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Draft Annual governance statement for Leicestershire Partnership NHS Trust 2022/23

1. Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum*.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Leicestershire Partnership NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Leicestershire Partnership NHS Trust for the year ended 31 March 2023 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

3.1 Leadership Arrangements

The Trust Board has overall accountability for the effective and efficient management of the Trust and for ensuring the Trust adheres to the principles of good governance. It is responsible for reviewing the effectiveness of the system of internal control, and for ensuring that the Trust has effective systems and processes in place for risks that threaten the Trust's ability to meet the objectives in its Step Up to Great strategy, and the achievement of it values. Strategic and corporate level risk is captured on the 'Organisational Risk Register' (ORR). Each ORR risk has a link to the relevant Step Up to Great component(s), has an assigned executive director, and refers to the governance route for oversight of the risk.

The Trust's framework for risk management describes the structure and accountabilities for risk at a senior leadership level, and the responsibility for all staff to know and understand the risk management systems within the Trust and to follow the Trust's policies, guidelines, and procedures.

Operational responsibility for risk management sits within clinical and corporate directorates, and our hosted services. Operational risk is captured on local and directorate risk registers held on the Ulysses risk system which allows for risk identification, management, and escalation in line with the Trust's risk management policy.

The risk management framework also describes the principal committees with a responsibility for the governance and oversight of risk within the Trust, and the reporting hierarchy to provide assurance to the Board that risk management processes are in place and remain effective. The responsibility for managing risk across the Trust has been delegated by the Board to the following level 1 committees; the Audit and Assurance Committee (AAC), the Quality Assurance Committee (QAC), the Finance and Performance Committee (FPC) and a newly introduced People and Culture Committee (PCC) which

has been included as a level 1 committee from February 2022 to focus on workforce as our highest area of risk.

With delegated authority from the Trust Board, The AAC has oversight of the system of internal control, governance and risk. Assurance over the systems and processes in place to support the management of risk is provided to the AAC on a quarterly basis. This includes any relevant updates on policy, training, strategy and innovation. The AAC also has oversight of the Trust's adherence to the Government Functional Standard 013: Counter Fraud. The score for component 3: Fraud, Bribery and Corruption Risk Assessment has been rated green for a second year as the Trust has embedded a process for identifying counter fraud risk and incorporating this into the Trust's risk management framework. 22 counter fraud risks have been identified on our local risk registers (held on our Ulysses system), these have been identified and reviewed by our Local Counter Fraud Specialist with relevant Trust staff.

The four main assurance committees (AAC, QAC, FPC and PCC) receive regular risk assurance reports relating to their remit (with some areas of risk such as waiting times and agency spend relating to more than one committee). The Joint Working Group, a sub-committee of the Board and a committee in common with Northamptonshire Healthcare NHS Foundation Trust oversees risk relating to joint programmes of work.

The Trust's Strategic Executive Board (SEB) has oversight of strategic level risks on the ORR. Financial pressures and system risks are also discussed at the Strategic Executive Board. This takes account of system pressures, and risk associated with the Integrated Care System and our system partners.

The Trust's Executive Management Board (EMB) has oversight of the ORR and operational level risks and focuses on the operational delivery of mitigating action to reduce risk.

Individual Executive Directors are responsible for overseeing a programme of risk management activities in their areas of responsibility and individually review risks within their remit at least once a month to ensure that the ORR is updated for each committee/Trust Board meeting.

During 2022/23 risk management and reporting processes have continued to mature. There is a strengthened assurance flow through the three levels of governance groups / committees up to the Trust Board, each providing a level of assurance over the management of risk and an opportunity to escalate any concerns or opportunities.

3.2 Staff training and guidance on the management of risk

Risk management training can be booked by all staff on our automated ULearn system. Full training sessions covering all six risk modules are scheduled in twice a month and module specific training is offered once a month. Ad hoc training is also provided upon request. Health and safety risk assessment training is provided on the Trust's induction programme for all new starters. The frequency and level of risk management training is identified through training need assessments, ensuring that individual members of staff have the relevant training to equip them for their duties and level of responsibility.

In addition, a range of policies are in place and available to staff via the Trust's intranet which describe the roles and responsibilities in relation to the identification, management and control of risk. Staff are made aware of these policies and are actively encouraged to access them to ensure that they understand their own roles and responsibilities.

Risk is an important tool in identifying and managing the learning lessons across the Trust. Risk specialists attend governance groups to facilitate learning and horizon scan for new and emerging risk, which is also informed by external reports (including audit, HealthWatch, feedback from our People's Council and Youth Advisory Board, our regulators and NHSE etc.), and internal reports (such as clinical audit, transformation, assurance reports and serious incident reports).

4. The risk and control framework

4.1 Risk Management Strategy

The Trust's framework for managing risk seeks to ensure that risks in relation to the delivery of services and care to patients are minimised, that the wellbeing of patients, staff and visitors is optimised and that the assets, business systems and income of the Trust are protected, and where possible opportunities are maximised.

The Trust will always be faced with internal and external factors and influences that make it uncertain whether and when it will achieve its objectives. The Risk Management Policy provides an approach to managing any type of risk; it can be applied to any activity, including decision making at all levels. The components of this framework and the characteristics of effective and efficient risk management (according to BS ISO 31000) have been customised over the last three years to enable the Trust to manage the effects of uncertainty relating to increasing financial pressures and COVID-19 on its objectives.

Strategic risk is identified in a number of ways;

- Annually, the Board considers any risk relating to the latest set of strategic objectives.
- The operational risk registers are subject to regular review and where necessary, risks can be escalated from the Directorate Risk Register onto the ORR when corporate oversight is required.
- Monthly review with Directors and with system partners can identify new risk for inclusion onto the ORR during the year.
- Review of risk undertaken at the SEB, EMB, level 1 Committees and the Trust Board can escalate risk for review and potential inclusion on the ORR. Risk is tracked through our governance and this allows for dynamic escalation and de-escalation, and assurance to be provided over key areas of risk.

The Trust Board determines the risk appetite which allows our risks to be identified and quantified in a structured way across the Trust's strategic objectives. This is done in development sessions which allow for open discussion and learning around risk, and plan how we aim to manage risks as a united board for the coming year. The Board's understanding and use of risk and a risk appetite allows us to make an informed choice over taking particular amounts of particular risks, in line with its overall strategy and in contrast to passive risk-taking. The Trust continues to base its risk appetite on the Good Governance Institute risk appetite matrix which accommodates different types of key risk that can be faced within each of our Step Up to Great objectives and areas of escalated corporate risk. A process for applying a risk tolerance is in place to support the practical application of risk appetite.

Previously, Covid-19 related risk has been managed directly through the Incident Control Centre utilising a specific risk and decision log overseen by SEB. Any Covid-19 risk has now been integrated into the Trust's 'business as usual' risk management and assurance arrangements. In addition to the usual reporting mechanisms for the ORR, pertinent risks are circulated in regular Flash Reports to the Trust Board.

Operational risks are identified at a local or directorate level and the risk owner will submit an initial risk assessment on Ulysses for review. This is reviewed by the Risk Review Group (risk specialists, the clinical governance leads, local counter fraud specialist and risk owners where relevant). The risk is quality assessed and then entered onto the system with the risk owner. Regular quality dashboards are presented to the Directorate Management Teams (DMT) which show fields such as whether the risk is in date for review, whether the actions are in date and whether all the fields are complete. If any are due for review or closure this is highlighted to the Directorate Management Teams and the risk owner is automatically notified. The Risk Team also follows this up to provide support where needed. The Risk Review Group also supports any escalation or de-escalation to or from the ORR.

As part of the annual internal audit programme, a core governance and risk audit has been undertaken to support the Head of Internal Audit Opinion for 2022/23. Over the last two years this has focussed on corporate governance and strategic risk management and has provided significant assurance. This year, the focus has been on governance at a directorate level. Whilst the audit was advisory (and therefore no assurance opinion was provided) the audit recommended several low-risk actions for each of the directorates.

4.2 Quality Governance

The Trust's quality governance and leadership structure ensures that the quality and safety of care is being routinely monitored across all services. The development of this continues to embed to ensure that there is an underpinning role culture to support the delivery of an effective and efficient governance framework. Work has continued to;

- Align and streamline the assurance flow through our revised committee structure.
- Continue the use of a governance table on all Board and committee reports to capture the following key fields for all papers requiring a decision;
    - STEP up to GREAT strategic alignment
    - Whether the decision required consistent with LPT's risk appetite
    - Any False and misleading information (FOMI) considerations
    - Positive confirmation that the content does not risk the safety of patients or the public
    - Equality considerations
- Continue to use a highlight report for all groups and committees in the governance structure. The template has recently been revised to allow for assurance ratings to be captured for current performance and progress over the delivery plan for improvement. The highlight reports include risk and policies as core items.
- There is a robust quality performance framework, risk management processes and reporting mechanisms in place to review and challenge performance and variation.
- We have a culture of open and transparent reporting of incidents and risks, supported by a governance structure with three levels of groups and committees to provide specialist oversight and assurance.
- There are monthly finance and performance reports, presenting RAG rated performance and exception narrative for national and local performance standards at a Trust and Directorate level.
- Reporting arrangements also include regular monitoring of progress with key performance measures via the quality account, and quarterly updates on incidents, claims, inquests, patient feedback, complaints and risk.
- We have introduced 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.
- We have re-routed policy oversight and compliance through the parent level 1 committees to promote accountability and oversight following the relevant level 2/3 sign off and consultation.
- Encouraged shorter more succinct reporting style for Board.
- Introduced a single slide format for reporting to executive team meetings. This includes a section to highlight pertinent risks alongside any narrative and escalations.

The Trust's risk and performance management arrangements inherently support the monitoring of ongoing compliance with the requirements for registration set by the CQC. Any risk to compliance identified through routine performance monitoring is escalated through the Trust's risk management

framework.

A range of mechanisms are in place to monitor compliance with the CQC's five domains of safe, effective, caring, responsive and well-led. In addition to the range of metrics included within the performance report, and other assurances received such as patient safety and clinical effectiveness reporting. There is regular oversight and scrutiny of compliance with registration and the fundamental standards;

- The SEB receives updates on the arrangements in place for maintaining registration and receives a monthly update on CQC related activity.
- The EMB has oversight of any concerns raised by the Quality Forum in its highlight report to the Quality and Safety Committee.
- The Quality and Safety Committee receives a regular update on CQC related activity and provides an assurance rating to the Trust Board via its highlight report. This highlight report is also discussed at the Strategic Executive Board.
- The Foundation for Great Patient Care forum monitors progress against CQC improvement action and includes deep dive presentations. A highlight report from the Foundation for Great Patient Care is presented to the Quality Forum with the escalation of any concerns.
- The Trust Board receives an update on key strategic level developments relating to the CQC.
- The Trust Board Development Programme has delivered regular well led sessions, resulting in an annual well led board narrative and updates on the inspection framework. In December 2022 we had a joint board development session (with Northamptonshire Healthcare NHS Foundation Trust under our Group Model arrangement) which had a focus on the CQC inspection framework, with a speaker from the CQC to outline changes taking place to the delivery of inspections across our region.
- The Trust has aligned the Foundations for High Standards Programme as part of a group working arrangement with NHFT on their Crystal Programme. A regular update is provided to SEB.
- During the pandemic we established a trust-wide senior clinical reference group to support key cross Trust clinical decisions in relation to managing the Trust response to COVID-19. This has remained in place as a core clinical decision-making group in the governance structure.

4.3 Data Security

The reporting and management of both data and security risks are supported by ensuring that all staff are reminded of their data security responsibilities through education and awareness. The Data Privacy Team regularly share 'One Minute Briefs' sharing key messages as reminders or as part of learning from incidents and run awareness campaigns on specific topics. Data security training forms part of mandatory training requirements.

Mandatory staff training is supported by a range of additional measures used to manage and mitigate information risks, including, physical security, data encryption, access controls, audit trail monitoring, departmental checklists and spot checks.

The effectiveness of these measures is reported to the Data Privacy Committee and the Finance and Performance Committee. This includes details of any personal data-related Serious Incidents, the Trust's annual Data Security and Protection Toolkit score and reports of other information governance incidents and audit reviews.

4.4 Major Risks

The Trust's risk profile in 2022/23 has had a focus on the safety and wellbeing of our patients and staff and has continued to accommodate the additional challenges and opportunities presenting from

the Covid-19 pandemic, winter, urgent and emergency care pressures and system developments as we work within the Leicester, Leicestershire and Rutland Integrated Care System.

Risks are linked to our strategy and are reviewed as part of a dynamic use of our Organisational Risk Register. We also review our risks in terms of the Leicester, Leicestershire and Rutland health system and share our major risks with our partners.

During the year, there have been sixteen high risk areas which have covered key clinical risks, staffing and corporate areas a detailed below;

- ORR59 - 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 (April, May, June and July).
- ORR60 - A high vacancy rate for registered nurses, AHPs, HCSWs and medical staff, is leading to high agency staff usage, which may result in poor quality care and patient harm (April, May, June, July and August).
- ORR61 - 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 (April, May, June, July and August).
- ORR65 - The present FM provision does not meet our quality standards or requirements, leading to the inability to provide effective hard and soft Facilities Management and maintenance services. This impacts compliance, timeliness of maintenance responses and quality of estates provision for patients, staff and visitors (April, May, June, July, August, September and October).
- ORR68 - 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 (April, May, June, July and August).
- ORR72 - 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 (April, May and June).
- ORR75 - 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 (April, May, June, July, August, September, October, November, December, January, February and March).
- ORR79 - 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 (April, May, September, October, November, December, January, February and March).
- ORR80 - If staff are not vaccinated against influenza, they pose a risk to the health and wellbeing of themselves, colleagues, patients and the wider community. This would adversely impact on Public Health, potentially leading to increased hospitalisation, increased staff sickness levels and staffing challenges and a risk to those who are vulnerable (April and May).
- ORR81 - 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) (August, September, October, November and December).
- ORR82 - The loss of the 11+ healthy together contract will mean a change in delivery for this service from LPT to the LA, impacting on Trust staff and income, and continuity of care for secondary school aged children (May, June, July and August).
- ORR83 - 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 (September, October, November, December, January, February and March).

- ORR84 - 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 (September, October, November, December, January, February and March).
- ORR85 - High agency usage is resulting in high spend, which may impact on the delivery of our financial targets for 2022/23 (September, October, November, December, January, February and March).
- ORR86 - 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 (September, October, November, December, January, February and March).
- ORR87 - 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 (November, December, January, February and March).

As at 31 March 2023 the Trust had the following risk profile;

Summary of the strategic risk profile on the organisational risk register has been provided below and maps each to the risk score as at the end of March 2023.

Current Strategic Risk Profile

Consequence						
	5					
	4		69 Performance Management	59 Incident Management 61 Staff Skills 64 Business Opportunity 66 Estates Strategy 68 Data Accessibility 72 Reaching Out 88 Closed Cultures 89 Cleaning Standards	75 Waiting Lists 79 Cyber Threat 83 Patient Records 84 Agency Usage 85 Agency Spend 87 Inherited FM issues	86 CMHT capacity
	3			73 Inclusive Culture 74 Sickness Levels 81 Financial Position	67 Green Agenda	
	2					
	1					
		1	2	3	4	5
		Likelihood				

4.5 NHS England's Well Led Framework

In June and July 2021, the CQC carried out a Well Led inspection of the Trust. The Trust was provided with positive feedback on being patient safety focused, values driven with good governance and leadership and having fostered partnership working. There was improvement attained in the well led domain which has progressed from inadequate to requires improvement, with many good characteristics.

The Trust has developed a self-assessment narrative against the well led key lines of enquiry for 2022/23 in readiness for an external review, and case studies which showcase good examples of well

led have been identified within the evidence library. Progress against well led is overseen within two key development programmes;

- Delivery of the 'Well Governed' objective within our Step Up to Great strategy. This programme is overseen by our Transformation and Quality Improvement Delivery Group.
- Delivery of our joint strategic priorities with NHFT, one of which is dedicated to Governance. This allows for the sharing of learning with NHFT which has a CQC rating of Outstanding for Well Led.

4.6 Compliance with NHS Provider Licence

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

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

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

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

The Trust has based its compliance declarations on evidence received during the year to demonstrate that effective systems and processes are in place to maintain and monitor the following;

- The effectiveness of governance structures, reviewed as part of the Head of Internal Audit Opinion which has provided significant assurance. Also the assurance flow based on highlight reports which provide escalation, linkages to the ORR and an assurance rating for each item for all level 1, 2 and 3 committees and groups.
- The responsibilities of Directors and Board committees detailed within an Accountability Framework and clear director accountabilities overseen at the Strategic Executive Board.
- Reporting lines and accountabilities between the Board of Directors, its committees and the Trust Executive Group. This is mapped out and a standard operating procedure is in place for the Strategic Executive Board. We also have a system map to identify our integration with system meetings; these flow back into the organisation via the Strategic Executive Board.
- The submission of timely and accurate information to assess risks to compliance with the Trust's licence.
- The Trusts System Oversight Framework rating is a "2" which means 'plans that have the support of system partners in place to address areas of challenge. Targeted support may be required to address specific identified issues'.
- The degree and rigour of oversight the Board of Directors has over the Trust's performance. Performance monitoring continues to mature and improve. The Executive Management Board has a dedicated performance meeting and a revised board performance report is in place.

The evidence base on which this declaration has been made includes the following;

- The Trust has Standing Orders, Standing Financial Instructions, and a Scheme of Delegation, which together describe how the Board of Directors discharge their duties through the Trust's governance structure;
- A risk management strategy which sets the standards for staff regarding the management and responsibility for risk throughout the Trust, describes the Trust's risk appetite and defines the framework and structure for risk management in LPT.
- There is an Organisational Risk Register (ORR) and subsidiary risk registers (i.e. risk assessment, local and directorate risk registers)**.** The Audit and Assurance Committee, Quality Assurance Committee and Finance & Performance Committee have provided assurance to the Trust Board over the management of risk via the highlight reports.
- A risk based Internal Audit programme has been delivered that includes audits of risk management and governance arrangements.
- The indicative Head of Internal Audit Opinion for 22/23 provides significant assurance on all three elements; audit outturn, follow up rate and strategic risk management.
- Self-assessment of performance against the CQC's 'well-led' domain.

4.7 Embedded Risk Management

Risk is embedded within core Trust business, including processes for major decision making. All business cases require an Equality Impact Assessment and a Quality Impact assessment. The Trust has strengthened its governance of EQIAs through the development of a new EQIA policy and enhanced framework overseen by the Transformation and Quality Improvement Delivery Group. EQIAs are signed off by the Medical Director or Director of Nursing, AHPs and Quality.

A Data Protection Impact Assessment is done where integral to the business case. All business cases must have appropriate review to provide assurance that they are clinically safe, financially sustainable and do not expose the Trust to unmitigated risk. Business cases must use the agreed business case templates (unless an alternative is specifically mandated e.g. by commissioners or for capital bids). If the business case has a clinical model this must be reviewed by the Director of Nursing, AHPs and Quality/ Medical Director; confirmation of review is required before the business case can progress for approval. The Director of Nursing., AHPs and Quality and the Medical Director review the clinical model for all business cases over £50k that directly impact on patients and involve changes to clinical staffing.

The business case is then progressively escalated in accordance with the Trust's Standing Financial Instructions (SFIs).

4.8 Workforce Strategies

In line with NHS Improvement Developing Workforce Safeguards policy and National Quality Board (NQB) standards, monthly and six-month staffing reports are provided to Trust Board to assure that the Trust is deploying sufficient, suitably qualified, competent, skilled, and experienced staff to meet care and treatment needs safely and effectively. This has ensured that NQB standards are embedded in the Trusts safe staffing governance with an agreed local staffing quality dashboard/scorecard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics including NICE red flags, planned staffing fill rates, Care Hours Per Patient Day (CHPPD) and quality and safety outcomes for patients, sensitive to nurse staffing (Nurse Sensitive Indicators) and patient experience feedback. The risks in relation to staffing, workforce and quality are reflected in the organisational risk register, understanding that not all risks can be fully mitigated, with actions in place to mitigate risks and impact to patient safety, quality, finance, performance and patient and staff experience.

The Trust continues to demonstrate compliance with the National Quality Board (NQB) expectations to publish safe staffing information each month. The safe staffing data is scrutinised for completeness

and performance by the Director of Nursing, AHPs and Quality and reported to NHS England (NHSE) via mandatory national returns.

The Trust also demonstrates compliance to ensure it meets staffing governance components in the annual nursing staff establishment reviews that have been completed across all inpatient areas using a triangulated methodology using national evidence-based tools, professional judgement and patient outcomes.

A Trust self-assessment against the NHS Winter 2022 preparedness: Nursing and Midwifery safer staffing Board Assurance Framework, November 2022 was completed that focused on preparedness, decision making and escalation processes to support safer nursing in line with NQB workforce standards.

The Trust continues to reflect NQB guidance measures of quality alongside care hours per patient day (CHPPD) to understand how staffing may affect the quality of care within the monthly and six-monthly reports together with learning from patient safety investigations and serious incidents. These measures are considered as 'balancing measures' where the impact of any workforce changes may become visible and the Trust continues to include all aspects of quality and indicators to provide a rounded view of the overall quality. Where risks associated with staffing continue or increase and mitigations prove insufficient this is escalated to the executive Director of Nursing, AHPs and Quality to the Trust board to maintain safety and care quality.

4.9 Care Quality Commission

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

In May and June 2021, the CQC carried out a core service inspection on our acute adult mental health wards, psychiatric intensive care units, mental health rehabilitation wards and the Agnes Unit.

The Trust retained the overall rating of requires improvement at this time and retained a good rating for the caring domain. The Trust achieved improvement in the overall core service ratings as none are now rated as inadequate. There was improvement attained in the well led domain which has progressed from inadequate to requires improvement but with many good characteristics.

The CQC issued the Trust with a Section 29A Warning Notice in relation to two areas;

- Service users on acute mental health wards having adequate access to call alarms to summon help for support or in an emergency, if required.
- progress with improvement in the ward environments at the Bradgate Mental health Unit to ensure these are fit for purpose and complied with guidance on shared sleeping arrangements on mental health wards ('dormitories').

An improvement plan was developed in response to the enforcement notice. The CQC undertook an unannounced reinspection of the acute wards for adults of working age and psychiatric intensive care units and the report, issued in May 2022 confirmed that all actions required in the enforcement action had been met. The CQC moved up the Trust's ratings for this core service in recognition of these improvements in the two key domains they inspected – Safety and Responsiveness. The Safety domain of the service has moved up from Inadequate to Requires Improvement. The Responsive domain has moved up from Requires Improvement to Good for this service. The Trust has retained the overall rating of requires improvement.

We continue to support system inspections and SEND inspections and review themes and learning from the Mental Health Act inspections. We remain on track for delivery of our CQC action plan.

4.10 Health and Safety Executive

The Trust has not received any enquiries or visits from the Health and Safety Executive during the year. The Trust has not received any intervention from the Health and Safety Executive during the reporting period that resulted in prosecution or enforcement notification. There have been no enquiries or visits from the Local Fire Authority, the Leicestershire Fire & Rescue Service. No formal

prosecution or enforcement notifications have been received.

4.11 Register of interests

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance.

The Trust uses an online self-declaration database tool 'Declare' which is recognised as the most effective way of capturing declarations of interest, gifts and hospitality, sponsorship and other potential conflicts of interests. Declare provides a robust management system and offers Trust wide transparency for business conduct declarations by all staff including our directors.

The Trust's Code of Conduct Policy is aligned to the NHSE model guidance and also includes an extended group of decision makers to include all staff who meet the following criteria: Band 8d or above or equivalent salary, all staff in the Procurement Team, Pharmacy Teams and Medical Devices Team. As of 31 March 2023, overall compliance for all decision makers is 88%; this exceeds the national NHSE target. All LPT's decision maker declarations can be publicly viewed: https://lpt.mydeclarations.co.uk/home

4.12 NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contribution and payments into the Scheme are in accordance with Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

These are automated processes run by a specialist payroll team to ensure that all staff are assessed and enrolled into the appropriate scheme for their circumstances.

4.13 Equality, Diversity and Human Rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. LPT is fully compliant with its legal and regulatory obligations under the equality Act 2010 and contractual EDI Standards. All information is published on its website in accordance with the EHRC's technical guidance on the publication of information on its external webpages.

All EDI reports, including those on compliance, are discussed and approved through the relevant EDI governance committees.

The Trust has an Executive Lead for Diversity and Inclusion and as part of the Group Model with NHFT there is a priority programme focussed on 'Together Against Racism'. Members of both Trust Boards have pledged commitment to being anti racist. This year, there have been two joint board sessions on together against racism resulting in an ongoing programme of improvement and development. The Trust also delivers a reverse mentoring programme. Both LPT and NHFT (under the Group arrangement) received the outstanding contribution for promoting EDI from the Asian Professionals National Alliance (APNA) NHS National awards. Our Head of International Recruitment was awarded the APNA super star award for 2022, and the Community Practitioners and Health Visitors Association (CPHVA) covid hero award. Our joint CEO won the Excellence in Leadership award. The Trust has been accredited with the NHS Pastoral Care Quality Award for supporting the international recruitment of nurses and midwives. NHSE Midlands was the MIDAS EDI Champion of the Year 2022.

4.14 Net Zero

The Trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and Adaptation Reporting requirements are complied with. The Trust has a Green Plan in place and is working with partners in the local health economy, and beyond, to address our responsibilities and commitments to the NHS Long Term Plan, reaching net zero by 2040 and securing a Greener NHS.

The Trust has put an emissions limit on lease cars to ensure that the fleet is as green as possible. Our plans for future new builds conform to the Government's MMC (modern methods of construction) and net zero carbon (NZC).

5 Review of Economy, Efficiency and Effectiveness of the Use of Resources

The Trust's Productivity and Efficiency Strategy describes the importance of embedding a value for money culture within the organisation, through financial training and awareness, multi-professional working, an open and transparent approach around our challenges, advanced partnership working, using research, learning and best practice. The Trust is a member of the HFMA healthcare costing for value institute.

The Trust has a robust process in place for monitoring the efficiency of the use of resources, most evidently through the financial efficiency programme. The efficiency plan is developed by services and peer reviewed in the enhancing value group and overseen by the Transformation Committee and Executive Team. Financial delivery of efficiencies is reported to FPC and Trust Board. All efficiency schemes must have an equality & quality impact assessment which has been approved by the Medical Director and Director of Nursing. A challenging efficiency target has been agreed for the 2023/24 financial plan, supported by a 2-stage recovery plan approach. The short-term plan will support identification and delivery of the outstanding efficiency target for 2023/24. The medium-term recovery plan will focus on the recurrent financial sustainability of the Trust, using a value in healthcare approach to ensure productivity and efficiency is understood and evidenced.

The Trust has a well-established expenditure control process. The requirement to use purchase orders for all applicable spend is also embedded. Both of these processes, together with the use of the authorised delegation limits and procurement requirements in the Trust's Standing Financial Instructions (SFIs), ensure that the Trust minimises unnecessary spend and ensures that value for money is considered before spend is incurred.

External and Internal Audit undertake a variety of audits on efficient use of resources to help understand any areas of weakness in internal controls.

The Trust submitted a self-assessment of its compliance with *Government Functional Standard 013: Counter Fraud* to the NHS Counter Fraud Authority (NHSCFA). The NHSCFA did not require further engagement with the Trust following consideration of the submission. A letter was received confirming compliance with Better Payments.

6 Information Governance

There are a number of controls in place to mitigate Information Governance (IG) related risk. The reporting and management of both data and security risks is supported by the local and directorate risk registers. Information Governance forms part of the Trust's mandatory training requirements. Regular reminders are provided by the 'ULearn' system and the importance of Data Security training is communicated to staff through staff communications. There are also a number of measures in place such as physical security, data encryption, access controls, audit trail monitoring, departmental checklists and spot checks. In addition, a comprehensive assessment of information security is taken annually as part of the Data Security and Protection Toolkit and further assurance is provided from internal audit and other reviews.

The effectiveness of these measures and oversight of the Data Security and Protection Toolkit is undertaken by the Data Privacy Group. This includes details of any personal data-related Serious Incidents, the Trust's annual Data Security and Protection Toolkit score and reports of other

information governance incidents, risks and audit reviews. The committee is currently providing positive (green rated) assurance over the management of risk to the Finance and Performance Committee.

During 2022-23 we had 7 incidents in relation to the mishandling of personal identifiable data classified as a 'reportable data breach' under the revised incident reporting guidance – *Guide to the Notification of Data Security and Protection Incidents* published by NHS Digital in conjunction with the Information Commissioners Office (ICO). The ICO confirmed in all cases that no further action was needed. The learning from these incidents has been shared through the Incident Review meetings and where appropriate key message reminders sent out to staff in 'One Minute' Briefs and through policy development and review.

All Information Governance incidents are scrutinised by the Data Privacy Committee in order to ascertain any organisational learning, which is shared through the relevant Service Directorate Governance Groups where relevant.

7 Data quality and governance

To ensure that the quality of data has the appropriate level of oversight at committee level, data quality has been incorporated into the Data Privacy Committee (DPC) with its role in driving and monitoring the information governance agenda and all its activities, of which data quality is an element. The DPC's split agenda has ensured an appropriate focus on data quality and the outputs reported to FPC via the highlight report.

Data Quality has been embedded as a key component of the Trust Strategy under the Well Led domain and the outputs aligned to the Data Quality Framework.

8 Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board and the audit and assurance committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

8.1 The Board

The current Trust Board of Directors comprises of a Chair, six non-executive Directors, a Chief Executive Officer and three other voting executive directors. In addition to this, the Trust has eight directors in attendance (non-voting) as detailed below;

Executive Directors - Voting

There are four voting Executive Directors comprising the Chief Executive, Director of Finance, Medical Director and the Director of Nursing, AHPs.

Directors – Non-Voting

There are eight Directors in Attendance plus the Trust Secretary (non-voting)

- The Deputy Chief Executive Officer
- The Trust's Operational Directors (one for each of the three clinical directorates)
- The Director of Human Resources and Organisational Development.

- Under the Group Model in place with Northamptonshire Healthcare NHS Foundation Trust, there are three Group Directors including a Director of Strategy, Director of Corporate Governance and Risk and a Chief Finance Officer across both trusts.

There were a number of changes to Executive and Non-Executive Directors during the reporting period;

- An interim Medical Director (Dr. Saquib Muhammad) is in place due to a vacancy which is currently out for substantive recruitment.
- A new Director of Mental Health was appointed (Tanya Hibbert, replacing Fiona Myers).
- Two non-executive director vacancies were filled during the year (Hetal Parmar, Chair of AAC and Alexander Carpenter, Chair of FPC).

The Board meets in public 6 times a year with a focus on assuring itself of the performance of the whole of the organisation. Standing items on the meeting agenda include patient voice and service user feedback, staff voice, finance and performance reports and the Organisational Risk Register. Detailed reports have been received on a broad range of strategic and governance issues.

To support the Board of Directors in fulfilling its duties effectively, level 1 committees are formally established with Board approved terms of reference. The remit and terms of reference of these Committees have been reviewed during the year to ensure continued robust governance and assurance. The importance of the triangulation of understanding, challenge and assurance between committees is recognised and reflected through cross-membership and reporting between committees and through the receipt of highlight reports to the Board of Directors.

The Board reviews its commitment to the codes of conduct and accountability for NHS Boards annually and is compliant with the codes of good practice for Boards, as applicable to a provider service NHS Trust, of the HM Treasury/Cabinet Office Corporate Governance Code.

All groups and committees in the corporate governance structure undertake an annual review of effectiveness (this includes the Joint Working Group, a committee in common with NHFT). The reviews confirmed that all groups and committees have achieved their aims and were deemed effective in the preceding year.

8.2 The Audit and Assurance Committee

The Audit and Assurance Committee (AAC) has non-executive director membership. It meets not less than four times a year and reports to the Board annually on its work in support of the Annual Governance Statement. The primary roles of the committee are to independently monitor and review our internal control systems, risk management arrangements, and provide independent advice and assurance to our Trust Board.

8.3 Quality and Assurance Committee

The Quality and Assurance Committee (QAC) is chaired by a non-executive director, has two other non-executive director members and executive directors in attendance. It meets on a bi-monthly basis for discussion and assurance that quality and safety arrangements are in place throughout the Trust and that they are working effectively. The Committee has oversight of any limited / part limited internal audits. It also receives updates on any quality summits, and assurance from all key areas within its remit.

8.4 Finance and Performance Committee

The Finance and Performance Committee (FPC) is chaired by a non-executive director, has two other non-executive director members and executive directors in attendance. It meets on a bi-monthly basis for discussion and assurance over the delivery of key financial strategies, key financial indicators, business development and investment, performance management, estate management and IT management.

The Committee has oversight of any limited / part limited internal audits. It also receives assurance from all key areas within its remit.

8.5 People and Culture Committee

The People and Culture Committee (PCC) is chaired by a non-executive director, has one other non-executive director member and executive directors in attendance. It meets on a bi-monthly basis for discussion and assurance that arrangements are in place throughout the Trust to mitigate workforce related risk and that they are working effectively. The first meeting of the PCC was held in February 2023.

8.6 Clinical Audit

The Trust maximises opportunity to learn from good practice and has a systematic quality improvement approach using the NHS Model for Improvement as its single approach to quality improvement. Clinical audit remains an integral part of the Trust's quality improvement approach. A programme of internal and external clinical audits for clinical quality assurance and control and the implementation of NICE quality standards provides robust mechanisms along with PDSA for quality improvement to be embedded. The Trust has an annual programme of national and local clinical audits which is presented to the Audit and Assurance Committee, with ongoing oversight of clinical audit outturn at the Clinical Effectiveness Group (CEG) where learning and triangulation also takes place.

During 2022/23 the Trust participated in four national audits and supported 26 local audits. Each clinical audit has an assigned quality improvement practitioner who supports the governance and learning process and each local clinical audit is discussed as part of our quality improvement design huddle to ensure that clinical audit is the most appropriate methodology to lead to improvement. Each clinical audit undertaken is linked to a Care Quality Commission domain and provides assurance over a level of compliance against associated key lines of enquiry.

There is a group programme approach to improvement underway with our buddy trust, Northamptonshire Healthcare Foundation Trust (NHFT) which is underpinned by the principles of quality improvement including clinical audit. 'Foundations 4 High Standards' is based on the four foundations of safety, support, self-assessment and surveillance and aligned to the Step Up to Great strategy.

8.7 Internal Audit

During the year 12 audits have been completed and will be taken into account in the Head of Internal Opinion. From the 2022/23 plan 10 audit reports were issued, and 2 reports were issued from the 2021/22 audit plan. Overall there were 5 advisory reports (which do not provide an assurance rating), 2 provided limited assurance (recruitment and retention from the 22/23 plan, and violence and aggression from the 21/22 plan). The remaining five provided Significant or Substantial (NHSE opinion wording) assurance including;

- Data security standards
- Business continuity
- Patient experience
- Cyber Security
- Remote consultations

Any limited or part limited assurance reports received from our internal auditors are reviewed by the lead Director and action owners, and presented to the Strategic Executive Group, and the relevant level one committee.

8.8 Head of Internal Audit Opinion

This year's interim Head of Internal Audit Opinion provides a Significant Assurance that there is a

generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

This opinion relates to all three main areas;

- Organisational Risk Register and strategic risk management. This section has been rated in the indicative Head of Internal Audit Opinion as Significant Assurance due to the maturity and embeddedness of risk management arrangements within the Trust. In part, this was evaluated on the basis of a Trust Board survey which showed that members were very positive about the culture of the Board, the ORR being reflective of the actual risks of the Trust and that there is meaningful review and challenge of the ORR.
- Individual assignments. This section has been rated as Significant Assurance. The threshold for substantial assurance is to have no limited or part limited assurance reviews during the year, and for there to be no themes around governance or clinical risk resulting from work undertaken. Our approach to audit planning is risk based and so we invite our auditors to assess those areas where the Trust has known risk. This is more likely to attract scope for limited assurance opinions in audit outturn.
- Follow up of actions. We have a strong internal follow up process, with oversight by the Executive Management Board and the Audit and Assurance Committee. The Trust achieved a 93% first follow up rate. This has been rated in the Head of Internal Audit Report as significant assurance. Our overall follow-up rate is 98%.

8.9 External Audit

The Local Audit and Accountability Act 2014 requires auditors of NHS Bodies to be satisfied that the organisation has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. This is supported by the Code of Audit Practice, published by the NAO in April 2015, which requires auditors to take into account their knowledge of the relevant local sector as a whole, and the audited body specifically, to identify any risks that, in the auditor's judgement, have the potential to cause the auditor to reach an inappropriate conclusion on the audited body's arrangements. KPMG, as the Trust's appointed external auditors, is required to provide the Trust with a Value for Money conclusion as part of the annual accounts audit; this is in accordance with changed National Audit Office guidance about these reviews for NHS bodies.

The external audit Value for Money Audit Plan has been issued with the following identification of risks of significant VFM weakness;

- Financial Sustainability, one significant risk identified – see below
- Governance. Rated Green, no issues identified
- Improving Economy, Efficiency and Effectiveness, one significant risk identified – see below

Financial Sustainability

Due to the current underlying deficit at both the Trust and Integrated Care Board (ICB) level there is a risk that the Trust does not have in place adequate arrangements to achieve financial sustainability in the medium term (KPMG)

The Trust has developed an efficiency plan for 2023/24 which delivers the required 4% target as part of the breakeven plan. A 3-year financial strategy will be prepared alongside the ICB 3-year financial strategy for revenue and capital.

8.10 Emergency Preparedness, Resilience and Response (EPRR)

The Trust is discharging its EPRR responsibilities, aligned to the Trust's EPRR Policy and the Civil Contingencies Act (2004). The Trust provided evidence of compliance against the Emergency Preparedness Resilience and Response (EPRR) core standards to NHS England for 2022/23 with an 84% compliance rate (fully compliant with 46 standards and partially compliant for 9 standards). This has resulted in a change in overall compliance rating from substantial to partial for 2022/23. The Trust

has an improvement plan in place to strengthen key areas including the recording of staff training against the Minimal Occupational Standards for EPRR, to develop a Personal Development Portfolio (PDP) for all responders involved in incident response and record all training subject to audit.

Our staff have been involved in the following exercises over the last year;

- Exercise Albus – ICB major incident training exercise (June 2023)
- Exercise Toucan I and II – online/telephone exercise run by NHSE testing in and out of hours communication and cascade mechanisms. (July and Oct 2022)
- Exercise Lemur – LRF power outage exercise (Nov 2022)
- Exercise Arctic Willow – workbook and tabletop exercise carried out via MS Teams testing the health response to multiple, concurrent operational and winter pressures. (Dec 2022)

Planning is underway for future exercises including:

- Exercise Mighty Oak a national Power Outage Exercises in March 2023
- Wider ICS exercises are also being planned with UHL and LPT to test Mass Countermeasures Plan.

9. Conclusion

My review confirms that no significant internal control issues have been identified, and that Leicestershire Partnership NHS Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives and minimises exposure to risk. The Trust is committed to the continuous improvement of processes of internal control and assurance and as such may introduce additional controls within the forthcoming financial year (2023/24).

Statement of the chief executive's responsibilities as the accountable officer of the trust

The Chief Executive of NHS England has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the trust
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- effective and sound financial management systems are in place and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, other items of comprehensive income and cash flows for the year.

As far as I am aware, there is no relevant audit information of which the trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed.....Chief Executive

Date.....

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

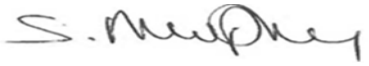
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy

By order of the Board

.....Date.....Chief Executive

16 May 2023

.....Date.....  . Finance Director

Certificate on summarisation schedules

Trust Accounts Consolidation (TAC) Summarisation Schedules for Leicestershire Partnership NHS Trust

Summarisation schedules numbers TAC01 to TAC34 and accompanying WGA sheets for 2022/23 have been completed and this certificate accompanies them.

Finance Director Certificate

1. I certify that the attached TAC schedules have been compiled and are in accordance with:
    - the financial records maintained by the NHS trust
    - accounting standards and policies which comply with the Department of Health and Social Care's Group Accounting Manual and
    - the template NHS provider accounting policies issued by NHS England, or any deviation from these policies has been fully explained in the Confirmation questions in the TAC schedules.
2. I certify that the TAC schedules are internally consistent and that there are no validation errors.
3. I certify that the information in the TAC schedules is consistent with the financial statements of the NHS Trust.

[Signature] 

[Name], Director of Finance SHARON MURPHY

[Date] 16 May 2023

Chief Executive Certificate

1. I acknowledge the accompanying TAC schedules, which have been prepared and certified by the Finance Director, as the TAC schedules which the Trust is required to submit to NHS England.
2. I have reviewed the schedules and agree the statements made by the Director of Finance above.

[Signature]

[Name], Chief Executive

[Date]