Leicestershire Partnership NHS Trust

Public Meeting of the Trust Board
28th March 2023, 9.30am-1.00pm
NSPCC, Gilmour Close, Leicester

Agenda Time	Item		Paper	Lead
9.30	1.	Apologies for absence: Anne Scott, Helen Thompson Welcome: Emma Wallis, Michelle Churchard-Smith, Mark Roberts	Verbal	Chair
		The Trust Board Members	A	
9.35	2.	Patient Voice Film - Supporting an autistic young man to live well in the community	verbal	Mark Roberts
9.45	3.	Staff Voice - Manpreet Sandhu	verbal	Mark Roberts/ Manpreet Sandhu
10.10	4.	Declarations of Interest Report • Declarations of Interest in respect of Items on the Agenda	B	Chair
	5.	Minutes of the Previous Public Meeting: 31 January 2023	C	Chair
	6.	Matters Arising	D	Chair
	7.	Chair's Report	E	Chair
	8.	Chief Executive's Report	F	Angela Hillery
Governance and Risk				
10.30	9.	Revised Terms of Reference for level 1 committees	G	Chris Oakes
	10.	Documents Signed Under Seal (Quarter 3)	H	Chris Oakes
	11.	Organisational Risk Register	I	Chris Oakes
Strategy and System Working				
10:50	12.	Service Presentation – Supporting autistic young people and those with a learning disability to live well in the community – progress and plans	slides	Mark Roberts/ Laura Smith/ Dr Jeanette Bowlay-Williams
11:20	13.	Break		
Quality Improvement and Compliance				
11:30	14.	Quality and Safety Committee Highlight Report – 28th February 2023	J	Moira Ingham
	15.	CQC Update Including Registration	K	Michelle Churchard
	16.	Patient and Carer Experience, Involvement and Complaints Report – Quarter 3	L	Emma Wallis
	17.	Safe Staffing Monthly Report	Mi & Mii	Emma Wallis
	18.	Patient Safety Incident and Serious Incident Learning Assurance Report	N	Michelle Churchard
	19.	Learning from Deaths Quarterly Report Q3	O	Saquib Muhammad
People and Culture				
12:00	20.	People and Culture Committee Highlight Report 28th February 2023	P	Ruth Marchington
	21.	People Plan 6-month Progress Report	Q	Sarah Willis
	22.	Health & Wellbeing Guardian Report	R	Cathy Ellis
	23.	Staffing Capacity and Capability 6m Report (NQB)	S	Emma Wallis/ Michelle Churchard
Performance and Assurance				

12:30	24.	Finance and Performance Committee Highlight Report – 28th February 2023	T	Alexander Carpenter Sharon Murphy
	25.	Finance Monthly Report – Month 11	U	Sharon Murphy
	26.	Performance Report – Month 11	V	Sharon Murphy
	27.	Charitable Funds Committee Highlight Report – 14th March 2023	W	Cathy Ellis
	28.	Audit and Risk Committee Highlight Report – 17th March 2023	X	Hetal Parmar
	29.	NHFT & LPT Committee in Common Highlight Report	Y	David Williams
	30.	Review of risk – any further risks as a result of board discussion?	verbal	Chair
	31.	Any other urgent business	verbal	Chair
	32.	Papers/updates not received in line with the work plan: NA	verbal	Chair
12.50	33.	Public questions on agenda items	verbal	Chair
1.00	34.	Close - Date of next public meeting: 30th May 2023		Chair

Our Trust Board

As of December 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
Managing director/deputy chief executive

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

Tanya Hibbert
Executive director of 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. Saquib Muhammad
Interim medical director

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

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Leicestershire Partnership NHS Trust

Trust Board Public Meeting – 28th March 2023

Declarations of Interest Report - March 2023

Purpose of the report

This report is to detail the Trust Board members' current declarations of interests. The Trust uses an online system Declare and does not hold paper copies. Trust Wide declarations for all decision makers are available to view here:

https://lpt.mydeclarations.co.uk/home

Analysis

Board Member	Declaration	Reference	Date of Declaration
Angela Hillery CEO	Loyalty Interests - National Mental Health Programme Board	3295	7.11.22
	Loyalty Interests - Member of NHS Midlands Strategic Transformation & Recovery Board and supporting work group - Safe Restoration and Recovery of Services Group	3296	7.11.22
	Loyalty Interests - Sister employed by William Blake charity – homes for people with a Learning Disability	3297	7.11.22
	Loyalty Interests – East Midland Alliance	3045, 3298 & 3299	6.6.22
	Loyalty Interests – DHSC led working group on Covid psychosocial response	3044	6.6.22
	Loyalty Interests – National Mental Health Recovery Planning working group	3043	6.6.22
	Loyalty Interests – Member of one or more LLR Integrated Care System boards or other ICB fora and Northamptonshire ICB forums	3042	6.6.22
	Loyalty Interests – Member of Royal College of Speech & Language Therapists	3041	6.6.22
	Loyalty Interests – Executive Reviewer for Care Quality Commission	3040	6.6.22

	Loyalty Interests – shared CEO role with NHFT and LPT	256	21.10.19 - ongoing
Mark Powell Deputy CEO/Managing Director	Nil Declaration	3148	5.9.22
	Hospitality – Harvey Nash - Meal provided for a small group during NHS Confed conference (£50)	3102	15.6.22
Cathy Ellis Chair of the Trust	Loyalty Interests – Raising Health	3167	29.09.22
	Loyalty Interests – familial relationship with bank staff nurse	357	19.5.20 - ongoing
	Loyalty Interests – Sibson District Church Council - Treasurer	111	25.1.19 - ongoing
	Loyalty Interests – University of Leicester – Lay member of Council & Finance Committee	109	25.1.19
Alexander Carpenter NED	Outside Employment – Natwest group - Head of Business Planning, Commercial & Institutional Banking	3104	17.7.22
Hetal Parmar NED	Outside Employment – Financial Services Santander UK	3144	24.8.22
	Outside Employment – The Mead Educational Trust	3143	9.7.22
	Outside Employment – Washwood Heath Multi Academy Trust	3097	9.7.22
Kevin Paterson NED	Outside Employment – University of Leicester Professor of Experimental Psychology	977	28.3.22 - ongoing
Moira Ingham NED	Outside Employment – University of Northampton Associate Lecturer in Nursing and Clinical Assessor at NMC Competency Test Centre	431	20.7.21 - ongoing
	Shareholdings and other ownership - Dingley Associates Ltd – 10 ordinary shares	433	20.7.21 - ongoing
Ruth Marchington NED	Loyalty Interests – National Lottery Community Fund External member on Audit and Risk committee	349	4.3.20 - ongoing

Faisal Hussain NED	Loyalty Interests – Raising Health	3200	1.11.22
	Loyalty Interests – Spinal Injuries Association Enterprise Company Director	3146	25.8.22
	Loyalty Interests – APNA NHS Network member	909	24.2.22 - ongoing
	Loyalty Interests – Member of the Disabled NHS Directors Network & Member of Steering Group.	910	24.2.22 - ongoing
	Loyalty Interests – Spinal Injuries Association Trustee and Company Director	912	24.2.22 - ongoing
Chris Oakes Director of Governance & Risk	Outside Employment – Joint Role as Director of Governance and Risk for LPT and Director of HR & OD for NHFT.	892	10.2.22
David Williams Director of Strategy & Partnerships	Loyalty Interests – Trustee for LPT Charity Raising Health	3138	16.8.22
	Outside Employment – Northamptonshire Healthcare NHS Foundation Trust - Director of Strategy & Partnerships with other trust in group	3137	16.8.22
Sarah Willis Director of HR	Nil Declaration	3136	16.8.22
Helen Thompson Director of FYPCLD	Loyalty Interest - Daughter is employed in FYPCLD - Executive Director has not been and will not be involved in the recruitment or direct management of the family member	3135	9.11.22
Sam Leak Director of Community Health Services	Nil Declaration	3148	5.9.22
Tanya Hibbert Director of Mental Health	Nil Declaration	3300	7.11.22
Sharon Murphy Director of Finance	Loyalty Interest – Raising Health	3191	14.10.22
	Nil Declaration	3141	19.8.22
Anne Scott Director of Nursing	Nil Declaration	3135 & 3134	18.8.22

Saquib Muhammad Interim Medical Director	Nil Declaration	3313	8.11.22
Paul Sheldon Chief Finance Officer	Outside Employment - Northamptonshire Healthcare FT - Joint role with LPT and NHFT	3139	17.8.22

Decision required

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

Governance table

For Board and Board Committees:	Public Trust Board 28th March 2023	
Paper sponsored by:	Chris Oakes, Director of Corporate Governance and Risk	
Paper authored by:	Corporate Affairs Manager	
Date submitted:	12.01.23	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	NA	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	NA	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Monthly report at Trust Board	
STEP up to GREAT strategic alignment*:	High **S**tandards	✓
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	✓
	Reaching Out	
	Equality, Leadership, Culture	✓
	Access to Services	
	Trust wide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	all
Is the decision required consistent with LPT's risk appetite:	NA	
False and misleading information (FOMI) considerations:	NA	
Positive confirmation that the content does not risk the safety of patients or the public	NA	
Equality considerations:	NA	

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Leicestershire Partnership NHS Trust

Minutes of the Public Meeting of the Trust Board
31 January 2023, NSPCC, Gilmour Close, Leicester

Present:
Cathy Ellis, Chair
Faisal Hussain, Non-Executive Director/Deputy Chair
Ruth Marchington, Non-Executive Director
Moira Ingham, Non-Executive Director
Alexander Carpenter, Non-Executive Director
Hetal Parmar, Non-Executive Director
Kevin Paterson, Non-Executive Director
Mark Powell, Managing Director/ Deputy Chief Executive
Sharon Murphy, Director of Finance
Saquib Muhammad, Interim Medical Director
Anne Scott, Director of Nursing AHPs and Quality

In Attendance:
Sam Leak, Director of Community Health Services
Tanya Hibbert, Director of Mental Health Services
Mark Roberts, Deputy Director of Families Young People and Children Services and Learning Disabilities and Learning Disability and Autism Collaborative Lead
Sarah Willis, Director of Human Resources & Organisational Development
Chris Oakes, Director of Governance and Risk
David Williams, Director of Strategy and Partnerships
Paul Sheldon, Chief Finance Officer
Kate Dyer Deputy Director of Governance and Risk & Trust Secretary
Sonja Whelan, Corporate Affairs Department (Minutes)

TB/23/001	Apologies for absence: Helen Thompson, Angela Hillery Welcome: Mark Roberts Observing: Francesca (Fran) Bolt, Management Trainee Dr Jon Crossley, Associate Director for Psychological Professions Kamy Basra, Associate Director of Communications Shadowing: Amirah Chohan, Health Visitor, City North, Area 5 Bengi O'Reilly, Clinical Quality Manager, NHS LLR ICB Presenting: Olivia McClure, Interim Team Manager, South/East Leics CMHT (Items 2&3) Dr Zarina Anwar, Consultant Psychiatrist (Item 3) John Edwards, Associate Director for MH (Item 11) Pauline Lewitt and Chris Moyo, Freedom to Speak Up Guardians (Item 20) The Trust Board Members – Paper A – introduced members of the Board.
TB/23/002	Patient Voice – Better Mental Health for All - verbal The Chair introduced Olivia McClure and invited her to read out the patient voice story:- *'I was initially referred to the community mental health team by my GP in March 2021. At that time I was experiencing symptoms of obsessive compulsive disorder (OCD),*

	predominantly checking behaviours. Following the referral, I had a phone appointment with a member of Doctor Villanova's team, in which the symptoms I was experiencing were discussed and an assessment carried out. The outcome of the assessment led to a diagnosis of OCD. Subsequently, my medication was reviewed, and I was referred to the community cognitive therapy team. In November 2021, I had a review phone appointment with Doctor Vilanova. The outcome was a planned discharge from mental health services following ERP therapy in approximately six months' time. Prior to commencing therapy, I received a phone call from a member of the team to discuss my symptoms and the process involved. My therapy started in May 2022 and I was discharged in September 2022. Following this, I had a review with the community mental health team in October 2022 and was discharged from services. This review was carried out by Olivia McClure. *I am very pleased with the care that I received throughout the process, from the initial GP referral, through assessment and therapy, and subsequent discharge. I was extremely impressed with how quickly I was assessed and referred for treatment, as I am aware that the service is currently under a lot of pressure. I was kept informed at all times and felt supported throughout. I was very happy with the nurse led care that was provided throughout the therapy process and my subsequent discharge and did not feel at any time that the care was lacking due to limited direct communication from a Doctor. I do not feel it made a difference that my discharge was carried out by a nurse, as opposed to a Doctor, what mattered was that I was discharged from services in a timely and appropriate manner. Overall, I feel it was a very positive experience and that the decision to discharge from services at that time, rather than prolonging the outcome waiting to be reviewed by a Doctor, was the right one'.* It was noted that although this particular service user was keen to give feedback and had received a positive experience, not all users had received such a streamlined process but this was the aim going forward. It was also noted that nurse discharge was not an uncommon occurrence. Faisal Hussain articulated the frustration experienced by both staff and service users when our services are not accessible and asked how we are supporting staff to meet the needs of our service users. Olivia McClure responded that the service would always talk to service users who called, being open and honest with service users and reminding them that access was still available. The Chair thanked Olivia for reading this information as the patient wanted to maintain anonymity.
TB/23/003	Staff Voice – Better Mental Health for All – verbal (Slides B) Dr Zarina Anwar and Olivia McClure presented these slides and described the history and context behind the Cedars CMHT caseload review and how all CMHTs had their own challenges, with South Leicestershire covering the largest areas in terms of open patients to consultants. Tools were developed according to patient need, consultants and nursing colleagues were engaged which enabled the caseload review to take place. As a result of the caseload review, net caseload had reduced from 1717-1630 which had been made possible by multi professional robust clinical review and working as one team. A key point of different between this and previous attempts at caseload reviews is

	that the patient is joined up with the resources available in the community ensuring safe discharge back to primary care. There was a marked change in culture in the Cedars CMHT with a much stronger ethos of genuine joint working for the benefit of patients. Faisal Hussain asked how the assurance was in place for not letting patients slip through the net/be discharged too quickly. Dr Anwar responded that the review had identified some patient needs had changed so this was picked up when reviewed and making sure care transferred and other CMHTs were meeting service user needs – close working with admin team was seen as key. Saquib Muhammad acknowledged the hard work which had been undertaken and expressed that often good ideas were borne out of necessity. He suggested further thought be given to recruitment of medical staff as CMHTs were historically seen as places medical staff wouldn't want to work. Sam Leak pondered whether patients being seen also had physical health problems and if so, asked the service to connect with her. This was a great example of what true collaboration can deliver and in terms of marketing, could write this up as a case study to share more widely. The Chair thanked the team for telling their story and for the great work they are doing to benefit patients.
TB/23/004	Declarations of Interest Report – Paper C No further declarations to report. **Resolved**: The Board accepted the report for information.
TB/23/005	Minutes of Previous Public Meeting: 29 November 2022 – Paper D **Resolved**: the minutes were approved as an accurate record of the meeting.
TB/23/006	Matters Arising – Paper E **Resolved:** The matters arising were agreed as complete.
TB/23/007	Chair's Report – Paper F The Chair presented the paper which summarised activities and key events between 29 November 2022 and 31 January 2023 and informed members that the Non Executive Directors enjoyed getting out to talk with staff but also to hear patient stories face to face. **Resolved**: The Board accepted the report for information.
TB/23/008	Chief Executive's Report – Paper G Mark Powell presented the paper which provided an update on current local issues and national policy developments since the last Trust Board meeting. Those national developments highlighted were mental health services boosted by £150m government funding, winter pressures and planning for 2023/24. Locally, there was positive news around 0-19 children's services and the public engagement around Hinckley Community Health Services. Ruth Marchington welcomed the partnership working with local authorities around the 0-19 programme and how this was a reflection of good partnership working. David Williams reminded colleagues that as members of the public, for both of these consultations for 0-19 and Hinckley we can complete the consultation. Kamy Basra, Associate Director for Communications would get some comms out on this.

	Faisal Hussain advised that on 13th January he had collected the Certificate from ????? (national network of South Asian clinicians in recognition of trust work on cultural inclusivity and TAR) of which LPT had been highlighted and spotlighted. There were various strands of funding which would become clear over the next few weeks and as soon as clarity Alexander Carpenter queried any stipulations to the additional mental health funding. This wasn't clear yet but would be shared as soon s that was the case. Hetal Parmar (HP) queried the new SEND framework as he felt it would be helpful to have more information around that. Mark Powell would provide further information to HP outside of the meeting. **Resolved**: The Trust Board received the report.
TB/23/009	Organisational Risk Register – Paper H Chris Oakes presented the paper which identified there are four risks where the current risk score is higher than the tolerance level, and the projected residual score will bring the risk in line with appetite. There is one risk (Risk 85 high agency spend) where the residual score (16) is higher than the appetite (9-11). This indicates that further mitigation action will be needed to bring the risk score down within agreed tolerance levels. Wording change to Risk 74 Sharon Murphy is going to be co-chair of a group to specifically look at agency reduction and would look at all considerations eg patient safety. This would also be considered as part of the ORR refresh. Alexander Carpenter questioned whether Risk 74 was truly reflective given the current cost of living crisis. Sarah Willis felt it was but was taking to the Strategic Workforce Committee to review. **Resolved:** The Trust Board was assured by the risk management process and that the ORR continues to reflect the risks relevant to the Trust.
TB/23/010	Proposed changes to Corporate Governance Structure – Paper I Chris Oakes outlined key changes to the governance structure, detailed within the paper. As a result of detailed discussions, five key changes were proposed:- 1. To introduce a new level 1 'People and Culture Committee' to be held on the same day as QAC/FPC with a separate Chair whilst ensuring NED cross cover. Proposing that Ruth Marchington Chair this Committee and a draft Terms of Reference is provided in Appendix One. In addition, the Terms of Reference for the Quality Assurance Committee will be revised and reviewed by the Committee in February 2023. The level 2 Workforce Group and Quality Forum will also receive updated Terms of Reference for review and approval at their next meetings to ensure that the relevant items are feeding into the respective committees. 2. Disband the Policy Committee and re-route policies though the parent level 1 committees to promote accountability and oversight following the relevant level 2/3 sign off and consultation. This forms part of a wider policy improvement programme which is underway. 3. Introduce a level 2 Collaboratives Oversight Group to provide assurance to FPC that leadership of ICS Collaboratives and Provider Collaboratives is delivering safe, caring, responsive, effective care and well led services. This will start to feed into FPC from February 2023. 4. Re-instate the Access Committee. A Terms of Reference has been approved by the Executive Management Board and the new Group will meet in February/March 2023.

	5. Renaming of level 1 and 2 groups to emphasise the distinction between assurance committees and delivery groups and the following proposal to rename the Quality Assurance Committee to the Quality and Safety Committee Faisal Hussain welcomed the People and Workforce Culture Committee but on disbanding the Policy Committee would want assurance that information is retained at a strategic and risk based level rather than operational. Chris Oakes responded that if this started to happen, it would be reviewed. Members were supportive of this approach which aligned to ongoing discussions around risk. **Resolved**: The Trust Board approved the key changes outlined and the Term of Reference for the People and Culture Committee.
TB/23/011	Service Presentation – Better Mental Health for All – Paper J John Edwards introduced himself and gave an overview of the presentation which had been circulated with the board papers pack. Drivers for transformation, achievements to date, progress against public consultation outcomes were all highlighted. Bringing together existing services into neighborhoods ensured services were fit for local populations with different needs according to different areas. Ruth Marchington offered thanks from the Board to all involved as this was a positive journey which was now materializing. In response to Faisal Hussain's question about peer support worker benefits, John Edwards iterated that there were now 28 peer support workers. The ambition of having 75 had been adjusted to accommodate working practices. There was robust training place. Anne Scott asked re – co–production – how do we make it clearer around co-prod philosophy and how is it being led across the system to transform mental health services. Tools being explored that create more systematic way of care in partnership. Central Access Point and the rapidly increasing demand was queried by Kevin Paterson and what immediate pressures there were on demand. John Edwards stated that the service was working with ICB colleagues in part around re-shoring up. Neighborhoods would start to ease the pressure and there would be a shift of demand. Saquib Muhammad asked to see the impact with interlinked services; the effect of this mental health transformation and how it is changing and as a result what are the outcome numbers. Alexander Carpenter asked in terms of co-production, what feedback mechanism was in place to ensure we are taking on board from staff and members of public. Also, building a narrative around demonstrating achievements and successes may help recruitment. How are we building that narrative to demonstrate some of the success and the journey we are on? John Edwards advised there were various means; working with the voluntary sector is interesting, trust processes to capture information, mechanisms for staff feedback. Narrative being presenting back via a website that was part of the consultation. Website is used to communicate back on progress. Working through how to fund the progression of that website, monthly cycle of shared slides to communicate to staff. Mark Powell asked whether there was some way of stratifying?? health inequalities and

	moving that agenda forward and moving resources forward to address that inequity. John Edwards – we have a needs basis calculator that looks at a range of different factors The Chair thanked John for his presentation,
TB/23/012	Integrated Care System Strategy – Paper K David Williams presented this paper and gave a recap on ICP and how the group develops the strategy for the future of integrated care in LLR. Faisal Hussain asked about the role of the joint strategic needs assessment and how that planned into the overall strategy – David Williams would check. **Resolved**: The Trust Board received and noted the draft for further development and continued input into that.
TB/23/013	Step Up To Great Strategy Progress Report – Paper L David Williams presented this paper and which summarised how the strategy was doing until the end of Q3 on SUTG with progress ranked and graded. Q4 update would be received at May Trust Board. Hetal Parmar queried special needs and how closely we worked alongside to support those children. Mark Roberts explained there is a new partnership board that is being created to take forward the SEN agenda across LLR. There is strong leadership and area of strength for us and close collaboration with all the Local authorities around that area of work. Well Led and LD being co-led at a regional basis is a developing area bringing the two elements together. Anne Scott added that we had a SEND inspection by Ofsted and CQC last November where significant improvements were found and LPT was not found wanting. Alexander Carpenter said it would be helpful to map the objectives to the actions so we could truly track what we were delivering against. This would then show the thread of how we are progressing against outcomes/objectives. **Resolved**: The Trust Board noted the engagement of LPT in the development of this strategy and continued to support the development and then implementation of this strategy and the ICB delivery plan.
TB/23/014	LPT/NHFT Group Chairs Highlight Report 10 January 2023 – Paper M Chris Oakes presented the highlight report flagging the second Board to Board workshop as a positive day and highlighted benefits of working together. **Resolved:** The Trust Board approved the report
TB/23/015	Quality Assurance Committee Highlight Report - 20 December 2022 – Paper N Moira Ingham presented the report which demonstrated some of the extensive work going on. Levels of pressure ulcers remained an issue and assurance was received around quality and safety review. **Resolved:** The Trust Board received the report for assurance.
TB/23/016	CQC Update Including Registration – Paper O Anne Scott presented the paper which provided assurance on compliance with the CQC fundamental standards and gave an overview of current inspection activities. Paper should read that last year we had 10 mental health inspections, not this year. At the time of writing this report we had no inspections this year. Trust wide learning has been shared and robust action plans to address areas of concern. **Resolved:** The Trust Board received the report for information and assurance.
TB/23/017	Safe Staffing Monthly Report (Oct & Nov 22) – Paper P Anne Scott presented the paper which provided a full overview of nursing safe staffing

	during the month of October 2022, including a summary/update of new staffing areas, potential risks, and actions to mitigate the risks to ensure that safety and care quality are maintained. The Chair commented this was a good report. **Resolved:** The Trust Board received the report for 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.
TB/23/018	Infection, Prevention and Control Report (6 monthly) – Paper Q Anne Scott presented the paper which provided assurance of a robust, effective and proactive infection prevention and control programme in place, in addition to updates on information, quality improvement learning and actions for compliance in regard to COVID-19 outbreaks and nosocomial COVID-19, report for Deaths from COVID-19, podiatry decontamination update, legionella incident (Rutland Memorial Community Hospital) and legionella incident (Loughborough Community Hospital). In response to Ruth Marchington's query about Risk 87 (cleaning), Anne Scott confirmed this risk was bing revisited to ensure it captures some of the concerns and would take away concerns raised by David Williams about the number of audits **Resolved**: The Trust Board received the report for assurance that monitoring processes are in place to ensure compliance
TB/23/019 Item 20	Freedom to Speak Up Guardian – 6 monthly report – Paper R Pauline Lewitt and Chris Moyo were in attendance for this item. Points highlighted were around the utilization of the FTSU process, patient safety and quality, staff safety and wellbeing, policy writing to aspire to compassionate policies. Pauline and Chris were working with the HWB lead, OD, EDI Lead and the People Promise Manager to ensure triangulation and proactive work. Ruth Marchington asked what a healthy speaking up culture looked like and offered further support from NEDs if required. Pauline confirmed a meeting had been arranged to get the assurance and understand what was required. Whether the HWB roadshows were being targeted at the right place with the right resources was also raised. Pauline clarified that issues being raised were not necessarily about staff HWB but that it came across during some conversations alongside other issues. Sarah Willis felt the focus was needed on change leaders to get to the bottom of what we are hearing as about culture and leadership. **Resolved:** The Trust Board received the report and noted the activity and actions relating to the FTSU workstream.
TB/23/020	Patient Safety Incident and Serious Incident Learning Assurance Report – Paper S Anne Scott presented the paper which provided assurance of the efficacy of the overall incident management and Duty of Candour compliance processes as well as reviews of our systems of control which 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. The Chair thanked Anne for this comprehensive report. **Resolved**: The Trust Board received the report for assurance.

TB/23/021	Finance and Performance Committee Highlight Report – 20 December 2022 – Paper T Alexander Carpenter highlighted the main points to note as the approval of the ToR for the new Access Delivery group, low levels of assurance around the financial position, number of medical devices out of date reducing again and helpful summary on the close down report on the FM transfer. **Resolved**: The Trust Board received the report for assurance.
TB/23/022	Finance Month 9 Report – Paper U Sharon Murphy presented the paper confirming a £2.5m deficit to date, 300k runrate (lower than previous months), DMH £4.7m deficit with runrate of 700k, Estates 200k runrate/ FYPC/LD was stable and enabling had improved. Forecast outturn £2.9m for year end (part of ICB position of £20m deficit). May be some additional income coming into system (stated in report) – this is not now the case so £20m is the figure. Better payment practice code positive performance Agency – £2.3m excluding surge wards Operational services except LD have decreased spend New agency group will look at what we can do to reduce target. Hetal Parma asked whether the cash position building up should be used on investments. Sharon Murphy explained the trust was seeing a result of higher interest rates generally so no intent to invest as various approval processes were needed. **Resolved:** The Trust Board received the report for assurance.
TB/23/023	Performance Month 9 Report – Paper V Sharon Murphy presented this paper identifying ongoing issues with mental health quality data pack show LLR position, so only LPT position shown. Performance position highlighted and the 23/24 metrics will come back to Board before the end of March. New format performance report well received so far - review of new performance report to be reviewed at Feb Board session. **Resolved:** The Trust Board received the report.
TB/23/024	Charitable Funds Committee Highlight Report 6.12.22 – Paper W Cathy Ellis presented this highlight report confirming the success of the Christmas Appeal and the LCFC support to the Beacon Unit. **Resolved**: The Trust Board received the report.
TB/23/025	Audit & Assurance Committee Highlight Report 9.12.22 – Paper X Hetal Parmar presented this report highlighting assurance levels. Self assessment assurance deemed to be partial. Internal/external audit follow up actions now addressed. The context behind being downgraded on core standards was explained by Mark Powell – the rating was correct but for context the EPRR is the core standards we need to achieve as an organisation. The core standards have been the same for a number of years and then they were changed last year and sent out for all to respond against the new standards. LPT responded; every single trust across country got downgraded to point of not being compliant. We went back with further evidence - actions now need to be in place where we are partially compliant. Will be problematic if we don't get ourselves back to fully compliant but confident there is a good plan in place. **Resolved**: The Trust Board received the report.
TB/22/026	Review of risk – any further risks as a result of board discussion? Highlighted as Risk 87 (cleaning) and Risk 74 (workforce).

TB/22/027	Any other urgent business No other business was raised.
TB/22/028	Papers/updates not received in line with the work plan: All papers received.
TB/22/029	Public questions on agenda items One question received:- In the January 2023 board performance report it is documented that the Trust is currently failing to meet the ADHD 18 week local RTT. You have said that the Trust has made non-recurrent funding has been made available to support a reduction in waiting times and investment and that plans are currently in development. As the parent of a child with an ADHD and a tic disorder diagnosis, who is awaiting treatment my question is this: 'How are Leicester Care Partnership ensuring that they are meeting their duty of care to children with an active diagnosis who are currently waiting to receive treatment?' Mark Roberts would respond personally to this member of the public but explained to members that Neurodevelopmental diagnostic and assessment pathway was much longer waits than we wanted – there is a business case moving through the ICB system and we are working with colleagues on prioritising the funding available in the system. The whole programme will address pre-diagnostic care, diagnosis and post diagnostic support as well. The support whilst children are waiting - if waiting for CAMHS service there is a duty system in place which stimulates for community paediatric GPs who can expedite concerns and there is an active ADHD duty system. Regarding the tic disorder – there is a digital portal 'my guidance' – there is a care package in relation to treatment to tics which has been published recently so Ms Edwards may not have seen this (it can be prescribed to family).
Close - next public meeting: 28th March 2023	

D

Leicestershire Partnership NHS Trust

TRUST BOARD 28 March 2023

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

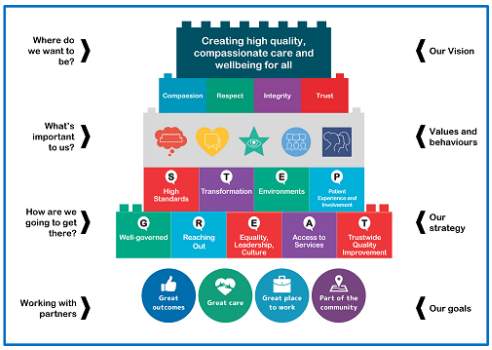
Action No	Meeting date and minute ref	Action/issue	Lead	Due date	Outcome/evidence actions are not considered complete without evidence)
962	23/009	Kate Dyer to schedule the annual review of the risk appetite at a future Board	KD	April 2023	Pending – Not due
963	23/011	Saquib Muhammed and Sarah Willis to use the CMHT case study and transformation of mental health services as a marketing tool in recruitment of Medical and Nursing staff.	SMuh/SW	April 2023	Pending – Not due
964	23/018	Anne Scott to review the target level of hand hygiene audits and reset the 2023/24 level to give sufficient assurance of compliance.	AS	April 2023	Pending – Not due
965	23/023	Sharon Murphy to bring the 2023/24 metrics to Board meeting in March.	SM	28.03.23	On agenda

E

Trust Board – 28 March 2023 – Chair's Report

Purpose of the report

Chairs report for information and accountability, summarising activities, and key events From 31 January 2023 to 28 March 2023.



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: ○ Arts in Mental Health ○ Stewart House ○ The PIER team ○ Safeguarding team ○ Heather Ward ○ The QI team ○ Single Point of Access team
Connecting for Quality Improvement (QI)	• CQC engagement meeting where the LPT team shared details of good practice and progress against CQC actions • Attended LPT's foundations for great patient care meeting and presented on the benefits and insight arising from Boardwalks • Met with the University of Leicester Estates team and with LPT's Associate Director of Estates & Facilities to share learnings on developing an Estates strategy and smart workplaces for staff. • Met with Lisa and Elie from the Bradgate Occupational Therapy team who work with patients in the Bradgate Therapy Garden. We viewed the new accessible patio area which will widen participation and started planning for the 2023 Let's Get Gardening Competition (LPT's own version of the Chelsea Flower Show)
Promoting Equality Leadership & Culture	• Joined the LGBTQ+ month staff stories event • Attended the NHS Confed National Diversity and inclusion programme event which focused on disability and hearing loss. • Angela and I joined the Nursing Fellows to give a talk on our career journeys and key lessons learned • Attended the Health & Wellbeing Roadshow to chat with staff at the Cedars Centre and hear how we can better support them

	• Joined the Menopause and Womens Health pathway meeting in an oversight capacity as Health and Wellbeing Guardian. • Celebrated International Women's Day, Angela and I were part of the panel for the Inclusive Leadership masterclass event. • 1:1 meeting with my cultural competence buddy • Meeting with Freedom to Speak Up Guardians to review activity and high-level themes reported by LPT staff
Building strong Stakeholder relationships	LLR Integrated Care System: • Attended LLR ICB meetings which covered the current operational, financial, and quality priorities for the ICS • Attended the ICB development session which included: 5 year forward plan; Board Assurance Framework; Adult Social Care. • Chaired the monthly LLR ICS Finance Committee meetings focusing on 2022/23 revenue spend, capital programme, 2023/24 financial plan, transformation, and key risks. • Meetings with David Sissling (Chair LLR ICS) & John MacDonald (Chair UHL) Other stakeholders: • Joined the Bishop of Leicester and local stakeholders for a Homeless event to showcase the work of the SoundCafe. • Attended the City Health & Wellbeing Board featuring: health and care successes and innovation over the Winter period; cost of living support; building capacity for care outside of hospital; children and young peoples health priorities; the ICB Forward Plan. • Meeting with Healthwatch to discuss LPT strategic and operational updates • Attended University of Leicester Council development session on Cyber security, the Council meeting and Finance Committee meeting
Good Governance	• LPT Board development session held on 21 February which included: Making data count presentation from NHSE; a review of LPT performance reporting; workshop input to the Freedom to Speak up planning tool facilitated by the Freedom to Speak Up Guardians; CQC Well-Led progress; and Board Committee highlight reports. • Joined the interview panels for Executive recruitment of Interim Deputy CEO and Medical Director. • Interviewed for a Non-Executive Director to Chair the Quality & Safety Committee, the successful candidate will join on 1 May. I would like to say a huge thank you, on behalf of the Board, to Moira Ingham who is leaving us at the end of April. She has made a significant contribution to the team.
Raising Health LPT's Charity	• Chaired the Charitable Funds Committee meeting • We are joining the Health & Wellbeing team on Roadshows to increase the charity profile and provide extra wellbeing support for our staff. • Our current fundraising appeals are detailed on our website https://www.raisinghealth.org.uk/

Abbreviations:

NHSE = NHS England

LLR = Leicester, Leicestershire & Rutland

ICS = Integrated Care System; ICP = Integrated Care Partnership; ICB = Integrated Care Board

NHFT = Northamptonshire Healthcare Foundation Trust

UHL = University Hospitals of Leicester

Governance table

For Board and Board Committees:	Trust Board 28 March 2023	
Paper sponsored by:	Cathy Ellis	
Paper authored by:	Cathy Ellis	
Date submitted:	17 March 2023	
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	X
	Patient Involvement	X
	Well **G**overned	X
	Reaching out	X
	Equality, Leadership, Culture	X
	Access to Services	X
	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	

F

Trust Board of Directors – 28 March 2023
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, Health Education England, NHS Providers, the NHS Confederation, and the Care Quality Commission (CQC).

Analysis of the Issue

National Developments

Winter pressures, Coronavirus COVID-19, Influenza and Scarlet Fever

In contrast with the change from winter to meteorological spring, pressure on the NHS remains unchanged and almost as high as described in my last report. Acute hospital beds across the country are consistently over 90% full, roughly 5% of those beds are occupied by people with COVID-19 and levels of influenza ('flu') are as high as they were in late November 2022 in the early stages of winter.

Commenting on the current situation, NHS national medical director Professor Sir Stephen Powis said that there are almost 5,000 more patients in NHS hospital beds every day compared to this time last year and the average number of patients in hospital who no longer meet the criteria to reside is up more than a sixth on the same week in 2022.

The latest national UK Health Security Agency (UKHSA) surveillance data shows that there are three times more patients in hospital with norovirus (commonly referred to as 'winter vomiting bug') than this time last year, a figure more than double the five-season average prior to the coronavirus (COVID-19) pandemic. Scarlet fever infections remain similarly high and are fluctuating with levels similar to those seen during the last comparably high season in 2017 to 2018.

UKHSA is also working closely with its partners to assess the risk to human health from avian influenza (or 'bird flu'). While the very high levels of transmission in wild birds presents a constant risk, there is no evidence so far that the virus is getting better at infecting humans or other mammals. Even so, Government guidance to the public is to avoid contact with sick or dead wild birds in public areas such as parks or waterways and to wash hands after feeding wild birds.

Two-year plan for Urgent and Emergency Care services

On 30 January 2023, the Government published a new two-year plan for the recovery of urgent and emergency care services, designed to reduce waiting times and improve patient experience. This plan emphasises the need for collaborative working between different providers in local care economies and centres on five areas: increasing urgent and emergency care capacity; growing the workforce; improving discharge; expanding 'out of hospital' care; and improving patient choice. The plan clarifies how funding previously announced by the Government will be used.

A key part of the plan will be reforming the way the NHS provides services including expanding care outside of hospitals. The NHS has already rolled out virtual wards – treating patients in their own homes – with growing evidence that these are a safe and efficient alternative to hospital care, particularly for people living with frailty. The plan will mean a further 3,000 'hospital at home' beds are created before next winter with the ambition of up to 50k people supported a month on a virtual ward. Urgent community response teams will also be scaled up to increase

the number of referrals and patients seen by a range of health and social care professionals within 2 hours, with services running 12 hours a day.

To access a copy of the plan, please visit the NHS England website:
https://www.england.nhs.uk/publication/delivery-plan-for-recovering-urgent-and-emergency-care-services/

Patients waiting more than 18 months down by 27%

Figures released by NHS England on 23 February 2023 show that the total number of people waiting more than 18 months has fallen by 27% from 54,382 on 15 January to 39,903 on 12 February. Over 75 NHS Trusts in England now have fewer than 100 patients waiting more than 18 months, which represents good progress towards the ambition to virtually eliminate these waits by April 2023.

For more information on the reduction in waiting lists please visit NHS England's website:
https://www.england.nhs.uk/2023/02/nhs-cuts-elective-backlog-with-longest-waiters-down-a-quarter-in-one-month/

£150m funding for mental health services

On 23 January 2023, the Government announced £150m would be made available to improve mental health urgent and emergency care services. In addition to more tailored emergency care and support in the community through specialised mental health ambulances, funding will be used to deliver over 30 schemes providing crisis cafes, crisis houses and other similar safe spaces, as well as over 20 new or improved health-based places of safety which provide a safe space for people detained by the police. Improvements to NHS 111 and crisis phone lines will also be rolled out. Beyond this, the Government is investing at least £2.3bn additional funding a year by April 2024 to expand and transform mental health services in England so that more people will be able to get the mental health support they need. This will mean mental health spending increases to 8.9% of all NHS funding.

For more information on this announcement, please visit the Government website:
https://www.gov.uk/government/news/mental-health-services-boosted-by-150-million-government-funding

Spring Budget 2023

On 15 March 2023, the Chancellor of the Exchequer the Rt Hon Jeremy Hunt MP delivered his Spring Budget to Parliament. Billed as a 'budget for growth' the budget focussed on the themes of the Government's industrial strategy – enterprise, employment, education and everywhere. Positively, the Office of Budget Responsibility (OBR) projects that whilst the UK economy will contract by 0.2% this year, a technical recession (two consecutive periods of negative growth) will be avoided.

Echoing previous announcements, the Spring Budget reconfirmed the Government's commitment to the urgent and emergency care recovery plan and highlighted forthcoming information on plans for recovery in the primary care sector. An NHS workforce plan will be published shortly, which is expected to be built on independently verified forecasts of the number and type of staff the NHS needs in 5, 10, and 15 years' time.

Aside from health-specific announcements, the changes to the Annual and Lifetime Allowance for pensions are welcomed to the extent they will help retain staff within the NHS workforce. The Chancellor expects these pension tax reforms to stop over 80% of NHS doctors from receiving a tax charge related to their pensions.

To access a copy of the Spring Budget 2023, please visit the Government website:
https://www.gov.uk/government/topical-events/spring-budget-2023.

HPV vaccine coverage in secondary school pupils

The UKHSA is urging any eligible young person that is not up to date with their Human Papillomavirus (HPV) vaccinations to contact their school nurse, school immunisation team or GP surgery for vaccination. The HPV vaccine is offered to all 12 to 13 year olds in school years 8 and 9 and follows a 2-dose schedule. Vaccine coverage has fallen recently due to the challenges posed by the COVID-19 pandemic, but young people remain eligible for vaccination until their 25th birthday.

The HPV vaccination programme in England has been shown to have dramatically lowered rates of harmful infections and cervical cancer in vaccinated women, with the strongest effects seen in those vaccinated at younger ages, and is saving lives. HPV vaccination also protects against genital warts and other cancers of the genital areas and anus, as well as some cancers of the head and neck.

For more information please visit the UKHSA website: https://www.gov.uk/government/news/concern-over-drop-in-hpv-vaccine-coverage-among-secondary-school-pupils

Mother-to-child transmission of hepatitis B eliminated in England

England has succeeded in meeting the World Health Organisation (WHO) target for eliminating mother-to-child transmission of Hepatitis B – a viral infection that affects the liver and if untreated can lead to serious liver damage. Pregnant women who have hepatitis B can pass the infection onto their baby around the time of birth – one of the most common routes of infection globally. To reduce the chances of a baby developing the infection, all pregnant women in England are offered an antenatal blood test for hepatitis B. For women who test positive for hepatitis B, their new-born babies are offered a course of hepatitis B vaccination starting at birth.

In addition to the targeted infant vaccination programme, in 2017 the UK introduced universal infant hepatitis B immunisation within the 6-in-1 vaccine at 8, 12 and 16 weeks of age. In 2021 quarterly coverage for these three doses was 91 to 92 per cent, exceeding the WHO target of 90%. Through this successful three-pronged approach, England has now met the WHO criteria for elimination of mother to child transmission.

For more information please visit the government website: https://www.gov.uk/government/news/mother-to-child-transmission-of-hepatitis-b-eliminated-in-england

New medical technology (medtech) strategy

On 3 February 2023, the Government published the inaugural medical technology (medtech) strategy for the UK, setting out how it will ensure the health and social care system can reliably access safe, effective, and innovative medical technologies. Through the strategy, the Government seeks to address four priorities, to:

- ensure resilience and continuity of supply of medtech products;
- support innovation and encouraging thriving, dynamic markets;
- develop enabling infrastructure; and
- focus on specific key issues and markets.

The strategy is designed to support delivery of the right product, at the right price, and in the right place, and, the continued delivery of high-quality care, outstanding patient safety and excellent patient outcomes in a way that makes best use of taxpayer money.

To access a copy of the strategy, please visit the Government website:
https://www.gov.uk/government/publications/medical-technology-strategy

Innovative projects to trial new ways to improve sexual health and HIV outcomes

On 6 February 2023, the UKHSA announced a series of projects across the country that have been awarded up to £30k each to boost engagement and outreach activity to reduce sexual health inequalities in underserved LGBT+ communities. Funding has been awarded to community based, voluntary sector organisations to offer services including vaccinations in community settings such as pubs and music festivals, raising awareness of sexual health issues at sex-on-premises venues, and communications to reduce anxiety around the mpox (monkeypox) vaccine.

For more information on the projects to which funding has been awarded, please visit the Government's website: https://www.gov.uk/government/news/innovative-projects-to-trial-new-ways-to-improve-sexual-health-and-hiv-outcomes

Rollout of family hubs

On 9 February, the Government announced it had selected 14 local authorities across the country to be trailblazers in its Family Hubs and Start for Life Programme. These areas will receive extra funding, leading the way and supporting other areas to improve services offered to families through family hubs. The Government has indicated that it will soon announce the award of funding to a further five local authorities to lead the transition of services which used to operate under the Sure Start banner over to the Family Hub model, enabling a further 12 local authorities across England to open family hubs by March 2024.

Family hubs are a place-based way of joining up locally in the planning and delivery of family services. They bring services together to improve access, improve the connections between families, professionals, services, and providers, and put relationships at the heart of family support. Family hubs offer support to families from conception and two, and to those with children of all ages, which is 0-19 or up to 25 for those with special educational needs and disabilities (SEND), with a great Start for Life offer at their core.

For more information on the trailblazers, please visit the Government's website: https://www.gov.uk/government/publications/trailblazers-for-the-family-hubs-and-start-for-life-programme/trailblazers-for-the-family-hubs-and-start-for-life-programme, and for more information on the Family Hubs and Start for Life Programme please see here: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1096786/Family_Hubs_and_Start_for_Life_programme_guide.pdf.

New Community Diagnostic Centres

On 13 February 2023, the Government announced 19 new Community Diagnostic Centres (CDCs) would be rolled out across the country as part of the elective recovery plan and to reduce NHS waiting lists. CDCs are based in convenient locations such as shopping centres and football stadiums allowing people to access tests more quickly. They house a range of equipment including MRI, CT, X-ray and ultrasound scanners and offer services including blood tests or heart rhythm and blood pressure monitoring. Once referred by a GP, pharmacist or hospital, patients can access CDCs in their local area to get any concerning symptoms checked out.

For more information on the elective recovery plan, please visit the NHS England website: https://www.england.nhs.uk/coronavirus/publication/delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care/.

Consultation launches on regulation of physician associates

On 17 February 2023, the Government launched a consultation on proposals to regulate Anaesthesia Associates (AA) and Physician Associates (PA) through the General Medical Council (GMC). Closing on 16 May, the consultation also

seeks views on wider reforms to the regulatory framework for each of the nine healthcare professional regulators. The proposals would give the GMC powers to register AAs and PAs, set standards of practice, approve education programmes, and operate fitness to practise procedures. It would make it an offence for someone with intent to deceive to use the titles Anaesthesia Associate and/or Physician Associate, falsely represent someone to have an approved qualification, make false representations on the content of the register and to procure the inclusion/exclusion of information in the register.

For more information on, and to participate in, the consultation please visit the Government's website: https://www.gov.uk/government/consultations/regulating-anaesthesia-associates-and-physician-associates.

Artificial intelligence pilot to cut missed hospital appointments

Artificial intelligence (AI) that predicts likely missed appointments and offers back-up bookings will be piloted by Mid and South Essex NHS Foundation Trust in a bid to allow an additional 80-100,000 patients to be seen each year. If successful, and rolled out widely, the technology would have the potential to save the NHS in the region of £1.2bn by cutting around eight million missed hospital appointments each year.

The technology breaks down the reasons why someone may not attend an appointment – using a range of external insights including the weather, traffic and jobs – then arranges appointments for the most convenient time for patients – for example, it will give evening and weekend slots to those less able to take time off during the day.

The technology was created by Deep Medical and co-designed by a frontline worker and NHS clinical fellow.

For more information please see the NHS England website: https://www.england.nhs.uk/2023/02/nhs-pilots-artificial-untelligence-software-to-cut-missed-hospital-appointments/

NHS Diabetes Prevention Programme

The results of a study conducted by the University of Manchester show that the NHS Diabetes Prevention Programme is linked to a 20% reduction in the risk of diabetes progression in those with pre-diabetes referred to the programme (compared to those not referred). The mechanism for achieving the reduction is risk is likely to be through weight reduction, with previous work showing that people who attended the programme were associated with a significant reduction in weight - the key factor in reducing risk - of 2.3 kg on average. Prior work also showed levels of HbA1c - the average blood sugar levels for the previous two to three months - reduced by a significant 1.26 mmol/mol.

More information on the Healthier You NHS Diabetes Prevention Programme is available via the NHS England website: https://www.england.nhs.uk/diabetes/diabetes-prevention/.

The NHS workforce is the most diverse it has ever been

On 22 February 2023, NHS England published the Workforce Race Equality Standard (WRES) for 2022, which shows that Black and Minority Ethnic (BAME) staff now make up almost a quarter of the workforce nationally (24.2 %). This is a modest increase in the proportion of BAME staff in the NHS this time last year (22.4%). Nationally, 42% of doctors and dentists, and 29% of nurses, midwives and health visitors are from a BAME background. Whilst there has also been an increase in BAME representation at board level, BAME staff remain proportionally under-represented in senior leadership positions.

The WRES report also showed that slightly more BAME than white staff reported harassment, bullying or abuse from patients (29.2% compared to 27%); the percentage of staff believing their trust provides equal opportunities for career progression and opportunities has fallen for white staff (from 59.6% to 58.7%) but increased slightly for BAME

staff (44.0% to 44.4%); and white shortlisted job applicants were 1.54 times more likely to be appointed from shortlisting than their BAME counterparts (a slight improvement on the previous year's figure of 1.61).

For more information on the 2022 WRES, please visit the NHS England website: https://www.england.nhs.uk/2023/02/new-figures-show-nhs-workforce-most-diverse-it-has-ever-been/

NHS Digital and NHS England complete merger

On 1 February 2023, NHS England and NHS Digital legally merged to create a new, single organisation to lead the NHS in England. It brings the NHS national data and technology expertise into one organisation, creating a closer link between the collection and analysis of data to help drive improvement in patient outcomes. The merger stems from a decision made in parliament to change the regulations to abolish NHS Digital. It means that NHS England becomes the custodian of national health and social care datasets and the single executive non-departmental public body with responsibility for digital technology, data and health service delivery in the NHS.

From 1 April 2023, Health Education England – the body responsible for the education and training of the health workforce – will also become part of a new NHS England. These changes are designed to build on the strengths and expertise of its legacy organisations, while avoiding duplicate activities. By the end of 2023/24 the new organisation will be between 30 and 40% smaller than the current combined size of NHS England, Health Education England and NHS Digital.

For more information on the transfer of functions from NHS Digital to NHS England, please see the NHS Digital website: https://digital.nhs.uk/about-nhs-digital/corporate-information-and-documents/directions-and-data-provision-notices/secretary-of-state-directions/nhs-england-de-identified-data-analytics-and-publication-directions-2023.

Expansion of NHS 111

On 30 January 2023, NHS England announced an expansion of NHS 111 that will increase access to specialist paediatric advice for children and introduce direct access to urgent mental health support. Parents and carers seeking health advice for children and young people using NHS 111 online or by calling NHS 111 will have increased access to specialist advice, including support from paediatric clinicians who can help them manage illness at home or decide the best route for their care. Direct access to urgent mental health support using NHS 111 is also being rolled out across the country – with people being able to select the mental health option when they call up for help.

For more information, please see the NHS England website: https://www.england.nhs.uk/2023/01/expansion-of-nhs-111-to-transform-patient-access/

Care Quality Commission awarded funding to encourage innovation and accelerate improvement

In February, the Department for Business, Energy and Industrial Strategy (BEIS) awarded the Care Quality Commission (CQC) approximately £120k to explore how the regulatory environment could be designed in a way that enables innovation to flourish. Over a six month period, the CQC will be working with a group of innovators and partners within the health and care system to: capture examples of high-quality innovation and share this learning; explore and articulate the role of an enabling and supportive regulator in an innovative health and care system; and pilot a suite of innovative-supporting activities and products to accelerate innovation and improvement based on research evidence about the way we can impact improvement in health and social care.

For more information please see the BEIS website: https://www.gov.uk/government/publications/projects-selected-for-the-regulators-pioneer-fund/projects-selected-for-the-regulators-pioneer-fund-2022.

CQC approach to assessing local authorities

From April 2023, the CQC will have new powers to assess Local Authorities (LAs) in England to examine how well LAs meet their duties under the Care Act (2014). The CQC has now published interim guidance on how it will assess LAs, which focuses on: themes and quality statements, evidence categories, how the CQC will assess LAs; and reporting and sharing information. The CQC expects to start a limited number of pilot assessments from April, covering up to five LAs between April and September 2023. From September, the CQC will start formal assessments, aiming to conduct up to 20 assessments between September and December. Further formal assessments will follow from early 2024 onwards.

For more information on the interim guidance please visit the CQC's website:
https://www.cqc.org.uk/sites/default/files/2023-02/20230228%20Interim%20Guidance%20for%20Local%20Authority%20Assessments%20FINAL.pdf

Progress in improving mental health services in England

On 9 February 2023, the National Audit Office (NAO) published a report on progress in improving mental health services in England. The report concluded that the NHS has expanded mental health service provision between 2016/17 and 2021/22, with 0.9 million more people accessing services than before. While waiting time standards have been met for talking therapy services and early intervention in psychosis services, standards for eating disorder services for children and young people have not been met where waiting times have increased following surges in demand during the pandemic. Between April and June 2022, just 68% of young people who were urgently referred to eating disorder services were seen within a week, against a standard of 95%.

The NHS has taken some important first steps towards closing the gap between mental and physical health services, although services remain under pressure and many people using them are reporting poor experiences. The NHS mental health workforce increased by 22% between 2016-17 and 2021-22, but staff shortages and the speed of expanding the existing workforce remain a major constraint. Reasons for shortages include difficulties recruiting and retaining staff, high turnover between service areas, and competition from health and non-health sectors.

The share of funding for mental health services has also increased slowly, reflecting the pace set by NHSE's targets. Although the NHS is on track to meet commitments to increase health spending by £3.4 billion by 2023-24, between 2016-17 and 2020-21 the percentage of local funding spent on mental health services only went up from 11.0% to 11.4%.

To access a copy of the report, please visit the National Audit Office website:
https://www.nao.org.uk/reports/progress-in-improving-mental-health-services-in-england/

Local Developments

Top NHS chief executive ranking by HSJ

I was honoured to be named the number one chief executive in the NHS by the HSJ on 20 March which I believe is a recognition of all staff across both LPT and NHFT .

The HSJ recognised the 'pioneer' work leading two Trusts since 2019, a trend which is being replicated in other parts of the country. Closer collaboration and partnership working was a key reason including leadership of the NHS support for independent mental healthcare provider St Andrew's, helping them on their quality improvement journey. NHFT and LPT are lead providers for regional CAMHS and adult eating disorder collaboratives, and a key part of the East Midlands Alliance for mental health and learning disabilities.

New Autism Space launched on LPT website

A new online hub for autistic people is now available on the Leicestershire Partnership NHS Trust website and has been launched in time for Neurodiversity Celebration Week (13 – 19 March 2023). To view Autism Space, visit: www.leicspart.nhs.uk/autism-space/

Autism Space is a free and safe online area providing clear, reliable and accessible advice and information about autism related topics – as well as a directory of support services available in Leicester, Leicestershire and Rutland (LLR). Visitors can expect advice and information on topics from understanding the autism diagnosis and assessment process, to support in education and employment, mental health and emotional wellbeing support and much more. There also a range of videos in different languages and easy read and read aloud options on the website.

The information has been put together by specialists from Leicestershire Partnership NHS Trust, Leicester City Council and the Learning Disability and Autism Collaborative, bringing together professionals from across LLR. Local autistic people and their families have also been an integral part of its design and content creation.

Rutland hospital inpatient ward reopens after £1.5m refurb

The inpatient ward at Rutland Memorial Hospital has been reopened on 6 March 2023 following a £1.5m refurbishment. The 18-bed ward relocated temporarily to Loughborough last August so contractors could carry out the work. It has involved replacing gas boilers, remodelling patient bays, improving the flooring, removing asbestos and redecorating. Two of the longest-serving members of staff had the honour of cutting the ribbon to reopen the ward. Read more here: Rutland inpatient ward reopened after £1.5m refurbishment - Leicestershire Partnership NHS Trust (leicspart.nhs.uk) and watch a short film about it here: https://youtu.be/251ZZzaD13s

Student Nurse Bethan in line for two national awards

A Leicester student has been shortlisted for two national awards. Bethan Jones is a finalist in two categories in the Student Nursing Times awards, for clinical research and for work with children. Wishing her all the best for when the awards are announced on 28 April.

Bethan, 25, originally from Nottingham, is carrying out a master's degree in nursing and leadership at the University of Leicester. As part of her studies she has undertaken placements with both Leicestershire Partnership NHS Trust, and with University Hospitals of Leicester. At LPT she helped design a four-week placement which will help future nursing students get their first taste of research, which in turn will help them to deliver better care for patients. She will be discussing the initiative at a nursing conference later this year, and evaluating it for an academic publication.

NHS Careers and jobs Event was a huge success

LPT led a system-wide NHS careers and jobs event on 11 March, which was attended by more than 1400 people at the Morningside Arena. With representation from across health and social care in Leicester, Leicestershire and Rutland, this was a fantastic blueprint for the future and reflects our commitment to ramping up recruitment activity at LPT.

Change leaders event on 14 March

More than 60 change leaders attended the second of our relaunched Our Future Our Way programme events.

The room was buzzing with some great questions and enthusiasm from the 60 plus change leaders who attended, to begin a refreshed Discovery phase of the Our Future Our Way culture improvement programme. The change leaders reviewed data from what our staff are telling us about their experience of working in and delivering

care at our Trust. They have started to formulate questions that will be used to engage staff further to really understand some of your answers to the staff survey, and then bring the results into a set of priorities to co-design further improvements in staff and patient safety for you.

I was pleased to attend the whole session as chief executive and demonstrate our commitment as a Trust Board. Also, thanks to James Mullins, director of patient safety, for joining us and to Kamy Basra, associate director of communications, and the project team for holding another successful event.

Group selected for Provider Collaboratives innovator scheme

We are proud to announce that the Leicestershire Partnership and Northamptonshire Healthcare Group has been selected by NHS England as one of only nine participants in a new national innovator scheme.

The NHS England Provider Collaborative Innovators Scheme will connect national policy and support directly to the partnership working we deliver in our systems. This will accelerate our vision for creating high quality, compassionate care, and wellbeing for all.

Only nine participants were chosen by NHS England from applications across the country to take part and receive support in this scheme, and we were the only collaborative to have been successfully selected in the East Midlands, demonstrating the strong collaboration both organisations have developed and our potential to achieve more.

The key benefits of becoming a provider collaborative innovator are:

- Support from NHS England to us and our partners, to develop better collaborations, faster
- We can influence national service transformation and national policy
- A network of nine innovators who we can learn from to improve care

We will use this opportunity to accelerate partnerships in Leicestershire, Leicester City & Rutland, in Northamptonshire and with our partners across the East Midlands.

Freedom to Speak Up National Webinar

As part of our ongoing support for Freedom to Speak Up (F2SU), I recently attended a webinar aimed at Executive leads for F2SU to hear about the nationally revised F2SU guidance and share best practice with other leads in the country.

NHS England and National Guardian Office (NGO) have also provided organisations with accompanying reflection and planning tools which enable the development of cultures and behaviours that are responsive to staff feedback.

For further information on the national policy, guidance and planning tool, please visit the NHS England website: https://www.england.nhs.uk/ourwork/freedom-to-speak-up/developing-freedom-to-speak-up-arrangements-in-the-nhs/

Relevant External Meetings attended

Chief Executive and Deputy Chief Executive external meetings

February	March
CQC engagement meeting	City Health and Wellbeing Board
Rutland Collaborative Workshop	LLR System Executive Committee development session
NHS CEO's and Chairs discussion	LLR System Executive Committee
Mark Farmer	NHSE Midlands Regional and National MH deep dive
Integrated Care Board	NHSE MH programme director
LLR ICB CEO	Inclusive Leadership Masterclass with NHFT
Liz Kendall MP	REACH staff network leads meeting with NHFT
National Mental Health Programme Board	LLR System Executive Development Committee
LLR ICB Chief People Officer	East Midlands Alliance CEO's
LLR ICB System Executive Development session	NHS CEO's meeting
East Midlands Alliance CEO weekly meeting	Principles of Health Command Training NHSE
CEO Birmingham and Solihull Mental Health Trust	Together Against Racism with NHFT
NHSE National Director of Mental Health	LLR QSRM with NHSE
National Mental Health trusts Chief Executives	LLR Integrated Care Board and development session
Healthwatch	* East Midlands Alliance CEO weekly meeting
NHS CEO's meeting	*NHS providers round table – Improvement and support
LLR System Executive Committee	
CEO Advisory group Mental Health	
East Midlands Alliance Board	
GGI Governance webinar	
Midlands CEO meeting	

Proposal

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

Decision Required

The Board is asked to consider this report and to decide whether it requires any clarification or further information on the content.

Governance Table

For Board and Board Committees:	Trust Board 28 March 2023	
Paper sponsored by:	Angela Hillery, Chief Executive	
Paper authored by:	Angela Hillery, Chief Executive Kate Dyer, Deputy Director of Governance and Risk / Trust Secretary (LPT) Richard Smith, Assistant Director of Corporate Governance (NHFT)	
Date submitted:	23 March 2023	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	None	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	n/a	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Routine board report	
STEP up to GREAT strategic alignment*:	High **S**tandards	
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	Yes
	Reaching Out	
	Equality, Leadership, Culture	
	Access to Services	
	Trust wide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	none
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Confirmed	
Equality considerations:	None	

Leicestershire Partnership NHS Trust

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Trust Board 28 March 2023

Revised Level 1 Committee Terms of Reference

Purpose of the report

To update three Level 1 Committee Terms of Reference

Analysis of the issue

Following approval of changes to the governance structure by the Trust Board on the 31 January 2023, a terms of reference has been developed for the new People and Culture Committee (Appendix A), and revised terms of reference have been provided for the Quality and Safety Committee (Appendix B) and the Finance and Performance Committee (Appendix C) with tracked changes to illustrate the changes made.

Proposal

- Adopt the terms of reference provided in appendices
- Update the relevant level 2 and 3 delivery group terms of reference accordingly

Decision required

Approve the Level 1 Committee terms of reference provided in this report.

Appendix A

People and Culture Committee

Terms of Reference

References to 'the Committee' shall mean the People and Culture Committee

Purpose of Committee

The People and Culture Committee is a Level 1 sub-committee of the Trust Board and will exercise its delegated authority in line with the standing orders of the Trust Board and its approved Terms of Reference. Its principal purpose is the provision of assurance to the Trust Board on the mitigation of risks relating to people and culture.

The Committee will assess at each meeting the level of assurance it has received from the reports presented to it and identify if it was assured, partly, or not assured. Areas where insufficient assurance has been received and a brief commentary on actions to be taken as a result will be highlighted to the Board.

The Committee reserves the right to commission further pieces of work to obtain further assurance.

Duties

The Committee will receive highlight reports, and an annual committee review from the level 2 Workforce Group.

It will routinely receive;

- Information on the Organisational Risk Register (ORR) risk relating to people and culture.
- Assurance reports on risks identified on the Organisational Risk Register (ORR) relating to people and culture which are high or significant (ie rated RED).
- Assurance reports on escalations from the level 2 workforce group.
- Statutory reports required as subgroup of the Trust board including;
    - Guardian for Safer Working six monthly report
    - Staff side facilities statement annual report
    - Safe and Effective Staffing Review six monthly report

Membership and Secretary

The members and in attendance membership of the Committee is listed in Appendix 1. Membership of the Committee will be reviewed and agreed annually with the Trust Board.

The Chair of the Committee shall be one of the independent Non-Executive Directors selected by the Chair of the Trust Board. In their absence their place will be taken by another independent Non-Executive Director. NED attendance will provide cross cover with both the Quality Assurance Committee and the Finance and Performance Committee.

The Committee shall be supported administratively by the corporate secretariat. This includes production of the Committee information pack and papers to be circulated within 7 days prior to the meeting, attend the meetings to take the minutes, keep a record of matters

arising and issues to be carried forward and generally provide support to the Chair and members of the Committee.

The agenda will be agreed with the Chair following consultation with the Director of HR and OD.

Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda and supporting papers will be forwarded to each member of the Committee, and any other person required to attend, no later than 5 working days before the date of the meeting.

The agenda for each meeting will include an item 'Declarations of interest in respect of items on the agenda'. Any declarations made will be recorded in the minutes of the meeting.

Minutes of Committee meetings shall be circulated promptly to all members of the Committee.

Quorum

The quorum necessary for the transaction of business shall be three and must include a Non-executive Director and a Director of HR and OD or Deputy. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

Frequency

The Committee shall meet bimonthly (not less than 6 times a year) and at such other times as the Chair of the Committee shall require at the exigency of the business. Members will be expected to attend at least three-quarters (75%) of all meetings.

Annual Review

The Committee shall, at least once a year, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Trust Board for approval.

Membership of the Committee

	Workforce Committee
Membership	• NED **(chair)** • NED x 1 • Director of HR and OD **(Executive Lead)** • Director of Nursing, AHPs and Quality • Medical Director • Operational Directors • Director of Governance and Risk
In attendance	• Deputy Director of Nursing, AHP & Quality • Deputy Director of Governance and Risk • Head of Equality, Diversity and Inclusion • Directorate representation • Other managers will be invited to attend as and when required
Frequency	Not less than 6 times per 12 months
Day and times	The last Tuesday of every other month 12-1pm

Appendix B

Quality and Safety~~Assurance~~ Committee

Terms of Reference

References to "the Committee" shall mean the Quality and Safety Committee

Purpose of Committee

The Quality and Safety Committee is a (Level 1) Committee of the Trust Board and will exercise its delegated authority in line with the Standing Orders of the Trust Board and its approved Terms of Reference. Its principal purpose is the provision of assurance to the Trust Board of effective quality and safety~~governance~~ arrangements, with a focus on areas related to the Trust's Step Up To Great Strategy and will work to a plan built around assurance that the Trust delivers services that are safe, effective, caring, responsive and well led and compliant with regulations.

The Committee will assess at each meeting the level of assurance it has received from the reports presented to it and identify if it was assured, partly, or not assured. Any immediate high risk concerns raised during the meeting will be shared directly with all Board members.

The Committee shall make whatever recommendations to the Trust Board it deems appropriate on any area within its remit where action or improvement is needed.

The Committee reserves the right to commission further pieces of work to obtain further assurance

Duties

The Committee will receive regular highlight reports, and an annual committee review from the level 2 delivery groups ~~committees~~ which are direct reports;

- ~~Strategic Workforce Committee~~ ~~Policy Committee~~Health and Safety Committee
- Quality Forum
- Safeguarding Group~~Committee~~
- Mental Health Act Group~~Legislative Committee~~

It will also receive assurance over;

Quality

- Receive assurance on the delivery of the quality and safety elements of Step Up To Great
- Receive performance and compliance reports relating to quality and safety measures
- Scrutinise and gain assurances relating to required standards, and the mitigation of risk and substandard quality performance.
- Receive assurance that services are safe, effective, caring, well led and responsive
- Receive assurance on;

- The draft Quality Account and on-going monitoring of quality priority metrics
- Serious incidents and never events
- End of life and Learning from Deaths
- Privacy and dignity
- Single sex accommodation
- Controlled drugs and medicines management
- ~~Workforce, Equality, Diversity and Inclusion~~
- Patient Experience, complaints and compliments

Safety

- Receive assurance on issues of patient safety, patient experience and patient outcomes and promote the involvement of service users, carers and the public;
- Receive assurance on:
  - Health and safety
  - Safeguarding arrangements across the organisation
  - Suicide prevention
  - Sexual Safety
  - Infection Prevention and Control / Flu Plan
  - Mental health act and mental capacity act

~~**Workforce**~~

- ~~Monitor and review key workforce related matters to understand the effects on quality and patient safety;~~
- ~~To oversee delivery of key human resources and organisational development programmes including 'our future our way', leadership behaviours, WRES and WDES~~
- ~~To monitor performance against by Directorate through the dashboard reporting to the Performance Committee;~~
- ~~Receive assurance on;~~
  - ~~Safe Staffing and Guardian of Safe Working Hours~~
  - ~~Nursing and AHP revalidation~~
  - ~~Workforce performance including sickness/absence, appraisal and mandatory training compliance~~

Governance

- Review and receive assurance on compliance with regulatory requirements including CQC and NHSE~~I~~ within the remit of the Committee;
- Ensure the effectiveness of the Trust's quality and safety governance arrangements and advise the Trust Board and Audit & Risk~~Assurance~~ Committee; it will also liaise with the Finance and Performance Committee and People and Culture Committee as necessary;
- Ensure the effectiveness of the WeImproveQ and arrangements for research and development within the Trust
- Through liaison with the Audit and Risk Committee, be sighted on limited, split

and no opinion quality-related audits commissioned as part of the Internal Audit Plan so that the Committee can assess/ seek assurance over the actions instigated to address the recommendations arising from such audits;

- Oversight of the outcomes of clinical audits for key lines of enquiry to gain assurance in relation to quality and safety, utilising the appropriate level 2 committee to escalate where appropriate.
- External visits log including key outcomes and relevant reports
- Disseminate within the organisation learning from assurances and information, including improvement identified through liaison with Northamptonshire Healthcare NHS Foundation Trust.
- The Quality and Safety Committee to provide a bi-monthly summary of escalated issues to the Integrated Care Board System Quality and Safety Committee

Risk

- Exercise oversight of and assurance on those ORR risks assigned to it in line with the Trust's Risk Management Strategy;
- Where appropriate, commission a deep dive thematic review to undertake greater analysis where level of risk warrants.

Membership

The members and in attendance membership of the Committee is listed in Appendix 1. Membership of the Committee will be reviewed and agreed annually with the Trust Board.

The Chair of the Committee shall be one of the independent Non-Executive Directors selected by the Chair of the Trust Board. In their absence their place will be taken by another independent Non-Executive Director.

Secretary

The Committee shall be supported administratively by the Corporate Affairs Manager. This includes; production of the Committee information pack to be circulated within 7 days prior to the meeting, attend the meetings to take the minutes, keep a record of matters arsing and issues to be carried forward and generally provide support to the Chair and members of the Committee.

The agenda will be agreed with the Chair following consultation with the Director of Nursing, AHPs & Quality.

Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda and supporting papers will be forwarded to each member of the Committee, and any other person required to attend, no later than 5 working days before the date of the meeting.

The agenda for each meeting will include an item "Declarations of interest in respect of items on the agenda". Any declarations made will be recorded in the minutes of the meeting.

Minutes of Committee meetings shall be circulated promptly to all members of the Committee.

Quorum

The quorum necessary for the transaction of business shall be three, and must include a Non-executive Director and clinical Executive Director. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

Frequency

The Committee shall meet bi monthly (not less than 6 times a year) and at such other times as the Chair of the Committee shall require at the exigency of the business.

The Quality and Safety Committee, People and Culture Committee and the Finance and Performance Committee will hold joint workshops for any key joint agenda items where relevant and will report on recommendations separately.

Members will be expected to attend at least three-quarters (75%) of all meetings.

Annual Review

The Committee shall, at least once a year, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Trust Board for approval.

Membership of the Committee

	Quality and Assurance Committee
Membership	• NED **(chair)** • NED x 2 (including one who also attends PPC / FPC) • Director of Nursing, AHP & Quality **(Executive Lead)** • Medical Director • A Service Director • ~~Director of Human Resources & OD~~ • Director of Governance and Risk
In attendance	• Deputy Director of Nursing, AHP & Quality • Deputy Director of Governance and Risk • Head of Health and Safety • Head of QI • Head of Equality, Diversity and Inclusion • Directorate representation • ~~Clinical Commissioning Group~~ Representative from the Integrated Care Board • Other managers will be invited to attend as and when required
Frequency	Not less than 6 times per 12 months
Day and times	The last Tuesday of every other month / 9am-11:30am to be extended to Midday where required.

Appendix C

Finance and Performance Committee

Terms of Reference

References to "the Committee" shall mean the Finance and Performance Committee

Purpose of Committee

The Finance and Performance Committee is a (Level 1) Committee of the Trust Board and will exercise its delegated authority in line with the Standing Orders of the Trust Board and its approved Terms of Reference. Its principal purpose is the provision of assurance to the Trust Board of effective governance arrangements, with a focus on areas related to the Trust's Step Up To Great Strategy and will work to a plan built around assurance over the delivery of key financial strategies, key financial indicators, business development and investment, performance management, estate management and IT management.

The Committee will assess at each meeting the level of assurance it has received from the reports presented to it and identify if it was assured, partly, or not assured. Any immediate high risk concerns raised during the meeting will be shared directly with all Board members.

The Committee shall make whatever recommendations to the Trust Board it deems appropriate on any area within its remit where action or improvement is needed.

The Committee reserves the right to commission further pieces of work to obtain further assurance

As a Committee of the Board of Directors, it is important that the Finance and Performance Committee minimises areas of overlap with the Audit Committee. Therefore, the following specific areas of responsibility will be excluded from the Finance and Performance Committee Agenda:

- Audit – External and Internal;
- Arrangements for and Subsequent Adoption of Annual Accounts;
- Standing Financial Instructions and Scheme of Delegation;
- Local Counter Fraud Specialist work

Duties

The Committee will receive regular highlight reports, and an annual committee review from the level 2 delivery groups ~~committees~~ which are direct reports;

- Estates and Medical Equipment Group~~Committee~~
- ~~-~~ Transformation and QI Group~~Committee~~
- ~~- IM&T Committee~~
- Data Privacy Group~~Committee~~
- Capital Management Committee
- ~~Strategic Waiting Times~~ Access Group~~Committee~~
- Collaborative and Commissioning Group

The committee will ensure that the Trust has in place a comprehensive financial and performance management control framework; it will review the requirements for the development of financial and performance reporting systems and will receive assurance over;

Finance

- To review and monitor performance against all statutory and organisational financial targets.
- To review and make recommendations to Board on budgets, strategic plans and long-term investment strategy. This review will include reviewing the Long Term Financial Model (or equivalent planning model) and associated strategies; Cost Improvement Programmes; capital programmes; activity and capacity plans, and Annual Business Plan, and any financial/budgetary arrangements with partners.
- To review and make recommendations to Board on all significant investment and divestment proposals under the Trust's Scheme of Reservation and Delegation, and in line with best practice investment appraisal techniques, the five-year Long Term Financial Model and agreed strategies; and to approve any financing or use of financial instruments within its delegation.
- To ensure there are robust arrangements for overview and scrutiny of;
  - The estates, procurement and IT strategies, and their delivery.
  - Capital development plan
  - The treasury management function
  - Approval of accounting policies and treasury management policy.

Business Development and Contracting

- To ensure an appropriate and robust business development framework is in place and to regularly review its operation.
- To oversee and approve under delegated limits the investment appraisal of business cases and wider business development opportunities
- To review regularly the Trust's performance against tender bids, both successful and unsuccessful
- To ensure an appropriate and robust response is in place for contracting, and that the Trust has timely and accurate costing and activity information to support the process.
- To ensure the Board of Directors is advised of any significant variation in activity and its impact on income and costs.
- Receive assurance on;
  - Joint ventures
  - Operational plan

Performance

- To scrutinise the performance of operational and corporate services in their contribution to the achievement of strategic objectives, KPIs and contractual targets.
- To ensure that an effective performance management and data quality system is in place.
- To ensure that there are effective emergency and business continuity

arrangements in place for the Trust.

- To ensure the arrangements and performance of the shared facilities management services are adequate and monitored regularly throughout the financial year.
- To review the performance, business plans and value added contribution from hosted services on a regular basis.
- To oversee the assessment of benefits realisation and achievement of value for money for areas of delegated responsibility
- To receive assurance on;
    - Information Governance Toolkit Declaration
    - Data Quality
    - Emergency and Business Continuity Annual Report
    - LPT Major incident plan
    - Premises Assurance Model
    - PLACE
    - Fire Safety
    - Medical Devices
    - Pertinent external visits, reviews, inquiries and investigations
    - Sustainability
    - Hosted services (360 Assurance and LHIS)

Governance

- Ensure the effectiveness of the Trust's finance and performance governance arrangements and advise the Trust Board and Audit & Assurance Committee; it will also liaise with the Quality and Safety ~~Assurance~~ Committee, and the People and Culture Committee as necessary;
- Through liaison with the Audit Committee, be sighted on limited, split or no opinion finance and performance-related audits commissioned as part of the Internal Audit Plan so that the Committee can assess/ seek assurance over the actions instigated to address the recommendations arising from such audits;
- Disseminate within the organisation learning from assurances and information, including improvement identified through liaison with Northamptonshire Healthcare NHS Foundation Trust.

Risk

- Exercise oversight of and assurance on those ORR risks assigned to it in line with the Trust's Risk Management Strategy;
- Where appropriate, commission a deep dive thematic review to undertake greater analysis where level of risk warrants.

Membership

The members and in attendance membership of the Committee is listed in Appendix 1. Membership of the Committee will be reviewed and agreed annually with the Trust Board.

The Chair of the Committee shall be one of the independent Non-Executive Directors selected by the Chair of the Trust Board. In their absence their place will be taken by another independent Non-Executive Director.

Secretary

The Committee shall be supported administratively by the Corporate Affairs Manager. This includes; production of the Committee information pack to be circulated within 7 days prior to the meeting, attend the meetings to take the minutes, keep a record of matters arsing and issues to be carried forward and generally provide support to the Chair and members of the Committee.

The agenda will be agreed with the Chair following consultation with the Director of Finance, Business and Estates.

Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda and supporting papers will be forwarded to each member of the Committee, and any other person required to attend, no later than 5 working days before the date of the meeting.

The agenda for each meeting will include an item “Declarations of interest in respect of items on the agenda”. Any declarations made will be recorded in the minutes of the meeting.

Minutes of Committee meetings shall be circulated promptly to all members of the Committee.

Quorum

The quorum necessary for the transaction of business shall be three, and must include a Non-executive Director and an Executive Director. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

Frequency

The Committee shall meet bi monthly (not less than 6 times a year) and at such other times as the Chair of the Committee shall require at the exigency of the business.

The Quality Assurance Committee and the Finance and Performance Committee will hold joint workshops for any key joint agenda items where relevant and will report on recommendations separately.

Members will be expected to attend at least three-quarters (75%) of all meetings.

Annual Review

The Committee shall, at least once a year, review its own performance, constitution and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Trust Board for approval.

Membership of the Committee

	Quality and Assurance Committee
Membership	• NED **(chair)** • NED x 2 (including one who also attends QSAC and PCC) • Director of Finance, Business and Estates **(Executive Lead)** • Director of Strategy and Business Development • A Service Director • The Medical Director or Director of Nursing, AHPs and Quality • Director of Governance and Risk
In attendance	• Deputy Director of Finance • Deputy Director of Governance and Risk • Other managers will be invited to attend as and when required
Frequency	Not less than 6 times per 12 months
Day and times	The last Tuesday of every other month /13:00 until 15:30 to be extended to 16:00 where required

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Leicestershire Partnership NHS Trust

Trust Board Public Meeting – 28th March 2023

Documents Signed Under Seal – Quarter 3 Report

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

Purpose of the report

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

Use of Seal – General guide

(i) All contracts for the purchase/lease of land and/or building

Analysis

The documents shown below have been signed under seal during quarter 3 2022/23 from 1st October to 31st December 2022.

Seal Register Number	Type	Description	Date Recorded
004	Lease	Lease of part of Westcotes Health Centre, Leicester signed by Angela Hillery and Sharon Murphy.	March 2023

Decision required

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

Governance table

For Board and Board Committees:	Public Trust Board 28th March 2023
Paper sponsored by:	Chris Oakes, Director of Corporate Governance and Risk
Paper authored by:	Corporate Affairs Manager
Date submitted:	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	NA
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	NA
State whether this is a 'one off' report or, if not,	Quarterly report at Trust Board

when an update report will be provided for the purposes of corporate Agenda planning		
STEP up to GREAT strategic alignment*:	High **S**tandards	
	Transformation	
	Environments	✓
	Patient Involvement	
	Well **G**overned	✓
	Reaching out	
	Equality, Leadership, Culture	
	Access to Services	✓
	Trust wide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	all
Is the decision required consistent with LPT's risk appetite:	NA	
False and misleading information (FOMI) considerations:	NA	
Positive confirmation that the content does not risk the safety of patients or the public	NA	
Equality considerations:	NA	

Leicestershire Partnership NHS Trust

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Trust Board 28 March 2023

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 20 strategic risks on the ORR, of which seven have a high current risk score. The high-risk profile for the Trust includes the following areas;

- Waiting lists
- Cyber threat
- Electronic Patient Record
- Vacancy rate (safety and quality)
- High agency usage (finance)
- Medical capacity in CMHT
- Inherited FM risk

There is one risk (Risk 85 high agency spend) where the residual score (16) is being tolerated at a higher level than the Trust's cautious appetite for financial risk (9-11). The toleration of this risk, and consideration of further mitigation action is reviewed monthly in line with the Executive Director risk review cycle.

Following approval at the January 2023 Trust Board meeting, a new level 1 'People and Culture Committee' was introduced to gain assurance over significant strategic workforce risks. The three ORR risks relating to delivery of the Equality, Leadership and Culture element of our Step Up To Great (SUTG) strategy have therefore been moved from the oversight of the Quality and Safety Committee (QSC) to the People and Culture Committee;

- Risk 61 A lack of staff with appropriate skills will not be able to safely meet patient care needs, which may lead to poor patient outcomes and experience.
- Risk 73 If we don't create an inclusive culture, it will affect staff and patient experience, which may lead to poorer quality and safety outcomes.
- Risk 74 The impact of additional pressures on service delivery may compromise the health and wellbeing of our staff, leading to increased sickness levels.

There are also currently two further risks on the ORR which rely on workforce related actions to provide mitigations;

- Risk 84 A high vacancy rate for registered nurses, AHPs, HCSWs and medical staff, is leading to high temporary staff usage, which may impact on the quality of patient outcomes, safety, quality and experience **(High Standards risk overseen by the Quality and Safety Committee)**.
- Risk 85 High agency usage is resulting in high spend, which may impact on the delivery of our financial targets for 2022/23 **(Well Governed risk held by the Finance and Performance Committee)**.

The People and Culture Committee will be reviewing action plans relating to wider workforce issues, these will relate to risks 84 and 85; the assurance ratings provided by the Committee will be shared with the Quality and Safety Committee and the Finance and Performance Committee in the ORR

summary reports so that a wider assessment of the risk is achieved. Risks 84 and 85 will be included within the People and Culture ORR summary report for information from April 2023.

The addition of risk 89 was approved by the QSC in February 2023;

Risk 89 Following the transfer of soft FM service, there are potential gaps in the sustainability of compliance with national cleaning standards and waste regulation which may impact on healthcare acquired infections and patient outcomes.

Strategic risks March 2023

No.	Title	SU2G	Initial risk	Current risk	Residual Risk	Tolerance
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	12	8	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.	Equality, Leadership and Culture	16	12	8	16-20
64	If we do not retain existing and/or develop new business opportunities, we will have less financial sustainability and infrastructure resulting in a loss of income and influence within the LLR system.	Transformation	12	12	9	9-11
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 identified resource for the green agenda, leading to non-compliance with the NHS commitment to NHS Carbon Zero.	Environments	12	12	9	9-11
68	A lack of accessibility and reliability of data reporting and analysis will impact on the Trust's ability to use information for decision making, which may impact on the quality of care provided.	Well Governed	16	12	12	9-11
69	If we do not appropriately manage performance, it will impact on the Trust's ability to effectively deliver services, which could lead to poor quality care and poor patient experience.	Well Governed	8	8	4	9-11
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	9	6	16-20
74	The impact of additional pressures on service delivery may compromise the health and wellbeing of our staff, 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
79	The Cyber threat landscape is currently considered significant due to the geopolitical conflicts, high prevalence of cyber-attack vectors, increase in published vulnerabilities, etc which could lead to a significant impact on IT systems that support patient services and potential data breaches	Well Governed	16	16	12	16-20
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	Well Governed	15	9	9	9-11

	strategy (including LLR strategy)					
83	Restricted access and use of electronic patient record systems will result in incomplete electronic patient records including the recording of physical observations. This will impact on the delivery of effective and safe patient care	High Standards	16	16	12	16-20
84	A high vacancy rate for registered nurses, AHPs, HCSWs and medical staff, is leading to high temporary staff usage, which may impact on the quality of patient outcomes, safety, quality and experience.	High Standards	16	16	8	16-20
85	High agency usage is resulting in high spend, which may impact on the delivery of our financial targets for 2022/23	Well Governed	20	20	16	9-11
86	A lack of capacity within the workforce model and a high vacancy rate is reducing our ability to assess and follow up patients in community mental health services in a timely way, impacting on the safety of care and the mental wellbeing for our patients.	High Standards	20	20	16	16-20
87	Following the establishment of a new FM service, there is a risk of unknown issues based on historical maintenance resulting in the Trust not meeting its quality standards or requirements.	Environment	16	16	12	16-20
88	Risk of closed cultures within services that may lead to poor patient, staff and family experience and organisational and reputational risk.	High Standards	12	12	8	16-20
89	Following the transfer of soft FM service, there are potential gaps in the sustainability of compliance with national cleaning standards and waste regulation which may impact on healthcare acquired infections and patient outcomes.	Environment	12	12	8	16-20

Proposal

Changes to Scoring

Risk 68 A lack of accessibility and reliability of data reporting and analysis will impact on the Trust's ability to use information for decision making, which may impact on the quality of care provided.

The residual risk has increased from 8 to 12 due to issues impacting on the delivery of actions. The residual score is now higher than the Trust's cautious appetite for regulatory risk. Actions will be monitored during March and April 2023 and a further update will be provided to the Finance and Performance Committee next month.

Decision required

Trust board is assured by the risk management process and that the ORR continues to be reflect strategic risks relevant to the Trust.

Leicestershire Partnership NHS Trust

Governance Table

For Board and Board Committees:	Trust Board 28 March 2023	
Paper sponsored by:	Chris Oakes, Director of Governance and Risk	
Paper authored by:	Kate Dyer, Deputy Director of Governance and Risk	
Date submitted:	22 March 2023	
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	

Leicestershire Partnership NHS Trust

Organisational Risk Register
March 2023

Based on the risk appetite matrix produced by the Good Governance Institute

Risk No: 59	Date included	29 November 2021	Date revised	09/03/2023
Objective: S	High Standards			
Risk Title:	Lack of staff capacity is causing delays in the incident management process, including the review and closure of a backlog of reported incidents, the investigation and report writing of SIs and the closure of resulting actions. This will result in delays in learning and could lead to poor quality care and patient harm as well as reputational damage.			
Risk owner:	Exec: Operational Directors and Director of Nursing, AHPs and Quality		Local: Head of Patient Safety	
Governance:	Quality Forum / QSC / 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:	• Incident reporting policy, centralised SI reporting and oversight process, and approved exec sign off process • Incident investigation training monthly rolling programme • DMH pilot programme – new cyclical process for managing and learning from SI's • Initial meeting held with the ICB for PSIRF to determine LLR ICB approach – ongoing engagement within ICB / System • Recruitment of additional SI investigators and clinical governance officers • Learning lessons community of practice		
	Gaps:	• Resource and workforce challenges due to winter pressures • Short term safeguarding and ANP capacity to input into SI reviews in a timely way • Delivery of trajectories for improvement		
Assurances	Internal:	Source • Reports/ minutes from Incident Oversight Group, Incident Review Meeting and Quality Forum and Executive Team. • Monthly Quality Monitoring Report – Patient Safety Incident Investigation Report • Increased frequency of sign off meetings • Collaboration with the Group learning lesson exchange group • Clinical governance structure • Directorate improvement plans in place monitored via Incident Oversight Group	Evidence • Patient Safety Trust Board reporting includes patent stories to support learning • Directorate improvement plans - monitored via EMB, IOG and through to Quality Forum • Early learning from Incident Review Meeting • Reduced rate of complaints from families relating to SIs due to enhanced engagement.	Assurance Rating Amber
	External:	Source: • CQC Inspection 2021 • CCG sign off and feedback for SI reporting	Evidence: • CQC feedback The trust must ensure that managers review incident in a timely way, in line with trust policy. (Reg17 (1)) • CCG – number of reports signed off / number returned for additional work	Assurance Rating Green
	Gaps:			

Actions	Date: Mar 23	Actions: Approval of a tailored quality improvement plan	Owner: TH/SL/HT	Progress: Developed – awaiting sign off

Status
Amber

Risk No: 61	Date included	29 November 2021	Date revised	01/03/2023
Objective: S	High Standards and Equality, Leadership, Culture			
Risk Title:	A lack of staff with appropriate skills will not be able to safely meet patient care needs, which may lead to poor patient outcomes and experience.			
Risk owner:	Exec: Director of HR & OD	Local: Head of Education, Training and Development		
Governance:	SWC / PCC / 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:

- Mandatory and Role Essential Training Policy, Study Leave Policy, Safer staffing policies and guidance
- National and local People Plan
- Mandated clinical supervision
- Role applicable competency framework / Annual training needs analysis
- E rostering in place across inpatient services and community
- Reintroduction of system for bank staff who are unable to book shifts unless they are fully compliant with mandatory training
- On-going recruitment programme / STAR days
- Annual establishment reviews / Winter BAF actions revised and reviewed
- New process for amending compliance requirements to position numbers / Manager compliance and DNA reports live on ulearn
- Deteriorating Workforce and Sepsis Group in place to progress and review training and compliance for ILS and BLS
- Reporting and monitoring of monthly course unutilised spaces and cancelled courses/places / New report of Mandatory Training SME and course update logs to TED
- new report on DPA training compliance for pre-learning to go to DMT monthly
- MHA for Drs reviewed and amended refresh by MHA Governance Delivery Grp accepted by TED

Gaps:

- Elements of mandatory and role essential training compliance for our non-substantive/bank workforce
- Knowledge of the skill set for individual bank and agency staff
- Knowledge of Agency staff skills outside of the on-framework agency
- Clinical matron role for supporting the skills training and clinical supervision for bank and agency staff
- Emphasis on the role of sepsis awareness and deteriorating patient training for all staff

Assurances

	Source:	Evidence:	
Internal:	• SWC , Directorate Workforce groups , retention working group • Quarterly workforce triangulation to ops exec - hotspots and action • LLR People Programme Delivery Group • Workforce planning supply Trust Approach • Workforce and safe staffing, tipping points and actions aligned to OPEL levels and governed through SWC • Hotspots identified on Directorate Risk Registers • Weekly safe staffing meeting • Learning from SI's and quality improvements • Monthly clinical education forum • Winter BAF actions reviewed at Winter Committee	• Mandatory Training and Role Essential Training Flash Report- monthly • Supervision compliance report- monthly • Noc trust board and SEB deep dive • Directorate risk registers received at DMTs • Quarterly triangulation document to Exec Team with action plan. • Training capacity DNA spaces monitored at Training Education Development Group Monthly • Monthly pre-learning report on DPA training • SME report to TED/SWC • New PCC discussion on agency compliance	Assurance Rating Green
External			
Gaps:			

Actions

Date:	Actions:	Owner:	Progress	Status
Feb 23	• Increase compliance for ILS, NEWS 2 and sepsis for substantive and bank staff	Helen Briggs	Ongoing	Green
April 23	• ILS training compliance for 113 agency RNs who regularly work in in-patients	Helen Briggs	Meeting held 8.2.23, TNA completed, compliance check to be completed by agency, GAP identified, training to be sourced	Green
April 23	• SWG consider risk and agency compliance	Emma Wallis		
Mar 23	• Increase the cascade of flat lift awareness and competency assessment to use equipment on inpatient wards	Helen Briggs	Ongoing	

Risk No: 64	Date included	29 November 2021	Date revised	01/03/2023
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 Partnerships		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:	• Sufficient oversight of individual service sustainability

Assurances	Internal:	Source: Commissioning & Collaborative Committee and first meeting Transformation and QI Committee Joint Working Group (JWG) of LPT & NHFT Executive, board meetings & board development sessions Finance and Performance Committee	Evidence: Transformation Committee will review progress of internal transformational priorities. JWG reviews progress on key joint priorities. Executive, Board meetings and development sessions include a focus on our strategic priorities and transformation. Evidence available in papers, agenda and minutes Business pipeline report	Assurance Rating Green
	External:	Source: Internal Audit HOIAO Feedback from NHS E/I Feedback from stakeholders (CQC, CCG/ICB & local authorities) Attendance at local authority scrutiny meetings	Evidence: Formal feedback from audit opinion, formal meetings and our stakeholder feedback.	Assurance Rating Green
	Gaps:	Further building of our work with voluntary and community organisations		

Actions	Date: Mar 23	Actions: Liaison with Director of Finance and Operational Directors to identify way forward	Owner: Executive Director of Strategy & Partnerships	Progress: ongoing	Status Green

Risk No: 66	Date included	29 November 2021	Date revised	21/03/2023
Objective: E	Environments			
Risk Title:	The lack of detail around accommodation requirements in strategic business planning, means that the Estates Strategy cannot adequately plan for potential building solutions, leading to an estate configuration which is not fit to deliver high quality healthcare.			
Risk owner:	Exec: Chief Finance Officer		Local: Associate Director Estates & Facilities	
Governance:	Estates Committee / FPC / Board - Monthly Review			

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

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

Controls	Description:	• Approved Strategic plan for the elimination of dormitory accommodation • New Hospitals Programme (NHP) Expression of Interest submitted • Refresh of Mental Health inpatient Strategic Outline Case and bed modelling • Tripe R outputs • Estates Strategy refresh in progress • Capital resource prioritisation framework • Refreshed SUTG strategy 2021
	Gaps:	• Finalise ward moves to confirm phasing order for dormitories. Works continue on programme. • Directorate and enabling business plans to support wider Estates plan 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 Green
	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
	June 23	• Implementation of Dormitory Eradication programme.	Richard Brown	• Dorm scheme. Complex project - remains on plan, reported to NHSE Estates. [status Green].	Green
	March 24	• Estates delivery plan	Richard Brown	• In draft – estimated trajectory 6 to 12 months	Amber
	June 23	• Production of the Trust's estates 5-year plan	Paul Sheldon	• Being drafted and consulted	Amber

Risk No: 67	Date included	29 November 2021	Date revised	01/03/23
Objective: E	Environments			
Risk Title:	The Trust does not have 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:	• 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 Green NHS Board meets monthly – LPT in attendance • Job Descriptions approved for Head of Sustainability, and Sustainability Manager (potential secondment/development role) • Working with NHFT to deliver across the Group
	Gaps:	• Lack of data on carbon footprint • Lack of historic Sustainable Development Management Plan

Assurances	Internal:	Source: Green plan approved Regular reporting	Evidence:	Assurance Rating Amber
	External:	Source: LLR Green Board Work to share across the Group with NHFT knowledge and experience on sustainability	Evidence: Green Board Committees in Common	Assurance Rating Amber
	Gaps:			

Actions	Date: Mar 23	Actions: Recruit to a Head of Sustainability role	Owner: CFO	Progress: In progress.	Status Amber

Risk No: 68	Date included	29 November 2021	Date revised	13/03/23
Objective: G	Well Governed			
Risk Title:	A lack of accessibility and reliability of data reporting and analysis will impact on the Trust's ability to use information for decision making, which may impact on the quality of care provided.			
Risk owner:	Exec: Director of Finance & Performance		Local: Head of Information	
Governance:	Data Privacy Committee / FPC / Board - Monthly Review			

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

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

Controls

Description:

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

Gaps:

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

Assurances

Internal:

- Performance review meetings include Directorate level metrics
- FPC / Trust Board
- Clinical audit / Annual record keeping audit
- Data security and protection toolkit self assessment
- Regular oversight reports from the IM&T Committee
- Data quality committee
- Local Risk register

Evidence:

- DSPT 'standards met' annual submission made in June 2022
- Data quality actions reported to FPC via Data Privacy Committee
- Local risks reviewed in Data Privacy Committee
- Delivery of phase 1 21/22 data quality work plan
- SEB approved Data Quality Plan Implementation and Campaign on 02/12/22

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, phase 1 has defined the frameworks for quality data, phase 2 of action plan needs to fully embed the approach
- External Account (quality account indicators) Not undertaken for 19/20 or 20/21 and not required for 21/22

Actions

Date:	Actions:	Owner:	Progress:	Status
Mar 23	• Trust wide data quality comms campaign	SM	Working with comms team	Green
Apr 23	• Implement priority SNOMED coding areas	SM	Concerns around resource to support implementation	Red
Apr 23	• Trust resource must be agreed for SNOMED implementation (statutory requirement from 01/04/23)	SM	Agreed at SEB as Trust priority now at I, M & T delivery group for milestones & resource agreement	Green
Dec 23	• Continue to implement SNOMED		Clarity for 23/24 resources to be agreed by end of March 23	Amber
Dec 23	• Delivery of phase 2 of data quality plan – embedding processes & implementing kitemark approach	SM SM	Data quality plan approved by DQC in December 2022 & approved by SEB	Green

Risk No: 69	Date included	29 November 2021	Date revised	13/03/23	
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:	EMB / FPC / Board - Monthly Review				

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

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

Controls	Description:	• Board approved Performance management framework • Board level performance dashboard • Revised governance framework • SUTG plan • SOP in place	
	Gaps:	• Capacity of the information team due to demands from national sitrep reporting • 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 amber (FPC - August 2022) • Escalated items from performance reviews reported to OEB. • Performance reports narrative updated by Directorate Business Managers prior to release.
	External:	Source: • CQC inspection 2021 • External and internal audit	Evidence: • Internal audit review of performance framework 21/22 – significant assurance
	Gaps:	• Fully embedded system (demonstrated once level 2 dashboards are fully implemented) • Trust wide approach to reporting planned post covid performance & capacity	

	Assurance Rating
Internal:	Amber
External:	Green

~~Actions~~	Date:	Actions:	Action Owner:	Progress:	Status
	tbd	• Restructure of information team	SM	MOC on hold	Amber
	tbd	• Phase 2 review of information team, including approach to performance framework management	SM	on hold	Amber
	Feb 23	• Making Data Count training for operational leads	SM	Completed	Green
	Feb 23	• Board development session on making data count	SM	Completed	Green
	Mar 23	• Finalise 23/24 metrics & performance report	SM	Final approval planned for 31/03/23 SEB	Green
	Apr 23	• Agree priority information projects for 23/24, including dashboard & SNOMED implementation	SM	List agreed at 03/03/23 SEB, now at I, M & T delivery group for milestones & resource agreement	

Risk No: 72	Date included	29 November 2021	Date revised	01/03/2023
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 Partnerships		Local: Head of Strategy	
Governance:	Transformation Committee / FPC / Board – Monthly Review			

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

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

Controls	Description:	• 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 Reaching out delivery plan as part of the Step Up to Great (SUTG) strategy and plan	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	Mar 23	Social value framework co-produced	David Williams	Ongoing	Amber
	Mar 23	Further agreement on our approach and calculating impact and value	David Williams	Internal assessment underway	Amber
	Mar 23	Development of inequalities data in an accessible format	David Williams/ Information Team	Some data complete, exploring with performance how this can be available to all. Local Public health team will provide the analysis.	Amber

Risk No: 73	Date included	29 November 2021	Date revised	01/03/2023
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 / PCC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	3	3	9
Residual Risk	3	2	6

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. • Zero tolerance campaign launched • Equality Objectives within staff appraisals • Cultural Competency Programme		
	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 • WRES and WDES data reports to QAC (August 22)	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:			

	Date:	Actions:	Owner:	Progress:	Status
Actions	Mar 23	Feedback and impact review of the cultural competency programme for 22/23	Haseeb A		Amber
	April 23	Review outputs of staff survey	HA and KB		Amber

Risk No: 74	Date included	29 November 2021	Date revised	01/03/2023			
Objective: E	Equality, Leadership, Culture						
Risk Title:	The impact of additional pressures on service delivery may compromise the health and wellbeing of our staff, leading to increased sickness levels.						
Risk owner:	Exec: Director of HR & OD		Local: Deputy Director of HR and OD				
Governance:	SWC / PCC / Board - Monthly Review						

	Consequence	Likelihood	Combined
Current Risk	3	3	9
Residual Risk	3	2	6

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

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 • Rolling programme of health and wellbeing roadshows		
	Gaps:	- Impact of financial pressures on health and wellbeing		
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 • Staff side – feedback • Action plan reporting through SG AND ICC • People plan • HWB Guardian update to Board	Assurance Rating Green
	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: Mar 23 Ongoing March 23	Actions: • Task and finish group review financial HWB for staff • Operational directorate focus on sickness levels over winter period • SWG deep dive on sickness absence / consider the impact of strike action / Staff Survey results	Action Owner: DN, KB and AH SL, HT and TH CT	Progress: Progressing with continuous review Ongoing	Status Green Green

Risk No: 75	Date included	29 November 2021	Date revised	01/03/23
Objective: A	Access to Services			
Risk Title:	Increasing numbers of patients on waiting lists and increasing lengths of delay in accessing services will mean that patients may not be able to access the right care at the right time and may lead to poor experience and harm.			
Risk owner:	Exec: Medical Director		Local: Operational Executive Directors	
Governance:	Access Delivery Group / FPC / Board - Monthly Review			

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

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

Controls	Description:	• Access Policy • Waiting list management approaches and Standardised Operational Processes applied to waiting lists in all services including waiting list validation, patient tracking lists, demand capacity modelling . • Trajectories in place to plot performance of waiting times improvement in prioritised services. • Service pathway re-design including measures as part of the Step up to Great MH transformation programme • System planning (design groups) established to manage patient flow and investment • 22/23 access priorities agreed and plans in place • Approaches in services to reduce risk of harm while waiting by supporting service users with appropriate information
	Gaps:	• Capacity and resources • Recurrent funding for non recurrent solutions • 23/24 access priorities to be agreed

Assurances	Internal:	Source: • Executive Management Board – Performance reviews • Directorate level deep dives. • Waiting time performance reported to Finance and Performance Committee • Checks of safety of patients waiting • Directorate risks including access where appropriate	Evidence: • Performance dashboards and reporting to DMTs, EMB and Trust Board • Trajectory for improvement and measurement against trajectory • Transformation plans	Assurance Rating Amber
	External:	Source: • Internal Audit – Remote Consultations 2022/23 • Internal Audit – Patient Experience 2022/23 significant assurance • CQC inspection • System performance monitoring • National benchmarking data • Quality / Contract Monitoring with ICB • LDA	Evidence: NHSE QRSM LDA regional oversight board delivery plan / metrics	Assurance Rating Amber
	Gaps:	• Access Delivery Group to be established (replaces Improving Access Committee)		

	Date:	Actions:	Owner:	Progress:	Status
Actions	Ongoing	Delivery of priority service plans (22/23) for reducing waiting lists FYPCLD – Comm Paeds / Audiology/ CAMHS Eating Disorders/CAMHS Access/SALT. Plans in place DMH – CMHT/ ADHD/memory assessment / TSPPD / CBT/DPS. Plans in place CHS – CINNS, Continence. Plans in place	Operational Directors	In progress – ongoing. Trajectories being determined and discussed at a newly convened Access Delivery Group and oversight at EMB	Amber
	Mar 23	Signed off plans for priority areas by end March 2023 DMH/CHS/FYPC			Amber

Risk No: 79	Date included	29.03.22	Date revised	13/03/23
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/ Board Monthly Review			

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

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

Controls

Description:

- Multiple tiers of controls including ongoing assessment and scanning of boundaries, geo-blocking and supporting information security policies
- Governance controls – reporting to Data Privacy and IM&T Committee on Cyber and Information Security / SIRO Structure / mandatory training / bespoke training
- Audits on Information Security Management System (ISMS), ISO, DSPT – with significant assurance
- Continuity Planning and Disaster Recovery – exercises and reviews. Business Continuity Plans for all services incl loss of IT systems in accordance with the EPRR Policy
- 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
- Regular One Minute Brief messages and communications reminding staff how to recognise a potential Phishing email or request for credentials
- Increased collaborative working with other NHS organisations to share intelligence and learning
- 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
- Home working risk assessment includes confidentiality clauses and accessing clinical systems, which requires signature of staff member
- Phishing simulation exercise August 2022 enabled assessment of Trust's vulnerability – further planned

Gaps:

- Authentication of identity at service desk contact – implementation of multifactor authentication at all levels of the organisation
- Increase in NHS cyber threats seen in 2022
- Some staff clicked through links from August phishing exercise
- Staff continue to click through, as demonstrated in recent attack - c10% of staff who received the e-mail (similar % to August)
- Audit and assurance regarding the testing of Business Continuity Plans - feeding into the 2023/24 planning process for internal audit plan

Assurances

	Source:	Evidence:	
Internal:	Cyber security working group 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 Business Continuity plans Mandatory training compliance reports	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 External scrutiny at multiple levels – Police Cyber resilience, National Cyber Security Centre (NCSC), BitSight assessment, NHS Secure Boundary scanning and reporting	Accreditation report Audit report Audit Report – substantial assurance NHS Digital submission	Assurance Rating Green
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress:	Status:
Mar 23	Joint exercise with HIS to test plans in the event of a cyber security breach	EPRR Lead / HIS	Approach agreed at DQC	Green
Jun 23	Multi Factor authentication will be mandated by NHS Digital for NHS mail accounts	HIS	Working group set up	Green
Mar 24	IT Business continuity plan for prolonged downtime part of 23/24 internal audit plan	SM	Audit plan to be agreed at March Audit & risk committee	Green

Risk No: 81	Date included	29 April 2022	Date revised	13/03/23
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:	EMB / FPC / Board monthly			

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

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
- Revised forecast & recovery plan drafted in response to financial risks materialising in year
- 2023/24 planning guidance states that capital allocations will be based on delivery of either break even or NHSE agreed deficit positions

Gaps:

- Culture change required across system partners
- LLR ICB medium term capital strategy not yet in place
- LLR ICB medium term revenue strategy not yet in place
- LPT 22/23 April plan delivered a £1.4m deficit- revised breakeven, best endeavours plan submitted
- ICS Risk/gain share could adversely impact on LPT's financial position
- Operational pressures in DMH inpatient areas have led to overspends which cannot be fully mitigated by the Trust – Trust's likely case forecast has been revised to c£2.9m deficit
- Operating costs of the Beacon Unit significant exceed the cost per case income secured.
- ICB unmitigated pressure c£20m at month 9 (including LPT's likely forecast deficit)
- ICB risk share final date to be agreed to give organisations certainty around year end targets
- 2023/24 planning risks emerging around workforce bureau, health & wellbeing hub & winter capacity funding from the ICB which could impact on Q1 if LPT is not able to quickly enact mitigations
- Draft 2023/24 financial plan had £20m deficit for LPT & £158m for LLR ICB

ICB highest scored operational finance risks:

- Elective care backlog (score 20)
- Urgent care pressure (score 16)

- Financial risk has reduced to 9, following agreement of 2022/23 deficit value with NHSE

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
- Delivery against recovery plan actions will be reported monthly via finance report
- LLR ICB Finance committee oversight

Evidence:

- Reports & updates from Internal & external auditors
- Monthly Director of Finance report to FPC / Trust Board – highlight report assurance rating
- Ongoing oversight and management of all aspects of financial position against plans
- Monthly reports to OEB/SEB/FPC/Board/ICB finance committee on all aspects of delivery against plan
- Mitigation plans for capital and revenue to ensure plans are delivered
- MHOST safer staffing review completed for Beacon ~~(to Trust Board in Jan 23~~

Assurance Rating Green

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
- HFMA checklist audit Q3 22/23

Evidence:

- 2021/22 annual accounts unqualified opinion
- Significant assurance
- Significant assurance
- significant assurance
- 360 Assurance review complete, report issued & presented to Dec Audit Committee

Assurance Rating Green

Gaps: If the Trust moves to a deficit, it will break the in year duty to break even, but the statutory duty is to deliver break even "taking one financial year with another". The Trust will have a 2 year period to return to surplus to ensure that the statutory duty can still be achieved.

Actions

Date:	Actions:	Owner:	Progress:	Status
Mar 23	Contribute to LLR ICB capital & financial strategy development	SM	Ongoing	Green
Mar 23	Revise LPT medium term capital & financial strategy to ensure alignment with ICS strategy	SM	Will be drafted alongside 23/24 plan	Green
Mar 23	Continued monitoring and management of the Trust's delivery of the 2022/23 financial plan, incl recovery actions	SM	Ongoing – Board approved a change in Forecast outturn on 13/12/22	Green
Mar 23	Review contractual arrangements for the Beacon Unit	HT		Green
Mar 23	Continue to mitigate draft 2023/24 financial plan risks & reduce deficit	SM		
Mar 23	Submit final 2023/24 Financial plan	SM	Board sign off planned 28/03/23	

Risk No: 83	Date included	August 2022	Date revised	01/03/2023
Objective: S	High Standards			
Risk Title:	Restricted access and use of electronic patient record systems will result in incomplete electronic patient records including the recording of physical observations. This will impact on the delivery of effective and safe patient care			
Risk owner:	Exec Lead: Director of Strategy and Business Development			
Governance:	EMB / FPC / 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 ..

- Ward staff can contact LHIS (including OOH) to gain temporary, emergency access for staff, to use both SystmOne and Brigid
- Online training available – links are on the Kn (knowledge) base button, on SystmOne home screen. This is available to all SystmOne users.
- Business Continuity Plans implemented in event of handset failure (paper charts)
- Desktop and laptops available to record observations in some wards

Gaps:

- WiFi access inconsistent across LPT sites
- RA sponsor required to manage the access request. Currently, there are gaps in some services, of adequate numbers of RA sponsors.
- Mobile phone displays difficult to read and use causing incorrect options to be chosen e.g. observations.
- Staff may not be aware of training resources / support materials / Not all areas have SystmOne superusers/ champions
- Agency staff can only access the system by logging into an active SystmOne account
- Scanning not completed in a timely way due to mitigation of internet access being revert to paper records.
- Unconfirmed potential for improvements to be made by updating the handheld devices/phones, from Motorola to Samsung
- In consistent trust wide method of recording bedside observations for patients when Brigid/WIFI not working
- Ward staff access to the physical handsets and/or log in for temporary staff
- Impact of reduced access to systems results in reduced access to nurse in charge alerts
- Handset devices are not of adequate standard / Not enough access to desktops or laptops on wards for when devices are not working.
- Bank/agency staff can login on Brigid using other staff member log in details (safety and legal implications)

Assurances

Internal:	Source: Incidents relating to access to IT systems Serious incidents reporting difficulties in access to IT systems	Evidence: Patient Safety Patient Safety	Assurance Rating Amber
External:	Source: CQC inspections/MHA visits	Evidence: CQC inspection report 2022	Assurance Rating Amber
Gaps:			

Actions

Date:	Actions:	Action Owner	Progress:	Status
Mar 23	• Quantify gaps in RA sponsors across the Directorates and recruit RA sponsors	T. Singh/CSOs by Directorates	• Progress revised to March 2023 for further review next month	Amber
Mar 23	• Identifying champions and super users in clinical areas and do they understand their role	Csos by Directorates		
Mar 23	• Process for agency staff to identify and access RA sponsors to be clarified and published	Ops Directors		
Mar 23	• Reminders for staff re training resources	Ops Directors		
Mar 23	• Identifying training requirements and support materials / accessibility / format	J. Hames and CSOs		
Mar 23	• Supporting agency staff to access training and support materials prior to shift	CSS		
Mar 23	• Agency staff contract management to ensure staff have a smartcard prior to booking a shift	CSS		
Mar 23	• Staff behaviours programme	CSOS/Team Leaders / charge nurses		
Mar 23	• Process for reviewing SOP for authorisation	CSS		
Mar 23	• LPT IG/DPO to consider review of SystmOne access versus data privacy	Tirath Singh		
Mar 23	• Ensure that resolution of access issues mitigates scanning risk			
Mar 23	• Training information being sent out to staff via CSS.			
Mar 23	• HIS scoping handset options for Brigid			

Risk No: 84	Date included	August 2022	Date revised	09/03/2023
Objective: S	High Standards			
Risk Title:	A high vacancy rate for registered nurses, AHPs, HCSWs and medical staff, is leading to high temporary staff usage, which may impact on the quality of patient outcomes, safety, quality and experience.			
Risk owner:	Exec: Director of Nursing, AHPs and Quality		Local: Assistant Director of Nursing & Quality	
Governance:	Quality Forum and SWC / QSC / Board - Monthly Review			

	Consequence	Likelihood	Combined
Current Risk	4	4	16
Residual Risk	4	2	8
Tolerance Level Significant 16-20 (Appetite People-Seek)			

Controls

Description:	• Safe staffing policy / induction policy for substantive and temporary staffing including agency staff • Revised dynamic risk assessment process for additional staffing requests • Safer Staffing Board Assurance Framework November 2021 • Weekly safer staffing and safety huddle • Staff forecasting and quality impact assessments • Decision tool and escalation framework for resolution of staff shortages • Staffing escalation plans for business continuity and surge plans • Winter plan • Direct support programme with NHSE for reducing HCA vacancies • Nursing and midwifery self assessment tool – NHSE / workforce leads • Enhanced training programme for Bank staff • International nursing and AHP recruitment programme and comprehensive induction in place • LLR AHP faculty – short term funding to support recruitment and retention – recruitment video for AHPS and support worker career and appraisal tool
Gaps:	• National and local workforce shortages – particularly in LD, mental health, medical mental health workforce, AHPs (OT and Physiotherapy) and community nursing • Increased pressure on staffing capacity winter/covid • Additional support and supervision in practice during transition period for internally recruited staff • Impact of work resulting from the QI collaboratives focusing on pressure ulcers, mental health observations and the deteriorating patient

Assurances

Internal:	Bank clinical supervision report to the professional standards group with themes and trends for monitoring bank staff induction, support and skills Daily safe staffing huddle, Winter Preparedness 2021 Nursing Safer Staffing BAF November 2021, National safe staffing return Monthly Safe staffing report including monitoring harm / nurse sensitive indicators Reporting to Trust Board and level 1 assurance committee	• Self-assessment complete 4 key themes to enhance assurance, action plan developed • Weekly situational and forecast staffing meeting • Workforce and Agency Reduction Plan to New PCC	Assurance Rating Green
External:	• Internal Audit – Agency Staffing due Q4 2022/23 • National reporting – fill rates and care hours per patient day - NHSE		Assurance Amber
Gaps:			

Actions

Date:	Actions:	Owner:	Progress:	Status
August 23	Embedding of Schwartz Rounds	D Rennie	On track with launch for August 2023.	Green
Sept 23	Development of QI collaborative improvement plans	JM, EW, MCS	All three QI collaborative groups have been established. Programmes are embedded within SUTG 2023/24 strategic plan.	Amber
Sept 23	Delivery of the recruitment and agency plan link to (risk 85). Specific Medical workforce Plan	Sarah Willis	On target for 0 Healthcare Support worker vacancies for July 2023.	Amber
August 23	Delivery of actions from the Nursing and midwifery self assessment tool	E. Wallis	Recruited a HCSW clinical lead to support the trajectory. SWC update in March 2023	FFGPC Amber
May 2023	Implementation of the Foundations for Great Nursing Care Programme and Daisy award celebrating excellence in nursing care	E. Wallis	FFGPC group established, engagement events booked for May and June 23 DAISY Project group established and signed agreement with launch date 11 May 2023	Daisy Green Amber

Risk No: 85	Date included	August 2022	Date revised	01/03/23
Objective: S	Well Governed			
Risk Title:	High agency usage is resulting in high spend, which may impact on the delivery of our financial targets for 2022/23			
Risk owner:	Exec: Director of Finance / Director HR		Local: Deputy Director of Finance	
Governance:	EMB/FPC/Board - Monthly Review			

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

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

Controls

Description:

- DRA process ensures all agency shifts appropriately approved against establishment
- Agency spend separately coded on ledger
- Budget reports show agency spend by cost centre & reviewed by budget holders & management accountants
- Pre-approval process for all non clinical agency staff prior to NHSE approval being sought
- HCL master vend approach ensures agreed rates paid for staff
- Reducing reliance on agency project clearly defined with specific financial target for spend reduction & specific actions
- Agency estimated WTE included on cost centre reports to highlight total level of staffing being used compared to budget
- Establishment control approach put in place to reconcile finance and HR information through ESR and arrive at an accurate staffing picture
- Recruitment plans in place to address administration HCA/HCSW vacancies to zero, and reduce vacancies in other high agency usage workforces
- Budget holder training & 'back to basics' finance engagement programme.

Gaps:

- Off framework agency does not conform to NHSE price caps
- Gaps in establishment in ESR & General ledger reconciliation; staff could be working to different views of the funded establishment
- Operational pressures could lead to higher than planned agency use
- Agency reduction required to deliver 22/23 plan is a material decrease on current usage
- Budget holder training could be out of date/new budget holders may not have received training during Covid
- Agency spend is not decreasing fast enough to deliver LPT 22/23 plan value £23m & is contributing to the Trust's forecast deficit

Assurances

	Source	Evidence	
Internal:	• Reducing reliance on agency project QI approach & reporting – fortnightly meeting addressing all aspects of agency reduction plan • Operational oversight & management of cost forecasts through Directorate Management Teams • Finance and Performance Committee report includes agency reporting • LLR ICB Finance committee oversight	• Progress reporting to EMB including deep dive in December 22 • Workforce and agency reduction plan received at the new PCC • Monthly reports to OEB/SEB/FPC/Board/ICB finance committee on all aspects of delivery against financial plan, including agency • Mitigation plans for revenue to demonstrate requirements for financial plan delivery, including agency targets	Assurance Rating Green
External:	• NHSE monitoring of system delivery against Agency ceiling • 360 Assurance audit for agency staffing planned for Q4 – ToR approved		Assurance Rating Amber
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress:	Status
March 23	Implement actions from Workforce and Agency Reduction Plan	Sarah Willis	All actions progressing	Green
Ongoing	Stop off framework agency use	Directorates	"	Green
Mar 23	Recruitment of additional bank capacity in recruitment	Sarah Willis	"	Green
Mar 23	Review RRP schemes available to substantive and bank staff	SW	"	Green
Ongoing	Implement new rolling programme of bank recruitment	SW	Review progress March 2023	Green

Risk No: 86	Date included	14/09/22	Date revised	01/03/23
Objective: S	High Standards			
Risk Title:	A lack of capacity within the workforce model and a high vacancy rate is reducing our ability to assess and follow up patients in community mental health services in a timely way, impacting on the safety of care and the mental wellbeing for our patients.			
Risk owner:	Exec Lead: Medical Director		Local: Clinical Director – Planned Care	
Governance:	EMB/QSC/ Board – Monthly Review			

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

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

Controls

Description:

- CMHT task and finish group
- A Planned Treatment and Recovery Team rapid response task and finish group
- Skill mix and career pathway task and finish group
- Workforce solutions in recruitment is supported by Trust policies and processes
- Crisis Team joint referral SOP
- Revised Duty System across all CMHTs
- CMHT workforce and risk assessment action plan
- Mental Health multi professional workforce plan
- pathway for overseas recruitment of consultant psychiatrists
- SUTG MH Transformation Programme
- Revised level 2 Waiting Times Delivery Group chaired by interim Medical Director

Gaps:

- Consultant Psychiatrist vacancies across the AMH planned care teams, the use of locums and the increasing difficulty in recruiting both substantive and locum staff
- Impact of transformation work to move the CMHTs to Planned Treatment and Recovery Teams
- Increased waiting times with repeated cancellations of clinics
- Temporary staff do not always have Approved Clinician status and managing patients on CTOs
- Workforce availability of staff with other skills/ knowledge – NMP's, ACP'S, AC's, Physician Associates, Pharmacists.

Assurances

Internal:	Source: • Operational risk 5087 Planned Treatment and Recovery Teams Staffing Risk • Review of measures including complaints, incidents and learning from deaths reported monthly through Quality and Safety DMT. • Cancelled clinics and waiting time data reported monthly through performance and finance DMT. • Quality summits – March 22 and September 22 • Caseload reviews progressing – not yet concluded • CMHT workforce and risk assessment action plan	Evidence: • SEB paper Addressing the Consultant Psychiatrist vacancies in DMH – current issues, plans and next steps 1 July 2022 • CMHT Risk Paper to DMT in August 2022. • Quality Summit briefing to SEB May 2022	Assurance Rating Amber
External	Source:	Evidence:	Assurance Rating Amber
Gaps:			

Actions

Date:	Actions:	Action Owner	Progress:	Status
Mar 23	Physician Associate recruitment plan	Saquib Muhammad	• Ongoing recruitment progressing – review in March	Amber
Mar 23	Delivery of an improvement plan to address risks and support transformation	John Edwards	• Ongoing delivery – review in March	Amber

Risk No: 87	Date included	18 November 2022	Date revised	01/03/2023
Objective: E	Environments			
Risk Title:	Following the establishment of a new FM service, there is a risk of unknown issues based on historical maintenance resulting in the Trust not meeting its quality standards or requirements.			
Risk owner:	Exec: Chief Finance Officer		Local: Associate Director Estates & Facilities	
Governance:	Estates Committee / FPC / Board - Monthly Review			

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

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

Controls	Description:	• 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 • New in-house senior team • Performance metrics with full data availability in development from 1 November 2022
	Gaps:	• Inherited and unquantified unknown issues • Staffing 60% vacancies in Cleaning Team.

Assurances	Internal:	Source: FM Oversight Group Estates and Medical Equipment Committee FPC Estates risk register	Evidence: • In house data (from 1 November 2022) • Ongoing review of audit actions • Monthly estates updates including health and safety reviews • FPC estates updates	Assurance Rating Amber
	External:	Source: • CQC inspection 2021	Evidence: • CQC report	Assurance Rating Amber
	Gaps:	• Missing historical data from previous FM provider		

	Date:	Actions:	Action Owner:	Progress:	Status
Actions	Ongoing	Process for regular oversight of performance metrics as data is collated from 1 November 2022	Paul Sheldon	EMIC – PS (review of first 3 months data)	Amber
	Ongoing	Appointments to senior team and onboarding of new staff from January	Paul Sheldon	Progressing	Amber
	Ongoing	Compliance and safety testing	Paul Sheldon	Ongoing – no finish date. Work started and becoming business as usual	Amber

Risk No: 88	Date included	29/11/22	Date revised	08/03/23
Objective: S	High Standards			
Risk Title:	Risk of closed cultures within services that may lead to poor patient, staff and family experience and organisational and reputational risk.			
Risk owner:	Exec Lead: Director of Nursing, AHPs and Quality	Local: Group Director of Patient Safety		
Governance:	EMB/QSC/ 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:

- Governance processes and systems (Board to Ward)
- Recruitment and HR processes
- NHS staff survey
- Complaints & PALS processes
- Patient safety investigations, human factors and learning lessons processes
- Freedom to speak up processes and culture
- Cultural change workstream
- Ongoing work to reduce restrictive practices such as seclusion and long-term segregation
- Audits, practice and application of the Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards. This includes application, where required, of Gillick competency and Fraser Guidelines.
- Practice and application of safeguarding processes
- Advocacy support to service users and families
- Community Education Treatment Reviews in Learning Disability Services
- External scrutiny and visits from commissioners, regulators and local authority safeguarding
- Service led self-assessment and quality assurance processes and accreditation programmes
- Service visits by Executive team, Non-Executive Directors, and Governors
- Quality summits and associated improvement programmes within directorates
- Focussed quality & safety reviews (example of Langley ward in March 2023)

Gaps:

- Recognition of closed cultures is not built into staff induction and training, including for bank & agency staff.
- Output of recommendations from Quality & Safety review

Assurances

Internal:	Source: • Trust governance (committees, sub-committees, directorate level) • Patient safety, patient experience & safeguarding groups • Self-assessment & accreditation processes	Evidence: • Minutes from governance meetings and committees	Assurance Rating Amber
External:	Source: • CQC/MHA visits • Commissioner/LA safeguarding visits	Evidence: • CQC reports • Commissioner feedback/Safeguarding reviews	Assurance Rating Amber
Gaps:			

Actions

Date:	Actions:	Action Owner	Progress:	Status
Mar 23 Mar 23	• Quality & Safety review paper presented at QAC in December 2022 • Delivery of recommendations from Quality & Safety review reported to QAC/EMB/FFHS	James Mullins	• Q&S review reported to SEB & QAC • Recommendations and governance paper reported to QAC in February 2023 and SEB in March 2023	Amber

Risk No: 89	Date included	28/02/23	Date revised	08/03/23
Objective: S	Environment			
Risk Title:	Following the transfer of soft FM service, there are potential gaps in the sustainability of compliance with national cleaning standards and waste regulation which may impact on healthcare acquired infections and patient outcomes.			
Risk owner:	Exec Lead: Chief Finance Officer		Local: Associate Director of Estates and Facilities	
Governance:	IPCC / QSC / 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:	• National standards of healthcare cleanliness • Contract management with NHSPS 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 6 monthly report to Trust Board • SOPs in place to describe key responsibilities • Audit programme – national standards cleaning audit, IPC audit including cleaning, environmental audits by FM team, pre-acceptance waste audit, internal waste audits • On outbreak wards staff aligned to task for whole shift • Rapid response team • IPC operational meeting • Environmental checklist in Matron quality and safety checks • Quality accreditations / 15 steps / boardwalks • PLACE - patient led assessment of the care environment
Gaps:	• Recruitment. On transfer of services into LPT approximately 20% vacancy rate unfilled by any other sources. • Clearly defined roles and responsibilities for clinical staff re cleaning • On transfer – national standards of healthcare standards had not been implemented (including cleaning and auditing) – current gap with plan to implement. • Availability of technical cleaning audit performance • Appropriately trained estates team in place – still recruiting to management functions

Assurances

Internal:	Source: • Estates Committee (Soft FM report to EMEC (FPC) and IPC (QAC) • IPC Bi-Annual report to Trust Board • PLACE reporting – EMEC • Waste management meetings • DMTs • Internal audit programme	• IPC BAF • Cleaning report • Waste report • IA reporting • IPC walk arounds • Incident reporting	Assurance Rating Amber
External:	Source: • CQC inspections including MHA visits • PLACE – patient and carer led assessments	Evidence: Good PLACE scores – awaiting benchmark data CQC feedback has not escalated cleaning as an issue	Assurance Rating Green
Gaps:			

Actions

Date:	Actions:	Action Owner:	Progress	Status:
31 Mar 23	Implementation of national standards of healthcare cleanliness including training of both facilities and clinical staff	Helen Walton/HoN/IPC	Agreed with IPC team. Roll out programme to be determined.	Amber
Sept 23	Substantive recruitment (currently utilising agency or framework agreements)	Helen Walton	6 month programme – update due Sept 23	Amber
Sept 23	Reinstatement of PLACE	Helen Walton	Ongoing	Amber
Mar 23	Implement IPC and Estates environment audit programme	Amanda Hemsley / Helen Walton	Ongoing	Amber
April 23	Implement cleaning and efficacy audit programme	Helen Walton	Ongoing	Amber

Risk Scoring and Appetite

Leicestershire Partnership NHS Trust

Risk Scoring Matrix

The following matrix is used to grade risk
The scores obtained from individual consequence and likelihood risk scoring are assigned grades as follows;
1 Very Low (green)
2 Low (yellow)
3 Moderate (Amber)
4 High (red)
5 Significant (red)

The following matrix is used to grade **combined** risk scores. Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Consequence	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Risk Appetite and Tolerance Level

Risk type	Appetite level	Appetite Descriptor	Tolerance	Tolerance Descriptor
Financial	Cautious	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	Moderate 9-11	Preference for sage delivery options hath have a low degree of residual risk and only a limited reward potential.
Regulatory	Cautious	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	Moderate 9-11	Preference for sage delivery options hath have a low degree of residual risk and only a limited reward potential.
Quality	Seek	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	Significant 16-20	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).
Reputational	Cautious	We are prepared to accept the possibility of limited financial risk. However, VFM is our primary concern.	Moderate 9-11	Preference for sage delivery options hath have a low degree of residual risk and only a limited reward potential.
People	Seek	We will pursue innovation wherever appropriate. We are willing to take decisions on quality where there may be higher inherent risks but the potential for significant longer-term gains.	Significant 16-20	Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk).

Based on the risk appetite matrix produced by the Good Governance Institute

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Leicestershire Partnership NHS Trust

Quality & Safety – 28th February 2023 09.00-11.30 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 and Quality – verbal escalations	NA	LPT continues to support winter pressures in the system with increased capacity and flexibility in Community Health Services. Service visits by the Chief Nurse and Chief Medical Officer have gone well. Final figures for staff flu vaccination and Covid boosters are above the regional average. The Infection Prevention and Control team are analysing the increase in Clostridium Difficile cases for antimicrobial use and environmental factors. There have been Quality Summits on Watermead, with a robust action plan; also the Community Mental Health Team (CMHT) related to identified staffing risk; and a follow-up summit for the Beacon Unit which shows positive improvement in staffing and risk reduction. Progress on Watermead and CMHT will be reported back to Q&S Committee as per workplan.	86, 89
Joint Director of Patient Safety Update – Paper C	MEDIUM	Received an update on actions taken as a result of the Quality and Safety review, discussed at the December meeting. Clear governance of actions shown and good progress so far. Positive feedback on review methodology from NHS England. Agreed that the work on closed cultures needs to tie in with wider culture development work and there needs to be link to Quality Dashboard and new format Performance Report. Q&S will receive 6 monthly updates on the actions.	73, 88

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
Quality Forum Highlight Report 12th January 2023 - Paper D	MEDIUM	Improvement trend on Serious Incident Completions, with each directorate own recovery plan. There has been slow progress so advocating change in process using quality improvement methodology. Work underway to establish an End of Life Care group with a patient and carer voice. Cleaning standards risk escalated to the Organisational Risk Register. The committee took high assurance on oversight demonstrated by the Quality Forum but elements discussed need to show more progress.	59, 89
Safeguarding Committee Highlight Report 25th January 2023 – Paper E	MEDIUM	Issues of capacity in the Safeguarding Team were noted. All vacancies have been recruited to and staff will be in place by mid-April. Additional supervision sessions for safeguarding children have been provided for the Families Young People and Children (FYPC) Directorate and a new Supervision Safeguarding Strategy is being developed for staff across the trust.	61, 84
Safeguarding Quarter 3 Report – Paper F	MEDIUM	Following changes to Teen Health 11+ Services by Leicestershire and Rutland local authorities, LPT are providing 2 Health Practitioners to support children referred. There will be an evaluation of these changes at the end of year one in August. Compliance with new safeguarding training is expected to exceed 90% target by December. There is still no national guidance on introduction of Liberty Protection Standards. Quality Improvement Plan is on track but would benefit from further data to demonstrate progress.	61, 84
Trust Ligature Reduction Group Update – Paper G	HIGH	There have been only 3 incidents of fixed ligatures in last 3 months, while non-fixed ligatures remain a high reporting issue. There are more changes to the Ulysses system to assist with coding and review of incidents involving non-fixed ligatures. The groups will merge from March and continue to meet monthly.	59

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
CQC Action Plan Assurance Report – Paper H	HIGH	Assurance received on compliance with actions. 3 MHA Inspections reports have been received, actions being addressed and robust method of shared learning. Thematic analysis of themes has been done and the committee asked for report on themes to come in next report or via highlight report. Work ongoing to involve service users and carers in Accreditation visits. November system Special Educational Needs (SEND) inspection showed positive changes but some system improvements still necessary which LPT is supporting.	
Medical Director – verbal escalations	NA	Ongoing challenge of recruitment and retention of medical staff. 4 new consultants recruited on Bradgate Unit, 2 of which were LPT registrars. Junior Doctor industrial action going ahead with approximately 105 intending to be on strike for 3 days. Plans have been made to provide safe clinical cover, focussing on in-patient areas and some routine work will have to be cancelled.	
Mental Health Act Governance Delivery Group Highlight Report – Paper I	MEDIUM	Fully compliant with statutory requirements of Mental Health Act (MHA). Code of Practice compliance shows some improvements in reading of rights and consent to treatment on admission, but not consistent across all areas. Recording of Section 17 remains a challenge due to technical issues. Recording of MHA training by doctors is being addressed and compliance is over 90%.	61
Performance Report (Month 10) – Quality and Workforce Measures – Paper J	MEDIUM	Slight increase in Grade 4 Pressure Ulcers being investigated. Stage 2 incidence levels have remained constant so a benchmarking exercise is underway along with collaborative quality improvement work with NHFT. Apart from flu vaccinations all other CQUINS are expected to meet targets, including annual Learning Disability health checks. Some workforce data will be reported to the People and Culture Committee in future for a deep dive into	84

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
		sickness and absence and health and wellbeing.	
Six Month Safe and Effective Staffing Review – Paper K	MEDIUM	Vacancies for registered nurses still above national average. Slight decrease in number of planned shifts filled by temporary staff but still at a high level. No correlation between patient complaints and nurse sensitive indicators. A triangulated establishment review has been completed which will inform the workforce plan.	84
Annual Workforce and Service User Equality Reports – Papers L, Li	HIGH	These papers inform the public duty to publish but also identify learning and action plans where gaps exist. Some variances in workforce data but none significant. Workforce report will go to People and Culture Committee in future. Health Inequalities is a priority in the Quality Account and service user data collection will need to reflect this. Some over-representation of black people in restraint and seclusion data was noted and is being reviewed.	
Step Up To Great Mental Health delivery plan – Papers M, Mi	MEDIUM	This was received as a follow up action (690) as to how plan is being monitored. All actions identified are on track including those requiring further support. Robust project management methodology demonstrated. The committee requested more outcome measures of the actions when it receives the next iteration.	86
Organisational Risk Register – Paper N	MEDIUM	Noted those risks now moving to the People and Culture Committee and new risk 89 related to cleaning standards. Reiterated need for clear quality and safety lens on any risks arising from deep dives, quality summits and use these to inform the risk register going forward.	
Quality and Safety Committee revised Terms of Reference – Paper O	NA	These were approved with minor changes to group titles before submission to the Trust Board	

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
Health & Safety Committee Highlight Report 12th January 2023 – Paper P	HIGH	Issue of Occupational Health provider non-attendance at meetings noted and will be taken up in contract discussions.	
Policy Report – Paper Q	LOW	The report received was not in the correct format and requires further clarity on governance of policies, including reporting to level 2 groups. Resource requirement to upload policies on system also needs to be addressed. Return with complete paper at next meeting.	
Research and Development Reports (Q2 & Q3) – Papers – R, Ri	HIGH	Recruitment challenge referred to People and Culture Committee. All other aspects highly positive. Frequency of reporting to this committee will be reviewed as part of next year's workplan.	
Paper/Updates not received in line with the workplan	NA	• Revised workplan to be agreed at April meeting. • Revised Corporate Governance Flow Chart to be received at April meeting.	

Chair of Committee:	Moira Ingham, Non-Executive Director 16.03.23

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Leicestershire Partnership NHS Trust

Trust Board – 28th March 2023

Care Quality Commission Update

Purpose of the report

This report provides assurance on our compliance with the CQC fundamental standards and an overview of current inspection activities. The Trust continues to prioritise quality improvement, patient care and compliance with the Care Quality Commission (CQC) fundamental standards in all care delivery.

Analysis of the issue

CQC Inspection Activity

The CQC will continue to prioritise inspections based on services where there is evidence of risk or harm to patients.

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. Sustaining the May/June/July 2021 and February 2022 improvement action plans.
2. Participation in CQC Mental Health Act inspections.
3. Participation in external quality service reviews and commissioner inspections

Scrutiny and Governance

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

- Ongoing monthly meetings with key nominated leads from the directorates and the Quality Compliance and Regulation team, to update evidence of embeddedness and sustained governance and oversight.

Action Plan Summary

1. All 'must do' and 'should do' actions from the May/June/July 2021 and February 2022 inspections 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 communications bulletins.

Mental Health Act Inspections

Since January 2023 there has been one Mental Health Act inspection carried out on:

- Gwendolen ward.

The trust has now received the report for the inspection and the ward has an individual action plan to address areas of concern.

Themes and commonalities from the recent reports have been shared at the Foundations for Great Patient Care meeting and Service Ward Sister / Charge Nurse meetings to focus the learning from the inspection findings.

External Visits

Since January 2023, colleagues from the Integrated Care Board (ICB) have visited:

- Thornton ward
- Agnes Unit
- Welford ward

The University of Leicester Medical School undertook a visit to review the undergraduate medical education provision as part of an annual quality monitoring cycle in January 2023. Feedback back confirmed that LPT will continue to provide and partner with the University to train future doctors.

NHS England visited the wards at the Evington Centre on the 7th March 2023 to review progress on the dormitory elimination programme.

On the 9th March 2023 a Quality Network for Eating Disorders visit was undertaken on Welford (ED) ward. This was an initial visit, whereby they assessed if the service meets the required standards, identifying any areas of improvement, which will be reviewed within 6 months, with the plan of being accredited. At this the trust awaits the final report.

Quality Visits

Since January 2023, there has been nine Quality Visits carried out by the Quality Compliance and Regulation team on:

- Thornton ward
- Aston ward
- Ward 1 St Lukes Hospital
- Ward 3 St Lukes Hospital
- Watermead ward
- Arran ward
- Skye ward
- Sycamore ward
- Cedar ward

Feedback was provided to the ward following the visit in the new style of a huddle and each ward is acting on the information provided.

Valuing High Standards Accreditation (VHSA) – Self Assessment

The newly designed self-assessment tool which forms part of the VHSA approach launched in January 2023 with Families, Young People and Childrens Services and Learning Disabilities Services, and Community Health Services now using the tool.

The Directorate for Mental Health and Enabling Services are to implement the tool over the forthcoming months.

Through self-assessment it is planned that staff will have a greater understanding of where their evidence and hard work sits within the trusts STEP up to GREAT ambitions and will be able to articulate their achievements internally, with partners or regulators.

It is planned that service users, patients and carers will partner with us, creating more opportunities for collaborative work and towards lived experience leadership of the programme.

Potential Risks

None

Decision required

For information.

Governance table

For Board and Board Committees:	Public Trust Board 28th March 2023	
Paper sponsored by:	Anne Scott, Executive Director of Nursing, AHP's and Quality	
Paper authored by:	Jane Gourley Head of Quality, Compliance and Regulation	
Date submitted:	14th March 2023	
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:		
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 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
	Trust wide Quality Improvement	Yes
Organisational Risk Register considerations:	List risk number and title of risk	N/A
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	

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Leicestershire Partnership NHS Trust

Trust Board – 28th March 2023

Patient and Carer Experience and Involvement (PCEI) Quarterly Report (including Complaints) Quarter 3, 2022/23

Purpose of the report

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

Analysis of the issue

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

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

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

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

Patient Experience including complaints, concerns, and compliments

In Q3, the Trust formally registered 37 complaints, which is a significant decrease compared to the same period last year and a further decrease from Q1. Whilst the numbers are going in the right direction, it is important to note that Q3 saw an increase in the number of complaints received which were referred to our Corporate Patient Safety Team for review. In all, 14 cases were sent to Patient Safety in Q3 for review, with 7 being agreed to be investigated as a Serious Incident or Internal Investigation.

As a result of the increased number of referrals to Patient Safety, the PALS and Complaints Team are now working more closely with the Patient Safety Team to ensure the most appropriate avenue of investigation is being pursued with the hope that we can identify any themes and trends as early as possible.

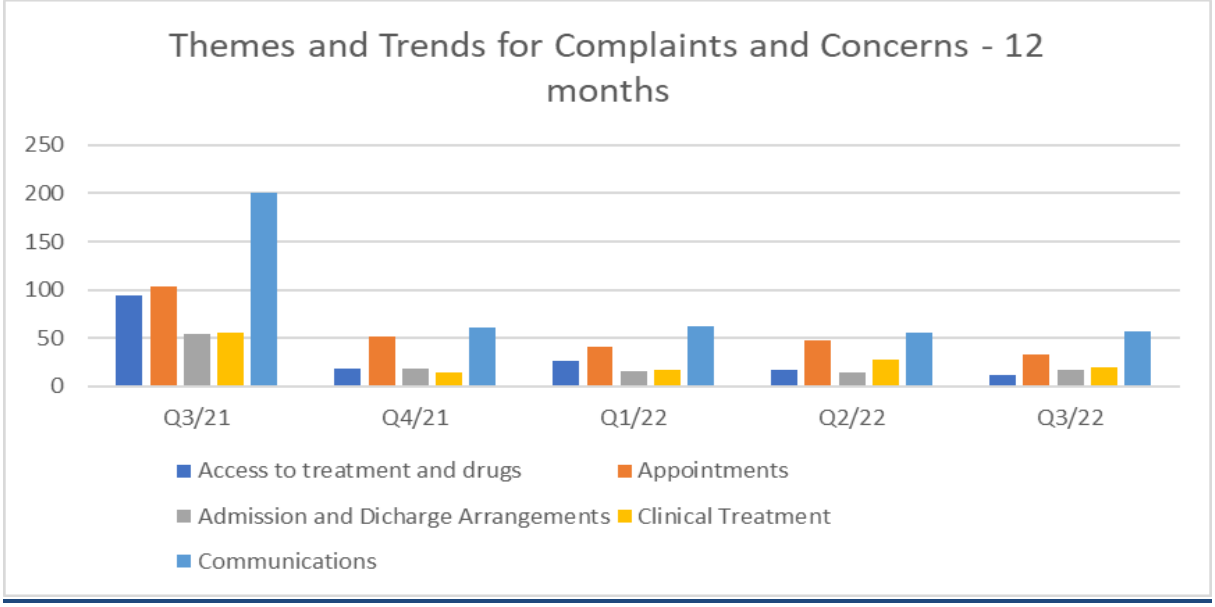
Complaints Performance in the Quarter

- 97% complaints were acknowledged within 3 working days
- 6 complaints breached their given timeframes in the quarter.
- 16 complaints were managed within timescales agreed with complainant.
- 1 complaint has been paused due to the patient's presentation and remains as such.

- 7 complaints were reopened in Q3. The reasons being new questions (2), unresolved issues (2) and not all issues addressed (3).

Complaint Themes

The Team continues to work with the directorates to ensure that complaints being received are logged appropriately on Ulysses and where necessary, a change in the logging categories and/or area is being made before a case is closed, ensuring that the data being reported to NHS England via the KO41a yearly return, provides an accurate picture of the complaints being received by the Trust.



Responding to Complaints

Community Health Service Directorate have seen a noticeable decrease in complaints, having only received six complaints during the quarter. Concerns have been raised within the Directorate, regarding the increase in concerns/complaints escalating through the Patient Safety Process, with 4 concerns escalated to serious incident investigations. The directorate are undertaking a deeper dive into understanding why this is happening and why patients/ families are not contacting the service directly to raise an incident, or the issue identified by the service in the first instance.

The Directorate have established their Patient and Carer Experience Group, which has membership from a range of disciplines from across the directorate, including operational and clinical leads. The group will focus on the themes and trends from complaints, concerns and compliments giving a greater oversight for the directorate on patient experience and identifying opportunities for learning and improvement.

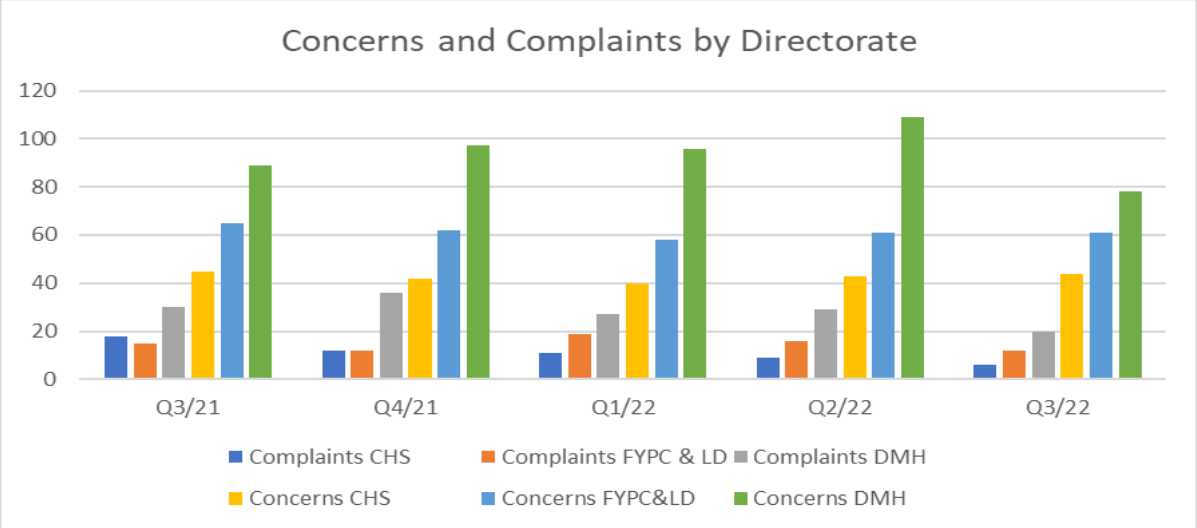
Families, Young People and Children and Learning Disabilities Directorate, in response to the recent increase in complaints in relation to Community Paediatrics, CAMHS Community Services and CYP SALT, the Governance Team have worked with service lines to ensure they are reviewing complaints/concerns, identifying any themes, and putting actions in place to respond/support. This has included:

- Review capacity and options to increase this to enable services to respond within timeframes – there are now have more staff trained and supported to respond to complaints/concerns for these services.
- Looked at themes of the complaints/concerns and identified trends relating to waiting times and communication. The Team have worked with service leads to develop communication about waiting times and service demands which went on the website and in referral for

assessment letters. They have also introduced other options for engaging with complainants such as resolution meetings – since introducing these, we have been a positive impact on complaints/concerns.

- Working with the Complaints Team and service lines to support staff dealing with complaints/concerns re quality of responses and managing engaging with complainants – this is an area of work in progress still as newer staff gain more experience.
- CAMHS Community Services, undertake monthly thematic reviews of all complaints/concerns to understand types of complaints/concerns, what action has already taken place and if service leads have assurance of these actions – this is an example of good practice in having oversight and grip for these services, and they are able to use this to feedback to families re service improvements.

Directorate of Mental Health have reported seeing a noticeable increase in resolution meetings being requested by complainants. The Directorate noted no specific themes and trends; however, the issues being raised are complex, with the involvement of acutely unwell patients/complainants. The Directorate has also completed a review of complaints and concerns from the past 2 years, in respect of the Community Mental Health teams four main themes, Communication, Patient Care, Appointment and Waiting Times and Prescribing. The review found that communication concerns were mainly in relation to Medical Outpatient Clinics, in response changes have been made to the duty system, which has reduced concerns regarding medics not calling back. There is a plan in place for the ADHD service. The Governance Team has undergone recruitment of new staff with new colleagues joining the directorate starting in January 2023.



Peer Review

The second Peer Review took place during the quarter with a focus on cases from FYPC/LD. 16 people attended, including a Peer Support Worker and 2 members of the involvement network as Experts by Experience (EBE), with a mixture of clinical and non-clinical staff from all areas of the Trust attending.

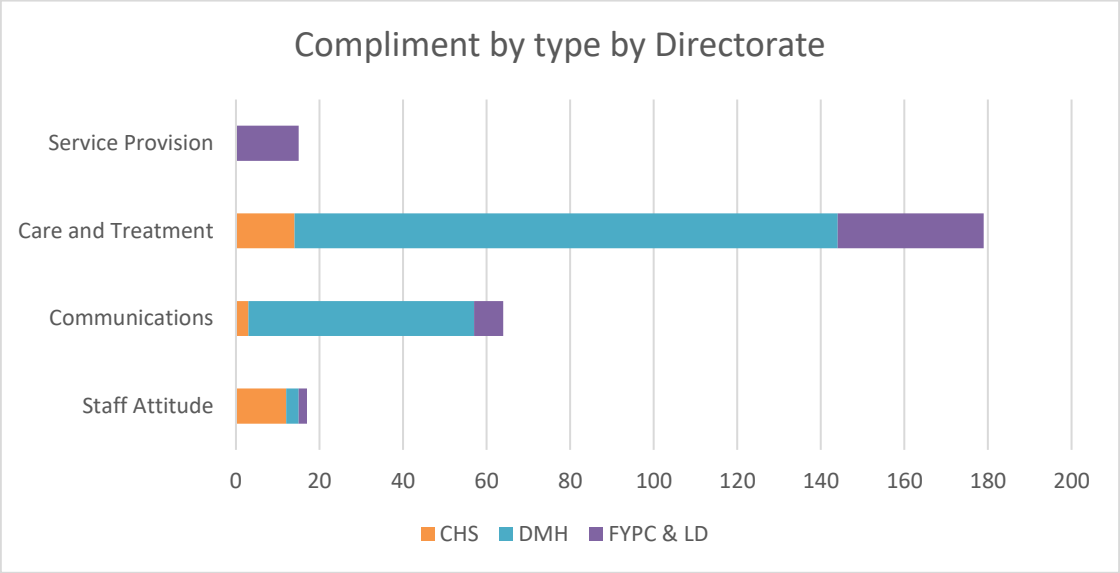
Following the Peer Review session, the team has worked directly with one of the EBE who attended to agree significant changes to the initial complaint acknowledgement letter, and it is hoped that by the end of Q4, this will be signed off and be the standard letter for all new complaints received. The next Peer Review session has been planned for 8 February 2023 and will focus on DMH complaints.

There was an increase in both CQC, and MP Enquiries and concerns raised by patients and families via these routes during the quarter with a total of 13 CQC Concerns/Enquiries and 14 MP Concerns/Enquiries.

Directorate	CQC Enquiries/Concerns	MP Enquiries/Concerns
Directorate of Mental Health	12	4
Community Health Services	1	
Families, Young People, Children and Learning Disabilities		7
Corporate Services		3

Compliments

283 compliments were received in the quarter, this equated to 48% of all feedback received (excluding FFT feedback). The key themes for positive experience via compliments were Happy with Care and Treatment, Good Communication and Attitude of staff.



Good news story
Complaints ULearn Module has progressed further, the final changes have been submitted to the development team for review, in addition to these several bespoke training sessions on complaints and concerns have now taken place with staff, as well as a weekly virtual drop-in session hosted by the PALS and Complaints Team to enable staff to gain advice and support.

Keys areas of concern
No current areas of concern

Assurance

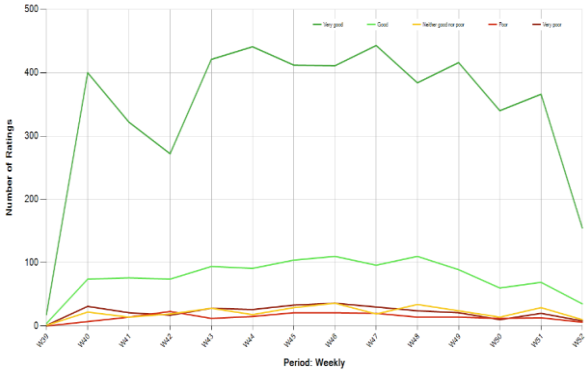
- The Complaints and PALS work reports into the Complaints Review group which then reports into the Quality Forum, Quality Assurance Committee and Trust board for assurance.

Friends and Family Test and Patient Surveys

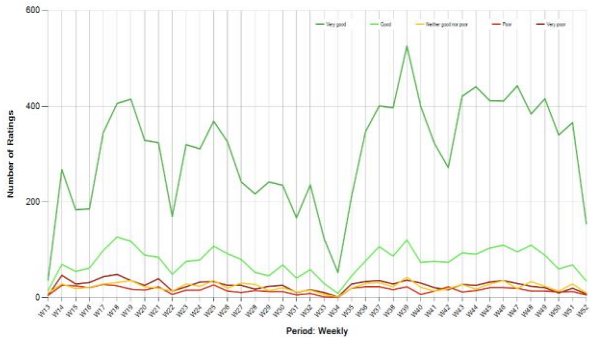
Overview

Since the beginning of the year there has been a steady increase in the number of responses received in relation to the Friends and Family Test (FFT). Results also demonstrate a steady increase in satisfaction in the overall care and treatment provided by the Trust.

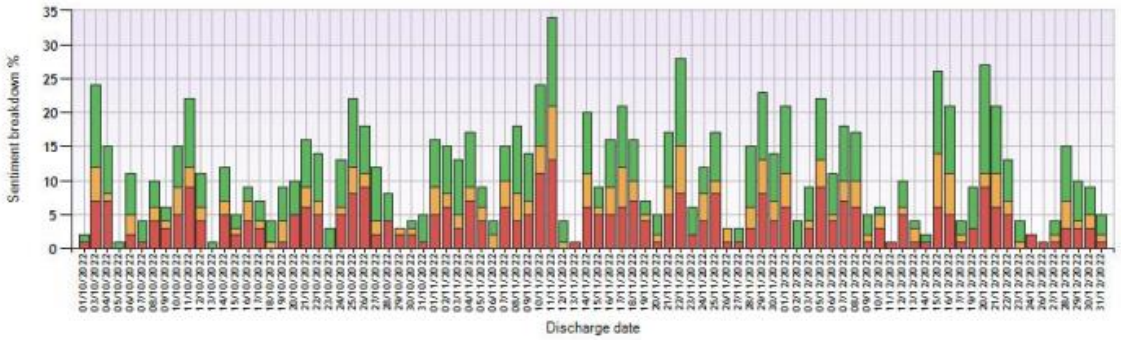
In Q3 the Trust received 6778 individual responses to the FFT question which equated to a response rate of 9% which is a 1% rise from responses in Quarter 2 and a 3% rise from the April 2022. Of these responses 87% (Q1 83%) reported a positive experience of care and a 7% (decrease of 2% from Q2) response rate recording negative or poor experience of care.



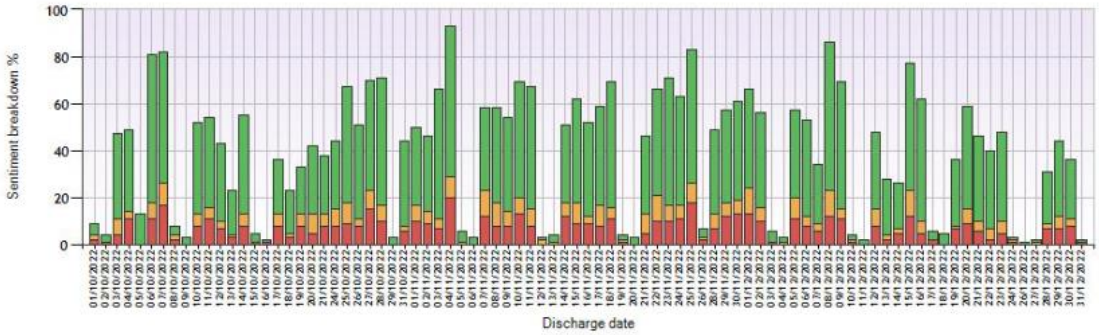
FFT Trend Analysis for the Q3



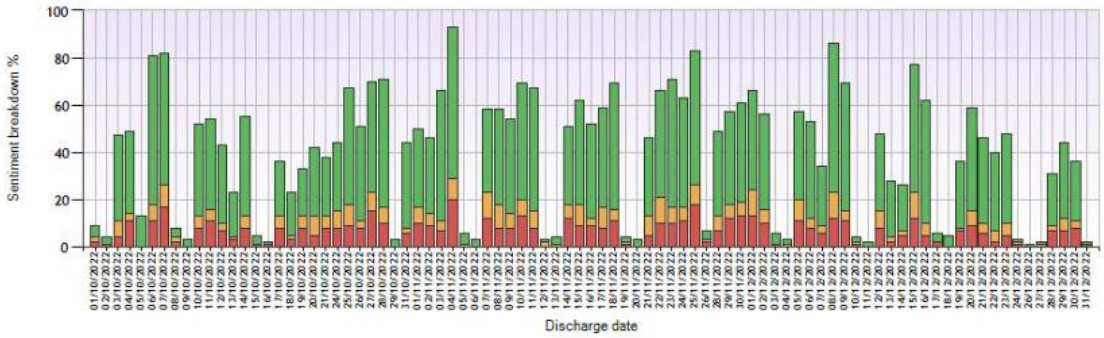
FFT Trend Analysis for the Year 2022/23 up to end of Q3



Sentiment Analysis for Directorate of Mental Health for Q3



Sentiment Analysis for Community Health Services for Q3



Sentiment Analysis for Families, Children and Young People and Learning Disabilities for Q3

FFT in action

The CAMHS Eating Disorder Team at Loughborough hospital have created feedback chalk boards on the walls to act as areas for young people and carers to add their views, advice, and feedback. Four big clouds with different prompts and themes have been painted into the wall along with a doodle board in the other corner where the games are kept making the display age inclusive. Despite this being a relatively new addition, the team have received many responses such as '**I think I am great just for coming here' 'you are not alone'** and '**be honest, they can't help if you don't let them'** plus some colourful doodles and animal's noises dotted around. The doodle board also offers a prompt of drawing what recovery means to you – drawings include rainbows, snails, and butterflies. Overall, it seems to have been a success so far and is a nice reminder when you come onto the unit.

The Bradgate Unit have undertaken several activities throughout the quarter, including creating business cards that will attached to staff lanyards to allow for easy and face access to collecting patient feedback.

Introduction of Meet & greet volunteers within the Unit reception. This has been incredibly beneficial and positive for visitors to the Unit. One of the volunteers received positive feedback and interactions. The Team is in the process of using out volunteers to gain feedback, as we are keen to improve the patient, carer and visitor experience

Key Areas of concern

There are no key areas of concern.

Good news story

Our FFT provider Healthcare Communications delivered their first Directorate Envoy training session in December. The recording is available for any DMH staff who were not able to attend. Healthcare Communications comms are currently confirming two further training dates FYPC/LD and CHS staff

Assurance

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

Feedback into Action

Providing a patient perspective – Recruitment Panels
Our pool of in house trained network members is growing along with requests for more patient representation at interview panels. During the quarter several service users and carers supported various recruitment across the Trust including Deputy Director of Mental Health, Deputy Director of Nursing, Peer support workers, Senior project manager for Integrated Neighbourhoods, Personality Disorder Service Lead, plus much more.

Feedback – Reader Panel Update

During the quarter the Reader Panel reviewed the following documents: Occupational Therapy evaluation survey, Lymphoedema leaflets, Inpatient food review poster, and inpatient food survey, Feedback & complaints poster/flyer, and the Chaperone poster.

Bradgate Mental Health Unit and Mental Health Services for Older People (MHSOP) teams have been working closely with the patient experience team, the reader panel, and our patient information lead to gain feedback on new and improved welcome packs. These include glossy images of staff and scenery across Leicestershire. It was essential that all documents also involved carers and the reader panel was of support providing a lived experience perspective. We were able to take on board feedback and have a fantastic, finished product.

Quality Improvement – Inpatient Food Review
One of the top priorities that came out of PLACE (Patient Led Assessments of the Care Environment) was inpatient food. Following the PLACE assessments, a further review has taken place of inpatient food along with one of our patient leaders working collaboratively with the project lead. Early improvements that have been identified include:

- Management food day planned to test out new food options with patient/carer PLACE assessors attending
- The monitoring of food waste is now in place
- A catering lead for the trust is being appointed
- A patient survey has been created to monitor the feedback of patients experience of food
- Creating a checklist for ward staff/managers so they can observe and audit meal serving standards

The People's Council

No meetings have taken place during the quarter. Work has been undertaken to review the role, structure, and function of the Council. This has been done with the Council Chair, Mark Farmer, Mark Powell, Anne Scott, and Alison Kirk. Revised roles and recruitment will be taking place in Q4 in readiness to commence the work of the Council in 2023/24.

LPT Youth Advisory Board (YAB)

YAB continue to meet virtually, each week on MS TEAMS. Activity during the quarter include:

Raising Health Christmas Campaign 2022 The YAB joined together with Raising Health to support the trust wide campaign this year, to provide all inpatients and this year due to their support CYP

accessing CAMHS outpatient services. The group members have been supporting the fundraising efforts in their own communities with bake sales and non-uniform days to support the campaign.

Joint Strategic Needs Assessment, Mental Health Priorities Leicestershire - The Public Health Registrar within Leicestershire attended YAB to discuss and share and gain ideas from young people (YP) around mental health plans and priorities, they engaged with the group to establish their views on current challenges, how services engage with CYP and ideas for prevention. The views of the YAB will feed into the plans moving forward.

Data Gathering information- LHIS Patient Registration forms LHIS Information & Technology project leads attended YAB following a session with the LPT Reader Panel, this session was to share and gain young people's views on the development of patient registration forms, that are under development for all patients to complete virtually (parents/carers for younger CYP) and be added onto health records. These forms include key demographic questions, to avoid patients completing these multiple times before access to services, and to ensure that records are up to date.

Gender Identity FAQ development - Following meeting with the Deputy Head of Nursing FYPC LD, in October the group spent a YAB session developing and providing feedback and ideas to support staff as part of the Gender Identity working group project. Young people provided great ideas to support this work and to ensure that they feel inclusive when accessing services. Ideas for staff to wear pronoun badges, protect young people's privacy and dignity were common themes throughout the session. A full presentation has been shared with the working group to move this forward. One member of the YAB who identifies as transgender has offered and expressed interest to be part of this work with staff moving forward.

Feedback- Complaints, Concerns and Compliments the Complaints and PALS (Patient Advice and Liaison Service) Manager attended a session and presented to the YAB the themes and type of feedback received through complaints and concerns directly from/related to YP. The figures for YP sharing their own feedback are extremely low, with parents and carers feeding back through pals and complaints services on behalf of young people. The group discussed why they felt this may be and provided ideas and suggestions to make feedback options more YP friendly, including the use of SMS, email and communications that appeals to young people. The feedback will be taken to the Complaints Review Group (CRG) for discussion in December

Young Peoples Access to Primary Care - Integrated Care Board Children and Young Peoples engagement lead Jacob Brown facilitated a
consultation session with the YAB to understand young people's (YPs) views around accessing primary care (GPs), preferred options, barriers and support at appointments. This session will feed into a wider system project along with the views of other YP from across Leicester, Leicestershire and Rutland, a summary of findings and next steps will be presented to the group in spring 2023.

MIND The YAB met with LLRs new Chief MIND Officer, the interactive session facilitated and explored what Mental Health Support the charity could look to offering and supporting young people across the community and local area as plans are being developed and moved forward. Further co-design with MIND to explore services for CYP in the future is currently being discussed.

Assurance

- Both the People's Council and Youth Advisory Board's work reports into the Patient and Carer Experience Group, Quality Forum, Quality Assurance Committee and Trust board for assurance.

Responding to 360 Assurance Audit Recommendations

A 360 Assurance Audit on Patient Experience was undertaken during the summer of 2022. Key findings from the audit were:

1. Although, the Patient and Carer Experience and Involvement (PCEI) Report is produced quarterly and includes information on how patient experience data has been captured and analysed into themes, there is **no action plan which details the actions required to address the issues raised/themes and/or to make quality improvements**.
2. From information within directorate teams, it was identified that whilst there is a lot of work completed within directorates around capturing patient experience and how this may have made service improvements, **this is not always fed back/escalated wider within the Trust**.
3. The Trust does use the 'You said, we did' method of sharing how patient experience has clearly made changes to service improvement. However, during the audit we were not **provided with any specific example of these**, nor were any included in the Newsletter nor in the quarterly Patient Experience and Involvement report.

To respond to the recommendations several actions have been agreed and implementation commenced during the quarter, these included:

- Re-establishment of Patient & Carer Experience & Groups within each directorate, including alignment with existing EDI Groups.
- Directorate Groups to have lived experience represented through a Patient or Carer Partner (from April 2024)
- Group membership to ensure senior leadership oversight/membership from clinical, operational, medical, and administrative staff members.
- Work with directorates will focus their work to either work on one of the key themes from patient experience e.g., theme from complaints or to focus on a current issue/risk which the directorate is working on e.g., waiting times, accessible information standard.
- Move Patient and Carer Experience Group (level 3) meetings to quarterly
- Oversight and assurance of patient experience and involvement via People's Council, moving to a quarterly meeting.

Community Health Services have held their first meeting with both the Directorate of Mental Health and Families, Young People and Children and Learning Disabilities arranging planning meetings to commence Q4.

It is proposed that updates from these groups will be reported through this quarterly report.

Proposal

- The Quality Forum is asked to be assured of the work of the Patient Experience and Involvement Team.
- All risks and mitigations have been set out within **key concerns.**

Decision required

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

Governance table

For Board and Board Committees:	Trust Board 28th March 2023	
Paper sponsored by:	Anne Scott, Director of Nursing, AHPs and Quality	
Paper authored by:	Alison Kirk, Head of Patient Experience, and Involvement	
Date submitted:	14 March 2023	
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, 9th March 2023	
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	X
	Single Patient **R**ecord	
	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:	Y	
False and misleading information (FOMI) considerations:	NA	
Positive confirmation that the content does not risk the safety of patients or the public	Y	
Equality considerations:	Considered	

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Leicestershire Partnership NHS Trust

Public Trust Board – 28 March 2023

Safe Staffing – December 2022

Purpose of the report

This report provides a full overview of nursing safe staffing during the month of December 2022, including a summary/update of new staffing areas to note, 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. (Annex 1 contains in-patient scorecard).

Analysis of the issue

Right Staff

- Temporary worker utilisation rate slightly increased this month; 0.19% reported at 42.51% overall and Trust wide agency usage increased this month by 1.1% to 21.26% overall.
- In December 2022; 28 inpatient wards/units utilised above 6% agency staff to meet safe staffing levels, this equates to 87.50% of our inpatient Wards and Units, changes from last month include Stewart House and Mill Lodge.
- Senior nursing review is undertaken to triangulate metrics where there is high percentage of temporary worker/agency utilisation or concerns directly relating to; increased acuity, high caseloads of high-risk patients, increased staff sickness, ability to fill additional shifts and potential impact to safe and effective care.
- The table below identifies the key areas to note from a safe staffing, quality, safety, and experience review:

Area	Situation	Actions/Mitigations	Risk rating
CHS in Patients	High percentage of temporary workforce on ten out of eleven wards. Beechwood, Clarendon and East ward - above 30% and St Luke's ward 1 and Rutland ward over 37.0% temporary workforce, due to vacancies, enhanced observations, increased patient levels of acuity requiring additional HCA support, annual leave and sickness. A review of the NSIs has identified an increase in the number of falls incidents from twenty-nine in November to thirty- seven in December 2022. Ward areas to note are Clarendon, Rutland and Snibston. The number of medication incidents increased to twenty-two this month. The number of category 2 pressure ulcers developed in our care has increased to ten.	Daily staffing reviews, staff movement to ensure substantive RN cover, e-rostering reviewed. Review of increased incidences has not identified any direct correlation between number of staff on duty and impact to quality and safety of patient care/outcomes. A review of themes of investigations has identified an emerging correlation between staff skills, confidence, and competencies as a contributory factor for deteriorating patient, pressure ulcer prevention and falls. Clinical teams working with substantive staff, regular and block booked agency workers providing role essential/specific training for staff working on the wards. There were eleven staffing related incidents reported in month. Two incidents reported - East Ward and Ward 4 (Surge ward at Coalville) relating to having one RN on shift, (red flag) these were risk assessed and mitigations put into place as these are wards on a dual site. There was no direct impact on patient care, however impact was noted on staff health and well-being. The community hospitals matron lead for falls is focusing on falls assessments education, care planning, footwear, and alternative equipment. Health and Safety team continue with flat lifting equipment training, ensuring safe transfer and maintaining dignity of patients following a fall. Flat lift training is monitored through service line governance forum. A QI focus on preventative management of pressure ulcers has commenced, led by the matron lead for pressure ulcer prevention. Progress continues with Tissue Viability Nurse Specialist team to improve education and training for both staff and patients on pressure ulcer prevention and leaflets/posters shared with all wards. A review of pressure relieving mattresses has taken place and ordering of additional equipment to support preventative management. Monitoring is through directorate pressure ulcer prevention working group.	
DMH **In patient**	High percentage of temporary workforce on all wards. Ashby, Watermead and Griffin wards above 60%, due to high acuity, patient complexity and increased therapeutic observations. Thornton - reduced fill rates for RNs on days due to a change in planned staffing reduced to 2 RNs due to bed reduction. Phoenix - reduced fill rate for RNs on nights. MHSOP wards, no change to key area's noted -Kirby, Welford Coleman, and Gwendolen. Reduced fill rates for RNs on days on Kirby. A review of the NSI's has identified a decrease in the number of falls incidents from sixty in November to thirty-nine in December 2022. The number of medication incidents decreased to six this month.	Staffing is risk assessed daily across all DMH and MHSOP wards and staff moved to support safe staffing levels, skill mix, and patient needs. Staff movement not always reflected on e- roster impacting accuracy of fill rate data. Review of increased incidences has not identified any direct correlation between staffing and the impact to quality and safety of patient care/outcomes. Recruitment ongoing. Medication Administration Technicians and Nurse Associates are not reflected in the fill rates hence rates not achieved, RN to Patient ratio is 1:12/1:10 as per staffing model. Falls huddles in place and physiotherapy reviews for patients with sustained falls and increased risk of falling. Review of NSIs has identified no correlation with staffing levels and impact to quality and safety of patient care/outcomes.	
FYPCLD **In-patients**	No change to key areas noted- Beacon, Agnes, and Langley wards. Reduced fill rate for Beacon - Patient acuity reduced and staffing levels adjusted accordindly.	Mitigation remains in place- potential risks being closely monitored. Review of NSIs has identified no correlation with staffing levels and impact to quality and safety of patient care/outcomes.	

	A review of the NSIs has identified an increase from four falls in November to six in December and increase to six medication errors in December from four in November 2022.		
CHS Community	No change to key areas noted - City East, City West, East Central and Hinckley Hubs with Overall OPEL rating at level 3/ level 3 actions due to increased patient acuity with increased caseloads, high vacancy levels and absence. Essential visits maintained.	Daily review of all non-essential activities per Level 3 OPEL actions. Reprioritised patient assessments. Pressure ulcer and community nursing quality improvement and transformational plans continue.	
DMH Community	Services continue with High RN vacancies in the Crisis Mental Health team, City Central, Melton, and Charnwood CMHT. High locum use continues.	Mitigation remains in place, potential risks closely monitored within Directorate. Quality Summit took place in November 2022.	
FYPC.LD Community	No change to key area's previously noted - LD Community rated red and no change to Healthy Together, Psychology, Therapy, and Looked After Children.	Mitigation remains in place with potential risks being closely monitored within Directorate.	

Measures to monitor the impact of staffing on quality.

National Quality Board guidance suggests drawing on measures of quality alongside care hours per patient day (CHPPD) to understand how staffing may affect the quality of care. Suggested indicators include patient and staff feedback, completion of key clinical processes – NEWS, observations, VTE risk assessments, medication omissions, patient harms including pressure ulcer prevalence and in-patient falls and learning from patient safety investigations and serious incidents.

Triangulation of complaints and nurse sensitive indicators with planned versus actual staffing has not identified any direct correlation between staffing levels and the impact on quality and safety of patients. We are starting to see correlation of impact of staffing skill mix and competencies as a contributory factor in some serious incident and incident reviews. The key high-level themes are linked to deteriorating patient and NEWS escalation, mental health observations and pressure ulcer risk assessment and prevention, there are specific Trust groups working on improvement plans and new group collaboratives established with NHFT led by our group director for patient safety and deputy directors of nursing and quality specific to these three areas.

Staffing and safety and incident reviews have identified that as workload, acuity and dependency increases with mitigating actions such as re-prioritisation of visits, step down of non-clinical activities, review of training, movement of staff and increased reliance on agency workers there is an impact on role essential training, equipment training such as use of Flat Lift equipment, timeliness of care plan and risk assessment updates and challenges with clinical continuity and oversight of standards. Senior clinicians and leaders are working every day to minimise and mitigate these risks however it is important to note this reality in practice and impact to patient and staff experience.

Right Skills

Staff Group	Appraisal	Clinical Supervision	Core Mandatory Training	Data Security Awareness IG	Basic Life Support	Immediate Life Support
All Substantive	81.8%	79.4%	All compliance subjects green	93.0%	87.1%	77.9%
Bank					64.9%	55.8%

- Compliance with face-to-face mandatory training is reported through the Training Education Development and Strategic Workforce Committee.
- In response to the emerging correlation between staff skills and competencies and incidences as a contributory factor and focused patient safety collaboratives for deteriorating patient, mental health observations and pressure ulcer prevention, clinical teams and services have worked with block booked agency workers to provide role

essential/specific training for staff working in CRISIS and urgent mental health care teams and community nursing.

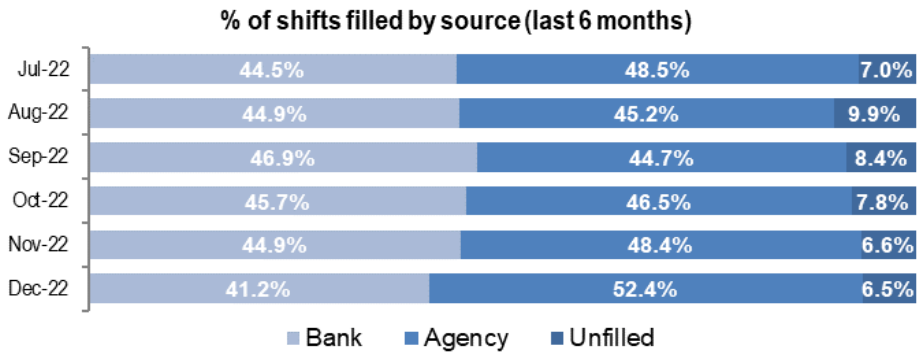
- Due to increased reliance on agency workers with no assurance that RNs are trained in ILS and recognition of deteriorating patient, plans are progressing to upskill, train and prioritise regular agency workers for area's identified at risk; in Community Hospitals, Beacon Unit, MHSOP wards based at the Evington centre and Agnes unit. Assurance is in place that agency workers are trained in BLS as per national skills framework for on-framework agencies.

Train the trainer Flat Lift equipment training has been rolled out by the Trust Manual Handling Lead with a focus on staff working in Community Hospitals and MHSOP wards, further work to include regular agency workers to be trained.

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.

Table 1 - Temporary Workforce



Care Hours Per Patient Day (CHPPD)

The total Trust CHPPD average (including ward based AHPs) is calculated by the Corporate Business Information Team at 10.8 CHPPD (national average 10.8) lower than November 2022, ranging between 4.6 (Stewart House) and 63.9 (Agnes Unit) CHPPD. CHPPD is calculated by the total actual staffing hours divided by the total occupied bed days (OBDs). 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. Table 2 reflects the variation in directorate and table 3 illustrates the proportion of staff absent due to sickness absence.

Table 2 – CHPPD by Directorate (previous 12 months)

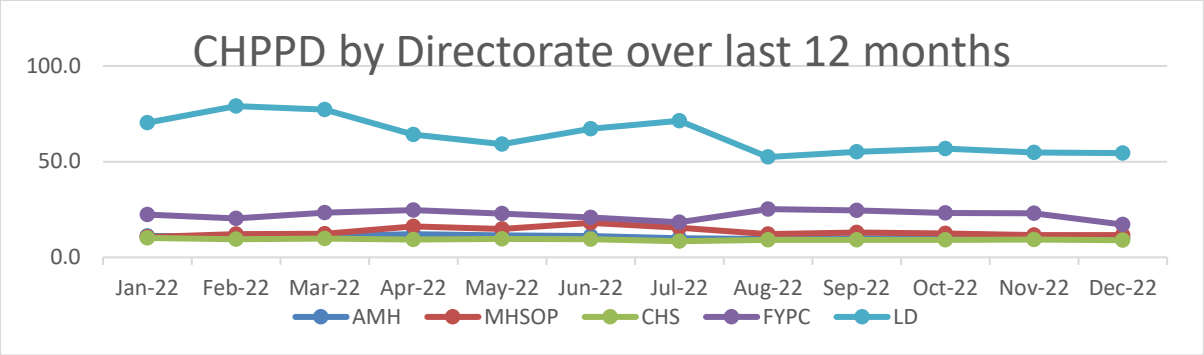


Table 3 – including CHPPD, RN Vacancies, Sickness and RN Turnover Rate

Directorate	CHPPD	RN vacancies (WTE)	RN Vacancies (%)	RN Sickness %	RN 12m Turnover rate %
CHS	8.9	139.1	22.7%	5.8%	10.6%
DMH Inc MHSOP	9.9 11.7	142.6	20.6%	7.6%	8.1%
FYPC LD	17.1 54.4	105.9	19.3%	8.4%	9.6%
All clinical directorates combined	10.8	387.6	20.9%	6.0%	9.5%

The RN vacancy position is at 387.6 Whole Time Equivalent (WTE) with a 20.9% vacancy rate. The change in vacancy WTE is impacted as much by changes to the establishment as it is changes to how many staff are in post/recruitment/turnover. RN turnover for nurses is at 9.5%**, (**includes all reasons for leaving **-** voluntary leavers**,** retirements, dismissals etc). This is below the Trust target of 10%. Progress continues by participating in the People Promise Exemplar scheme which started April 2022 and a dedicated People Promise Manager who is focusing on retention and working with system /regional/national colleagues and teams to review existing retention approaches and develop further activity**.** As part of our Agency Reduction plan, we aim to reduce registered nurse turnover by 0.5% by holding stay conversations, analysing exit interview responses and by promoting/expanding our flexible working offer. Sickness and absence give an indication of staffing pressure within each directorate.

Recruitment Pipeline

Throughout December 2022 we continue to grow and develop our nursing workforce. A total of 16.8 WTE nursing staff (bands 5 to 8a) were appointed. There was no onboarding of International Recruited Nurse's in December 2022, the next onboarding will take place in January 2023 with one Mental Health Nurse committing to coming to LPT. In addition to local recruitment activity a number of staff are in the pipeline and due to commence in post over a 3-month period.

Health and Well Being

The health and well-being of all our staff remains a key priority. The trust continues to support staff mental and physical health through referrals, signposting, communications, health and wellbeing champions and access to available resources.

Proposal

Considering the triangulated review of workforce metrics, nurse sensitive indicators, patient feedback and outcomes in December 2022 it is anticipated that staffing challenges continue to increase. There is emerging evidence that current controls and business continuity plans are not fully mitigating the impact to the quality and safety of patient care across all services, at all times with high temporary workforce utilisation to maintain safety.

Whilst there has been no evidence through the in-patient monthly triangulated review of Nurse Sensitive Indicators and quality metrics that staffing numbers is a contributory factor to patient harm. We are starting to see some correlation of impact of staffing skill mix and competencies as a contributory factor in some serious incident and incident reviews predominantly linked to pressure ulcer deterioration, deteriorating patient and mental health observations. There is a level of concern about pressure ulcer harm in community nursing and the longer-term impact of deferred visits at times of critical staffing, and potential for unknown risks and impact to outcomes and harm linked to reduced service offer/Health assessments in Healthy Together teams and Looked After Children services, 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.

Annexe 1
December 2022

Ward Group	Ward	Average no. of Beds on Ward	Average no. of Occupied Beds	Fill Rate Analysis (National Return) – Actual Hours Worked divided by Planned Hours: Nurse Day (Early & Late Shift) – Average % fill rate registered nurses	Nurse Day (Early & Late Shift) – Average % fill rate care staff	Nurse Night – Average % fill rate registered nurses	Nurse Night – Average % fill rate care staff	AHP Day – Average % fill rate registered AHP	AHP Day – Average % fill rate non-registered AHP	% Temporary Workers (NURSING ONLY) – Total	Bank	Agency	Overall CHPPD (Nursing And AHP)	Medication Errors	Falls	Complaints	PU Category 2	PU Category 4	Staffing Related Incidents
				>=80%	>=80%	>=80%	>=80%	-	-	<20%									
DMH Bradgate	Ashby	14	14	100.9%	214.9%	103.8%	181.8%			61.6%	16.0%	45.6%	10.4	1↓	0↓	0↓			
	Beaumont	23	22	107.2%	268.4%	106.1%	123.1%			50.8%	17.8%	33.0%	6.3	0↓	2↓	0→			
	Belvoir Unit	9	10	126.4%	184.0%	101.7%	217.8%			50.9%	24.7%	26.2%	16.8	0→	1↓	0→			
	Bosworth	14	14	116.9%	113.7%	105.7%	102.9%		100.0%	50.4%	24.6%	25.8%	7.7	0↓	0↓	0→			
	Heather	17	18	105.1%	201.3%	105.3%	163.6%			54.1%	32.6%	21.5%	8.3	0↓	2→	0→			
	Thornton	14	12	68.4%	184.5%	89.4%	117.8%			29.6%	20.6%	9.0%	7.7	0→	0→	0→			
	Watermead	20	20	109.7%	251.5%	103.9%	197.2%			63.4%	21.3%	42.1%	8.0	3→	1↓	0→			
	Griffin - Herschel Prins	6	6	102.4%	217.6%	102.9%	473.7%			63.2%	27.6%	35.6%	29.9	0→	1↑	0→			
DMH Other	Phoenix - Herschel Prins	12	12	101.5%	128.8%	52.9%	181.5%		100.0%	40.6%	26.1%	14.4%	10.2	0↓	0→	0→			
	Skye Wing - Stewart House	27	30	93.7%	100.8%	104.5%	114.7%			30.2%	24.2%	6.0%	4.6	1↑	1↓	0→			
	Willows	9	9	200.5%	129.3%	151.8%	115.7%			64.3%	44.1%	20.3%	12.7	1↓	2→	0→			
	Mill Lodge	13	14	163.2%	141.0%	123.7%	163.1%			43.8%	38.1%	5.8%	16.5	0↓	1↓	0→			
	Kirby	22	23	71.3%	121.7%	127.0%	135.4%	100.0%	100.0%	38.1%	22.6%	15.5%	7.8	0↓	3↓	0→			
	Welford	16	17	95.8%	108.7%	131.2%	193.7%			44.7%	30.6%	14.1%	8.6	0↓	4↓	0→			
	Coleman	16	18	102.6%	213.6%	104.6%	449.7%	100.0%	100.0%	69.6%	38.1%	31.5%	18.4	0→	11↑	1↑			
	Gwendolen	16	19	91.5%	148.8%	130.4%	150.6%			49.1%	29.6%	19.6%	13.7	0→	10↓	0→			
CHS City	Beechwood Ward - BC03	23	24	106.1%	122.8%	96.5%	123.5%	100.0%	100.0%	30.5%	13.2%	17.3%	8.8	6↑	2→	0→	0↓	0→	
	Clarendon Ward - CW01	19	21	88.4%	123.0%	104.7%	125.6%	100.0%	100.0%	30.1%	8.4%	21.7%	9.9	1→	6↑	0→	3↑	0→	
CHS East	Dalgleish Ward - MMDW	15	16	98.4%	83.1%	105.4%	104.5%	100.0%	100.0%	19.4%	6.8%	12.5%	8.2	6↑	4↑	0→	0→	0→	
	Rutland Ward - RURW	18	17	103.6%	158.1%	99.9%	107.9%	100.0%	100.0%	37.8%	16.1%	21.7%	8.3	2↑	7↑	0→	1↑	0→	
	Ward 1 - SL1	19	21	94.6%	117.9%	101.7%	151.6%	100.0%	100.0%	39.6%	19.0%	20.6%	8.8	3↑	2↓	0→	1↑	0→	
	Ward 3 - SL3	12	13	107.3%	91.5%	100.0%	96.3%	100.0%	100.0%	23.1%	14.4%	8.7%	9.7	1↓	1↑	0→	0↓	0→	
CHS West	Ellistown Ward - CVEL	17	19	98.4%	108.9%	95.1%	101.6%	100.0%	100.0%	20.9%	5.7%	15.2%	8.0	1↑	2↓	0→	0→	0→	
	Snibston Ward - CVSN	18	19	84.4%	125.3%	101.4%	152.1%	100.0%	100.0%	29.0%	11.5%	17.5%	9.5	0↓	6↑	0→	1↓	0→	
	East Ward - HSEW	23	24	126.1%	126.2%	122.4%	144.8%	100.0%	100.0%	31.4%	8.9%	22.5%	9.2	2↓	3↓	0→	1↑	0→	
	North Ward - HSNW	17	18	99.6%	90.0%	97.7%	88.6%	100.0%	100.0%	20.7%	6.4%	14.3%	8.6	0↓	3↑	0→	1↓	0→	
	Swithland Ward - LBSW	19	20	104.9%	95.6%	88.6%	149.7%	100.0%	100.0%	15.4%	6.0%	9.4%	8.3	0→	1↓	0→	2↑	0→	
FYPC	Langley	12	15	88.7%	116.4%	124.7%	130.6%	100.0%		41.2%	32.9%	8.3%	15.1	2↑	1→	0→			
	CAMHS Beacon Ward - Inpatient Adolescent	7	17	79.6%	96.0%	162.9%	63.7%	100.0%		52.7%	29.9%	22.8%	20.5	3↑	2↑	0→			
LD	Agnes Unit	1	1	104.4%	92.0%	128.1%	126.7%			59.4%	15.4%	44.0%	63.9	1↑	0↓	0→			
	Gillivers	2	6	110.0%	92.3%	133.3%	81.7%			9.1%	9.1%	0.0%	32.7	0→	3↑	0→			
	1 The Grange	1	4	-	78.8%	-	133.2%			17.3%	17.3%	0.0%	45.4	0→	0↓	0→			

Governance table

For Board and Board Committees:	Trust Board 28.3.23	
Paper sponsored by:	Anne Scott Executive Director of Nursing, AHPs and Quality	
Paper authored by:	Elaine Curtin Workforce and Safe staffing Matron Emma Wallis Deputy Director of Nursing and Quality	
Date submitted:	28.03.2023	
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	√
	Single Patient **R**ecord	
	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:	Considered	

Mii

Leicestershire Partnership NHS Trust

Public Trust Board – 28 March 2023

Safe Staffing – January 2023

Purpose of the report

This report provides a full overview of nursing safe staffing during the month of January 2023, including a summary/update of new staffing areas to note, 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. (Annex 1 contains in-patient scorecard).

Analysis of the issue

Right Staff

- Temporary worker utilisation rate increased this month; 1.2% reported at 43.71% overall and Trust wide agency usage slightly increased this month by 0.36% to 21.62% overall.
- In January 2023; 29 inpatient wards/units utilised above 6% agency staff to meet safe staffing levels, this equates to 87.87% of our inpatient Wards and Units, no changes from last month.
- Senior nursing review is undertaken to triangulate metrics where there is high percentage of temporary worker/agency utilisation or concerns directly relating to; increased acuity, high caseloads of high-risk patients, increased staff sickness, ability to fill additional shifts and the potential impact to safe and effective care.
- The table below identifies the key areas to note from a safe staffing, quality, safety, and experience review:

Area	Situation	Actions/Mitigations	Risk rating
CHS in Patients	High percentage of temporary workforce on ten out of eleven wards due to vacancies, annual leave, enhanced observations, increased patient levels of acuity including delirium presentation of patients requiring additional HCA support. Key areas to note ward 4 (surge ward) at 50% temporary workforce due to block booking of agency staff, East ward at 41.7% due to an additional 5 beds being opened to support system pressure and Rutland at 41.2 % undergoing refurbishment. A review of the NSIs has identified an increase in the number of falls incidents from thirty-seven in December to forty-seven in January 2023. Ward areas to note are East ward, Dalgleish and Beechwood The number of medication incidents has decreased from twenty-two in December to eleven in January 2023. The number of category 2 pressure ulcers developed in our care has increased to nine	Daily staffing reviews, staff movement to ensure substantive RN cover, e-rostering reviewed. Review of increased incidences has not identified any direct correlation between number of staff on duty and impact to quality and safety of patient care/outcomes. There were fifteen staffing related incidents reported in month. These incidents were relating to lack of fill by agency, last minute cancellations due to sickness, delayed tasks, impact on available staff to provide 1:1 enhanced observations and access to electronic systems. There was no direct impact on patient care on each of these occasions, however impact noted on health and wellbeing of staff. A review of themes of investigations has identified an emerging correlation between staff skills, confidence, and competencies as a contributory factor for deteriorating patient, pressure ulcer prevention and falls. Clinical teams working with substantive staff, regular and block booked agency workers providing role essential/specific training for staff working on the wards. The senior team with community hospitals matron lead for falls will be completing a deep dive into falls and also focusing on falls assessments education, care planning, footwear, and alternative equipment. Flat lifting equipment is in place to ensure safe transfer and maintenance of dignity for patients following a fall and flat lift training continues to be monitored through service line governance forum. Flat lift training compliance at 69% and a focus for February 2023. A QI focus on preventative management of pressure ulcers has commenced, led by the matron lead for pressure ulcer prevention. Progress continues with Tissue Viability Nurse Specialist team to improve education and training for both staff and patients on pressure ulcer prevention and leaflets/posters shared with all wards. Monitoring is through directorate pressure ulcer prevention working group. Additional pressure relieving mattresses and equipment have been purchased to support preventative management.	
DMH **In patient**	High percentage of temporary workforce on all wards. Beaumont, Belvoir, Bosworth, Heather, Watermead, Griffin and Willows – above 50 % temporary workforce due to vacancies, high acuity, patient complexity and increased therapeutic observations. Thornton - planned staffing reduced to 2 RN's due to reduction in beds, hence reduced fill rates on days. Phoenix - reduced fill rate for RNs on nights. MHSOP wards, no change to key area's noted -Kirby, Welford Coleman, and Gwendolen. Reduced fill rates for RNs on days on Kirby, and Gwendolen. A review of the NSI's has identified a increase in the number of falls incidents from thirty-nine in December 2022 to 42 in January 2023. The number of medication incidents decreased to six this month. The number of medication incidents decreased to fourteen this month	Staffing is risk assessed daily across all DMH and MHSOP wards and staff moved to support safe staffing levels, skill mix, and patient needs. Staff movement not always reflected on e- roster impacting accuracy of fill rate data. Review of increased incidences has not identified any direct correlation between staffing and the impact to quality and safety of patient care/outcomes. Active recruitment ongoing. Medication Administration Technicians and Nurse Associates are not reflected in the fill rates hence rates not achieved, RN to Patient ratio is 1:12/1:10 as per staffing model. All patients receive a falls risk assessment/multi-factorial falls risk assessment on admission. Falls huddles in place and physiotherapy reviews for patients with sustained falls and increased risk of falling. Review of NSIs has identified no correlation with staffing levels and impact to quality and safety of patient care/outcomes.	
FYPCLD **In-patients**	No change to key areas noted- Beacon, Agnes, and Langley wards. Reduced fill rates for The Grange.	Mitigation remains in place- potential risks being closely monitored. Staff movement from the Gillivers (due to re-furnishment) to the Grange for safe staffing levels. Staff movement not always reflected on e- roster impacting accuracy of fill rate data.	

	A review of the NSIs has identified an increase in falls from six in December 2022 to nine in January 2023 and increase to twelve medication errors in January 2023 from six in December 2022.	Review of NSIs has identified no correlation with staffing levels and impact to quality and safety of patient care/outcomes.	
CHS Community	No change to key areas noted - City East, City West, East Central and Hinckley Hubs with Overall OPEL rating at level 3/ level 3 actions due to increased patient acuity with increased caseloads, high vacancy levels and absence. Essential visits maintained.	Daily review of all non-essential activities per Level 3 OPEL actions. Reprioritised patient assessments. Pressure ulcer and community nursing quality improvement and transformational plans continue.	
DMH Community	Services continue with High RN vacancies in the Crisis Mental Health team, City Central, Melton, and Charnwood CMHT. High locum use continues.	Mitigation remains in place, potential risks closely monitored within Directorate. Quality Summit in November 2022 and QI plan in place.	
FYPC.LD Community	No change to key area's previously noted - LD Community rated red and no change to Healthy Together, Psychology, Therapy and Looked After Children.	Mitigation remains in place with potential risks being closely monitored within Directorate.	

Measures to monitor the impact of staffing on quality.

National Quality Board guidance suggests drawing on measures of quality alongside care hours per patient day (CHPPD) to understand how staffing may affect the quality of care. Suggested indicators include patient and staff feedback, completion of key clinical processes – NEWS, observations, VTE risk assessments, medication omissions, patient harms including pressure ulcer prevalence and in-patient falls and learning from patient safety investigations and serious incidents.

Triangulation of complaints and nurse sensitive indicators with planned versus actual staffing has not identified any direct correlation between staffing levels and the impact on quality and safety of patients. We are starting to see some correlation of impact of staffing skill mix and competencies as a contributory factor in some serious incident and incident reviews. The key high-level themes are linked to deteriorating patient and NEWS escalation, mental health observations and pressure ulcer risk assessment and prevention, there are specific Trust groups working on improvement plans and new group collaboratives established with NHFT led by our group director for patient safety and deputy directors of nursing and quality specific to these three areas.

Staffing and safety and incident reviews have identified that as workload, acuity and dependency increases with mitigating actions such as re-prioritisation of visits, step down of non-clinical activities, review of training, movement of staff and increased reliance on agency workers there is an impact on role essential training, equipment training such as use of Flat Lift equipment, timeliness of care plan and risk assessment updates and challenges with clinical continuity and oversight of standards. Senior clinicians and leaders are working every day to minimise and mitigate these risks however it is important to note this reality in practice and impact to patient and staff experience.

Right Skills

Staff Group	Appraisal	Clinical Supervision	Core Mandatory Training	Data Security Awareness IG	Basic Life Support	Immediate Life Support
All Substantive	81.9%	81.1%	All compliance subjects green	94.4%	88.3%	82.1%
Bank					66.9%	58.8%

- Compliance with face-to-face mandatory training is reported through the Training Education Development and Strategic Workforce Committee.
- In response to the emerging correlation between staff skills and competencies and incidences as a contributory factor and focused patient safety collaboratives for deteriorating patient, mental health observations and pressure ulcer prevention, clinical teams and services have worked with block booked agency workers to provide role

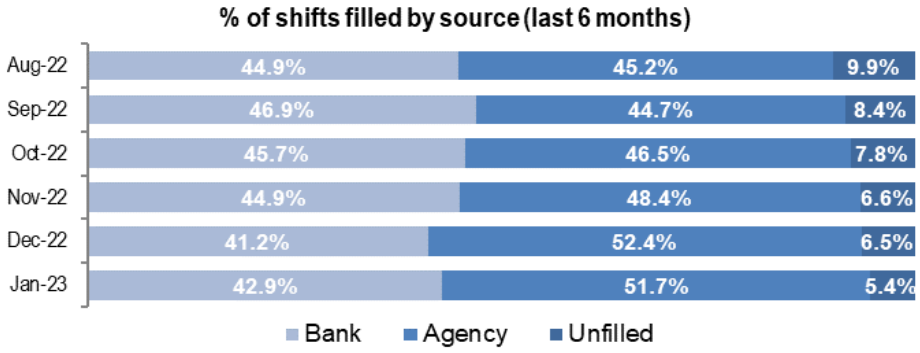
essential/specific training for staff working in CRISIS and urgent mental health care teams and community nursing.

- Train the trainer Flat Lift equipment training has been rolled out by the Trust Manual Handling Lead with a focus on staff working in Community Hospitals and MHSOP wards, further work to include regular agency workers to be trained.
- Flat lift training compliance figures (as reported at the Trust falls group) is currently 69% for CHS and 32% for MHSOP

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.

Table 1 - Temporary Workforce



Care Hours Per Patient Day (CHPPD)

The total Trust CHPPD average (including ward based AHPs) is calculated by the Corporate Business Information Team at 10.9 CHPPD (national average 10.8) consistent with December 2022, ranging between 5.7 (Stewart House) and 70.6 (Agnes unit) CHPPD. CHPPD is calculated by the total actual staffing hours divided by the total occupied bed days (OBDs). 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. Table 2 reflects the variation in directorate and table 3 illustrates the proportion of staff absent due to sickness absence.

Table 2 – CHPPD by Directorate (previous 12 months)

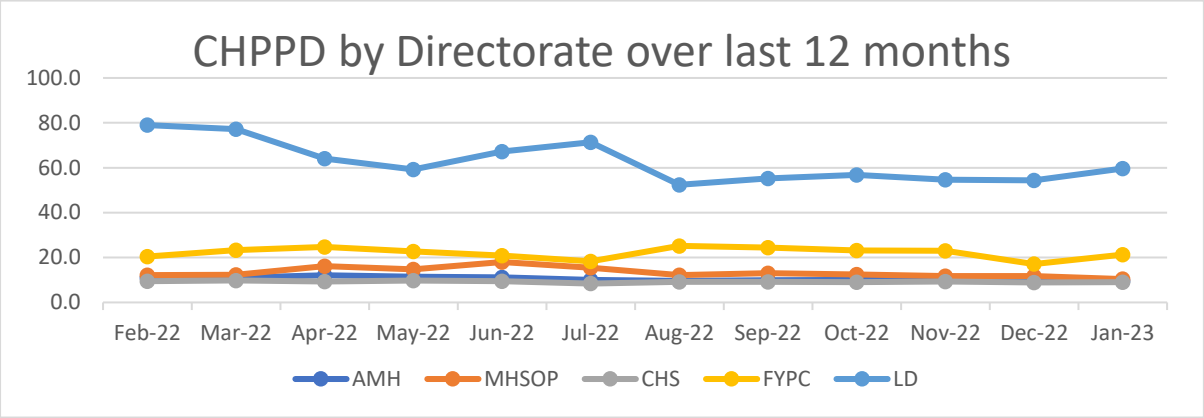


Table 3 – including CHPPD, RN Vacancies, Sickness and RN Turnover Rate.

Directorate	CHPPD	RN vacancies (WTE)	RN Vacancies (%)	RN Sickness %	RN 12m Turnover rate %
CHS	9.1	136.2	22.3%	4.8%	11.0%
DMH Inc MHSOP	9.6 10.4	154.0	22.0%	6.7%	8.1%
FYPC LD	21.3 59.7	112.4	20.3%	7.5%	9.6%
All clinical directorates combined	10.9	402.6	21.6%	5.9%	9.5%

The RN vacancy position is at 402.6 Whole Time Equivalent (WTE) with a 21.6% vacancy rate. The change in vacancy WTE is impacted as much by changes to the establishment as it is changes to how many staff are in post/recruitment/turnover. RN turnover for nurses is at 9.5%**, (**includes all reasons for leaving **-** voluntary leavers**,** retirements, dismissals etc). This is below the trusts target of 10%. Progress continues by participating in the People Promise Exemplar scheme focusing on retention working with system /regional/national teams to review existing retention approaches and develop further activity**.** Development of three key priority nursing retention actions areas; increasing pride and recognition, improving flexible working and accessible career development pathways.

Recruitment Pipeline

Throughout January 2023 we continue to grow and develop our nursing workforce. A total of 17.6 WTE nursing staff (bands 5 to 8a) were appointed. In addition to local recruitment activity a number of staff are in the pipeline and due to commence in post over a 3-month period.

Health and Well Being

The health and well-being of all our staff remains a key priority. The trust continues to support staff mental and physical health through referrals, signposting, communications, health and wellbeing champions and access to available resources.

Proposal

Considering the triangulated review of workforce metrics, nurse sensitive indicators, patient feedback and outcomes in January 2023 staffing challenges continue to increase. There is emerging evidence that current controls and business continuity plans are not fully mitigating the impact to the quality and safety of patient care across all services, at all times hence with temporary workforce utilisation to maintain safety.

Whilst there has been no evidence through the in-patient monthly triangulated review of Nurse Sensitive Indicators and quality metrics that staffing numbers is a contributory factor to patient harm, we are starting to see some correlation of impact of staffing skill mix and competencies as a contributory factor in some serious incident and incident reviews linked to deteriorating patient, pressure ulcer harm and mental health observations. There is a level of concern about pressure ulcer harm in community nursing and longer term impact of deferred visits, and potential for unknown risks and impact to outcomes and harm linked to reduced service offer/Health assessments in Healthy Together teams and Looked After Children services, 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

Annexe 1 January 2023

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	Complaint	PU Category 2	PU Category 4	Staffing related Incidents
				>=80%	>=80%	>=80%	>=80%	-	-	<20%									
DMH Bradgate	Ashby	14	14	91.7%	178.5%	104.4%	134.4%			42.3%	11.8%	30.5%	8.6	0↓	0→	0→			
	Beaumont	23	22	113.1%	314.0%	104.4%	160.8%			56.0%	24.5%	31.6%	7.3	0→	2→	0→			
	Belvoir Unit	9	10	141.1%	247.8%	106.1%	310.9%			57.9%	29.7%	28.2%	22.1	0→	0↓	0→			
	Bosworth	14	14	128.1%	136.8%	105.2%	143.3%		100.0%	56.3%	28.3%	28.0%	9.5	1↑	4↑	0→			
	Heather	18	18	105.6%	148.0%	104.9%	104.7%			52.6%	33.4%	19.2%	6.4	0→	1↓	0→			
	Thornton	12	12	68.6%	220.9%	91.3%	122.9%			36.9%	24.8%	12.1%	9.7	0→	0→	0→			
	Watermead	21	20	107.1%	202.8%	105.3%	183.5%			61.7%	21.9%	39.8%	6.9	3→	0↓	0→			
	Griffin - Herschel Prins	6	6	105.0%	214.0%	100.9%	498.0%			58.6%	32.1%	26.5%	28.1	0→	1→	0→			
DMH Other	Phoenix - Herschel Prins	12	12	104.7%	127.5%	52.3%	190.3%		100.0%	46.2%	24.9%	21.3%	10.3	0→	0→	0→			
	Skye Wing - Stewart House	28	30	120.6%	125.6%	143.3%	149.6%			39.4%	38.0%	1.4%	5.7	0↓	0↓	0→			
	Willows	12	9	173.9%	122.2%	140.0%	119.2%			59.7%	47.5%	12.2%	9.9	1→	1↓	0→			
	Mill Lodge	12	14	116.6%	128.4%	103.2%	110.2%			31.3%	26.5%	4.9%	14.1	0→	4↑	0→			
	Kirby	21	23	65.9%	117.3%	127.5%	139.9%	100.0%	100.0%	39.6%	26.8%	12.8%	7.8	1↑	4↑	0→			
	Welford	17	17	97.2%	124.4%	133.3%	216.4%			47.1%	33.2%	13.9%	8.8	6↑	9↑	0→			
	Coleman	18	18	105.1%	168.9%	104.5%	296.1%	100.0%	100.0%	65.7%	47.9%	17.8%	13.4	2↑	3↓	0→			
	Gwendolen	16	19	77.7%	117.1%	141.4%	158.2%			43.0%	27.4%	15.7%	12.2	0→	13↑	0→			
CHS City	Beechwood Ward - BC03	21	24	116.3%	113.3%	101.8%	133.4%	100.0%	100.0%	38.1%	17.4%	20.7%	9.1	2↓	5↑	1↑	0→	0→	
	Clarendon Ward - CW01	20	21	85.6%	127.8%	97.6%	145.6%	100.0%	100.0%	27.6%	9.4%	18.2%	9.6	2↑	4↓	0→	0↓	0→	
CHS East	Dalgleish Ward - MMDW	16	17	110.2%	89.9%	102.8%	105.6%	100.0%	100.0%	18.0%	6.2%	11.8%	7.9	0↓	7↑	0→	3↑	0→	
	Rutland Ward - RURW	18	17	119.2%	164.9%	116.8%	125.8%	100.0%	100.0%	41.2%	19.3%	21.8%	8.9	0↓	3↓	0→	0↓	0→	
	Ward 1 - SL1	19	21	91.6%	115.7%	101.4%	146.1%	100.0%	100.0%	34.7%	23.8%	10.9%	8.9	0↓	3↑	0→	1→	0→	
	Ward 3 - SL3	13	14	113.6%	88.3%	100.0%	96.1%	100.0%	100.0%	19.9%	11.9%	8.0%	9.4	0↓	1→	0→	0→	0→	
CHS West	Ellistown Ward - CVEL	18	20	102.7%	121.3%	104.5%	122.5%	100.0%	100.0%	22.3%	5.7%	16.6%	8.5	0↓	2→	0→	1↑	0→	
	Snibston Ward - CVSN	19	20	84.5%	128.3%	100.0%	153.0%	100.0%	100.0%	28.6%	11.1%	17.4%	9.0	1↑	3↓	0→	0↓	0→	
	East Ward - HSEW	27	28	142.3%	151.5%	157.3%	195.3%	100.0%	100.0%	41.7%	10.5%	31.2%	9.8	2→	9↑	0→	1→	0→	
	North Ward - HSNW	18	19	99.6%	91.6%	100.9%	111.5%	100.0%	100.0%	31.6%	12.2%	19.4%	8.9	0→	3↑	0→	1→	0→	
	Ward 4 - CVW4	11	15	96.6%	118.6%	99.9%	145.9%	100.0%	100.0%	50.0%	0.0%	50.0%	12.0	3	3	1	0	0	
	Swithland Ward - LBSW	20	22	102.7%	101.1%	99.8%	183.5%	100.0%	100.0%	22.6%	7.7%	14.9%	8.5	1↑	3↑	0→	2→	0→	
FYPC	Langley	13	15	88.8%	103.5%	130.6%	52.5%	100.0%		47.0%	34.8%	12.3%	15.7	5↑	7↓	0→			
	CAMHS Beacon Ward - Inpatient Adolescent	7	17	93.6%	117.2%	111.9%	90.5%	100.0%		63.5%	18.1%	45.3%	31.5	6↑	0↓	0→			
LD	Agnes Unit	2	1	135.7%	106.7%	127.1%	175.1%			64.9%	14.9%	50.1%	70.6	0↓	0→	0→			
	Gillivers	2	5	119.6%	89.6%	136.7%	88.2%			3.5%	3.5%	0.0%	46.0	0→	0↓	0→			
	1 The Grange	2	3	62.8%	60.2%	4.5%	128.7%			10.7%	10.7%	0.0%	32.2	1↑	2↑	0→			

Governance table

For Board and Board Committees:	Trust Board 28.3.23	
Paper sponsored by:	Anne Scott Executive Director of Nursing, AHPs and Quality	
Paper authored by:	Elaine Curtin Workforce and Safe staffing Matron Emma Wallis Deputy Director of Nursing and Quality	
Date submitted:	28.03.2023	
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	√
	Single Patient **R**ecord	
	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:	Considered	

N

Leicestershire Partnership NHS Trust

Trust Board Patient Safety Incident and Serious Incident Learning Assurance Report March 2023

Purpose of the report

This report for January and February 2023 provides assurance on our incident management and Duty of Candour compliance processes and reviews systems of control which 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 on 'Being Open', numbers of serious incident (SI) investigations, themes emerging from recently completed investigation action plans, a review of recent Ulysses incidents and associated lessons learned.

Analysis of the issue

Teams are working together to continuously improve the review and triangulation of incidents with other sources of quality data. Where incident investigations identify areas of learning not previously known or reported, this is considered in relation to ongoing governance oversight. Teams are also working closely to ensure the relationship between investigation findings and key priorities are identified for quality improvement projects and support, with strengthening oversight.

Patient Safety Strategy (NHSE 2019): Recently the CQC have highlighted areas in regulation that will need to align with new thinking about safety in 5 key areas through ongoing monitoring and inspection:

- The importance of culture
- Building expertise – both internal and external
- Involving everyone
- Consistent oversight and support
- Regulating safety

Below are the work streams in place across the Trust linking to these areas:

Patient Safety Partners – (*involving everyone*) These posts are an important part of our future patient safety plan and culture and essential to attract and renumerate suitable candidates.

Change Leaders – (***importance of culture***) Our Future Our Way change leaders continue to work through the discovery phase, through a safety lens of Human Factors and system thinking and Quality Improvement.

Patient Safety Training – (*building expertise*) National training modules and our internal Human Factors skills and knowledge will support delivery of change across the organisation. A Trust Board development session with the Healthcare Safety Investigation Branch will be planned to present responsibilities in this new framework. This will be an opportunity to strengthen our approach and challenge ourselves on whether we have an open and transparent and improvement focussed culture.

Learning Lessons – (*involving everyone*) The Learning Lessons group has been re-launched as a 'Community of Learning' using Community of Practice methodology, consisting of a diverse range of colleagues with expertise/understanding of 'learning'. There was a very successful session exploring 'are we really learning from complaints or just responding' exploring the difference between 'explaining' vs 'finding out' and actually 'learning'.

Learning From Patient Safety Events (LFPSE) – LFPSE is a new system that has been developed to replace the National Reporting and Learning System (NRLS). Within LPT, working with Ulysses, our incident reporting system, we are in the testing phase currently which has identified some concerns with Ulysses, being worked through.

Patient Safety Incident Response Framework (PSIRF) - The project group continues to meet to understand the requirements of the PSIRF (discovery phase) and to review the available data and agree our Patient Safety Incident Response Plan (PSIRP). We are also benchmarking with Derbyshire Healthcare NHS Foundation Trust as early adopters of PSIRF, to learn from their experience and working with our Communications Team to ensure preparation for this new approach.

Investigation compliance with timescales set out in the current serious incident framework – Challenges continue with our compliance with timescales, although there have been a number of changes made in an attempt to address this with varying success. The Incident Oversight Group have proposed a QI project to closely consider which stages of the process are most delayed to target out efforts. Commencing in April a proposed new streamlined process will be in place to better support timelines.

Royal College of Psychiatrists Serious Incident Review Accreditation Standards (SIRAN) –We are working towards accreditation through SIRAN; their review visit in January was positive, with good feedback about the quality of our Duty of Candour, our family engagement processes, and our patient story format, which will be shared more widely with other organisations as good practice. The review also noted our compassion and the voice of the patient/families within our reporting, with a 'clear and well written SI policy'. As part of the process, further evidence has been provided with the outcome due in May; the achievement would be an excellent foundation to build on.

Analysis of Patient Safety Incidents reported - (Appendix 1 contains Statistical Process Control (SPC) charts utilising the NHSI Toolkit to support the narrative and analysis and local speciality incident information. The overall position is also included for all investigations and action plans).

All incidents reported across LPT - 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.

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.

Pressure Ulcers - **Patients affected by pressure ulcers developed whilst in LPT care** – Recent data (January 2023) showed all pressure ulcer incidences were within the control limits, however, Category 3 and 4 incidences have increased compared to previous months. Further review and investigation will identify contributory factors and additional themes for improvement. The strategic group have reviewed the current quality improvement projects and noted the improvement work, to ensure all substantive Healthcare Support Workers (HCSW) within the Community Nursing hubs have been appropriately trained. A more senior task and finish group will review local improvement actions and our new Group Quality Improvement Pressure Ulcer Prevention Collaborative has recently formed.

Falls – review continues against the National Audit for Inpatient Fractures Report, developing improved processes and resources to support staff to deliver best practice. An example is the review of post falls processes to improve the quality of checking and use of equipment. Falls incidents are reviewed each month, receiving feedback and assurance from the directorates on scrutiny of incidents.

Deteriorating Patients – Focused improvement work looking into the earlier recognition of deteriorating patients is developing across the Trust with a group focusing on reporting systems and consistency in practice, this will allow a deeper dive into learning and communication. A Group Collaborative with NHFT is also in development to ensure standardised practice and joint learning.

All Self-Harm including Patient Suicide – Inpatient self-harm behaviours continue to range from low harm to multiple attempts. A task and finish group are investigating how patients self-harm whilst under close observation; a national concern across Mental Health organisations, and our third group collaborative is focusing on sharing best practice and quality improvement within this area. We are represented within a new National group reviewing mental health safe and therapeutic observations, which will enable our workstreams to nationally align. There is also a task and finish group working to agree an

approach to patients who overdose and refuse to access treatment. Recent learning from incidents suggests there is lack of clarity for staff between life-saving treatment and the Mental Health Act/Mental Capacity Act. Whilst this work concludes, interim guidance has been provided.

Suicide Prevention - A recent National confidential inquiry has identified and reported a national increase in suicides in patients with a diagnosis of personality disorder; the Trust Suicide Prevention group will be reviewing the latest report to explore learning. The Trust group has re-established and is completing a self-assessment of our provision against the National Confidential Inquiry into Suicide in Mental Health (NCISH), safety and self-harm toolkits. To note, progress has been delayed whilst a Trust-wide joint Suicide Prevention and Self-harm Lead role is considered.

Medication incidents - Learning from medication related incidents is maximised to ensure learning themes are identified, system actions are implemented, changing culture from incidents being related to systems rather than individuals, in particular review of the safety actions for safe prescribing of Sodium Valproate. There has recently been an increase in incidents involving insulin in patients in the community with a task and finish group commenced to consider.

Integrated Care Boards/Collaboratives/Commissioners/Coroner/CQC - The CQC receives 72hr reports for newly notified SI's, completed SI reports/action plans/evidence and any additional information required. We continue to work with our other 'commissioners' to provide assurances.

Learning from Deaths (LfD) - This process is supported by a Trust co-ordinator and bereavement nurse, providing valuable service to our patients' families. Feedback from families is carefully gathered to understand where care has been good, allowing learning dissemination. Early themes identified: communication with families and information sharing on discharge to support ongoing care; both have actions in place and will be monitored and reported at the End-of-Life Steering Group.

Patient Stories/Sharing Learning - Patient stories are used to share learning Trust-wide to ensure focused learning, part of our culture and new way of thinking. Evidence suggests that staff learn better from patient stories, and storyboards post incident are developing. The appendices illustrate stories provided by directorates which have been shared within Improvement Groups for cross trust learning.

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 28th March 2023	
Paper sponsored by:	Dr Anne Scott	
Paper authored by:	Tracy Ward, Head of Patient Safety	
Date submitted:	16/03/23	
State which Board Committee or other forum within the Trust's governance structure.	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	
STEP up to GREAT strategic alignment*:	High **S**tandards	X
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	X
	Single Patient **R**ecord	
	Equality, Leadership, Culture	
	Access to Services	
	Trust Wide QI	X
Organisational Risk Register considerations:	List risk number and title of risk	1. 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. 2. Trust may not demonstrate learning from incidents and events and does not effectively share that learning across the whole organisation.
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:		
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:		

Leicestershire Partnership NHS Trust

Public Trust Board of Directors

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

1. Purpose of the report

This report is presented to the Trust Board as assurance of the efficacy of the Learning from Deaths (LfD), Child Death Overview Panel (CDOP), Learning Disabilities Mortality Review (LeDeR), and Serious Incident (SI) processes in adherence to the National Quality Board (NQB) guidance on Learning from Deaths (2017). This Report presents data from October to December 2022 (Quarter 3: Q3) as well as learning from Q3 and previous quarters not already reported, at Leicestershire Partnership Trust (LPT).

2. Analysis of the issue

The information presented in this report is based on reports submitted from the directorates and collated by the Learning from Deaths Governance and Quality Assurance Coordinator within the patient safety team. LfD meetings are carried out monthly within DMH/MHSOP and FYPC/LD. LfD meetings in CHS are carried out on an ad-hoc basis should further discussion be identified through the ME process or as identified by LPT Staff.

- Demographics - There remains a theme around the full and accurate gathering of demographic information. This is not being consistently completed at a service level (particularly Disability, sexual orientation, and Religion although there has been an improvement in the recording of ethnicity). Ongoing work with directorates to emphasise the importance of this data as a means of better understanding and overcoming potential health inequalities.
- LfD QSR forms – The Learning from Deaths Coordinator adds basic demographics and incident details from Ulysses to the form. Furthermore, if the death is discussed at an Incident Review Meeting (IRM), the notes recorded on Ulysses and a copy of the ISMR are also included.
- The ME process - The ME process is fully embedded in CHS and has been extended to include DMH inpatient deaths from 1st January 2023. The ME's office agrees the proposed cause of death and the overall accuracy of the medical certificate of cause of death (MCCD) with the doctor completing it. The ME will discuss the cause of death with the next of kin/informant and establish if they have questions or any concerns with care before death. Any learning or good practice identified is shared through the LPT's Learning from Deaths email lpt.learningfromdeaths@nhs.net.
- During quarter three we have been working to ensure that we are maximising the learning. The majority of the deaths within CHS are expected i.e. the patient has been identified as end of life and a conversation held in relation to Respect. All CHS inpatient deaths are reviewed by the ME including a conversation with the family and any learning shared with us. In addition, our bereavement support nurse will follow up with the family in 6/8 weeks to offer any support in relation to

their bereavement. This is also an opportunity to proactively ask for feedback in relation to their relatives care for our learning either positive or areas to improve. This learning is shared with the end-of-life steering group. Where there has been an unexpected death these are reviewed usually using an Initial service managers review (ISMR) that is discussed at the weekly incident review meeting (IRM) and from there the decision is made to review as a serious incident/internal investigation or remain as an ISMR, the outcome of all of these reviews will be heard and discussed at CHS's learning from deaths forum meeting.

- Outstanding reviews
    - FYPC/LD and MHSOP have no reviews outstanding from the previous year, 1st April 21 to 31st March 22.
    - DMH have further reduced their backlog of outstanding reviews from the previous year, 1st April 21 to 31st March 22, from 20 (6%) outstanding to 7 (2%) outstanding and these are being completed as a priority.
      Training sessions have been completed within DMH to increase the number of clinicians undertaking reviews which is starting to have an impact in reducing the backlog.

      It should be noted that the average deaths per month for review within DMH has increased by 44% over the last 6 months from an average of 9 deaths per month to 13 deaths per month.

- FYPC/LD meetings are ongoing regarding the review the format of their LfD meetings, Terms of Reference and Group membership.

3. Proposal

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

4. Demographics

Demographic information is provided in Charts 1-6. It remains clear that demographic information is not being captured at a service level. The CPST are working with the Information Team to progress this. Tom Gregory, Clinical Safety Office/IM&T Clinical Lead has clarified the actions from the DQ committee meeting for this and will be arranging to meet up with Kim Dawson and Colin Purves to look at the dashboard that they can create for protected characteristics. This will then be taken back to DQC for the next meeting. It can then be added to the DQ Plan which is owned by Sarah Ratcliffe. Is there an update?

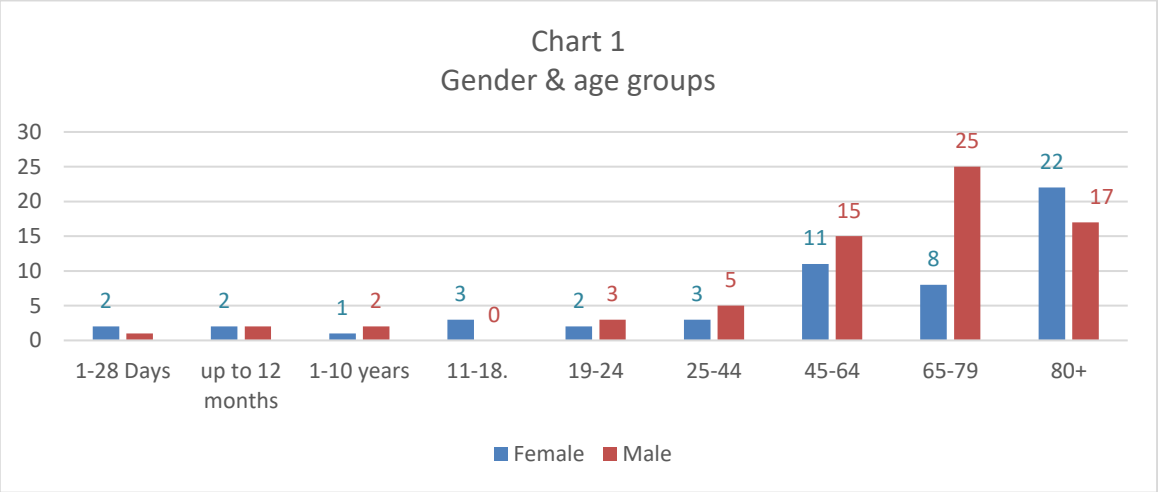


Chart 1
Gender & age groups
30
25
20
15
10
5
0
2
2
1
2
3
0
2
3
3
5
11
15
8
25
22
17
1-28 Days
up to 12 months
1-10 years
11-18.
19-24
25-44
45-64
65-79
80+
Female
Male

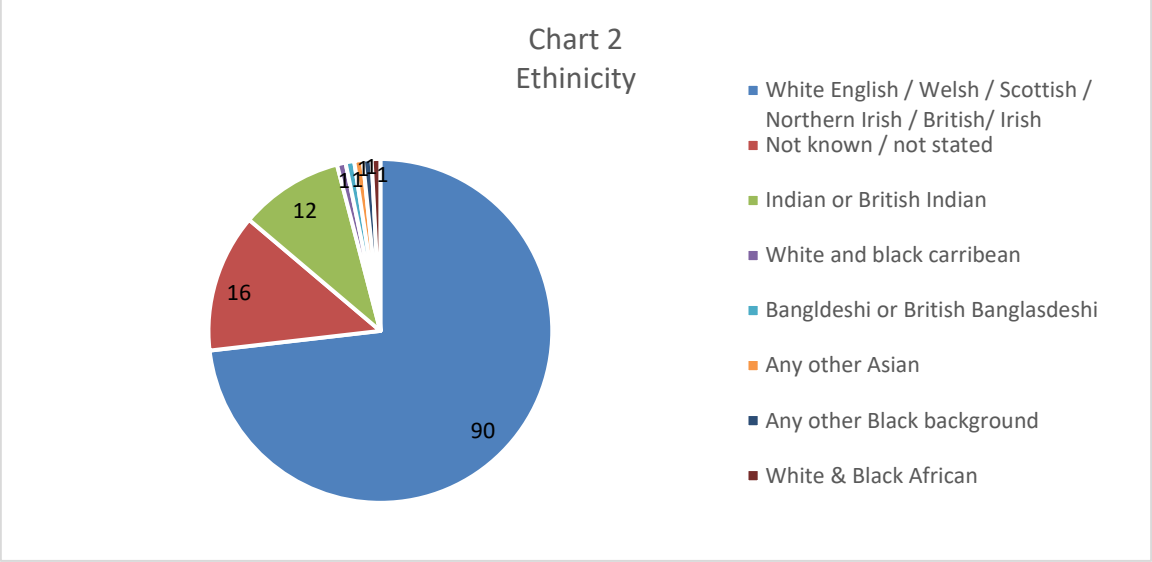


Chart 2
Ethinicity
12
16
90
1
1
1
1
White English / Welsh / Scottish / Northern Irish / British/ Irish
Not known / not stated
Indian or British Indian
White and black carribean
Bangldeshi or British Banglasdeshi
Any other Asian
Any other Black background
White & Black African

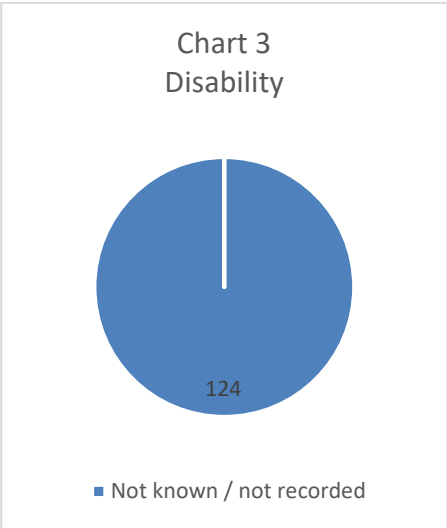


Chart 3
Disability
124
Not known / not recorded

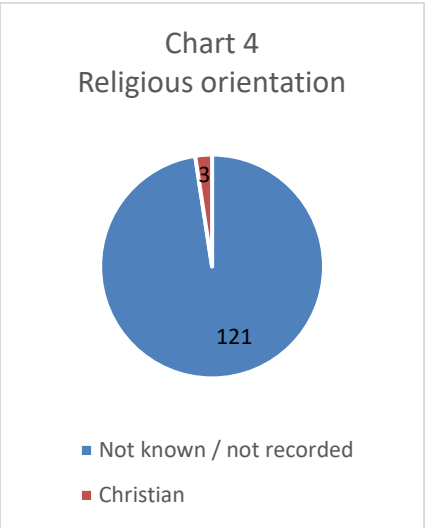


Chart 4
Religious orientation
3
121
Not known / not recorded
Christian

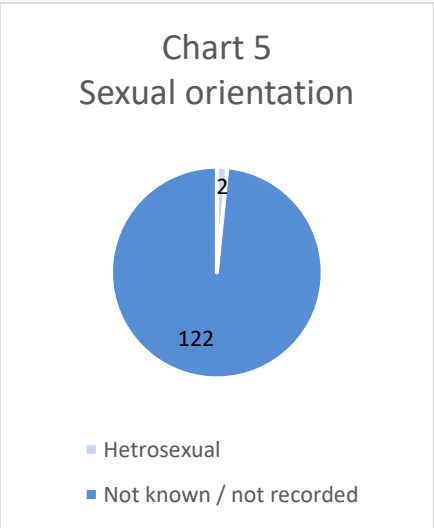
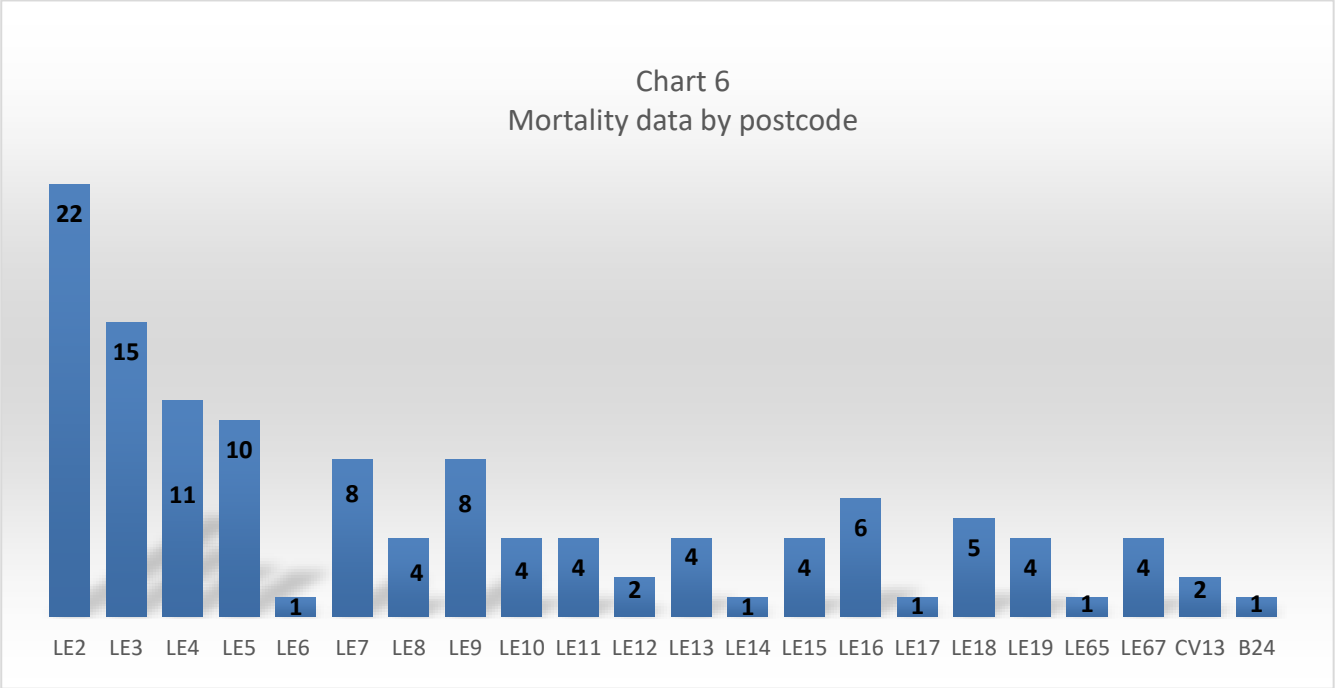


Chart 5
Sexual orientation
2
122
Hetrosexual
Not known / not recorded



Backlog of reviews of deaths

In adherence with NHS/I (2017) recommendations, the number and percentages of deaths reviewed through mSJR case record review and the Serious Incident (SI) process across LPT are shown in Table 2:

Table 1: Annual backlog of deaths (Q3)

Breakdown by Directorate										
	CHS			DMH/MHSOP				FYPC/LD		
	Q1 (Apr 22 - Jun 22)	Q2 (Jul 22 - Sep 22)*	Q3 (Oct 22 - Dec 22)	**Q1-Q4 (Apr 21- to Mar 22)**	Q1 (Apr 22 - Jun 22)	Q2 (Jul 22 to Sep 22)**	Q3 (Oct 22 - Dec 22)	Q1 (Apr 22 - Jun 22)	Q2 (Jul 22 - Sep 22)***	Q3 (Oct 22 - Dec 22)
Number of deaths reviewed	40	45	25	**303**	56	67	40	19	19	17
Percentage of deaths reviewed	100%	100%	100%	**98%**	85%	88%	55%	100%	100%	65%
Number of deaths outstanding for Directorate review	0	0	0	**7**	10	9	33	0	0	9

Percentage outstanding for directorate review	0%	0%	0%	**2%**	15%	12%	45%	0%	0%	35%

KEY

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

*CHS's Q2 total is 3 more than previously reported due to 3 September deaths being reported in November 22.

**DMH's Q2 total is 11 more than previously reported due to 8 SI's inadvertently not being included in figures, 1 August death that was reported in December and 2 September deaths that were reported in October.

***FYPC/LD's** Q2 total is 1 more than previously reported due to 1 Internal Investigation inadvertently not being included in figures

CHS

CHS's have one action to be completed from their action plan from Quarter 1 as per below:

Quarter 1 Action Plan

Recommendation	Agreed Action	Lead	Completion Date	Outcome
• RESPECT forms - There is always room for improvement, these are often revisited on admission and re written.	ANP update/refresher training	LR	October 2022	October's ANP educational session will be focused on Version 3 of the ReSPECT form. Erin Ford, ANP, will approach appropriate Consultant Geriatrician or practitioner to deliver this session.
• Management plans - Nurses rely on management plans to use in SBAR to OOH Dr's etc.	To have a clearer structure within SystmOne in relation to management plans	LR and JD	March 2023 ~~Jan 2023~~	Leon Ratcliffe and Jonathan Dexter working with SystmOne to implement a clear and robust visual prompt for staff in relation to OOH management plans Getting the change around IT has been a challenge coupled with winter pressures and the current bed crisis the emphasis has been on service delivery. There is a meeting planned with IM&T to progress.
• Lack of access to SystmOne – It is concerning that agency nurses did not have access as it is essential to have access to SystmOne as a basic standard. Access to SystmOne is necessary to provide safe patient care. This results in substantive staff having to document for the whole ward.	There is an agreed SOP for obtaining SystmOne access for all CHS agency nurses.	Matron (SS)	Completed	Flow Chart - For obtaining SystmOne C Non Substantive staff SystmOne access Fina

In adherence with NHS/I (2017) recommendations Table 2 also shows the number of deaths reported by each Directorate for Q3. Formal investigations consist of Serious Incident (SI) investigations and modified Structured Judgement Reviews (mSJR) case record reviews:

- There were 124 deaths considered in Q3.
- There was a total of 7 deaths for Serious Incident Investigation.
- There were 13 adult deaths of individuals with Learning Disabilities which are undergoing LeDeR review within FYPC.
- There were 2 unexpected deaths within CHS of which 1 is being investigated as an Internal and the other will go through the End-of-Life Steering group. Expected deaths will have a Respect form/ACP in place and unexpected not. Also, an expected death would have a clear EOL/management plan in place.

Table 2: Number of deaths (Q3)

Q3 Mortality Data										
	Oct			Nov			Dec			Total
	C	D	F	C	D	F	C	D	F	
Number of Deaths	10	25	12	7	25	8	8	23	6	**124**
Consideration for formal investigation										
	C	D	F	C	D	F	C	D	F	Total
Serious Incident	0	3	0	0	2	0	1	1	0	**7**
mSJR* Case record review	10	25	12	7	25	8	8	23	6	**124**
Learning Disabilities deaths			5			4			4	**13**
Number of deaths reviewed/investigated and as a result considered more likely than not to be due to problems in care	0	0	0	0	0	0	0	0	0	**0**
Learning										
	C	D	F	C	D	F	C	D	F	Total
Number of family contacted for feedback	10	10	3	7	0	0	8	0	0	**38**
Number of family feeding back	4	2	1	3	0	0	1	0	0	**11**
Number of awaiting feedback from family	0	0	0	0	0	0	0	0	0	**0**

KEY

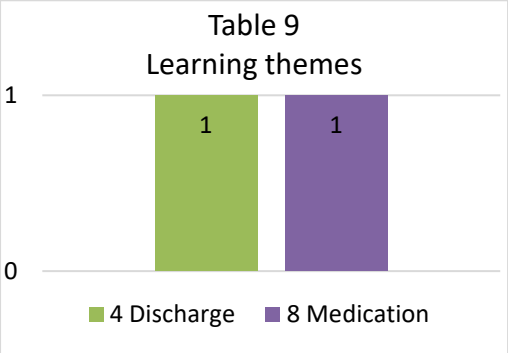
C: *Community Health Services;* ***D:*** *Directorate of Mental Health/Mental Health Service for Older People;* ***F:*** *Families Young Persons and Children/LD*

The Diana team complete the LfD QSR form within 48 hours of the child's death. All families where there is involvement from the Diana service at the time of the child's death will be contacted for feedback. All child deaths will be reviewed through the Child Death Overview Panel which will provide families a further platform to prove feedback.

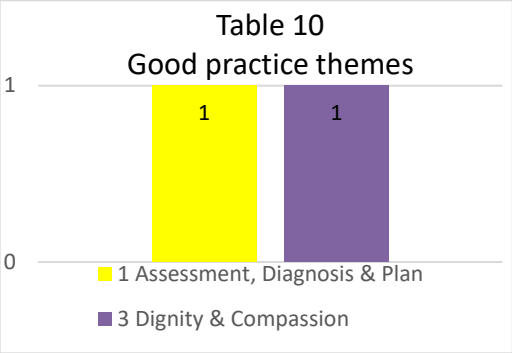
5. Learning themes and good practice identified

CHS

Learning themes (Q3)



Good practice themes (Q3)



There are no actions in response to the themes identified and no concerns identified by the ME's office.

Full details of learning themes and good practice can be found in Appendix 1.

Feedback from the National Medical Examiner (ME) process

CHS identified 1 death that wasn't referred to the ME's office. The ME's office advised that as a certificate had already been issued and likely that relatives had already had contact with the registrars/received the certificate, it was felt that there would be no need for ME involvement.

Positive feedback from families regarding LPT care provided.

- Happy with care - excellent at both LRI and St Luke's.
- St Luke's fantastic.
- St Luke's nursing care was excellent.
- Fantastic at St Luke's
- Nurses in both hospitals given fantastic care (North Ward, Hinckley & Bosworth Community Hospital).
- They were brilliant. Looked after mum really well. (Ellistown ward, Coalville Community Hospital)

Negative feedback from families regarding LPT care provided.

- Daughter expressed concern that it took a long time to come to establish a diagnosis despite being in hospital for total of 4 month in 2 admissions; delay

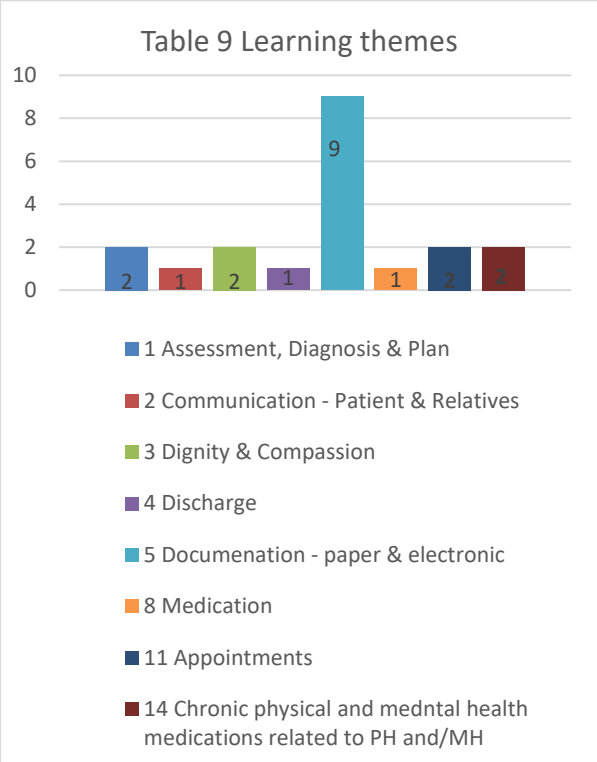
in getting scans or results. Nursing care was good. Would like Bereavement Nurse to follow up. Bereavement Nurse will make contact.

- Many issues. Bereavement Nurse will call to discuss.

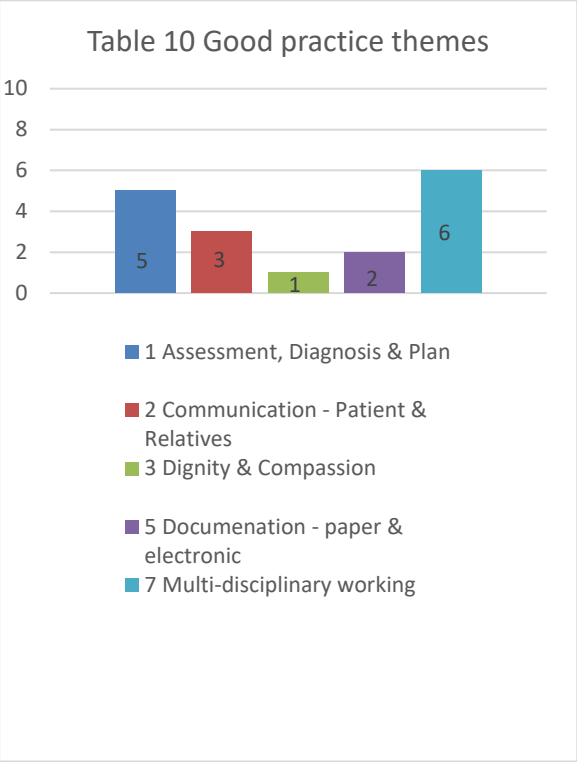
DMH/MHSOP

There were no common themes identified.

Learning themes (Q3)



Good practice themes (Q3)



Full details of learning themes and good practice can be found in Appendix 1.

Actions taken in response to identified themes/issues, actions planned and an assessment of impact of actions

- Staff knowledge (14.41 Chronic Physical and Mental Health Problems and Medications related to physical health and/or mental health)

Guidance notes on SystmOne to be reviewed and discussed with Alison O'Donnell regarding training / possible email to staff.

- Lack of contact (5.13 Documentation and Correspondence with Patients / Other Clinical Teams)

There does not appear to be any communication with elderly father, who lived with patient and administered medication. Previous safeguarding concerns raised that father had lost his access to his motor scooter as patient had crashed it intoxicated. Reflection with CPN will take place.

- CAP Triage process (1.1 Assessment and Assessment)

Declined assessment – 10th May 2021 felt to have capacity – no capacity assessment noted or recorded. Action: Alcohol dependence – referred for CBT, reference to Turning point in the notes in March 2019 and June 2020. The CAP Triage process is being reviewed in line with national guidance. SBAR already completed and there is a paper that will be going to the Quality & Safety Summit in January 23.

- Transformation workstream (2.4. Communications and 2.4. Results / Management / Discharge plan)

Outpatient review in November 2020 identified follow up for 2 months' time, next review was September 2021. Action: Communication from outpatients when reviews are not scheduled as planned could be communicated with the patient. Dr Vesna Acovski & Sam Hamer to take this forward with the transformation workstream. Part of the process will be looking at patient expectation and how we communicate with them if we are unable to meet appointments when advised.

- Discharge (4.12 Discharge and Discharge Planning)

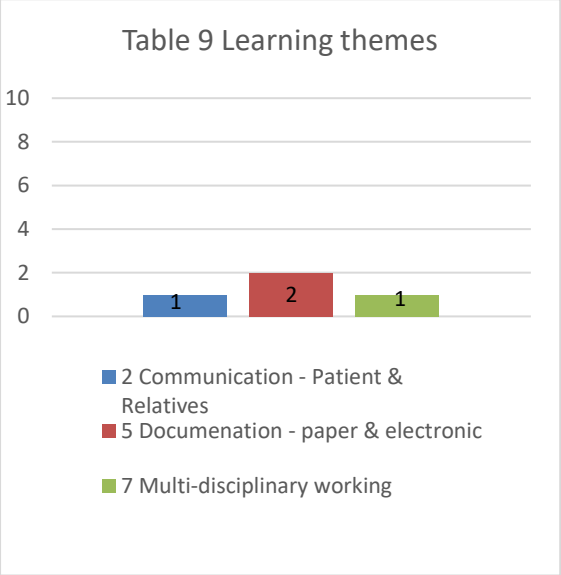
There were no mental health concerns so probably should have considered discharge. Action: JN & SH to liaise with Sanjay Rao, Vesna Acovski and Debbie to review as part of the caseload review and discharge planning and arrange for the Discharge SOP to be included in the Locum Inductions so that they are aware of the thresholds for discharge.

- Did not attend (11.32 Appointments and Did Not Attend)

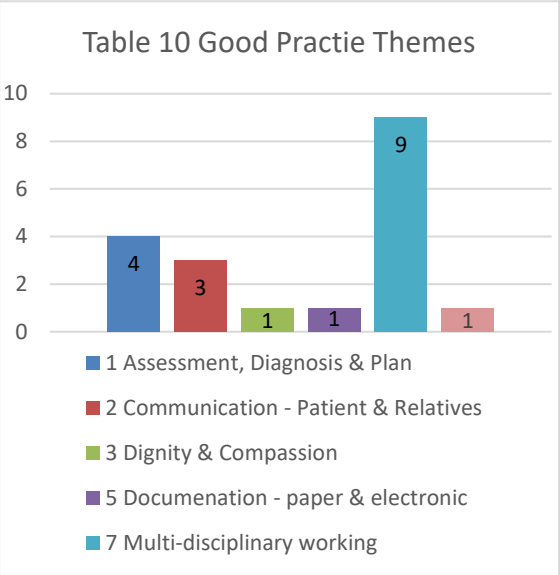
DNA letters / opt in and further appointments. Action: Explore / check DNA process for those that miss appointments. This is covered in the updated DNA Policy which has just been reviewed and is awaiting sign off.

FYPC/LD

Learning themes (Q3)



Good practice themes (Q3)



Full details of learning themes and good practice can be found in **Appendix 1.**

Actions taken in response to identified themes/issues, actions planned and an assessment of impact of actions

- Diagnostic overshadowing

Although there was some really good practice looking holistically at ruling out all the possible causes of agitation before going down behaviour route the issue of diagnostic overshadowing was discussed in November's Learning from Deaths meeting. Thea discussion was around diagnostic over shadowing and perhaps comorbidity of dementia being a potential theme and although it was not LPT learning, the service is very mindful of that certain cohorts of people might be disadvantaged because of that. The discussion was also around not always been good at having a ceiling of care for patients, especially with dementia and being proactive although it's not necessarily the LD team's responsibility to do that. It's a physical health need and that should of a collaborative and potentially dependent upon how robust the annual health checks are. Dr Shweta, Gangavati to discuss with Dr Rohit Gumber to ascertain if there is a forum to have a more strategic level discussion.

6. Decision required

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

7. Governance table

For Board and Board Committees:	Trust Board	
Paper presented by:		
Paper sponsored by:	Prof Mohammed Al-Uzri	
Paper authored by:	Tracy Ward/Evelyn Finnigan	
Date submitted:		
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	N/A	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:	Report provided to the Trust Board quarterly	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Report provided to the Trust Board quarterly	
STEP up to GREAT strategic alignment*:	High **S**tandards	✓
	Transformation	
	Environments	
	Patient Involvement	✓
	Well **G**overned	
	Single Patient **R**ecord	
	Equality, Leadership, Culture	
	Access to Services	
	Trust wide Quality Improvement	✓
Organisational Risk Register considerations:	List risk number and title of risk	1, 3
Is the decision required consistent with LPT's risk appetite?		
False and misleading information (FOMI) considerations:		
Positive confirmation that the content does not risk the safety of patients or the public		
Equality considerations:		

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

CHS

Learning themes and issues identified as part of the review/investigation.

4 Discharge	
4.10. Follow up Management Plan	Discharge not discussed, until sometime into the admission. Discussion reply preferred place of care wasn't documented in notes until 5 weeks after end-of-life paperwork commenced. Unsure whether some decision should have been made a little earlier on. Patient had plateaued. Maybe there was an opportunity to discuss discharge.
8 Medication	
8.34 Administration	Syringe driver prescribed on admission to manage symptoms. Patient did not receive medications in syringe driver. Patient was then agitated later that day and required PRN rescue medication to relieve symptoms. If syringe driver had been administered when prescribed it is likely that the patient would not have become distressed, negating the need for rescue medication to be administered, and for the patient to have a peaceful end of life in comfort. There is an SI with a similar theme so this case will be pulled together with that case.

Good practice themes identified as part of the review/investigation.

1 Assessment	
1.3 Assessment and management plan	Patient admitted from home for symptom management, which was addressed on admission with a clear plan.
3 Dignity & Compassion	
E3.8 Dignity & Compassion and Compassion & Attitude	This was a difficult case. Patient developed delirium post stroke. Must have been hard for team to observe. Particularly as patient was refusing to eat and drink. Very good care, psychological support was sought from In-reach. Family updated regularly.

DHM/MHSOP

Learning themes and issues identified as part of the review/investigation.

1. Assessment, Diagnosis & Plan	
1.1 Assessment and Assessment	Declined assessment – 10th May 2021 felt to have capacity – no capacity assessment noted or recorded. Alcohol dependence – referred for CBT, reference to Turning point in the notes in March 2019 and June 2020. The CAP Triage process is being reviewed in line with national guidance. SBAR already completed and there is a paper that will be going to the Quality & Safety Summit in January 23.
1.3 Assessment and Management Plan	Some gaps in follow up noted, however appears patient was not always welcoming of calls
2. Communication	
2.4 Communication and Results / Management / Discharge	Outpatient review in November 2020 identified follow up for 2 months' time, next review was September 2021. Communication from outpatients when reviews are not scheduled as planned could be communicated with the patient. To be taken forward with the transformation workstream. Part of the process will be looking at patient expectation and how we communicate with them if we are unable to meet appointments when advised.
3. Dignity & Compassion	
3.8 Dignity & compassion and Compassion / attitude	The Outpatient team did not show compassion to the son of the patient in a distressing time.
	No contact with the family however not clear if family were involved in this patient's care.
4. Discharge	
4.12 Discharge and Discharge Planning.	There were no mental health concerns so probably should have considered discharge. To be reviewed as part of the caseload review and discharge planning and arrange for the Discharge SOP to be included in the Locum Inductions so that they are aware of the thresholds for discharge.
5 Documentation - Paper & Electronic	
E5.13. Documentation and Correspondence with Patients/Other Clinical Teams	Lack of contact from MHF and CPN with each other. No care plans since 2020 Does not appear to be any communication with elderly father, who lived with patient and administered medication. Previous safeguarding concerns raised that father had lost his access to his motor scooter as Pt had crashed it intoxicated. Reflection with CPN will take place.
	Referral was seen and triaged on day of referral. Communication with GP advising of referral being placed on waiting list and potential for delay in allocation.

	Both patient and NoK did not receive letters and were not aware of assessments when arranged. No documentation of Follow up call on 17th August to make aware of appointment. Within the Communication template mentions that patient does not answer the phone due to cold calling scams. Advised to call 2-3 times in a row. There is no alert on SystmOne to make aware of this or handover to LPT services in regards to this.
	Correspondence to patient and NOK to ensure this is checked and appropriate. This has been fedback to Team Leader to have conversation and reflection with team.
	There was no regular contact with the patient from LPT and if deemed unnecessary due to patient's mental health being stable should the patient have been discharged from secondary care.
5.14. Clinical Documentation within Clinical Record	No evidence of any care plan or risk assessment being completed during the period of assessment. Whilst the lack of documentation has not directly impacted this death there needs to be a discussion with team lead re clinical documentation and ensuring needs and risk are fully captured.
	Whilst the lack of documentation has not directly impacted this death there needs to be a discussion with team lead re clinical documentation and ensuring needs and risk are fully captured.
	Risk summary and management of risk (risk assessment in ED didn't reflect risks management).
	Numerous physical health concerns, but communication between mental and physical health not robust. Discharge planning was identified on the 14th of October, but no documentation that this had been started or communicated. This has been picked up with CPN through Team Manager for City Central.
8 Medication	
8.21. Medication and Prescribing	A delay in the patient receiving memantine after it had initially been agreed in July. She didn't receive her first dose until October. Action: To consider ways to make the process more efficient e.g., if bloods required, organise for them to be taken when decision made to commence medication. Passed to In-Reach Team to review.
11 Appointments	
11.32 Appointments and Did not attend	DNA letters / opt in and further appointments. Action: Explore / check DNA process for those that miss appointments. This is covered in the updated DNA Policy which has just been reviewed and is awaiting sign off.
11.33 Appointments & Arrangements - e.g.	The patient had not been seen face to face by his CPN since the start of Covid. There is an expectation that once

chaperone, miscommunication	services are functioning as usual the patient would be seen face to face for some of the appointments.
14 Chronic Physical and Mental Health problems	
14.41 Chronic Physical and Mental Health Problems and Medications related to PH and/or MH	May need to improve staff knowledge around this subject through medicine's management training. Guidance notes on SystmOne to be reviewed and regarding training/possible email to staff.
	In 2011 patient was pre diabetic, their anti-psychotic medication was not changed or an alternative considered until November 2018.

FYPC/LD

Learning themes and issues identified as part of the review/investigation.

2 Communication – Patients & Relatives	
2.6. Communication – Patients & Relatives and Reasonable Adjustments	Whilst communication within the MDT was very good, the basic under-standing of what the risks were of not allowing / encouraging the patient to have Bloods, ultimately impacted on the longer-term management.
5 Documentation – Paper & Electronic	
5.13. Correspondence with Patients/Other Clinical Teams	Was on a routine waiting list for physio which, due to staff shortages and capacity. Approximately 10 month wait for mobility and transfers assessment. JBW to flag with Julia re deterioration whilst on waiting list. Action: LfD mtg 22/11/22. JR Diagnostic over shadowing was discussed as a potential theme although not LPT learning, there may have been opportunities missed around changes in mobility being put down to being due to their learning disability rather than physical heath.
	Although good practice has noted good information sharing system in place, it would be easier if acute team could see our records.
5.14. Documentation and Clinical Documentation within Clinical Record	It would have been beneficial to have been able to read UHL's notes to have a better understanding. There is a Trust-wide steering group already looking at better integration.
7 Multi-disciplinary Team Working	
C7.18 Multi-disciplinary working and Inter-speciality liaison/Continuity of care/ownership.	Action: No learning for LPT but agreed action to highlight that this gentleman was vulnerable to regular moves and because of all his health concerns, the real worry is that information is not well transferred from home to home and it happens so frequently. Shared with LeDeR Group via Siouxie Nelson & Rebecca Eccles.

Good practice themes identified as part of the review/investigation.

1 Assessment, Diagnosis & Plan	
1.1 Assessment and Assessment.	Baby received assessment by PHN HV during universal review and was correctly identified as having additional health needs, therefore placed onto UPP pathway and offered additional visits. The primary reason for additional visits was growth reviews. The baby was on a strict feeding plan (given by NNU team, not PHN HV) to ensure maintenance of blood sugars.
1.1 Assessment and Assessment plus 1.3. Assessment and Management plan.	Physical health prioritised. Learning disability team were extremely responsive, providing responsive care.
1.3. Assessment and Management plan.	Very detailed eating & drinking plan, good physiotherapy input and appropriate equipment in place.
	Patient had robust eating & drinking plan.
2 Communication – Patients & Relatives	
2.4 Communication and Results/Management/ Discharge plan.	Health Visitor called mother to arrange the contact within our guidance timeframe.
	Really good practice in terms of communication and assessments and recommendations.
2.5 Communication – Patients & Relatives and Imminence of death, DNACPR, Prognosis.	Excellent communication by Diana Service regrading understanding of end-of-life prognosis.
3 Dignity & Compassion	
3.8. Compassion / Attitude	Services were able to ensure the family got their wish regarding end-of-life care.
	Feedback from mum who felt that it was NHS care at its best that her son's needs were never discounted due to his learning disability, and all options were open to him.
	It is a testament to the team to ensure patient was able to stay out of hospital.
5 Documentation	
5.14 Documentation and Clinical Documentation within Clinical Record.	The PHN HV recorded details of each visit clearly on the S1 electronic health record, she also recorded an ongoing plan. The PHN HV followed the SOG.
	Tasks on SystmOne being used more consistently.
7 Multi-disciplinary Team Working	
7.18 Multi-disciplinary working and Inter-speciality	Learning disability team were aware to be careful about the accuracy of the information being given by the care home who, from experience, had a tendency to elaborate on information."

liaison/Continuity of care/ownership.	Really good collaborative practice around coordination between Physio, speech and language therapy, GP, the home and the community nurses and psychiatry. Holistically looking at ruling out all the possible causes of agitation before going down behaviour route.
	Health Visitor called the hospital to get an update from the nursing staff.
	Good liaison and have a good system in place between the acute team and speech and language therapy. Good information sharing system in place although it would be easier if acute team could see our records.
	Strong links between community and acute hospital team led to joined up care
	Diana Service had great communication with Rainbows and their staff in the hospital.
	Patient and SALT liaised with inpatient setting whilst Patient was in hospital. When patient was discharged under palliative care, Access took a call from the care home manager, contacted the involved PT who completed RFIs to OT and SALT. Each AHP team responded promptly to this referral; PT visited within 24 hours, OT visited the day after allocation, SALT telephoned to give advice the day after call to Access received.
	Really good collaborative practice around coordination between Physio, speech and language therapy, GP, the home and the community nurses and psychiatry. Holistically looking at ruling out all the possible causes of agitation before going down behaviour route.
7.19 Multi-disciplinary working and Inter-speciality referrals/review.	LPT assisted in identifying an alternative placement and engaged well with trying to find out what was going on because patient's health had deteriorated so rapidly. When discharged from hospital for EOL care, the Community LD Team continued to be involved in supporting and advising staff at the home.
9 Ceiling of Care	
9.25 Ceiling of Care and Monitoring.	Good monitoring.

Appendix 2: Learning and Good practice

Learning from Deaths Learning & Good Practice Themes Guidance

Cat	Theme & Sub theme code	Theme & Sub Themes	Theming Code Combos
	1	**Assessment, Diagnosis & Plan**	
C or E	1.1	Assessment	C11 C12 C13 E11 E12 E13
C	1.2	Diagnosis	
C or E	1.3	Management plan	
	2	**Communication – Patients & Relatives**	
C or E	2.4	Results/Management / Discharge Plan	C24 C25 C26 E24 E25 E26
E	2.5	Imminence of death, DNACPR, Prognosis	
C or E	2.6	Reasonable adjustments	
	3	**Dignity & Compassion**	
C or E	3.7	ADL Assistance/ Reasonable Adjustments	C37 C38 C39 E37 E38 E39
C or E	3.8	Compassion / Attitude	
C or E	3.9	Environment	
	4	**Discharge**	
C	4.10	F/up management plan	C410 C411 C412 E410 E411 E412
C or E	4.11	Equipment/POC	
C or E	4.12	Discharge Planning	
	5	**Documentation - Paper & Electronic**	
C or E	5.13	Correspondence – with patients, other clinical teams	C513 C514 C515 E513 E514 E515
C or E	5.14	Clinician documentation within the clinical record	
C or E	5.15	Completion of clinical forms i.e. DNACPR, Consent, Nursing Assessments	
	6	**Investigations / Results**	
C	6.16	Investigations	C616 C617 E616 E617
C	6.17	Results	
	7	**Multi-Disciplinary Working**	
C or E	7.18	Inter-speciality liaison/continuity of care/ownership	C718 C719 C720 E718 E719 E720
C or E	7.19	Inter-speciality referrals/review	
C or E	7.20	Inter team issues (within same specialty)	
	8	**Medication**	
C or E	8.21	Prescribing	C821 C822 C823 C824 E821 E822 E823 E824
C or E	8.22	Supply	
C or E	8.23	Administration	
C or E	8.24	Review	
	9	**Ceiling of Care**	
C or E	9.25	Monitoring	C925 C926 C927 E925 E926 E927
C or E	9.26	Recognition	
C or E	9.27	Escalation / Ceiling of Care	
	10	**Safeguarding**	
C or E	**10.28**	**Risk to themselves**	C1028 C1029 C1030 E1028 E1029 E1030
C or E	**10.29**	**Risk to others**	
C or E	**10.30**	**Known to safeguarding**	
C or E	**10.31**	**Safeguarding concerns and voids**	
	11	**Appointments**	
C or E	**11.32**	**Did not attend**	C1131 C1132
C or E	**11.33**	**Arrangements – e.g. chaperone, miscommunication**	

Cat	Theme & Sub theme code	Theme & Sub Themes	Theming Code Combos
	12	**Transfer & Handover**	
C or E	12.34	Delays to correct speciality/setting	C1233 C1234 E1233 E1234 C1235 E1235
C or E	12.35	Inappropriate Outlying / Transfer arrangements incl where pt not clinically fit for transfer, or inappropriate transfer arrangements to take into account level of acuity	
C or E	12.36	Omissions/Errors in Handover communication	
	13	**Self-harm**	
C or E	13.37	Drug and alcohol misuse	C1337, C1338 E1337, E1338
C or E	13.38	Physical self-harm: e.g. cutting, ligaturing, head banging	
	14	**Chronic physical and mental health problems**	
C or E	14.39	Unknown impact of PH on MH or vice versa	C1439, C1440, C1441 E1439, E1440, E1441
C or E	14.40	Mismanagement of both PH and MH including deterioration	
C or E	14.41	Medications related to PH and/or MH	
	15	**Isolation & loneliness**	
C or E	14.42	Recognition of the impact of isolation and loneliness	C1442, C1443, C1444 E1442, E1443, E1444
C or E	14.43	Lack of support	
C or E	14.44	Multi-agency support	

Abbreviations: C: Clinical care; **E:** End of Life; **ADL:** Activities of Daily Living; **POC:** Point of Care; **DNACPR:** Do Not Attempt Cardio Pulmonary Resuscitation

Version 1.1 – Updated 13/10/2022

Appendix 3 Theming guidance

1. Glossary

Category: Point of discussion is based on the clinical care (C) or end of life care of the patient (E).

Theme: The overarching general construct or feature associated with the care of the patient.

Sub-theme: Specific construct or feature associated with the care of the patient; stems from the theme.

Sub-theme codes: Number allocated to the sub-theme.

Theme code: Number allocated to the theme.

Theming code combos: Combination of the category (C or E) + Theme code (1-12) + Subtheme code (1-35).

2. The coding process

Information from each directorate is to be coded so that we can see which themes are prominent throughout the trust, highlight gaps in knowledge or practice, and have a streamlined way of learning, sharing, and acting on our Learning from Death process:

Coded learning impact and actions

Learning Code/Theme	Learning Impact	Learning Action
DMH		
C927: Clinical care, Monitoring, recognition & Escalation/Ceiling of Care.	-Void amongst support workers in escalating health concerns when patients not compliant with medications (physical and mental health).	-Educating support workers in escalating to medics/senior clinicians when abnormal physical health parameters.

P

Leicestershire Partnership NHS Trust

People and Culture Committee – 28 February 2023 12 noon-1300

Highlight Report

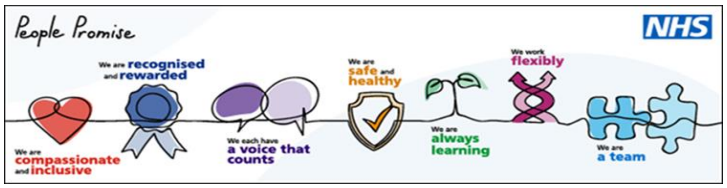
Strength of Assurance	Colour to use in 'Strength of Assurance' column below
Low	Red - there are significant gaps in assurance and/or not properly assured as to the adequacy of action plans/controls
Medium	Amber - there is reasonable level of assurance but some issues identified to be addressed.
High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

Agenda Item:	Assurance Level: Process and Action	Assurance Level: Impact	Committee escalation:	ORR Risk Reference:
Strategic Workforce Group (SWG)	Green	Amber	Issues escalated to the People and Culture committee were on the agenda and covered by the Workforce and Agency reduction plan assurance report – below.	
Organisational Risk Register (ORR)	Amber -need to confirm new committee considering appropriate ORR risks	Amber – two of current risks considered are red; one is outside appetite	The committee noted the mitigating action of a deep dive planned by SWG on sickness absence and the increased focus on mandatory training for bank staff and agency workers.	Risk 61 Risk 73 Risk 74
			The Committee also discussed two risks allocated to other level one committees: Risk 84 relating to the impact of a high vacancy rate (a red current risk) and Risk 85 relating to the impact of high agency use (a red current risk and outside risk appetite). Mitigating action for these risks was covered under the Workforce and Agency reduction plan- see below.	Risk 84 Risk 85
Policy Report	Amber- governance process to be adjusted	Amber	It was agreed this report needs to come via the SWG in future as difficult for a level one committee to assign responsibility and deadlines for policy updating. 10 Policies overdue for review at present but current policies still apply in the meantime.	

Agenda Item:	Assurance Level: Process and Action	Assurance Level: Impact	Committee escalation:	ORR Risk Reference:
Workforce and Agency Reduction Plan	Assurance was discussed under each workstream & target			
Agency Reduction: Stop off framework use Reduction in agency spend	Amber	Red	Committee welcomed further disaggregation of data including by hotspots and staff group so that assurance on impact of action can be more easily assessed/seen. Agreed different actions needed, to have greater impact. Green shoots on reduction but needs to be sustained over several months before confident assurance can be given. Each Directorate to have its own improvement plan so can track more specifically action and performance improvement and increase local ownership of plan.	Risk 85
Recruitment & Retention: Increase number of Health Care Assistants (HCAs) on bank Reduce trust vacancies	Amber	Amber	Plan for reducing admin and nursing support vacancies likely to be achieved by revised date of June/July. On track for achieving Registered Nurses short term target. Agreed need short- term and long- term creative strategy for consultant recruitment. Lack of resource in HR impacting on target to increase number of HCAs on bank.	Risk 84
Growth & Development: Improve Registered Nurse (RN) Retention	Green	Green	Committee was fully assured on RN retention action and impact. Consideration of action and impact on embedding use of new roles and discussion re skill mixing was delayed until the next meeting due to time constraints.	Risk 84 Risk 61
Transformation Committee Highlight report			This is a level two group reporting to Finance and Performance Committee. Agreed highlight report not needed for People and Culture Committee as agency reduction assurance data provided elsewhere.	
Staff Survey			To be considered at next	

Agenda Item:	Assurance Level: Process and Action	Assurance Level: Impact	Committee escalation:	ORR Risk Reference:
			committee	

Chair of Committee:	Ruth Marchington



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NHS
Leicestershire Partnership
NHS Trust

Trust Board 28th March 2023

People Plan – Refresh 2023 - 2025

This report is being presented to Trust Board members as the refreshed LPT People Plan.

Purpose of the Report

The purpose of this report is to provide awareness of the refreshed LPT People Plan which aligns with the NHS People plan under the 4 domains of:

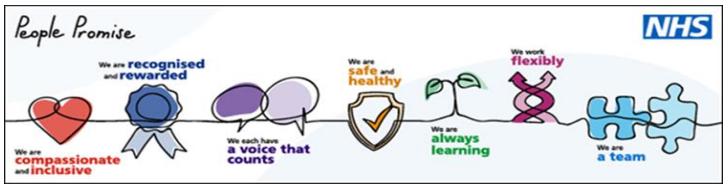
- **Looking after our people**
- **Belonging in the NHS**
- **New ways of working**
- **Growing for the future**

Our people plan and priority objectives set out within it have been identified in collaboration with our staff. We have incorporated staff survey feedback and the people promise exemplar programme actions. This report also provides the Health and Wellbeing Guardian Principles update as an attachment.

The Trust Wide Workforce, Recruitment and Agency Plan has been developed in conjunction with our people plan and people promise and sets out our ambition and plans to address the significant workforce challenges the Trust faces in particular the vacancy rate and agency use.

Assurance Approval

Trust board are asked to endorse the refreshed LPT people plan.



For Board and Board Committees:	Trust Board 28.3.23	
Paper sponsored by:	Sarah Willis, Director of HR & OD	
Paper authored by:	Sarah Willis Director of HR & OD	
Date submitted:	28th March 2023	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Strategic Executive Board	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e., assured/ partially assured / not assured:		
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Progress updates to SWG, PCC and Trust board 6 monthly	
STEP up to GREAT strategic alignment*:	High **S**tandards	
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	
	Reaching Out	
	Equality, Leadership, Culture	X
	Access to Services	
	Trust Wide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	61 73 74 84 85
Is the decision required consistent with LPT's risk appetite:	n/a	
False and misleading information (FOMI) considerations:	no	
Positive confirmation that the content does not risk the safety of patients or the public	No Risk	
Equality considerations:	Included	

Our People Plan and Promise 2023 - 2025

NHS
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NHS Trust

Our Future Our Way
Improving culture, leadership, inclusion

Our Approach

Our People Plan is developed through feedback from our Staff

- Staff Survey and quarterly Pulse Survey
- Freedom to Speak up feedback
- Our Future Our Way – Change Leaders
- Listening Sessions
- Staff Networks
- Health and wellbeing roadshows

It connects with our:

- Trust-wide strategy Step up to great
- Clinical Plan
- Financial Plan
- LLR System / NHS East Midlands Alliance and our Group
- NHS People Promise

Our leadership behaviours are:

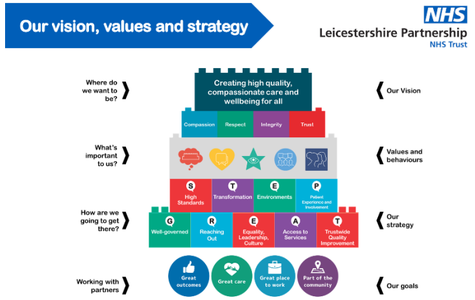
Valuing one another

Recognising and valuing people's differences

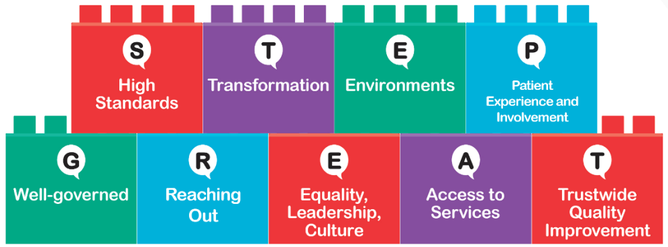
Working together

Taking personal responsibility

Always learning and improving



Feedback into Action



Our Future Our Way

Improving culture, leadership, inclusion

Introduction from our CEO and Directors

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

These high-level overarching themes are reflective of the national NHS People Plan and People Promise, as well as the ongoing feedback of our LPT family over the last year. They showcase the areas we will focus on, underpinned by programmes of work with measurable outcomes. This is an evolving plan, and will be updated as we move through the years to reflect the changing needs of our health and social care landscape.

Putting your feedback into action is paramount, and we are committed to continuing to listen, learn and support improvements through your involvement with the Our Future Our Way culture programme.

NHS People Plan People Promise

Looking after our people

We will make the NHS a better place to work by ensuring staff are safe and healthy, physically and mentally well and able to work flexibly

Belonging in the NHS

We will take action to ensure the NHS is inclusive and diverse a place where discrimination, violence and bullying do not occur

New ways of working and delivering care

We make effective use of the full range of our people's skills and experience

Growing for the future

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

People Plan - Our Actions

Delivery of the HWB Plan
Continue to support staff with their health and wellbeing

Financial wellbeing support
(co-ordinated by Cost-of-living Group)

Workforce agency reduction plan
Continue to maintain quality and patient safety by developing our workforce and reducing our reliance on agency

Medical Workforce strategy
Develop robust plan to enable growth, development and retention of trainees

Nurturing our volunteers
Continue to grow and nurture our volunteers as a part of our workforce, including training and development opportunities

Recruitment Marketing Plan
Focus on key areas of recruitment, through staff stories, campaigns, events and outreach activities

OD Offer and Line Manager Pathway refresh
Building inclusive, compassionate leadership

Looking after our people

Belonging in the **NHS**

Growing for **the future**

New ways of **working** and **delivering care**

LLR Active Bystander programme
Enable change through courageous conversations to address micro-aggressions and micro-incivilities

Together Against Racism – Group ambition
Acknowledge racism and discrimination exists and take action to tackle it together

Talent management and succession planning
To support career aspirations, put in place development opportunities and enable teams to create succession plans

Growing our own/new roles
Focus across system on career development, career progression, new roles for multidisciplinary working to provide the right capacity at the right time to deliver patient care

Deliver EDI Plan
Our data informed WRES and WRES action plans include reverse mentoring, cultural intelligence learning sets, mandatory diverse interview panels, and increasing listening activities.

Culture, leadership and inclusion programme
Co-design improvements in our culture – lead by our change leaders and supporting a speaking up and learning culture

Workforce planning
Embed structured workforce planning across the trust to ensure long term capacity and sustainability of workforce

People Promise exemplar
Flexible working and other interventions to improve retention

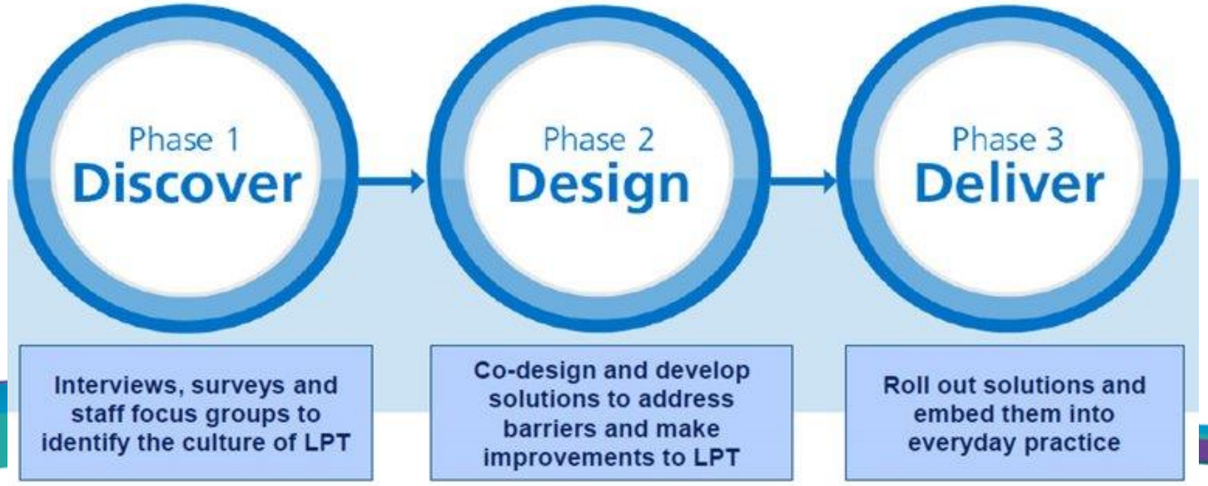
Improving Culture, Leadership and Inclusion with our Change Leaders

Our Future Our Way
Improving culture, leadership, inclusion

We will continue to co-design with our people improvements to our culture, inclusion and leadership in order to create high quality, compassionate care and wellbeing for all
We will continue to embed our Leadership Behaviours

Feedback into Action

- Focus Groups
- Staff networks
- Staff Survey
- Feedback Boxes / Road shows
- Freedom to Speak Up Guardians
- Co-design using QI methods



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Leicestershire Partnership NHS Trust

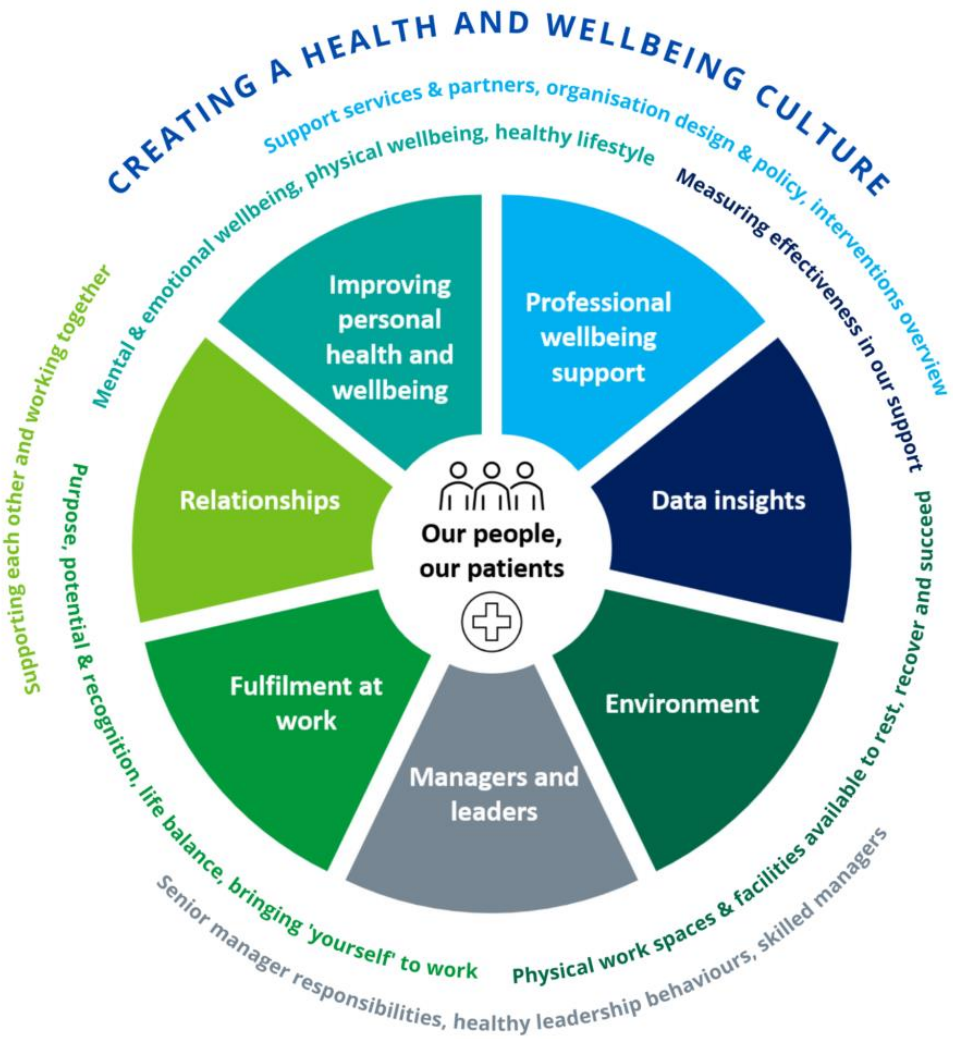
Trust Board 28 March 2023: The Health & Wellbeing Guardian (HWBG) 6 monthly report

Purpose of the report

In LPT we are striving for a culture of positive health and wellbeing (HWB) because this is critical for the recruitment and retention of our staff, and their everyday experience at work. We know that staff who are supported with their HWB will deliver high quality patient care. The role of the HWBG is to seek assurance on this objective and champion HWB at the Board.

Analysis

We are using the NHS England framework and diagnostic tool to develop high quality health and wellbeing interventions which will feature in our 2023 people plan. The framework will lead to a holistic assessment of wellbeing at LPT and highlight areas for development. The framework is shown below:



The table below highlights the 9 principles for the role of the HWBG and details the evidence to provide assurance on the work we are doing to support the HWB of our staff.

The 9 Principles	**LPT HWB support for staff (*and evidence of outcome measures*)**	**Actions in development**
1. The health and wellbeing of people working and learning in the NHS should not be compromised by the work they do	• The Board has a People Plan for LPT, 6 monthly progress report to Board. • Staff.Net includes HWB resources for staff and managers, which is regularly refreshed with new content. (*7,953 hits on HWB pages in last 6 months*) • Monthly roadshows to LPT sites, the HWBG has attended some roadshows. (*Feedback from over 500 staff. Actions implemented include: provision of a microwave; outdoor furniture for staff breaks; bitesize HWB videos, staff room furniture, invites to attend team meetings).* • Flexible working is actively promoted in all recruitment campaigns. *(2022 Staff survey score 7.0 which is above the average benchmark of 6.8 and an improvement of 0.1 since 2021)* • 40 HWB Champions are embedded in many teams across LPT and many of them are Our Future Our Way Change Leaders. There is a monthly champions meeting, the HWBG has attended meetings. (*2022 staff survey support for work/life balance is 6.9 which is above the average of 6.7 and an improvement of 0.2 since 2021)*	The NICE NG212 Mental wellbeing at work guidance has been evaluated to ensure compliance.
2. Where an individual or team has been exposed to a distressing event, the wellbeing impact on staff has been checked.	• Immediate support is offered locally and psychological support is offered as a follow up. • Following a Serious Incident there is a learning event held with members of the team • Serious Incidents are reviewed on a weekly basis *(and learning is evidenced in Board reports)* • Freedom to Speak Up Guardians (FTSUG) actively promote LPT's "safety first" culture encouraging staff to speak up. A report is presented to the Board on a 6-monthly basis with key themes. *(2022 Staff survey score 6.8 is in line with average)*	Schwartz rounds implementation in 2023 A Post-Incident staff support pathway is being developed by the Associate Director of Psychological Professions.

The 9 Principles	**LPT HWB support for staff (*and evidence of outcome measures*)**	**Actions in development**
3. Wellbeing conversations regularly take place, including at induction.	• HWB is included in our induction event. • Staff appraisals include a health and wellbeing conversation *(Appraisal completion rate Jan 2023 is 82.6%) (2022 Staff survey results score 5.2 which is above the average of 4.9 and an increase of 0.3 since 2021)*	HWB toolkit for managers to enable easy access to resources. HWB Lead training to run Making Every Contact Count sessions across LPT and LLR.
4. NHS staff will have access to self-refer to a proactive confidential Occupational Health service that promotes and protects wellbeing	• Occupational Health (OH) services, Amica, and our self-referral to Musculoskeletal services are all regularly promoted. • National strategy to grow our OH services in the NHS. HWB team meet regularly with HR & OH to target staff support • The LLR Mental Health Wellbeing Hub is available to all NHS and social care staff and usage is monitored	
5. The death by suicide of any member of staff will be independently examined and reported to the Board and HWBG	• The Suicide Prevention lead for the Trust has shared resources which are included in the HWB presentation and are available on Staff.Net • Suicide Prevention awareness training is mandatory for all staff. • Commitment that suicide of any NHS staff member whilst in employment would be independently reviewed. • Annual communication campaign to promote the HWB offer on suicide prevention awareness days. NHS wellbeing apps inc. Stay Alive, Shiny Mind and Headspace	.

The 9 Principles	**LPT HWB support for staff (*and evidence of outcome measures*)**	**Actions in development**
6. All NHS staff are in an environment that is both safe and supportive of their mental wellbeing	• Holistic assessment of the compassionate inclusive culture, (*2022 staff survey score of 7.1 compared to average of 7.2, compassionate leadership score of 7.5 compared to 7.4 average)* • LPT HWB calendar with a monthly HWB topic to support psychological and physical wellbeing - shared though our HWB Champions meetings, HWB communications and social media. • Wellbeing Wednesday lunchtime activity sessions: HWB Drop in, Mindfulness, Yoga, Pilates, Tai Chi. *(Wellbeing Wednesday uptake stands at 841 inc. live and recorded attendees in the last 6 months)* • Infection Prevention Control practices are embedded and audited across LPT (6 *monthly Board report*) • Covid and flu vaccinations are available to all staff *(Jan 2023 53.7% staff have had a flu jab)* • There is input from the Health & Safety Team to ensure safe environments*. (2022 staff survey score 5.5 which is below average of 5.7)* • The programme to upgrade staff rooms to a consistent standard across the trust has been completed in 2022 *(investment of >£100,000).*	
7. The NHS will ensure the cultural and spiritual needs of its staff are protected. It will ensure equitable and appropriate wellbeing support for overseas staff.	• Promotion and celebration of cultural and religious festivals with staff networks (*attendance of circa 50 staff per event)* • Overseas nurses pastoral care as part of their induction and settling in period, (*positive feedback received from all nurses*). • The HWB team links with the chaplaincy service and EDI team to raise awareness of spiritual wellbeing, signposting to culturally diverse resources e.g.- Liberate Meditation app, multi-faith prayer rooms. *(2022 Staff survey for diversity and inclusion score 8.5 which is above the average 8.3 and a 0.1 improvement on 2021)*	

The 9 Principles	**LPT HWB support for staff (*and evidence of outcome measures*)**	**Actions in development**
8. The NHS will ensure the wellbeing of and make the necessary adjustments for the nine groups protected under the Equality Act 2010	• The HWB team link with the EDI team to ensure regular promotion and signposting of HWB through staff support networks for REACH, LGBTQ+, Carers, Young voices, MAPLE (Mental & Physical Life Experience), Women's. There is Exec sponsorship of each group and HWBG support. • The nine protected characterises are part of the HWB events, inc. neurodiversity week and international women's day • Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) have action plans and measurable targets*. (2022 Staff survey for diversity and inclusion score 8.5 which is above the average 8.3 and a 0.1 improvement on 2021)* • Developing a women's health pathway to support the mental, emotional and physical health of staff experiencing menopausal symptoms. HWBG has oversight role in task and finish group.	The Equality Delivery System (EDS) 2022 is being reviewed with the EDI team to ensure compliance of the agreed domains.
9. The wellbeing guardian will appropriately challenge the board to ensure that the same weight is given to wellbeing as to other aspects of organisational performance.	• The HWBG uses the 6-monthly People Plan progress report and NHSE 9 principles to hold the Board to account and seek assurance on delivery of HWB actions and outcomes. • The HWB of staff is a strategic theme in conversations at Board meetings, evidenced in the minutes. *(2022 Staff survey burnout score of 5.2 which is in line with the average, an improvement of 0.2 on 2021)*	The HWB Board pledges will be shared through Trust-wide communications in 2023/24.

Decision required:

The Board is asked to receive evidence of the HWB support given to staff and related outcomes for assurance purposes against the 9 principles, and identify any gaps in provision.

Governance table

For Board and Board Committees:	Trust Board 28 March 2023	
Paper sponsored by:	Cathy Ellis Health & Wellbeing Guardian	
Paper authored by:	Cathy Ellis Health & Wellbeing Guardian	
Date submitted:	17 March 2023	
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 at public board meeting every 6 months	
STEP up to GREAT strategic alignment*:	High Standards	
	Transformation	
	Environments	
	Patient Involvement	
	Well Governed	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:	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 health and wellbeing	

Leicestershire Partnership NHS Trust

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Public Trust Board - 28 March 2023

Six-month Safe and Effective Staffing review- July 2022- December 2022

The purpose of the report is to provide a six-month overview of nursing safe staffing including right staff, right skills, right place; establishment reviews, workforce planning, new and developing roles and recruitment and retention in line with NHS Improvement (NHSI) *Developing Workforce Safeguards policy* 1.

Summary

- In December the vacancy rate overall for registered nursing (RN) and registered health visiting staff is 21.8% and has reduced by 1.2% from June 2022. Trust-wide recruitment projects continue to work towards addressing the deficits as part of overarching workforce planning.
- Average CHPPD for inpatient areas across July 2022 to December 2022 was 11.4 a small reduction from the previous 6 month reporting at 12.2 CHPPD. It is noted that at 11.4 CHPPD this remains above average (compared to peer median of 10.7 and national average of 10.3) predominantly due to high acuity areas with a higher than average staff to patient ratio such as the Agnes Unit.
- There is an increase in RN fill rate on days overall and a reduction in fill rate for both RNs and HCSW on nights. Planned safe staffing levels were maintained, fill rate variation is reflected in response to increased ward activity, occupied beds and patient complexity.
- On average 43.21% of all planned shifts were filled by temporary staff, a reduction from the previous six months by 1.05%. Of the temporary worker utilisation, the average percentage filled by agency staff is 22.53% an increase from the last six months by 0.52%. Temporary worker demand increases closer to the start of the shift. The highest volume of shifts sent to Centralised Staffing Solutions (CSS) is to meet planned staffing due to vacancies, followed by patient acuity and last minute sickness and cancellations.
- Agency Reduction Group is meeting every 2 weeks, current focus on eliminating off-framework use and improving rostering performance.

- Triangulation of complaints and nurse sensitive indicators with planned versus actual staffing has not identified any direct correlation between staffing levels and the impact on quality and safety of patient care. However, we have identified some correlation of impact of staffing skill mix and competencies as a contributory factor in some serious incident and incident reviews.
- The key high-level themes from the incidents are linked to the deteriorating patient and NEWS escalation, mental health observations and pressure ulcer risk assessment and prevention, there are specific Trust groups working on improvement plans and new group collaboratives established with NHFT led by our group director for patient safety and deputy directors of nursing and quality specific to these three areas.
- Key Actions: NHS Winter 2022 preparedness: Nursing and Midwifery safer staffing Board Assurance Framework, November 2022, version 2 focuses on preparedness, decision making and escalation processes to support safer nursing in line with NQB workforce standards. Executive Directors of Nursing in all Trusts are expected to work with their Board and with their respective, ICB to align system approaches to workforce planning and consider whether system level solutions are appropriate. In response the Trust has revised and updated winter staffing board assurance framework and identified no additions to the KLOE, detailing the evidence to provide assurance.
- Triangulated nursing staff establishment reviews for annual resetting of safe staffing were presented to the Strategic Executive Board (SEB) on 3 February 2023. SEB have asked for additional work to be undertaken in relation to supplementary roles proposed to support safe staffing.
- The Trust-wide staffing and safety huddle continues to meet weekly to review staffing forecast through a safety lens.
- Completion of the NHS England Nursing and Midwifery Retention self-assessment has identified three priority areas: flexible working, pride and meaningful recognition, and professional development and careers.
- The health and well-being of all our staff remain a key priority. The Trust continues to support staff mental and physical health through referrals, signposting, communications, health and wellbeing champions, and access to available resources.

Background

All NHS Trusts are required to deploy sufficient, suitably qualified, competent, skilled, and experienced staff to meet care and treatment needs safely and effectively, National Quality Board (NQB), *Safe sustainable and productive staffing* 2.

The previous six month safe and effective staffing report was presented to Trust Board on 27 September 2022. The monthly Trust safe staffing reports provide a triangulated overview of nursing safe staffing for our in-patient areas and community teams. The report includes actual staffing against planned staffing (fill rates), Care Hours Per Patient Day (CHPPD) and quality and safety outcomes for patients sensitive to nurse staffing.

In responding to winter planning, surge and escalation plans were reviewed, decisions regarding service prioritisation, skill mix, and nurse ratios were taken in conjunction with a review of patient acuity and dependency, professional judgement, and the environment of care. Proposals for redeployment and surge/escalation plans were revised and connected to the ICB wider system, governed through the Trust winter planning committee.

Analysis of the issue

Trust overview - 'Right staff, Right Skills, Right Place'

Right Staff

The overall trust-wide summary of % of fill rate actual versus total planned shifts by registered nurses (RN) and health care support workers (HCSW) in the last six months is detailed in the table below.

	DAY		NIGHT	
Trust wide	% actual vs total planned shifts RN	% actual vs total planned shifts care HCSW	% actual vs total planned shifts RN	% actual vs total planned shifts care HCSW
July-22	88.3%	115.7%	103.6%	151.9%
Aug-22	98.3%	120.0%	106.5%	139.0%

Sep-22	101.5%	123.7%	108.8%	144.5%
Oct-22	99.3%	125.4%	109.7%	149.6%
Nov-22	102.6%	125.9%	109.7%	148.6%
Dec-22	104.7%	127.6%	108.8%	140.9%
Average	**99.0%**	**123.0%**	**107.8%**	**145.7%**

There is an increase in RN fill rate on days overall and a reduction in fill rate for both RNs and HCSW on nights. Planned safe staffing levels were maintained, fill rate variation is reflected in response to increased ward activity, occupied beds and patient complexity.

Exception reporting is provided within the Trust monthly safe staffing report per Ward/Unit and by Directorate.

Community Health Services (CHS)

Community Hospitals have reported operating at an amber risk overall for the last six months. Areas to note where actual RN staffing levels did not consistently meet RN planned fill rates on day shifts above 80% were Beechwood, Rutland, Clarendon, North Ward and Snibston wards. These areas are utilising above 30% temporary workforce to meet planned staffing and respond to increased patient acuity. Daily staffing reviews take place and staff deployed to ensure substantive RN cover across the shifts and in response to rising acuity and dependency.

CHS opened an additional 15 bedded surge ward at Coalville Hospital to support patients medically optimised for discharge awaiting packages of care/ transfer to care homes. To date, full occupancy has not been met and the service is reviewing options to reconfigure the ward for mixed-sex accommodation to support flow in the system. An additional 5 beds were opened on East Ward in December 2022 too.

CHS community continues with an overall OPEL rating level 3 and action level 3/4 due to increased patient acuity, increased caseloads, and high levels of vacancies and absence. Essential visits have been maintained throughout and reprioritisation of assessments, visits,

and workload is undertaken daily with oversight from community matrons. Key areas to note are City Hubs and Hinckley Hubs impacted because of staff vacancies. Community services utilise a temporary workforce where staff have the skills and competencies to provide safe care.

Directorate of Mental Health (DMH)

DMH in-patient wards utilise a high percentage of temporary workforce on all wards to meet planned safe staffing levels due to higher numbers of vacancies and increased patient acuity and levels of observations required for patient safety. There are key ward areas to note; Ashby, Beaumont, Belvoir, Watermead, and Griffin Ward utilising above 55% temporary workforce.

Areas to note where actual RN fill rates did not consistently meet planned RN levels are Kirby, Welford, and Coleman Wards in Mental Health Services for Older People. with fill rates falling to 49.4% on Coleman. These Wards have Medication Administration Assistants and Nursing Associates as part of their planned staffing and skill mix and these roles are not reflected in the planned staffing fill rates, reported by exception.

Increased above-average CHPPD was evident in Griffin, Gwendolen, Coleman, and Mill Lodge as a direct result of greater acuity and dependency, necessitating a higher ratio of nursing staff to maintain the safety of patients and staff.

DMH community services continue to have RMN vacancies across the peri-natal mental health team, primary mental health, and crisis mental health team. Retention and recruitment plans continue to be prioritised and services are utilising temporary workforce known to service with the appropriate competence to deliver care with re-prioritisation of patient assessments to manage caseloads.

Medic vacancies remain high for psychology and psychiatry and the services have not seen an improvement over the last twelve months. Waiting times, response times, and assessments are impacted as a direct result, and assessments are reprioritised in response.

Families Younger People Children (FYPC) /Learning Disabilities (LD)

The Beacon and Agnes Unit inpatient areas continue with high utilisation of temporary workforce impacting on continuity of care. The units continue to staff most night shifts with the required level of RN's to HCSW ratio for 7-9 patients, a mix of substantive and temporary registered staff. Recruitment to vacant posts at band 5 and band 2 continues, progressing although remains challenging and is reflective of the national picture.

Psychology and Therapy vacancies continue to be areas to note across FYPC/LD reflective of the national picture and recruitment/ retention actions continue including recruitment to alternative posts such as Therapy Assistants and Positive Behaviour Leads. Learning disabilities community physiotherapy is rated amber, and the team continue to assess and treat all red and amber RAG-rated referrals. Recruitment process is ongoing as there are challenges across all community services in recruiting qualified and support staff into vacancies.

Public Health Nursing- Healthy Together continue with an increase in vacancies across the County reflective of the age profile of the service and staff retirement in addition to reduced numbers of Specialist Community Public Health Nurses nationally. The service is working to a prioritised model of delivery and redeployment of staff across the locality in response. Looked after Children's team is operating at a high-risk level due continued high vacancy level over the last twelve months. Recruitment to several RN posts will increase the service provision and it is anticipated that the risk level will reduce.

Right Skills

Mandatory and Role-Essential Training:

- Core mandatory and clinical compliance scores demonstrate significant improvement month on month.
- Safeguarding Adults Level 3 is a new subject and will be rolled out to Band 6 & 7 initially.
- There is sufficient capacity on all courses to provide face-to-face training. Spaces for Basic Life Support in hospitals are good, and for Immediate Life Support, there is low compliance but good capacity.

- LD & Autism training Part A is now available for all staff as part of the role essential training package, Part B – Living with LD & Autism will be available in six months' time.

Correct to 1st December 2022 Trust-wide substantive staff compliance with core mandatory training is 91.6% against a target of 85%. Mandatory training compliance for bank-only nursing staff is 81.3%. Work continues to ensure active bank staff is compliant with mandatory training and booking shifts is enabled only for staff who are compliant.

Area to note;

Resuscitation training is a mandatory training requirement for all clinical (registered and non-registered) staff. Options for delivery of Level 1 resuscitation training have been proposed for all non-clinical staff in line with the standards set in the Core Skills Training Framework (CSTF) and ensure that Leicestershire Partnership (LPT) NHS Trust remains fully aligned with the training standards. The determination of which resuscitation training each staff requires is identified in the national core skills training framework. All training in the Trust is accredited by the UK Resus Council. There are two forms of resus delivered: Basic Life Support; and Immediate Life Support.

Basic Life Support (BLS):

Compliance substantive staff as of 1 December 2022-**86.8**% (Green, trending up)

Compliance for bank staff as of 1 December 2022- **63.5**% (Red, trending up)

Immediate Life Support (ILS):

Compliance substantive staff as of 1 December 2022- **82.2**% (Amber, trending up)

Compliance for bank staff as1 December 2022 - **58.1**% (Red, trending down)

Right Place

Care Hours Per Patient Per Day

Care Hours Per Patient Day (CHPPD) is a measure of workforce that is most useful at ward level to compare workforce deployment over time, with similar wards in the trust or at other

trusts. This measure should be used alongside clinical quality and safety outcome measures to reduce unwarranted variation and support delivery of high quality, efficient patient care.

CHPPD is calculated by adding the hours of registered nurses to the hours of healthcare support workers and dividing the total by every 24 hours of in-patient admissions (approximating 24 patient hours by counts of patients at midnight).

The Trust CHPPD average (including ward based AHPs) is reported at 11.4 CHPPD. General variation reflects the diversity of services, complex and specialist care provided across the Trust. Analysis has not identified significant variation at the service level; indicating that staff are being deployed productively across services. It should be noted that the Trust monthly CHPPD reporting includes ward based AHPs and nurses.

- Provider value = 11.4 above average (partners in region= 10.6 NHFT and Notts 10.5)
- Peer median =10.7
- National median= 10.3

Factors impacting results include the health roster needs to ensure it accurately differentiates supervisory clinical hours and actual hours.

Factors impacting CHPPD: acuity levels- constant change, staff sickness and absence above average- reconfiguration of wards/ line of sight, experience, and skill of the ward team on duty, high utilisation of temporary workforce who may not know the ward environment.

Measures to monitor the impact of staffing on quality

NQB guidance suggests drawing on measures of quality alongside care hours per patient day (CHPPD) to understand how staffing may affect the quality of care. Suggested indicators include patient and staff feedback, completion of key clinical processes – NEWS, observations, VTE risk assessments, medication omissions, patient harms including pressure ulcer prevalence and in-patient falls and learning from patient safety investigations and serious incidents. These measures are best considered as 'balancing measures' where the impact of any workforce changes may become visible, they are not intended to include all aspects of quality, other indicators will be needed to provide a rounded view of the overall quality.

Triangulation of complaints and nurse sensitive indicators with planned versus actual staffing has not identified any direct correlation between staffing levels and the impact on quality and safety of patient care. We are starting to see correlation of impact of staffing skill mix and competencies as a contributory factor in some serious incident and incident reviews. The key high-level themes are linked to deteriorating patient and NEWS escalation, mental health observations and pressure ulcer risk assessment and prevention, there are specific Trust groups working on improvement plans and new group collaboratives established with NHFT led by our Group Director for Patient Safety and Deputy Directors of Nursing and Quality specific to these three areas.

Staffing and safety and incident reviews have identified that as workload, acuity and dependency increases with mitigating actions such as re-prioritisation of visits, step down of non-clinical activities, review of training, movement of staff and increased reliance on agency workers there is an impact on role essential training, equipment training such as use of Flat Lift equipment, timeliness of care plan and risk assessment updates and challenges with clinical continuity and oversight of standards. Senior clinicians and leaders are working every day to minimise and mitigate these risks however it is important to note this reality in practice and impact to patient and staff experience.

Establishment reviews- Inpatient Wards

The annual nursing staff establishment reviews for safe staffing have been completed across all inpatient areas using a triangulated methodology using national evidence based tools; Safer Nursing Care Tool (for adult inpatient wards in community hospitals), Mental Health Optimal Staffing Tool (for adult inpatient Mental Health hospitals), Learning Disability Optimal Staffing Tool (Learning Disability Inpatient Units), professional judgement and patient outcomes.

To note, this is the first formal Trust annual establishment review using the aforementioned methodology. Due to the pandemic response annual re-setting was paused. In responding to Covid-19 staffing surge and escalation plans, decisions regarding skill mix and nurse ratios

were taken in conjunction with a review of patient acuity and dependency, professional judgement and the environment of care.

Triangulated establishment reviews for annual resetting were presented to the Strategic Executive Board (SEB) on 3 February 2023. SEB have asked for additional work to be undertaken in relation to skill-mixing and supplementary roles proposed to support safe staffing.

Workforce planning

Workforce Planning

Effective workforce planning is vital to ensure appropriate levels of skills of staff are available to deliver safe, high-quality care to patients and service users. It comes as part of the CQC regulations, but fundamentally is at the heart of the trust committed to ensuring that we are providing safe care for our patients and service users.

Head of Workforce Transformation and Planning is working with directorate operational and professional leads to update the workforce plans. These plans will incorporate the workforce implications of the establishment reviews, profiling and forecasting to fill any new roles. Impact to finance, recruitment, learning and development and where there is a proposal to introduce a new role, the 'Skill Mix Proposal Pack' process will be completed to ensure the correct governance and equality, quality, and impact assessment.

Electronic Rostering

LPT uses Allocate HealthRoster to manage the planning and deployment of substantive, bank and agency staff for around one third of the Trust. All inpatient wards use HealthRoster as well as some community teams. Using recommendation from the Carter Review, the focus is supporting services to make the best use of substantive staff time by:

- Improving timeliness of rosters being published, this lead time has been adjusted to 12 weeks. This means rosters should be made available to staff with 12 weeks' notice.
- Reducing unused hours (hours staff have been paid for but not yet worked)

- Reducing accrued time off in lieu (TOIL) (hours that have been worked but not paid for)
- Effective planning of annual leave to avoid pressure points at certain times of the year

Detailed reports on rostering effectiveness are provided to services each month to measure the impact of different initiatives and to help identify areas for improvement.

There are several units which have made great progress with rostering twelve weeks in advance. The eRostering dashboard is reviewed and shared with directorates prior to commencement of the roster period. Services are supported by a SOP to support resolution of unused hours and how to use the system effectively. Roster reviews are completed with roster managers to cleanse, resolve and train managers on effective use of HealthRoster. A face to face HealthRoster training course has been developed, it runs monthly, is for a half a day, is suited to all types of experience ranging from a new starter to a refresher through to advanced and is available to be booked via uLearn.

Safe care

The Trust has procured Allocate SafeCare which integrates fully with HealthRoster and offers the ability to monitor actual patient demand at key points during the day and accurately align staffing to match. The objective data identifying actual staffing requirement also helps avoid habitual temporary staff use and allow informed decision making as to when temporary staff are required. The user interface is accessible and easy to use and provides live user-friendly dashboard reporting.

SafeCare also has a positive impact on improving accuracy of rosters through contemporaneous updating of changes which further informs decision making and visibility. The net result of the above is an improved utilisation of substantive staff and reduction in temporary staff requirement. LPT will commence a pilot use of SafeCare at the Bradgate Unit early February 2023. A paper will be sent to the executive team to detail the pilot and learning from it.

Allocate (the system suppliers) have been in long standing conversations with Imperial Innovations about using their evidenced based tools within SafeCare and have now reached

an agreement which comes with a reoccurring cost. This has been approved and further work is required to embed the system into daily operation.

Weekly Staffing and Safety Huddles

The weekly Trust safe staffing cell huddle continues to review staffing areas to note under planned levels (shift and staff required), quality and safety issues, red flags to note and monitoring of real time staffing levels. There is a continued focus on e-roster practice, temporary workforce usage and ongoing review of areas where off framework agency use is high. The staffing huddle increases in frequency in response to safe staffing escalation and prior to periods of public and school holidays to ensure staffing remains safe and effective.

Recruitment and Retention

International Nurse Recruitment

The Trust has recruited a total of 52 International Nurses since November 2021.

The IRN lead recently visited the Republic of Ireland to explore opportunities for opening additional pipelines to recruit overseas nurses. Conversations took place with Atlantic Technological University student nurses (mental health, learning disabilities, and physical health adult nurses). This is a longer-term investment, and initial scoping suggests the opportunity to recruit to 4 MH, 2 LD and up to 5 Adult Nurses however there are restrictions in place until September 2023.

There was no onboarding of IRN in December 2022 as the next onboarding will take place in January 2023 with 1 MH Nurse committing to coming to LPT. In preparation for supporting IRN into Mental Health, LPT has supported an MH OSCE trainer to complete the 'train the trainer' programme and this will enable MH candidate with the OSCE test due in January 2023. Collaborative working continues with UHL.

Healthcare Support Workers Zero Vacancy ambition

Healthcare support workers (HCSWs) are an integral part of our clinical teams, and the Trust continues to work with NHS England (NHSE) through a programme of direct support and actions to progress recruitment, onboarding, retention and supporting HCSWs new to the role.

Turnover for HCSWs is consistent at 10% and the increase in vacancies is not related to the number of leavers. The vacancy rate has reduced from 23.5% to 19.7% in November 2022 (reduction of 3.8% / 46wte). Vacancy rates to date are 169.7 WTE with FYPC/LD demonstrating the largest proportion of HCSWs (band 3) in Healthy Together Public Health Nursing.

The Trust continues to progress with plans to recruit and grow our own. Headlines and ongoing actions include:

- Appointing Onboarding Officers whose role is to provide practical support to recruiting managers
- Implementation of monthly HCSWs interview centres enabling shortlisting and ID checks to be undertaken promptly- 28 interview slots per month
- Reducing the amount of time taken to undertake recruitment checks
- Two induction sessions per month with 96 spaces
- A process to enable workforce bureau bank staff to take on substantive roles in LPT has been developed
- Each clinical directorate has a working group to plan and monitor HCSW recruitment

Career development pathways have been enhanced to enable HCSWs to grow their careers in LPT with the expansion of expanding our training to professional roles to external candidates and supporting quality candidates in training programmes. The Talent for Care programme and soft skills course is available to all existing HCSWs supporting the development of nursing careers.

Registered Nurses

Challenges continue across all three Directorates to recruit to RN vacancies in line with the National shortage. The current vacancy rate is 21.8% and remains high despite a slight reduction of 1.2% since June 2022.

Staff group	Budgeted establishment (fte)	Actual staff in post (fte)	Vacancies (fte)	Vacancy rate (%)
Registered nursing, midwifery and health visiting staff	**1926.5**	**1506.5**	**420.0**	21.8%

Progress continues by participating in the People Promise Exemplar scheme which started April 2022, and having a dedicated People Promise Manager who is focusing on retention and working with system colleagues/regional/national NHSE/I teams to review existing retention approaches and develop further activity**.**

In July 2022, NHS England Ruth May, Chief Nursing Officer (CNO) outlined two important principles to support the retention of nurses and midwives, namely:

- Targeted intervention for different career stages, early career, experience at work and late career
- A bundle approach to deliver sustained gains, including 5 high impact actions; complete a retention self-assessment, implement national preceptorship framework, implement legacy mentoring schemes, encourage and promote flexible retirement and develop a menopause policy.

Completion of the NHS England Nursing and Midwifery Retention self-assessment has identified three priority areas: flexible working, pride and meaningful recognition, and professional development and careers. Our plan is due to be presented to the Strategic Workforce Committee outlining our key actions to achieve self-assessment and high impact actions, which includes:

- The implementation of the national Preceptorship Framework Trust-wide
- Refreshing and updating the Career Development Framework from volunteer to Director of Nursing, AHPs and Quality
- The launch of the DAISY award scheme for extraordinary nurses for pride and meaningful recognition and flexible working Trust-wide

Professional Nurse Advocates

The Trust continues to grow the number of Professional Nurse Advocates (PNAs), equipping RN with the skills to listen and support staff through restorative supervision, career conversations and thematic quality improvements.

Health Education England funded additional training places to support all Trusts to reach the trajectory of one trained PNA for every 20 RNs. This offer has become an integral part of the Trust's health and well-being offer for all staff. A central database shows the number of PNAs per cohort and a working group meets monthly to progress actions in adherence to NHSE PNA programme, overseen by the PNA strategic working group. Numbers of qualified PNAs and trainees in the pipeline continues to grow and there is a work plan in place to progress the project and maximise the impact across clinical services.

		Staff by directorate			
PNA pipeline	No. of staff	CHS	FYPC/LD	DMH	Enabling
Qualified PNAs	9	4	5	0	0
Cohort 4	8 (currently in training)	2	3	3	0
Cohort 5	9 (Jan/Feb 2023)	0	1	8	0
Cohort 6	9 (start dates TBC)	0	1	7	1
Total	35	6	10	18	1

Nursing Associates

The nursing associate role was created to bridge the gap between unregistered healthcare support workers and registered nurses – creating a further entry point into registered nurse training – and to provide additional support in clinical practice. The role helps provide high quality person-centred care. Training is a two year programme with a two year top up to become NMC (Nursing & Midwifery Council) Registered Nurses.

There are currently 21.5 wte (23 headcount) Registered Nursing Associates working in clinical areas with a further 20.6 wte (22 headcount) currently training with 17 wte due to complete in February and September 2023. A grow our own nursing campaign commences in January 2023, the system is also looking at recruit to train options too to widen access.

Registered Nurse Degree Apprenticeship

Registered Nurse Degree Apprenticeship (RNDA) supports employers to develop their healthcare workforce to become NMC (Nursing & Midwifery Council) Registered Nurses in the fields of Adult, Children and Young People, Learning Disabilities or Mental Health nursing over a four year programme.

There are currently 28 staff on the programme: 9 in adult, 4 child, 9 mental health and 5 learning disability fields of practice due to complete in May and June 2023. Currently recruiting to 5 available RNDA posts with 6 applications.

Decision required

The Trust Board is asked to confirm a level of assurance considering the report.

References

1. NHS Improvement (October 2018) Developing Workforce Safeguards Supporting providers to deliver high quality care through safe and effective staffing.

2. National Quality Board (July 2016): Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time. Safe sustainable and productive staffing.

For Board and Board Committees:	Trust Board 28.3.23	
Paper sponsored by:	Anne Scott, Executive Director of Nursing, AHPs and Quality	
Paper authored by:	Emma Wallis Deputy Director of Nursing and Quality	
Date submitted:	08.03.22	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	Quality Assurance Committee 14.02.23 Amber assurance	
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	Six Monthly report	
STEP up to GREAT strategic alignment*:	High **S**tandards	√
	Transformation	
	Environments	
	Patient Involvement	
	Well **G**overned	√
	Single Patient **R**ecord	
	Equality, Leadership, Culture	
	Access to Services	
	Trust wide Quality Improvement	
Organisational Risk Register considerations:	List risk number and title of risk	1: Deliver Harm Free Care 4: Services unable to meet safe staffing requirements
Is the decision required consistent with LPT's risk appetite:	Yes	
False and misleading information (FOMI) considerations:	None	
Positive confirmation that the content does not risk the safety of patients or the public	Yes	
Equality considerations:		

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Leicestershire Partnership NHS Trust

FPC – 28th February 2023

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 Strategy and Partnerships Update - verbal	NA	Verbal update given to Committee.	64
Director of Finance Update - verbal	NA	Verbal update given to Committee	81, 85
Finance Report Month 10 – Paper C	High	The committee received high assurance about the current financial position as the trust is reporting a £2.6m deficit in month 10 against an agreed year-end forecast of £2.9m adverse. All directorates remain focused on delivering the year-end financial plan and agency spending continues to be carefully tracked. The capital spend remains on track. FPC noted the change from previous reporting of low levels of assurance in previous updates.	81, 85
Capital Management Committee Highlight Reports 11 January and 8 February 2023 – Paper D	High	A high level of assurance was received from the Capital Management Committee Highlight report.	81
Business Pipeline – Bids and Tenders Update – Paper E	High	Leicester partnership & Northants Healthcare Group has been selected as one of only nine participants in the new national provider collaborator Innovators Scheme. The boards have been informed and have discussed this at the recent board workshops.	64
Performance	Medium	Performance remains stable.	69, 72, 75

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
Report Month 10 – Paper F		Directorate of Mental Health is stable this month and the narrative has been updated in all areas. In the directorate of Community health upward performance trajectories are evident and anticipated into next month and beyond. Continence services continue with improvement work. FYPC & LD all metrics are showing improvement apart from audiology which has fallen behind target - increased clinic capacity has been put in place to support. CAMHS is on an upward trajectory, with areas needing improvement being dependent on investment cases in progress. It was noted that neurodevelopmental waits were affecting both CAMHS and community paediatrics.	
CFO – Strategic Estates Update - verbal	NA	Verbal update given to Committee	66
The Green Plan – Update on Progress - verbal	NA	Verbal update given to Committee	67
Estates and Medical Equipment Committee Highlight Report 14 December 2023 and 18 January 2023 – Paper G	High	The Committee agreed a high level of assurance was received from the report.	66, 87
Organisational Risk Register – Paper H	High	There have not been any significant changes for the FPC risks this month. It was agreed further discussions around risk 72 were needed for clarity. Risk 69 remains under review.	All
FPC Terms of Reference and Work Plan Review – Paper I	High	N/A	All
Policy Report – Paper J	NA	Discussions were held around overdue policies detailed in the report. The Policy Committee will contact the relevant subcommittees asking for clear recovery plans.	All
Transformation and Quality Improvement Delivery Group 13 December 2022,	High	A high level of assurance was received from the Transformation and Quality Improvement Delivery Group report.	64, 66, 72

Agenda Item:	Assurance level:	Committee escalation:	ORR Risk Reference:
10 January and 14 February 2023 – Paper K			
IM&T Committee December 2022 and 13 January 2023 – Paper L	High	There were no risks to raise with the Committee.	79
Data Privacy Committee 6 December 2022 and 10 January 2023 – Paper M	High	The low assurance item detailed in the report have been mitigated by the team and therefore a high level of assurance was taken.	68, 79
Date and Time of Next Meeting: 25 April 2023 -2.00 – 4.00 pm via Microsoft Teams			

Chair of Committee:	Alexander Carpenter

Leicestershire Partnership NHS
NHS Trust

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Month 11 Trust Finance Report

Purpose of the Report

- To provide an update on the Trust financial position.

Proposal

- Trust Board is recommended to review the summary financial position and accept the reported year to date financial performance.

Decision required: N/A

Governance table

For Board and Board Committees:	Trust Board 28th March 2023	
Paper sponsored by:	Sharon Murphy, Director of Finance & Performance	
Paper authored by:	Chris Poyser, Head of Corporate Finance Jackie Moore, Financial Controller	
Date submitted:	22/03/2023	
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 Management 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	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).

Finance Report for the period ended **28 February 2023**

For presentation at the **Trust Board** **28 March 2023**

Contents

Executive Summary and overall performance against targets

1. This report presents the financial position for the period ended 28 February 2023 (Month 11). A net income and expenditure deficit of £2.8m is reported for the period. This is an adverse variance of £2.5m from the planned YTD deficit of £0.3m.

2. The February YTD I&E deficit (compared to January) worsened by £162k. Whilst the YTD position has deteriorated, this is a significant improvement on the previous trend, and reflects the additional mitigations and recovery actions identified to support the outturn position.

3. Within the overall month 11 position, net operational budgets report a £4.5m overspend. Directorate overspends include DMH (£5.9m) and Estates and FM services (£0.7m). CHS and Enabling services are underspending by £1.2m and £1.1m respectively. The remaining services are at, or close to break-even.

4. Central reserves report a favourable variance of £2.0m which partially offsets the operational deficit, resulting in the overall net Trust deficit variance against plan of £2.5m.

5. Closing cash for February stood at £32.2m. This equates to 40.6 days' operating costs.

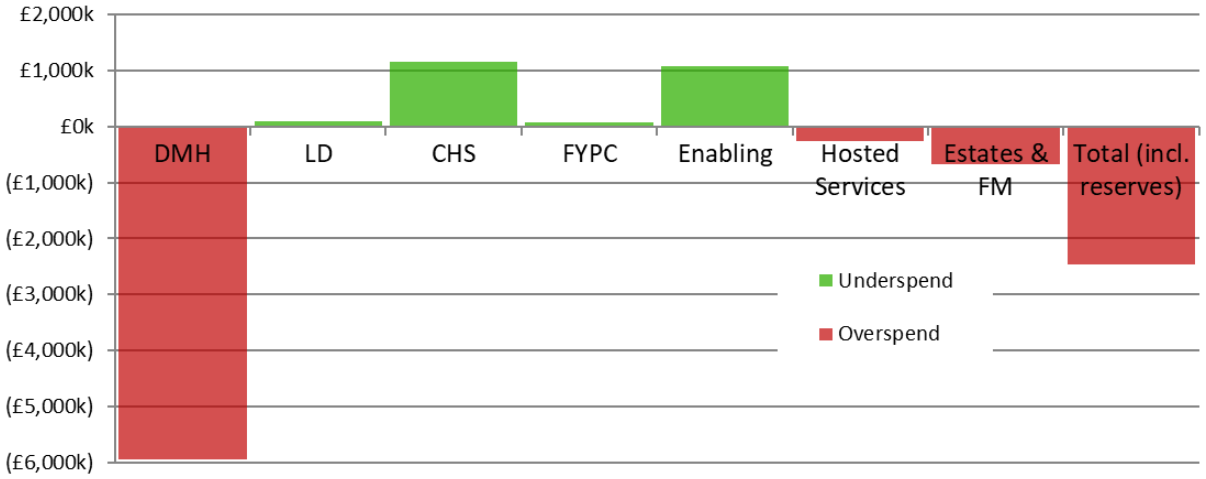
Performance against key targets and KPIs

NHS Trust Statutory Duties	Year to date	Year end f'cast	Comments
1. Income and Expenditure break-even.	R	R	The Trust is reporting a financial deficit position at the end of February 2023. **[see 'Service I&E position' and *Appendix A*]**. The year end position is forecast to be a deficit of £2.9m
2. Remain within Capital Resource Limit (CRL).	G	G	The capital spend for February is £15.8m, which is within limits. The year end forecast is also within the limits for the year.
3. Achieve the Capital Cost Absorption Duty (Return on Capital).	G	G	The dividend payable is based on the actual average relevant net assets; therefore, the capital cost absorption rate will automatically be 3.5%.
4. Remain within External Financing Limit (EFL).	n/a	G	The current cash level is £32.2m. The year-end forecast is £28m.

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 February.
6. Achieve Efficiency Savings targets.	A	A	Efficiency savings performance at M11 is £216k short of the £4.9m target. The forecast for the year is a shortfall of £282k against the annual target of £5.6m (95% delivery)
7. Deliver a financial surplus	n/a	n/a	The NHS Financial framework 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)	A	A	This former national metric is not currently being used for formal reporting purposes. Estimates suggest that based on current performance the Trust would be achieving a low 2 / high 3 rating (the I&E deficit being somewhat offset by a strong cash balance)
9. Achieve retained cash balances in line with plan	G	G	A cash balance of £32.2m was achieved at the end of February 2023. The cash level is forecast to be £28m at the end of the year, £5m above plan. **[See 'cash and working capital']**
10. Deliver capital investment in line with plan (within +/- 15% YTD planned spend levels)	A	G	Capital expenditure totals £15.8m, 17% below planned levels of £19m. Lower than expected property leases is mainly responsible for the variance. **[See 'Capital Programme 2022/23'].**

Income and Expenditure position

The initial year to date plan assumed a £0.3m deficit for M11. The actual deficit is £2.8m – an overspend against plan of £2.5m. The total overspend against plan includes a net operational overspend of £4.5m, partially offset by a reserves underspend of £2.0m. The reserves position includes the impact of some of the mitigations / recovery actions also reflected in the year end forecast, where these are already delivering savings. The operational overspends / underspends are shown in the table below:



Additional analysis of directorate performance

The Mental Health directorate is overspent by £5.95m to end of month 11. This is an adverse movement of £719k from month 10. The movement is mainly due to nursing agency and locum expenditure. Agency spend increased by £133k due to the February mid-term break, teachers strike and outbreak of covid in Coleman and Welford wards. The nursing agency and locum spend to date is £9.7m and £3.9m respectively. The directorate is forecasting a £6.7m overspend for the year and the main cost drivers are inpatients wards - £8.9m overspent and medical staffing £3.8m overspent. These overspends are mitigated by underspends within Psychology £1.4m, planned care £0.8m, perinatal £0.7m and investment slippage £2.2m

The FYPC out-turn position at month 11 is a £72k underspend, this represented an improvement on last month. The underspend resulted from vacancies with services including Healthy Together and Nutrition and Dietetics and slippage related to delays in recruitment linked to investment funding. Beacon and Langley remained the main overspent budgets with Beacon attracting additional agency in the month due to patient acuity for which an EPC has been presented to the CAMHS Provider collaborative requesting additional funding. The Community Paeds overspend increased in the month due to additional staff employed to address the wait lists and non pay related to Cytogenetic tests. The non pay budget continued to show pressures in the month particularly related to Cytogenetic costs,

Medical equipment, IT expenses, VPN and mobiles. The CIP was showing full recovery at month 11.

The LD financial position at month 11 reported an underspend of £98k. This was a further improvement on the previous month and reflected the increasing improving position against the Agnes Unit and vacancies within Community related budgets. A further underspend related to slippage on investments funds resulting from delays in recruitment. The CIP was showing full recovery at month 11.

The CHS service is reporting an overall underspend of £1.15m at month eleven.. The position has improved further by £285k from the previous month, due to the inclusion of the anticipated income relating to the Surge ward and the 5 additional beds at Hinckley hospital where the costs are much lower than the income to be received. There was an increase in agency / bank costs during February as a result of these additional beds. Although the Directorates position is positive, it should to be noted that there are cost pressures within the ward setting and in some non-pay categories in particularly the continence supplies budget, currently overspending by £259k due to the increase in price and patient assessments. Travel budgets are also overspending by £142k due to the temporary increase in the rate payable and mobile phones are reporting a £122k overspend.

Enabling Services are underspent by £1.0m as at M11. This is a positive movement of £320k compared to M10. Additional income has been received in relation to Psychology Students services and staff on secondment with other organisations.

Estates Services are overspent by £679k as at M11. This is a negative movement of £253k compared to M10 (£426k adverse variance). The adverse movement relates to increased utility costs and consultancy costs for carrying out water pipe assessments for Legionella.

Hosted services are overspent by £267k as at M11. This is a negative movement of £267k compared to M10 and predominantly relates to the Vaccination Programme.

Forecast position

Appendix F provides a Trust level view of the key risks, pressures and mitigations and the potential impact of these on the year end position.

The forecast year end position remains in line with the £2.9m deficit forecast reported last month. This position has been agreed with system partners and forms part of the total £20m forecast deficit for the system as a whole. The system forecast position was agreed with NHSE during December.

Efficiency Savings

Scheme Ref	Scheme name	Non-pay	Agreed plan £	Year end forecast £	Y/e f'cast variance £	YTD plan £	YTD actual £	YTD variance £
CHS 1	Travel	NON PAY	90,000	90,000	0	82,500	82,500	0
CHS 2	Comm / Inpatient Management Non Pay savings	NON PAY	90,000	90,000	0	82,500	82,500	0
CHS 6	Comm Nursing / Therapy - Service review of investments - estimated	PAY	253,000	253,000	0	231,917	231,917	0
CHS 8	Virtual ward + Long COVID Rehab- Service review of investments + potential N/R slippage - estmated	PAY	65,000	65,000	0	59,583	59,583	0
CHS 9	LDU Review	PAY	90,000	90,000	0	82,500	82,500	0
CHS 10	Procurement - contract reviews i.e taxis, continence supplies etc	NON PAY	149,000	149,000	0	136,583	136,583	0
CHS 12	Other Non Pay savings - N/R	NON PAY	23,000	23,000	0	21,083	21,083	0
	CHS - total		**760,000**	**760,000**	**0**	**696,667**	**696,667**	**0**
LD 3	Travel savings against baseline 2019/20 cost	NON PAY	23,000	45,168	22,168	21,083	43,068	21,984
LD 4	Agency reduction Agnes in 22/23 against 21/22 out-turn	PAY	100,000	77,777	-22,223	88,889	66,666	-22,223
	LD - total		**123,000**	**122,945**	**-55**	**109,972**	**109,734**	**-239**
FYPC1	Travel savings against baseline 2019/20 cost	NON PAY	100,000	131,332	31,332	91,667	119,532	27,866
FYPC2	Integrated Primary care offer (PMHW)	PAY	100,000	99,996	-4	91,667	91,663	-3
FYPC3	Agency reduction HUB & CAP in 22/23 against 21/22 out-turn	PAY	50,000	38,892	-11,108	44,444	33,336	-11,108
FYPC4	Agency reduction Beacon & Langley (against 21/22 out-turn)	PAY	150,000	150,003	3	133,333	133,336	3
FYPC5	Digital offer to reduce printing & postage costs	NON PAY	20,000	0	-20,000	16,667	0	-16,667
	FYPC - total		**420,000**	**420,224**	**224**	**377,778**	**377,868**	**90**
DMH 1	Travel savings against baseline 2019/20 cost	NON PAY	50,000	50,000	0	45,837	45,837	0
DMH 2	Volunteer Transport	NON PAY	75,000	0	-75,000	68,750	0	-68,750
DMH 3	Oxevision	PAY	20,000	0	-20,000	16,667	0	-16,667
DMH 4	Agency reduction in spend for HCSW	PAY	300,000	37,500	-262,500	262,500	37,500	-225,000
DMH 5	Agency reduction in spend for Admin	PAY	100,000	95,000	-5,000	90,000	80,000	-10,000
DMH 6	eRoster advance planning for 12 weeks	PAY	50,000	50,001	1	42,857	42,858	1
DMH 7	Medical locums	PAY	50,000	10,000	-40,000	45,000	10,000	-35,000
DMH 8	Covid bank incentive payments	PAY	300,000	0	-300,000	240,000	0	-240,000
	DMH - total		**945,000**	**242,501**	**-702,499**	**811,610**	**216,195**	**-595,416**
ENAB 1	Bring Legal services in-house and reduce Legal Fees costs	NON PAY	52,000	52,000	0	47,667	44,400	-3,267
ENAB 2	Savings from Non Pay budgets in Quality team	NON PAY	34,000	34,000	0	31,167	31,166	-1
ENAB 3	Drugs (Clozapine Repatriations) & Non Pay	NON PAY	56,000	56,000	0	51,333	51,334	1
ENAB 4	Finance Directorate (including Procurement, Info. Team & IG:	PAY	80,000	80,000	0	73,333	73,334	1
ENAB 5	Travel Savings from HR & Other Non Pay N/R	NON PAY	85,000	85,000	0	77,917	77,916	-1
ENAB 6	Business Development N / R Savings	NON PAY	25,000	25,000	0	22,917	22,916	-1
ENAB 7	Enabling non-recurrent schemes	NON PAY	0	0	0	0	3,268	3,268
	ENABLING - total		**332,000**	**332,000**	**0**	**304,333**	**304,334**	**0**
T1	Travel Savings	NON PAY	413,000	413,000	0	378,583	378,583	0
T2	Corporate led agency reduction schemes	PAY	605,000	75,000	-530,000	505,000	75,000	-430,000
T3	Mobile phone contract savings	NON PAY	125,000	125,000	0	114,583	114,583	0
T4	Review of patient taxis	NON PAY	0	0	0	0	0	0
T5	Capital charges reduction	NON PAY	850,000	350,000	-500,000	779,163	458,332	-320,831
T6	Balance sheet flexibility	PAY	1,027,000	1,577,001	550,001	870,587	1,280,140	409,553
T7	Review external income generation	INCOME	0	0	0	0	0	0
T8	VAT reclaims and interest receivable	NON PAY	0	900,000	900,000	0	721,000	721,000
	TRUSTWIDE - total		**3,020,000**	**3,440,001**	**420,001**	**2,647,917**	**3,027,639**	**379,722**
	GRAND TOTAL		**5,600,000**	**5,317,669**	**-282,331**	**4,948,277**	**4,732,435**	**-215,842**

As at the end of month 11, £4,732k savings are being delivered against the year-to-date target of £4,948k (a shortfall of £216k). The DMH CIP position shows a £595k shortfall against the YTD target, all other directorates are delivering planned savings in full. The majority of the DMH shortfall is being offset by additional corporate savings (including balance sheet gains, additional VAT reclaims and interest receivable).

The forecast year end position shows savings of £5,318k against the annual target of £5,600k. This would be a shortfall of £282k and equates to delivery of 95% of the target for the year.

Within the Trustwide position, capital charges savings of £500k had originally been assumed through the Trust adopting a 'hypothetical model' for valuing Trust buildings. This is an extremely complex area and is now likely to take place in 23/24. As such, the potential efficiency savings from this scheme have been excluded from the overall CIP position. Additional balance sheet savings have been identified that cover the shortfall and so the overall CIP position has not been affected.

Statement of Financial Position (SoFP)

PERIOD: February 2023	2021/22 31/03/22 Audited (Restated) £'000's	2022/23 28/02/23 February £'000's
NON CURRENT ASSETS		
Property, Plant and Equipment	192,037	197,968
Intangible assets	4,818	4,440
IFRS16 - Right of use (ROU) assets	44,792	42,634
Trade and other receivables	932	933
Total Non Current Assets	**242,579**	**245,975**
CURRENT ASSETS		
Inventories	418	368
Trade and other receivables	8,087	13,488
Cash and Cash Equivalents	31,991	32,204
Total Current Assets	**40,496**	**46,060**
Non current assets held for sale	**0**	**0**
TOTAL ASSETS	**283,075**	**292,035**
CURRENT LIABILITIES		
Trade and other payables	(28,460)	(37,837)
Borrowings	(285)	(285)
Borrowings - IFRS16 ROU assets	(3,322)	(3,412)
Capital Investment Loan - Current	(186)	(186)
Provisions	(3,588)	(3,196)
Total Current Liabilities	**(35,841)**	**(44,916)**
NET CURRENT ASSETS (LIABILITIES)	**4,655**	**1,144**
NON CURRENT LIABILITIES		
Borrowings	(7,177)	(7,178)
Borrowings - IFRS16 ROU assets	(41,470)	(39,405)
Capital Investment Loan - Non Current	(3,021)	(2,858)
Provisions	(1,256)	(1,256)
Total Non Current Liabilities	**(52,924)**	**(50,697)**
TOTAL ASSETS EMPLOYED	**194,310**	**196,422**
TAXPAYERS' EQUITY		
Public Dividend Capital	101,831	106,697
Retained Earnings	39,058	36,303
Revaluation reserve	53,421	53,422
TOTAL TAXPAYERS EQUITY	**194,310**	**196,422**

Non-current assets

Property, plant, and equipment (PPE) amounts to £198m, and includes capital additions of £14.7m, offset by depreciation charges.

Due to the adoption of IFRS-16 leases from 1st April 2022, non-current assets increased by £45m, 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. Two new leases have commenced since 1st of April 2022.

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). This is matched by an equivalent increase to our capital resource limit (the total amount the Trust can spend on capital).

Current assets

Current assets of £46m include cash of £32.2m and receivables of £13.5m.

Current Liabilities

Current liabilities amount to £44.9m and mainly relate to payables of £38m.

Net current assets / (liabilities) show net assets of 1.1m.

Working capital

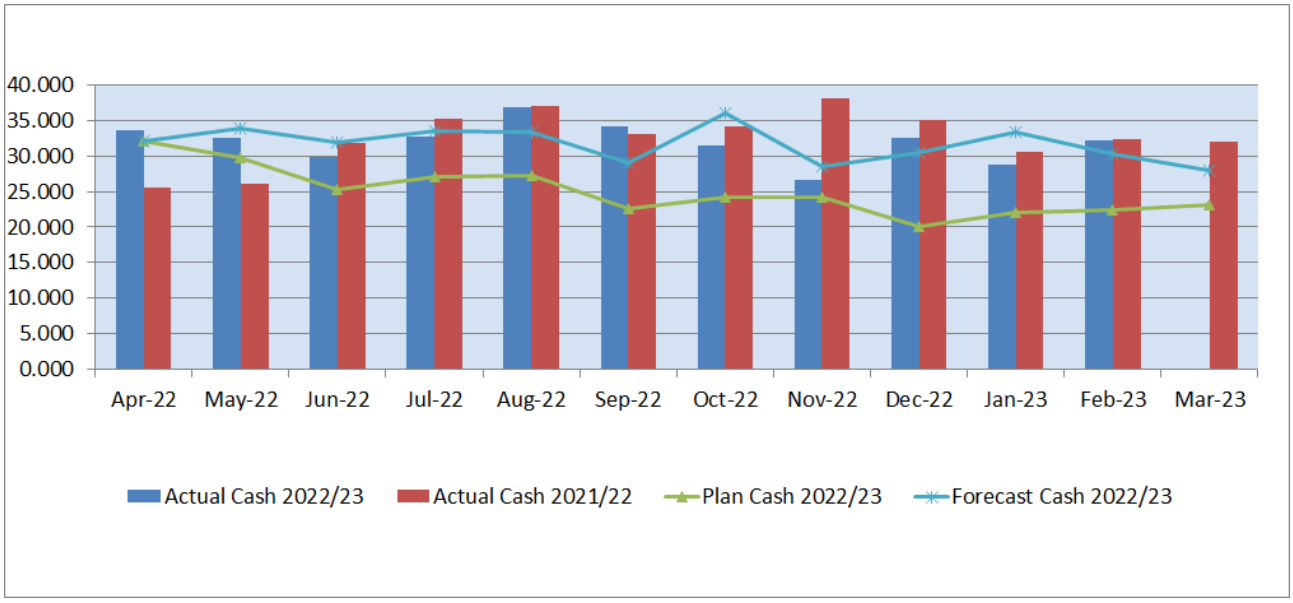
Cash and changes in working capital are reviewed on the following pages.

Taxpayers' Equity

February's deficit of £2.8m 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 February was £32.2m, an increase of £3.5m during the month.

The interest earned to date from the current bank account is £600k. If the current rate of return continues, forecast annual interest is estimated at c£720k (2021/22: £19k).

The forecast closing cash balance at the end of the year has increased to £28m; this is £3m more than last month's forecast of £25m. Changes to working capital assumptions in March (i.e., the level of debtors and creditors) will continue to impact on the final closing cash position. A cash-flow forecast is included at ***Appendix D.***

Receivables

Current receivables (debtors) total £13.5m; an increase of £0.7m during the month.

Receivables	Current Month February 2023					
	NHS	Non NHS	Emp's	Total	% Total	% Sales Ledger
	£'000	£'000	£'000	£'000		
Sales Ledger						
30 days or less	6,097	2,690	23	**8,810**	**61.09%**	**83.4%**
31 - 60 days	376	23	3	**402**	**2.79%**	**3.8%**
61 - 90 days	304	82	12	**398**	**2.76%**	**3.8%**
Over 90 days	404	352	195	**951**	**6.59%**	**9.0%**
	7,181	3,147	233	**10,561**	**73.23%**	**100.0%**
Non sales ledger	798	2,130	0	**2,928**	**20.30%**	
Total receivables current	**7,979**	**5,277**	**233**	**13,489**	**93.53%**	
Total receivables non current		933		933	**6.47%**	
Total	**7,979**	**6,210**	**233**	**14,422**	**100.00%**	**0.0%**

Debt greater than 90 days decreased by £30k since January and now stands at £951k. Receivables over 90 days should not account for more than 5% of the overall total receivables balance. The proportion at Month 11 is 6.59% (last month: 7.16%). Nottinghamshire Healthcare Foundation Trust is the highest valued aged debtor (£221k) – we have been informed outstanding invoices will be paid in March. Other lower value aged debtors include NHS England, UHL, NHS Property Services and ex-employee debt. The non-current receivables balance stands at £933k. It comprises of a £249k 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 £310k debt provision this month.

Payables

The current payables position in Month 11 is £38m –an increase of £4.8m since the previous month and an increase of £9.4m since the start of the year. This increase is due to expenditure accruals, deferred income (including Provider Collaborative deferred income) and the payment of UHL and NHS Property Services invoices being put on-hold due to disputed charges. Accruals and deferred income reserves 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/years.

Better Payment Practice Code (BPPC)

The specific target is to pay 95% of invoices within 30 days. The Trust achieved all 4 cumulative BPPC targets in February, however the number of Non-NHS invoices paid during the month did not achieve 95%. There is an issue with the automated payment of the Facilities Management catering invoices which has had a detrimental impact on the monthly BPPC stats. 200 Non-NHS invoices were paid late in February, of which 137 related to catering invoices. Further details are shown in Appendix B.

The Trust has received a letter from the NHSE National Director of Finance, congratulating us on our consistent delivery of the BPPC target this year.

Capital Programme 2022/23

Capital expenditure totals £15.8m at the end of February. This comprises of £14.7m relating to operational capital, and £1.1m for the commencement of two new property leases, required under IFRS16 rules to capitalise right-of-use assets. The current capital position is shown below:

	Annual Plan	Feb Actual	Year End Forecast	Revision to Plan
Sources of Funds	**£'000**	**£'000**	**£'000**	**£'000**
Depreciation & technical adjustments	9,500	8,719	9,370	(130)
PDC Dormitory elimination - Bradgate	4,000	4,000	4,000	0
PDC Enhancing MH urgent & emergency environments	0	0	795	795
PDC Cyber Security	0	61	72	72
Agnes unit PFI lifecycle costs	100	0	100	0
Cash utilisation from previous years' surplus - LPT	3,633	1,867	3,763	130
Cash utilisation to support stroke ward reserve - ICS	1,000	0	1,200	200
Cash utilisation to support system resource reserve - ICS	1,532	0	0	(1,532)
Charitable funds - Coalville garden	0	5	5	5
Charitable funds - Evington demential garden	0	22	22	22
IFRS-16 leases - borrowings	3,913	1,154	1,154	(2,759)
Total Capital funds	**23,678**	**15,828**	**20,481**	**(3,197)**
Application of Funds	**£'000**	**£'000**	**£'000**	**£'000**
Estates				
Estates Service Improvements	(6,395)	(5,697)	(6,996)	(601)
Estates backlog	(2,637)	(1,365)	(2,446)	191
Estates other rolling programmes	(1,090)	(384)	(821)	269
Estates Staffing	(431)	(431)	(436)	(5)
Estates & FM Transformation	(470)	(1,046)	(1,131)	(661)
Medical Devices	(200)	(11)	(20)	180
Estates Directorate bids	(2,847)	(1,672)	(3,409)	(562)
	(14,070)	**(10,606)**	**(15,259)**	**(1,189)**
IT Programme				
IM&T Rolling Programmes	(1,705)	(1,294)	(2,205)	(500)
IM&T Directorate bids	(1,158)	(2,393)	(2,305)	(1,147)
	(2,863)	**(3,687)**	**(4,510)**	**(1,647)**
ICS limits allocation (inc £50k for Stroke ward)	**(2,532)**	**0**	**(50)**	**2,482**
Contingencies	**(300)**	**(381)**	**492**	**792**
IFRS16 Leases / ROU Assets	**(3,913)**	**(1,154)**	**(1,154)**	**2,759**
Total Capital Expenditure	**(23,678)**	**(15,828)**	**(20,481)**	**3,197**
(Over)/underspend	**(0)**	**0**	**0**	**0**
Operational Capital Total - excluding IFRS16 leases	**(19,765)**	**(14,674)**	**(19,327)**	**438**

Operational Capital Expenditure (exc leases)

At the end of February, £14.7m (77%) has been spent on operational capital, which leaves £4.7m (23%) to be spent in the last month of the year. The majority of March's spend relates to the dormitory elimination scheme, the business case for the Glenfield site development, estates backlog/directorate improvements and IT equipment. The programme has been

running with an overcommitment in the final quarter of the year (currently £870k), to mitigate against any non-utilisation of the £4.7m still to spend in March.

The capital programme is under regular review to ensure a balanced plan by the end of the year. Schemes have been flexed/deferred to factor in any expenditure slippage (due to material delays, changes in scope, planning consent etc.).

Changes to capital programme

Month 11 changes (>£100k) made to this year's programme are shown at ***Appendix H.***

2023/24 Capital - update

The updated draft plan shows spend of £14.1m, which is an over-commitment of c.£0.8m. Discussions are continuing with ICB capital leads to facilitate a balanced capital plan for next year.

- The Capital Management Committee has prioritised all bids.
- There is pressure on next year's allocation due to the high level of scheme deferrals from 2022/23 – currently £1.7m.
- Due to planning delays and enhanced scope, there is a high level of committed expenditure relating to the Dormitory elimination programme £4.1m (no external funding after 2022/23).
- The funding gap of £0.8m can be addressed by in-year slippage.
- The System capital allocation is now £12.8m. In addition it is assumed that PDC of £250k will be available to support the Hinckley Hub equipment (from the clinical diagnostic centre £13m PDC funding allocation – tbc). The £5m ringfenced for the Stroke ward and £2m for Lutterworth hospital is excluded from the plan due to funding uncertainty.

APPENDIX A - Statement of Comprehensive Income (SoCI)

Statement of Comprehensive Income for the period ended 28 February 2023	YTD Actual M11 £000	YTD Budget M11 £000	YTD Var. M11 £000
Revenue			
Total income	341,095	337,095	3,999
Operating expenses	(337,474)	(331,014)	(6,460)
Operating surplus (deficit)	**3,620**	**6,081**	**(2,461)**
Investment revenue	0	0	0
Other gains and (losses)	0	0	0
Finance costs	(1,304)	(1,304)	0
Surplus/(deficit) for the period	**2,316**	**4,777**	**(2,461)**
Public dividend capital dividends payable	(5,071)	(5,071)	0
I&E surplus/(deficit) for the period (before tech. adjs)	**(2,755)**	**(294)**	**(2,461)**
NHS Control Total performance adjustments			
Exclude gain on asset disposals	**0**	**0**	**0**
NHSE/I I&E control total surplus	**(2,755)**	**(294)**	**(2,461)**
Other comprehensive income (Exc. Technical Adjs)			
Impairments and reversals	0	0	0
Gains on revaluations	0	0	0
Total comprehensive income for the period:	**(2,755)**	**(294)**	**(2,461)**
Trust EBITDA £000	**16,291**	**18,752**	**(2,461)**
Trust EBITDA margin %	**4.8%**	**5.6%**	**-0.8%**

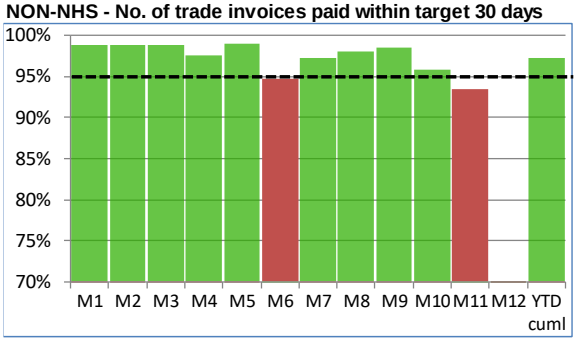
APPENDIX B – BPPC performance

Trust performance – current month (cumulative) v previous

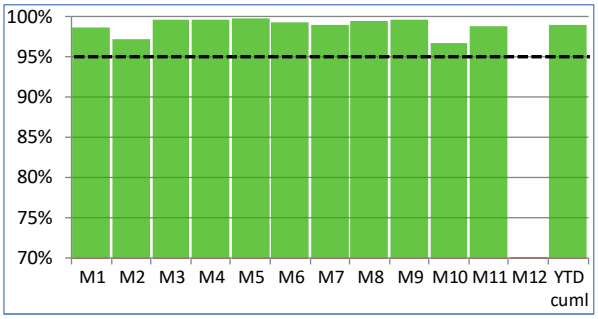
Better Payment Practice Code	February (Cumulative)		January (Cumulative)	
	Number	£000's	Number	£000's
Total Non-NHS trade invoices paid in the year	30,112	102,593	27,017	93,465
Total Non-NHS trade invoices paid within target	29,309	101,525	26,414	92,509
% of Non-NHS trade invoices paid within target	**97.3%**	**99.0%**	**97.8%**	**99.0%**
Total NHS trade invoices paid in the year	814	58,707	754	54,448
Total NHS trade invoices paid within target	792	57,694	732	53,435
% of NHS trade invoices paid within target	**97.3%**	**98.3%**	**97.1%**	**98.1%**
Grand total trade invoices paid in the year	30,926	161,300	27,771	147,913
Grand total trade invoices paid within target	30,101	159,219	27,146	145,944
% of total trade invoices paid within target	**97.3%**	**98.7%**	**97.7%**	**98.7%**

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

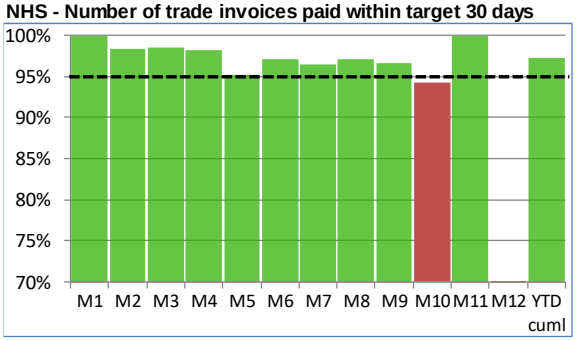
NON-NHS - No. of trade invoices paid within target 30 days



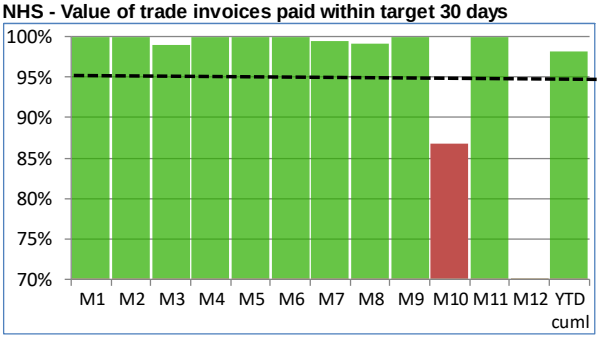
NON-NHS - Value of trade invoices paid within target 30 days



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 Actual	2022/23 M5 £000s Actual	2022/23 M6 £000s Actual	2022/23 M7 £000s Actual	2022/23 M8 £000s Actual	2022/23 M9 £000s Actual	2022/23 M10 £000s Actual	2022/23 M11 £000s Actual	2022/23 M12 £000s F'Cast	22/23 YTD £000s Actual	22/23 Year End £000s F'cast
DMH																
Consultant Costs	-3,586	-299	-330	-217	-307	-429	-411	-414	-456	-414	-395	-310	-289	-334	-3,972	-4,306
Nursing - Qualified	-6,589	-549	-965	-959	-1,052	-1,052	-742	-757	-542	-518	-552	-472	-604	-461	-8,215	-8,676
Nursing - Unqualified									-361	-325	-267	-253	-256	-316	-1,463	-1,779
Other clinical staff costs	-202	-17	-8	-43	-23	-23	-21	-28	-34	-21	-20	-20	37	-10	-204	-214
Non clinical staff costs	-317	-26	-16	-6	-27	-23	-15	-4	-10	-2	-2	-1	-3	-1	-108	-109
Sub-total - DMH	**-10,694**	**-891**	**-1,319**	**-1,225**	**-1,409**	**-1,527**	**-1,189**	**-1,203**	**-1,403**	**-1,280**	**-1,236**	**-1,057**	**-1,115**	**-1,122**	**-13,961**	**-15,083**
Spend relating to Investments					**-2**	**-1**	**0**						**0**	**0**	-3	**-3**
Spend relating to Covid															0	**0**
LEARNING DISABILITIES																
Consultant Costs	-133	-11	-37	-13	-22	-28	-19	-27	-25	-40	-52	8	-21	20	-274	-254
Nursing - Qualified	-2,418	-201	-200	-176	-153	-203	-138	-187	-71	-71	-95	-161	-104	-50	-1,559	-1,609
Nursing - Unqualified									-78	-59	-120	-101	-62	-70	-420	-490
Other clinical staff costs	-25	-2	0	-15	-14	-4	-15	0	0	0	0	0	0	0	-48	-48
Non clinical staff costs	-14	-1	-1	-6	-8	-6	-3	-6	0	0	0	0	0	0	-31	-31
Sub-total - LD	**-2,590**	**-215**	**-239**	**-209**	**-197**	**-240**	**-174**	**-220**	**-174**	**-170**	**-267**	**-254**	**-187**	**-100**	**-2,331**	**-2,431**
Spend relating to Investments															0	**0**
Spend relating to Covid															0	**0**
CHS																
Consultant Costs	0	0	0	0	0	0	0	0	0	-16	-6	-9	-14	0	-45	-45
Nursing - Qualified	-5,864	-489	-746	-683	-657	-561	-529	-512	-351	-404	-477	-467	-474	-500	-5,861	-6,361
Nursing - Unqualified									-232	-202	-274	-297	-276	-290	-1,281	-1,571
Other clinical staff costs	-639	-53	-50	-53	-51	-23	-29	-36	-45	-62	-42	-25	-45	-40	-463	-503
Non clinical staff costs	-31	-3	0	-14	4	-1	-1	0	0	0	0	0	0	0	-13	-13
Sub-total - CHS	**-6,534**	**-545**	**-796**	**-750**	**-705**	**-585**	**-560**	**-548**	**-629**	-684	**-799**	**-798**	**-809**	**-830**	**-7,663**	**-8,493**
Spend relating to surge ward							**-98**	**-120**	**-85**	**-165**	**-118**	**-179**	**-142**	**-210**	-907	**-1,117**
Spend relating to other investments			**-55**	**-55**	**-46**	**-40**									-195	**-195**
Spend relating to Covid			**-38**	**-18**	**-12**	**-12**	**-8**	**0**	**0**	**0**	**0**	**0**	**0**		-88	**-88**
FYPC																
Consultant Costs	-754	-63	-82	-71	-60	-83	-70	-109	-110	-94	-96	-96	-95	-90	-965	-1,055
Nursing - Qualified	-4,172	-348	-391	-378	-469	-294	-372	-372	-204	-176	-179	-168	-216	-165	-3,219	-3,384
Nursing - Unqualified									-87	-86	-35	-66	-90	-55	-364	-419
Other clinical staff costs	-48	-4	-2	-6	-9	-6	-7	-7	-6	-5	-5	-3	0	0	-55	-55
Non clinical staff costs	-117	-10	-2	-6	-16	-13	-13	-10	-7	-7	-5	-5	-4	-5	-87	-92
Sub-total - FYPC	**-5,091**	**-425**	**-476**	**-461**	**-554**	**-394**	**-462**	**-498**	**-413**	**-367**	**-320**	**-338**	**-406**	**-315**	**-4,690**	**-5,005**
Spend relating to Investments															0	**0**
Spend relating to Covid															0	**0**
ENAB, HOST AND RESERVES																
Consultant Costs			-2	-2	-2	-2	-2	2	13	0	0	0	0	0	5	5
Nursing - Qualified	-89	-7	0	90	0	0	0	6	0	-2	0	0	0	0	95	95
Nursing - Unqualified			0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other clinical staff costs	-302	-25	-18	-3	-24	-11	-13	-8	-6	11	-41	18	-36	-20	-132	-152
Non clinical staff costs	-1,592	-133	-99	-151	-112	-132	-125	-125	-64	-162	-61	-78	-87	-80	-1,196	-1,276
Sub-total - Enab/Host	**-1,982**	**-165**	**-119**	**-67**	**-138**	**-145**	**-140**	**-124**	**-58**	**-153**	**-102**	**-60**	**-123**	**-100**	**-1,229**	**-1,329**
Spend relating to Investments			**-8**	**-4**	**-5**	**6**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	-11	**-11**
Spend relating to Covid			**-65**	**-63**	**-42**	**-61**	**-40**	**-26**	**-7**	**-13**	**-15**	**-9**	**-9**	**-10**	-350	**-360**
TOTAL TRUST																
Consultant Costs	-4,483	-374	-450	-302	-391	-541	-502	-548	-578	-563	-549	-407	-420	-404	-5,251	-5,655
Nursing - Qualified	-19,132	-1,594	-2,302	-2,106	-2,331	-2,109	-1,781	-1,822	-1,168	-1,170	-1,303	-1,268	-1,399	-1,176	-18,759	-19,935
Nursing - Unqualified									-759	-672	-696	-717	-683	-731	-3,528	-4,259
Other clinical staff costs	-1,204	-100	-79	-120	-121	-66	-85	-78	-91	-78	-108	-31	-44	-70	-901	-971
Non clinical staff costs	-2,072	-173	-118	-183	-158	-175	-156	-145	-81	-171	-68	-84	-95	-86	-1,435	-1,521
Total	**-26,891**	**-2,241**	**-2,949**	**-2,712**	**-3,002**	**-2,892**	**-2,524**	**-2,594**	**-2,677**	**-2,654**	**-2,724**	**-2,507**	**-2,640**	**-2,467**	**-29,875**	**-32,342**
Total Trust - Surge Ward			**0**	**0**	**0**	**0**	**-98**	**-120**	**-85**	**-165**	**-118**	**-179**	**-142**	**-210**	-907	**-1,117**
Total Trust - Investment Agency Spend			**-63**	**-59**	**-53**	**-35**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	-209	**-209**
Total Trust - Covid Agency Spend			**-103**	**-81**	**-54**	**-73**	**-48**	**-26**	**-7**	**-13**	**-15**	**-9**	**-9**	**-10**	-438	**-448**
Total excl. C19, Surge and Investm. costs			**-2,784**	**-2,572**	**-2,895**	**-2,785**	**-2,378**	**-2,448**	**-2,585**	**-2,476**	**-2,591**	**-2,319**	**-2,489**	**-2,247**	**-28,321**	**-30,568**

Total agency costs for February are £2,640k.

Agency costs have worsened by £133k compared to January.

Excluding surge ward, covid and investment related agency costs, February's agency spend is £2,489k.

The year end forecast has increased to £32.3m (M10: £32.1m)

APPENDIX D – Cash flow forecast

2022/23 CASH-FLOW FORECAST	FEB	FEB	FEB	MAR	YTD	22/23
	FORECAST	ACTUAL	VARIANCE	FORECAST	ACTUAL	FORECAST
	£'000	£'000	£'000	£'000	£'000	£'000
OPENING BALANCE	**28,711**	**28,711**	**(4,630)**	**32,204**	**31,990**	**31,990**
INCOME						
Leicester & Leicesteshire CCG block contracts	26,147	26,528	**381**	26,242	271,290	297,532
Other CCG block contracts	828	125	**(703)**	1,021	2,386	3,407
East Midlands Provider Collaborative - CAMHS	516	96	**(420)**	48	1,095	1,143
Local Authorities block contracts	5,183	4,931	**(252)**	1,540	15,014	16,554
NHS England	1,254	691	**(563)**	1,254	9,469	10,723
UHL contract	481	0	**(481)**	719	1,943	2,662
MADEL	1,753	0	**(1,753)**	2,600	10,219	12,819
HIS income	50	340	**290**	226	2,381	2,607
360 Assurance income	280	150	**(130)**	380	1,939	2,319
UHL rental income	222	0	**(222)**	380	1,166	1,546
Previous year's income	0	42	**42**	0	4,875	4,875
VAT	589	589	**0**	568	6,398	6,966
Property sales	0	0	**0**	0	0	0
PDC for capital investment	867	867	**0**	0	4,867	4,867
Other income	1,068	937	**(185)**	3,264	11,827	15,091
Total Receipts	**39,238**	**35,296**	**(3,996)**	**38,242**	**344,869**	**383,111**
PAYMENTS						
Payroll	21,750	21,958	**20,304**	21,845	232,280	254,125
Capital	2,500	2,044	**(456)**	2,904	12,506	15,410
Non pay general expenditure	5,300	4,849	**(451)**	7,100	60,435	67,535
UHL - Estates & FM Services	3,621	0	**(3,621)**	3,621	5,202	8,823
UHL - Other contracts	158	0	**(158)**	316	1,550	1,866
NHS Property Services rents	600	0	**(600)**	800	3,306	4,106
Community Health Partnerships rents	146	146	**0**	146	1,447	1,593
Agency Nursing Costs	2,200	1,945	**(255)**	2,500	23,745	26,245
Out of Area (OOA) costs for patients placed in private hospitals	50	60	**10**	25	307	332
Turning Point	1,319	801	**(518)**	423	917	1,340
Public dividend capital payment (PDC)	0	0	**0**	2,766	2,733	5,499
Other finance costs (inc loan interest and principal repayments)	0	0	**0**	0	227	227
Total Payments	**37,644**	**31,803**	**14,255**	**42,446**	**344,655**	**387,101**
CLOSING CASH BOOK BALANCE	**30,305**	**32,204**	**(22,881)**	**28,000**	**32,204**	**28,000**

APPENDIX E – Covid-19 expenditure, February 2023

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	0	0	0	0	0	0	0	0	**0**
Bank	86	0	0	0	0	0	0	0	**86**
Agency	0	0	0	0	0	0	0	0	**0**
Existing workforce additional shifts									
Substantive	0	0	0	0	0	2	0	0	**2**
Bank	0	0	20	0	0	0	0	0	**20**
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	0	0	0	0	0	0	0	0	**0**
NHS 111 additional capacity	0	0	0	0	0	0	0	0	**0**
After care and support costs (community, mental health, primary care)	0	0	0	0	12	0	0	0	**12**
Infection prevention and control training	0	0	0	0	0	0	0	0	**0**
Remote working for non patient activites:									
IT/Communication services and equipment	0	0	0	0	0	3	0	0	**3**
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 11:	**86**	**0**	**20**	**0**	**12**	**5**	**0**	**0**	**123**
TOTAL M1 - M10 COVID COSTS:	**927**	**256**	**177**	**42**	**125**	**51**	**0**	**0**	**1,578**
TOTAL YTD COVID COSTS:	**1,013**	**256**	**197**	**42**	**137**	**56**	**0**	**0**	**1,701**

Note that the majority of cost still attributed to Covid relates to bank incentives. For the 2023/24 financial planning round and subsequent financial reporting, these incentives will no longer be categorised as covid costs.

APPENDIX F – Pressures, Mitigations and Risk analysis

The table below presents a summary of year end outturn pressures, risks and mitigations positions, under best, likely and worse scenarios.

The previous month 'likely' target is also included for comparison purposes.

Risk Scenarios - as at month 11 2022/23	Scenario Analysis			Movement since last month ('likely')	
Description	M11 BEST CASE £000	M11 LIKELY CASE £000	M11 WORST CASE £000	M10 LIKELY CASE £000	MOVEMENT SINCE LAST MONTH £000
22/23 budget break-even assumption	**0**	**0**	**0**	**0**	**0**
Operational positions					
Mental Health Directorate	(6,621)	(6,681)	(6,931)	(6,681)	0
Learning Disabilities	200	120	0	100	20
Community Health Services	1,600	1,400	0	1,400	0
Families, Young People and Childrens Services	300	105	0	100	5
Enabling Services	1,200	1,200	1,000	1,000	200
Estates	(650)	(950)	(1,000)	(650)	(300)
Hosted Services	100	0	(300)	50	(50)
Internal funding of DMH safer staffing	(1,340)	(1,340)	(1,340)	(1,340)	0
Operational Services - total	**(5,211)**	**(6,146)**	**(8,571)**	**(6,021)**	**(125)**
Trustwide/Corporate					
General price inflation risk - includes approved measures to support staff cost of living financial pressures.	0	0	(50)	0	0
Further income changes (including revised national out-of-system funding and 'LVA' approach)	0	0	(100)	0	0
Further pressure to support additional investment not funded within the plan offer (likely now includes PY effect of additional HR posts)	0	(45)	(45)	(45)	0
Part-year effect of overhead cost pressure due to new Healthy Together contract	(190)	(190)	(190)	(190)	0
Pay award funding shortfall (includes NI adjustment)	(413)	(413)	(413)	(413)	0
Additional system SDF income allocation and slippage	835	835	835	835	0
Additional financial recovery action plan (see below)	3,509	3,061	2,211	2,936	125
TOTAL:	**(1,470)**	**(2,898)**	**(6,323)**	**(2,898)**	**0**

RECOVERY PLAN / MITIGATIONS	BEST	LIKELY	WORST	LIKELY	£000
Trustwide - Interest on cash investments	325	300	275	300	0
Trustwide - VAT Recovery	0	0	0	0	0
Trustwide - additional Provider Collaborative Income	1,000	1,000	500	1,000	0
Trustwide - Direct Engagement	0	0	0	0	0
Trustwide - Hypothetical Valuations (cap chgs)	(500)	(500)	(500)	(500)	0
Enabling accruals and provisions release	436	436	436	436	0
DMH HEE income	60	0	0	0	0
Additional winter pressures and virtual ward funding	800	725	500	600	125
FYPC Local Authority pay award	200	100	0	100	0
FYPC accruals release	150	0	0	0	0
LD Extra Care suite	0	0	0	0	0
DMH Generic Drugs	38	0	0	0	0
DMH Progress Beds	0	0	0	0	0
LD additional STP income	1,000	1,000	1,000	1,000	0
TOTAL:	**3,509**	**3,061**	**2,211**	**2,936**	**125**

APPENDIX G – Financial run rates

The table below shows actual run-rates to M11. Further recovery actions are now reflected in the forecast run-rate and projected year end position.

DIRECTORATE		M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	*M12*	Total YTD	*Projected year end (before further recovery)*
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	*£'000*	£'000	*£'000*
		actual	actual	actual	actual	actual	actual	actual	actual	actual	actual	actual	*f'cast*	actual YTD	*forecast*
DMH	PAY	-7,283	-7,508	-7,247	-7,968	-7,492	-9,401	-8,114	-8,076	-8,043	-8,082	-8,030	*-8,071*	-87,244	***-95,315***
	NONPAY	-595	-543	-557	-584	-677	-620	-699	-738	-820	-693	-921	*-868*	-7,447	***-8,315***
	INCOME	407	540	319	459	470	470	478	587	626	623	637	*616*	5,616	***6,232***
		-7,471	**-7,511**	**-7,485**	**-8,093**	**-7,699**	**-9,551**	**-8,335**	**-8,227**	**-8,237**	**-8,152**	**-8,314**	***-8,323***	**-89,075**	***-97,398***
FYPC	PAY	-4,691	-4,925	-4,845	-4,822	-4,861	-5,909	-5,019	-4,495	-4,972	-5,246	-4,010	*-4,938*	-53,795	***-58,733***
	NONPAY	-309	-253	-461	-405	-361	-466	-377	-327	-421	-418	-403	*-380*	-4,201	***-4,581***
	INCOME	2,146	2,292	2,371	2,278	2,318	1,956	2,192	2,154	2,087	2,427	2,365	*2,190*	24,586	***26,776***
		-2,854	**-2,886**	**-2,935**	**-2,949**	**-2,904**	**-4,419**	**-3,204**	**-2,668**	**-3,306**	**-3,237**	**-2,048**	***-3,128***	**-33,410**	***-36,538***
LD	PAY	-1,139	-1,153	-1,139	-1,131	-1,125	-1,368	-1,117	-1,071	-1,156	-1,152	-1,296	*-1,104*	-12,847	***-13,951***
	NONPAY	-33	-25	-30	-46	-43	-41	-37	-37	-38	-29	-37	*-47*	-396	***-443***
	INCOME	6	13	7	6	0	10	44	-28	72	-22	54	*10*	162	***172***
		-1,166	**-1,165**	**-1,162**	**-1,171**	**-1,168**	**-1,399**	**-1,110**	**-1,136**	**-1,122**	**-1,203**	**-1,279**	***-1,141***	**-13,081**	***-14,222***
CHS	PAY	-5,836	-5,850	-5,797	-5,725	-5,676	-7,235	-5,945	-6,100	-6,013	-6,097	-6,206	*-6,235*	-66,480	***-72,715***
	NONPAY	-573	-508	-583	-601	-639	-643	-664	-607	-749	-731	-778	*-869*	-7,076	***-7,945***
	INCOME	259	252	286	270	273	274	199	265	221	283	330	*225*	2,912	***3,137***
		-6,150	**-6,106**	**-6,094**	**-6,056**	**-6,042**	**-7,604**	**-6,410**	**-6,442**	**-6,541**	**-6,544**	**-6,654**	***-6,879***	**-70,643**	***-77,522***
ENAB	PAY	-2,358	-2,242	-2,262	-2,296	-2,350	-2,711	-2,419	-2,420	-2,415	-2,455	-2,454	*-2,561*	-26,382	***-28,943***
	NONPAY	-813	-1,326	-1,140	-1,136	-1,083	-1,143	-1,174	-1,116	-1,093	-1,119	-1,253	*-1,033*	-12,396	***-13,429***
	INCOME	1,059	1,139	1,134	1,195	1,173	1,133	1,281	1,167	1,335	1,362	1,754	*1,526*	13,732	***15,258***
		-2,112	**-2,429**	**-2,268**	**-2,237**	**-2,260**	**-2,721**	**-2,312**	**-2,369**	**-2,173**	**-2,212**	**-1,953**	***-2,068***	**-25,046**	***-27,114***
ESTS	PAY	-30	-56	*-31*	*-43*	*-63*	-87	-72	-660	-700	-695	-737	*-735*	-3,174	***-3,909***
	NONPAY	-3,020	-2,981	*-3,026*	*-2,999*	*-3,038*	-3,340	-3,153	-2,572	-2,690	-2,800	-2,730	*-2,730*	-32,349	***-35,079***
	INCOME	229	234	*243*	*235*	*267*	242	243	241	241	241	241	*240*	2,657	***2,897***
		-2,821	**-2,803**	**-2,814**	**-2,807**	**-2,834**	**-3,185**	**-2,982**	**-2,991**	**-3,149**	**-3,254**	**-3,226**	***-3,225***	**-32,866**	***-36,091***
HOST	PAY	-1,617	-1,394	-995	-1,162	-1,084	-1,415	-1,183	-1,170	-1,221	-1,070	-1,132	*-1,175*	-13,443	***-14,618***
	NONPAY	-1,015	-1,140	-989	-799	-280	-824	-775	-857	-2,671	-1,314	-744	*-775*	-11,408	***-12,183***
	INCOME	2,413	2,711	2,005	1,856	1,256	2,189	1,850	2,033	3,831	2,300	1,563	*1,910*	24,007	***25,917***
		-219	**177**	**21**	**-105**	**-108**	**-50**	**-108**	**6**	**-61**	**-84**	**-313**	***-40***	**-844**	***-884***
RESVS	PAY	-498	266	-532	96	-734	1,793	284	-82	-41	38	-1,878	*-827*	-1,288	***-2,115***
	NONPAY	-500	-197	-916	-490	-32	-48	-378	-675	-208	-87	-392	*-408*	-3,923	***-4,331***
	INCOME	23,296	22,257	23,868	23,227	23,015	26,561	25,524	24,587	24,508	24,683	25,896	*25,896*	267,422	***293,318***
		22,298	**22,326**	**22,420**	**22,833**	**22,249**	**28,306**	**25,430**	**23,830**	**24,259**	**24,634**	**23,626**	***24,661***	**262,211**	***286,872***
TOTAL	PAY	**-23,452**	**-22,862**	**-22,848**	**-23,051**	**-23,385**	**-26,333**	**-23,585**	**-24,074**	**-24,561**	**-24,759**	**-25,743**	*-25,646*	-264,653	***-290,299***
	NONPAY	**-6,858**	**-6,973**	**-7,702**	**-7,060**	**-6,153**	**-7,125**	**-7,257**	**-6,929**	**-8,690**	**-7,191**	**-7,259**	*-7,110*	-79,197	***-86,307***
	INCOME	**29,815**	**29,438**	**30,233**	**29,526**	**28,772**	**32,835**	**31,811**	**31,006**	**32,921**	**31,897**	**32,840**	*32,613*	341,094	***373,707***
		-495	**-397**	**-317**	**-585**	**-766**	**-623**	**969**	**3**	**-330**	**-52**	**-162**	***-143***	**-2,755**	***-2,898***

APPENDIX H – Capital Changes M11

Ref	Scheme title	Previous Forecast (M10)	Updated Forecast (M11)	Required Changes (M10-M11 difference) to be approved	Comments
		£000	£000	£000	
	Operational Capital Scheme changes > £100k				
7C27	Valentine Centre - Electrical Switchgear, distribution boards, generator	0	(155)	(155)	Essential works
7P82	Backlog allocation - Belvoir boilers	(30)	(160)	(130)	Essential works
7C07	Medical Devices	(420)	(20)	400	£400k aproved in M10 to utilise slippage - cannot facilitate ordering
7C17	Rolling Replacement Programme	(1,050)	(1,550)	(500)	Exec team approved £500k year end spend due to medical devices not going ahead
7C93	LLR shared care records	(50)	57	107	VAT recovery on previous year's spend
	Various schemes (net change < £100k)			18	Net changes < £100k
	Total expenditure			**(260)**	
	Over/(under-commitment) contingency reserve	**613**	**873**	**260**	

Leicestershire Partnership NHS
NHS Trust

Executive Management Board 17/02/2023

Month 11 Trust finance report

Purpose of the Report

- To provide an update on the Trust financial position.

Proposal

- The Committee is recommended to review the summary financial position and accept the reported year to date financial performance.

Decision required: N/A

Governance table

For Board and Board Committees:	Trust Board	
Paper sponsored by:	Sharon Murphy, Director of Finance & Performance	
Paper authored by:	Chris Poyser, Head of Corporate Finance Jackie Moore, Financial Controller	
Date submitted:	20/03/2023	
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 Executive Management 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	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).
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	

V

Leicestershire Partnership NHS Trust

Trust Board – 28.03.23

Board Performance Report March 2023 (Month 11)

Purpose of the report

To provide the Trust Board with the Trust's performance against KPI's for February 2023 Month 11.

Analysis of the issue

The report is presented to Executive Management 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 and looking ahead to the next reporting period:

- Due to a cyber incident affecting multiple providers, LLR level performance figures sourced from the MHSDS publications have been published, however, NHS England have noted that these may not serve as an accurate reflection of performance.
  Previous months data will be backdated in due course. This affects the 'MH Core Data Pack' section of the report. Breakdown at Trust level are still included.
  CYPED metrics, which are sourced separately, have not yet been backdated for Quarter 2.

Decision required

The Trust Board is asked to

- Approve the performance report

Governance table

For Board and Board Committees:	Trust Board 28.3.23	
Paper sponsored by:	Sharon Murphy, Director of Finance and Performance	
Paper authored by:	Prakash Patel, Head of Information	
Date submitted:	20.03.23	
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	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
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	

2023/24 Board Performance Report refresh proposed metrics

Report area	Lead	Metric	Retain metric?	Stop reporting?	Reason for stopping reporting	Proposed new metrics or revised target	Reason for inclusion
Covid hospital acquired infection	Amanda Hemsley	Query if whole report needed	No	Yes - Remove	N/A		
Quality account	Deanne						
		The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period	yes				
		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	yes				
		The percentage of inpatients discharged with a subsequent inpatient admission within 30 days - 0-15 years	Yes				
		The percentage of inpatients discharged with a subsequent inpatient admission within 30 days - 16+ years	yes				
		The number of patient safety incidents reported within the Trust during the reporting period	Yes				
		The rate of patient safety incidents reported within the Trust during the reporting period	Yes				
		The number of such patient safety incidents that resulted in severe harm or death	Yes				

2023/24 Board Performance Report refresh proposed metrics

Report area	Lead	Metric	Retain metric?	Stop reporting?	Reason for stopping reporting	Proposed new metrics or revised target	Reason for inclusion
		The percentage of such patient safety incidents that resulted in severe harm or death	Yes				
		72 hour Follow Up after discharge (Aligned with national published data)	Yes				
CQUINS	Heather	23/24 CQUINs	yes				
		National audit data? TBC					
MH core data pack	Andres	Propose to move to an appendix for Trust level report	Yes				
NHS oversight	Praks	No changes to the current metrics	Yes				
Access waiting times DMH	Helen	Adult CMHT Access (Six weeks routine) - Incomplete pathway	Yes				
		Memory Clinic (18 week Local RTT) - Complete pathway	Yes				
		Memory Clinic (18 week Local RTT) - Incomplete pathway	Yes				
		ADHD (18 week local RTT) - Complete pathway	Yes				
		ADHD (18 week local RTT) - Incomplete pathway	Yes				
		Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral	Yes				

2023/24 Board Performance Report refresh proposed metrics

Report area	Lead	Metric	Retain metric?	Stop reporting?	Reason for stopping reporting	Proposed new metrics or revised target	Reason for inclusion
Access waiting times CHS	Vicki	CINSS (20 Working Days) - Complete Pathway	Yes				
		Continence - Complete Pathway	Yes				
Access waiting times FYPC/LD	Julia	CAMHS Eating Disorder (one week) - Complete pathway	Yes				
		CAMHS Eating Disorder (four weeks) - Complete pathway	Yes				
		Children and Young People's Access (four weeks) - Incomplete pathway	No	Remove	This has been compliant for 2022/2023		
		Children and Young People's Access (13 weeks) - Incomplete pathway	Yes				
		Community Paediatrics 18 week RTT – complete pathway	New			18-week RTT and numbers of patients waiting	Currently the trajectory is predicting an on-going deteriorating position
		AAAS (18 weeks) - Complete pathway (note change of name)	Yes				
		AAAS - No of Referrals - (18 weeks) - Complete pathway (note change of name)	Yes				
		LD Community (8 weeks) - Complete pathway	No	Remove	Target is not meaningful		
		LD Community - No of Referrals - (8 weeks) - Complete pathway	No	Remove	Target is not meaningful		
52 week waits	All/Anne	Cognitive Behavioural Therapy - No of waiters	Yes				
		Cognitive Behavioural Therapy - Longest waiter (weeks)	Yes				

2023/24 Board Performance Report refresh proposed metrics

Report area	Lead	Metric	Retain metric?	Stop reporting?	Reason for stopping reporting	Proposed new metrics or revised target	Reason for inclusion
		Dynamic Psychotherapy - No of waiters	Yes				
		Dynamic Psychotherapy - Longest waiter (weeks)	Yes				
		Therapy Service for People with Personality Disorder - assessment waits over 52 weeks - No of waiters	Yes				
		Therapy Service for People with Personality Disorder - assessment waits over 52 weeks - Longest waiter (weeks)	Yes				
		CAMHS - No of waiters	Yes				
		CAMHS - Longest waiter (weeks)	Yes				
		Community Paediatrics- No of waiters	New			Number of waiters for initial appointment over 52 weeks	Now have significant numbers waiting over 52 weeks
		Community Paediatrics – Longest waiter (weeks)	New			Longest waiter in weeks for initial appointment	Patients approaching 2 years
		All LD - No of waiters	Yes				
		All LD - Longest waiter (weeks)	Yes				
Patient Flow	Andres	Occupancy Rate - Mental Health Beds (excluding leave)	Yes				
		Occupancy Rate - Community Beds (excluding leave)	Yes				
		Average Length of stay - Community Hospitals	Yes				
		Delayed Transfers of Care	Yes				
		Gatekeeping	yes				

2023/24 Board Performance Report refresh proposed metrics

Report area	Lead	Metric	Retain metric?	Stop reporting?	Reason for stopping reporting	Proposed new metrics or revised target	Reason for inclusion
		Inpatient Admissions to LD and MH Wards with a Learning Disability (Rolling 12 months) - Adult	NO	This is provided by the CGG in the NHS oversight tab but on a monthly basis	Not been able to produce data in 22/23 – check if ICB can provide		
		Inpatient Admissions to LD and MH Wards with a Learning Disability (Rolling 12 months) - CYP	NO	This is provided by the CGG in the NHS oversight tab but on a monthly basis	Not been able to produce data in 22/23 - check if ICB can provide		
		Admissions to adult facilities of patients under 18 years old	yes				
Quality & Safety	Deanne/Emma	Serious incidents	Yes				
		Safe staffing - No. of wards not meeting >80% fill rate for RNs - Day	Yes				
		Safe staffing - No. of wards not meeting >80% fill rate for RNs - Night	Yes				
		Care Hours per patient day	Yes				
		No. of episodes of seclusions >2hrs	Yes				
		No. of episodes of prone (Supported) restraint	Yes				

2023/24 Board Performance Report refresh proposed metrics

Report area	Lead	Metric	Retain metric?	Stop reporting?	Reason for stopping reporting	Proposed new metrics or revised target	Reason for inclusion
		No. of episodes of prone (Unsupported) restraint	Yes				
		Total number of Restrictive Practices	Yes				
		No. of Category 2 pressure ulcers developed or deteriorated in LPT care	Yes				
		No. of Category 4 pressure ulcers developed or deteriorated in LPT care	Yes				
		Sepsis measure	New	Yes			Unable to include as a metric as data is not captured
		Cat 3 PU's and Medication Errors	New				
		complaints/ concerns /Compliments data-AK	New				Alison confirmed this can be reported monthly.
		No. of repeat falls	Yes				
		LD Annual Health Checks completed - YTD	Yes				
		LeDeR Reviews completed within timeframe - Allocated	Yes				
		LeDeR Reviews completed within timeframe - Awaiting Allocation	Yes				
		LeDeR Reviews completed within timeframe - On Hold	Yes				
HR workforce	Nicola	Normalised Workforce Turnover (Rolling previous 12 months) (10% target)					

2023/24 Board Performance Report refresh proposed metrics

Report area	Lead	Metric	Retain metric?	Stop reporting?	Reason for stopping reporting	Proposed new metrics or revised target	Reason for inclusion
		Vacancy Rate (10% target)					
		Sickness Absence					
		Sickness Absence Costs					
		Sickness Absence - YTD					
		Agency Costs					
		Core Mandatory Training Compliance for substantive staff					
		Staff with a Completed Annual Appraisal					
		% of staff from a BME background					
		Staff flu vaccination rate (frontline healthcare workers)					
		% of staff who have undertaken clinical supervision within the last 3 months					
		Health and Wellbeing Activity - No of LLR staff contacting the hub in the reporting period	No	Yes	Hub no longer in operation		

W

Leicestershire Partnership NHS Trust

CHARITABLE FUNDS COMMITTEE– DATE 14th March 2023

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	Risk 4618 described staff not being able to progress bids due to the covid 19 pandemic. It was agreed that as bids were now returning to normal levels the risk would be closed. A review of the risk register was undertaken against Governance and management; Operational; Finance & External Factor risks. It was agreed to keep a watching brief on these areas, but that no new risk was required at this point.	4669 5311
Six monthly review of Fundraising strategy and Annual Priorities	High	The regular update was received. It was agreed that good progress was being made in all areas of the strategy.	
Fundraising Manager's report	High	Highlights against Raising Health strategic objectives noted were: (Visibility) – 12 roadshow events are planned for this year, building on the success of last year's events. The charity's leaflets had been updated. (Income) – Events and fundraising continue for agreed schemes.	

Report	Assurance level*	Committee escalation	Risk Reference
		The Flagship appeals have now been confirmed as: • FYPC/LD - Autism Groups & Beacon Sensory Room • DMH - Outdoor gyms and Stewart House indoor gym • CHS - Dementia Friendly Wards Work is progressing with teams to identify the fundraising targets & to finalise the projects. (Grants) – schemes were progressing. The staff room refurbishment scheme was almost complete and the final purchases were being made. (Partnerships) – work continues to develop relationships with external partners, including working with corporate partners on sponsorship of the celebrating excellence awards event.	
Annual Review of Investment Performance	High	A representative from Cazenove, the charity's investment manager, presented the annual update. The economic picture remained challenging, particularly in respect of inflation & investment market performance. The portfolio was still delivering a return for the charity & the team were actively managing the portfolio to ensure that returns over the long term were above the target of inflation + 4%.	
Finance report – Q3	High	Total income was an increase of £116k at the end of quarter 3, comprising realised income of £244k and an unrealised investment loss of £128k. Expenditure was £268k at the end of quarter 3. Future expenditure commitments (including NHSCT and Carlton Hayes bids) total £266k The cash balance was £408k at the end of December. Cash was expected to remain in a good position in the rolling 3-year cash flow forecast. Total funds available was £2.3m at the end of quarter 3, a decrease of £152k since the start of the financial year, due to investment market values falling. The committee reviewed benchmarking of the charity's costs against similar sized NHS charities. It was agreed that benchmarking against local or similar non-acute trusts would also be helpful.	

Report	Assurance level*	Committee escalation	Risk Reference
New bids	High	The following 2023/24 running cost bids were approved: Raising Health Marketing Budget (£4k) Fundraising Manager Staffing (£58k) Charitable Funds Audit accounts independent examination and review (c£6k) Recharge of Finance staffing (£42k) Harlequin licence and support for fundraising, CRM, lottery and accounting software (£4k) Staff Lottery Prizes (£34k) Staff Lottery Staffing Cost (£14k) The following bid was not approved: Staff Lottery Superdraw prizes (£2.5k) It was agreed to investigate whether fewer, larger superdraws would have more impact on membership numbers. The revised bid would be reviewed by the Director of Finance under normal Raising Health delegation.	
New funds created	High	YODAS – Young onset of Dementia Assessment Service Dementia Friendly Environments	
Work plan	High	The work plan was reviewed and agreed for 2023/24.	
Review of risk register	High	No new risks were identified.	
AOB	High	None received.	

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

X

Leicestershire Partnership NHS Trust

TRUST BOARD – 28 March 2023

AUDIT AND ASSURANCE COMMITTEE – 17 March 2023

HIGHLIGHT REPORT

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

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

Report	Assurance level*	Committee escalation	ORR Risk Ref
Internal Audit Progress **Review of HFMA Improving NHS Financial Sustainability Checklist** **Head of Internal Audit Opinion 2022/23 Stage 2** **Draft 2023/24 Internal Audit Plan**	**High**	One final report (*Remote/Virtual Consultations)* had been issued since the previous meeting with significant assurance opinion. Actions had been agreed for the two medium risks and action dates were in place The implementation rate at first follow up was 95%, the overall follow up rate was 100%. Discussion focused on the feasibility of incorporating user feedback in future audits and on delivery of key performance indicators. Progress on the actions on LPT's self assessment against the 72 questions in the HFMA checklist was reported. Overall good progress was being made and there were no specific issues to highlight. The HoIAO stage two work had recently been completed, a positive position was reported and no change to this was expected at year end. The Committee approved the draft 2023/24 plan. Agreement had been given by LPT, UHL and the ICB for inclusion of a system wide review this year.	62, 70 71*
External Audit Progress **Draft Audit Plan 2022/23**	**High**	AAC received an update on the work undertaken since the last meeting and a summary of upcoming work. KPMG's risk assessment and planned audit approach was presented. Two significant risks associated with financial sustainability and improving economy, efficiency and effectiveness had been identified, a review of arrangements to mitigate these risks would be undertaken.	62, 70 71*

Report	Assurance level*		Committee escalation	ORR Risk Ref
Counter Fraud Progress **Counter Fraud Plan 2023/24**	**High**		The Committee received a summary of the work that was underway or had been completed since the last meeting. Very good progress was noted on compliance against the Counter Fraud Functional Standards, the recommendation would be that the Trust score itself green for submission to the Cabinet Office in May. Assurance was provided that a link between cyber security and fraudulent activity was being made through bespoke training. The plan was based on the achievement of a green score for the CFFS and the counter fraud resource had been reduced in view of the good position the Trust was currently in. The focus in 2023/24 would be on proactive detection.	62, 70 71*
Clinical Audit Annual Report	**High**	**Medium**	The Committee received and approved the Trusts Clinical Audit Annual Report for 2022/23 and noted the proposals for the next steps during 2023/24. AAC asked that in future, links were made between the activity and the outcomes to provide assurance that the right actions were in place. The Committee agreed there was a high level of assurance on the clinical audit processes in place but only a medium level for the outcomes.	
Chairs of QSC / FPC - updates on key issues	**High**		The only issue to highlight from the Quality and Safety Committee was the request for ORR 61 (*lack of staff with appropriate skills would not be able to safely meet patient care needs*) to be kept open pending a full review. This was due to the recent move back to face to face training and challenged compliance levels in mandatory training for temporary staff. Discussion at FPC on 28 February had focused on the financial position, performance and Estates Strategy, there were no specific issues to highlight. The Committee agreed there was a high level of assurance that QSC and FPC were operating in line with their objectives within LPT's governance. **The Committee was not quorate from this point**	62, 70 71*
Risk Management	**High**		An update was received on changes made to arrangements since the last meeting. Confirmation was received that approval had not been given to the closure of ORR 61. Further work would be undertaken on the risks aligned to the new People and Culture Committee and a report presented to the next AAC meeting. A high level of assurance was received on the systems and processes in place to secure an effective risk management and assurance framework.	62*

Report	Assurance level*	Committee escalation	ORR Risk Ref
Legal/Regulatory Issues	**N/A**	There were no specific legal and regulatory issues to highlight.	62*
Internal/External Audit Follow up of Actions	**High**	There were no outstanding actions from external audits for 2022/23.	62*
AAC Work Plan 2023/24	**High**	The plan was presented for information and would be circulated to Committee members for approval. From 1st April 2023, the Audit and Assurance Committee would change its name to the Audit and Risk Committee.	
Financial Waivers	**High**	The report covering quarter 3 of 2022/23 was presented, a total of 85 waivers with a value of just under £2m (excl. VAT) had been raised. 68 of the waivers at a value of c£1.5m directly related to the insourcing of the estates and facilities function and the contracts associated with delivering this service. A new sole provider process had been introduced which had helped to reduce the number of waivers received but focus would be given to those waivers that were raised due to insufficient time to go out to market.	62, 70 71*
Accounting Policies and Procedures	**High**	The accounting policy updates to support Trust Board in the approval of the 2022/23 annual accounts were presented. Work continued with external auditors on the approach to property, plant and equipment valuations. The report would be circulated to Committee members for approval.	
Freedom to Speak Up Update	**High**	The annual assurance review of the freedom to speak up process was presented, the key issues to highlight were; • Work with HR colleagues had commenced on the revision of the local Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy following the publication of the new national policy in June 2022. All NHS Trusts were expected to adopt the revised template by 2024. • Changes to the governance and reporting structure to provide assurance on the triangulation of information. • Numbers contacting the freedom to speak up team remained relatively low, reasons for this were not clear. • Work was taking place with the L&D team to raise awareness of three training packages available to different staff groups. The Committee agreed there was a high level of assurance on the information presented but there needed to be clarity on the outcomes freedom to speak up activity was trying to achieve for future reports.	

Report	Assurance level*	Committee escalation	ORR Risk Ref
Highlight reports	**High**	AAC received the highlight reports for the Quality and Safety, Finance and Performance, Charitable Funds and Remuneration Committees and agreed there was a high level of assurance as all issues highlighted by committee chairs were being addressed.	

Chair	**Alexander Carpenter**

*****principal risk(s) shown but will also cover other risk on ORR

Leicestershire Partnership and
Northamptonshire Healthcare Group

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Trust Board March 2023
Leicestershire Partnership & Northamptonshire Healthcare Group
Chairs' Joint Highlight Report

Purpose of the report

- This joint report from the LPT Committee in Common and NHFT Committee in Common Chairs provides assurance on the progress of the Group model, strategic priorities, governance framework and other work streams for LPT Trust Board and NHFT Trust Boards in March 2023.
- This report is prepared from papers distributed in the absence of the planned meeting of Tuesday 7th March 2023.

Analysis of the issue

- A Joint Board-to-Board took place in February 2023 which considered the benefits of group working, challenges to group working and opportunities for group working. The Committees received a summary from the workshop.
- The Committees received an update on work to progress our contribution to best practice governance expertise in the ICS and regional provider collaboratives and ongoing networking with system governance leads.
- The Committees received a proposal describing our next steps in the delivery of our strategic estates plan.
- A report describing work to progress greater engagement with our universities; including our self-assessment of where we are today was circulated. It asked the committee to "Acknowledge and endorse the self-assessment as an accurate picture of where we are today & to approve next steps in our goal"
- An updated Joint Employment Register was shared.

Proposal

- This LPT-NHFT Committees in Common Highlight report from the Joint Working Group meeting is normally offered to each Trust Board to reflect the achievements and direction of travel for the Group model. While the meeting did not happen on MS Teams, all papers were shared with members and comments welcome via e-mail. This report is prepared from papers distributed and feedback.

Decision required

- The Board is asked to note the 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

LPT Trust Governance Table

For Board and Board Committees:	Trust Board 28th March 2023	
Paper sponsored by:	David Williams	
Paper authored by:	Alison Gilmour	
Date submitted:	23 March 2023	
State which Board Committee or other forum within the Trust's governance structure, if any, have previously considered the report/this issue and the date of the relevant meeting(s):	LPT-NHFT CiC JWG 7 March 2023	
If considered elsewhere, state the level of assurance gained by the Board Committee or other forum i.e. assured/ partially assured / not assured:	Assured	
State whether this is a 'one off' report or, if not, when an update report will be provided for the purposes of corporate Agenda planning	Next update to Trust Board May 2023	
STEP up to GREAT strategic alignment*:	High **S**tandards	x
	Transformation	x
	Environments	x
	Patient Involvement	
	Well **G**overned	X
	Reaching Out	
	Equality, Leadership, Culture	X
	Access to Services	
	Trustwide Quality Improvement	X
Organisational Risk Register considerations:	List risk number and title of risk	
Is the decision required consistent with LPT's risk appetite:	yes	
False and misleading information (FOMI) considerations:	None identified	
Positive confirmation that the content does not risk the safety of patients or the public	None identified	
Equality considerations:	Outcome will apply equally to all staff in LPT	

Leicestershire Partnership and Northamptonshire Healthcare Group

NHS

Appendix A

LPT-NHFT Committees in Common (CiC) Joint Working Group (JWG) HIGHLIGHT REPORT 7 March 2023

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. Joint Board development Workshop		Joint Board Development Round Table feedback was shared summarizing: • **Benefits of Group working** – greater opportunities for shared learning improving patient outcomes; more efficient way of working; improved recruitment and retention & improved reputation in the marketplace, more flexibility; shared understanding of what Group is, does and means to me. • **Challenges to Group working** – Funding; Organisational Culture and some views that this was leading to a merger. Confirmed that LPT and NHFT are not merging and are not looking to merge and agreed boards would share this message. • **Opportunities for Group working** – could be applied to more areas e.g., corporate services and across organisational boundaries; shared ways of working leading to improved outcomes, efficiency	

Report	Assurance level	Committee escalation	ORR Risk Reference
		and better effectiveness; improved recruitment and retention through better career pathways and pay progression, equity in pay grades.	
2. Delivering our Strategic Framework	N/A	The Committees in Common received an update on work undertaken to demonstrating the joint working between the two Trusts within the Group Strategic Priority. A further update on the strategic framework would be provided to the next meeting of the Committees.	
3. Strategic Estates		A paper was shared describing our approach to delivering the first stage of the five-year estates plan for both NHFT and LPT. Common areas identified include: • Net Zero • Approach to one Public Estate • New ways of working Next steps proposed: • Confirm Estates five-year plan –to board development sessions in June 2023 • Work with Property Services • Continue to work with ICBs –but look to use Group influence to move agenda on Strategic Estates forward in both systems • Commence Net Zero/ sustainability joint working group	
4. Closer working with universities		The Committee received a report confirming our ambition to achieve greater working with universities. The report contained our self-assessment benchmarked against University Hospital Association principles. The self-assessment recognised that while we have made progress there is more to do and recommended next steps. Finally, the report proposed the development of a joint research strategy for publication in September 2023.	
5. Group Joint Employment Register		An updated Joint Employment Register was shared.	