approved measures to support staff cost of living financial pressures. Mitigation = potential to offset some of the pay support for lower bands with eventual 22/23 pay award funding	(452)	200	**(252)**	**(248)**	(96)	(252)	(252)	(500)
Risk of further income changes due to revised national out-of-system funding and 'LVA' approach			**0**	(800)	400	0	0	(800)
Further pressure to support additional investment not funded within the plan offer			**0**	(1,124)	0			(1,124)
Impact (above any initial benefit already reflected in operational forecasts) of reducing reliance on agency useage. Assume agency costs can be brought back into line with planning assumptions (£23m for the year)		1,833	**1,833**	(1,833)	1,833	1,833	0	0
Additional financial recovery action plan - to be determined (as required to deliver break-even in 'best-case' break-even position, and estimated c. 1% of budgets in 'likely risk adjusted case')		3,800	**3,800**	(3,800)	2,196	3,800	0	0
TOTAL:	**(17,527)**	**13,596**	**(3,931)**	**(15,809)**	**0**	**(3,931)**	**(9,564)**	**(19,740)**

APPENDIX G – Financial run rates

The table below shows actual run-rates to M3. Projections from M4 do not yet reflect further recovery actions (thus aligning with scenario 3 in ***Appendix F***)

	M1	M2	M3	*M4*	*M5*	*M6*	*M7*	*M8*	*M9*	*M10*	*M11*	*M12*	Year to date	*Risk adjusted outturn*
	£'000	£'000	£'000	*£'000*	*£'000*	*£'000*	*£'000*	*£'000*	*£'000*	*£'000*	*£'000*	*£'000*	£'000	*£'000*
	actual	actual	actual	*Risk adjusted forecast, before wider recovery actions*									actual YTD	
DMH														
PAY	-7,283	-7,508	-7,247	*-7,678*	*-7,632*	*-7,632*	*-7,532*	*-7,532*	*-7,540*	*-7,556*	*-7,549*	*-7,541*	-22,038	***-90,230***
NONPAY	-595	-543	-557	*-557*	*-557*	*-557*	*-557*	*-557*	*-557*	*-557*	*-557*	*-557*	-1,695	***-6,708***
INCOME	407	540	319	*450*	*450*	*450*	*450*	*450*	*450*	*450*	*450*	*450*	1,266	***5,316***
	-7,471	**-7,511**	**-7,485**	***-7,785***	***-7,739***	***-7,739***	***-7,639***	***-7,639***	***-7,647***	***-7,663***	***-7,656***	***-7,648***	**-22,467**	***-91,622***
LD														
PAY	-1,139	-1,153	-1,139	*-1,110*	*-1,110*	*-1,110*	*-1,110*	*-1,110*	*-1,110*	*-1,099*	*-1,095*	*-1,095*	-3,431	***-13,380***
NONPAY	-33	-25	-30	*-34*	*-34*	*-35*	*-35*	*-35*	*-35*	*-35*	*-35*	*-35*	-88	***-401***
INCOME	6	13	7	*7*	*7*	*7*	*7*	*7*	*7*	*7*	*7*	*7*	26	***89***
	-1,166	**-1,165**	**-1,162**	***-1,137***	***-1,137***	***-1,138***	***-1,138***	***-1,138***	***-1,138***	***-1,127***	***-1,123***	***-1,123***	**-3,493**	***-13,692***
CHS														
PAY	-5,836	-5,850	-5,797	*-5,810*	*-5,810*	*-5,810*	*-5,810*	*-5,826*	*-5,916*	*-5,895*	*-5,856*	*-5,856*	-17,483	***-70,073***
NONPAY	-573	-508	-583	*-580*	*-580*	*-580*	*-580*	*-600*	*-610*	*-610*	*-610*	*-681*	-1,664	***-7,095***
INCOME	259	252	286	*245*	*245*	*245*	*245*	*245*	*245*	*245*	*245*	*245*	797	***3,002***
	-6,150	**-6,106**	**-6,094**	***-6,145***	***-6,145***	***-6,145***	***-6,145***	***-6,181***	***-6,281***	***-6,260***	***-6,221***	***-6,292***	**-18,350**	***-74,165***
FYPC														
PAY	-4,691	-4,925	-4,845	*-4,800*	*-4,800*	*-4,750*	*-4,750*	*-4,750*	*-4,700*	*-4,650*	*-4,648*	*-4,646*	-14,461	***-56,955***
NONPAY	-309	-253	-461	*-370*	*-370*	*-370*	*-370*	*-370*	*-365*	*-365*	*-365*	*-365*	-1,023	***-4,333***
INCOME	2,146	2,292	2,371	*2,230*	*2,230*	*2,230*	*2,230*	*2,230*	*2,230*	*2,230*	*2,230*	*2,230*	6,809	***26,879***
	-2,854	**-2,886**	**-2,935**	***-2,940***	***-2,940***	***-2,890***	***-2,890***	***-2,890***	***-2,835***	***-2,785***	***-2,783***	***-2,781***	**-8,675**	***-34,409***
ENAB														
PAY	-2,245	-2,129	-2,149	*-2,243*	*-2,243*	*-2,243*	*-2,243*	*-2,243*	*-2,243*	*-2,243*	*-2,250*	*-2,253*	-6,523	***-26,727***
NONPAY	-926	-1,439	-1,253	*-1,200*	*-1,200*	*-1,200*	*-1,180*	*-1,180*	*-1,180*	*-1,180*	*-1,180*	*-1,200*	-3,618	***-14,318***
INCOME	1,059	1,139	1,134	*1,184*	*1,184*	*1,184*	*1,184*	*1,184*	*1,184*	*1,184*	*1,184*	*1,184*	3,332	***13,988***
	-2,112	**-2,429**	**-2,268**	***-2,259***	***-2,259***	***-2,259***	***-2,239***	***-2,239***	***-2,239***	***-2,239***	***-2,246***	***-2,269***	**-6,809**	***-27,057***
ESTS														
PAY	-30	-56	*-31*	*-31*	*-31*	*-31*	*-31*	*-31*	*-31*	*-31*	*-31*	*-31*	-117	***-396***
NONPAY	-3,020	-2,981	*-3,026*	*-3,050*	*-3,050*	*-3,050*	*-3,050*	*-3,050*	*-3,050*	*-3,050*	*-3,050*	*-3,051*	-9,027	***-36,478***
INCOME	229	234	*243*	*235*	*235*	*235*	*235*	*235*	*235*	*235*	*235*	*235*	706	***2,821***
	-2,821	**-2,803**	**-2,814**	***-2,846***	***-2,846***	***-2,846***	***-2,846***	***-2,846***	***-2,846***	***-2,846***	***-2,846***	***-2,847***	**-8,438**	***-34,053***
HOST														
PAY	-1,617	-1,394	-995	*-991*	*-991*	*-1,001*	*-1,011*	*-1,021*	*-1,021*	*-1,031*	*-1,031*	*-1,031*	-4,006	***-13,135***
NONPAY	-1,015	-1,140	-989	*-1,083*	*-1,083*	*-1,083*	*-1,093*	*-1,093*	*-1,103*	*-1,103*	*-1,103*	*-1,101*	-3,144	***-12,989***
INCOME	2,413	2,711	2,008	*2,042*	*2,042*	*2,052*	*2,052*	*2,062*	*2,062*	*2,062*	*2,062*	*2,062*	7,132	***25,630***
	-219	**177**	**24**	***-32***	***-32***	***-32***	***-52***	***-52***	***-62***	***-72***	***-72***	***-70***	**-18**	***-494***
RESERVES														
PAY	-498	266	-532	*-405*	*-405*	*-405*	*-405*	*-405*	*-405*	*-405*	*-405*	*-405*	-764	***-4,409***
NONPAY	-500	-197	-916	*-466*	*-466*	*-466*	*-467*	*-467*	*-467*	*-467*	*-467*	*-467*	-1,613	***-5,813***
INCOME	23,296	22,257	23,868	*23,300*	*22,930*	*22,930*	*22,930*	*22,930*	*22,930*	*22,930*	*22,930*	*22,920*	69,421	***276,151***
	22,298	**22,326**	**22,420**	***22,429***	***22,059***	***22,059***	***22,058***	***22,058***	***22,058***	***22,058***	***22,058***	***22,048***	**67,044**	***265,929***
TRUST														
PAY	**-23,339**	**-22,749**	**-22,735**	***-23,068***	***-23,022***	***-22,982***	***-22,892***	***-22,918***	***-22,966***	***-22,910***	***-22,865***	***-22,858***	-68,823	***-275,305***
NONPAY	**-6,971**	**-7,086**	**-7,815**	***-7,340***	***-7,340***	***-7,341***	***-7,332***	***-7,352***	***-7,367***	***-7,367***	***-7,368***	***-7,457***	-21,872	***-88,136***
INCOME	**29,815**	**29,438**	**30,236**	***29,693***	***29,323***	***29,333***	***29,333***	***29,343***	***29,343***	***29,343***	***29,343***	***29,333***	89,489	***353,876***
	-495	**-397**	**-314**	***-715***	***-1,039***	***-990***	***-891***	***-927***	***-990***	***-934***	***-890***	***-982***	**-1,208**	***-9,564***

Leicestershire Partnership NHS Trust

Trust Board meeting 26/07/2022

Month 3 Trust finance report

Purpose of the Report

- To provide an update on the Trust financial position.

Proposal

- The Trust Board is recommended to review the summary financial position and receive assurance that year to date financial performance is in line with plan.

Decision required: N/A

Governance table

For Board and Board Committees:	Trust Board 26.7.22	
Paper sponsored by:	Sharon Murphy, Director of Finance & Performance	
Paper authored by:	Amjad Kadri, Acting Head of Corporate Finance Jackie Moore, Financial Controller	
Date submitted:	18/07/2022	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Regular report issued to Operational Executive Board, Finance & Performance Committee and Trust Board meeting.	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Monthly update report	
STEP up to GREAT strategic alignment*:	High **S**tandards	
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	x
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trustwide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	781- Inadequate control, reporting and management of the Trust's 2022/23 financial position could mean we are unable to deliver our financial plan and adequately contribute to the LLR system plan, resulting in a breach of LPT's statutory duties and

		financial strategy (including LLR strategy).
Is the decision required consistent with LPT's risk appetite:	NA	
False and misleading information (FOMI) considerations:	NA	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:	NA	

Leicestershire Partnership NHS Trust

X

Trust Board – 26th July 2022

Annual update of Standing Financial Instructions (SFIs), Scheme of Delegation (SORD), and Standing Orders (SOs)

Purpose of the report

This report is for information only, to make Trust Board aware of the changes to the Trust's SFIs, SORD, and SOs, following approval by the Audit & Assurance Committee on the 10th of June 2022.

Analysis of the issue

The SFIs, SORD and SOs are reviewed annually to make sure they are still fit for purpose and facilitate the changing needs of the Trust, whilst still ensuring robust governance procedures are embedded to support the Trust's strategic plan/objectives.

Proposal

Appendix 1 shows the required changes. It includes the current requirement, the proposed requirement and also the rationale for change.

Decision required

This report is for information only. These changes were presented to the Strategic Executive Board on 27th May 2022 and approved by the Audit & Assurance Committee on the 10th of June 2022. Note – the SO changes, relating to the Custody of Seal, Sealing of Documents and Signature of Documents, received virtual approval by the Audit & Assurance Committee after the meeting on the 10th of June 2022.

1. SFI Changes – June 2022

		SFI Description	Current	Proposal	Rationale for change	Ref
1.	SFI/SORD	15. LOSSES AND SPECIAL PAYMENTS	Report to NHS-I any losses or special payments that are novel, contentious or repercussive in nature	Proposed special payments that are either (i) above £95,000 and/or (ii) considered potentially novel, contentious or could cause repercussions elsewhere in the public sector, should be submitted for HM Treasury approval.	Updated NHSE&I guidance	15.2.11
2.	SFI/SORD	15. LOSSES AND SPECIAL PAYMENTS	All losses and special payments will be reported annually to the Audit and Assurance Committee.	All losses will be annually reported to the Trust's Audit and Assurance Committee (along with the special payments data). Any losses over £300,000 will be subject to additional disclosures including a note in the accounts as identified by HMT Document: Managing Public Money.	Updated NHSE&I guidance	15.2.10
3.	SFI/SORD	6. BANK AND GOVERNMENT BANKING SERVICE (GBS) ACCOUNTS	The Finance & Performance Committee shall approve the banking arrangements in line with the provisions of the Treasury Management Policy.	The Audit & Assurance Committee shall approve the banking arrangements in line with the provisions of the Treasury Management Policy.	Alignment with committee responsibilities	6.1.1
4.	SFI	9. TENDERING AND CONTRACTING FOR THE PURCHASE OF GOODS AND SERVICES	Formal tendering procedures may be waived in the following circumstances:	Formal tendering procedures may be waived in certain circumstances and a CE Waiver form must be raised for CE signature. The circumstances permitted for raising	By removing the specific reasons from the SFI's and including them on the relevant forms, it enables the Trust to amend and adapt these reasons accordingly,	9.5.3.2

		SFI Description	Current	Proposal	Rationale for change	Ref
			9.5.3.2.1. in very exceptional circumstances, where Executive Directors decide that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record; or 9.5.3.2.2. where the requirement is covered by an existing contract; or 9.5.3.2.3. where NHS Supply Chain, relevant contracts available to the public sector or other NHS agreements can be utilised; or 9.5.3.2.4. where a consortium arrangement is in place and a lead organization has been appointed to carry out tendering activity on behalf of the consortium members; or 9.5.3.2.5. where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender; or 9.5.3.2.6. specialist expertise, such as ongoing	a CE waiver are detailed on the waiver form.	rather than undertaking a full SFI review.	

		SFI Description	Current	Proposal	Rationale for change	Ref
			maintenance contracts, is required and is available from only one source; or 9.5.3.2.7. when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate; or 9.5.3.2.8. there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; or 9.5.3.2.9. for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of			

		SFI Description	Current	Proposal	Rationale for change	Ref
			work for which they are commissioned. The Trust Secretary will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.			
5.	SFI	9. TENDERING AND CONTRACTING FOR THE PURCHASE OF GOODS AND SERVICES	New point	Formal tendering procedures may also be waived in certain circumstances that mean there is only a sole provider option to supply. In these instances, a Sole Provider Form must be raised and signed by the relevant Director. The circumstances permitted for raising a sole provider form are detailed on the form.	The introduction of a less onerous sole provider form allows us to monitor spend that doesn't have a contract and has only one legitimate source of supply.	9.5.3.3
6.	SORD	9. TENDERING AND CONTRACTING FOR THE PURCHASE OF GOODS AND SERVICES	Formal tenders (not less than 3) will be sought for contracts with an estimated total contract life value over £50,000. Local tender exercise limits: £50,001 to EU tender limits A minimum of 3 written quotations will be required for orders/contracts with a lifetime	Formal tenders (not less than 3) will be sought for contracts with an estimated total contract life value over £50,000 (not inclusive of VAT). Local tender exercise limits: £50,001 to EU tender limits (not inclusive of VAT) A minimum of 3 written quotations will be required for orders/contracts with a lifetime	Clarity that limits are not inclusive of VAT.	9.5.1 9.7.1.1 & 9.7.2.1

		SFI Description	Current	Proposal	Rationale for change	Ref
			value over £10,000, but less than £50,000	value over £10,000, but less than £50,000 (not inclusive of VAT)		
7.	SFI/SORD	BANK AND GOVERNMENT BANKING SERVICE (GBS) ACCOUNTS	The Finance & Performance Committee shall approve the banking arrangements in line with the provisions of the Treasury Management Policy.	Trust Board shall approve the banking arrangements in line with the provisions of the Treasury Management Policy.	Alignment with the Treasury Management Policy	6.1.1

2. SO CHANGES TO THE CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS – June 2022

		SO Description	Current	Proposal	Rationale for change	Ref
1.	SO	Custody of Seal	The common seal of the Trust shall be kept by the Chief Executive, or a nominated Deputy, by him/her in a secure place.	The common seal of the Trust shall be kept by a nominated seal holder, or a nominated Deputy, in a secure place.	Alignment with more efficient operational processes	8.1
2.	SO	Register of Sealing	The Chief Executive shall keep a register in which he/she, or another manager of the Trust authorised by him/her, shall enter a record of the sealing of every document. A report of the use of the seal shall be made to the Board at least quarterly. The report shall contain details of the seal number, the description of the document and the date of sealing.	The nominated seal holder shall keep a register in which he/she, or another manager of the Trust authorised, shall enter a record of the sealing of every in-scope document. A report of the use of the seal shall be made to the Board each quarter. The report shall contain details of the seal number, the description of the document and the date of sealing.		8.3

		SO Description	Current	Proposal	Rationale for change	Ref
3.	SO	Use of Seal – General guide	(i) All contracts for the purchase/lease of land and/or building (ii) All contracts for capital works exceeding £100,000 (iii) All lease agreements where the annual lease charge exceeds £10,000 per annum and the period of the lease exceeds beyond five years (iv) Any other lease agreement where the total payable under the lease exceeds £100,000 (v) Any contract or agreement with organisations other than NHS or other government bodies including local authorities where the annual costs exceed or are expected to exceed £100,000	(i) All contracts for the purchase/lease of land and/or building (ii) As and when a third-party contractor requests the use of the seal		8.4

Governance table

For Board and Board Committees:	Trust Board (26.07.2022)	
Paper sponsored by:	Sharon Murphy, Director of Finance & Procurement	
Paper authored by:	Jackie Moore, Financial Controller	
Date submitted:	15.07.2022	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	SEB (27.05.2022) A&AC (10.06.2022)	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Assured	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Next report to be submitted to Trust Board for final approval	
STEP up to GREAT strategic alignment*:	High **S**tandards	
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	X
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trustwide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	All Finance risks
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	N/A	
Positive confirmation that the content does not risk the safety of patients or the public	Yes, there is no risk to patients or public	
Equality considerations:	No equality impact	

Y

Leicestershire Partnership NHS Trust

Public Trust Board – 26.07.22

Board Performance Report June 2022 (Month 3)

Purpose of the report

To provide the Trust Board with the Trust's performance against KPI's for June 2022 Month 3.

Analysis of the issue

The report is presented to Operational Executive Team each month, prior to it being released to level 1 committees.

Proposal

The following should be noted by the Trust Board with their review of the report:

- The '72-hour follow-up after discharge' metric has increased performance following correction of data for June-22. Previous months performance is expected to increase once national reporting has been updated.
- The NHS System Oversight Framework Segmentation Score has been added under 'Regulatory Ratings' within the 'NHS Oversight' section.
- E.Coli bloodstream infections data has not been received for June-22 from UHL.

Decision required

The Trust Board is asked to

- Approve the performance report

Governance table

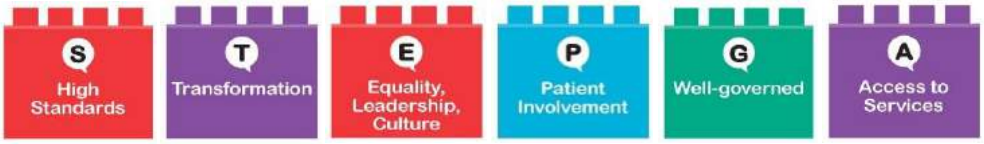
For Board and Board Committees:	Trust Board 26.7.22	
Paper sponsored by:	Sharon Murphy, Interim Director of Finance and Performance	
Paper authored by:	Prakash Patel, Acting Head of Information	
Date submitted:	18.07.22	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	N/A	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	None	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Standard month end report	
STEP up to GREAT strategic alignment*:	High **S**tandards	
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	x
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trustwide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	20 - Performance management framework is not fit for purpose
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:	None identified	

Leicestershire Partnership NHS
NHS Trust

Trust Board
26 July 2022

Board Performance Report
June 2022 (Month 3)

The metrics in this report relate to the following bricks in the Step Up to Great Strategy



Highlighted Performance Movements - June 2022

Improved performance:

Metric	Performance	
Gatekeeping Target is >=95%	100.0%	
Discharges followed up within 72hrs Target is >=80%	82.0%	

Deteriorating Performance:

Metric	Performance	
ADHD (18 week local RTT) Target is Complete - 95%	5.3%	
Aspergers - 18 weeks (complete pathway) Target is 95%	0.0%	

Other areas to highlight:

Metric	Performance (No)	
Serious Incidents	5	Increased from 3 reported last month
Total number of Category 4 pressure ulcers developed or deteriorated in LPT care	4	Increased from 2 reported last month
No. of episodes of prone (Supported) restraint	1	Increased from 2 reported last month
No. of repeat falls *Target decreasing trend*	32	Increased from 36 reported last month

1. Hospital Acquired COVID Infection Reporting

A nosocomial infection is an infection that is acquired in a hospital or other health care facility. How likely each patient Covid-19 case is to be a nosocomial case is based on the duration of time between admission to a healthcare facility and positive specimen date;.

- **Hospital-Onset Probable Healthcare-Associated** – positive specimen date 8 -14 days after hospital admission.
- **Hospital-Onset Definite Healthcare-Associated** – positive specimen date 15 or more days after hospital admission.

Indicator	Trust Position												
Total Admissions		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Sparkline
	Total Admissions	398	437	418	404	412	391	436	403	379	400	359	397	
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Sparkline
	Total Admissions	360	383	380										
Covid Positive Prior to Admission		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Sparkline
	Total Covid +ve Admissions	1	0	3	6	20	12	13	12	17	30	4	25	
	Covid +ve Admission Rate	0.3%	0.0%	0.7%	1.5%	4.9%	3.1%	3.0%	3.0%	4.5%	7.5%	1.1%	6.3%	
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Sparkline
	Total Covid +ve Admissions	13	3	7										
	Covid +ve Admission Rate	3.6%	0.8%	1.8%										
Covid Positive Following Swab During Admission	No of Days	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Sparkline
	0-2	0	0	0	0	1	1	2	1	3	4	6	5	
	3-7	0	1	0	0	2	1	1	1	8	6	7	9	
	8-14	0	0	0	0	1	0	3	1	7	6	2	7	
	15 and over	1	0	0	0	2	2	11	0	38	43	11	22	
	Hospital Acquired Rate *	0.3%	0.0%	0.0%	0.0%	0.7%	0.5%	3.2%	0.2%	11.9%	12.3%	3.6%	7.3%	
	No of Days	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Sparkline
	0-2	3	0	4										
	3-7	17	2	9										
	8-14	15	2	5										
	15 and over	34	5	33										
	Hospital Acquired Rate *	13.6%	1.8%	10.0%										
	• Community-Onset (CO) positive specimen date - <=2 days after hospital admission or hospital attendance. *• Hospital-Onset Indeterminate Healthcare Associated (HO.IHA) – positive specimen date 3-7 days after hospital admission.* *• Hospital-Onset Probable Healthcare-Associated (HO.pHA) – positive specimen date 8 -14 days after hospital admission.* *• Hospital-Onset Definite Healthcare-Associated (HO.dHA) – positive specimen date 15 or more days after hospital admission.* ** - Includes the Hospital-Onset Probable Healthcare-Associated and Hospital-Onset Definite Healthcare-Associated categories.*												
Overall Covid Positive Admissions Rate		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Sparkline
	Total Covid +ve Admissions	2	1	3	6	26	16	30	15	73	89	30	68	
	Average Covid +ve Admissions	0.5%	0.2%	0.7%	1.5%	6.3%	4.1%	6.9%	3.7%	19.3%	22.3%	8.4%	17.1%	
		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Sparkline
	Total Covid +ve Admissions	82	12	58										
	Average Covid +ve Admissions	22.8%	3.1%	15.3%										

Current LPT data sources for nosocomial Covid-19

Daily Directorate Covid-19 Sit-rep reports

The template includes; number of confirmed Covid-19 patients diagnosed with Covid-19 between midnight to 23.59:59 on the day before against the date of the positive specimen in line with the above definitions. This information is submitted directly to the ICC and copied to the Trust Infection Prevention and Control team.

IPC team local access database

The IPC team have a local access database for clinical patient reviews that captures all patients with long term infections and more recently Covid-19. The data source is taken from the daily Directorate sit-reps, or through IPC referrals. Data is validated using SystmOne records and ilab to confirm results. The system is backed up daily.

The objective is to move to a utilising System1 functionality when it is available, with reporting through Qliksense. The Information and IPC teams are currently working up this system and process.

Internal reporting

The increase in nosocomial Covid-19 cases and admissions in June 2022 reflects the new wave of increased cases due to two new Omicron sub-variants which has nationally led to an increase in community transtion and subsequently nosocomial cases and outbreaks. Covid restrictions have lifted in social and health settings such as universal mask use, people are mixing more, which gives the virus more chances to spread. Local surveillance and data is used to shape actions and guidance in line with our local risk assessments and in conjunction with system partners

Actions to minimise nosocomial Covid-19 infection

The weekly Trust wide outbreak meeting has been reinstated due to an increase in Covid-19 outbreaks to ensure lessons learnt and actions are widely shared.

2. Quality Account

The following standards form the measures for the 2020/21 Quality Account that are being reported against in 2022/23 until the new metrics have been agreed.

Standard	Trust Performance	RAG/ Comments on recovery plan position	SPC Flag	
			Assurance of Meeting Target	Trend
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period Target is >=95%	Jan-22: 100.0%; Feb-22: 98.5%; Mar-22: 100.0%; Apr-22: 98.4%; May-22: 98.1%; Jun-22: 100.0%		?	UP Over the series of data points being measured, key standards are being delivered inconsistently
The Trusts "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period No Target	2017/18: 7.4; 2018/19: 6.4; 2019/20: 7.1; 2020/21: 6.9; 2021/22: 6.4	The majority of scores within Leicestershire Partnership NHS Trust sit in the bottom 20% of the Trusts surveyed by Quality Health. There are 7 scores in the intermediate 60% range and no scores in the top 20% range. Despite this, the Trust does perform fairly well on the score for service users knowing how to contact the person in charge of organising their care if they have a concern.	n/a	n/a *Not applicable for SPC as reported infrequently*
The percentage of inpatients discharged with a subsequent inpatient admission within 30 days No Target	**Age 0-15** Jan-22: 0.0%; Feb-22: 0.0%; Mar-22: 0.0%; Apr-22: 0.0%; May-22: 0.0%; Jun-22: 0.0% **Age 16 or over** Jan-22: 5.8%; Feb-22: 3.7%; Mar-22: 5.9%; Apr-22: 5.8%; May-22: 5.2%; Jun-22: 5.5%		n/a	n/a
The number and, where available rate of patient safety incidents reported within the Trust during the reporting period No Target	Jan-22: 1167, 53.5%; Feb-22: 1132, 60.7%; Mar-22: 1203, 54.0%; Apr-22: 1389, 58.0%; May-22: 1342, 63.6%; Jun-22: 1209, 60.5%		n/a	n/a
The number and percentage of such patient safety incidents that resulted in severe harm or death No Target	Jan-22: 8, 0.7%; Feb-22: 14, 1.2%; Mar-22: 9, 0.7%; Apr-22: 11, 0.8%; May-22: 9, 0.7%; Jun-22: 4, 0.3%		n/a	n/a
72 hour Follow Up after discharge Target is >=80% *Aligned with national published data* *(reported a quarter in arrears)*	Oct-21: 54.0%; Nov-21: 56.0%; Dec-21: 60.0%; Jan-22: 59.0%; Feb-22: 61.0%; Mar-22: 82.0%	• LPTs internal reports have been amended to reflect the national reporting which has resulted in a fall in performance. • Investigation of LPTs data indicates differences in reporting methodology and, therefore, a proportion of follow up contacts recorded in LPT will not flow into the MHSDS. • This does not mean that performance has dropped in terms of clinical interventions. • The has been corrected retrospectively and will be resubmitted to the MHSDS.	N/A	N/A

3. CQUINs

The following indicators form part of the 2022/2023 National CQUIN scheme. These will be reported in line with the national submission requirements

4. Mental Health Core Data Pack

The following indicators are LPT's performance as per the Mental Health Core Data Pack. The source for this data is nationally submitted data. Performance is published a quarter in arrears.

<table>
<tr><th>Target</th><th>Trust Performance</th><th>RAG/ Comments on recovery plan position (LPT)</th></tr>
<tr><td>(B1) Discharges followed up within 72hrs

Target is >=80%</td><td>
<table>
<tr><th></th><th>Oct-21</th><th>Nov-21</th><th>Dec-21</th><th>Jan-22</th><th>Feb-22</th><th>Mar-22</th></tr>
<tr><td>LLR</td><td>52.0%</td><td>57.0%</td><td>61.0%</td><td>64.0%</td><td>60.0%</td><td>82.0%</td></tr>
<tr><td>LPT</td><td>54.0%</td><td>56.0%</td><td>60.0%</td><td>59.0%</td><td>61.0%</td><td>82.0%</td></tr>
</table>
</td><td>• LPTs internal reports have been amended to reflect the national reporting which has resulted in a fall in performance.
• Investigation of LPTs data indicates differences in reporting methodology and, therefore, a proportion of follow up contacts recorded in LPT will not flow into the MHSDS.
• This does not mean that performance has dropped in terms of clinical interventions.
• The has been corrected retrospectively and will be resubmitted to the MHSDS.</td></tr>
<tr><td>(D1) Community Mental Health Access (2+ contacts)

No Target</td><td>
<table>
<tr><th></th><th>Oct-21</th><th>Nov-21</th><th>Dec-21</th><th>Jan-22</th><th>Feb-22</th><th>Mar-22</th></tr>
<tr><td>LLR</td><td>8545</td><td>9120</td><td>9520</td><td>9980</td><td>10440</td><td>10940</td></tr>
<tr><td>LPT</td><td>8450</td><td>9035</td><td>9475</td><td>9940</td><td>10410</td><td>10950</td></tr>
</table>
</td><td></td></tr>
<tr><td>(E1) CYP access (1+ contact)

LLR Target is 9531</td><td>
<table>
<tr><th></th><th>Oct-21</th><th>Nov-21</th><th>Dec-21</th><th>Jan-22</th><th>Feb-22</th><th>Mar-22</th></tr>
<tr><td>LLR</td><td>8505</td><td>8465</td><td>8480</td><td>10465</td><td>11055</td><td>11545</td></tr>
<tr><td>LPT</td><td>5680</td><td>5740</td><td>5710</td><td>5795</td><td>5860</td><td>5895</td></tr>
</table>
</td><td></td></tr>
<tr><td>(E4) CYP eating disorders waiting time - Routine

Target is >=95%

Rolling 12 months (quarterly)</td><td>
<table>
<tr><th></th><th>Nov-21</th><th>Dec-21</th><th>Jan-22</th><th>Feb-22</th><th>Mar-22</th><th>Apr-22</th></tr>
<tr><td>LLR</td><td></td><td>33.0%</td><td></td><td></td><td>31.4%</td><td></td></tr>
<tr><td>LPT</td><td></td><td>32.7%</td><td></td><td></td><td>31.4%</td><td></td></tr>
</table>
</td><td></td></tr>
<tr><td>(E5) CYP eating disorders waiting time - Urgent

Target is >=95%

Rolling 12 months (quarterly)</td><td>
<table>
<tr><th></th><th>Nov-21</th><th>Dec-21</th><th>Jan-22</th><th>Feb-22</th><th>Mar-22</th><th>Apr-22</th></tr>
<tr><td>LLR</td><td></td><td>64.2%</td><td></td><td></td><td>68.1%</td><td></td></tr>
<tr><td>LPT</td><td></td><td>64.2%</td><td></td><td></td><td>68.1%</td><td></td></tr>
</table>
</td><td></td></tr>
<tr><td>(G3) EIP waiting times - MHSDS

Target is >=60%</td><td>
<table>
<tr><th></th><th>Oct-21</th><th>Nov-21</th><th>Dec-21</th><th>Jan-22</th><th>Feb-22</th><th>Mar-22</th></tr>
<tr><td>LLR</td><td>65.6%</td><td>67.8%</td><td>79.5%</td><td>79.2%</td><td>74.0%</td><td>83.0%</td></tr>
<tr><td>LPT</td><td>65.2%</td><td>69.0%</td><td>77.8%</td><td>80.9%</td><td>76.0%</td><td>83.3%</td></tr>
</table>
</td><td></td></tr>
<tr><td>(I1) Individual Placement Support

LLR Target is 553</td><td>
<table>
<tr><th></th><th>Oct-21</th><th>Nov-21</th><th>Dec-21</th><th>Jan-22</th><th>Feb-22</th><th>Mar-22</th></tr>
<tr><td>LLR</td><td>190</td><td>210</td><td>220</td><td>245</td><td>265</td><td>290</td></tr>
<tr><td>LPT</td><td>190</td><td>210</td><td>220</td><td>245</td><td>265</td><td>290</td></tr>
</table>
</td><td>Significant recruitment has recently taken place which should improve compliance against targets going forward.</td></tr>
</table>

(K2) OOA bed days - inappropriate only

No Target

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
LLR	0	0	0	0	0	0
LPT	0	0	0	0	0	0

(L1) Perinatal access - rolling 12 months

No Target

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
LLR	430	420	405	495	550	660
LPT	430	415	395	485	535	655

As below.

(L2) Perinatal access - year to date

LLR Target is 1085

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
LLR	380	420	460	520	580	640
LPT	345	345	455	515	570	635

- Demand and capacity completed, findings are currently being finalised.
- Communication plan has been developed with the intention of increasing the portfolio of the service and, therefore, the nubmer of referrals.
- Working closely with NHFT colleagues with the intent of sharing best practice with our buddy Trust.
- Strengthening of the leadership team supporting the Perinatal Service via recruitment to supporting roles.

(N1) Data Quality - Consistency

No Target

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
LLR	100.0%	80.0%	80.0%	100.0%	100.0%	100.0%
LPT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

(N2) Data Quality - Coverage

Target is >=85%

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
LLR	66.7%	66.7%	71.4%	71.4%	71.4%	71.4%
LPT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

(N3) Data Quality - Outcomes

Target is >=40%

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
LLR	29.1%	28.5%	28.4%	28.2%	28.3%	27.8%
LPT	29.1%	28.6%	28.4%	28.3%	28.4%	28.0%

(N4) Data Quality - DQMI score

Target is >=80

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
LLR	57.3	63.0	57.0	55.8	57.3	59.0
LPT	93.0	93.0	90.0	90.0	93.0	93.0

(N5) Data Quality - SNOMED CT

Target is >=85%

	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
LLR	74.3%	72.7%	74.5%	72.7%	73.2%	71.7%
LPT	75.9%	75.9%	75.7%	76.1%	76.0%	74.3%

5. NHS Oversight

The following targets form part of the 2021/22 NHS Oversight Framework that are being reported against in 2022/23. We continue working with Commissioners to understand the metrics to be reported at system/organisational level.

Target	Trust Performance						RAG/ Comments on recovery plan position
2-hour urgent response activity Early Implementer Target is 70% *(Local data)*	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	
				71.1%	73.9%	79.8%	
Daily discharges as % of patients who no longer meet the criteria to reside in hospital No Target	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	
				15.3%	13.4%	16.4%	
Reliance on specialist inpatient care for adults with a learning disability and/or autism *(CCG data)* No Target	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	
				30	29	31	
Reliance on specialist inpatient care for children with a learning disability and/or autism *(CCG data)* No Target	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	
				4	4	5	
Regulator Ratings No Target	Overall CQC rating (provision of high quality care)		2021/2022	NHS SOF Segmentation Score		2022/2023	
			2			2	
	2 = requires improvement			*Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues*			
Potential under-reporting of patient safety incidents - Number of months in which patient safety incidents or events were reported to the NRLS No Target	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
	April 2022 is the most recent data published						
National Patient Safety Alerts not completed by deadline No Target	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	
				0	0	0	
	Reporting is at point in time and cannot be backdated.						
MRSA Infection Rate No Target *(local data)*	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	
	0	0	0	0	0	0	

Clostridium difficile infection rate No Target *(local data)*	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	
	1	3	1	0	2	0	
E.coli bloodstream infections No Target *(local data - month in arrears)*	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	
					3	TBC	
VTE Risk Assessment No Target	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	
	Indicator is a placeholder as is not yet defined in the SOF Technical Guidance						
Percentage of people aged 65 and over who received a flu vaccination No Target *LLR data*	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	
	32.8%	63.6%	80.1%	83.1%	83.2%	83.5%	
	February 2022 is the most recent data published						
Proportions of patient activities with an ethnicity code No Target	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	
	Indicator is a placeholder as is not yet defined in the SOF Technical Guidance						

6(a). Access - Waiting Time Standards - DMH

The following performance measures (reported a month in arrears) are key waiting time standards for the Trust:

Target	Performance							RAG/ Comments on recovery plan position	SPC Flag	
									Assurance of Meeting Target	Trend
Adult CMHT Access Six weeks routine Target is 95%		Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	•New assessment model is being trialled and will be rolled out across all CMHTs as workforce allows. This will link into system wide working including working in system partnership. •A new duty system which combines medic and professional duty rotas into one is being rolled out. 4 community teams have implemented this and it will continue to roll out to all community teams by end of June. The purpose of this is to increase capacity in the medical workforce and improve communication for patients. •Caseload reviewing the skill mix of each of the teams to ensure that each patient is seeing the most appropriate practitioner and that caseloads are aligned to the appropriate clinician	N/A	N/A
	Complete	71.7%	62.2%	61.6%	65.4%	63.4%	56.7%			
	Incomplete	72.5%	72.1%	71.1%	61.5%	55.8%	57.1%		NO	UP
									Key standards are not being delivered but are improving	
Memory Clinic (18 week Local RTT) Target is 95%		Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	•Attempts to recruit to nursing posts have so far been unsuccessful. The advert is now to be posted as a Mental Health Professional vacancy to broaden the options. •Looking at other posts within the service to support the future model, eg Advanced Clinical Practitioners. • As part of SUTG to review the current memory service pathway with the team and agree what the future model will look like. • QI Work being undertaken including demand and capacity work, review of clinic capacity (estates) and pilot of OT post	N/A	N/A
	Complete	49.2%	30.8%	44.3%	43.3%	41.2%	39.7%			
	Incomplete	79.7%	78.6%	72.7%	64.8%	62.9%	64.9%		N/A	N/A
ADHD (18 week local RTT) Target is: Complete - 95% Incomplete - 92%		Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	• A recovery plan has been developed with engagement through a time out day including clinicians and commissioners. •Band 4 recruitment currently taking place to support with Qb testing. The ADHD Assistant Service Manager has been appointed and commences in post 19th June 2022 •Series of monthly team workshops to be put in place to develop pathways, initially looking at assessment process and how this can be improved. • There is MHIS funding which will be used to deliver System wide ADHD support	N/A	N/A
	Complete	6.3%	14.3%	7.1%	12.5%	38.9%	5.3%			
	Incomplete	29.8%	28.0%	26.1%	21.9%	15.2%	9.5%		N/A	N/A
Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral Target is >=60%		Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22		?	UP
		90.9%	85.7%	75.0%	94.1%	92.3%	88.5%			
									Over the series of data points being measured, key standards are being delivered inconsistently	

6(b). Access - Waiting Time Standards - CHS

The following performance measures (reported a month in arrears) are key waiting time standards for the Trust:

Target	Performance						RAG/ Comments on recovery plan position	SPC Flag	
								Assurance of Meeting Target	Trend
CINSS - 20 Working Days (Complete Pathway) Target is 95%	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	•Urgent compliance consistently 100% •31.6% reduction in waiting list numbers over past 6 months. •Overall clock stops (new patients starting treatment) in last 6 months has increased. •Longest waiters at 28 & 29 weeks, but drops to 24 weeks after this. •Number of discharges in May-22 increased which helped with patient flow.	N/A	N/A
	32.2%	32.3%	21.1%	26.4%	22.8%	25.8%			
Continence (Complete Pathway) Target is 95%	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	•Numbers waiting decreased month on month since Dec 2021 (1940 to 1378) •50+ day waiters has decreased month on month since Dec 2021 (1286 to 755) •Complete compliance has increased from 36.6% in Dec 2021 to 48% in May 2022 •Incomplete compliance has increased from 24% in Dec 2021 to 39% in May 2022 •Clinical face to face DNA rate decreased to 14% from 2%	N/A	N/A
	36.6%	41.2%	47.6%	42.1%	39.8%	48.2%			

6(c). Access - Waiting Time Standards - FYPC

The following performance measures (reported a month in arrears) are key waiting time standards for the Trust:

Target	Performance							RAG/ Comments on recovery plan position	SPC Flag	
									Assurance of Meeting Target	Trend
CAMHS Eating Disorder – one week (complete pathway) Target is 95%		Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Urgent - The Service has seen a sustained increase in urgent referrals, which is consistent with the National profile. Referrals are prioritised and additional capacity has been agreed through the MHIS. An improvement plan and trajectory are in place, which has Executive oversight. CYP are supported in the community whilst waiting through First Steps	?	NO CHANGE
		100.0%	100.0%	100.0%	83.3%	50.0%	100.0%		Over the series of data points being measured, key standards are being delivered inconsistently	
CAMHS Eating Disorder – four weeks (complete pathway) Target is 95%		Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Routine - routine referrals are being delayed due to the prioritisation of urgent cases. Additional capacity has been agreed through the MHIS and an improvement plan is in place, with Executive oversight. The current recovery trajectory has plateaued due to new posts being filled slower than anticipated. However, once new staff in post we expect the trajectory to recover.	NO	NO CHANGE
		25.0%	50.0%	30.0%	20.0%	25.0%	25.0%		Over the series of data points being measured, key standards are not being delivered and are deteriorating	
Children and Young People's Access – four weeks (incomplete pathway) Target is 92%		Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	The service are now consistently meeting this target	?	UP
		100.0%	100.0%	100.0%	100.0%	100.0%	93.8%		Over the series of data points being measured, key standards are being delivered inconsistently	
Children and Young People's Access – 13 weeks (incomplete pathway) Target is 92%		Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	A recent spike in referrals is being addressed through additional clinics	?	DOWN
		100.0%	90.0%	86.3%	84.4%	90.3%	43.5%		Over the series of data points being measured, key standards are being delivered inconsistently	
Aspergers - 18 weeks (complete pathway) Target is 95%	Wait for Treatment	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Adult Autism Assessment Service – 0% - The service did not meet the measure, with all 18 patients seen outside the measure. The service has received record referrals with 847 referrals by the end of 2021/22. This would be an increase of 122% from the 2020/21 referral rate of 20/21 or 54% from the previous record of 549 referrals in 2019/20.	N/A	N/A
		75.0%	6.5%	30.0%	35.7%	0.0%	0.0%			
	No. of Referrals	92	70	67	78	60	95			
LD Community - 8 weeks (complete pathway) Target is 95%	Wait for Assessment	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	The service has implemented a new 'Access' pathway, which completes the initial core assessment for all pathways and then directing to the apprpriate pathway. The KPI's for this new process are being completed. The current data is illustrating the backlog of patients waiting prior to new Access pathway as the last few complete	N/A	N/A
		72.1%	49.3%	20.7%	16.7%	6.7%	65.7%			
	No. of Referrals	78	3	0	90	69	77			
6-week wait for diagnostic procedures (Incomplete) Target is >=99%		Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	In line with national COVID-19 guidance, this service was suspended. It was re-established in October 2020. We were able to address a significant amount of the backlog in 2021/22 with additional Headroom Investment. The service is struggling with staffing issues now with 2 staff going on maternity/adoption leave and we are in the process of recruiting cover. The service has reviewed their COVID IPC arrangements and are now offering close to pre-covid numbers per clinic. A new trajectory for the service has been completed and there is a slow recovery until August then with recruitment completed this rapidly increases from September with expected full recovery in December 2022	YES	DOWN
		57.9%	67.9%	79.0%	85.9%	74.1%	70.1%		Key standards are being delivered but are deteriorating	

7. 52 week waits

No patient should wait for more than 52 weeks from referral to the start of their treatment.

The following services have 52 week waits within their service:

Target	Trust Performance						Longest wait (latest month)	RAG/ Comments on recovery plan position	SPC Flag	
									Assurance of Meeting Target	Trend
Cognitive Behavioural Therapy	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	65 weeks	The CBT improvement plan remains effective in supporting the number of 52 week waiters to fall. Trajectories are being reset for 2022/23.	NO	DOWN
	23	16	10	9	14	18			Key standards are not being delivered but are improving	
Dynamic Psychotherapy	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	107 weeks	The number of 52 week waiters are below the planned trajectory. Long term, sustainable reduction in wait times to be delivered via Step Up to Great Mental Health transformation plan, integrating assessment and intervention within the locality Treatment and Recovery Teams. Trajectories are being reset for 2022/23.	NO	DOWN
	24	24	14	11	9	11			Key standards are not being delivered but are improving	
Therapy Service for People with Personality Disorder - Treatment waiters over 52 weeks	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	508 weeks	• Jan-April 2022 the service has commenced with training SCM groups. These groups have also trained SCM staff to begin the roll out of locality SCM-Decider programme. • Following recruitment of new staff and the development of the SCM decider programme, a significant number of service users being offered and completing treatment within locality teams over the next 12-18 months. • Implementing a QI approach to evaluate this implementation plan. • Trajectories are being reset for 2022/23. • The longest patient waiting is a processing error. The patient has been seen for assessment and treatment. Reporting methodology is currently being scoped.	NO	UP
	472	490	479	478	501	472			Key standards are not being delivered and are deteriorating/ not improving	
Therapy Service for People with Personality Disorder - assessment waits over 52 weeks (a month in arrears)	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	190 weeks	• The TSPPD Service is achieving against the agreed trajectory to reduce the number of patients waiting for assessment for over 52 weeks. • As part of step-up-great the service continues to work to a position whereby all first assessments for planned treatment, which includes those going onto the TSPPD pathway, will be provided through the planned treatment and recovery teams as part of a pathfinder/consulter assessment process. This will serve as the initial assessment as part of an integrated planned community offer. • Trajectories are being reset for 2022/23.	N/A	N/A
	324	330	329	326	320	321				
CAMHS	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	93 weeks	As at 3rd June 125 waiting over a year, 121 for treatment and 4 for neuro-developmental diagnosis. This is a sustained improvement position. Both lists are performing against the expected trajectory. Average wait for an ND assessment is 25 weeks down from a peak of 38 weeks, this is a sustained gradual recovery	NO	NO CHANGE
	148	150	136	138	124	121			Key standards are not being delivered and are deteriorating/ not improving	
All LD - No's waiting over 52 weeks	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	93 weeks	The majority of these are with the Adult Autism Service. There are still a few not wishing to be seen due to increase vulnerabilities.	N/A	N/A
	30	42	55	58	75	83				

8. Patient Flow

The following measures are key indicators of patient flow:

Target	Trust Performance						RAG/ Comments on recovery plan position	SPC Flag	
								Assurance of Meeting Target	Trend
Occupancy Rate - Mental Health Beds (excluding leave) Target is <=85%	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Occupancy levels are closely monitored and actions taken in line with the covid surge plans to ensure adequate capacity is available on a day to day basis.	?	NO CHANGE
	80.1%	83.8%	81.2%	74.8%	81.7%	85.4%		Over the series of data points being measured, key standards are being delivered inconsistently	
Occupancy Rate - Community Beds (excluding leave) Target is >=93%	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Work continues to identify the reasons for delayed discharges to LPT and now working collaboratively to ensure patients are not delayed going forwards. Extended criteria to admit patients awaiting packages of care with a start date (this may contribute to increased length of stay going forwards).	?	NO CHANGE
	82.7%	90.2%	87.9%	91.8%	93.5%	93.0%		Over the series of data points being measured, key standards are being delivered inconsistently	
Average Length of stay Community hospitals National benchmark is 25 days.	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	The Trust consistently is below the national benchmark of 25 days.	YES	UP
	19.5	20.3	21.1	21.1	25.2	23.2		Key standards are being delivered but are deteriorating	
Delayed Transfers of Care Target is <=3.5% across LLR	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	NHS Digital has advised this national metric is being paused to release resources to support the COVID-19 response. We will continue to monitor locally.	?	NO CHANGE
	3.7%	4.9%	5.1%	6.4%	4.6%	5.4%		Over the series of data points being measured, key standards are being delivered inconsistently	
Gatekeeping Target is >=95%	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22		?	UP
	100.0%	98.5%	100.0%	98.4%	98.1%	100.0%		Over the series of data points being measured, key standards are being delivered inconsistently	
Inpatient Admissions to LD and MH Wards with a Learning Disability *(Rolling 12 Month)* Target: Adult =36 CYP=3	**Adult**						The service are working through issues with the data.	N/A	N/A
	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22			
	13	14	14	11					
	CYP								
	Work is ongoing to define and agree methodology. Back-dated information will be produced once information is signed off.								
Admissions to adult facilities of patients under 18 years old Target = 0	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22		n/a	n/a
	0	0	0	0	0	0			

9. Quality and Safety

Target	Trust Performance							RAG/ Comments on recovery plan position	SPC Flag	
									Assurance of Meeting Target	Trend
Serious incidents		Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22		?	NO CHANGE
		6	7	6	1	3	5		Over the series of data points being measured, key standards are being delivered inconsistently	
	Indicator under review									
Safe staffing No. of wards not meeting >80% fill rate for RNs Target 0		Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22		NO	NO CHANGE
	Day	7	4	5	3	3	4			
	Night	1	0	0	0	0	1		Key standards are not being delivered and are not improving *SPC based on day shift*	
Care Hours per patient day No Target		Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22		N/A	N/A
		12.1	11.9	12.1	12.7	12.3	12.4		Key standard has no target; however performance is consistent	
No. of episodes of seclusions >2hrs Target decreasing trend		Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22		N/A	NO CHANGE
		19	16	10	19	20	13		Key standard has no target; however performance is consistent	
No. of episodes of prone (Supported) restraint Target decreasing trend		Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22		N/A	DOWN
		3	2	3	2	0	1		Key standard has no target; however performance is consistent	
No. of episodes of prone (Unsupported) restraint Target decreasing trend		Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22		N/A	NO CHANGE
		0	0	1	0	0	0		Key standard has no target; however performance is consistent	
Total number of Restrictive Practices (No target)		Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22		N/A	N/A
		267	246	353	317	315	190			

No. of Category 2 and 4 pressure ulcers developed or deteriorated in LPT care Target decreasing trend (RAG based on commissioner trajectory)		Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22		N/A	NO CHANGE
	Category 2	122	100	95	90	89	84			
	Category 4	1	4	2	6	2	4		N/A	NO CHANGE
									Key standard has no target; however performance is consistent for category 2 and consistent for category 4	
No. of repeat falls Target decreasing trend		Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22		N/A	DOWN
		38	33	37	31	36	32			
									Key standard has no target; however performance is consistent	
LD Annual Health Checks completed - YTD Target is 70%		Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Year To date from 1 April 2022	N/A	N/A
		43.9%	62.0%	73.1%	2.5%	5.2%	11.9%			
LeDeR Reviews completed within timeframe (No Target)		Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	New LeDeR system is in place – need to redefine.	N/A	N/A
	Allocated	28	23	18	37	36	28			
	Awaiting Allocation	22	10	9	7	4	3		N/A	N/A
	On Hold	2	3	1	0	0	0		N/A	N/A

10. Workforce/HR

Target	Trust Performance						RAG/ Comments on recovery plan position	SPC Flag	
								Assurance of Meeting Target	Trend
Normalised Workforce Turnover rate (Rolling previous 12 months) Target is <=10%	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22		YES	NO CHANGE
	9.4%	9.2%	9.4%	9.6%	9.4%	9.4%		Key standards are being consistently delivered and are improving performance	
Vacancy rate Target is <=7%	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22		NO	UP
	11.1%	10.7%	11.3%	12.3%	14.1%	14.3%		Key standards are not being delivered and are deteriorating	
Health and Well-being Sickness Absence (1 month in arrears) Target is <=4.5%	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22		NO	NO CHANGE
	5.4%	5.9%	5.3%	4.7%	5.0%	4.7%		Key standards are not being delivered and are deteriorating	
Health and Well-being Sickness Absence Costs (1 month in arrears) Target is TBC	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22		n/a	n/a
	£816,587	£877,250	£686,317	£737,217	£745,360	£721,616			
Health and Well-being Sickness Absence YTD (1 month in arrears) Target is <=4.5%	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22		n/a	n/a
	5.2%	5.3%	5.0%	5.2%	5.0%	4.8%		Not applicable for SPC as measuring cumulative data	
Agency Costs Target is <=£641,666 (NHSI national target)	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22		NO	UP
	£2,751,823	£2,611,046	£3,816,160	£2,949,230	£2,711,773	£3,000,167		Key standards are not being delivered and are not improving	
Core Mandatory Training Compliance for substantive staff Target is >=85%	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22		YES	NO CHANGE
	93.7%	90.0%	82.1%	87.8%	91.8%	93.3%		Key standards are being consistently delivered and are improving	
Staff with a Completed Annual Appraisal Target is >=80%	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22		YES	DOWN
	73.7%	72.5%	75.6%	76.8%	79.1%	80.3%		Key standards are being delivered but are deteriorating	
% of staff from a BME background Target is >= 22.5%	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22		?	UP
	24.7%	24.8%	24.8%	24.8%	24.9%	25.1%		Over the series of data points being measured, key standards are being delivered inconsistently	
Staff flu vaccination rate (frontline healthcare workers) Target is >= 80%	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22		n/a	n/a
	59.6%	59.8%	59.8%	n/a	n/a	n/a			
% of staff who have undertaken clinical supervision within the last 3 months Target is >=85%	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22		NO	NO CHANGE
	71.3%	73.1%	72.1%	77.7%	81.4%	80.9%		Key standards are not being delivered and are deteriorating/ not improving	
Health and Wellbeing Activity - No of LLR staff contacting the hub in the reporting period (1 month in arrears)	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22		N/A	N/A
	301	360	320	355	400	359			

RAG rating against improvement plans

A simple RAG rating is used to assess compliance to the recovery plan:

- Red – a target that is not being delivered
- Amber – a target that is not being delivered but has an approved recovery plan with trajectory that is being met or there is a query about delivery
- Green – a target that is being delivered

Statistical process control (SPC) ratings against performance

The Trust has introduced SPC icons to indicate assurance of whether the process is expected to consistently meet or fail the target; and if a process is in special cause or common cause variation.

Icon	Performance Description
NO	The system is expected to consistently fail the target
YES	The system is expected to consistently pass the target
?	The system may achieve or fail the target subject to random variation

Icon	Trend Description
UP	Special cause variation – cause for concern (indicator where high is a concern)
DOWN	Special cause variation – cause for concern (indicator where low is a concern)
NO CHANGE	Common cause variation
UP	Special cause variation – improvement (indicator where high is good)
DOWN	Special cause variation – improvement (indicator where low is good)

Useful icon combinations to understand performance:

Performance	Trend	Description
YES	UP/ DOWN or NO CHANGE	Key standards are being consistently delivered and are improving/ maintaining performance
YES	UP/ DOWN	Key standards are being delivered but are deteriorating
?	Any trend icon	Over the series of data points being measured, key standards are being delivered inconsistently
NO	UP/ DOWN	Key standards are not being delivered but are improving
NO	UP/ DOWN or NO CHANGE	Key standards are not being delivered and are deteriorating/ not improving

Performance headlines – June 2022

The SPC measure includes data up to the current reporting month for the indicator

Key:			
	The SPC measure has improved from previous month	**NEW**	The first assessment of a metric using SPC
	The SPC has not changed from previous month	**R**	Metric will be removed from future reports
	The SPC measure has deteriorated from previous month	**C**	Change in performance can be attributed to COVID-19

Key standards being consistently delivered and improving or maintaining performance

Normalised Workforce Turnover rate
Core Mandatory Training Compliance for Substantive Staff

Key standards being delivered but deteriorating

C 6-week wait for diagnostic procedures
Staff with a Completed Annual Appraisal
C Length of stay - Community Services

Key standards being delivered inconsistently

CAMHS ED one week (complete)
Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral
CAMHS Eating Disorder – four weeks - (complete pathway)
Children and Young People's Access – 13 weeks (incomplete pathway)
C Occupancy rate – mental health beds (excluding leave)
C Average Length of stay (excluding leave) from Bradgate acute wards
Delayed transfer of care (DToC)
Gatekeeping
C Diff
STEIS action plans completed within timescales
C Occupancy rate – community beds (excluding leave)
% of staff from a BME background
MH Data Quality Maturity Index

Key standards not being delivered but improving

Dynamic Psychotherapy over 52 weeks
Cognitive Behavioural Therapy over 52 weeks
Adult CMHT Access six week routine (incomplete)

Key standards not being delivered but deteriorating/ not improving

Safe Staffing
Personality Disorder over 52 weeks
CAMHS over 52 weeks
Sickness Absence
Agency Cost
Vacancy rate
Children and Young People's Access – four weeks (incomplete pathway)
% of staff who have undertaken clinical supervision within the last 3 months

Key standard we are unable to assess using SPC

Patient experience of mental health services
Readmissions with 28 days
Patient safety incidents
Patient safety incidents resulting in severe harm or death
Serious incidents (no target)
Quality indicators (no targets)
Cardio-metabolic assessment and treatment for people with psychosis
Admissions to adult facilities of patients under 16 years old

Governance table

For Board and Board Committees:	Trust Board	
Paper sponsored by:	Sharon Murphy - Interim Director of Finance and Performance	
Paper authored by:	Information Team	
Date submitted:	18/07/2022	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):		
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Monthly report	
STEP up to GREAT strategic alignment*:	High **S**tandards	
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	x
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trustwide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	20 - Performance management framework is not fit for purpose
Is the decision required consistent with LPT's risk appetite:		
False and misleading information (FOMI) considerations:		
Positive confirmation that the content does not risk the safety of patients or the public		
Equality considerations:		

Z

Leicestershire Partnership NHS Trust

CHARITABLE FUNDS COMMITTEE– DATE 6th JUNE 2022

HIGHLIGHT REPORT

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

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

Report	Assurance level*	Committee escalation	Risk Reference
Review of Risk Register	High	The risk assessment 4669 (estates resources available to support projects) would be retained until specific estates dependent projects had been completed.	4669
Raising Health annual investment strategy review	High	The charity's investment strategy had been refreshed and minor updates made to ensure current investment information was included. The update was approved.	
Annual Review of the Effectiveness of the Committee, Review of the Terms of Reference, Approval of the Annual Workplan, and review of Committee Membership	High	The annual review papers were reviewed and agreed. The Non-Executive Director trustee post had been refreshed in accordance with the Terms of Reference. Ruth Marchington was thanked for her work as a Trustee and for her support to the charity. Faisal Hussain replaces Ruth as the NED Trustee.	
Fundraising Manager's report	High	The Fundraising Manager provided an update on activities to 31st May. Highlights against Raising Health strategic objectives noted were: (Visibility) Signage – The Raising Health Signage is now in place. There has been particular focus on marketing and awareness during this quarter;	

Report	Assurance level*	Committee escalation	Risk Reference
		information leaflets have been created or updated, presentations given to Directorate Management Teams and their subgroups and presentations to the Wellbeing Champions group. (Income) – Events and fundraising continue for agreed schemes. NHSCT will be releasing funding of £30,000 for the development of member charities. The committee discussed the application process and how that could inform what we used the funding for. (Grants) - Golden Ticket Scheme – The Tesco vouchers to spend on Health and wellbeing products or activities had been distributed to all teams. (Partnerships) – work continues to develop relationships with external partners.	
Finance report – Q4	High	Total income was £358k at quarter 4, comprising realised income of £254k and an unrealised investment gain of £104k. Expenditure was £515k to quarter 4. Future expenditure commitments total £409k. The cash balance was £439k at the end of March. Cash was expected to remain in a good position in the rolling 3 year cash flow forecast. Total funds available was £2.4m at the end of quarter 4, a decrease of £157k over the financial year. These figures would form the basis of the 21/22 annual accounts.	
Review SFIs and SORD	High	The Trust's Standing Financial Instructions updates were reviewed and approved.	
Updates on Previous Bids	High	Estates projects – work on the Coalville Hospital garden would restart when the weather was suitable. Dementia Garden Evington Centre – work was almost complete. Carlton Hayes – the bids received for round 1 of 22/23 funding was oversubscribed, the bids were being worked through. Any bids over £3k would be circulated for committee approval.	4669

Report	Assurance level*	Committee escalation	Risk Reference
New bids received	High	Approved bids: • Staff networks £4k was approved - £1k each for BAME, MAPLE, Spectrum and Women's network. The EDI team would be asked to check if any other networks should be included. LPT OD resources to support the networks would be investigated.	
Benefits realisation – assessing VFM of long term projects research and development	High	A comprehensive update was received on research and development bids that had been previously approved. Progress was clear for all schemes.	
New funds created	High	None reported.	
Work plan	High	The work plan was reviewed and agreed for 2022/23. Procurement process for investment advisors' appointment to be added to the 2023/24 workplan.	
New Charitable Funds Bank Account	High	Approval was given to open a new charity bank account for investment purposes. The value of the Financial Services Compensation Scheme for charities would be checked before funding was moved to the bank account, to ensure our funds were appropriately protected.	
Review of risk register	Medium	The mismatch between the charity's running costs and decreasing income from investments and donations was highlighted as an area of concern. A trustees' meeting would discuss this separately. It was agreed that a new risk should be created.	
AOB	High	None received.	

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

AAA

Leicestershire Partnership NHS Trust

TRUST BOARD – 26 July 2022

AUDIT AND ASSURANCE COMMITTEE – 10 June 2022

HIGHLIGHT REPORT

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

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

Report	Assurance level*	Committee escalation	ORR Risk Ref
Going Concern Assessment	**High**	The Committee received the report and supported the assertion that the Trust be formally recognised as a Going Concern with the 2021/22 annual accounts completed on that basis.	62, 70 71*
Audited Financial Accounts 2021/22	**High**	The Committee approved the audited accounts for presentation to the Trust EGM. The key issues that impacted on the accounts related to LPT's building valuations which had increased the balance sheet by c£12m due to the application of national indices, and cash at the end of the year was £32m which was a good cash position.	62, 70 71*
KPMG Auditors Annual Report 2021/22 **ISA 260 Audit Memorandum**	**High**	A summary of the findings and key issues arising from the audit of LPT on its accounts, annual report, value for money, regularity and other reporting was presented. The external auditors emphasised the very good result and acknowledged the significant amount of work that had gone in to getting the Trust to the position it was in. The audit of the 2021/22 financial statements was substantially complete and a clean audit opinion was expected to be given. No significant weaknesses were identified in terms of the value for money arrangements and no recommendations were made.	62, 70 71*
Head of Internal Audit Opinion	**High**	There had been no change made to the HoIAO since the interim report was presented in April. Overall a significant assurance opinion was given with all three elements (ORR and strategic risk management; individual assignments; and follow up of actions) also receiving significant assurance opinion.	62, 70 71*

Report	Assurance level*	Committee escalation	ORR Risk Ref
		The follow up rate had not changed from the interim report at 93% for first follow up implementation and 99% for overall implementation. The Annual Report was also presented, which set out service delivery by 360 Assurance during 2021/22.	
Annual Report & Quality Account 2021/22	**High**	The Committee acknowledged the reports gave a good insight of the work of the Trust during the year, its financial position and the state of its risk and control frameworks. The general consensus of members was that the appearance and content of the reports were much improved from previous years.	62, 70 71*
Internal Audit Progress Report	**High**	An update on Internal Audit activity since the last meeting was received, two final reports had been issued, both with significant assurance opinion. Internal Audit had followed up two actions in 2022/23 which were both implemented at first follow up giving a rate of 100% and substantial assurance. Assurance was received that Internal Audit was on track to complete the 2022/23 plan by the end of the year.	62, 70 71*
Counter Fraud Progress Report	**High**	The Committee received a summary of the work that was underway or had been completed since the last AAC meeting. LPT had achieved green for the Counter Fraud Functional Standard Return across the board which was a very positive step.	62, 70 71*
Clinical Audit Forward Plan	**High**	An update on the agreed audit activity for the 2022/23 financial year was presented, this was a combination of new projects planned for the coming year, existing projects that were continuing beyond year end and national audits relevant to the work of the Trust. The Committee approved the plan and noted the next steps during 2022/23.	
Committee Annual Effectiveness Reviews		The Audit and Assurance Committee was assured of its annual report and that it was operating within Trust governance arrangements. The Committee received assurance that the Charitable Funds, Finance and Performance, Quality Assurance and Remuneration Committees were operating within Trust governance arrangements.	
Risk Manage-ment Update	**High**	There had been four new additions to the ORR which were around the cyber threat landscape, vaccination of staff against influenza, the Trust's financial position for 2022/23 and the loss of the Healthy Together contract. Two risks had also been closed, 63 (*demand of winter pressures ……. may lead to poor quality of care*) and 76 (*the introduction of vaccination as a condition of deployment),* both related to COVID.	62*

Report	Assurance level*	Committee escalation	ORR Risk Ref
Legal and Regulatory Issues	**High**	There were no specific legal and regulatory issues to highlight but an update was received on some of the improvements being made to the Ulysses system.	62*
Internal and External Audit Follow up of Actions	**High**	The 2021/22 year-end overall follow up rate was 99%. The Pentana automated system was now being used and the Committee felt confident there was good oversight of delivery of both Internal and External Audit actions.	62*
Financial Waivers	**Medium**	55 waivers with a total value of c£4.5m had been raised during quarter 4 of 2021/22. The increase in value of waivers was attributable to the Adult Eating Disorder Services and two lots of financial waivers within one financial year due to the timing of when they were raised. The process for waivers was currently being reviewed and there were expected to be fewer waivers once the new process was in place.	62, 70 71*
Losses and Special Payments 2021/22	**High**	The Committee received the annual report as part of the closing down accounts process as stipulated in the Trust's SFIs. There was nothing specific to highlight.	62, 70 71*
Accounting Policies	**High**	The Committee approved the accounting policies to support Trust Board in the approval of the 2021/22 annual accounts.	62, 70 71*
Annual Update of SFIs and SORD	**High**	The Committee approved the proposed changes to the Trust's Standing Orders and Standing Financial Instructions.	

Chair	**Darren Hickman**

*****principal risk(s) shown but will also cover other risk on ORR