Leicestershire Partnership NHS Trust

# Public Meeting of the Trust Board
# 9.30 am Tuesday 7th July 2020
# Venue: Microsoft Teams
# AGENDA

**1) Covid-19 2) Quality and Safety 3) Health and Wellbeing of Staff 4) Risk 5) Finance and Impacts on Performance 6) Statutory requirements**

| Public meeting | | | |
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| **Time** | | **Item** | **Lead** |
| 9.30 | 1 | Apologies for absence and welcome to meeting – Trust Board Members *(Paper A)* | Chair |
| 9.35 | 2 | Patient voice film – Mental Health Theme | GK |
| 9.40 | 3 | Staff voice – Mental Health Theme | GK |
| 9.55 | 4 | Declarations of interest in respect of items on the agenda | Chair |
| | 5 | Minutes of the previous public meeting: 27th May 2020 *(Paper B)* | Chair |
| | 6 | Matters arising *(Paper C)* | Chair |
| 10.10 | 7 | Chair's Report *(Paper D)* | Chair |
| 10.20 | 8 | Chief Executive's Report *(Paper E)* | AHillery |
| | | **Governance and Risk** | |
| 10.35 | 9 | Organisational Risk Register *(Paper F)* | CO |
| 10.45 | 10 | Level 1 Committees Annual Reports *(Paper G)(To Follow after Audit Committee meeting 3rd July 2020)* | CO |
| 10.55 | 11 | Documents Signed Under Seal Q4 2019/20 and Q1 2020/21 *(Paper H)* | CO |
| | | **Strategy and System Working** | |
| 11.00 | 12 | Service Presentation – Mental Heath – Managing through COVID-19 *(Paper I)* | GK |
| 11.20 | 13 | Break | |
| | | **Quality Improvement and Compliance** | |
| 11.30 | 14 | Video - Coalville Community Hospital Discharge Video | Chair |
| 11.35 | 15 | Quality Assurance Committee Highlight report 16.06.20 *(Paper J)* | LR |
| 11.40 | 16 | Director of Nursing's Report including AHP report *(Paper K)* | AS |
| 11.50 | 17 | Infection Prevention and Control Board Assurance Framework (Updated version) *(Paper L)* | AS |

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| 11.55 | 18 | Care Quality Commission (CQC) progress Report *(Verbal)* | AS |
| 12.05 | 19 | Patient Safety Incident and Serious Incident Learning Report *(Paper M)* | AS |
| 12.10 | 20 | Patient and Carer Experience and Involvement Quarterly Report Q4 *(Paper Ni)*<br>Improving our Complaints Report *(Paper Nii)* | AS |
| 12.20 | 21 | Learning From Deaths Q4 Report *(Paper O)* | AHiremath |
| 12.30 | 22 | Safer Staffing - Monthly Report *(Paper P)* | AS |
| 12.35 | 23 | Freedom To Speak Up Guardian Annual Report *(Paper Q)* | PL |
| 12.45 | 24 | Annual Equality Report including Workforce Race Equality Standard Annual Report *(Paper R)* | SW |
| | | **Performance and Assurance** | |
| 12.55 | 25 | Finance and Performance Committee Highlight Report 16.06.20 *(Paper S)* | GR |
| 1.00 | 26 | Finance monthly report – Month 2 *(Paper T)* | DC |
| 1.10 | 27 | Performance Report – Month 2 *(Paper U)* | DC |
| 1.20 | 28 | Charitable Funds Committee Highlight Report – 11.06.20 *(Paper V)* | CE |
| 1.25 | 29 | Review of risk – any further risks as a result of board discussion? | Chair |
| | 30 | Any other urgent business | Chair |
| | 31 | Papers/updates not received in line with the work plan: | Chair |
| | 32 | Public questions on agenda items | Chair |
| | 33 | Feedback on today's meeting | Chair |
| 1.30 | 34 | **Date of next public meeting:**<br>**1st September 2020 venue Guthlaxton Committee Room, County Hall.** | Chair |

It is recommended that, pursuant to Section 1 (2), Public Bodies (Admission to Meetings) Act l960, representatives of the press and other members of the public be excluded from the following meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Leicestershire Partnership NHS Trust

# Confidential Trust Board Meeting
# 2.00 pm on Tuesday 7th July 2020
# Venue: Microsoft Teams
# AGENDA

**Confidential Agenda**

| Time | | Item | Lead |
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| 2.00 | 1 | Apologies for absence: | Chair |
| 2.00 | 2 | Declarations of interest in respect of items on the agenda | Chair |
| | 3 | Minutes of the previous confidential meeting:<br>EGM - 27th May 2020 *(Paper AAi)*<br>Confidential - 27th May 2020 *(Paper AAii)* | Chair |
| | 4 | Matters arising *(Paper BB)* | Chair |
| 2.05 | 5 | Chief Executive's report *(Verbal)* | AHillery |
| | | **Governance and Risk** | |
| 2.15 | 6 | Trust's Annual Governance Statement 2019/2020 *(Paper CC)* | CO |
| | | **Strategy and System Working** | |
| 2.20 | 7 | Draft Business Case Facilities Management *(Paper DD)* | DC |
| | | **Quality Improvement and Compliance** | |
| 2.35 | 8 | Serious Incident Summaries Q1 Report *(Paper EE)* | AS |
| 2.45 | 9 | Domestic Homicide Review, Child Safeguarding Learning Review and Safeguarding Adult Review Report Quarter 1 2020 *(Paper FF)* | AS |
| 2.55 | 10 | Review of risk – any further risks as a result of board discussion? | Chair |
| | 11 | Confirmed minutes from all committee meetings available to Board members on request. | Chair |
| | 12 | Any Other Business | Chair |
| | 13 | Papers/updates not received in line with the work plan: | Chair |
| | 14 | Feedback on today's meeting | Chair |
| 3.00 | 15 | Close | |

# Our Trust Board

## As of June 2020

NHS
Leicestershire Partnership
NHS Trust

**Cathy Ellis**
Chair

**Angela Hillery**
Chief Executive

**Daniela Cecchini**
Deputy Chief Executive and Director of finance

**Geoff Rowbotham**
Non-Executive Director and Deputy Chair

**Faisal Hussain**
Non-Executive Director

**Liz Rowbotham**
Non-Executive Director

**Prof. Kevin Harris**
Non-Executive Director

**Ruth Marchington**
Non-Executive Director

**Darren Hickman**
Non-Executive Director and Senior Independent Director

**Rachel Bilsborough**
Director of community health services

**Gordon King**
Director of adult mental health

**Helen Thompson**
Director of families, young people and children's services and adult learning disabilities

**Sarah Willis**
Director of human resources and organisational development

**Chris Oakes**
Director of corporate governance and risk

**David Williams**
Director of strategy and business development

**Dr. Avinash Hiremath**
Interim Medical Director

**Dr. Anne Scott**
Interim Director of nursing, allied health professionals and quality

Leicestershire Partnership NHS Trust

**Leicestershire Partnership NHS Trust Public Trust Board Meeting 7th July 2020 – Video Presentation**

Video 1:

Agenda Item 2 – Patient Voice – Mental Health Theme

https://youtu.be/8G0acSCrSjY

Leicestershire Partnership NHS Trust

**Leicestershire Partnership NHS Trust Public Trust Board Meeting 7th July 2020 – Video Presentation**

Video 2:

Agenda Item 3 – Staff Voice – Mental Health Theme

This video is for background viewing as part of the Staff Voice item. Subtitles are advised as in some places the sound is quiet.

https://www.youtube.com/watch?v=KO6NUYEWuuQ

UNCONFIRMED

Leicestershire Partnership NHS Trust

**Trust Board**

**B**

**Minutes of the Public Meeting of the Trust Board**
**Wednesday 27th May 2020 10.00am**

**Microsoft Teams**

**Present:**

Ms Cathy Ellis, Chair
Mr Geoff Rowbotham, Non-Executive Director/Deputy Chair
Mr Darren Hickman, Non-Executive Director
Ms Ruth Marchington, Non-Executive Director
Mrs Elizabeth Rowbotham, Non-Executive Director
Mr Faisal Hussain, Non-Executive Director
Ms Angela Hillery, Chief Executive
Dr Sue Elcock, Medical Director
Dr Anne Scott, Director of Nursing AHPs and Quality

**In Attendance:**

Ms Rachel Bilsborough, Director of Community Health Services
Mr Gordon King, Interim Director of Mental Health
Ms Helen Thompson, Director, Families, Young People & Children Services & Learning Disability Services
Mrs Sarah Willis, Director of Human Resources & Organisational Development
Mr Chris Oakes, Director of Corporate Governance and Risk
Mr David Williams, Director of Strategy and Business Development
Ms Kate Dyer, Head of Governance and Interim Company Secretary
Mr Mark Farmer, Healthwatch
Ms Deanne Rennie, Interim Deputy Director of Nursing AHPs and Quality
Ms Rachel Travis-Pruden, Deputy Head of Nursing AMH/LD
Ms Sally Camm, Next Director Scheme
Mrs Kay Rippin, Corporate Affairs Manager (Minutes)

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| TB/20/085 | **Apologies for absence and welcome to meeting - Chair**<br>Apologies were received from Ms Dani Cecchini, Director of Finance and Professor Kevin Harris, Non-Executive Director. |
| TB/20/086 | **Beaumont Ward, Bradgate Mental Health Unit Covid-19 Video:**<br>The attendees watched this staff experience video showing a day in the life of Funminiyi Adenle, Charge Nurse/Ward Manager on Beaumont Ward living through the challenges of the Covid-19 period and balancing his home and work life. The video was shown on ITV News locally and shows Funminiyi to be an inspirational |

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| | leader despite the anxieties he feels for himself and his family.<br>Angela Hillery detailed how the BAME staff listening events are key and will continue to support our staff. Yvonne Coghill is supporting these events and is at the forefront of this work nationally. LPT's risk assessments continue to be co-produced and staff's anxieties are not underestimated. Gordon King commented that Funminiyi Adenle is an inspirational leader and has helped shape the BAME staff risk assessments. His report gives an insightful picture of the challenges of nursing on a Covid-19 mental health ward |
| TB/20/087 | **Declarations of interest in respect of items on the agenda - Chair**<br><br>The Chair reminded all Board members to record any declarations or a nil return on the Self Service LPT Declare. The Board members confirmed that they had no conflicts of interest in relation to the agenda items.<br>**Action: No action required.** |
| TB/20/088 | **Minutes of the previous public meeting: 5th May 2020 (Paper A) - Chair**<br>The minutes were agreed as an accurate record of the meeting and no amendments were required.<br>**Action: No action required.**<br>**Resolved: The Board agreed the minutes of the Public Trust Board Meeting 5th May 2020** |
| TB/20/089 | **Matters arising (Paper B) - Chair**<br>Actions 914 and 915 were rated as complete and green, Action 907 an amber item on paper B, was being presented on today's agenda so was now complete.<br>**Action: No action required.**<br>**Resolved: The Board agreed action 907 was complete.** |
| TB/20/090 | **Chairman's Report (Paper C) - Chair**<br>The Chair offered thanks to all staff for their hard work and stepping up to great during this Covid-19 period.<br>The Chair described continued visible leadership from Board members through staff briefings, videos and Twitter during this period. The Chair joined the BAME staff listening event with Yvonne Coghill who is the National Director for the Workforce Race Equality Standard (WRES) programme. At this event, staff were able to raise concerns and be assured that risk assessments will be undertaken for all BAME staff which will be tailored and personalised to their needs. The Chair also joined the first ever staff networks MS Teams meeting where over 60 members of staff attended. Positive feedback was received from staff who found this a more accessible and inclusive way to meet.<br>The Chair described the good governance that has continued throughout the Covid-19 period with The Board and level 1 committee meetings continuing to meet. The agendas focus on 6 areas: Covid19, quality &safety, health & wellbeing of staff, risk, finance & performance, statutory requirements. Non-Executive Director team meetings have continued with the Chair every week on MS Teams to brief on Covid19 related matters and ensure alignment of committee governance.<br>The Chair thanked the public and local businesses for all of their support for both staff and the Trust's charity, Raising Health.<br>**Action: No action was required.** |

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| TB/20/091 | **Chief Executive's Report (Paper D) - AH**<br>Angela Hillery offered enormous thanks to everyone across the Trust, to stakeholders and to partners. We are now moving into phase two which is managing through the Covid-19 incident and we need to ensure that all service restarts are safe. Admissions to Lutterworth Fielding Palmer Hospital have been temporarily suspended for the safety of patients and staff during this period.<br>Angela Hillery confirmed that collaborative work continues between the Trust, Sussex Partnership Foundation Trust and Northamptonshire Healthcare Foundation Trust in response to the impact of Covid-19 on colleagues with protected characteristics, specifically those staff from a BAME background. The CEOs, Directors of Nursing, Human Resource Directors and Equality & Inclusion Leads are working together to support over 3000 colleagues across the 3 trusts. This includes sharing data sets including analysis of workforce profiles, Covid Absence data & BAME Network feedback, shared operational Risk Assessment and sharing outcomes and actions. This work has now been shared nationally and we will continue to use the collaborative to remain proactive in this area.<br>The CQC visits remain on pause, but relationship meetings continue and the relationship with the CQC remains very active during this Covid-19 period.<br>Angela Hillery confirmed that we do not have a contract with commissioners at this time as we are in a level 4 command and control with central funding. Collaborative work across Leicester, Leicestershire and Rutland (LLR) and Northamptonshire continues on demand and capacity modelling, with CEOs meeting regularly.<br>Angela Hillery described some of the mental health responses to Covid-19 as excellent and aligned to the Trust's long term plans.<br>Angela Hillery offered thanks for their work to both Sue Elcock and Frank Lusk who are leaving the Trust this month<br><br>Geoff Rowbotham asked if there was a timeline on risk assessments with staff with protected characteristics and if these results could be brought back to Board to help shape thinking for the future. Geoff Rowbotham also commented on the positivity of the collaborative work stating that many communities do not recognise the borders that the NHS create. This was an opportunity for population health management to improve outcomes.<br>Angela Hillery described work being conducted by Alison Tonge who is the regional director of Population Health Management. This work provides a real opportunity for providers and commissioners and work on this has already begun. Angela Hillery suggested that looking at the restoration and recovery phase and what has been learnt and what has benefitted us would be a useful session in a future Board development meeting.<br>Sarah Willis confirmed that enhancements are being made to the risk assessments following 4 virtual meetings held with over 200 managers and the feedback gathered at these meetings. A risk matrix is currently being developed.<br><br>Mark Farmer, Healthwatch echoed the thanks already offered to staff for helping the population of LLR stay well during Covid-19. The patient and carer voice needs to be present during the recovery phase and conversations around this are ongoing with Dani Cecchini, Rachel Bilsborough and Alison Kirk.<br>Mark Farmer, Healthwatch also questioned if the clarity of the mental health investment standard will have an impact for LPT. Angela Hillery confirmed that mental health has a clear expectation of recovery resource and rightly so. Discussions around this are ongoing at the National Mental Health Group where |

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| | Angela Hillery represents the Midlands region. Angela Hillery confirmed that patient experience and co-production are fundamental and the best way to ensure that services are up to standard. LPT remains committed to that.<br>Rachel Bilsborough confirmed that in the early Covid-19 stages it was important to make rapid decisions but moving forward thinking around future models can involve patients and carers and this is currently being work on. Gordon King agreed that moving forward co-production will be key for mental health step up to great.<br>Helen Thompson confirmed that this has already begun with Young People's Top Ten Tips for lockdown and the Learning Disability Short Breaks service, staff are contacting users to consult on what they would like to see moving forward and how can we do this safely.<br>Darren Hickman asked how the Digital Development Programme will impact on LPT and Angela Hillery confirmed that all Trusts are involved and the ambition will be different since the surge in digital technology since Covid-19. David Williams added that all in LLR will be working on this together and the Recovery Cell is looking at this in conjunction with Primary Care and UHL. The Information Management and Technology Group (IM&T) will be considering a revised strategy. David Williams also confirmed plans to work with Mark Farmer, Healthwatch on the Learning Disabilities Transforming Care work.<br>Faisal Hussain commented that the letters to children/families have been received very positively in the Facebook staff group; also the correspondence to BAME staff and the workshops and listening events help staff know that they are being listened to and he thanked the team for this work. Angela Hillery's final comment was that whilst we seek to capture the patient experience we must also, as a Trust Board, remain sighted on those who are not accessing the services at this time when they would have ordinarily done so.<br>**Action: No action required.** |
| TB/20/092 | **Organisational Risk Register (ORR) and Covid-19 Risk (Paper E) – CO**<br>Chris Oakes introduced the paper and confirmed that it had been to the Exec Team, Quality Assurance Committee (QAC) and Finance and Performance Committee (FPC) and been rated as green (High Assurance) in both committees. The team are currently reviewing the risks on the Incident Control Centre (ICC) for transferring onto the ORR as necessary. Chis Oakes asked the Trust Board members to review the new slides in the ORR slide pack to ensure they felt that they were appropriately placed. Kate Dyer added that slide 40 will be updated at the point additional risks are added to the slide pack.<br>The Chair confirmed that the Board was being asked to approve the additional Covid risk; note the amendments; close risk 29 and accept the new post Covid risk for June around bed capacity.<br>Geoff Rowbotham raised the possibility of a second Covid-19 spike and questioned if this was clear in the risks. Chris Oakes confirmed that this is a developing process and this risk may need to be added moving forward.<br>Liz Rowbotham added that the Quality Assurance Committee (QAC) have been very supportive of the work on the ORR and around the new Covid-19 risks which have been developed from the ICC risks. Ruth Marchington added that QAC have also received very thorough Safeguarding Reports and that we need to keep an eye on this as lockdown lifts and new data emerges. This will continue to be monitored through QAC.<br>**Action: No action required.**<br>**Resolved: The Board approved the additional Covid risk; noted the** |

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| | **amendments; agreed the closure of risk 29 and accepted the new post Covid-19 risk for June around bed capacity.** |
| TB/20/093 | **Step Up To Great Priorities Progress Report (Paper F) – DW**<br>David Williams presented paper F and asked the Board to note the report and to receive assurance that processes are in place to monitor the delivery of priority programmes sitting under the Step up to Great Quality Improvement Plan. David Williams confirmed that approaches continue to be revised as necessary, accreditation continues using different methods for example self-review as opposed to peer review. SystmOne is currently on hold and meetings around this will be resumed in June2020 to decide how to proceed. Transformation work has continued as planned in Adult Mental Health, Families, Young People and Children's Services and Learning Disabilities with patient involvement ongoing. Governance work is complete.<br>The Chair thanked David Williams for the clarity that the report offered and asked what the next steps for the Mental Health Strategic Outline case for estates were. David Williams confirmed that this had gone to the CCGs and was now being followed up to get more detail.<br>Ruth Marchington asked about the Equality, Leadership and Culture slide – which details the priorities for the restoration and recovery plans – but doesn't reflect the priorities in the Annual Report in relation to the data/impact on BAME staff and communities. David Williams confirmed that this has been addressed but is not contained in this slide and will be added. It does however feature in the BAME staff listening sections of the paper.<br>Mark Farmer, Healthwatch commented that the development of the Urgent Care Hub and the 24/7 self-referral access system are massive steps forward. Gordon King confirmed that self-referral is very important in the system and crisis and Community Mental Health Team colleagues are working closely and there is much work to do to develop this to ensure it works well beyond Covid-19.<br><br>Faisal Hussain commented that those who do not access our services also need consideration and LPT needs to consider how their reach can be improved for these people during the restoration and recovery period, particularly to address health inequalities. Angela Hillery confirmed that this would be an important discussion to be held at a Trust Board development session.<br>Darren Hickman commented that triangulations with the Quality Account did not fully reflect the priorities under the Step Up To Great strategy and this should be considered moving forward. Darren Hickman also questioned if there would be any risks around the extension of the Rio patient record system if this was required. David Williams confirmed that there was already a period of crossover between Rio and SystmOne and an extension is not a problem if needed.<br>**Action: Consider recovery and reset and health inequalities/access to services for discussion at a future Trust Board Development session.**<br>**Resolved: The Board agreed that assurance was received from the report.** |
| TB/20/094 | **Hinckley and Bosworth Community Hospital Covid-19 Video:**<br>The staff video filmed at the Hinckley and Bosworth Community Hospital during the Covid-19 period was viewed by all attendees. The video demonstrated the sense of team and how safe and supported the staff felt working there. It showed the staff wobble room facility and hearts on the wall placed for patients going home. Rachel Bilsborough confirmed that the team's response had been fantastic, that patients |

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| | transferred to the Trust and arriving at the hospital are often still very poorly and there has been much learning involved for staff. Most experiences of redeployment have been positive but for those whose experience was less positive we need to look into why and learn from this. The Chair thanked all the staff involved for stepping forward and stepping up to great.<br>Faisal Hussain commented on the flipside of the positive narratives – are there things that could have been done better or quicker? Can we learn from these for next time? Rachel Bilsborough agreed that this was an important question and one that had been asked of staff with responses informing any response to a second wave. All of the staff involved in this video were asked about improvements that could be made but none were suggested. This is a testament to the local leaders and the teams supporting them.<br>Angela Hillery confirmed that redeployment was not dealt with as a blanket approach and any staff with concerns have been able to raise their concerns through different channels to feed into the learning.<br>Sarah Willis confirmed that a Staff Health Check survey was conducted one month ago and overall feedback was largely positive. There were over 700 lines of comments received back and these are being fed into the Senior Leadership Forum next week. This feedback has been sighted by all directorates through the ICC silver command and put into plans of action for learning. The Chair commented that this demonstrates what a learning organisation LPT is. |
| TB/20/095 | **Director of Nursing's Report including AHP report – Covid-19 (Paper G) -AS**<br>Anne Scott presented the paper which focused on quality and safety in light of Covid-19 and had been presented to QAC on 19th May 2020. Since national guidance was published in light of COVID-19, CQUINS for 20/21 remain on hold until August 2020. For 2019/20 LPT achieved 3 out of 5 CQUIN targets. The flu CQUIN was 0.07% off the minimum 60% threshold but was a 5% improvement from the previous year. Whilst the Quality Schedule is postponed, the Deputy Director of Nursing, AHP and Quality and the Quality Lead for the CCG, continue to have a monthly virtual meeting to catch up. The Safer Staffing and IPC current reports are being presented at Board today. Anne Scott offered thanks to the IPC Team who have worked tirelessly during this Covid-19 period. There has been a national pause on complaints, pausing the investigation of clinical and medical complaints from 1 April 2020 for a period of three months. All new complaints are now triaged to identify any safeguarding and patient safety issues. The Message to a Loved One Scheme has been fantastic, facilitating the sharing of messages between patients who are currently not able to receive visitors due to Covid-19 restrictions, and their loved ones. The scheme is available to all inpatients across the Trust. Anne Scott confirmed that work with Mark Farmer, Healthwatch to establish a People's Council has commenced with a view to getting the Council up and running by the summer.<br>Mark Farmer, Healthwatch added that the communications around the People's Council will need to be stepped up as it launches and that this initiative will fundamentally change how LPT does patient engagement.<br>**Action: No action required.**<br>**Resolved: The Board agreed that assurance was received from the report.** |
| TB/20/096 | **Quality Assurance Committee (QAC) Highlight report 19.05.20 (Paper Hi) - LR**<br>Liz Rowbotham introduced Paper Hi explaining that the amount of high assurance detailed in the report is a real credit to the work that has been going on in the Trust. |

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| | Updates around Safeguarding at QAC have allowed the members to feel well informed around the emerging risks and work being undertaken. High assurances have come to QAC from the Quality Forum although some areas remain amber (medium assurance) including the Hand Hygiene Audits (due to lack of audits not low hygiene); data from the Mental Health Act - Learning Lessons and seclusions data and the Duty of Candour – often with the 'so what' answers missing. This has been reported to the Quality Forum and they will continue to report back to QAC. The Deep Dive into Transforming Care for learning disability patients held on 19th May demonstrated a good plan but with a long way to go to achieve. The Transformation Committee will now follow this up.<br>Angela Hillery added that within Transforming Care, LLR are not in a good position but now have refreshed leadership and stronger engagement with NHSI.<br>**Action: No action required.**<br>**Resolved: The Board agreed that assurance was received from the report.** |
| TB/20/097 | **Joint Quality Assurance Committee (QAC) and Finance and Performance Committee (FPC) Highlight Report 17.03.20 (Paper Hii) - LR**<br>Liz Rowbotham presented the joint report QAC and FPC report from 17th March 2020. This showed both Waiting Times and Patient Harm Process as offering medium assurance at this stage. There is ongoing work around the Quality Impact Assessments and significant progress has been made on these.<br>**Action: No action required.**<br>**Resolved: The Board agreed that assurance was received from the report.** |
| TB/20/098 | **Care Quality Commission (CQC) progress Report (Oral) - AS**<br>An oral update was given by Anne Scott who confirmed that all outstanding actions from the last CQC inspection are now complete and the Quality Surveillance Tracker is now the tool used to monito progress. The Provider Information Request (PIR) highlighted 5 key lines of enquiry and these have been added to the action log and are monitored through the Foundations For Great Patient Care Group meetings. Engagement meetings with the CQC are going well and the CQC feel that LPT are in a good place and virtual staff focus groups are expected to begin shortly.<br>Angela Hillery confirmed that Our Time to Shine communications has been refreshed and all work we do can form part of our evidence for the CQC, but that inspections will not be going ahead as they did previously. Darren Hickman asked about the content of the meetings being held with the CQC and Anne Scott confirmed that the CQC Emergency Framework was based on a risk analysis basis. Angela Hillery added that the CQC are aware of the improvements LPT have been evidencing and it's this that they are focusing on, rather than potential emergency framework risks.<br>**Action: No action required.**<br>**Resolved: The Board agreed that assurance was received from the report.** |
| TB/20/099 | **Safer Staffing - Update Report (Paper I) - AS**<br>Anne Scott presented paper I confirming that nationally four actions were put into place to expand the nursing workforce in response to the COVID-19 pandemic and that LPT now have 27 aspirant nurses, from DeMontfort, Coventry and Open Universities who are working across our inpatient services in all 3 directorates. The temporary worker utilisation rate decreased this month by 3.69% reported at 20.0%, and Trust wide agency usage decreased this month by 1.02% to 3.0%. The |

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| | decreased bank and agency utilisation in April 2020 reflects the reduced bed occupancy and flexed staffing levels to meet the patient needs. On 24 March 2020, the Trust made the decision to cancel all face to face training courses until 30 June 2020 and all subject compliance dates have been extended by six months. Clinical supervision rates have reduced and are now showing as at 67.4%. Work is being undertaken to understand why and it is felt that it is down to the recording of the supervision rather than less supervision taking place. We are working to improve the recording of clinical supervision.<br>The Trust three 'COVID-19' wards; Beaumont, Gwendolen and East Ward continue to operate to maintain separation between possible and confirmed COVID-19 patients and support patient and staff cohorting, however the Trust surge capacity beds have not been utilised since 30 April 2020. Anne Scott concluded that considering the triangulated review of workforce metrics, nurse sensitive indicators and patient feedback the Board should be assured that there is sufficient resilience across the Trust to ensure that every ward and community team is safely staffed. Angela Hillery stressed the importance of highlighting the issues around clinical supervision rates and that finding solutions to this was a priority to get a grip within the next 4 weeks. Helen Thompson confirmed that this is an operational priority and Anne Scott added that there have been no increases in incidents of concern therefore this has had no impact on patient outcome.<br>**Action: No action required.**<br>**Resolved: The Board received assurance from the Report around Safer Staffing.** |
| TB/20/100 | **Guardian of Safe Working Hours (Junior Doctors Contract) Quarter 4 Report (Paper J) - SE**<br>Sue Elcock presented the paper confirming that the trainees have been extremely proactive seeking redeployment in all areas of the Trust to support during the Covid-19 period. The planned rota changes and consultations were paused at the start of the Covid-19 period but have now restarted with a view to having a central duty rota which will mean that the current non-compliances will no longer be non-compliant under the new rota system. The consultation with Junior Doctors is restarting this afternoon to resolve the shift pattern. The focus on BAME staff risk assessments has also been reflected in the on-call rota.<br>**Action: No action required**<br>**Resolved: The Board received assurance from the Report around Safe Working hours.** |
| TB/20/101 | **Patient Safety Incident and SI Learning Report – (Covid-19 focus) (Paper K) - AS**<br>Anne Scott presented paper K confirming that March and April 2020 saw a reduction in overall incident reports. During COVID-19, staff continue to work to monitor the safety of all patients. The Patient Safety Improvement Group continue to meet virtually to ensure focus and the subgroups continue to consider specific quality and safety areas, in particular within falls, pressure ulcers and the deteriorating patient. There is a continued small but significant increase in grade 4 pressure ulcers with all acquired or deteriorated in the community rather than in hospital. This has been supported by the Pressure Ulcer group. Across the Trust there has been an increase in the number of falls reported. This is likely to be related to the acuity of patients currently and the Falls Group are continuing to meet and monitor these falls, including a risk assessment of low level beds.. There |

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| | was a rise in self-harm 'moderate and above incidents' in January 2020 but then a decline in February. This decline in number of incidents has continued to reduce during March and April and this is likely to be as a result of reduced informal mental health admissions. Suicide reporting locally has not seen an increase in patients in our care but has seen an increase in attempted and completed suicides in the LLR population.<br>Liz Rowbotham confirmed that the increased in Duty of Candour breaches in January and February related to pressure ulcers in a specific team and is being investigated and being reported back to the Quality Assurance Committee who will report back to Trust Board.<br>Geoff Rowbotham thanked the team for the insightful report. He asked if we were sufficiently sighted on these matters now to take a more proactive approach by predicting where these risks may arise and put in place strategies to stop them emerging? Anne Scott responded that this was an important point and that improvement work in the patient safety team is ongoing, trying understand what is predictable. Rachel Bilsborough added that the three directorates have re-profiled their common Directorate Management Team agenda and the focus is on quality and safety. Each week the teams look at an issue using real time data which enables the team to think proactively. Angela Hillery confirmed that these areas were useful for the Quality Assurance Committee to monitor and consider looking at incidents against each service line to see if there were any patterns. Liz Rowbotham agreed that this can be monitored by QAC and they will also be picking up violence and aggression and personality disorder pathways as part of this review.<br>**Action: No action required**<br>**Resolved: The Board agreed that assurance was received from the report.** |
| TB/20/102 | **Infection Prevention Control (IPC) Report (including Response to NHSI/E IPC Guidance) (Paper L) – AS**<br><br>Anne Scott presented the six monthly report and the Board Assurance Framework (BAF) Self – Assessment as requested by NHSI in early May to provide assurance from the Director of Infection Prevention and Control (DIPaC) that the trust has a robust, effective and proactive infection prevention and control strategy and work programme in place, that demonstrates compliance with the Health and Social Care Act 2008 which is also referred to as the Hygiene Code. Anne Scott confirmed that the team continue to work to respond to COVID well and maintain an element of business as usual and asked the Board to note in the report the updated Self Assessment analysis against the BAF. In light of Covid-19 the IPC team and lead nurses have reviewed 47 pieces of guidance as detailed in the report. Since the BAF Self – Assessment was completed and this paper was written, the IPC Board Assurance Framework has been further revised (on 22nd May 2020) and the following additional actions have been identified – Training records for donning and doffing of PPE; Audit and assurance of PPE and Audit work around hand hygiene. With regards to the audits around hand hygiene it is important to note that this refers to a lack of audit rather than a lack of compliance. An improvement plan is underway and already the audit numbers are shown to be increasing in the May 2020 data. Anne Scott confirmed that an updated IPC Board Assurance Framework reflecting the revised version of the 22nd May will be presented to the Quality Assurance Committee on 16th June and then will come to Trust Board on 7th July 2020. |

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| | Angela Hillery commented that a huge amount of work has been done in a very agile way and the LPT and NHFT have worked very well together and thanks were extended to all staff involved.<br><br>**Action: The updated revised (22nd May) IPC Board Assurance Framework to be presented to the Quality Assurance Committee on 16th June and then will come to Trust Board on 7th July 2020**<br>**Resolved: The Board received assurance from the report.** |
| TB/20/103 | **Finance and Performance Committee (FPC) Highlight Report 19.05.20 (Paper M) - GR**<br>Geoff Rowbotham presented the FPC highlight report confirming that the focus remains on the 6 priorities during Covid-19. It was recognised that a number of key areas are in a period of rapid transition and assurance is sought with this in mind. Geoff Rowbotham confirmed that there were three themes in the report. 1) High assurance – the Organisational Risk Register (ORR) process and application and the new governance structure. The Gwendolen House outage incident; national security and the Estates Management Team. 2) Emerging risks as a result of Covid-19 include waiting times, Trust performance, the financial position and contracting. 3) The potential emerging impact of Covid-19 on 2021 planning already put in place, with capital expenditure changes as this emerges.<br>**Action: No action required.**<br>**Resolved: The Board agreed that assurance was received from the report.** |
| TB/20/104 | **Finance monthly report – month 1 including Update on 20/21 (Paper N) - DC**<br>Dani Cecchini presented paper N confirming that we remain in a Level 4 incident situation and all contracting and financial planning has been suspended. The Trust is being reimbursed centrally for running costs (on the basis of period 9 2019/20 cost plus inflation), Covid-19 costs are being recovered and a top up is available to ensure that all Trusts break even for the period month 1 to month 4. The assurance remains amber (medium) due to the lack of clarity around what will happen post July 2020. The cash position in month 1 and 2 is higher than forecast due to receiving central block payments in advance and this supports the going concern assumption in the accounts.<br>The revised capital programme has been to the Finance and Performance Committee (FPC) and has now been agreed by the STP and the £11.8m capital resource for LPT can now be factored into the STP capital limit. This does not include the Strategic outline case for the rebuilding of mental health wards. The capital budget will be presented at FPC on 16th June and then back to Trust board on 7th July.<br>The Chair asked about the operational overspend and what is being done to ensure that this does not grow and Dani Cecchini confirmed that they are still waiting for planning guidance and the expectation is that a plan will be resubmitted for the end of July, end of October and year end, each containing various milestone decision points. Any changes that are made will impact on contracting moving forward and this will need to be considered.<br>Mark Farmer, Healthwatch commented that he felt it was important for patients and carers to be involved in the financial plans and felt that resourcing for engagement and increased disabled access were important considerations to be made. Dani Cecchini confirmed that a strategic view will be taken on these matters as part of revising the capital programme – we need to look at ways to make provision to |

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| | improve some of the services in this planning round. Angela Hillery added that there were three segments to the financial picture – understanding the Covid-19 costs and being clear about what these are; understanding what has been acceleration against the long term plan and the mental health investment standard; and finally consideration of cost pressures that would exist ordinarily. This will be discussed at Executive Team meetings and reported through the Finance and Performance Committee. Faisal Hussain added that with regards to disability access, Andy Donoghue included this in the Estates Strategy and evidence of upgrading access points with automated doors over the last 12 months. Ruth Marchington confirmed that these conversations have been ongoing at the Quality Assurance Committee also.<br>**Action: Dani Cecchini to present an update on the Capital to 7th July Trust Board.**<br>**Resolved: The Board received assurance from the report.** |
| TB/20/105 | **Performance Report – Month 1 (Paper O) - DC**<br>Dani Cecchini presented the month1 performance report to the Board which showed a cross reference with business critical service changes so that the impact of Covid-19 on performance is clear. An additional paper showing the Quality Account Indicators that Dani Cecchini had circulated separately, will be included in the report moving forward.<br>Darren Hickman asked if the increasing vacancy rate trend has been influenced by Covid-19. Sarah Willis confirmed that Covid-19 will have had an impact as recruitment activity had been diverted to meet the surge capacity and some recruitment activity had been paused. With regards to the surge capacity,1000 candidates expressed an interest but these vacancies have slowed down now and business as usual recruitment is returning. A Deep dive into recruitment is planned for QAC in July 2020.<br>Liz Rowbotham confirmed that Tracy Ward continues to update the Quality Assurance Committee on the Quality Account Indicators. The Chair added that moving forward it will become more apparent the effect Covid-19 is having on waiting times and this will be something that the Recovery Cell will monitor and respond to, helping to prioritise where necessary and feeding this into the recovery trajectories<br>**Action: No action required.**<br>**Resolved: The Board agreed** |
| TB/20/106 | **Audit and Assurance Committee Highlight Report 01.05.20 (Paper P) - DH**<br>Darren Hickman presented paper P which had detail of many of the reports received at the earlier Extraordinary General Meeting (EGM). The internal audit plan is to revisit in June due to the changes caused by the Covid-19 effects. Audits are planned to be completed during the first quarter of 2020-2021.<br>**Action: No action required.**<br>**Resolved: The Board agreed assurance was received from the report.** |
| TB/20/107 | **Charitable Funds Committee Highlight Report 10.03.20; 22.04.20 & 11.05.20 (Paper Qi & Qii) - CE**<br>Cathy Ellis presented the Highlight Reports from the Charitable Funds Committee meetings. It has been a very busy time for the committee. A new Fundraising Manager has been recruited and the pre-recruitment checks process is currently ongoing. Raising Health has received £373,000 since the beginning of April 2020 |

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| | which has come from NHS Charities Together, , local donations from the public and from businesses, Carton Hayes Fund and also a large individual legacy donation has been received. People's generosity has been amazing. Moving forward for NHS Charities Together (who have received significant sums) there is a bidding process for the next phase of grants. David Williams will be working with the Cathy Ellis to bid alongside partners for funds to support the population to stay well and stay out of hospital.<br>Cathy Ellis confirmed that the Raising Health year-end accounts and the audit review offer significant assurance and Cathy Ellis thanked the finance team for all their work in supporting the charity through this busy time.<br>Geoff Rowbotham commented that with such impressive figures LPT needs to think big and Cathy Ellis agreed and suggested that it may be a good discussion to have at a Board Development session in the future. Faisal Hussain suggested that this may be an opportunity to work with voluntary sector partners to help LPT to access funds for example the Community Fund. The Chair agreed that during phase two of the NHS Charities Together grants LPT would be identifying partners to work with moving forward. Ruth Marchington added that the Raising Health Strategy was focused around being more ambitious and this is a great opportunity to build on this.<br>**Action: To discuss strategic aims for the Raising Health charity at a future Board development session.**<br>**Resolved: The Board agreed assurance was received from the reports.** |
| TB/20/108 | **Review of risk – any further risks as a result of board discussion? - Chair**<br>No Further risks were identified.<br>**Action: No action required**<br>**Resolved: The Board agreed no further risks had been identified during the meeting.** |
| TB/20/109 | **Any other urgent business - Chair**<br>The Chair confirmed that Frank Lusk had retired from the Trust and Chris Oakes confirmed that he would be returning on the Bank for 2 days a week to support the Trust. Chris thanked Frank for his significant contribution to LPT over many years. Sue Elcock is also leaving the Trust and the Chair offered thanks for her leadership as Medical Director for the Trust. Angela Hillery added that the new role is a fantastic opportunity for Sue Elcock to work clinically in forensic services and securing the role is testament to her clinical leadership. The Chair welcomed Avinash Hiremath to the team as Interim Medical Director.<br>**Action: No action required** |
| TB/20/110 | **Papers/updates not received in line with the work plan – Chair**<br>1) Codes of conduct and fit proper person test – this was refreshed in October 2020 HR has confirmed that this is complete for Board Directors<br>2) Documents signed under seal – no new documents since last update.<br>3) Standing orders and SFIs – recently reviewed and so not scheduled to come back to Trust Board<br>4) Learning from deaths – Q2 and Q3 came to March Board – Q4 will come to 7th July Trust Board meeting.<br>**Action: Learning from deaths Q4 Report to come to 7th July Trust Board meeting – AHiremath** |

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| TB/20/111 | **LPT Annual General Meeting – Agree date/mode - Chair**<br>The Chair confirmed that we are not in a position to agree this today but that it is likely to be held in September 2020 in a way that meets social distancing guidelines in force at the time. Updates will follow at a future meeting.<br>**Action: Details of the LPT Annual General Meeting to be updated at the July Board.** |
| TB/20/112 | **Public questions on agenda items – Chair**<br><br>One Question was received from Rosita Page, District and County Councillor:<br><br>In the light of the complicated circumstances and the longstanding uncertainties could I as the local member please ask the board for a full evaluation as to the future of the Fielding Palmer Hospital in Lutterworth asap please.<br>How can we utilise this resource to enhance future patient care for all of the residents in Lutterworth and the wider surrounding community.<br>Being mindful of the advent of major development adding to the future care needs , utilising new and existing S106 funds and working in partnership with all of the stakeholders to secure a mutual benefit whilst the situation is still fluid .Thank you , much appreciated and I am looking forward to the reply.<br><br>Rachel Bilsborough Responded:<br><br>The global impact of Covid-19 has resulted in Leicestershire Partnership NHS Trust temporarily suspending admissions of patients to Fielding Palmer Hospital in Lutterworth. This difficult decision has been made through the Trust's Incident Control Centre, which has oversight of all operational service changes the Trust has made in response to the Covid-19 pandemic.<br><br>This is not a decision we have taken lightly, however patient and staff safety remains our highest priority. Unfortunately, the structure and layout of the small Victorian hospital does not meet the requirements for social distancing which is so important to prevent the spread of coronavirus. Additional in-patient beds in all our other community hospitals, such as in Market Harborough and Hinckley, are being used for patients.<br><br>We will lift this suspension once it is safe to do so. This decision will be taken based on any new national guidance in relation to COVID-19, including infection prevention and control measures and social distancing requirements.<br><br>This temporary measure will allow partner organisations to safely resume some outpatient services in the town. This may include cardiology, minor surgery and gynecology outpatient services.<br><br>NHS partners have informed stakeholders and the local community of these changes, which were made urgently in line with national guidance and following a risk assessment of local community healthcare facilities.<br><br>The CCGs and LPT remain fully committed to working with the people of Lutterworth – as well as the local authority, District and Town councils, Healthwatch and other stakeholders - to understand what matters to them before any long-term |

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| | changes are proposed to NHS services in the town. This includes exploring any opportunities to utilise new and existing section 106 monies.<br><br>This involvement will be a natural continuation of the collaborative work that was well underway as part of the Better Care Together programme, prior to the Coronavirus pandemic. The Community Service Redesign work stream is developing plans for the future of community services right the way across Leicester, Leicestershire and Rutland. Understandably this work has had to pause, but will resume as soon as practical.<br><br>Angela Hillery confirmed that this was a welcome question and that place based discussions are what the future is about. Rachel Bilsborough confirmed that Health watch will be able to help support the move into phase two of the community redesign in order to help secure the service user engagement that we had during phase one.<br><br>Ms Sally Camm, Next Director Scheme commented that it was a pleasure and a privilege to be at this meeting today and to see how well set up for the future LPT is.<br>**Action: None required** |
| TB/20/113 | **Feedback on the meeting:**<br>The Chair thanked Mark Farmer for linking patient engagement and co-production throughout the meeting and for how much he supports LPT and enhances LPT's Board discussions Angela Hillery commented that Mark Farmer supports LPT's co-production agenda throughout and also that the format of the Board papers helps to shape discussions which makes a real difference to the analysis. Geoff Rowbotham agreed that the papers now support strategic conversations at Board meetings. |
| TB/20/114 | **Date of next public meeting:**<br><br>**7th July 2020 venue: MS Teams.** |

C

Leicestershire Partnership NHS Trust

# TRUST BOARD 7th July 2020

## MATTERS ARISING FROM THE PUBLIC TRUST BOARD MEETINGS

All actions raised at the Trust Board will be included on this 'Matters Arising action list' master. This will be kept by the 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 month and minute ref | Action/issue | Lead | Due date | Outcome/evidence actions are not considered complete without evidence) |
|---|---|---|---|---|---|
| 907 | December TB/19/218 | QAC to feed back to the Board once the Deep Dive into Transforming Care which is due to be done in April 2020, is completed. | Helen Thompson | 27th May 2020 | Complete - Covered in QAC Highlight report presented at meeting 27th May 2020. |
| 916 | 27th May TB/20/093 | Consider recovery and reset and health inequalities/access to services for discussion at a future Trust Board Development session. | Cathy Ellis/Chris Oakes | June 2020 | Complete - A recovery and restoration slot has been allocated on the Trust Board development agenda for the 26 June. Health inequalities / access to services will feature in this session. |
| 917 | 27th May 2020 TB/20/102 | The updated IPC Board Assurance framework to be presented to the | Anne Scott | 7th July 2020 | Complete - Included on July 7th agenda |

| Action No | Meeting month and minute ref | Action/issue | Lead | Due date | Outcome/evidence actions are not considered complete without evidence) |
|---|---|---|---|---|---|
| | | Quality Assurance Committee on 16th June and then will come to Trust Board on 7th July 2020 | | | |
| 918 | 27th May 2020 TB/20/104 | An update on the Capital position to be presented to the 7th July Trust Board. | Dani Cecchini | 7th July 2020 | Complete - Included on July 7th agenda |
| 919 | 27th May 2020 TB/20/107 | To discuss strategic aims for the Raising Health charity at a future Board development session. | Cathy Ellis | 7th July 2020 | Complete - On the Trust Board Development Agenda for 4th August |
| 920 | 27th May 2020 TB/20/110 | Learning from deaths Q4 Report to come to 7th July Trust Board meeting. | Avinash Hiremath | 7th July 2020 | Complete - Included on July 7th agenda |
| 921 | 27th May 2020 TB/20/111 | Details of the LPT Annual General Meeting to be updated at the July Board | Cathy Ellis/Kamy Basra | 7th July 2020 | Complete - The AGM will be in September, the exact date will be confirmed. The format will be virtual so that presentations can be streamed live and we can have a Q&A session. |

D


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

**Trust Board 7th July 2020**
**LPT Chair's report summarising activities and key events**
**From 27th May 2020 to 7th July 2020**

**Thank you to all LPT staff who have stepped up to great during the Covid-19 pandemic**

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| **Hearing the patient and staff voice** | • In order to comply with government Covid-19 guidelines and visitor restrictions, Chair and Non-Execs Boardwalks were postponed from mid-March. We are looking at ways to connect virtually with staff until we are able to resume visits safely. |
| **Connecting for Quality improvement** | • The CQC inspection has been postponed. Regular focus on service improvement is being maintained at the weekly Foundation for Great Patient Care meetings.<br>• I had the great honour of judging the mental health gardens which have been lovingly tended by our staff and patients. The winner of the "Let's Get Gardening" competition for 2020 is … |
| **Promoting Equality Leadership & Culture** | • Visible leadership from Board members through "all staff" briefings, videos, Twitter.<br>• Attended LPT's virtual Pride event<br>• Chaired Mental Health Act Managers team meeting – patient panels are now being held using MS Teams. The meeting also included a training session on equality, diversity & inclusion |
| **Building strong Stakeholder relationships** | • Meeting with Harborough District Council leaders to discuss Feilding Palmer Hospital temporary closure and wider Lutterworth health needs<br>• Represented LLR NHS at the Leicester City Homeless Charter oversight meeting<br>• Chaired Leicestershire Academic Health Partnership Board<br>• Planning for restoration and recovery phase in these meetings:<br>o LLR System meeting of CEOs & Chairs<br>o weekly NHS Confederation Mental Health Chairs network calls<br>o fortnightly NHSI Regional Director calls with Midlands Chairs<br>• East Midlands Alliance meeting of mental health trust CEOs and Chairs focused on areas of collaboration and priorities for 2020/21<br>• University of Leicester meetings : Buddy relationship meeting with Head of School of Allied Health professionals, University Council; University Finance committee |
| **Good Governance** | • The Board and level 1 committee meetings have continued to ensure good governance during the Covid19 period. Observed the Audit Committee which included the annual reviews of all level 1 committees.<br>• Non-Executive Director team meetings with Chair every week on MS Teams to brief on Covid-19 matters and ensure alignment of committee governance.<br>• Completed CEO and Non-Executive Director appraisals<br>• Interviewed for new Medical Director |
| **LPT's Charity : Raising Health** | • Thank you to the public for their support of the NHS during the Covid-19 pandemic. LPT staff continue to receive gifts and treats directly into their teams.<br>• Chaired Charitable Funds Committee – focused on 2020/21 priorities for Raising Health and bids to use Covid-19 donations from NHS Charities Together and local organisations. |

**Abbreviations:** **LLR** = Leicester, Leicestershire & Rutland; **NHSI** = NHS Improvement **CQC** = Care Quality Commission

Leicestershire Partnership NHS Trust

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| Meeting Name and date | 7th July 2020 |
| Paper number | E |

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| Name of Report<br>CEO Report |

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| For approval | | For assurance | | For information | x |

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|---|---|---|---|
| Presented by | Angela Hillery, CEO | Author (s) | Angela Hillery, CEO<br>Sinead Ellis-Austin, Business Manager |

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

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

| Assurance : What assurance does this report provide in respect of the Organisational Risk Register? | Links to ORR risk numbers |
|---|---|
| n/a | None believed to apply |

| Recommendations of the report |
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| The Board is asked to consider this report and seek clarification or further information pertaining to it as required. |

## 1. Introduction/Background

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 Providers and the Trust's regulators.

## 2. Aim

The aim of this paper is to ensure the Board is updated on national and local developments with the Health and Social care sector.

## 3. Recommendations

The Board is asked to consider this report and seek any clarification or further information pertaining to it as required.

## 4. Discussion

**Coronavirus**

The Trust continues to follow national guidance released regarding coronavirus and we are communicating regularly with staff to ensure they are well informed of the latest developments.

Our staff continue to adapt brilliantly and I am so proud of all their hard work and commitment. We continue to find innovative ways to ensure our patients are cared for during these difficult times and I am humbled by the support the staff show each other and their patients of which examples are highlighted through our regular Trust wide communication.

We remain in a Level 4 incident and as such the Incident Control Centre (ICC) continues to manage the on-going situation whilst the Recovery Co-ordinating cell is focused on leading the restoration and recovery of our services in line with national guidance. This cell continues to work closely with the LLR System Recovery Cell to ensure alignment with the wider system. The Trust continues to work closely as part of the wider LLR system on the response to Covid-19. Health leaders hold ongoing briefing's with local MPs, which provides us the opportunity to share our progress and shared plans for the future.

I continue to chair a weekly Strategic Gold Co-ordination meeting across LPT and NHFT with the recovery leads from both Trusts, who continue to work together closely and share best practice.

In addition to representing the Midlands region for MH on the national recovery and restoration group and the representing this group at the national Department of Health & Social Care group. I will also be involved in a national CEO advisory group going forward.

The Board will continue to receive updates regarding the Trusts response to Covid-19 via the weekly Flash Reports which include a dedicated risk register for the Covid-19 situation.

I would like to take this opportunity to reflect on recent events which I know will have impacted on our valued members of staff within our Trust. This is an emotional and sensitive time for lots of our staff and our communities. We have held staff listening events with colleagues and managers to understand the impact of the awful tragedy in America and the Covid-19 pandemic is having and how we can best support people. I have shared my thoughts with staff through videos and emails

to make it clear that the Trust promotes inclusivity and diversity and does not tolerate discrimination in any form. My expectation is that all staff will actively work towards being an anti-racist organisation.

**National Updates**

**NHSE/I**

**Model Hospital Trust Ambassador programme**

NHSI is now looking for staff within mental health and ambulance trusts to become Trust Ambassadors. The Model Hospital Trust Ambassadors are trained local experts who can:

- benefit from previews and learning opportunities within the Model Hospital
- help shape and influence the Model Hospital as a trusted local expert for your organisation, with knowledge of local context and practices
- champion the Model Hospital within your trust. Acting as a key contact for your organisation, sharing the latest developments and supporting colleagues to actively use the tool
- network nationally with other trust ambassadors sharing ideas, best practice and learning between trusts

NHSI is encouraging Trusts to become a Model Hospital Trust Ambassador and benefit from a training programme and a direct link in to other trusts across the country.

(https://improvement.nhs.uk/resources/model-hospital-trust-ambassadors-programme/)

**Veteran Aware NHS trusts**

A group of 53 NHS providers have been accredited as exemplars of the best care for veterans, helping to drive improvements in NHS care for people who serve or have served in the UK armed forces and their families.

Veteran Aware providers will:

- provide leaflets and posters to veterans and their families explaining what to expect
- train relevant staff to be aware of veterans' needs and the commitments of the NHS under the Armed Forces Covenant
- inform staff if a veteran or their GP has told the hospital they have served in the armed forces
- ensure that members of the armed forces community do not face disadvantage compared to other citizens when accessing NHS services
- signpost to extra services that might be provided to the armed forces community by a charity or service organisation in the trust
- look into what services are available in their locality, which patients would benefit from being referred to

The 53 NHS trusts that have been accredited as 'Veteran Aware' include LPT. The recognition means that patients who have served in the UK armed forces will be cared for by frontline staff who have

received training and education on their specific needs and who can also signpost them to other local support services. NHSI's ambition is to accredit all NHS providers in England as Veteran Aware.

**(https://improvement.nhs.uk/resources/veteran-aware-hospitals/)**

**NHS Race and Health Observatory**

The NHS Race and Health Observatory, which will be hosted by the NHS Confederation, will identify and tackle the specific health challenges facing people from BAME backgrounds. It comes amid significant concerns about the particular impact of the COVID-19 virus on people from black, Asian and ethnic minority (BAME) backgrounds.

The Observatory will involve experts from this country and internationally, and will offer analysis and policy recommendations to improve health outcomes for NHS patients, communities and staff.

The founding of the NHS Race and Health Observatory, comes after the latest assessment of race equality in the NHS – published to coincide with a major BMJ event on race and the NHS – recently showed a significant increase in representation of BAME people at board level across the country. The decision to establish the Centre was announced 'in principle' at the BMJ event. The independent body's first action will be to establish a steering group and will aim to be fully established this year.

**NHS launches new online support for people with diabetes**

New online tools for people living with diabetes are now available to help people manage their condition during the coronavirus pandemic. Three new services will allow people to manage their condition online, with a range of online videos and training available on each app for children and adults.

Recent findings show that people with diabetes face a significantly higher risk of dying with COVID-19 but better management of the condition can help improve control and lead to better outcomes. NHS investment in the technology means that patients will be offered advice on treatment and care, as well as training to adopt healthy behaviours on diet and exercise. This remote support will complement patients' appointments, many of which have been going ahead throughout the pandemic, through video consultations or via telephone, and more recently in COVID protected areas.

(https://www.england.nhs.uk/2020/06/nhs-launches-new-online-support-for-people-with-diabetes/)

**The new primary care network contract**

Almost all GP practices in England have signed up to the new Primary Care Network (PCN) contract for the next year, meaning they will receive a share of half a billion pounds a year of extra investment to employ more staff and deliver more services in or near to people's homes – a total investment of £1.4 billion by 23/24 to help deliver an extra 26,000 workforce roles.

The new agreement between GPs and the NHS will deliver improved care for patients, including:

- Additional support for care home residents – clinicians will carry out weekly check ins to care homes and each PCN will have a clinical lead for care homes in their area. Already, as part of general practice's response to the COVID pandemic, 100% of care homes now have an identified clinical lead with over 99% of practices now incorporating weekly care home resident check ins.
- More clinical pharmacists – helping people taking multiple or complex medications (polypharmacy) receive regular structured medication reviews to ensure their medication works better for them.

- Improved early cancer diagnosis – as part of the NHS Long Term Plan ambition to save more lives by improving early cancer diagnosis rates, PCNs will improve the referral process, increase screening uptake, and to better understand local populations and what they can do to support earlier cancer diagnosis.

Doctors, nurses, and frontline clinicians will benefit with increased numbers of staff in general practice. As part of the reformed Additional Roles Reimbursement Scheme, NHS England and NHS Improvement will reimburse 100% staff salaries of ten additional general practice roles such as clinical pharmacists, physiotherapists, physician associates, dieticians and health and wellbeing coaches to help provide patients with the care they need by an appropriate specialist.

(https://www.england.nhs.uk/2020/06/nhs-england-announces-overwhelming-take-up-of-new-primary-care-network-contract/)

**Inspiring the next generation of NHS Staff**

Health Education England (HEE) is working with the charity, Inspiring the Future, to encourage more NHS staff to volunteer as an NHS Ambassador and inspire school children to become the NHS staff of the future.

NHS Ambassadors will take part in school activities such as assemblies, speed networking, career days and many more, alongside new interactive virtual sessions to connect with children and young people online. Since the campaign began our NHS Ambassadors have interacted with over 400,000 young people through Inspiring the Future.

(https://www.hee.nhs.uk/news-blogs-events/news/inspiring-next-generation-nhs-staff)

**CQC**

The CQC will now be publishing regular insight documents intended to highlight COVID-19 related pressures. These documents will include information gathered through a variety of sources and will be used to understand the wider impact of COVID-19, to share regular updates with local, regional, and national system partners and the Department of Health and Social Care, and to highlight any emerging trends and issues.

(https://www.cqc.org.uk/news/stories/sharing-insight-asking-questions-encouraging-collaboration-cqc-publishes-first-insight-document-on-covid-19-pressures)

**CQC publishes data on deaths of people with a learning disability:**

Supported by the Office of National Statistics (ONS), the CQC have completed a targeted piece of analysis to better understand the impact of coronavirus (COVID-19) on people with a learning disability, some of whom may be autistic, and a comparison to the number of deaths during this period compared to the number of deaths last year.

This analysis looked at all deaths notified to CQC between 10 April and 15 May from providers registered with CQC who provide care to people with a learning disability and/or autism (including providers of adult social care, independent hospitals and in the community) and where the person who died was indicated to have a learning disability on the death notification form.

This data shows that between 10 April and 15 May this year, 386 people with a learning disability, some of whom may also be autistic, died who were receiving care from services which provide support for people with a learning disability and/or autism. This is a 134% increase in the number death notifications compared to the same period last year. The figures show that the impact on this group of people is being felt at a younger age range than in the wider population.

(https://www.cqc.org.uk/news/stories/cqc-publishes-data-deaths-people-learning-disability)

**Recent appointments**

**Regional Director of Public Health for Midlands/PHE Regional Director**

Dr Sue Ibbotson has been substantively appointed as the Regional Director of Public Health for the Midlands from 1st June. Sue has previously worked as PHE Director for the West Midlands and replaces Rashmi Shukla who has been undertaking this role on an interim basis.

**Local Developments**

***Leicester, Leicestershire and Rutland (LLR Better Care Together Update)***

The latest edition of the Covid-19 LLR Stakeholder bulletin can be found here.

***Collaborative Modelling: LLR & Northants***

Clinical Commissioning Groups and provider organisations within LLR & Northants continue to meet on a regular basis and work together on the approach to COVID-19 data modelling. System leads in LLR have agreed that the existing demand and capacity tool in the Northants region will be replicated within the LLR system and work is taking place to progress this.

***LLR – Transformational Work (Covid-19)***

Restoring, recovering and resetting health and care services is something that we are committed to delivering as a LLR system. The LLR system has agreed a clear mandate with all organisations working together to recover; we are doing this with a focus that we will focus transformation based on local needs with local place based plans. The transformational work will follow ten principles agreed across LLR.

1. Safety first approach
2. Equitable care for all
3. Involve our patients and public
4. Have a virtual by default approach
5. Arrange care in local settings
6. Provide excellent care
7. Enhanced care in the community
8. Have an enabling culture
9. Drive technology, innovation and sustainability
10. Work as one system with a system workforce

These 10 plans are underpinned by streamlined governance processes across LLR, an aggregate system financial model, a joint workforce strategy and a robust system and organisational demand and capacity model. Across LLR we are working well with partners to deliver a system recovery, to ensure we are all jointly prepared for any future peaks and that we have reviewed demand and capacity across our services to enable us to respond to differing demands in different services.

Further details can be found in Appendix 1.

**Recent events**

May and June have been a busy time for the Trust, here are some of the things that we have been celebrating throughout that time:

***National Volunteer Week (1 to 7 June 2020)***

We have a fantastic group of volunteers who help support the work we do in the Trust, and help support our patients. There has also been a brilliant response from people coming forward to offer their time and skills to volunteer across the LLR system during the COVID-19 Pandemic.


It is so important that the work that our volunteers undertake is recognised.

***Dieticians Week (1 to 5 June 2020)***

It was great to see that a campaign developed by the CCGs for Leicester, Leicestershire and Rutland "Your Healthy Kitchen" winning the Healthcare Campaign Award at the CIPR Excellence Awards. Well done to LPT's community dietitian, Jessica Mhesuria, who developed the recipes and starred in the campaign.

***Mental Health Awareness Week (18th – 24th May)***

There was a huge amount of partnership working across the LLR system to promote messages for our population in Leicestershire to seek support during Mental Health Awareness Week. The Start A Conversation campaign includes information around access to LPT's 24-hour central access helpline which I discussed in my last CEO report.

***Learning Disabilities Awareness Week – (15th to 21st June)***

This year's theme has been friendship in Lockdown and it was great to see so many examples highlighting the ways our learning disabilities colleagues are supporting service users and their carers during the Covid-19 pandemic. These examples have been shared throughout the Trust using the main LPT comms routes.

***Royal College of Psychiatrists - National initiative***

Our Consultant Psychiatrists are at the forefront of a national initiative to support people who are unable to speak English to maintain positive mental health through Covid-19. Five of our Consultant Psychiatrist colleagues have recorded multilingual self-help messages for the Royal College of Psychiatrists. They feature in a suite of five short videos giving advice about staying active, maintaining family contact and stress-reducing exercise and activities.

**(https://www.leicspart.nhs.uk/news/transcultural-videos/ )**

***Launch of LPT's Leadership Behaviour Framework***

This month we have launched the Trusts Leadership Behaviour Framework, this will enable us to support our staff to fully embed the five key behaviours that were agreed as part of the "Our Future, Our Way" culture change programme.

**Valuing one another**

**Recognising and valuing people's differences**

**Working together**

**Taking personal responsibility**

**Always learning and improving**

A supporting booklet and e-learning package are also available to staff which describe in more detail what each of the behaviours looks like in practice. The leadership behaviours will be fed through our recruitment and appraisal processes from July and dedicated training sessions will be carried out.

***Relevant External Meetings attended since last Trust Board meeting***

Whilst Boardwalks and formal service visits have been suspended throughout this time for IPC reasons, we are ensuring that leadership is visible across the Trust through a range of digital solutions including MS Teams, Skype, recorded videos, the daily staff briefing and Twitter.

***Executive Directors: external meetings since last Trust Board***

| May/June 2020 | |
|---|---|
| BCT NHS Formal CFOs meeting | Leicestershire Academic Health Partners Board |
| Buddy Forum | LLR Covid 19 Alert System |
| CCG/CHS Restoration & Recovery – Community Beds | LLR Workforce Cell Group |
| CAMHS Q&P | LLR People Board Planning |
| Community Network Board Meeting | LLR Health Economy Strategy Co-ordinating Group |
| Covid-19 Recovery Cell | LLR Health Overview |
| Covid-19 MH Weekly call – Central | LLR TCP Executive |
| COVID-19 Response weekly (webinar) | LLR System Recovery Cell |
| Clinical Leadership Group | LLR MP Briefing |
| Co-operation Agreement and FM Performance - UHL | Maintaining Momentum in Digital MH following Covid-19 (webinar) |
| Digital Enabling Group | Mental Health Collaborative Board Meeting |
| East Midlands HR Directors Network Meeting | Midlands Regional Mental Health Oversight Group (RMHOG) |
| East Midlands Health Science Network (EMAHSN)- Mental Health programmes | National CEO Advisory Group |
| East Midlands Mental Health & Learning Disability Alliance D&C Programme | National Chief Executives Restoration and Recovery Working Group |
| East Midlands Alliance CEO Meeting | NHFT (Paul Flecknoe ) |
| Future Integrated Respiratory Model Meeting - West CCG | NHS Providers Board check-in meeting |
| FYPC LD Recovery Transforming Care | NHS Midlands and Lancashire Commissioning Support Unit (Pritesh Patel) |
| FYPC LD Recovery Mental Health, Emotional Health & Wellbeing & ND | NHSE/I COVID-19 Update (webinar) |
| FYPC LD Recovery SEN | NHSE/I Finance Discussion M2 |
| FYPC Recovery Supporting Acute Services | Regional Medical Directors Group Call |
| FYPC LD Recovery Core meeting | Remote Consultations for Children |
| Harborough District Council Stakeholder Briefing | System Workforce Planning and Recovery Work |
| Healthwatch | Strategic Gold Co-Ordination |
| Healthy Together (City) Annual Review meeting | Virtual Staff Surgery |
| Integrated Community Board | West CCG (Tamsin Hooton) |
| IRG Meeting | 2 Systems CEO Meeting (Leicester & Northants) |

| | |
|---|---|
| Leicester City CCG (Rachna Vyas) | *CCG/CHS Restoration & Recovery |
| | *Leicestershire, Leicester and Rutland Joint Health Overview and Scrutiny Committee |
| *CQC/LPT Engagement Meeting | |
| * Leicestershire, Leicester and Rutland (Joint) Health Overview and Scrutiny Committee | |
| * Leicester Health and Wellbeing Scrutiny Commission | |
| Virtual Staff Surgery | |

**Scheduled but have not yet taken place at the time this report has been prepared*

## 5. Conclusions

The Board is asked to consider this report and seek clarification or further information as required.

**Appendices**

Appendix 1: LLR Clinical Vision Slides

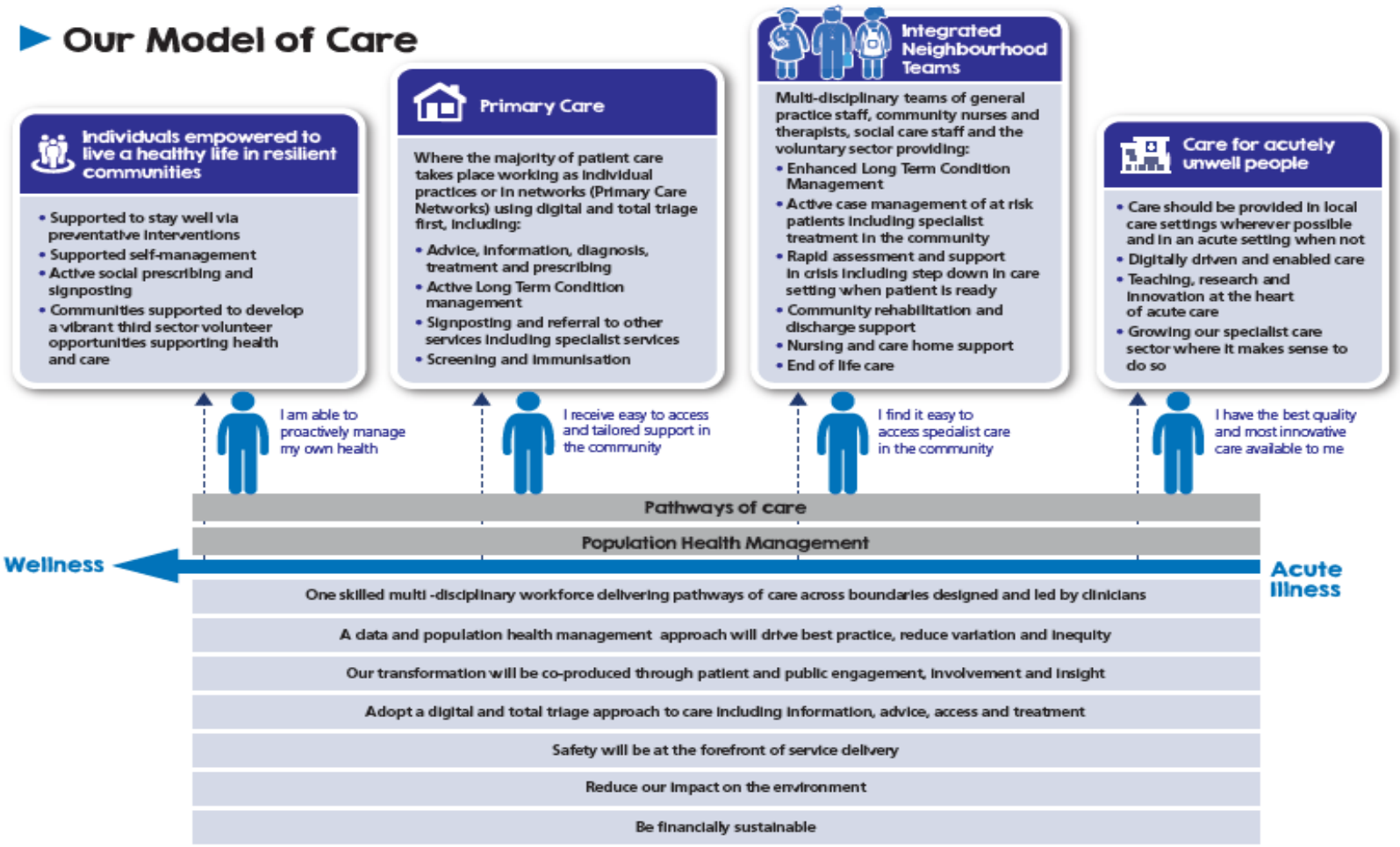
# DELIVERING THE LLR MODEL OF CARE

# Context

- ✓Clear mandate across LLR that we will design transformed models of care at system level
- ✓Clear mandate that delivery will be driven at a local, place based level
- ✓Clear mandate that any organisational plans across health and care will contribute to system model of care
- ✓Clear, clinical and practitioner led directives from CLG for ‘reset’

- ✓These will be underpinned by:
  - ✓Streamlined governance across and within systems
  - ✓A joint workforce strategy
  - ✓An aggregate system financial model
  - ✓A robust system and organisational demand and capacity model

# The LLR model of care



# Our System Expectations

| | |
|---|---|
| **1** | **Safety first approach**<br>We will adopt a safety-first approach to markedly reduce the infection hazard for patients and staff |
| | ✓ We will make sure that every service applies the latest Infection, Prevention and Control guidance<br>✓ We will ensure that every provider of services has appropriate cohorting arrangements in place for patients and staff<br>✓ We will have the right Personal Protective Equipment to maintain safety for our staff and patients<br>✓ As we transform our models of care we will ensure we adapt our safeguarding arrangements<br>✓ We will provide health and well-being support to all our staff |
| **2** | **Equitable care for all**<br>We will pursue high-quality, equitable care for all focusing on health inequalities, community development and the impact of COVID-19 on our BAME community and staff |
| | ✓ We will ensure that physical and mental health have parity<br>✓ We will direct resources to where there is greatest need based on population health data by 1st April 2021<br>✓ We will develop Place and Locality Based Plans that will contribute to closing the health inequalities gap and support community resilience by 31st December 2020<br>✓ We will work with our academic and research partners to focus on the risk factors for COVID-19 and develop appropriate interventions by 30th September 2020<br>✓ We will work with our BAME staff to manage the enhanced risks that this group has from infection of COVID-19 |
| **3** | **Involve our patients and public**<br>We will transform our public and patient involvement and seek to co-produce strategies which improve the health and wellbeing of local people |
| | ✓ We will develop and implement a new approach and dialogue with our public to ensure advice and care is accessible when needed from the right setting by 31st December 2020<br>✓ We will develop innovative ways of engaging with our population and we will always involve patients in shaping our transformational programmes<br>✓ We will develop a compact with local people which sets what they can expect from their NHS and what we would ask them to do in return by 30th December 2020 |

# Our System Expectations

| | |
|---|---|
| **4** | **Have a virtual by default approach**<br>Remote consultations at the front-end of all care pathways in all health and care settings especially before escalations of care |
| | ✓ We will ensure that prior to an escalation of care every patient is reviewed remotely by a relevant clinician seeking specialist opinion when appropriate to ensure that the patient is seen in the right setting by 30th September 2020<br>✓ We will adopt a primary care 'total triage' approach for patients that need a consultation and this will be done remotely unless there is a clinical reason not to do so by the end of August 2020<br>✓ We will ensure that all referrals to UHL for elective services will be done via a fully completed PRISM form by 30th November 2020<br>✓ We will ensure that all relevant specialities will have advice and guidance in place including a telephone/video option by 30th December 2020<br>✓ We will conduct 70% of outpatient appointments and follow-ups virtually either by telephone or video consultation by 30th December 2020<br>✓ We will ensure there is an alternative for those that cannot access the virtual option |
| **5** | **Arrange care in local settings**<br>There will be a decisive shift away from hospitals to care in local settings based **around Primary Care Networks** |
| | ✓ We will produce 'Place Based Plan's for the three 'places' (Leicestershire, Leicester City and Rutland) and the seven 'localities' across Leicestershire (North West Leicestershire; Charnwood; Hinckley & Bosworth; Oadby & Wigston; Harborough; Melton; and Blaby) by 31st December 2020<br>✓ We will provide a 2 hour community based response from a multi-disciplinary team to keep people at home and avoid admissions by 31st October 2020<br>✓ We will discharge patients from hospital to the right setting on the day they are deemed medically fit by 31st October 2020<br>✓ We will manage our actual and virtual bed base as one resource across Leicester, Leicestershire and Rutland with all discharges co-ordinated through a central service by 31st October 2020<br>✓ We will develop community based integrated multi- disciplinary teams including appropriate specialist support that will work as one team around the patient 31st October 2020<br>✓ We will work with out of county providers to make sure that pathways are clear and understood by patients and clinicians |

# Our System Expectations

| | |
|---|---|
| **6** | **Provide excellent care**<br>We develop standardised end-to end LLR pathways/clinical networks, tackling unwarranted variation, quality improvement, through a population health management approach |
| | ✓ We will develop and implement standardised pathways for major conditions that improve outcomes, reduce health inequalities and reduce unwarranted variation by 31st March 2021<br>✓ We will use population health management approaches to risk stratify and segment our population and use this information to support transformation and commissioning of care<br>✓ We will provide Primary Care Networks with data to identify unwarranted variation by 31st July 2020<br>✓ We will encourage all clinicians to work at the top of their licence by 30th November 2020<br>✓ We will deliver NHS performance requirements across all services by 31st March 2022 |
| **7** | **Enhanced care in the community**<br>Working with local government and the third sector we will provide enhanced care in the community |
| | ✓ We will use population health management approaches to identify those at risk patients and use our multi-disciplinary integrated teams to support them by 31st October 2020<br>✓ We will ensure all patients that need a care plan have one, which is regularly reviewed and can be accessed by all those caring for the patient by 31st October 2020<br>✓ We will provide an enhanced offer to Care Homes by 30th November 2020<br>✓ We will work with communities to harness the volunteer and third sector to support local people by 31st March 2021 |

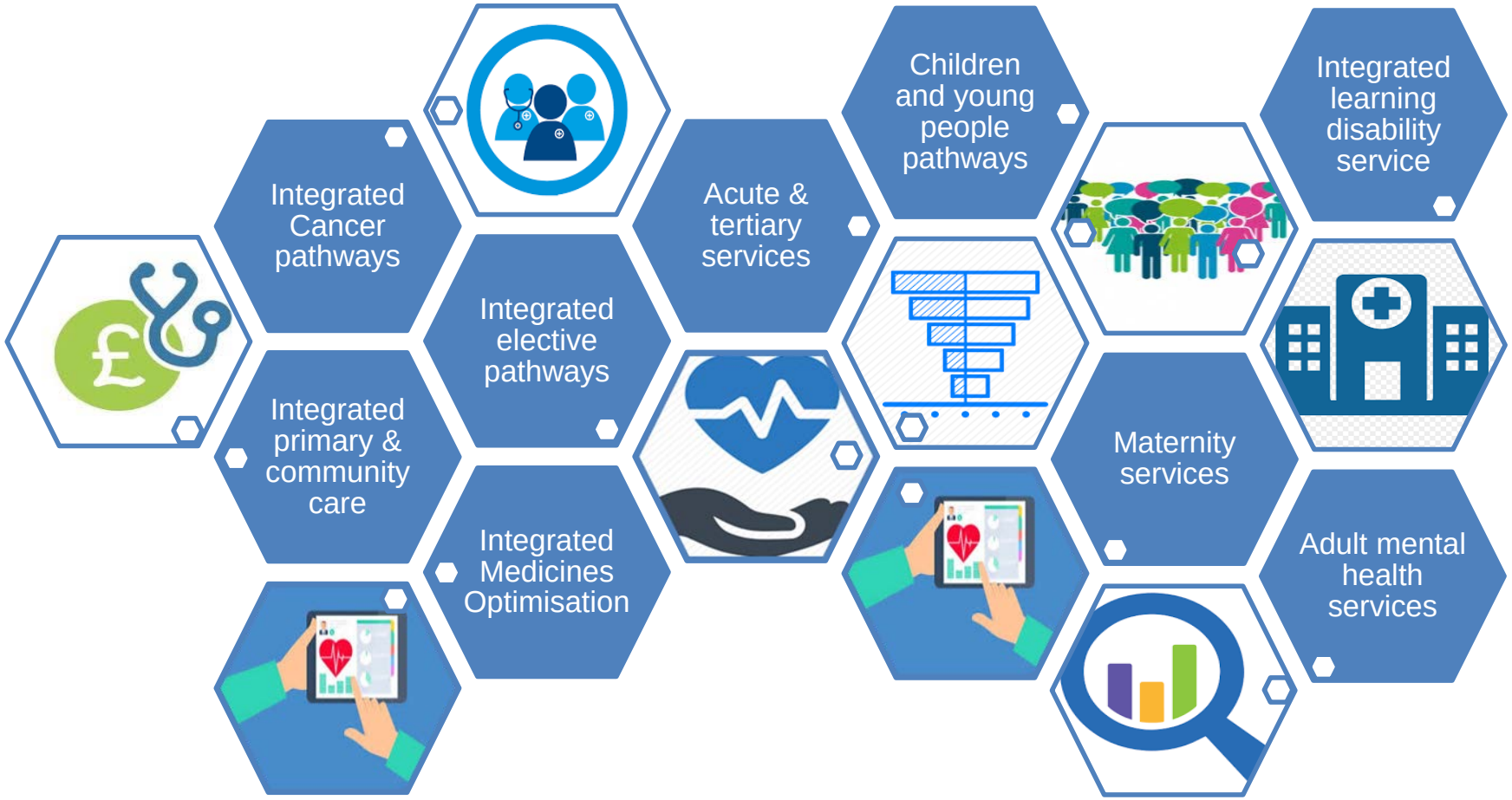
# Our System Expectations

| | |
|---|---|
| **8** | **Have an enabling culture**<br>We will put in enabling mechanisms to create a culture where our workforce thrive and are nurtured and there is simplified decision-making and governance structures |
| | ✓ We will review and implement a new simplified system wide governance structure that enables transformation to be undertaken rapidly by 30th June 2020<br>✓ We will develop a single system wide Programme Management Office to support system efficiency and transformation by 30th June 2020<br>✓ We will establish clinical networks that enable specialists, general practice, primary care networks and other professionals to work together across the system by 30th June 2020<br>✓ We will develop clinical and managerial opportunities for secondment, rotation and shadowing by 31st March 2021 that supports our underrepresented groups<br>✓ We will ensure all staff involved in transformation are trained and competent in applying the quality improvement methodology adopted by the system<br>✓ We will embed a culture of learning from best practice and research |
| **9** | **Drive technology, innovation and sustainability**<br>Technology, innovation, financial and environmental sustainability will underpin all our services |
| | ✓ We will work with our partners to increase IT literacy skills in our population<br>✓ We will ensure that multi-disciplinary team meetings are supported by the right technology which enables clinicians and services to review individual patients' needs together by 30th September 2020<br>✓ We will undertake an assessment of remote patient monitoring technology and AI to enable improved productivity and support to patients by 30th September 2020<br>✓ We will deliver interoperability between NerveCentre and Systm1 by 30th June 2020<br>✓ We will use technology to support flexible, mobile and home based working to reduce our office footprint, environmental impact and running cost by 30th December 2020<br>✓ We will develop a clear, deliverable plan by 30th September 2020 to restore the system's finances |

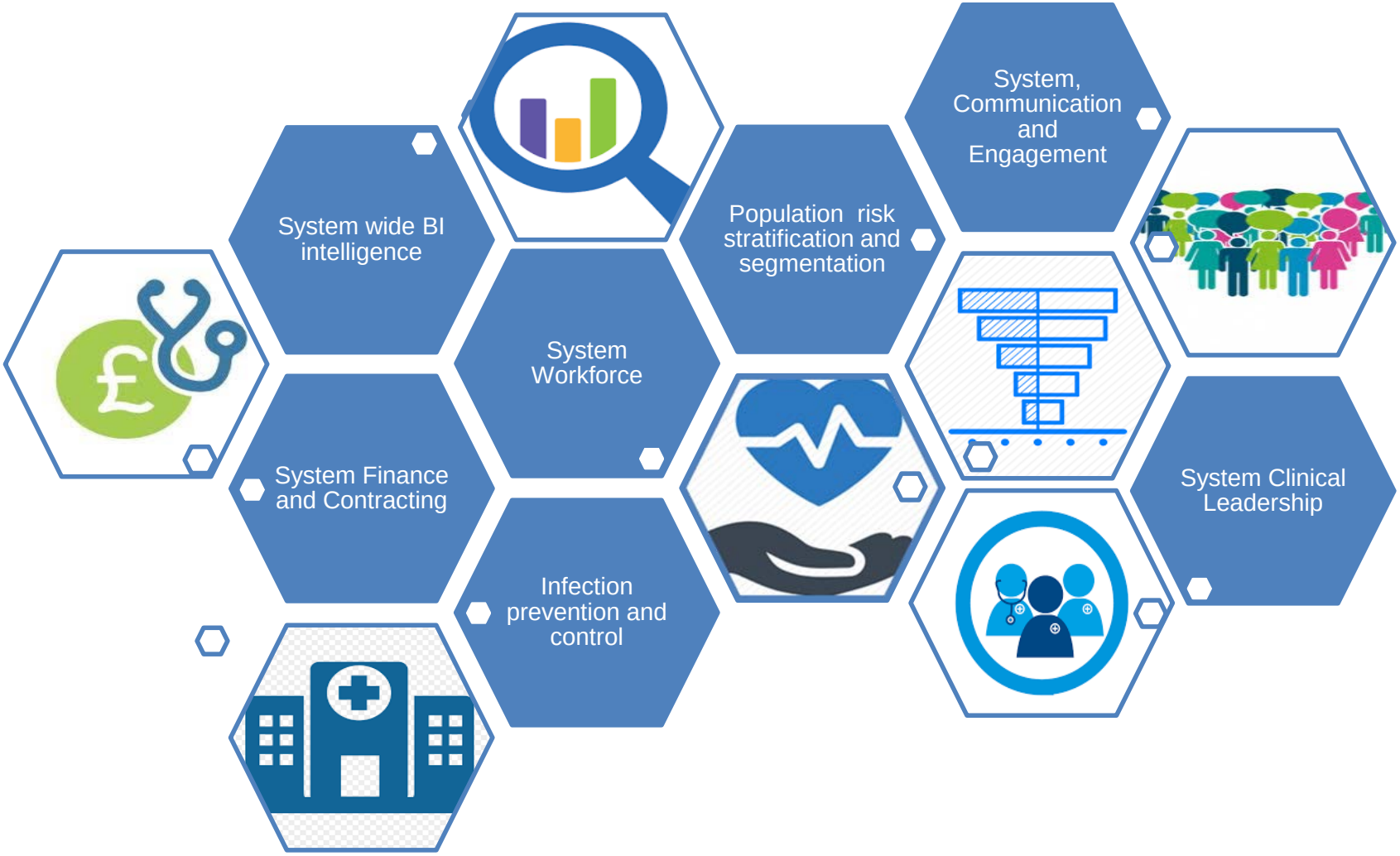
# Our System Expectations

| 10 | **Work as one system with a system workforce**<br>We will take collaborative working to a new level by dissolving boundaries between services providers. |
|---|---|
| | ✓ We will explore and implement volunteer models that support our population and services by 31st March 2021<br>✓ We will develop integrated workforce models that enable our pathway approach to be delivered and do not duplicate resources by 31st March 2021<br>✓ We will use our experience from the COVID-19 emergency to develop mutual aid protocols and arrangements across our providers by 30th September 2020<br>✓ We will explore opportunities for shared service teams for our back office functions by 31st March 2021<br>✓ We will become an Integrated Care System by 31st March 2021 |

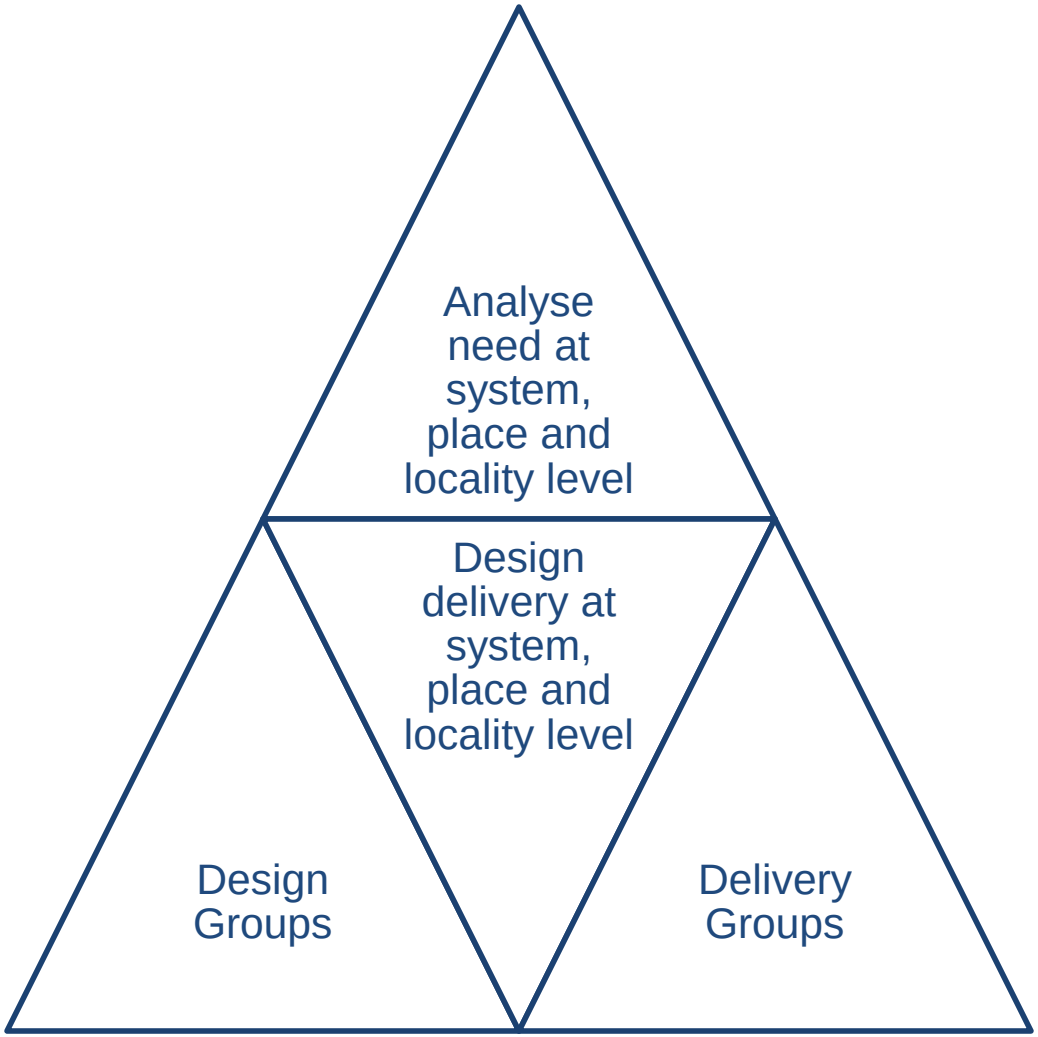
# Moving to delivery – Design Groups



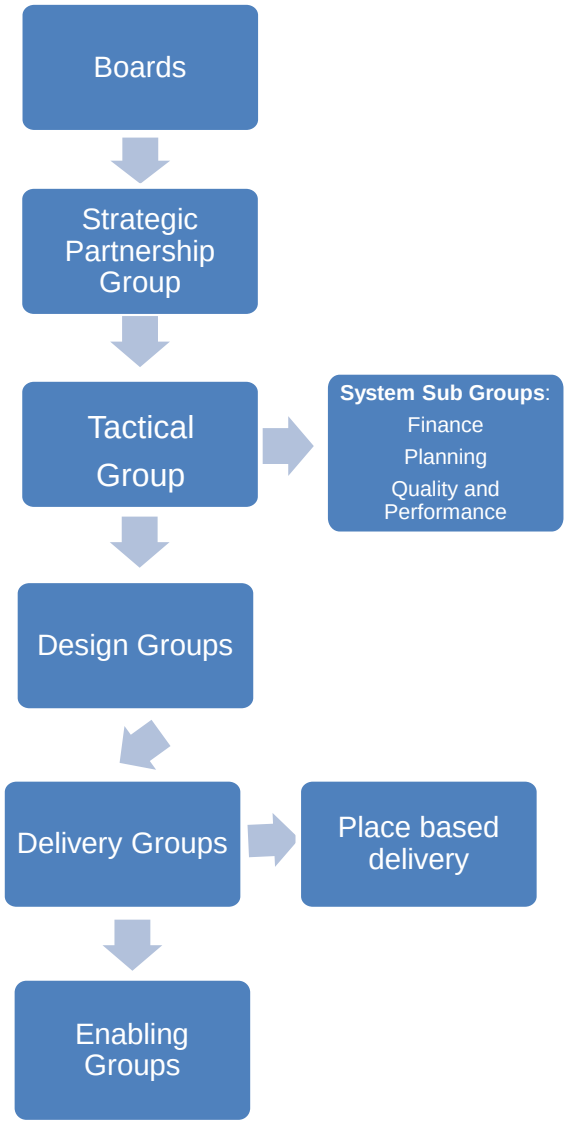
# Moving to delivery – Enabling Groups



# Moving to delivery – place based design



# Standardised governance




- This would replace all non-statutory BCT structures
- Boards retain statutory responsibility until legislation changes
- **Strategic Partnership Group** would agree system strategy; models of care; implementation plans for each area; setting the system resource plan (including people, BI intelligence and finances). They would take assurance on delivery from the Tactical Group and provide escalation from the Tactical Group (CEOs; Chairs: Non Executive/Lay)
- **Tactical Group** will ensure that design and working groups deliver to the strategy; implementation plans; budgets and performance requirements (CEO; Executive Teams)
- The **Design Groups** would be tasked to design the system wide model of care for their area based on the system model of care, 10 Expectations and the financial and performance requirements and get this signed off by the Strategic Partnership Group. They would be held to account for delivery by the Tactical Group (multi disciplinary across system)
- The **Delivery Groups** would design and deliver any specific sub-sets (multi disciplinary across system)
- The **Place Based Groups** would apply the system model of care to their specific area i.e. Local Authority specific, PCN specific or specialty specific
- **Enabling Groups** will work with Delivery and Work Area Groups to develop and design plans as required

# Roles

strategic fit

design

## Oversight & approval

- LLR Strategic Partnership Board
- LLR Tactical Group

## Advice, peer review and championing change

- LLR Clinical Leadership Group
- LLR Clinical Reference Group
- Organisational clinical and practitioner leadership groups
- Enabling Groups

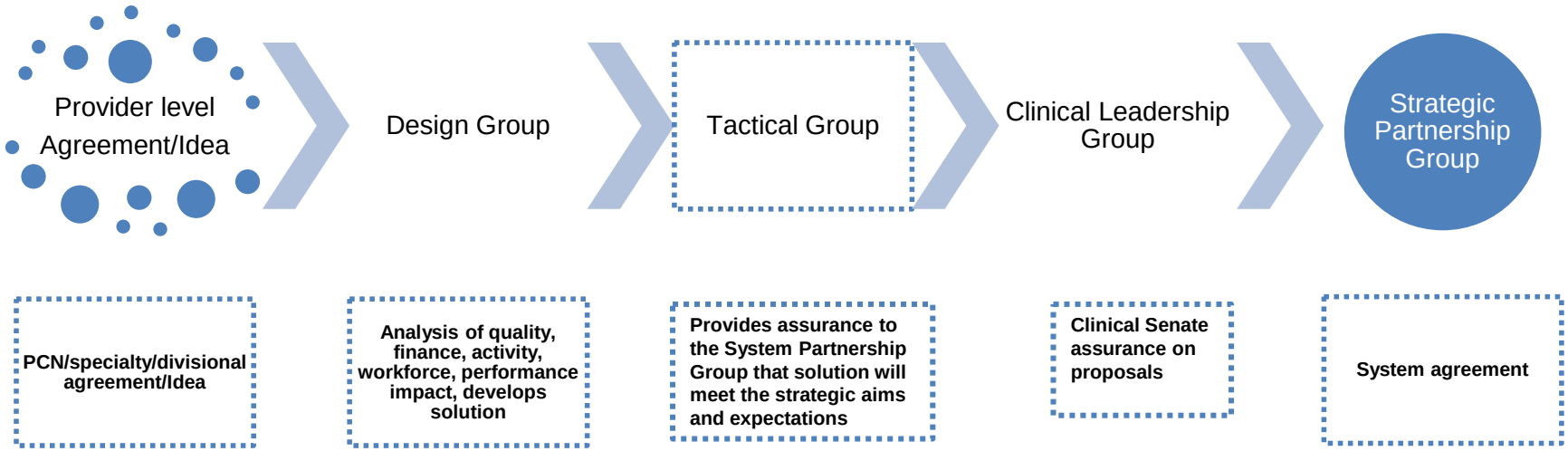
## Leadership for transformation

- CCG exec team
- UHL exec team
- LA exec teams
- LPT exec team

## Design and Delivery Groups - System teams to enable joint delivery

delivery

# From frontline ideas to agreement…



# Roles of each group

| Group | Responsibility | Membership |
|---|---|---|
| Strategic Partnership Group | ➢ Approve the system clinical model and system strategy<br>➢ Address health inequalities<br>➢ Approve system financial model<br>➢ Approve system Operational Plan<br>➢ Manage any escalations from the Tactical Group including performance<br>➢ Undertake direct engagement with the elected executives of the Upper Tier Authorities including representation on this group if LAs wish<br>➢ Ensure collaboration across the system<br>➢ Ensure that our plans include public and patient insight and engagement<br>➢ Actions that are agreed are on behalf of our individual organisations and any decisions requiring formal decision outside of individual's delegation would need to go through individual Boards | CEO's of NHS Organisations<br>Executive representation as required<br>Chairs of CCGs<br>Chairs of NHS Provider Organisations<br>Primary Care Network Clinical Directors x 3<br>Non-Executive member from each Provider organisation<br>Lay Member from LLR CCGs<br>Director of Public Health (with agreement of LAs)<br>Healthwatch x 2 |
| Tactical Group | ➢ Develop and recommend plans and ensure implementation on behalf of the Strategic Partnership Group<br>➢ Develop strategic and operational plans for approval by SPB<br>➢ Confirm and challenge the proposals from the Design Groups to meet the system clinical model and strategy<br>➢ Monitor Implementation Plans to deliver the system Strategy and Operational Plans<br>➢ Manage system performance including activity, target performance, quality and financial<br>➢ Manage escalations from the Design Group | Executive of NHS organisations, including Medical Directors<br>CCG/PCN Clinical representation<br>Director of Public Health and Social Care or their representatives (with the agreement of LAs) |
| Design Groups | ➢ Develop proposals for specific models of care, pathways that met the strategy and operational plans set<br>➢ Implement approved proposals, models of care , pathways<br>➢ Manage performance in specific are including activity, target performance, quality and efficiencies<br>➢ Review implementation to inform future proposals | Multi disciplinary team drawn from across the system with skills to respond the specific design area |

# Roles of each group

| Group | Responsibility | Membership |
|---|---|---|
| Delivery Groups | ➢ As above but for sub set areas – e.g. for specialities within Elective Care | Multi disciplinary team drawn from across the system with skills to respond the specific delivery area |
| Placed Based Group | ➢ Implementation of the Design and Delivery Groups proposals at a local level | Multi disciplinary team drawn from across the system with skills to respond the specific design and delivery area |
| Enabling Groups | ➢ Provide specialist advice and support to the Design and Delivery Groups<br>➢ Develop system strategy and plans for specialist areas | Multi disciplinary team drawn from across the system with skills to respond the specific enabling, design and delivery area |

## What level of sign off do we want? – For example

**SPB**: Sets the clinical model, expectations, performance requirements, resource allocation

**Delivery Groups**: develop their response to this

**Decision Level**:

If proposals from the Design Group is within the parameters set by the SPB – no further decision level required other than the Design Group approving proposals

If proposals by the Design Group are outside of the parameters set by the SPB or relate to statutory responsibility of one or more of the organisations, for example consultation, than the approval is with the Strategic Partnership Board

# Proposed leadership of each group

| Design Group | Senior Responsible Officer |
|---|---|
| Integrated Cancer Pathways | Sam Leek |
| Integrated Primary and Community Care | Rachna Vyas |
| Integrated Medicines Optimisation | Clare Ellwood |
| Integrated Elective Pathways | Debra Mitchell |
| Acute and Tertiary Services | Fiona Lennon |
| Children and Young People Pathway | Helen Thompson |
| Integrated Learning Disability Services | David Williams |
| Maternity Services | Sue McLeod/Mel Thwaites |
| Adult Mental Health | Gordon King |

| System Enabling Group | Senior Responsible Officer |
|---|---|
| Estates | Sarah Prema |
| Communications and Engagement | Richard Morris |
| Workforce | Sarah Willis and Hazel Wyton |
| Business Intelligence | Ket Chudasama and Simon Pizzey |
| Finance | One of the Directors of Finance |
| Infection, Prevention and Control | One of the Chief Nurses |
| Clinical Leadership Group | Professor Mayur Lakhani |

# Engagement plan

| Current structure | Date of meeting | Comments |
|---|---|---|
| Integrated Community Board | June 2nd | Generally agreed – worried about size of scope |
| Planned Care Board | June 4th | Agreed |
| LLR Cancer Board | June 29th | |
| A&E Delivery Board | Via UEC cell | |
| LD Board | Awaiting date | |
| Mental Health Board | Awaiting date | |
| LMSN | July 7th | |
| Children & YP Delivery Group | June 16th | |

# Engagement plan

| Current structure | Date of meeting | Comments |
|---|---|---|
| PCN CD's | Awaiting date | |
| LLR Clinical Reference Group | June 17th | |
| UHL Executive Board (or equivalent) | June 9th | |
| LPT exec | June 8th | |
| LA SMT – City | Awaiting date | |
| LA SMT – County | Awaiting date | |
| LA SMT – Rutland | Awaiting date | |

# Example of The ask of design groups – step 1

| **MODEL OF CARE: LLR design group – Integrated elective pathways** | |
|---|---|
| LLR Design principle:<br><br>**We will have a 'virtual by default' approach** | Every elective referral will be made via PRISM, with all mandatory fields completed (except for agreed clinical exceptions)<br><br>Relevant specialties will have timely access to virtual advice and guidance prior to referral<br><br>Every PRISM referral will be triaged by secondary care and allocated to:<br>• No further treatment required/back to GP with plan<br>• Virtual OP clinic via phone or video<br>• Face to face OP clinic<br><br>Every speciality will follow a 'patient initiated follow up' model of care (except for agreed clinical exceptions) |

DRAFT FOR DISCUSSION ONLY

**Programme Team:** Planned Care
**Scheme Name:** Virtual Clinics

| Estimated Financial Impact (£ net 2020/21) | | |
|---|---|---|
| Low | Medium | High |
| <500K | 500k-1,500k | >1,500k |

## Scheme Contacts

**SRO:** Debra Mitchell

**Project Manager:** Tracy Jesa

**Sponsoring Clinician:** Dr Dan Barnes, Dr Sulaxni Nainani, Dr Ash Kothari

**Activity & Finance Leads:** Rakesh Solanki, Gareth Jones

## 2020/21 Scheme Scope

**Scope**
- To increase the number of non face 2 face appointments (virtual and remote) in secondary care.
- The specialty-level clinical follow up panels will have determined the appropriate patient cohorts (category b)

**Progress**
Virtual clinics up and running (through the work of 'Four Eye's) in a range of specialties, however this is not routine and the process is not standardised or consistently recorded.
- Outpatients transformation model of care had been co-designed and agreed by system partners (Planned Care Board, UHL ESB, CCG LLR CRG, Joint HOSC).
- Draft high level activity and finances developed as part of LTP submission in Oct 2019

**Key Milestones**
- Agree of the definition of a non face 2 face appointment (what constitutes a virtual i.e. contingent upon contact) - Jan
- Review Four Eyes reports on baselined virtual activity and ensure it meets the agreed definition - Jan
- Develop a virtual clinic 'how a specialty can set it up' guide - Jan
- Resolve system interoperability issues related to virtual clinics within secondary care departments and across the system and with patients - by end Mar
- Identify Consultant job plan changes - end Mar
- Develop patients and staff communications to explain what virtual clinics are (building on existing comms strategy) - Jan
- Sharing of assumptions and costing information to identify what cost will be reduced and its rate - Jan to end Feb

## Expected Impact

**REFER TO FOLLOW UP EXCEPTION PANELS TO UNDERSTAND ACTIVITY & FINANCIAL IMPLICATIONS BY CATAGORY**

**Outcomes:**
- Reduction in face 2 face follow ups in secondary care
- Increase in virtual
- Reduced follow up waiting list
- Improved patient experience scores
- Reduction in outpatient journeys (by carbon footprint)
- improved staff satisfaction scores

**Activity:**
From scope (category b) 2020/21 figures only
c43,000 Outpatients non F2F at all providers (8,500 new and 34,500 F Ups)

**Finance:**
From scope (category b) 2020/21 figures only
c£2.0m Outpatients non F2F at all providers (£763k new and £1.3m F Ups)

**Investment required:**
IT infrastructure to be upgraded to enable interoperability (hardware, software and training)
Clinical time to review follow up waiting lists to identify suitable patients
Development of Follow Up App

**Expected impact:**
Assumed April 2020 impact

## System-wide priority specialties impacted

| | | | | | |
|---|---|---|---|---|---|
| Clinical Haematology | Gastroenterology | Respiratory | Gynaecology | Nephrology | Maternity |
| General Surgery | Endocrinology | Emergency Medicine | Intensive Care | Palliative Medicine | ENT |
| Urology | Integrated Medicine | Geriatric Medicine | Ophthalmology | Diagnostic Imaging | Trauma & Orthopaedics |
| Dermatology | Rheumatology | Neurology | Cardiology | Diabetology | |

# The ask of design groups – step 2

| **Symptom pathway: Diabetes** | |
|---|---|
| LLR Design principle:<br><br>**We will have a 'virtual by default' approach** | ✓Every patient will have a quality assured care plan addressing diabetic needs as well as other related co-morbidities<br>✓Every high risk diabetic patient will have a patient passport, enabling them priority access to virtual pre-hospital crisis support as needed<br>✓Every elective referral will be made via PRISM, with all mandatory fields completed<br>✓Relevant specialties will have timely access to virtual advice and guidance prior to referral<br>✓Every PRISM referral will be triaged by secondary care and allocated to:<br>• No further treatment required/back to GP with plan<br>• Virtual OP clinic via phone or video<br>• Face to face OP clinic<br>✓Every speciality will follow a 'patient initiated follow up' model of care (except for agreed clinical exceptions) |

# Standardised models of care

| Design level for the system | Elective services | Integrated primary & community services | Cancer services | Acute & tertiary services | Childrens services | Learning disability services | Adult Mental Health services | Maternity services |
|---|---|---|---|---|---|---|---|---|
| Provider Operational level models of care<br><br>*(incorporating activity, workforce, finance, quality)* | System-wide Operational plans for delivery (symptom/specialty) | | | | | | | |
| | Place based plans for delivery | | | | | | | |
| | Divisional level plans for delivery | | | | | | | |

# Discussion

Does this enable the system to deliver the 10 design principles outlined?

Leicestershire Partnership NHS Trust

| | |
|---|---|
| Meeting Name and date | Trust Board 7 July.2020 |
| Paper number | F |

| |
|---|
| Name of Report: Organisational Risk Register |

| | | | | | |
|---|---|---|---|---|---|
| For approval | | For assurance | ✓ | For information | |

| | | | |
|---|---|---|---|
| Presented by | Chris Oakes, Shared Director of Corporate Governance and Risk | Author | Kate Dyer, Head of Governance and Interim Company Secretary |

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

| Report previously reviewed by | |
|---|---|
| Committee / Group | Date |
| | |

| Assurance: What assurance does this report provide in respect of the Organisational Risk Register Risks? | Links to ORR risk numbers |
|---|---|
| This report provides a summary of the Organisational Risk Register (ORR), including current and residual risk scores. | Whole ORR |

| Recommendations of the report |
|---|
| Note the amendments made to the ORR and the Trust's current and residual risk profile.<br>Approve the inclusion of risk 48 |

# Organisational Risk Register June 2020

## 1 Introduction

1.1 The Organisational Risk Register (ORR) is presented as part of a continuing risk review process. At each meeting the Trust Board receives the summary ORR highlighting any risk changes and updates since the last Board. The Executive Team regularly considers the ORR, with the Quality Assurance Committee (QAC) and the Finance and Performance Committee (FPC) exercising their delegated responsibility from the Board to review, and gain assurance on their allocated risks. The ORR is then updated to reflect committee recommendations and the revised summary ORR presented to the following Trust Board.

1.2 This report outlines risks from the ORR as at 25th June 2020.

## 2. Discussion

There are 31 risks on the ORR, seven are COVID-19 specific and one is in draft.

2.1 Since May 2020 there have been three closures;

Risk 29 The trajectory to achieve the out of area placement is not maintained.
All actions have been completed and the residual risk score was met, this was in line with the risk appetite. This is no longer deemed to be a live risk for the Trust.

Risk 38 Unable to deliver the operational plan due to financial pressures from the system and funding settlement

Risk 39 Failure to deliver CIP and manage our costs to enable the ongoing function of the business – maintain sustainability of the Trust.
The two financial risks are no longer applicable during COVID; a new financial risk has been proposed below.

2.2 There is one new proposed risk

Risk 48 We are unable to contain expenditure, or to recover income in line with the limits imposed by NHSEI under the COVID financial regime.

Full detail of this risk is presented in draft within the ORR pack.

There are two risks currently being scoped for inclusion next month, one for community service redesign phase two (community hospital bed based model of care) and one for Ageing Well.

2.4 Significant changes to existing risks

Risk 40 The ability of the Trust to deliver high quality care may be affected during a Coronavirus COVID-19 pandemic

Following the addition of a suite of COVID-19 risks, the original COVID-19 risk (number 40) remains relevant and has been updated to provide clarity over this risk being attributable to spikes in COVID-19 related activity.

From June 2020, the temporary red COVID impact boxes will start to be removed and the information will be absorbed within the main narrative for each risk to reflect business as usual.

2.5 Risk scoring

Current and residual scores have changed since May 2020 for two risks;

Risk 22 Information systems and processes are not robust enough to militate against cyber-attacks and information breaches

The current risk score has reduced from 16 to 12, and the residual score has reduced from 12 to 8. This is due to a number of additional controls which were detailed in full in the latest update to FPC.

Risk 25 Staff do not fully engage and embrace the Trusts culture and collective leadership

The current risk score has reduced from 16 to 12, and the residual score has reduced from 12 to 8. This is due to an increase in controls, and a strengthening of existing controls. This includes the delivery of virtual leadership forums and the establishment of an organisational development delivery plan.

2.6 Risk appetite scores have reduced for the following two risks;

Risk 9 Inability to maintain the level of cleanliness required within the Hygiene Standards

The appetite for this risk was 12, in line with the residual score. On further review, given the COVID circumstances the Trust has lowered this appetite to an 8.

Risk 28 Delayed access to assessment and treatment impacts on patient safety and outcomes

The appetite for this risk was increased up to 16 last month however upon further reflection it was felt that this risk is fundamental to the need for transformation and that the appetite should remain where it had previously been at 12. The changes in approach to delivery models are closely aligned to delivery of the Step Up to Great ambition and the performance team and therefore the Trust would not tolerate a high residual risk score.

The risk appetite score for these two risks is now lower than the residual score, indicating that further action is needed to mitigate these risks. The risk appetite is the marker for where the Trust will tolerate the residual score.

Further actions are currently being determined; these will be presented next month with a corresponding decrease in the residual risk score where appropriate.

## 3. Analysis

3.1 There are currently 18 high risks (58% of the ORR), two of which are rated 20;

Risk 28 Delayed access to assessment and treatment impacts on patient safety and outcomes.

Risk 40 The ability of the Trust to deliver high quality care may be affected during a Coronavirus COVID-19 pandemic.

3.2. ORR Summary June 2020

| Risk No. | Title | Owner | Committee Group | SUTG | Months on ORR | Current risk | Residual Risk |
|---|---|---|---|---|---|---|---|
| 1 | The Trust's clinical systems and processes may not consistently deliver harm free care. | DoN | QAC | High Standards | 8 | 16 | 8 |
| 2 | The Trust's safeguarding systems do not fully safeguard patients and support frontline staff and services. | DoN | QAC | High Standards | 8 | 12 | 8 |
| 3 | The Trust does not learn from incidents and events and does not effectively share that learning across the whole organisation. | DoN | QAC | High Standards | 8 | 16 | 8 |
| 4 | Services are unable to meet safe staffing requirements | DoHR | QAC | High Standards | 8 | 12 | 8 |
| 5 | Capacity and capability to deliver regulator standards | DoN | QAC | High Standards | 8 | 16 | 12 |
| 6 | The step up to great mental health strategy does not deliver improved mental health services that meet quality, safety and contractual requirements and are sustainable. | DoAMH | FPC | Transformation | 8 | 16 | 12 |
| 8 | The transformation plan does not deliver improved outcomes for people with LD and/or autism. | DoLD | FPC | Transformation | 8 | 16 | 12 |
| 9 | Inability to maintain the level of cleanliness required within the Hygiene Standards | DoF / DoN | QAC/FPC | Environment | 8 | 16 | 12 |
| 10 | The Trust does not implement planned and reactive maintenance of the estate leading to an unacceptable environment for patients to be treated in | DoF | FPC | Environment | 8 | 16 | 12 |
| 11 | The current estate configuration does not allow for the delivery of high quality healthcare | DoF | FPC | Environment | 8 | 16 | 12 |
| 12 | Service users, carers and families do not have a positive experience of care, do not feel able to participate effectively and share their experiences. | DoN | QAC | Patient Involvement | 8 | 9 | 6 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 16 | The Leicester/Leicestershire / Rutland system is unable to work together to deliver an ICS | DoS/CEO | FPC | Well Governed | 8 | 12 | 8 |
| 20 | Performance management framework is not fit for purpose | DoF | FPC | Well Governed | 8 | 8 | 4 |
| 22 | Information systems and processes are not robust enough to militate against cyber-attacks and information breaches | DoF | FPC | Well Governed | 8 | 12 | 8 |
| 23 | Failure to deliver the EPR system and demonstrate the benefits of the system | MD | FPC | Single Patient Record | 8 | 8 | 4 |
| 24 | Failure to deliver workforce equality, diversity and inclusion | DoHR | QAC | Equality, Leadership, Culture | 8 | 12 | 9 |
| 25 | Staff do not fully engage and embrace the Trusts culture and collective leadership | DoHR | QAC | Equality, Leadership and Culture | 8 | 12 | 8 |
| 26 | Insufficient staffing levels to meet capacity and demand and provide quality services | DoHR | QAC | Equality, Leadership and Culture | 8 | 16 | 12 |
| 27 | The health and well-being of our staff is not maintained and improved | DoHR | QAC | Equality, Leadership and Culture | 8 | 9 | 6 |
| 28 | Delayed access to assessment and treatment impacts on patient safety and outcomes | DD / MD | QAC / FPC | Access to Services | 8 | 20 | 16 |
| 33 | Insufficient executive capacity (including Joint Chief Executive role) to cover demand and impacts on LPT ability to achieve its strategic aims | DoHR/CEO | Combined Exec Board | Well Governed | 5 | 12 | 8 |
| 35 | The quality and availability of data reporting is not sufficiently mature to inform quality decision making | DoF | FPC | Well Governed | 5 | 16 | 12 |
| 40 | The ability of the Trust to deliver high quality care may be affected during a Coronavirus COVID-19 pandemic | DoN | QAC / FPC | COVID-19 High Standards | 4 | 20 | 15 |
| 41 | The Trust may not appropriately manage the health and well-being of our BAME staff , and staff with key protected characteristics given the disproportionate impact of COVID-19 | DoHR | Combined Exec Board | COVID-19 Equality, Leadership and Culture / High Standards | 1 | 15 | 10 |
| 42 | The Trust may not appropriately manage its patients with LD and Autism given the known disproportionate adverse impact of COVID-19 on this patient group | ADoFYPC/ LD | Combined Exec Board | COVID-19 High Standards | 1 | 12 | 8 |
| 43 | The Trust response to COVID-19 may negatively impact on the safety and well-being of vulnerable patients detained under the Mental Health Act | MD | Combined Exec Board | COVID-19 High Standards | 1 | 15 | 10 |
| 44 | A post COVID-19 surge in referrals would have a detrimental impact on waiting times and patient harm if | DoF | Combined Exec Board | COVID-19 Access to Services / | 1 | 16 | 12 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | the Trust is unable to increase capacity | | | High Standards | | | |
| 45 | A post COVID-19 surge in legal challenge would have a detrimental impact on our reputation and financial position | DoGR | Combined Exec Board | COVID-19 Well Governed | 1 | 9 | 6 |
| 46 | We are unable to restore or recover our services, impacting on our ability to deliver against national requirements and commissioned activity | DoF | Combined Exec Board | COVID-19 Well Governed | 1 | 16 | 12 |
| 47 | We are unable to provide a COVID-19 safe environment for our staff and patients | DoF | Combined Exec Board | COVID-19 Well Governed / High Standards | 1 | 15 | 10 |
| 48 | We are unable to contain expenditure, or to recover income in line with the limits imposed by NHSEI under the COVID financial regime. | DoF | FPC | Well Governed | Draft | 15 | 10 |

3.3 Heat Map

The heat maps below illustrate the current and residual risk levels of risks on the ORR in June 2020.

Current risk levels given the existing set of controls.

| Consequence | | | | | | |
|---|---|---|---|---|---|---|
| | 5 | | | 41,43,47, *48* | 40 | |
| | 4 | | 20,23 | 2,4,16,22,25,33, 42 | 1,3,5,6,8,9,10,11,26,35,44,46 | 28 |
| | 3 | | | 12,27,45 | 24 | |
| | 2 | | | | | |
| | 1 | | | | | |
| | | 1 | 2 | 3 | 4 | 5 |
| | | Likelihood | | | | |

Residual risk levels remaining once additional controls are implemented.

| Consequence | | | | | | |
|---|---|---|---|---|---|---|
| | 5 | | 41,43,47, *48* | 40 | | |
| | 4 | 20,23 | 1,2,3,4,16,22,25,33,42 | 5,6,8,9,10,11,26, 35, 44,46 | 28 | |
| | 3 | | 12,27,45 | 24 | | |
| | 2 | | | | | |
| | 1 | | | | | |
| | | 1 | 2 | 3 | 4 | 5 |
| | | Likelihood | | | | |

## 4. Conclusion

The Trust continues to operate within its risk management framework, and the ORR has been updated to reflect the changing risk profile for June 2020. In the last month, three risks have been closed, and one new financial risk has been proposed for inclusion. There have been a number of changes to risk scoring, including appetite to ensure that we are sufficiently mitigating risk.

## Appendix A: LPT Risk Appetite Matrix

| **Risk levels** ➤<br><br>**Key elements** ➘ | **0**<br><br>**Avoid**<br>Avoidance of risk and uncertainty is a Key Organisational objective | **1**<br><br>**Minimal** (ALARP)<br>(as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential | **2**<br><br>**Cautious**<br>Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward. | **3**<br><br>**Open**<br>Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM) | **4**<br><br>**Seek**<br>Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). | **5**<br><br>**Mature**<br>Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust |
|---|---|---|---|---|---|---|
| **Financial/VFM** | Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern. | Only prepared to accept the possibility of very limited financial loss if essential.<br>VfM is the primary concern. | Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints.<br>Resources generally restricted to existing commitments. | Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price).<br>Resources allocated in order to capitalise on opportunities. | Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach. | Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself. |
| **Compliance/ regulatory** | Play safe, avoid anything which could be challenged, even unsuccessfully. | Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances. | Limited tolerance for exposure to risk. Want to be reasonably sure we would win any challenge. | Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences. | Chances of losing any challenge are real and consequences would be significant. A win would be a great coup. | Consistently pushing back on regulatory burden. Front foot approach informs better regulation. |
| **Innovation/ Quality/Outcomes/ Patient Benefit** | Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority.<br>General avoidance of systems /technology developments. | Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations. | Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems/ technology developments limited to improvements to protection of current operations. | Innovation supported with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery. Responsibility for non-critical decisions may be devolved. | Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control. | Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice. |
| **Reputation** | No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern. | Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention. | Tolerance for risk taking<br>limited to those events where there is little chance of any significant repercussion for the<br>organisation should there be a failure. Mitigations in place for any undue interest. | Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation. | Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation. | Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks. |
| **APPETITE** | **NONE** | **LOW** | **MODERATE** | **HIGH** | **SIGNIFICANT** | |

Appendix B: Risk Scoring Matrices

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 No: 1** | High Standards | Date included: | 01.10.19 |
| **Risk Title:** | The Trust's clinical systems and processes may not consistently deliver harm free care. | | |
| **Risk Owner:** | Director of Nursing, AHP and Quality | **Date Last Reviewed:** | 02.06.2020 |
| **Governance / review:** | PSIG, Quality Forum, QAC / monthly review | | |

| | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 4 | 4 | 16 |
| **Residual Risk** | 4 | 2 | 8 |
| **Risk Appetite** | 4 | 2 | 8 |

## Controls

**Description:**

- Staff Safety Huddles and Debrief
- Mandatory & Role Related Training available ; Clinical Supervision
- Thematic reviews of patient safety incidents and QI approach adopted by the Trust
- Infection Prevention & Control policies & the monitoring of
- Step up to Great Strategy
- Patient Safety Plan - aligned to the National Patient Safety Plan
- Patient Safety Improvement Group (PSIG)
- Accreditation in MHSOP wards and developing Trust wide
- Nutrition & Pressure Ulcers Prevention Group (quarterly)
- Falls Group – monitoring of incidents, themes, and national aligning to best practice
- Suicide Reduction Plan in keeping with National Confidential Enquires Report
- 'Freedom to Speak Up Guardian'
- Deteriorating Patient Group
- Accreditation Matron in post
- Harm assessment process / Learning from Death and Suicide Prevention Clinician recruited 01/06/20

**Impact of covid-19**

reduced numbers of staff to investigate incidents and drive improvements forward.
Reduction in some governance forums /changed focus.
The impact on patients not diagnosed with COVID19 has reduced visibility.
There is a concern that deterioration of patients condition will be attributed to COVID19
Some training suspended
All Leicester inquests suspended until 30/09/20)

**Gaps:**

- Implementation of recommendations from the External report on quality governance
- Developing an agreed set of clinical and professional standards and values
- Mandatory and role related training compliance across both substantive and bank staff

## Assurances

**Internal:**

- Quality Forum / Quality Assurance Committee / Strategic Workforce Committee
- All associated policies
- Professional standards group
- Revised quality governance structure being embedded; Revalidation and registration process in place
- Associate Director of Nursing in place who leads on professional practice
- Mental Health Act Reviews
- Mortality reviews & Learning from Deaths Process
- Trust wide Adult & Child Safeguarding
- Mandatory training reports ; Clinical supervision reports
- **SUTG**: High Standards Change Programme (at scoping stage)
- **Performance Report:** Serious Incidents (number of)

**Evidence:**

- Learning from deaths report to Trust Board
- Performance dashboard to FPC and Trust Board
- QAC assurance report to Board
- Update on progress of local Quality Accreditation (QAC paper F 16.03.20)
- Harm review paper (QAC 16.03.20)

**Assurance Rating**
Green

**External:**

- Patient/family and staff FFT / PALS feedback
- CQC inspection
- Professional Bodies e.g. NMC, GMC, HCPC
- Quality Contract and Monitoring with CCG & Specialised Commissioning
- Health watch Leicester
- Coroner feedback
- LLR Transferring Care Safely Group/LPT engaged (acute/secondary provider feedback)
- External reviews of quality governance
- **Internal Audit Plan 2020/21:** Patient Safety Q2; Duty of Candour Q 2/3; Management of Non-Fixed Ligaturing Q2; Medicines Management Q2; Implementation of the Mental Capacity (Amendment) Act 2019 Q tbc

**Evidence:**

- Patient experience report to QAC
- CQC report and action plan to QAC

**Assurance Rating**
Amber

**Gaps:**

- Patient Safety Walk-rounds
- Compliance with mandatory & role related training, staff knowledge around physical health and speciality
- Staff vacancies across the professions and high bank /agency use. Increased use of redeployment and non familiar staff

## Actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| July 20 | • Implementing external quality governance report supported by 'buddying' with NHFT – implement new SI process and structures | Exec Team | • Review of SI and Complaint process complete<br>• Identified in transformation programmes. | Amber |
| Jun 20 | • Plan for a coordinated recruitment process | T Ward | | |
| Sept 21 | • Accreditation Matron to implement quality accreditation trust wide | T Ward | | |

| | | | |
|---|---|---|---|
| **Risk No: 2** | High Standards | Date included: | 01.10.19 |
| **Risk Title:** | The Trust's safeguarding systems do not fully safeguard patients and support frontline staff and services. | | |
| **Risk Owner:** | Director of Nursing, AHP and Quality | **Date Last Reviewed:** | 01.06.20 |
| **Governance / Review:** | Legislative Group, QAC / Monthly Review | | |

| High Standards | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 4 | 3 | 12 |
| **Residual Risk** | 4 | 2 | 8 |
| **Risk Appetite** | 4 | 2 | 8 |

**Impact of covid-19**
Lessons learned not being fully disseminated as fully.
Safeguarding Board recommencing work (all multi-agency reviews underway)
Team training postponed . Limited training in place for clinical staff,.
Work is continuing from the external review action plan, however this is proving to be challenging in terms of being able to fully implement.
RO23 on the ICC RR - An increase in domestic abuse, coupled with a lack of opportunity to identify cases will create a post COVD influx of referrals which will impact on frontline services and the Safeguarding team's capacity to provide support.
Pace of changes and increase in safeguarding work impacts on capacity of frontline services and safeguarding team.

## Controls

**Description**

- Safeguarding Team disseminate lessons learnt from investigations and reviews, Section 42 enquiries Care Act 2014) and through participation in multi-agency statutory reviews. processes (Child Safeguarding Practice Review [CSPR], Safeguarding Adult Review and Domestic Homicide Review .
- Legislative Committee oversight under new Quality Governance Framework.
- Identified Safeguarding Lead Nurses (Trust Lead, Child Lead, Adult Lead) and named Doctor for safeguarding children.
- Internal governance structure to manage safeguarding in place via Directorate oversight.
- Members of four local Safeguarding Boards, two Community Safety Partnerships and the Safeguarding Vulnerabilities
- Executive Committee.
- Adult and Children's Safeguarding Team in place.

**Gaps:**

- Availability of training due to capacity
- Sufficient access to medical advice
- Lack of consistent approach to how lessons are learnt and how they are disseminated across the Clinical Directorates through to front line staff.
- The number of Multi Agency Reviews (CSPR, SAR and DHR) across LLR is above the national average for the number of reviews commissioned within a locality area the size of LLR .
- The safeguarding training offer from the LPT Safeguarding Team is not compliant with national standards and guidelines.

## Assurances

**Internal:**

**Source:**

- Legislative Committee
- Quality Forum provides oversight and challenge to the Legislative Committee.
- Quality Assurance Committee.
- Annual Quality Account.
- External review commissioned regarding safeguarding structures within LPT outlined 32 recommendations
- The identified Safeguarding Lead Nurses access safeguarding supervision external to the organisation.
- Annual Safeguarding Report.
- **SUTG:** High Standards Change Programme (at scoping stage)

**Evidence:**

- Safeguarding report presented to Trust Board. (May 2020)
- Key Performance Indicators for the Legislative Committee.
- Progress and update reports regarding the external review action plan.
- Action plan
- Safeguarding update (QAC paper May 2020)

**Assurance Rating**
Amber

**External:**

**Source:**

- CQC inspections (contribution to CCG Safeguarding Inspections /direct LPT CQC Inspection)
- Commissioner meetings, including quarterly safeguarding assurance template (SAT) Membership of four Local Safeguarding Boards, including the Boards' respective sub-committees , i.e. Performance Group, Policy Group and Review Group
- **Internal Audit Plan 2020/21:** Clinical Quality – Patient Safety Q2

**Evidence:**

- External review of safeguarding structures report
- CQC report
- Local Safeguarding Board reports and minutes

**Assurance Rating**
Amber

**Gaps:**

- Training figures
- Full implementation of the external review recommendations
- Increasing demand of frontline safeguarding work as well as increasing number of multi-agency reviews throughout Covid period

## Key actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| Sept 20 | • Implement and embed the 32 recommendations from the external review. | Neil King | • External review completed and report accepted by the Trust. Action plan developed for all 32 recommendations. | Amber |
| Aug 20 | • Training capacity and offer to be reviewed as part of the external review recommendations (to be deferred and held in abeyance) | Neil King | • Training to be deferred given large scale deliveries not possible due to Covid. | |
| Aug 20 | • Recruit to vacant posts. | Neil King | • Recruitment to vacant posts is ongoing, some completed – awaiting one vacancy (recruited to) to commence employment. | |
| July 20 | • Outline changing trend analysis throughout Covid period to highlight increasing work | | • Safeguarding to become part of the recovery work in ICC | |

| | | | |
|---|---|---|---|
| **Risk No: 3** | High Standards | Date included: | 01.10.19 |
| **Risk Title:** | The Trust does not learn from incidents and events and does not effectively share that learning across the whole organisation. | | |
| **Risk Owner:** | Director of Nursing, AHP and Quality | Date Last Reviewed: | 02.06.20 |
| **Governance / Review:** | Learning Lessons Exchange Group, Quality Forum, QAC / Monthly Review | | |

| High Standards | Consequence | Likelihood | Combined |
|---|---|---|---|
| **Current Risk** | 4 | 4 | 16 |
| **Residual Risk** | 4 | 2 | 8 |
| **Risk Appetite** | 4 | 2 | 8 |

## Controls

**Description:**

- Centralised process for identifying, processing, investigating, scrutiny and identifying Learning through the Serious Incident Process
- Complaints process and PALs team
- Patient and Staff Safety Incident review via triage and directorate responsibility
- Outcomes from Clinical Audit & service evaluation
- Working towards a robust Risk Management Process for identifying and manging risks to enhance learning
- Learning from Deaths Group
- Learning lessons Exchange Group
- Patient Safety Improvement Group

**Gaps:**

- A robust Directorate level governance processes/systems

**Impact of covid-19**

The opportunity for shared learning is reduced due to the reduction in some governance forums. and their focus
Coroner feedback paused
Reduced feedback from patients / families

## Assurances

**Internal:**

| Source: | Evidence: | Assurance Rating |
|---|---|---|
| • Learning from deaths report<br>• Patient safety quarterly report<br>• Highlight report from Patient safety group<br>• Highlight report from the Learning Lessons Exchange<br>• Foundation for Great Patient Care<br>• Escalation from Quality Forum to QAC<br>• Incident review group meet weekly to review potential SI's and all COVID19 incidents and escalate to ICC<br>• **SUTG:** High Standards Change Programme (at scoping stage)<br>• **Performance Report:** STEIS SI action plans completed within timescales. | • Regular reports and minutes from meetings<br>• Highlight information and escalation processes<br>• Reduction in harm and incidents<br>• Reduction in concerns and complaints<br>• Improved staff feedback | Amber |

**External:**

| Source: | Evidence: | Assurance Rating |
|---|---|---|
| • Feedback from patients/families<br>• CQC statutory inspection framework<br>• Quality and Serious Incident oversight by Commissioners & specialist commissioning<br>• Coroner feedback<br>• National Confidential Enquiries<br>• Solicitor feedback learning points<br>• **Internal Audit Plan 2020/21:** Patient Safety Q2 | • Patient experience report to QAC<br>• CQC report | Amber |

**Gaps:**

- Demonstrating changes based on learning
- Clarity and ownership of SI processes
- Triangulation with complaints and PALs

## Key actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| July 20 | Implement the redesign of governance structures within directorates | Anne Scott | Implementation plan being developed | Amber |
| July 20 | Reporting format for learning papers to include actions and progress against actions | Tracy Ward | | |
| July 20 | Triangulate with complaints and PALs | TW / AK | | |

| | | | |
|---|---|---|---|
| **Risk No: 4** | High Standards | Date included: | 01.10.19 |
| **Risk Title:** | Services are unable to meet 'safe staffing' requirements | | |
| **Risk Owner:** | Director of HR / Director of Nursing | Date Last Reviewed: | 01.06.20 |
| **Governance / Review:** | Learning and OD Group, Quality Forum, QAC / Monthly Review | | |

| High Standards | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 4 | 3 | 12 |
| **Residual Risk** | 4 | 2 | 8 |
| **Risk Appetite** | 4 | 2 | 8 |

## Controls

**Description:**

- Monthly safe staffing reports with oversight and triangulation of fill rates, skill mix, temporary worker utilisation, vacancies, CHPPD, core clinical and mandatory training, patient experience feedback and Nurse Sensitive indicators
- 6 monthly establishment reviews include workforce planning, new and developing roles and recruitment and retention
- All reviews are in line with the NQB guidance for safe sustainable and productive staffing and the NHSI Developing Workforce Safeguards policy.
- Hot spot areas are escalated weekly to the Director of Nursing AHPs & Quality and monthly within the safe staffing report with actions to mitigate the risks.
- MHOST tool for review of patient acuity and dependency
- evidenced based tool for acuity and dependency measurement

**Gaps:**

- Trust wide safe staffing safeguards SOP

**Impact of covid-19**

Safe staffing reports continue to flow to Trust Board
Monitoring in I/P and Community settings (B&A, and substantive staffing levels)
QF continuing
Staff absence related to Covid-19 reported in monthly reports from March to review impact
National safe staffing return to recommence June 20, incl retrospective data from paused months
Reduced bed occupancy
Flexing our safe staffing numbers to meet patient acuity and occupancy
Ward changes and closures included in monthly reporting
Staff absences linked to COVID
Impact on right skills, face to face training cancelled until 31 June 20 only exception redeployed or new starters attend one stop educational programme.
NHS Digital has paused safe staffing submissions for 3 months to June 20 – we continue to monitor the impact on quality and safety through the monthly reports.
Re-deployment / Surge wards / Delay in 6 monthly establishment reviews

## Assurances

**Internal:**

**Source:**

- Workforce Planning capacity - funded establishments and 6 monthly reviews
- Analysis of NSIs, outcomes and patient experience feedback
- Analysis of CHPPD and fill rates
- Analysis of temporary worker utilisation
- 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.
- **SUTG:** High Standards Change Programme (at scoping stage)
- **Performance Report:** Safe Staffing

**Evidence:**

- Trust Workforce Plan
- Monthly and 6 monthly safe staffing reviews
- Analysis of the CHPPD has not identified variation at service level, indicating that staff are being deployed productively across services.
- Analysis of NSIs has not identified correlation between staffing and impact to quality, safety and patient outcomes

**Assurance Rating**
Green

**External:**

**Source:**

- NHSE Safe staffing trends – monthly submission
- The Department of Health and Social Care's group annual governance statement - NHSI
- Single Oversight Framework
- **Internal Audit Plan 2020/21:** Safe Staffing Q2

**Evidence:**

- Unify and Healthroster data
- SOF / AGS

**Assurance Rating**
Amber

**Gaps:**

- Evidence based acuity and dependency data for all in-patient areas
- Plan for more centralised recruitment

## Key actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| Aug 20<br>Jun 21 | • To develop a Trust wide safe staffing safeguards SOP<br>• To procure and implement Allocate SafeCare.to monitor actual patient demand at key points during the day and accurately align staffing to match | Emma Wallis<br>Amrik Singh | • The DRA off-framework staffing process and deployment has been reviewed and will feed into the SOP.<br>• This has been delayed for a year due to a regional procurement exercise. | Green |

| | | | |
|---|---|---|---|
| **Risk No: 5** | High Standards | Date included: | 01.10.19 |
| **Risk Title:** | Capacity and capability to deliver regulator standards | | |
| **Risk Owner:** | Director of Nursing, AHP and Quality | Date Last Reviewed: | 24.06.20 |
| **Governance / Review:** | Foundation for Great Patient Care, Quality Forum, QAC / Monthly Review | | |

| | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 4 | 4 | 16 |
| **Residual Risk** | 4 | 3 | 12 |
| **Risk Appetite** | 4 | 3 | 12 |

## Controls

**Description:**

- Quality Improvement work programme / Quality accreditation
- Foundation for Great Patient Care with KLOEs driving the agenda / CQC project manager in post
- Quality Surveillance Tracker
- Core standards training / 3 phased methodology
- NHFT buddy programme / Revised Governance structure – plus COVID-19 governance arrangements
- Book of brilliance
- Step up to great strategy
- Senior Leadership and Extended Senior Leadership Team Meetings / Board development sessions – on hold
- Completed CQC action plan and ongoing improvement programmes
- IPC inspection and action plan
- Risk management strategy and ORR - plus additional RM arrangements for COVD-19
- Action cards
- Approval of new AMAT database CQC module
- Knowledge library
- Time to shine online workshops rolled out
- CQC inspection preparation checklist available in Time to Shine Booklet

**Gaps:**

- Understanding of the impact of COVID related decision making on regular standards

## Assurances

| | | | |
|---|---|---|---|
| **Internal:** | • Audit and Quality Accreditation programmes - on hold<br>• Quality forum<br>• PIR analysis and inclusion on tracker<br>• Foundation for great patient care – weekly highlight report<br>• ORR Reporting<br>• AMAT tool being used for meds management audits - monitored by pharmacy and showing significant improvement<br>• Weekly CQC report to the Exec team with update to quality surveillance tracker<br>• **SUTG:** High Standards Change Programme (at scoping stage) | **Evidence:**<br>• CQC update report to QAC<br>• Weekly update report to Exec Team<br>• Foundation for Great Patient Care highlight report to Quality Forum – demonstrating good attendance and engagement<br>• ORR reports | **Assurance Rating**<br>Amber |
| **External:** | • CQC inspection and engagement meetings / discussions / Emergency Support Framework<br>• Regulator discussions (SIAM / informal discussions with NHSEI) – on hold<br>• Third line assurance over compliance (outside of the CQC)<br>• CQRG – discussions with Commissioners<br>• Regulator inspections including HSE, NHSIPC<br>• KPMG value for money conclusion<br>• 360 Assurance internal audit | **Evidence:**<br>• Inspection report<br>• Minutes of CQC engagement and SIAM meetings<br>• 3rd party assurance reports (HSE, IPC, NHFT buddy visits)<br>• External reports on governance and SI management | **Assurance Rating**<br>Amber |

**Gaps:**

- NED boardwalks and feedback forms - on hold

## Key actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| July 20<br>Aug20 | • Feedback on Director interviews to be given at CEB 3 July 2020<br>• Time to Shine Workshops – on-going delivery | Julie Rubenzer<br>Mia Morris | Interviews held, feedback session to follow on 3 July 20<br>On-gong delivery of workshops, well attended with good feedback. Training figures to be reported in CQC report to QAC | Amber |
| Aug 20 | • Deep dive reviews into impact of COVID on KLOE – ongoing at the Foundation for Great Patient Care | Julie Rubenzer | On-going. Smoking deep dive 24 June 20 | |

| | | | |
|---|---|---|---|
| **Risk No: 6** | Transformation | Date included: | 01.10.19 |
| **Risk Title:** | The step up to great mental health strategy does not deliver improved mental health services that meet quality, safety and contractual requirements and are sustainable. | | |
| **Risk Owner:** | Director MH | Date Last Reviewed: | 26.05.20 |
| **Governance / Review:** | Transformation Committee, FPC / Monthly Review | | |

| | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 4 | 4 | 16 |
| **Residual Risk** | 4 | 3 | 12 |
| **Risk Appetite** | 4 | 2 | 8 |

## Controls

**Description:**

- Step up to great system wide pathway redesign high level launch
- Developing delivery plan
- Resources identified to deliver plan
- Programme management in place with DMT oversight
- on-going engagement with staff, service users and carers

**Gaps:**

**Medium Term**

- Governance and due process in place to address challenges over the year

**Longer Term**

- Quality and timeliness of engagement with external partners
- Effective balance of conflicting short term priorities, with the development of the longer term vision and plan
- System financial sustainability and mental health investment standard
- Leadership development
- Robust stakeholder management and engagement plan
- QIA risk assessment process

**Impact of covid-19**

- Less focus on the 9 work streams in SUTG mental health however we have expedited certain aspects of planning e.g. central access point went live in April 20 (due date was June 20).
- Community rehab team went live Monday 4 May 20 – again expedited against COVID.
- Other areas of development not linked to SUTG include mental health ED as part of mental health crisis hub - introduced in April 20
- Work underway with Graeme Jones to ensure process is sound related to transformation; there will be learning from COVID embedded within that process.

## Assurances

| | Source: | Evidence: | Assurance Rating |
|---|---|---|---|
| **Internal:** | • Large scale co-production events<br>• Project Initiation Document<br>• LPT Trust Board quarterly updates<br>• Directorate Management Team (DMT)<br>• Implementation plan<br>• **SUTG:** Step up to Great Mental Health | • QIB update papers<br>• SUTG project delivery dashboard<br>• Out of area improvement | Amber |
| **External:** | • Health and Wellbeing Board scrutiny<br>• STP Better Care Together Plan – Mental Health work stream<br>• System MH Partnership Board governance<br>• City MH partnership Board scrutiny<br>• MH Clinical Forum monthly updates<br>• CPM monthly progress updates<br>• MH collaborative | • External presentations<br>• SIAM minutes<br>• CQC engagement minutes | Amber |

**Gaps:**

- Signed off clinical models
- Affordable workforce model
- Management of change and associated EIA and QIA
- Agreed internal governance pathways

## Key actions

| Date: | Actions: delayed due to COVID | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| July 20 | • Formal sign off of detailed delivery plan | GK | • Extensive engagement with mental health directorate<br>• Confirmation of transformation programme and transformation committee | Amber |
| July 20 | • Formal sign off of associated clinical model | GK | | |
| July 20 | • Set up work streams for delivery plan | GK | | |
| July 20 | • Develop financial plan for 2020 delivery plan | GK | | |
| July 20 | • Determine the QIA risk assessment process | GK | | |

| | | | |
|---|---|---|---|
| **Risk No: 8** | Transformation | Date included: | 01.10.19 |
| **Risk Title:** | The transformation plan does not deliver improved outcomes for people with LD and/or autism. | | |
| **Risk Owner:** | Divisional Director, FYPC and LD Services | Date Last Reviewed: | 03.06.20 |
| **Governance / Review:** | Transformation Committee, FPC / Monthly Review | | |

| Transformation | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 4 | 4 | 16 |
| **Residual Risk** | 4 | 3 | 12 |
| **Risk Appetite** | 4 | 3 | 12 |

## Controls

**Description:**

- LLR weekly review of TCP cohort
- Clinical leadership and ownership
- Transforming care pre-admission process for people with LD and / or autism
- Risk of Admission Register (ROAR)
- Full RCA for anyone that falls outside of the defined process for admission
- Care and Treatment Reviews
- SDIP for LD Rehab at the Agnes Unit
- Develop LD Forensic Community Network
- LD Outreach team offer alternative to admission
- 12 point discharge plan is utilised and monitored via discharge planning meetings
- There is an Accountable Officer (LPT CEO), an SRO and an Exec Lead
- LD forensic training package for health and social care staff
- System wide LeDeR reviews
- Interim staff cover though use of redeployed short breaks staffing to strengthen outreach offer for risk stratified patients including bank holidays

**Impact of covid-19**

- Capacity to prioritise system improvement plan
- Increased Nos of people on Risk Of Admission Register due to escalating behaviours / reduced community support / placement breakdown / short breaks and day centre temporary closure
- Delayed discharges due to reduced provider resilience and staffing
- Training: forensics and to AMH staff compromised by social distancing
- Rehab proposal / forensics funding not agreed due to contract slippage and Q1 roll-over of budgets
- Care (Education) Treatment Reviews taking place virtually and shortened

**Gaps:**

- Treatment and support for ASD only diagnosis (without LD)
- System wide workforce plan
- Local LD rehab capacity
- Appropriate community placements in LLR

## Assurances

**Internal:**

**Source:**

- SOP for in hours and out of hours CTRs and CETRs to reduce risk of admission
- Risk of admission register
- Root Cause Analysis for all admissions
- Project management
- Transformation Committee
- Improvement plan for AMH staff
- Business case for the treatment and support for ASD only diagnosis (without LD)

**Evidence:**

- List of people at risk of admission
- Learning from RCAs to reduce risk of future admissions
- Report into transformation committee

**Assurance Rating**
Green

**External:**

**Source:**

- Adult Case Managers (CCGs / Specialised Commissioning)
- External input into Root Cause Analysis on all admissions
- External review from Moorhouse December 2019 priority recommendations
- System LD and Autism Executive
- **Internal Audit Plan 2020/21:** Collaborative Care Planning Q2

**Evidence:**

- Learning from RCAs to reduce future admissions

**Assurance Rating**
Amber

**Gaps:**

- CCG Case Managers for children
- System based support for effective discharge of Ministry Of Justice cases into the community

## Key actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| July 20 | • Deliver LD Rehab SDIP within agreed timescales | HT | • Links to rehab proposal awaiting CCG approval | Amber |
| Dec 20 | • Implementation of improvement plan from Moorhouse report with partners | HT | • Agreed an improvement plan. | |
| July 20 | • Full consideration of business cases for funding (for the treatment and support for ASD) | HT | • Business case developed - awaiting contract negotiations | |
| July 20 | • Implementing plan to skill up health and social care staff in Forensic capability | HT | • Impacted by cancellation of training in March 20 due to social distancing. Exploring online options | |

| | | | |
|---|---|---|---|
| Risk No: 9 | Environment | Date included: | 01.10.19 |
| Risk Title: | Inability to maintain the level of cleanliness required within the Hygiene Standards | | |
| Risk Owner: | Director of Finance, Business & Estates and Deputy Chief Executive / Director of Nursing | Date Last Reviewed: | 24.06.20 |
| Governance / Review: | IPCC, QAC and FPC / Monthly Review | | |

| | Consequence | Likelihood | Combined |
|---|---|---|---|
| Current Risk | 4 | 4 | 16 |
| Residual Risk | 4 | 3 | 12 |
| Risk Appetite | 4 | 2 | 8 |

## Controls

**Description:**

- Collaborative agreement in place with UHL for provision of soft facilities management (including cleaning standa
- Use of the Hygiene standards
- Appropriately trained estates team in place
- Backlog maintenance controls
- Hygiene Code gap analysis undertaken – Aug 2019
- Estates rep sits on/reports into IPC Group (cleaning/water/waste/decontamination)
- Infection control team / IPC quarterly report and annual report
- PLACE Audit action plan
- SOPs in place to describe key responsibilities
- Audit programme includes Cleaners rooms and trolleys

**Gaps:**

- Accuracy of reporting process from UHL FM service

**Impact of covid-19**

Increased focus on IPC across UHL and LPT combined with potential increased sickness from cleaning staff has increased the current and residual risk scores – flexing and risk based working has ensured cleaning has remained at required levels but will need continual review through recovery activities ie lifting cleaning of 'Amber' areas to same level as 'Red' areas.

Possible need to withdraw cleaning from non-critical areas to backfill staff into critical areas – keep under review through recovery

Possible difficulties in obtaining supplies & consumables – keep under review

Potential lack of engagement with SLA and any improvement in reporting (response times / accuracy)

## Assurances

**Internal:**

**Source:**

- Cleaning report to the Estates Committee
- Finance and Performance Committee
- IPC Group to QAC
- Bi-monthly contractual cleaning forum (estates/IPC/NHS PS/UHL) - this goes to estates committee and FPC.
- Reporting against the delivery of the Estates Strategy
- Regular cleaning audits and KPI score monitoring
- Regular assurance information from UHL
- IPC Bi-Annual report to Trust Board

DMTs

- Monthly reports to FPC (Estates) and QAC - (IPC)
- PLACE scores and report for 2019

**Assurance Rating**
Amber

**External:**

**Source:**

- NHSI IPC audit
- CQC inspections
- PLACE audits

**Evidence:**

- PLACE audit
- NHSI audit received
- National Guidance on C Diff
- Premises Assurance Model

**Assurance Rating**
Amber

**Gaps:**

- Regular performance reports against hygiene standards and regular review at IPC
- NHSI re-visit in Jan 2020 identified gaps – risk re-scored to reflect current and residual risk

## Key actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| Aug 20<br>Sept 20<br>Aug 20 | • PLACE audit action plan<br>• Clear and agreed reporting mechanism against Hygiene standards<br>• Agree 20/21 FM SLA and performance KPIs | Helen Walton<br>Emma Wallis<br>Andy Donoghue | • Progress paused due to COVID – to be re-instated after recovery<br>• Bi-monthly reporting to cleaning forum<br>• Currently paused (COVID) – to be re-instated as part of recovery exercise | Amber |

| | | | |
|---|---|---|---|
| **Risk No: 10** | Environment | Date included: | 01.10.19 |
| **Risk Title:** | The Trust does not implement planned and reactive maintenance of the estate leading to an unacceptable environment for patients to be treated in | | |
| **Risk Owner:** | Director of Finance, Business & Estates and Deputy Chief Executive | Date Last Reviewed: | 01.06.20 |
| **Governance / Review:** | Estates Committee, FPC / Monthly Review | | |

| Environments | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 4 | 4 | 16 |
| **Residual Risk** | 4 | 3 | 12 |
| **Risk Appetite** | 4 | 3 | 12 |

## Controls

**Description:**

- Contract management with NHSPS for provision of facilities management
- Collaborative agreement with UHL for provision of facilities management
- Appropriately trained estates team in place
- Health and Safety Reviews
- Backlog maintenance controls
- P21 partners in place
- Revenue and capital budget setting process in place
- Condition survey for the inpatient estate completed 2018
- Approved Estates Strategy
- Planned and preventative maintenance plan held by UHL
- New FM Oversight Group – weekly meetings to track FM risks/issues (Dec 2019 onwards)
- FM Transformation Board (Jan 2020 onwards)
- PPM schedules (12 month forward view) received from UHL Dec 2019 and assessed as adequate

**Impact of covid-19**

- Estates Committee was suspended (Mar/Apr) but is now meeting again
- Recovery works ongoing – including work led by H&S team to determine how environments can be occupied/re-occupied in a manner that ensures maximum safety for staff and zoning of clinical areas to maximise segregation of COVID positive patients.
- Possible difficulties in accessing 'locked-down' areas – Contractors working to 'Action Card' requirements regarding access/PPE etc..
- Possible issues with completing backlog schemes on the capital prog - Programme has now been reviewed and priority schemes progressing

**Gaps:**

- Lack of systematic process for identify high risk areas requiring maintenance
- Not complying with the KPIs
- Unsatisfactory delivery against our facilities management agreement
- Maintenance is not always undertaken in a timely way
- Clarity over the arrangements for managing risk with FM until April 2021

## Assurances

**Internal:**

**Source:**

- Estates committee / FPC
- FM oversight Group
- Initial review to identify high risk areas of the estate that require maintenance completed Reporting of FM KPIs to FPC
- Estates risk register
- Audit action plan – track via FM Oversight Group
- Self assessment on premises assurance model
- Foundation for Great Patient Care quality surveillance tracker, deep dives and escalation process

**Evidence:**

- Report to the Estates Committee, and then to FPC which details performance
- PPM performance report
- Reports demonstrating implementation of the Estate Strategy to the Estates Committee
- Reports to the FM oversight group.

**Assurance Rating**
Amber

**External:**

**Source:**

- NHSI / CQC / HSE / Fire service
- 360 Assurance internal audit of estates maintenance - Limited Assurance

**Evidence:**

- Audits and reports
- PLACE scores

**Assurance Rating**
Amber

**Gaps:**

- Lack of assurance on information received from UHL due to inconsistent audits
- Assurance information not being received from NHSPS
- Poor performance against set KPI resulting in lack of assurance
- Report for property services

## Key actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| Jul 20 | • PMO for premises assurance model | AD | • PMO project plan in place requires review of milestones | Amber |
| June 20 | • Decision on in-house to FPC | **AD/SO** | • Final business case in draft – due to TB June 20 | |
| Sept 20 | • Final KPIs to be agreed as part of the 20/21 SLA | AD | • Currently paused (COVID) – to be re-instated as part of recovery exercise | |
| Sept 20 | • FM transformation plan | AD/SO | • FM Transition Board has been paused. To be re-set once a better understanding of COVID-19 recovery is understood.<br>• Working Groups established. | |

| | | | |
|---|---|---|---|
| **Risk No: 11** | Environment | Date included: | 01.10.19 |
| **Risk Title:** | The current estate configuration does not allow for the delivery of high quality healthcare | | |
| **Risk Owner:** | Director of Finance, Business & Estates and Deputy Chief Executive | **Date Last Reviewed:** | 15.06.20 |
| **Governance / Review:** | Estates Committee, FPC / Monthly Review | | |

| Environments | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 4 | 4 | 16 |
| **Residual Risk** | 4 | 3 | 12 |
| **Risk Appetite** | 4 | 3 | 12 |

## Controls

**Description:**

- A dedicated estates team in place
- Estates Strategy approved by the Trust Board in Oct 2019.
- Capital resource prioritisation framework
- Condition surveys have been completed in priority areas (in-patient estate)
- The mental health inpatient re-provision soc
- Health and Safety Risk Assessments in place
- Clinical risk assessment to mitigate re privacy and dignity
- Business case for interim dormitory solution approved by the Board Jan 20
- Approved Strategic plan for the elimination of dormitory accommodation

**Impact of covid-19**

- Delay to estates workshop
- Potential slippage of plan to address dormitory accommodation – Work now progressing for Yr 1 schemes (scoping & design)
- CAMHS – potential further delay to the current 6 week slippage.
- Slippage on backlog maintenance and non essential works

**Gaps:**

- Lack of derogation process to the Board
- Premises Assurance Model to be updated
- Challenges around availability of capital funding
- A plan to address weaknesses in the configuration
- An understanding of the full impact of coronavirus on progress of delivery of actions

## Assurances

**Internal:**

**Source:**

- Monthly report to FPC on progress against the Estate Strategy
- Health and Safety Reports and confirmation of compliance with actions
- The soc was signed off by the Board in October 2019
- Strategic Estates and Medical Equipment Committee
- Finance and Performance Committee
- Health and Safety Committee
- Directorate Health and Safety Action Groups
- Building of new CAMHs Unit
- Annual PLACE inspections
- 3 year plan to eliminate dormitory accommodation (AMH/MHSOP) agreed by Trust Board

**Evidence:**

- Monthly report to FPC on progress against the Estate Strategy
- Health and Safety Reports and confirmation of compliance with actions
- The soc was signed off by the Board in October 2019
- PLACE report for 2019

**Assurance Rating**
Amber

**External:**

**Source:**

- PLACE audits
- NHSI
- CQC
- HSE
- Fire service
- KPMG audit of financial and quality accounts

**Evidence:**

- CQC report
- 360 audit

**Assurance Rating**
Amber

**Gaps ..**

- Premises Assurance Model

## Key actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| July 20 | • Estates Workshop | A Donoghue | • Workshop cancelled – new date TBC | Amber |
| Aug 20 | • Overall ~~transformation~~ **delivery plan for Estate Strategy** | AD | • System wide LLR estates transformation under consideration | |
| July 20 | • In-patient reconfiguration – phase 1 OBC (Bradgate) to be agreed | AD | • Agreed with NHSEI that approval not required for SOC | |
| Aug 20 | • Implementation of plan for the dormitories (20/21 to 22/23) | AD | • Yr 1 works (Aston ward) currently in design for planning application | |

| | | | |
|---|---|---|---|
| **Risk No: 12** | Patient Involvement | Date included: | 01.10.19 |
| **Risk Title:** | Service users, carers and families do not have a positive experience of care, do not feel able to participate effectively and share their experiences. | | |
| **Risk Owner:** | Director of Nursing, AHP and Quality | Date Last Reviewed: | 28.05.2020 |
| **Governance / Review:** | Patient and Carer Experience Group, Quality Forum, QAC / Monthly Review | | |

| Patient Involvement | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 3 | 3 | 9 |
| **Residual Risk** | 3 | 2 | 6 |
| **Risk Appetite** | 3 | 2 | 6 |

## Controls

**Description:**

- Patient Involvement Experience Strategy and Team
- Patient surveys / Friends and Family Test
- Envoy Patient Experience portal
- Equality and diversity work
- Annual Quality Account
- Care planning audit programme
- Three year patient experience and involvement delivery plan 2019/2022
- Collaborative care programme
- Recovery café programme
- Patient Involvement Co-Design Group in place
- New Friends and Family Test Automated system now in place May 2020
- Three year Patient Experience and Involvement Delivery Plan in place for 2019-2022

**Impact of covid-19**
Delay to relaunch of FFT – launch to be delayed until July 2020
Delay to patient experience survey – July 2020
Delay to launch of People's Council – September 2020

**Gaps:**

- Lack of use of carer assessments to develop better understanding of the link between incidents and concerns when introducing new pathways
- Friends and Family Test automated system implementation due to be completed July 2020
- No strategic lead for carers or carers strategy in place

## Assurances

**Internal:**

**Source:**
- Patient and Carer Experience Group established
- Equality Diversity and Inclusion Patient Experience and Involvement Group established
- Complaints Review Group established
- Quarterly Patient Experience and Involvement Reports
- Quality Forum
- Quality Assurance Committee
- Patient Involvement Programme
- Delivery plan in place and reported monthly through Quality Improvement Board

**Evidence:**
- Monthly Highlight Reports from PCEG to Quality Forum
- Three year patient experience and involvement delivery plan in place
- Service User Involvement Group established
- Friends and Family Test feedback
- Compliments, concerns and complaints feedback received

**Assurance Rating**
Green

**External:**

**Source:**
- Community Mental Health Survey
- CQC inspections
- MHA visits
- Joint Strategic Needs Assessment
- Healthwatch
- **Internal Audit Plan 2020/21:** Collaborative Care Planning Q2

**Evidence:**
- Community Mental Health Survey Report and supporting improvement plan
- CQC Reports
- Ward Accreditation programme being progressed
- Step up to Great monthly reports

**Assurance Rating**
Green

**Gaps:**

- No carers lead or strategy in place
- FFT system not fit for purpose (new system planned for 2020/21)

## Key actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| July 20 | • Launch Patient Experience survey | Alison Kirk | • Co-design taking place to inform implementation of patient involvement framework | Amber |
| July 20 | • Re-launch FFT | AK | • Patient Involvement Framework launched with active patient and carer involvement in place | |
| Jun 20 | • Carers Option Paper - way forward to be agreed | AK | • Patient leadership programme finalised and implementation dates agreed | |
| July 20 | • Commence recruitment to People's Council VCSO's membership | AK | • Online patient involvement system and processes in place | |
| July 20 | • Launch patient leadership training programme | AK | • Co-design People's Council terms of reference and paperwork | |
| July 20 | • Approve and adopt the Trust wide reward and recognition policy | AK | | |
| Sept 20 | • Launch Peoples Council | AK | | |
| Jun 20 | • Deliver the complaints improvement programme | AK/MS | | |

| | | | |
|---|---|---|---|
| **Risk No: 16** | Well - Governed | Date included: | 01.10.19 |
| **Risk Title:** | The Leicester/Leicestershire / Rutland system is unable to deliver the agreed plan for Integrated Care Systems | | |
| **Risk Owner:** | Director of Strategy and Business Development | Date Last Reviewed: | 26.05.20 |
| **Governance / Review:** | Transformation Committee , FPC / Monthly Review | | |

| Well-governed | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 4 | 3 | 12 |
| **Residual Risk** | 4 | 2 | 8 |
| **Risk Appetite** | 4 | 2 | 8 |

## Controls

**Description:**

- LPT will play our role in system meetings and the development of the ICS proposal, through honest and trusting discussions.
- A consistent agreed objective and system narrative that is used and tested in all system meetings, with all partners.
- Regular discussion and engagement with our Senior Leadership Team.
- Chief officers meeting fortnightly
- Chief officers have signed up to working together to resolve and deliver system issues and transformation
- Shared purpose agreed with chief officers
- Senior system staff ( CEO, DoF & DoS for all organisations meet monthly)
- Risk sharing agreement
- System leader agreed conversations on new behaviours and agreement to a system control total now in place,
- will be formalised during the contractual process.

**Impact of covid-19**
The focus on delivery today will impact on the system plan for the future as resources are moved to managing immediate safety issues. The management of COVID has demonstrated that the LLR system can deliver change quickly and as a united group of stakeholders.

**Gaps:**

- Ensuring individual organisations maintain commitment to the agreed priorities for the ICS
- The system is introducing a governance process for the partnership board, which will include, shared purpose, risk sharing and how a provider alliance system will operate
- We are introducing a governance process for the 2 way flow of information and engagement between our senor leadership team and our Directors.
- Clear agreed transformation plan
- Clear strategy for bed based services within community hospitals

## Assurances

| | Source: | Evidence: | Assurance Rating |
|---|---|---|---|
| **Internal:** | • Formal updates from system meetings to Executive meetings, Board sub-committees and Trust Board.<br>• Regular discussion at executive meetings and with senior leaders.<br>• Work in progress to develop greater partnership working between organisations which enable the provider alliance concept to be tested. | • Minutes from Executive meetings, Board sub-committees, Trust Board and SLT meetings | green |
| **External:** | • System assessment against the ICS maturity matrix<br>• NHS E & I assessment of system maturity<br>• System meetings and system performance dashboards<br>• Assessment of the System's Long Term Plan Submission<br>• LLR Strategic Executive | • Joint shared document of our system assessment<br>• Summary of NHS E/I assessment of the system<br>• Papers and minutes from system meetings<br>• Formal feedback on our LTP from NHS E/I | |

**Gaps:**

- No national blue-print
- Agreement with NHSEI on forward plan
- Confirm local authorities role in the ICS

## Key actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| Jun 20 | • Agree recovery actions and support LLR recovery cell | DW and RB | • 10 key priorities for change have been agreed within LLR, weekly conversations now being held to deliver longer term change. | |
| Jun 20 | • Agree LLR vision and high level action plan | AH, DC & DW | | |

| | | | |
|---|---|---|---|
| **Risk No: 20** | Well - Governed | Date included: | 01.10.19 |
| **Risk Title:** | Performance management framework is not fit for purpose | | |
| **Risk Owner:** | Director of Finance, Business & Estates and Deputy Chief Executive | Date Last Reviewed: | 24.06.20 |
| **Governance / Review:** | FPC / Monthly Review | | |

| | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 4 | 2 | 8 |
| **Residual Risk** | 4 | 1 | 4 |
| **Risk Appetite** | 4 | 1 | 4 |

## Controls

**Description:**

- Information asset owners in place / SIRO in place
- Clinical system training in place
- Board approved Performance management framework / Board level performance dashboard
- Revised governance framework
- STUG plan
- SOP in place
- 360 data quality audits
- Nationally submitted data / Information team in place
- Simplified board reporting and an agreed set of KPIs for the Board
- Committee dashboards with KPIs owned by QAC/FPC
- Performance review meetings

**Gaps:**

- Embeddedness
- Reporting for each level
- Escalation criteria from QAC to the Trust Board
- Avoidable harm measures
- External Quality Account audit – no data testing due to COVID
- Capacity of the information team due to demands from national sitrep reporting

## Assurances

| | | | |
|---|---|---|---|
| **Internal:** | **Source:**<br>• FPC / QAC<br>• Performance review meetings<br>• DMT meetings<br>• Trust Board | **Evidence:**<br>• Simple Dashboards to Finance and Performance Committee / QAC of KPIs that the committees own<br>• Simplified Board report<br>• ORR reports<br>• Performance report update on quality metrics / KPIs . Agreement by QAC/FPC on the set of KPIs for the Board<br>• Performance review meetings restarted in May/June to review month 1 & restoration/recovery of services post Covid.<br>• Month 3 reviews will revise performance trajectories & targets based on services' assessment of service restoration status | **Assurance Rating**<br>Amber |
| **External:** | **Source:**<br>• Contract monitoring of quality indicators by Commissioners<br>• Finance, Technical and Performance monitoring of contracted performance indicators<br>• NHSI / CQC inspections SIAM<br>• External and internal audit | **Evidence:**<br>• Internal audit of performance scheduled for 2020/21 | **Assurance Rating**<br>Amber |

**Gaps:**

- Fully embedded system
- Established regular cycle of reporting

## Key actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| Sept 20 | • Demonstration of consistent period of review (6 months) | DC | • Evaluation of performance review meetings in Sept 20 | Amber |
| Sept 20 | • 6 monthly review led by level 1 committees | DC | | |
| Jun 20 | • Consideration of avoidable harm measures including impact of partial or full COVID related closures | SE/ A Scott | • QIA of COVID related closures in train. | |
| Jun 20 | • Determine escalation criteria from QAC to the Trust Board | A Scott | | |
| Jun 20 | • Consider the introduction of avoidable harm measures | SE / A Scott | | |

| | | | |
|---|---|---|---|
| **Risk No: 22** | Well-Governed | Date included: | 01.10.19 |
| **Risk Title:** | Information systems and processes are not robust enough to militate against cyber attacks and information breaches | | |
| **Risk Owner:** | Director of Finance, Business & Estates and Deputy Chief Executive | Date Last Reviewed: | 27.05.20 |
| **Governance / Review:** | Data Privacy Committee, FPC / Monthly Review | | |

| | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 4 | 3 | 12 |
| **Residual Risk** | 4 | 2 | 8 |
| **Risk Appetite** | 4 | 2 | 8 |

## Controls

**Description:**

- Ongoing assessment of robustness of the cyber risk framework
- LHIS together with their cyber security arrangements working in conjunction with Head of Data Privacy
- Disaster recovery
- Emergency Preparedness (EPRR)
- IMT Committee
- Data privacy committee
- Information security policies
- List of policies (see governance on a page)
- Data Security and Protection Toolkit with Internal Audit report of Significant Assurance
- SIRO structure
- Data Protection by Design and Default (DPIAs) included in PMO structure
- Membership of the Cyber Associates Network for early notification of national and local issues
- Guidance updates to support videoconferencing with service users and homeworking in light of COVID-19

**Impact of covid-19**

- The national cyber security centre has assessed that COVID-19 presents an increased risk of cyber attack to healthcare services.

This risk is managed through the Data Privacy Committee which will commence remotely from June 20. Despite having not met since March 20, the mechanisms for monitoring and escalation are robust and have not negatively impacted the risk

**Gaps:**

- Similar data breaches occurring but in different services suggesting that shared learning across the Trust is not taking place
- New digital posts that are required - (we have a CIO) we have data quality champions missing

## Assurances

| | Source: | Evidence: | Assurance Rating |
|---|---|---|---|
| **Internal:** | • LHIS re-accreditation of the secure email system (DCB1596) and Cyber Essentials Consultancy.<br>• Review and testing disaster recovery processes.<br>• IG training compliance<br>• Part of the Data Privacy Committee dashboard for 2020/21<br>• Reporting of incidents<br>• Cyber 'hygiene' review and response to NHSE/I April 20 | • Accreditation report<br>• Outputs of Disaster Recovery Testing in remediation action plan<br>• GDPR reports to FPC<br>• Self assessment paper to FPC 17.03.20<br>• Data breach reports to Data Privacy Committee<br>• Cyber Security and COVID-19 paper to FPC 19.05.20 | Green |
| **External:** | • 360 Assurance internal audit of data security standards – Complete December 2019 Advisory<br>• Assessment of Cyber Resilience by NHS Digital Consultants through UCRF<br>• NHS digital cyber training at Board<br>• **Internal Audit Plan 2020/21:** Data Security Standards Q4 | • Report to data privacy<br>• Significant Assurance Internal Audit Report for DSPT 2020 | Green |

**Gaps ..**

- Consideration of the UCRF report to the data privacy committee

## Key actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| Jun 20 | • Review of ICO reportable data breaches | Sam Kirkland | • Regular liaison with LHIS cyber security manager to ensure arrangements remain robust.<br>• Some reviews in place following the major outage. | Green |
| Jul 20 | • Bring the UCRF through the committee structure and establish a regular report | SK | | |
| Aug 20 | • Data Privacy Group to review in detail the self assessment | SK | | |
| Aug 20 | • Review IT business continuity arrangements | Mike Ryan / SK | | |

| | | | |
|---|---|---|---|
| **Risk No: 23** | Single Patient Record | Date included: | 01.10.19 |
| **Risk Title:** | Failure to deliver the EPR system and demonstrate the benefits of the system | | |
| **Risk Owner:** | Director of Strategy and Business Development | Date Last Reviewed: | 26.05.20 |
| **Governance / Review:** | IM&T Delivery Group, FPC / Monthly Review | | |

| | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 4 | 2 | 8 |
| **Residual Risk** | 4 | 1 | 4 |
| **Risk Appetite** | 4 | 1 | 4 |

## Controls

**Description:**

- SEPR Project Board
- Training plan for EPR implementation
- Data migration plan (6th cycle)
- Reporting and monitoring arrangements
- Implementation plan
- Communication plan
- Benefits

**Gaps:**

- Completion of final stage of data migration
- Formal contingency plan

**Impact of covid-19**

- Paused SEPR project board resuming on the 23rd of June
- Training has been paused, however other business change activates have continued
- June 'Go Live' deferred, proposed 'Go Live' of 3rd of November, which is within tolerance for competition before current system contract termination date of the 18th of November.
- Investigating business contingency plan to remain on current system for longer period post contract with a short term extension

Positive Impact

- The need to observe social distancing during training has empowered the project team to embrace new technologies (MS Team etc) and training methods to offer a more blended learning approach rather then traditional classroom training

## Assurances

| | Source: | Evidence: | Assurance Rating |
|---|---|---|---|
| **Internal:** | • Training plan involving Learning and Development and Nursing<br>• Monitoring trajectory of training delivery<br>• Significant progress on data migration and cleansing work<br>• EPR Project Board in place and will continue for at least 6 months post full transfer to support ongoing data improvement.<br>• **SUTG:** Single EPR Programme Plan | • Delivery reports to Finance and Performance<br>• Monthly reports to QIB<br>• EPR update to QAC 17.03.20 | Green |
| **External:** | • 360 Assurance internal audit – patient records EPR<br>• SystmOne benchmarking inform project<br>• Company providing SystmOne has track record of implementation and delivery<br>• SystmOne is a market leader | 360 Assurance internal audit | Green |

**Gaps:**

- Accuracy of reporting function
- Contingencies not formalised with clear go / no go criteria defined
- Agreed plan for formal evaluation

## Key actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| Jun 20<br>Jun 20<br>Jun 20 | • Compete the contingency plan (Negotiate contract extension with Serverlec for current Rio EPR)<br>• Board development day<br>• Develop a plan for formal evaluation | | | Green |

| | | | |
|---|---|---|---|
| **Risk No: 24** | Equality, Leadership, Culture | Date included: | 01.10.19 |
| **Risk Title:** | Failure to deliver workforce equality, diversity and inclusion | | |
| **Risk Owner:** | Director of HR & OD | Date Last Reviewed: | 23.06.20 |
| **Governance / Review:** | SWC, QAC / Monthly Review | | |

| | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 3 | 4 | 12 |
| **Residual Risk** | 3 | 3 | 9 |
| **Risk Appetite** | 3 | 3 | 9 |

## Controls

**Description:**

- The Trust has embarked on a programme of work to improve the experience of BAME staff
- Independent focus groups run and led by national WRES team
- Delivery of key actions from focus group
- Electronic system controls to support identification of staff who want to progress in their careers
- Staff survey results
- WRES /WDES data and action plans
- Staff support groups
- Annual Report on WRES
- Appraisal
- Continued listening events with staff
- Reverse mentoring
- Cultural ambassadors
- Equality and Diversity Inclusion Group
- Our Future Our Way / Leadership behaviours
- EDI Group
- Virtual Staff support groups meeting via M Teams
- BAME risk assessment process in operation
- Staff listening session CEO letter to all BAME STAFF

**Impact of covid-19**

- Equality diversity and inclusion meeting – virtual meeting
- Postponement of conference
- Virtual Staff support groups meeting via M Teams
- BAME Staff listening sessions
- CEO sent letter to all BAME staff
- Risk assessments for BAME Staff and protected characteristics

**Gaps:**

- Delivery against outcome measures
- Delivery against WRES and diversity metrics
- Staff survey performance
- Limited representation of BAME staff at senior levels
- Lack of career development for BAME staff at all levels
- Experience of bullying and harassment of BAME staff

## Assurances

**Internal:**

- WRES action plan
- Diversity workforce dashboard
- Trust board equalities report
- Annual Equalities Action Plan
- Staff support groups
- Equality Programme plan
- **Performance Report:** Percentage of staff from a BME background

**Evidence:**

- Progress reports on WRES action plan June 2020
- Staff survey report Trust Board 3rd March
- EDI Bi annual report to EDI committee June 2020
- EDI group 19th May 16th June
- Annual meeting schedule across the year

**Assurance Rating** Amber

**External:**

**Source:**

- Staff survey 2019
- National WRES metrics and report
- Engagement with national WRES team
- **Internal Audit Plan 2020/21:** Workforce Strategy Q1

**Evidence:**

- Trust Board reports on national WRES programme

**Assurance Rating** Amber

**Gaps:** Embeddedness

## Key actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| Aug 21 | • WRES Delivery action plan | Haseeb Ahmed | • Newly formed EDI group | Amber |
| July 20 | • Reverse mentoring cohort 2 | Kathryn Burt | • Impact assessment of reverse mentoring complete | |
| Aug 21 | • WRES cultural pilot programme plan developed and agreed – paused due to covid | SW | • Continue to recruit BAME interview panel members | |
| July 20 | • Programme of WeNuture OD sessions - moving to virtual sessions (in development) | SW | • BAME Risk Assessments in progress | |
| Aug 21 | • EDI system conference – cancelled due to covid | SW | • Virtual Listening Sessions ongoing | |
| June 20 | • Responding to National Workforce Equalities letter from NHSEI | SW | | |

| | | | |
|---|---|---|---|
| **Risk No: 25** | Equality, Leadership, Culture | Date included: | 01.10.19 |
| **Risk Title:** | Staff do not fully engage and embrace the Trusts culture and collective leadership | | |
| **Risk Owner:** | Director of HR & OD | Date Last Reviewed: | 23.06.20 |
| **Governance / Review:** | SWC, QAC / Monthly Review | | |

| | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 4 | 3 | 12 |
| **Residual Risk** | 4 | 2 | 8 |
| **Risk Appetite** | 4 | 2 | 8 |

## Controls

**Description:**

- Our Future Our Way is LPT's Culture, Inclusion and Leadership programme.
- Change champions in place, facilitating sessions where possible
- Training provided to all change champions
- Monthly report to SWG and Exec team
- Line Management pathway
- Leadership and Team development programme
- Learning and development annual plan
- Communications strategy in place supporting engagement with staff
- Vision co designed and live
- 9 priorities identified and communicated as part of the Our Future Our Way
- Leadership behaviours
- Virtual Leadership Forum M teams
- OD delivery plan

**Impact of covid-19**

- OD delivery plan – bitesize sessions for all staff on relevant topics (such as health and wellbeing)
- Schedule of virtual SLT in the diary

**Gaps:**

- Embedded appraisal system aligned to behaviours
- Leadership conferences / Leadership programme aligned to behaviours
- OD input into transformation programmes
- Robust plans for addressing specific concerns around cultural ownership such as Bare Below the Elbow

## Assurances

| | | | |
|---|---|---|---|
| **Internal:** | • Staff survey results<br>• Board approval of change champion programme<br>• Programme plan in place and approved by Trust Board<br>• 92 change champions engaged<br>• Focus groups<br>• Strategic workforce group<br>• Attendance at virtual SLT | **Evidence:**<br>Staff survey report to Board 3rd March<br>Board update on leadership behaviours progress Jan 20<br>Virtual SLT 3rd May June 5th 140 + attendees<br>SWC quarterly meetings continuing – papers include leadership behaviours update, appraisal framework, OD plan for bitesize sessions | **Assurance Rating**<br>Green |
| **External:** | **Source:**<br>• Staff survey / Staff Friends and family test<br>• External recognition of initiatives<br>• NHSI Well led external review<br>• CQC Well Led review<br>• NHSI Support on the culture and leadership programme<br>• WRES programme<br>• People Plan<br>• **Internal Audit Plan 2020/21:** Workforce Strategy Q1 | **Evidence:**<br>SIAM feedback<br>CQC engagement meeting feedback | **Assurance Rating**<br>Green |
| **Gaps:** | • Embedding new culture | | |

## Key actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| July 20 | • Appraisal system aligned with leadership behaviours framework | SW | - Drafted for approval | Amber |
| Sept 20 | • Step up to Great conference | SW | - Date to be determined | |
| Aug 20 | • Schedule of extended exec team meetings | SW | - Being drawn up | |
| July 20 | • Leadership development programme linked to leadership behaviours | SW | - Drafted for approval | |
| June 20 | • Training programme – Soft launch working on e-learning due to covid | SW | - Launched Behaviours | |
| July 2020 | • SWC meeting | | - Change Champions re-engaged | |

| | | | |
|---|---|---|---|
| **Risk No: 26** | Equality, Leadership, Culture | Date included: | 01.10.19 |
| **Risk Title:** | Insufficient staffing levels to meet capacity and demand and provide quality services | | |
| **Risk Owner:** | Director of HR & OD | Date Last Reviewed: | 23.06.20 |
| **Governance / Review:** | SWC, QAC / Monthly Review | | |

| | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 4 | 4 | 16 |
| **Residual Risk** | 4 | 3 | 12 |
| **Risk Appetite** | 4 | 3 | 12 |

## Controls

**Description:**

- Recruitment action plan in place
- Service level workforce groups with action plans in place
- E rostering in place across inpatient services
- Auto planner within CHS
- Safer staffing reports with oversight of staff levels
- Centralised temporary staff service
- Regular recruitment conferences and schedule of events
- Recruitment and retention schemes in place
- Growing our own workforce
- LLR System and LWAB working together on system initiatives
- Flexible working guidance launched
- Proposal for super enhancing recruitment and attraction campaign and Bespoke plan for integrated Ageing Well recruitment campaign

**Impact of covid-19**

- Directorate workforce supply meetings replaced by covid supply meetings.
- Significant Covid related recruitment activity taken place to support Surge capacity
- Bring back staff
- Retirees
- Aging well started
- Recruitment team moving to business as usual recruitment

**Gaps:**

- Workforce Planning capacity
- Community Service Redesign
- National workforce nursing supply challenges
- National medical workforce challenges within CAMHS
- Full utilisation rostering
- Medical consultant capacity concerns in AMH/CAMHS
- A centralised trust wide approach to recruitment

## Assurances

**Internal:**

**Source:**

- Third cohort of nurse associate roles
- Further development of other roles
- Reengineering of clinical roles
- SWC , Directorate Workforce groups , retention working group
- Workforce and Wellbeing Board
- Transformation committee
- HR Team
- Electronic recruitment system
- Staff staffing report
- **SUTG:** Workforce Transformation Programme Plan
- **Performance Report:** Targets x 2 for sufficient staffing (Turnover and Vacancy)

**Evidence:**

- Progress reports to SWC Jan 16th
- Performance dashboard monthly
- Workforce reports monthly
- Varying trends. KPI showing Green for Turnover and Red for Vacancy (Feb 2020)

**Assurance Rating**
Amber

**External:**

**Source:**

- National NHS people plan
- NHS retention support and benchmarking data
- Benchmarking reports
- **Internal Audit Plan 2020/21:** Workforce Strategy Q1

**Evidence:**

- Engagement with development of NHS people plan

**Assurance Rating**
Amber

**Gaps:**

- National gap in detail around NHS people plan as published in June 2019
- National people plan not published
- National workforce supply

## Key

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| Dec 20 | • Transformation programme on centralised recruitment – paused | Sarah Willis | • Centralised recruitment agreed as a transformation committee programme being developed | Amber |
| Dec 20 | • Consideration of overseas recruitment | SW | • Conversations with UHL on overseas recruitment taking place | |
| Aug 20 | • System wide workforce planning strategy | SW | | |

| | | | |
|---|---|---|---|
| **Risk No: 27** | Equality, Leadership, Culture | Date included: | 01.10.19 |
| **Risk Title:** | The health and well being of our staff is not maintained and improved | | |
| **Risk Owner:** | Director of HR & OD | Date Last Reviewed: | 23.06.20 |
| **Governance / Review:** | SWC, QAC / Monthly Review | | |

| | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 3 | 3 | 9 |
| **Residual Risk** | 3 | 2 | 6 |
| **Risk Appetite** | 3 | 2 | 6 |

## Controls

**Description:**

- Occupational health service wellbeing strategy and implementation plan
- Workforce and wellbeing group
- Wellbeing calendar – including a range of wellbeing events
- Counselling service
- 1:1s, Supervision, Appraisal
- Focus on wellbeing, sickness management policy
- Anti bullying harassment and advice service
- Bullying and harassment sub group
- Annual Health and Wellbeing event
- Health and wellbeing champions
- Staff Physiotherapy scheme
- MH first aid training
- Mindfulness programmes
- Leadership Behaviours Framework

**Impact of covid-19**

- Health and Wellbeing Approach and bulletin launched
- Psychological support offer for staff
- Virtual exercise classes
- Wobble Rooms
- NHS People national support
- Daily Sickness absence monitoring

**Gaps:**

- Embedding of culture and leadership plan
- Embedding of WRES plan
- Appraisals linked to Leadership Behaviours Framework (see action on risk 26)
- post incident psychological support for staff

## Assurances

**Internal:**

- Monitoring sickness reports workforce reports
- Sickness reviews within divisions
- Wellbeing element of appraisal
- Wellbeing conferences
- Occupational health department
- Staff reps
- Amica

**Evidence:**

- Performance management report monthly
- Staff side and management meetings monthly
- SWC reports
- Occupational Health annual report
- Referrals to Amica

**Assurance Rating**
Amber

**External:**

**Source:**

- NHSI reporting,
- NHSI wellbeing initiatives
- People plan

**Evidence:**

- NHSI benchmarking reports
- Attendance at external NHSI wellbeing workshops

**Assurance Rating**
Amber

**Gaps:**

- Ongoing implementation of action plan associated with Health and Well being Approach.
- Review Health and Well being Approach in Nov 2019
- Embedding of National People Plan

## Key actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| Oct 20 | Review of progress against the health and wellbeing approach and action plan | Kathryn Burt | NHS long terms people plan well being event attending in Nov | Amber |
| Nov 20 | Refreshed health and wellbeing approach for 2020 ongoing review at senior leaders forum | SW | | |
| Nov 20 | | SW | LPT health and wellbeing conference in Nov 20 | |
| Sept 20 | System level support for post incident psychological support for staff | SW/Amica | Developed a business case to support mental health referrals for employees approved and now commencing implementation. Paused | |
| June 20 | Appointment of a psychologist for staff referral support | | | |
| | Develop Weekly OD bite size virtual sessions | SW | Session Commenced | |

| | | | |
|---|---|---|---|
| **Risk No: 28** | Access to Services | Date included: | 01.10.19 |
| **Risk Title:** | Delayed access to assessment and treatment impacts on patient safety and outcomes | | |
| **Risk Owner:** | Divisional Directors / Medical Director | Date Last Reviewed: | 26.05.20 |
| **Governance /** | Waiting List and Harm Prevention Committee, FPC and QAC / Monthly Review | | |

| Access to Services | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 4 | 5 | 20 |
| **Residual Risk** | 4 | 4 | 16 |
| **Risk Appetite** | 4 | 3 | 12 |

## Controls

**Description:**

- Strategic risk based approach to waiting time management approved by Trust Board
- Weekly patient tracking list sessions operational in all prioritised services
- NHSI demand and capacity management training complete
- Trajectories and improvement plans in place for priority services
- Joint waiting times group and harm assurance group in operation
- System Improvement and Assurance meeting oversight of Trust waiting times
- Business planning and contract discussions
- Outsourcing arrangements where appropriate (eg HEALIOS)
- Staff productivity and efficiency programmes in place via service transformation
- Winter planning/OPEL framework/daily escalation tool/calls in place
- Business cases to address high risk areas
- Demand and capacity analysis of priority services with long wait times
- Revised performance report with narrative
- Merged access and harm free group

**Impact of covid-19**

- The outcomes for CYP, adults and older people may be adversely impacted as a result of temporary service suspensions or prioritisation of clinical service delivery
- Identification of patients clinical needs may be delayed.
- Patient experience is adversely impacted through delays in access to medium and low priority treatment
- Clinical services are prioritising restoration and recovery plans using the likelihood of harm as a denominator for prioritisation

**Gaps:**

- Robust access policy
- Embedded harm review process
- LLR financial sustainability plan
- Lack of funding to match growth in population / prevalence / demand

## Assurances

**Internal:**

**Source:**

- Directorate performance reports
- Waiting time performance reported to Finance and Performance Committee monthly
- Internal strategic waiting times approach
- FPC regular waiting times report
- Daily OPEL escalation template
- Waiting times and harm minimisation Programme plan

**Evidence:**

- Performance management dashboard
- Dashboards to DMTs
- Reports into waiting times group
- Harm review process update to QAC 17.03.20

**Assurance Rating Amber**

**External:**

**Source:**

- Finance, Technical and Performance meetings with commissions with escalation of issues to contract performance meeting
- NHSI system improvement and assurance meeting (SIAM)
- NHS Improvement Support Team review of CAMHs
- CQC inspection process; AEDB
- Contract Performance Meetings and monthly returns
- NHSI Regional Escalation oversight of 4 hr performance
- 360 Assurance internal audit of waiting times - due Q4 2019/20
- **Internal Audit Plan 2020/21:** Patient Safety Q2

**Evidence:**

- Audit reports
- SIAM feedback
- CQC report

**Assurance Rating Amber**

**Gaps:**

- Lack of overall assurance framework and performance management framework
- Sharing the learning

## Key actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| July 20 | Review of Access Policy including definition of 52 week access and treatment waits – on hold | Divisional Directors | Policy review extension due to COVID | Amber |
| July 20 | Agreeing priorities for MHIS and growth with commissioners | | Delays in agreeing 20/21 contract | |
| July 20 | Trajectories for all contractual targets to be agreed post COVID through the recovery cell. | | The Directorate recovery cell will temporarily replace the merged access and harm free group | |

| | | | |
|---|---|---|---|
| **Risk No: 33** | Well - Governed | Date included: | 01.10.19 |
| **Risk Title:** | Insufficient executive capacity (including Shared Chief Executive role) to cover demand and impacts on LPT ability to achieve it's strategic aims | | |
| **Risk Owner:** | Director of HR & OD/Chief Executive | **Date Last Reviewed:** | 23.06.20 |
| **Governance / Review:** | Strategic Exec Board, Trust Board / Monthly Review | | |

| Well-governed | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 4 | 3 | 12 |
| **Residual Risk** | 4 | 2 | 8 |
| **Risk Appetite** | 4 | 2 | 8 |

**Impact of covid-19**
ICC CEO call with LPT/NHFT
Phase 2 Gold Command – weekly

## Controls

**Description:**

- Shared Chief Executive appointed with NHFT (NHFT rated outstanding overall and outstanding for well led domain)
- Overall Well-led inadequate rating from CQC
- No Vacant Executive team posts / Additional temporary supernumerary support from external sources
- Buddy arrangements with NHFT / Supportive oversight from NHSI/E
- Deputy Chief Executive position created strengthening executive capacity for LPT
- Business manager /LPT Programme Lead role for NHFT working closely with the Chief Executive across both organisations
- Lead LPT Director for the Buddying Programme – DoN
- Resources identified to support buddy programme via NHFT directors
- Set days/working pattern for CEO role allowing shared resource time spent each week to be auditable with exceptions according to needs
- Regular review of buddy work programme and impacts
- Discussion at Board of Directors Nominations and Remunerations Committee
- MOU between LPT and stakeholders (NHFT, NHSEI) setting out the capacity and resource requirements for each organisation for the buddying programme
- Agreed funding with NHSEI and NHFT
- Shared Director posts with NHFT from January 2020 – Governance & Strategy
- Deputy CEO in place
- Recruitment of substantive Director of Adult Mental Health
- Substantive Appointment of deputy CEO
- Appointment of interim Director of Nursing, AHPS and Quality
- Appointment of an interim Medical Director

**Gaps ..**

- Embedding deputy level support for shared Directors
- Embedding new governance process

## Assurances

| | Source: | Evidence: | Assurance Rating |
|---|---|---|---|
| **Internal:** | • New governance process<br>• Organisational risk register<br>• Review at SEB and Exec. boards<br>• Review at Performance Committee/ Rem comm<br>• Regular monitoring of LPT KPI's/ strategic priorities<br>• Review at Trust Board<br>• 1:1's CEO with Directors to monitor impact<br>• 1:1's Directors with direct reports to monitor impact<br>• DMT's/Corporate management team meetings<br>• Positive outcomes/benefits from exec. involvement with NHFT including innovations from joint learning and development of directors and deputies through inclusion in programme<br>• Well Led action plan | • Remcom paper on exec capacity<br>• Buddy programme meeting minutes<br>• SUTG update report<br>• New governance process agreed<br>• Leadership presentations to Board and senior management team<br>• SLT meetings | Green |
| **External:** | • Support from NHSI/E<br>• Buddying support from NHFT / Ongoing support from NHSI / Engagement meetings CQC<br>• Perspectives on CQC/NHSI support of shared role<br>• Regional and national recognition of effective joint working across the Trusts | • Regular contact and positive feedback from NHSI<br>• Positive feedback at assessment<br>• CQC inspection | Green |

**Gaps ..**

## Actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| Nov 20 | • Appointment of deputy infrastructure to support shared director posts | SW/CEO | | Green |
| July 20 | • Future appointment of medical director | SW/CEO | External Advert out interviews end June 2020 | |

| | | | |
|---|---|---|---|
| **Risk No: 35** | Well Governed | Date included: | 01.10.19 |
| **Risk Title:** | The quality and availability of data reporting is not sufficiently mature to inform quality decision making | | |
| **Risk Owner:** | Director of Finance, Business & Estates and Deputy Chief Executive | **Date Last Reviewed:** | 24.06.20 |
| **Governance / Review:** | FPC / Monthly Review | | |

| Well-governed | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 4 | 4 | 16 |
| **Residual Risk** | 4 | 3 | 12 |
| **Risk Appetite** | 4 | 3 | 12 |

## Controls

**Description:**

- Executive senior information risk officer (SIRO) sponsorship
- Performance management framework
- Performance reports
- Regular reporting of data quality maturity index in board reports
- Annual benchmark reporting against peers
- Contractual data quality improvement plans (DQIP)
- Experienced subject matter experts in the corporate information team
- National guidance
- Electronic patient records (EPR)
- Data quality kite mark is included against some metrics

**Gaps:**

- Control framework for data and information
- Assurance framework
- Non compliance with policies
- Capacity to deliver the changes
- Accountability framework
- Complete data quality reports for local and national data sets
- Knowledge of data quality incidents
- Configuration of systems to support requirements of information standards and NHS data models
- Robust technical infrastructure to support timely and accessible use of data
- Lack of system that allows validated data on a consistent basis at directorate level
- Strategy refresh to be undertaken
- Consideration of skill mix and need to address any capability and capacity challenge
- No monitoring solution available to measure timeliness of data input
- Challenges in the system to ensure information is timely and appropriate
- Inability to progress at pace due to competing priorities and lack of capacity in the corporate Information team.
- There is a delay ito the transformational approach to improving data quality.

## Assurances

| | Source: | Evidence: | Assurance Rating |
|---|---|---|---|
| **Internal:** | • FPC / Trust Board<br>• Clinical audit<br>• Annual record keeping audit<br>• Data quality flag for priority KPIs | • Quarterly DQIP report to FPC (last one 17.03.20) | Amber |
| **External:** | • External audit<br>• Benchmarking reports<br>• **Internal Audit Plan 2020/21:** Data Quality Framework Q 3/4 | • Data quality framework 19/20 – Significant assurance rating | Amber |

**Gaps:**

- Internal process for testing compliance
- Process for responding to external feedback

## Key actions

| Date: | Actions: | Action Owner: | Progress: | Status: |
|---|---|---|---|---|
| Sept 20 | • Create dedicated data quality group | Dani Cecchini | Contingent on demands of COVID – may develop from data cell | Red |
| Dec 20 | • Configure clinical systems to meet national information standards | LHIS (IW) | Contingent on demands of COVID | |
| Dec 20 | • Further develop data warehouse to national information standards | LHIS | Contingent on demands of COVID | |
| Sept 20 | • Investigate investment opportunities to exploit Business Intelligence tools to support improved data quality reporting | Laura Hughes | Funding identified in capital plan | |

| | | | |
|---|---|---|---|
| **Risk No: 40** | High standards | Date included: | 11.03.20 |
| **Risk Title:** | The ability of the Trust to deliver high quality care may be affected during a Coronavirus COVID-19 pandemic | | |
| **Risk Owner:** | Director of Finance, Business & Estates and Deputy Chief Executive | Date Last Reviewed: | 03.06.20 |
| **Governance / Review:** | Combined Exec Board / Fortnightly | | |

| | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 5 | 4 | 20 |
| **Residual Risk** | 5 | 3 | 15 |
| **Risk Appetite** | 5 | 3 | 15 |

## Controls

**Description:**

- National level 4 major incident led by COBR with national, regional and local resilience structures and policies in place
- COVID-19 Incident Management Team and Control Centre open 8 – 8 7days per week / Single point contact 24/7 email and dedicated phone
- LPT Gold, Silver and Bronze chain of command with role specific cells to support the ICC
- Approved, interim governance and risk management arrangements with focus on action, risk and decision logs
- Prioritisation of critical services and maintenance of business continuity plans
- Policy controls are in place for IPC, major incident place, Flu pandemic
- Participation in national and LLR health resilience forums
- National weekly Webinars / Communications for COVID-19 both internally and externally
- Communication of information – Staff Room and daily Email
- Staff guidance on Management of isolation and reporting / Agile home working policy / Occupational Health dedicated phone lines
- National guidance on workforce / National and system updates including modelling on the development of the pandemic
- Procurement hub with PPE planning and distribution
- Impact of COVD-19 on existing ORR and local / Directorate risk registers
- Established surge capacity in line with system requirements
- Trust Wide risk assessment for impact of COVID-19 on staff with protected characteristics
- Full quality risk impact assessments for any full or partial service closures

**Gaps:**

- Inconsistency in the distribution of PPE stock
- A full of the understanding of the impact of COVID-19 on individual staff with protected characteristics
- Anticipation of and planning for future spikes and surges of COVID-19
- Embedded system of antibody testing to support the test and trace

## Assurances

| | | | |
|---|---|---|---|
| **Internal:** | • Weekly flash report to Board<br>• Communications structures to staff<br>• 7-day per week COVID-19 major incident meetings<br>• COVID related National Guidance reviewed daily<br>• Monitoring of unintended consequences of rapid and high pressured decision making<br>• Daily National PPE SitReps<br>• Daily national NHSE/I patient related SitRep also provided to the LLR system<br>• Health Economy Tactical Coordinating Group (HETCG) SitRep (2 times a week)<br>• Daily staffing swabbing SitRep / CEO daily SitRep | **Evidence:**<br>• Weekly Flash report to Board<br>• Daily staff COVID-19 briefing<br>• Monthly risk report to level one committees<br>• Directorate highlight reports<br>• Situation Reports (SitReps)<br>• Regular staff and stakeholder briefings<br>• ICC decision log | **Assurance Rating**<br>Green |
| **External:** | • Department of health / Public Health England / NHSEI / COBR / Chief Medical Officer<br>• LLR system advice and planning / Joint CEO exec daily ( Mon-Fri) reporting structure<br>• Gov.uk COVID-19 information email alerts / National webinars<br>• Buddy relationship with NHFT | **Evidence:**<br>• Records of strategic gold coordinating group meetings | **Assurance Rating**<br>Amber |
| **Gaps:** | | | |

| | **Actions:** | **Action Owner:** | **Progress:** | **Status:** |
|---|---|---|---|---|
| Ongoing<br>Jun 20<br>Jun 20<br>On-going | • Procurement Hub to continue to respond to PPE concerns<br>• Anticipating and planning for future spikes and surges in COVID-19<br>• Agree an alert system within LLR to step up activity<br>• On-going development of plans to implement the antibody tests as well as nasal swabs | Sarah H<br>ICC<br>ICC<br>ICC | • Procurement Hub have systems and processes in place to respond to PPE shortages<br>• Work within LLR system data cell to develop system demand and capacity plan and alert system.<br>• Trust working with EM Alliance to develop specific MH demand and capacity modelling tool<br>• Plans being developed in ICC to support antibody testing. | Green |

| | | | |
|---|---|---|---|
| **Risk 41** | Equality, Leadership and Culture / High Standards | Date Included on ORR | 27.05.20 |
| **Risk Title** | The Trust may not appropriately manage the health and well-being of our BAME staff , and staff with key protected characteristics given the disproportionate impact of COVID-19 | | |
| **Risk Owner:** | Director of HR & OD | Date Last Reviewed: | 27.05.20 |
| **Governance / Review** | Combined Exec Board / Fortnightly | | |

| | Equality, Leadership, Culture (E) | High Standards (S) | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|---|---|
| **Current Risk** | | | 5 | 3 | 15 |
| **Residual Risk** | | | 5 | 2 | 10 |
| **Risk Appetite** | | | 5 | 2 | 10 |

## Controls

**Description:**

- National level 4 major incident led by COBR with national, regional and local resilience structures and policies in place
- Participation in national and LLR health resilience forums
- COVID-19 Incident Management Team and Control Centre
- LPT Gold, Silver and Bronze chain of command with role specific cells to support the ICC
- National weekly Webinars / Communications for COVID-19 both internally and externally
- Collaboration with NHFT and Sussex Partnership NHS Trust
- Communication of information – staffnet and daily emails
- Staff guidance on Management of isolation and reporting / Agile home working policy / Occupational Health dedicated phone lines
- Procurement cell with PPE planning and distribution
- Virtual network meetings / Listening Group meeting for BAME colleagues
- Re-deployment exercise / Swabbing and testing availability for all staff immediately upon reporting of symptoms
- Service user feedback / Bank staff feedback
- Government and NHS Employers, NHS Confederation guidance and briefing papers
- LPT action cards to provide advice i.e. around pregnancy, death notification etc.
- Risk assessment tool in place for vulnerable / shielding staff

**Gaps ..**

- Understanding clusters / provide data by location
- Analysis of use of staff risk assessment tool - to be discussed at the webinar 29.04.20

## Assurances

| | | | |
|---|---|---|---|
| **Internal:** | Source:<br>• Regular data analysis with narrative<br>• Communications structures to staff<br>• 7-day per week COVID related National Guidance reviewed daily<br>• Monitoring of unintended consequences of rapid and high pressured decision making | Evidence:<br>Data report to ICC - plan for weekly update<br>Daily communications, e.g. 28.04.20 reference to pregnancy | Assurance Rating Amber |
| **External:** | Source:<br>• Department of health / Public Health England / NHSEI / Cobra / Chief Medical Officer<br>• Government and LLR system advice and planning / Joint CEO exec daily<br>• Gov.uk COVID-19 information email alerts / National webinars<br>• Buddy relationship with NHFT<br>• CQC updated Reg 15 death notification form (incl info on protected characteristics). | Evidence:<br>• Records of Joint CEO daily conference calls<br>• NHSEI weekly data of deaths by ethnicity | Assurance Rating Amber |

**Gaps:**

- NHSEI/PHE review of the impact of coronavirus on BAME communities yet to be undertaken
- NHS Employers inquiry on the impact of Covid-19 on people with protected characteristics under the Equality Act; age, disability, sex, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sexual orientation and gender reassignment – to be completed.
- Data from CQC reg 15 death notification forms – to be shared with system partners.

## Actions

| Date: | Actions: | Action Owner: | Progress | Status: |
|---|---|---|---|---|
| May 20 | Staff Webinar Virtual Staff networks taking place for staff support groups associated with Protected Characteristics | SW<br>SW/HA | Correspondence being sent to provide guidance around support available and an invite to the event 29.04.20 | Amber |
| May 20 | Further data analysis | SW | | |
| May 20 | Joint working across LPT NHFT and Sussex partnership | SW | | |
| May 20 | Risk assessment for staff with protected characteristics | SW | | |

| | | | |
|---|---|---|---|
| **Risk 42** | High Standards | Date Included on ORR | 27.05.20 |
| **Risk Title** | The Trust may not appropriately manage its patients with LD and Autism given the known disproportionate adverse impact of COVID-19 on this patient group | | |
| **Risk Owner:** | Assistant Director FYPC&LD | Date Last Reviewed: | 27.05.20 |
| **Governance / Review** | Combined Exec Board / Fortnightly | | |

| High Standards | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 4 | 3 | 12 |
| **Residual Risk** | 4 | 2 | 8 |
| **Risk Appetite** | 4 | 2 | 8 |

## Controls

**Description:**

- Active engagement in bi-weekly multiagency LD & Autism Sub-cell to inform and coordinate response
- Monitoring of changes to care needs from multiagency LD & Autism Sub-cell
- Covid-19 LD National Guidance
- Creation of isolation Pod at the Agnes Unit for suspected C19 patients and new admissions
- Closure of Short Breaks facility with increase outreach support
- LLR multi-agency LD and Autism response service contribution
- Refreshed care plans and risk assessments
- Use of digital technology for undertaking assessments and clinical discussions
- Virtual weekly discharge meetings
- Virtual Care and Treatment Reviews
- Risk stratified caseload of people who used short breaks; shared information with social care teams and agreed bespoke wrap-around support packages
- Re-deployed short breaks staff to: increase outreach teams reach and intensity and provide BH cover; staff up Agnes Unit
- Regular telephone contact with people on caseload and easy read information on Covid-19 distributed
- Visits continuing where families / carers comfortable
- COVID-19 Incident Management Team and Control Centre
- LPT Gold, Silver and Bronze chain of command with role specific cells to support the ICC
- Service user feedback
- LPT action cards to provide advice
- Action plan in place to avoid unnecessary admissions to AMH wards of service users with LD and/or Autism
- Quality impact assessments for all service closures

**Gaps:**

- Knowledge of reduction in staff with specialist learning disabilities/autism training as a result of COVID-19
- Planned discharge dates being declined by care placement providers
- Cancellation of face to f ace training of MH staff on ROAR process

## Assurances

| | | | |
|---|---|---|---|
| **Internal:** | Source:<br>• Daily SitRep which records COVID-19 deaths with LD / Autism condition<br>• Communications structures to staff<br>• 7-day per week COVID related National Guidance reviewed daily<br>• Monitoring of unintended consequences of rapid and high pressured decision making | Evidence:<br>SitRep data – daily (submitted to CQC weekly) | Assurance Rating Amber |
| **External:** | Source:<br>• Department of health / Public Health England / NHSEI / Cobra / Chief Medical Officer<br>• Government and LLR system advice and planning / Joint CEO exec daily<br>• Gov.uk COVID-19 information email alerts / National webinars<br>• Buddy relationship with NHFT | Evidence:<br>• Records of Joint CEO daily conference calls<br>• NHSEI weekly data of deaths which includes those who have been treated for a mental health condition or have a learning disability and/or autism | Assurance Rating Amber |
| **Gaps:** | | | |

## Action

| Date: | | Action Owner: | Progress | Status: |
|---|---|---|---|---|
| June 20<br>July 20 | E-learning pack for AMH staff to be published on Ulearn by 8th June 2020<br>Sub cell / ICC recovery cell plan | Mark Roberts<br>Mark Roberts / Recovery Cell | | Amber |

| | | | |
|---|---|---|---|
| **Risk 43** | High Standards | Date Included on ORR | 27.05.20 |
| **Risk Title** | The Trust response to COVID-19 may negatively impact on the safety and well-being of vulnerable patients detained under the Mental Health Act. | | |
| **Risk Owner:** | Medical Director | Date Last Reviewed: | 27.05.20 |
| **Governance / Review** | Combined Exec Board / Fortnightly | | |

| | High Standards | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|---|
| **Current Risk** | | 5 | 3 | 15 |
| **Residual Risk** | | 5 | 2 | 10 |
| **Risk Appetite** | | 5 | 2 | 10 |

## Controls

**Description:**

- Guidance from NHSEI
- Emergency Coronavirus Act 2020 - MHA legislation and associated Code of Practice (remains the same)
- MHA Service support (Weightmans solicitors) for advice through Legal Dept
- Legal input into Action Cards (includes MHA) kept up to date.
- MHA Policy and procedure – MHA Policy Database
- Documentation Policies within operational services (MHA content specific guidance)
- COVID-19 Incident Management Team and Control Centre / LPT Gold, Silver and Bronze chain of command with role specific cells to support the ICC
- MHA Service Continuity Plans
- Communication of information through ICC submission of continuity plans
- Clinical Lead / interim Medical Director
- Managers Panel Members (Hospital Mangers)
- MHA training (role specific training)
- Independent Mental Health Advocacy service (POhWER) commissioned by LA
- Review and response to NHSEI guidance (issued 19th May)

**Gaps:**

- Remote MHA Assessments
- MHA training is no longer classified as mandatory
- Use of the Advancing Mental Health Equalities Toolkit

## Assurances

| | Source: | Evidence: | |
|---|---|---|---|
| **Internal:** | • Regular dashboard (MHA activity) to LEG including number of tribunal applications<br>• MHA census at point of care – monthly (measures minimum standards at point of care)<br>• Incident reporting | Bi monthly report to LEG (end of year dashboard in June)<br>Bi monthly report to LEG<br>Bi monthly report to LEG | Assurance Rating Red |
| **External:** | Source:<br>• Mental Health Act focussed reviewer visits from CQC – remote in response to COVID-19<br>• Ad hoc IMHA service feedback<br>• Tribunal Service Mental Health | Evidence:<br>Process in place as part of continuity planning should notification be received<br>Service development to meet National Directions to include legal support to patients accessing service | Assurance Rating Amber |

**Gaps:**

- MHA training data
- Trend analysis and escalation of incidents, restrictive interventions etc for patients detained under the MHA (considering the impact of changes during COVID)
- Data from POhWER to demonstrate uptake – possible concern over access by patient's lacking capacity due to the nature of remote assessment

## Actions

| Date: | Actions: | Action Owner: | Progress | Status: |
|---|---|---|---|---|
| July 20 | • Remote Mental Health Act assessments being developed with LA / Process Flow Chart with LA (response to latest national guidance) | Alison Wheelton and Associate MD | Clinical lead identified, protocol in draft | Amber |
| July 20 | • Robust remote hearing process developed to undertake Managers Panel Hearings suspended as part of continuity planning | Alison Wheelton | Managed approach to clear backlog by 2nd week in June | |

| | | | |
|---|---|---|---|
| **Risk 44** | Access to Services and High Standards | Date Included on ORR | 27.05.20 |
| **Risk Title** | A post COVID-19 surge in referrals would have a detrimental impact on waiting times and patient harm if the Trust is unable to increase capacity | | |
| **Risk Owner:** | Director of Finance, Business & Estates and Deputy Chief Executive | Date Last Reviewed: | 27.05.20 |
| **Governance / Review** | Combined Exec Board / Fortnightly | | |

| | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 4 | 4 | 16 |
| **Residual Risk** | 4 | 3 | 12 |
| **Risk Appetite** | 4 | 3 | 12 |

## Controls

**Description:**

- Strategic risk based approach to waiting time management approved by Trust Board
- Weekly patient tracking list sessions operational in all prioritised services
- NHSI demand and capacity management training complete
- Joint waiting times group and harm assurance group in operation
- System Improvement and Assurance meeting oversight of Trust waiting times
- Business planning and contract discussions
- Outsourcing arrangements where appropriate (eg HEALIOS)
- Staff productivity and efficiency programmes in place via service transformation
- Winter planning/OPEL framework/daily escalation tool/calls in place
- Business cases to address high risk areas
- Demand and capacity analysis of priority services with long wait times
- Revised performance report with narrative
- Harm assessment process / Joint waiting times and harm prevention group
- Patient Safety Plan - aligned to the National Patient Safety Plan / Patient Safety Improvement Group (PSIG)
- Agreed joint working approach between LLR and Northants system to undertake demand and capacity modelling

**Gaps:**

- The outcomes for CYP, adults and older people may be adversely impacted as a result of temporary service suspensions or prioritisation of clinical service delivery
- Identification of patients clinical needs may be delayed.
- Patient experience is adversely impacted through delays in access to medium and low priority treatment
- Robust access policy
- Embedded harm review process

## Assurances

| | | | |
|---|---|---|---|
| **Internal:** | Source:<br>• Quality Forum / Quality Assurance Committee / Strategic Workforce Committee<br>• All associated policies<br>• Professional standards group<br>• Revised quality governance structure being embedded; Revalidation and registration process in place<br>• Associate Director of Nursing in place who leads on professional practice<br>• Trust wide Adult & Child Safeguarding<br>• Mandatory training reports ; Clinical supervision reports | Evidence:<br>Evidence:<br>• Regular reports and minutes from meetings<br>• Highlight information and escalation processes<br>• Reduction in harm and incidents<br>• Reduction in concerns and complaints<br>• Improved staff feedback<br>• Patient experience report | Assurance Rating Amber |
| **External:** | Source:<br>• Patient/family and staff FFT / PALS feedback<br>• Professional Bodies e.g. NMC, GMC, HCPC<br>• Quality Contract and Monitoring with CCG & Specialised Commissioning<br>• Health watch Leicester<br>• LLR Transferring Care Safely Group/LPT engaged (acute/secondary provider feedback) | | Assurance Rating Amber |

**Gaps:**

- Patient Safety Walk-rounds
- Compliance with mandatory & role related training, staff knowledge around physical health and speciality
- Staff vacancies across the professions and high bank /agency use. Increased use of redeployment and non familiar staff

## Action

| Date: | Actions | Action Owner: | Status: |
|---|---|---|---|
| July 20 | Joint LLR and Northants demand and capacity modelling | | Red |
| July 20 | Clarifying the programme of work to respond to the modelling | | |

| | | | |
|---|---|---|---|
| **Risk 45** | Well Governed | Date Included on ORR | 27.05.20 |
| **Risk Title** | A post COVID-19 surge in legal challenge would have a detrimental impact on our reputation and financial position. | | |
| **Risk Owner:** | Shared Director of Corporate Governance and Risk | Date Last Reviewed: | 27.05.20 |
| **Governance / Review** | Combined Exec Board / Fortnightly | | |

| Well-governed | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 3 | 3 | 9 |
| **Residual Risk** | 3 | 2 | 6 |
| **Risk Appetite** | 3 | 2 | 6 |

## Controls

### Description:

- Guidance provided by Public Health England, Chief Coroner, NHSI, HSE and DOH
- Coronavirus Act 2020 enacted to ease the burden on front line and adult Social care. CV Act 2020 reviewed by Legal Team.
- LPT Legal Team / Panel firms (Weightmans Solicitors) for Claims and Inquest Support
- LPT Claims Management Policy and in-house procedure currently in place
- Staffing side issues (e.g – swabbing and test results, unnecessary risk of exposure to COVID)
- Extra patient controls documentation e.g. temperature control
- Internal inquest process – reviewed in light of COVID and witnesses and Services update as to the current status of Inquests
- Inquests – all vacated until September 2020 at least (to be reviewed regularly in light of the Chief Coroner Guidance)
- Inquest relating to Covid-19 are usually 'natural causes' Inquests however there are instances where a death can be reported to the Coroner (e.g. death in workplace,
- Legal input into Action Cards (includes MHA, DoLs, Restraint etc.) to Medical Director and ICC for authorisation thereafter.
- Documentation Policies within Services (GMC / NMC Codes of Practice, Trust Policy )
- Legal Briefing to ICC Clinical Senate re prospective prosecution and outcome / Prompt Sheet to assist clinicians with comprehensive documentation of patient care to
- COVID-19 Incident Management Team and Control Centre / LPT Gold, Silver and Bronze chain of command with role specific cells to support the ICC
- Potential reputational risks of when patients are wanting to access services and cannot (e.g community services)
- Court of Protection – consideration of discharging non-capacitous individuals in the current climate
- Court of Protection – consideration of Services not running to full capacity and deterioration of mental health in the current climate could lead to future COP proceedings
- Court of Protection – attracting Judicial criticism for not adhering to s.49 MCA Court Orders in the current climate
- Approved, interim governance and risk management arrangements with focus on action, risk and decision logs
- Prioritisation of critical services and maintenance of business continuity plans
- Communication of information to staff – Staff Room and daily email / Staff guidance management of isolation and reporting / restraint/ safeguarding/ Agile home working policy / PPE/ Occupational Health
- Procurement hub with PPE planning and distribution
- Impact of COVD-19 on existing ORR and local / Directorate risk registers
- Established surge capacity in line with system requirements / Trust Wide risk assessment for impact of COVID-19 on staff with protected characteristics

### Gaps:

- Robust log required of all Guidance when received and resulting changes / updates made (via ICC)
- Risk assessments for individual patients where Services are not being accessed due to COVID-19
- Robust documentation of patient specific care decisions in relation to COVID (for example remote assessment) and any signposting provided . To include consideration of any limitations of patient assessments, information provided in terms of follow up etc.
- Robust documentation of the consideration of COVID upon discharge (e.g. was it safe to discharge in current climate)
- National shortages of PPE and inconsistent distribution of stock into LPT (addressed in Risk 40)
- Full quality risk impact assessments for any full or partial service closures (addressed in Risk 40)
- A full understanding of the impact of COVID-19 on our individual BAME patients, and patients with protected characteristics and / or additional conditions including LD and Autism.

## Assurances

### Internal:

- Report of high value claims and high profile inquests to ET /Inquest spreadsheet
- Weekly flash report to Board if required
- Communications structures to staff
- 7-day per week COVID-19 major incident meetings / COVID related National Guidance reviewed daily
- Monitoring of unintended consequences of rapid and high pressured decision making
- Daily National PPE SitReps / Daily staffing swabbing SitRep / CEO daily SitRep

Evidence:

- Fortnightly inquest spreadsheet to Service and Governance Leads
- Weekly Flash report to Board if required / ICC decision log
- Monthly claims and inquests report to ET
- Daily staff COVID-19 briefing
- Monthly risk report to level one committees / Directorate highlight reports
- Situation Reports (SitReps) / Regular staff and stakeholder briefings

Assurance Rating Amber

### External:

- Virtual legal forums / Peers trusts including UHL legal team / NHLSA / weekly Coroner feedback
- Department of health / Public Health England / NHSEI / COBR / Chief Medical Officer
- Gov.uk COVID-19 information email alerts / National webinars
- Buddy Trust

Evidence:

Assurance Rating Amber

### Gaps:

- Buddy relationship with NHFT
- Bi monthly health and safety committee meetings to review covid
- Riddor reporting

## Actions

| Date: | Actions | Action Owner: | Progress | Status: |
|---|---|---|---|---|
| July 20 | - Briefing for ET to propose the introduction of a risk assessment for patients who haven't been able to access a service due to changes in our provision as a result of COVID. | Legal Team / MCS | Being drafted | Amber |
| July 20 | - Prompt card for clinicians to support robust record keeping | Legal Team/Clinical Senate/Weightmans | Being drafted | |
| July 20 | - Seeking additional legal advice to ensure our process is fit for purpose | Legal Team | On-going | |

| | | | |
|---|---|---|---|
| **Risk 46** | Well Governed | Date Included on ORR | 27.05.20 |
| **Risk Title** | We are unable to restore or recover our services, impacting on our ability to deliver against national requirements and commissioned activity. | | |
| **Risk Owner:** | Director of Finance, Business & Estates and Deputy Chief Executive | Date Last Reviewed: | 27.05.20 |
| **Governance / Review** | Combined Exec Board / Fortnightly | | |

| Well-governed | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 4 | 4 | 16 |
| **Residual Risk** | 4 | 3 | 12 |
| **Risk Appetite** | 4 | 3 | 12 |

## Controls

**Description:**

- COVID-19 Incident Management Team and Control Centre with LPT Gold, Silver and Bronze chain of command
- Recovery cell to plan the restoration of services and enable recovery, linking in with all ICC specialist cells
- Approved, interim governance and risk management arrangements with focus on action, risk and decision logs
- Prioritisation of critical services and maintenance of business continuity plans
- Participation in national and LLR health resilience forums
- National weekly Webinars / Communications for COVID-19 both internally and externally
- Communication of information – Staff Room and daily Email
- National guidance on workforce / National and system updates including modelling on the development of the pandemic
- Impact of COVD-19 on existing ORR and local / Directorate risk registers
- High level restoration plans shared with regulators and agreed across LLR

**Gaps:**

- Detailed plans for restoration and recovery
- Detailed guidance re approach to restoration and recovery to ensure it is approached in a safe way
- Detailed guidance re approach to restoration and recovery where we propose to retain the learning from COVID.
- Clarity over the impact of partial school closures on our staff
- Ensuring adequate in-patient bed stock is maintained as we move through to recovery - balancing the need for a covid response and one for Mental Health specifically

## Assurances

| | Source: | Evidence: | |
|---|---|---|---|
| **Internal:** | • Weekly flash report to Board<br>• Communications structures to staff<br>• 7-day per week COVID-19 major incident meetings<br>• COVID related National Guidance reviewed daily<br>• Monitoring of unintended consequences of rapid and high pressured decision making<br>• Daily National PPE SitReps<br>• Daily staffing swabbing SitRep / CEO daily SitRep | • Weekly Flash report to Board<br>• Monthly claims and inquests report to ET<br>• Daily staff COVID-19 briefing<br>• Monthly risk report to level one committees<br>• Directorate highlight reports<br>• Situation Reports (SitReps)<br>• Regular staff and stakeholder briefings<br>• ICC decision log | Assurance Rating Amber |
| **External:** | Source:<br>• Virtual legal forums<br>• Department of health / Public Health England / NHSEI / COBR / Chief Medical Officer<br>• Gov.uk COVID-19 information email alerts / National webinars<br>• Buddy relationship with NHFT | Evidence: | Assurance Rating Red |

**Gaps ..**

## Actions

| Date: | Actions | Action Owner: | Progress | Status: |
|---|---|---|---|---|
| July 20 | Detailed plans for restoration and recovery | Recovery Cell | Initial plan submitted to NHSEI | Red |
| July 20 | Detailed guidance re our approach to restoration and recovery safely | Recovery Cell | | |
| July 20 | Detailed guidance re our approach to learning from COVID | Recovery Cell | | |

| | | | |
|---|---|---|---|
| **Risk 47** | Well Governed / High Standards | Date Included on ORR | 27.05.20 |
| **Risk Title** | We are unable to provide a COVID-19 safe environment for our staff and patients | | |
| **Risk Owner:** | Director of Finance, Business & Estates and Deputy Chief Executive / Director of HR & OD | Date Last Reviewed: | 27.05.20 |
| **Governance / Review** | Combined Exec Board / Fortnightly | | |

| | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 5 | 3 | 15 |
| **Residual Risk** | 5 | 2 | 10 |
| **Risk Appetite** | 5 | 2 | 10 |

## Controls

**Description:**

- National guidelines set out in 'Operating framework for urgent and planned services in hospital settings'
- PHE 'COVID-19 Infection prevention and Control guidelines'
- National guidelines set out in 'COVID-19 prioritisation within community health services'
- COVID-19 Incident Management Team and Control Centre with LPT Gold, Silver and Bronze chain of command
- Recovery cell to plan the restoration of services and enable recovery, linking in with all ICC specialist cells
- Clinical senate overview of service recovery and restoration plans
- Approved, interim governance and risk management arrangements with focus on action, risk and decision logs
- Risk assessment for all redeployed staff where vulnerable or shielding
- All staff who were able to work from home i.e. the work can be done at home have moved to working from home
- Silver command re-deployment of staff from services that had been stood down and deployed to services where extra surge was required
- Staff side involvement with process for bringing redeployed staff back into the services
- Agreed zoning and social distancing for the training centres
- Active participation in the Bring Back Staff (BBS) national scheme
- Liaison with third party organisations to explore surplus workforce e.g. LOROS, DMU etc
- Set up NHS Professionals as a source of supply
- Signed up to LLR system workforce sharing agreement
- Work with HEE to identify paid placements for third year nursing students as aspirant nurses
- Policy controls are in place for IPC, major incident place, Flu pandemic
- Participation in national and LLR health resilience forums
- Communication of information – Staff Room and daily Email
- Staff guidance on Management of isolation and reporting / Agile home working policy / Occupational Health dedicated phone lines
- Wellbeing support for staff
- National guidance on workforce / National and system updates including modelling on the development of the pandemic
- Procurement hub with PPE planning and distribution
- Increased swab capacity. Local testing stations set up for swabbing for primary mental health, community and care home staff. Swabbing centres established
- risk assessments for all bame and staff with high risk protected characteristics
- critical training undertaken including mask fit testing

**Gaps:**

- Full understanding of formal social distancing requirements for all sites is outstanding in readiness for staff return and restoration of services
- Impact of a surge in non covid referrals and acuity requiring face to face contact and an increase in workload
- Not yet finalised zoning plan

## Assurances

| | Source: | Evidence: | |
|---|---|---|---|
| **Internal:** | • Weekly flash report to Board<br>• Communications structures to staff<br>• 7-day per week COVID-19 major incident meetings<br>• COVID related National Guidance reviewed daily<br>• Monitoring of unintended consequences of rapid and high pressured decision making<br>• Daily National PPE SitReps / Daily national NHSE/I patient related SitRep also provided to the LLR system | • Weekly Flash report to Board<br>• Daily staff COVID-19 briefing<br>• Monthly risk report to level one committees<br>• Directorate highlight reports<br>• Situation Reports (SitReps)<br>• Regular staff and stakeholder briefings | Assurance Rating Amber |
| **External:** | Source:<br>• Buddy relationship with NHFT<br>• Department of health / Public Health England / NHSEI / COBR / Chief Medical Officer<br>• LLR system advice and planning / Joint CEO exec daily ( Mon-Fri) reporting structure | Evidence: | Assurance Rating Red |

**Gaps ..**

## Actions

| Date: | Actions | Action Owner: | Progress | Status: |
|---|---|---|---|---|
| July 20 | H&S team undertaking environmental RAs across all estate | Bernadette Keavney | | |
| June 20 | Consideration being given to 'attend anywhere' remote consultation product. | David Williams | | |
| May 20 | ICCs to consider the role of both Trusts in system staff health & wellbeing/psychological support. 'Frontline19' to be considered as part of the overall psychological support offer | Kathryn Burt | | Red |
| June 20 | The recovery cell and operational cells are currently reviewing zoning arrangements regarding bringing services patients / staff back safely | Recovery Cell | | |

| | | | |
|---|---|---|---|
| **Risk 47 DRAFT** | Well Governed | Date Included on ORR | 24.06.20 |
| **Risk Title** | We are unable to contain expenditure, or to recover income in line with the limits imposed by NHSEI under the COVID financial regime. | | |
| **Risk Owner:** | Director of Finance, Business & Estates and Deputy Chief Executive | Date Last Reviewed: | 24.06.20 |
| **Governance / Review** | FPC / monthly | | |

| | Conseq-uence | Likeli-hood | Combined |
|---|---|---|---|
| **Current Risk** | 5 | 3 | 15 |
| **Residual Risk** | 5 | 2 | 10 |
| **Risk Appetite** | 5 | 2 | 10 |

## Controls

**Description:**

- Block payment in place 01/04/20 – 31/10/20
- Top up payment ensures Trust will break even each month
- All covid related costs reimbursed centrally each month
- Transformation committee oversight of CIPs
- Operational oversight & management of costs through Directorate Management Teams
- Financial governance and control framework in place through Standing Financial Instructions with reporting to the Audit Committee
- Capital Management Committee's oversight of capital planning and agreed governance processes; Capital Financing strategy
- Treasury management policy , cash flow forecasting and management
- Underlying cost run rate will be reported to FPC, to manage & understand the underlying position
- Underlying cost run rate will be compared to 20/21 block income to identify any gaps

**Gaps:**

- Awaiting phase 3 guidance to clarify the basis on which financial plans will be set for 20/21 for the rest of the year
- NHSI guidance could change the approach to covid reimbursement/top up funding & leave us with a financial gap if all costs haven't been identified & claimed in a timely manner
- Investments/service changes could be progressed which are reimbursed via the block arrangement, but which commissioners do not agree to subsequently fund
- Ledger budgets are based on old contract values & could confuse 20/21 variance reporting
- CIP development & approval of QIA s

## Assurances

| | | | |
|---|---|---|---|
| **Internal:** | Source:<br>• Finance and Performance Committee report includes I & E, cash & capital reporting<br>• Audit Committee<br>• Transformation Committee oversight of CIP & QIA development<br>• CCG/LPT process to agree approach to investment funding in 20/21<br>• Capital management committee review & agreement of capital bids, in year plan delivery & annual development of capital plans | Evidence:<br>• Formal I & E, cash & capital monitoring<br>• Standing Financial instructions<br>• Transformation committee papers<br>• Documented process in place (once agreed)<br>• Highlight report<br>• Monthly Director of Finance report | Assurance Rating Amber |
| **External:** | Source:<br>• KPMG audit of 20/21 annual accounts and value for money conclusion<br>• Internal Audit Plan 2020/21: Integrity of the General Ledger and Financial Reporting Q3/4; Financial Systems Q3/4 | Evidence:<br>• 2019/20 annual accounts unqualified opinion<br>• Significant assurance IA opinions issued 2019/20 | Assurance Rating Green |

**Gaps ..**

## Actions

| Date: | Actions | Action Owner: | Progress | Status: |
|---|---|---|---|---|
| August 20 | To understand the baseline position | Sharon Murphy | | Green |
| August 20 | Budget and financial target re-setting | Sharon Murphy | Ongoing analysis continuing | |
| July 20 | Agree investment process with CCG leads | Sharon Murphy | In progress | |
| August 20 | Implement phase 3 NHSE/I guidance when received | Sharon Murphy | Waiting for guidance | |

Leicestershire Partnership NHS Trust

| | |
|---|---|
| Meeting Name and date | Trust Board 7 July 2020 |
| Paper number | G |

# Level 1 Committees Annual Reports 2019-20

| | | | | | |
|---|---|---|---|---|---|
| For approval | ✓ | For assurance | | For information | |

| | | | |
|---|---|---|---|
| Presented by | Chris Oakes, Director of Governance and Risk | Authors | Chairs and Executive leads for Level 1 Committees |

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

| Report previously reviewed by | |
|---|---|
| Committee / Group | Date |
| Draft annual reports were reviewed at each committee and then presented to the Audit and Assurance committees. | June 2020<br>3 July 2020 |

| Assurance: What assurance does this report provide in respect of the Organisational Risk Register? | Links to ORR risk numbers |
|---|---|
| Addressing CQC Inspection Well-Led, NHS I/E Committee reviews, and Internal Audit Governance audit concerns for Level 1 Board Committees. | 1,3, 16, 20, 22 |

| Recommendations of the report |
|---|
| The Board is asked to approve the annual reports 2019-20 for Level 1 Committees and proposed changes to Terms of References. |

Leicestershire Partnership NHS Trust

## 1. Introduction/Background

1.1 The CQC inspection in November 2018 with report published 27 February 2019 stated that 'the governance of the trust was poor' and 'did not have robust governance procedures to ensure that they could identify and address issues across the trust in a timely way'. It also stated 'the trust lacked a framework for endorsing and therefore learning from the positive quality projects taking place'.

1.2 The development of proposals for a revised Corporate Governance Structure was discussed in the NHFT and LPT "Buddy Forum", Executive Operations meetings, the 30 August 2019 Board, and a series of meetings during September 2019. It was also reflective of the findings of the External Governance Reviews. The Trust Board signed-off the new corporate governance arrangements at its 1 October 2019 meeting.

1.3 The implementation of the arrangements, and the support to Level 1 Board Committees, have been worked upon since that time and led since January 2020 by the Director of Governance and Risk.

1.4 As a result of COVID-19 the arrangements for the usual full annual reporting of all corporate governance committees except for Level 1 Committees ie those that report directly into the Board itself, and a simplified template used for feedback.

## 2. Aim

2.1 To review and approve the Annual Committee Reviews including proposed changes of reference for committees.

## 3. Recommendation

3.1 The Board is asked to approve the annual reports 2019-20 for Level 1 Committees and proposed changes to Terms of References.

## 4. Discussion

4.1 Annex A shows the current full corporate governance committee arrangements.

4.2 The committees reviewed their draft annual reports at meetings in June 2020.

4.3 Audit and Assurance Committee undertook a full oversight review of all annual reports at its 3 July 2020 meeting with Chairs of the Level 1 Committees in attendance or represented.

4.4 Quality Assurance Committee (QAC) and Finance and Performance Committee (FPC) are currently undergoing a full review of their workplan and areas of focus as described in their reports. Changes to their Terms of Reference (TORs) will follow and be presented to a future Board for approval. This is the outcome of reflections from working with the new arrangements since October 2020 and the input of corporate governance team support to the functioning of the committees.

4.5 Minor changes to the TORs for Charitable Funds, Audit and Assurance Committee, and Remuneration Committee have been highlighted in their reports and attached as Annexes to the same.

4.6 The removal of Level 1 Board Committees Mental Health Act Assurance Committee and Strategic Workforce Group during 2019 has not had any negative impact of the reporting-in to Trust Board, and provided additional capacity for Non-Executive and Executive Directors.

4.7 The comprehensive feedback from NHS I/E committee reviews was considered for input by the Corporate Governance team, Executive team review, and as part of the QAC and FPC annual reviews.

4.8 The Internal Audit Governance and Risk Management report (1920-LPT-24) received significant assurance for the corporate Governance element and the only low risk was "As part of the annual review of QAC, FPC and AAC forward work plans, specific focus should be undertaken to ensure that they reflect the duties and assurances as required per terms of reference. The Director of Corporate Governance and Risk to work with the Chairs of committees and where work plans/agendas are changed, any items removed are documented and the reasons for this captured to support the committee in ensuring it meets its terms of reference." The annual report work has addressed this risk and continues to do so through ongoing corporate governance development.

## 5. Conclusions

5.1 The annual review by Board committees has provided comprehensive reports reflecting robust self-reflections and seeking of wide range of opinions. Key outcomes have been recommendations to further strengthen governance arrangements in the proposed changes to TORs, and the scope and ambition of the committees' forward plans.

5.2 The reports demonstrate clear arrangements in place for lines of reporting, accountability for quality, finance, and performance corporate assurances to the Board.

5.3 The corporate governance development work is ongoing with proposed changes to the TORs for QAC and FPC and their workplans planned for the near future.

Annexes:

A Corporate Governance Diagram May 20

B Audit and Assurance Committee Annual Report

C Quality and Assurance Committee Annual Report

D Finance and Performance Committee Annual Report

E Charitable Funds Annual Report

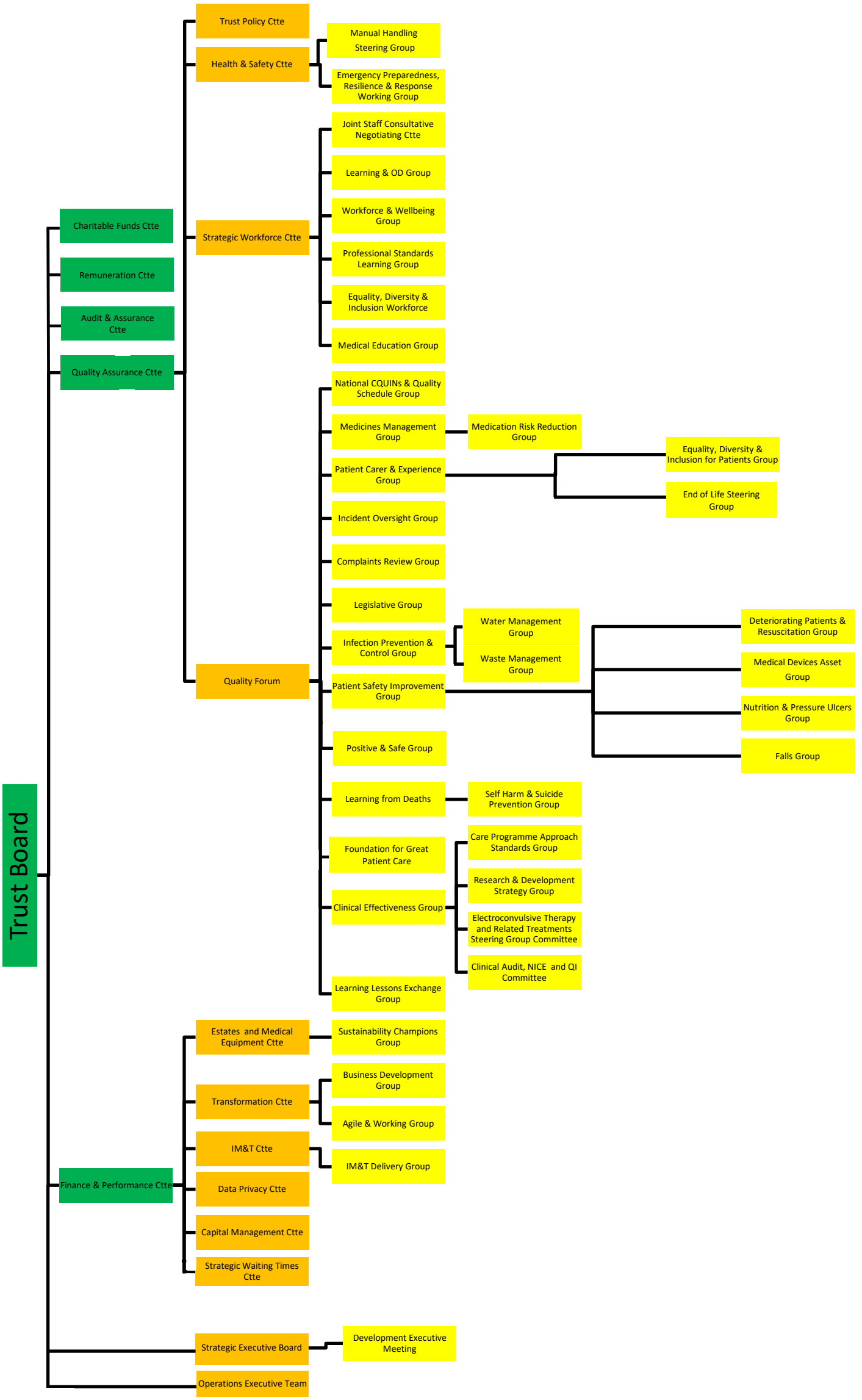
F Remuneration Committee Annual Report

# Corporate Governance Structure

Leicestershire Partnership NHS Trust

Level 1 Level 2 Level 3

Colour Code:
Green – Level 1
Amber – Level 2
Yellow – Level 3



Leicestershire Partnership NHS Trust

# ANNUAL REPORT

Year 2019-20

| | |
|---|---|
| **Committee/Group** | Audit and Assurance Committee |
| **Date** | 3 July 2020 |
| **Chair of Committee** | Darren Hickman |

| | Yes | No |
|---|---|---|
| **Q1. All TORs covered in workplan?**<br>The extant July 2019 approved TORs has had Section 2 Governance diagram removed (out of date), Section 3 Membership removed (duplicate of paragraph 4 of TORs), and Section 4 Work Programme removed (separate document that is being updated regularly). The standard duty from the Trust template on TORs for Public Sector Equality Duty has been added along with the supporting Appendix.<br><br>The recent change to administrative support arrangements for the committee has also been captured in Section 5.<br><br>Revised draft TORs are at the Annex.<br><br>The workplan has been amended through 2019/20 to ensure all items in the TORs are covered. Going forward for audit purposes if an item in the workplan is not taken to the Committee this will be noted at the meeting. | ☒ | ☐ |
| **Q2. External assurances?**<br>Assurances are received at every meeting from External Audit and Internal Audit services. The former focuses on the formal audit of the financial and quality accounts, along with value for money considerations. The latter has an extensive and agreed by committee programme of audit for corporate and clinical quality activities.<br><br>Counter Fraud service also provide periodic reporting to the Committee.<br><br>An External Governance review was undertaken and the findings reported to the May 2019 meeting. | ☒ | ☐ |
| **Q3. Membership Attendance Satisfactory?** | ☒ | ☐ |

| Director Member | Attendance: (Meetings attended/Total Meetings Held eg 4/5) |
|---|---|
| Darren Hickman | 5/5 |
| Liz Rowbotham | 5/5 |
| Geoff Rowbotham | 5/5 |

Meetings are supported regularly by the Director of Finance, Trust Secretary, Head of Quality Assurance, and representatives from External Audit, Internal Audit (360 Assurance) and Counter Fraud Service.

**Q4. Meetings well-run?** ☒ ☐

Papers are issued 5 workings days ahead of the meeting and are of good quality.

The agenda has scheduled timeslots for items that is followed allowing for more debate as needed. Meetings are prompt in starting and concluding as scheduled.

The minutes of the meetings reflect thorough and informed debate for items with a rigour for matters not proceeding as expected and support for positive progress as assured.

Deep dive topics have the longest agenda time to facilitate the quality of discussions.

As the priority for topics to be received changes the workplan is adapted to ensure the information flow is optimal.

After every meeting the Committee provides highlight reports for assurance levels received for agenda topics to the Trust Board.

<u>Achievements and Barriers</u>

Top three achievements or successes

- A deep dive review of Audit committee handbook at March 2019 meeting was followed-up by the reporting back of an External Governance review to the May 2019 meeting. Taken together a change of TORs was considered at the July meeting and subsequently approved at the Trust Board July 2019. This has resulted in the shift of oversight on behalf of the Board of the risk management arrangements from the Quality Assurance Committee to the Committee. It also had the outcome of an agreed view that a renewed focus for the Committee going forward was to act as the “third line of defence” ie to receive independent and more objective assurance and to triangulate and challenge assurance received from the sub-committees, whose role was the first and second lines of defence. An example of such activity subsequently undertaken was the Chair’s leading a deep dive discussion at the March 2020 meeting around contracting arrangements with partners and brought in intelligence from discussions he had held with Audit committees’ chairs in

partner NHS organisations.

- An ongoing focus throughout 2019/20 has been to improve the outcomes being seen from internal audits and the follow-up audit. A new process was introduced for sign-off of the draft TORs and final reports such that all the Executives were sighted, and also that a "prospective view" of management actions due to be reviewed at first follow-up was provided to all stakeholders. Whilst the final outcome was not as hoped (74% for follow-ups completed – 75% is significant assurance) there was continued improvement during the year and far greater awareness and ownership by the Executive for what is needed to be completed by when.

There were no perceived barriers perceived to the work of the Committee. When deep dives or more extensive reviews of topics are determined as needed the pertinent staff to assist are always engaged fully in the process. The Committee is well serviced by the corporate governance staff.

The key action being taken as a result of the above reflection is forward plan "deep dive" topics to ensure consideration of key topics such as "third line of defence" issues are covered.

Future Plans

The Committee's key priorities/focus/planned developments for next year:

- Oversight on governance arrangements for COVID-19 pandemic and in particular the Recovery and Restoration phase of services.
- Oversight on development of LLR system working and partnership arrangements.
- Assurance of governance and control arrangements for major LPT transformation programmes eg Facilities Management Services transfer, EPR implementation, and Equality, Leadership and Culture.
- Ensuring Internal Audit programme reflects a reframed impact arising from COVID-19 and to achieve Significant Assurance level for Head of Internal Audit Opinion 2020/21.
- Assurance that the Organisational Risk Register and Risk Management Strategy are meeting the needs of LPT.
- Oversight of control and governance related to key third party independent evidence and information eg assurance sources such as CQC, H&S, infection control inspections, Healthwatch reviews, and provision of services by 3rd parties( Payroll, Facilities).
- Consideration to performance and value for money arrangements for internal and external audit services.

Leicestershire Partnership NHS Trust

# Audit and Assurance Committee

## Terms of Reference

***References to "the Committee" shall mean the Audit and Assurance Committee***

### 1.0 Constitution

The Trust Board has established a committee known as the Audit and Assurance Committee (the Committee) reporting to the Trust Board, in accordance with standing order 4.

The Committee shall have terms of reference and powers and be subject to conditions, such as reporting back to the Trust Board, as the Trust Board shall decide and shall act in accordance with any legislation and regulation or direction issued by the regulator.

The Committee shall be a Non-executive Director led Committee of the Trust Board comprised of independent Non-executive Directors and Executive Directors with portfolio lead for the finance and performance agenda. The Committee has no executive powers, other than those specifically delegated in these terms of reference.

### 2.0 Purpose of Committee

The purpose of the Committee is to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's strategic objectives and statutory requirements

To recommend to the Trust Board from its Auditor Panel the appointment of external auditors.

### 3.0 Authority

The Committee is a Non-Executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

The Committee is authorised by Trust Board to investigate any activity within its terms of reference.

The Committee is authorised by Trust Board to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain, at the Trust's expense, any outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience or expertise, if it considers this to be necessary.

### 4.0 Membership

The Committee shall be comprised of three Non-executive Directors. A number of officers including the Finance Director and Trust Secretary will attend meetings of the Audit and Assurance Committee.

The membership will include:

- Three independent Non-executive Directors.

In attendance there will be the following officers from the Trust:

- Finance Director will hold executive responsibility for the meeting
- Head of Governance

Other in attendance will include:

- Director 360 Assurance (Internal Audit)
- Client Manager 360 Assurance (Internal Audit)
- Principal Anti-crime specialist 360 Assurance (Counter Fraud)
- Partner KPMG (External Audit)

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

Membership of the Committee will be reviewed and agreed annually by the Board.

In the situation of a prolonged absence of the Chair or a member of the Committee, the Trust Board will determine a replacement Chair. The Chair of the Trust Board will determine replacement of independent Non-executive Director membership.

The Chief Executive Officer, other executive directors and accountable managers may be invited to attend when the Committee is discussing areas of risk or operation that are the responsibility of that director or manager.

The Chief Executive Officer will be invited to attend, at least annually, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

Other staff of the Trust will be invited to attend for all or part of the meeting.

## 5.0 Administration

The Committee shall be supported administratively by Corporate Governance Department administrators.

The agenda will be agreed with the Chair following consultation with the Head of Governance and Director of Finance in consultation with the Chair of the meeting.

The Corporate Governance Department will support the production of the Committee pack and ensure the pack is circulated within the required timeline of five working days prior to the meeting, attend the meetings to take the minutes, keep a record of matters arsing and issues to be carried forward and generally provide support to the Chair and members of the Committee. .

## 6.0 Quorum

The quorum shall be two members of the Committee A duly convened meeting of the Committee which is quorate shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

## 7.0 Attendance at meetings

Only members of the Committee have a right to attend the Committee; however other officers of the Trust may be invited to attend the Committee either for specific discussion items or for the whole meeting as required by the Committee.

Other Non-executive Directors have an open invitation to attend the Committee as felt appropriate after advising the Chair of the Committee of their attendance.

Any independent Non-executive Director or officer of the Trust who is not part of the normal membership of the Committee will be in attendance at the meeting.

## 8.0 Frequency of Meetings

The Committee shall meet no less than five times a year and at such other times as the Chairman of the Committee shall require at the exigency of the business.

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

## 9.0 Agenda/Notice of Meetings

Unless otherwise agreed, notice of each Audit and Assurance Committee meeting will confirm the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, and any other person required to attend, no later than five working days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

The agenda for each meeting will include an item “Declarations of interest in respect of items on the agenda”.

## 10.0 Minutes of Meetings

Minutes of Committee meetings shall be circulated promptly to all members of the Committee and, once agreed, to the secretary of the Trust Board. The Committee’s minutes will be open to scrutiny by the Trust’s auditors.

The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

## 11.0 Duties

### Governance, Risk Management and Internal Control

Pay Due Regard to Equality in all of its decisions. All reports include a Due Regard question. In order to ensure that the committee fulfils its statutory obligations it will use the Public Sector Equality Duty checklist attached at Appendix in its decision making processes for agenda items.

To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives.

To review the Risk Management Strategy and receive a quarterly update report on the systems for updating and managing the Board Assurance Framework and Risk Management.

To review the adequacy of all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board.

To review the adequacy of the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.To review the adequacy of Trust policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements. To review the adequacy of the policy system as a key internal control mechanism. To review the code of business conduct policy.

To review the adequacy of Trust policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service.

To be responsible for reviewing the adequacy of Standing Orders, Standing Financial Instructions, and any suspension of the constitutional documents. To ensure there is an appropriate Scheme of Delegation and associated financial limits and to ensure that this is subject to regular review.

To review the quarterly report on losses and special payments

Receive information on the system used to manage any CQC recommendations or internal control mechanisms that are set up

To undertake on behalf of Trust Board an independent annual review of the Board Committees. This would be combined with the Committees' Annual Review for greater effectiveness. All Chairs of Board Committees attend either the May or July A&AC meetings to present their annual reviews.

In carrying out the duties listed above the Committee will primarily utilise the work of Internal Audit, External Audit, Counter Fraud Services and other assurance functions, but will not be limited to these audit functions. The Committee will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

**Internal Audit**

The Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.

This will be achieved by:

(a) consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;
(b) review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
(c) consideration of the major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources;
(d) ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
(e) annual review of the effectiveness of internal audit.

**External Audit**

The Committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

(a) consideration of the performance of the External Auditor;
(b) discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination, as appropriate, with other External Auditors in the local health economy;
(c) discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;
(d) review all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

**Other Assurance Functions**

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation including Counter Fraud Services, and consider the implications to the governance of the organisation.

These will include, but will not be limited to, any reviews by Department of Health Arm's Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Resolution, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).

In addition, the Committee will review the work of other Board committees within the organisation, whose work can provide relevant assurance to the Committee's own scope of work.

In reviewing the work of the Quality and Assurance committee, and issues around clinical risk management, the Committee will wish to satisfy themselves on the assurance that can be gained from the clinical audit function.

**Whistleblowing**

The Committee will review the effectiveness of the arrangements in place for allowing staff to raise, in confidence concerns about possible improprieties in financial, clinical and safety matters and ensure that any such concerns are investigated proportionately and independently.

**Management**

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

They may also request specific reports from individual functions within the organisation (e.g. clinical audit) as they may be appropriate to the overall arrangements.

The Committee will receive third party assurance reports on an annual basis from organisations that provide services to the Trust. These would include, but are not limited to:

Internal Audit
Payroll Management

**Financial Reporting**

The Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance.

The Committee should ensure that the systems for financial reporting to the Trust Board including those of budgetary control are subject to review as to the completeness and accuracy of the information provided.

The Committee shall review the Annual Report and Accounts before submission to the Board, focusing particularly on:

(a) the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
(b) changes in, and compliance with, accounting policies and practices;
(c) unadjusted mis-statements in the financial statements;
(d) major judgemental areas;
(e) significant adjustments resulting from the audit.

**Auditor Panel**

Panel membership comprises two Non-Executive members and the Director of Finance. A nominated Non-Executive is to act as Chair of the Audit Panel.

The Deputy Director of Finance shall normally attend the meetings.

One Non-Executive Director and the Director of Finance need to attend for quoracy.

The Panel is to conduct an appropriate LPT procurement process, as outlined in section 9 of the Trust's Standing Financial Instructions (SFIs) for the appointment of external auditors.

The Panel is to recommend to the Trust Board the appointment of external auditors.

The Panel is to ensure:

(a) Contract arrangements (i.e. procurement and the selection of external auditors) are appropriate.
(b) The relationship and communications with the external auditors are professional
(c) Conflicts of interest are effectively dealt with.

(d) It is also important that the Auditor Panel is alert to the possibility of conflicts of interest – for example, if non-audit services work is awarded to the external audit provider, how will the Auditor Panel ensure that the auditors' independence is maintained?

If the Trust Board asks the Panel it must advise on any proposal to enter into a liability limitation agreement with audit firms (this would be considered as part of the procurement process).

The Trust Board can determine to remove any member of the Auditor Panel including the Chair. The Chair of the Trust Board would need to re-consider the membership of the Committee in the case of a Non-executive Panel member being removed.

The Panel shall provide update reports to the Committee and to the Trust Board.

## 12.0 Reporting Responsibilities:

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

The Committee shall produce for the Trust Board an annual report on the work it has undertaken during the course of the year.

The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on:

(a) the fitness for purpose of the Assurance Framework;
(b) the completeness, and the extent to which risk management is embedded in the organisation;
(c) the integration of governance arrangements;

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

## 13.0 Annual Review

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

## 14.0 Risk Responsibility

The risk areas the Committee has special responsibility for will be those that fall within the remit of this Committee.

## Appendix - Public Sector Equality Duty check List

The Committee should assure itself that for relevant agenda items the following checklist questions have been addressed in full (and where appropriate a "Due Regard" assessment has been carried out:

1. (a) Who will be affected by this decision? What information is there about its likely effects on them?

(b) Have you consulted with people who might be affected?

(c) Could this decision affect some groups of people more than others? In particular, is it likely to have a disproportionately bad effect on some groups?

(d) Could the proposal be amended to avoid or reduce this disproportionate effect?

2. Could the decision be seen as favouring a particular group or denying opportunities to another? Might it cause tensions or resentment between people? How could this be addressed?

3. Does this decision offer an opportunity to promote equality? Does it offer an opportunity to promote good relations between different groups of people?

4. Accessible environments

(a) Physical access: will the decision affect how and when different groups of people are able to use a room or building? Has the committee taken advice on improving access for disabled people?

(b) Access to information (E.g. Large Print, Digital/electronic, BSL, Non-English translations etc): does the decision involve communication or publication of information? Has the committee taken advice on producing accessible formats?

5. Decisions should be reviewed to see what effects they have actually had. Do you need to make arrangements now so that information will be available for this review?

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Note: **Groups** refers to those protected under the Equality Act 2010 (age, disability, gender reassignment, Race, religion or belief, maternity or pregnancy, marriage or civil partnership, sexual orientation or sex).

Leicestershire Partnership NHS Trust

| | |
|---|---|
| Meeting Name and date | Trust Board 7 July 2020 |
| Paper number | Paper G – Annex C |

| |
|---|
| Name of Report: QAC Annual Committee Review |

| | | | | | |
|---|---|---|---|---|---|
| For approval | ✓ | For assurance | ✓ | For information | |

| | | | |
|---|---|---|---|
| Presented by | Liz Rowbotham<br>Non-Executive Director | Author | Kate Dyer, Head of Governance and Interim Company Secretary |

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

| Report previously reviewed by | |
|---|---|
| Committee / Group | Date |
| Quality Assurance Committee<br>Audit and Assurance Committee | 16 June 2020<br>3 July 2020 |

| Assurance: What assurance does this report provide in respect of the Organisational Risk Register Risks? | Links to ORR risk numbers |
|---|---|
| This report provides assurance regarding the oversight of all QAC related risks on the Organisational Risk Register (ORR). | |

| Recommendations of the report |
|---|
| To receive assurance that the Committee is operating within Trust governance arrangements.<br><br>To note the conclusions, recommendations and priorities for 2020/21 |

# Quality Assurance Committee
# Annual Review 2019/20

## Introduction

The Quality Assurance Committee (QAC) is chaired by a Non-Executive Director, has two other Non-Executive Director members, and meets on a monthly basis moving to bimonthly in 2020-21. It also has Trust Board Executive Director membership as well as Senior Clinical Directors, and commissioners in attendance. It is the key forum for discussion and assurance that quality governance arrangements are in place throughout the Trust and that they are working effectively. It is supported in its work by groups that are responsible for different aspects of quality and clinical governance overview such as patient safety, patient experience, and health and safety. These groups are scheduled such as to provide timely information to the QAC.

## Discussion

An annual review has been presented to support the QAC discussion and subsequent approval of the conclusions, recommendations and priorities for the 2020/21 year.

Feedback

Due to the demands of the COVID-19 pandemic, the level 2 committees will not be undertaking an annual review; it is noted that this feedback is not therefore available to inform this committee review.

Feedback from committee members has been incorporated into sections 2.4, 2.5 and 2.6 which describe committee effectiveness in terms of the achievements and successes, challenges and the key priorities for 2020/21.

COVID-19

As at 1 April 2020 for the foreseeable future, due to the COVID-19 pandemic, Committees will be focusing on the following six areas as a priority;

- Quality and Safety
- Finance and impacts on performance
- Risk
- Covid-19
- The Health and Wellbeing of staff
- Statutory requirements

As a result, the draft work plan for 2020/21 has been adapted to prioritise these areas between April 2020 and August 2020, with a view to resuming a full remit from September 2020.

Due to COVID-19 the internal audit plan is due to be evaluated in June 2020. The QAC work plan includes internal audit reports which have a limited or no assurance

opinion (or as part of a split opinion).

As the internal audit plans stands (at 05/06/20) those scheduled with QAC oversight include;

- Clinical Quality – Patient Safety
- Duty of Candour
- Management of non-fixed ligaturing
- Collaborative Care Planning
- Medicines Management
- Client-Wide Project - Liberty Protection Safeguards: Implementation of the Mental Capacity (Amendment) Act 2019
- Workforce Strategy
- Safe Staffing

Committee scheduling

- The Committee is scheduled to move from a monthly to a bi-monthly meeting structure from September 2020. Bi-monthly meetings were originally scheduled from January 2020 but due to COVID-19, monthly meetings were reinstated from March 2020.

**Conclusion**

A review of the QAC has been presented, with recommendations and priorities for 20/21 to be discussed by the Committee and approved

# QAC Committee Review 2019/20

## 1. Fulfilling the Terms of Reference

1.1 Terms of Reference and Work Plan

*In the main, duties of the ToR were covered through the work plan and agendas during the year. As the ToR and work plan changed mid-year to include workforce, a number of the gaps identified were received by the Strategic Workforce Committee. The Step up to Great strategy and regulatory feedback has resulted in on-going re-prioritisation of the original 2019/20 work programme for QAC.*

There are a number of areas where the ToR and the work plan do not fully align, and a number of items listed in either the ToR and / or the work plan where a paper was not received during the year; these include

- *Workforce plan for 2019/20 - This was taken to the SWC in January 2019.*
- *STP workforce strategy - This is on the SWC work plan for 2020/21*
- *Nursing revalidation report – this is has been prioritised within the 2020/21 annual plan.*
- *Caldicott Guardian annual report – this now falls under the remit of the data privacy group which feeds into the FPC. This will be reviewed for 2020/21 with a view to moving this to the oversight of the Trust Board.*
- *Annual report and review of strategic approach to equality diversity and inclusion - This was taken to the SWC in July 2019.*

A revised draft of the ToR will be presented to QAC in July 20. A draft work plan for 20/21 has been provided to the QAC, a revision is presented this month for approval. These revisions have addressed any items that the QAC would not be expected to receive going forward. The remaining items have been brought forward into the 20/21 work plan.

1.2 Membership

*Membership attendance has been satisfactory, it has included clinical representation and each meeting was quorate.*

The membership requirements changed mid-year. Initially the following members were listed in the ToR (up to December 2019);

- NED (chair)
- NED x 2
- Chief Nurse (Executive Lead)
- Medical Director
- Service Director

From January 2020, the membership included those identified above and the following;

- Director of Human Resources & OD
- Director of Finance or a representative for health and safety.

The quorum is three members of the Committee and must include a Non-Executive and a clinical Executive Director. Each meeting was quorate.

| Director Member | Attendance:<br>(11 meetings held in total) |
|---|---|
| NED chair (LR) | 10 plus 1 deputy |
| NED (RM) | 10 |
| NED (KH) | 8 |
| Director of Nursing (AMN / AS) | 11 |
| Medical Director | 8 plus 2 deputies |
| Service Director (RB) | 6 plus 4 deputies |
| Service Director (GK) | 2 |
| Additional members from January 2020 – attendance (2 meetings in total) | |
| Director of HR (SW) | 3 plus 1 deputy |
| Director of Finance / Rep from H&S | 1 (H&S) |

1.3 External Assurance

*The committee receives external assurance from a number of sources; this year the committee has received direct feedback on committee effectiveness from NHSI which overall was positive but contained a number of actions for further development. There are a number of omissions from this year, including external assurance from patient groups and commissioner quality visits.*

The committee receives external assurance from a number of sources including;

- NHSI observation and feedback of Board committees (December 2019). Overall feedback was positive. Detailed feedback for QAC and the joint QAC/FPC has been provided in appendix one with the latest progress against actions. Any outstanding items have been included in the recommendations section of the report.
- Inspections from third party regulators such as CQC, NHSI etc. This year the committee received assurance over a visit from NHSI focusing on infection, prevention and control; this feedback, and the Health and Safety inspection feedback were discussed in detail at the Committee.
- The Trust's Buddy relationship with Northamptonshire Healthcare NHS Foundation Trust which includes peer review visits.
- Commissioner quality visits although we note that the committee did not receive assurance from this source during the 19/20 year.
- Externally commissioned reviews including the Intensive Support Team (NHSI) and independent consultancy reports. For instance this year the IST worked with the FYPC Team to develop demand and capacity modelling;

this and the external review of safeguarding were discussed in detail at the Committee

- Internal Audit reports where limited or no assurance reports are received for quality related items. During the 2019/20 year, three reports were issued with a limited assurance opinion;
    - Clinical Audit and NICE – considered in detail at the Audit and Assurance Committee
    - Seclusion rooms – considered in detail at the QAC
    - Stakeholder audit – considered in detail at the QAC
- External auditors. This includes the external limited assurance review of data underpinning the quality account; however we note that due to COVID-19, this was not provided for 2019/20.
- NHS National annual staff survey and our local Staff Friends and Family Test/Pulse Survey.
- External review by patient groups and key stakeholder groups such as Healthwatch e.g. “Enter and View” visits, although we note that no assurance has been received by the QAC during 2019/20.
- National Accreditation scheme.
- Royal College inspections and visits.

## 2. Committee Effectiveness

*Overall, the meetings have been considered as well-run. The Committee priorities responded to the Step up to Great strategy throughout the year, which overrode the original priority to implement the recommendations from external SI and governance reviews. Significant changes have been made, including a joint QAC/FPC meeting, and changes risk and governance including the QAC oversight of workforce, QIB and buddy forum governance.*

### 2.1 2019/20 Priorities

The committee’s key priorities for the 2019/20 financial year were described as;

- *We endeavor to make the work plan as flexible as possible to ensure emerging business throughout the year can be accommodated.*
- *For 2019/20 the committee aims to embed the governance and SI review recommendations, increase the patient and users view to inform our work and ensure a greater emphasis is placed on quality improvement.*
- *Consideration will be given as to whether Healthwatch or users/carers can be involved directly in the committee*
- *A medicines oversight group will be established by July 2019*
- *Individual sub group recommendations will be reviewed mid-year to ensure progress.*
- *A review of the sub group structure will be undertaken during the year*
- *The agenda will continue to be focused on the “Step up to Great” priorities associated with the remit of the committee*

- *A specific agenda item will be introduce for the lead executive to keep the committee briefed on emerging issues both local and national from July 2019*

The majority of these recommendations were addressed throughout the year, with the exception of;

- Assurance over the embeddedness of the governance and SI review recommendations. This was superseded by the significant changes made to the governance structure, however QAC maintained line of sight with these.
- Patient voice (in the form of a body such as Heathwatch, or directly with patients/carers) and an increase in patient and user views to inform our work. This will be followed up in the 2020/21 work plan.

2.2 Deep Dives

In addition to in depth presentations where required throughout the year, the following deep dives topics were included during the year (additional deep dives were carried out at the joint QAC/FPC); these provide support for increased scrutiny of areas linked to key areas of risk;

- Seclusion actions including 360 internal audit report (Dec 19)
- Privacy and Dignity and Dormitories (March 20)

2.3 Key in-year changes

Governance and risk

- The Trust introduced a new, refocused strategy 'Step up to Great' with a new set of priorities for the Trust.
- The Trust's revised governance framework from October 2019 is leading to a streamlining of information flow throughout the organisation. Assurance and performance reports are received by QAC and FPC and assessed alongside risk identified on the ORR. An assurance rating is applied to each risk to summarise how assured we are based on the evidence from internal and external assurance sources, and how assured we are on the progress of the actions being delivered to mitigate the risks.
- Mid-year, the Committee changed to include oversight of the Quality Improvement Board, the Strategic Workforce Committee and the Buddy Forum.
- Strengthening of the committee structures building upon the October 2019 Board approved structures, their focus, role and relationship with the Board and the Executive Team; including the timetabling and processes to support committees and flow of information. This was approved by the Trust Board in March 2020.
- The Director of Corporate Governance and Risk has been working with the Chairs of FPC and QAC to agree increased rigor around the functioning of the committees and corporate governance support to the committee chairs. A new escalation process for 20/21 has been agreed with chairs of FPC

and QAC to support the collation of issue of papers.

- A revised risk management strategy and policy which was approved by the Audit and Assurance Committee, and the Trust Board in September 2019.
- A review and update to the current organisational model, directors' roles and accountabilities across both corporate and operational directorates.
- Trust Board development session to understand the risks to delivery of the Step up to Great plan, including emerging risks, embeddedness and sustainability. This formed the basis of the revised ORR which has been developed to address the Step Up To Great strategic objectives for this year and has had a period of maturity and development over the last 6 months
- Our approach to determining risk appetite has been strengthened, and a new framework was approved by the Trust Board in October 2019

Joint meetings

In 2019/20 the QAC and the FPC held quarterly joint meetings in recognition of areas of overlap in agenda items .This approach was approved by the Board and includes the following membership;

- Five Non-Executive Directors (including the QAC and FPC Chairs)
- Eight Directors (including the Director of Nursing, Director of Finance, Medical Director and Operational Directors).

Joint QAC and FPC Agenda Items have included;

- Elimination of Dormitory Accommodation
- CIP / QIA Report
- Estates Strategy
- Waiting times improvement and proposed harm assurance processes
- Progress on data quality improvement with specific reference to Quality account indicators
- Organisational Risk Register
- New Care Models (Forensic, CAMHS and Adult ED)

2.4 Achievements, successes

Feedback from Committee members primarily falls within the following three themes;

1. Revised Corporate Governance structure implemented
   - *Developed robust quality governance framework including the Quality Forum as a level 2 committee for QAC supported by our Buddy Trust NHFT.*
   - *Incorporated the work of the Strategic Workforce Committee.*
2. Strengthened assurance
   - *Strengthening assurance through to Board through improved highlight reporting*
   - *Improvements to assurance processes including excellent reports now being received from Quality Forum*

- *Robust deep dive inquiry facilitated*
- *Robust confirm and challenge assurance processes facilitated*
- *Buddy relationship with NHFT*
- *Agreeing appropriate performance indicators in the new performance report*

3. Development and integration of the ORR
   - *Implementing risk management framework and ORR*

2.5 Challenges

Feedback from Committee members primarily falls within the following three themes;

1. Pace and level of organisational change including the impact of COVID-19
2. Governance and risk changes
   - *Bedding in of new structure*
   - *Significant change throughout the organisation including human resource at pace posed some challenge to the development of a rhythm however this was quickly and well managed*
   - *Taken some time to develop the ORR to a position where we now have confidence in it - so during some months in 2019/20 we were unable to consider risks appropriately resulting in too much focus on the process*
3. Committee effectiveness
   - *Amount of work to be covered v time constraints within agenda which still occasionally overrun*
   - *Back to back same day committee meetings are not conducive to health, well-being and attention*
   - *Although improved, volume of papers/pages can still feel overwhelming at times*

## 3. Future Plans

*The future plans and priorities identified for the QAC will ensure that the Committee is focusing on the right agenda during 20/21*

3.1 Feedback from Committee members primarily falls within the following four themes;

1. Developing Governance
   - *Oversight of work plans and execution of the terms of reference*
   - *Continue to strengthen the committee and membership*
   - *Embedding revised governance framework*
   - *Managing the quantity of assurance from the Quality Forum agenda*
2. Strengthening performance and assurance
   - *Continue to focus on deep dive areas of work*
   - *Strengthen the SI and complaint assurance from QAC to Board.*
   - *Performance on quality indicators*
   - *Assurance mapping through the tiers*

3. Impact of the COVID-19 pandemic

- *Restoration of services and clear understanding of impact on performance following COVID 19 – the QAC will have oversight of assurance over the harm review process to mitigate the adverse impact of COVID-19*
- *Patient and Carer involvement on transformation changes which are proposed to be retained following COVID 19 and progress against strategy – the QAC will have oversight of assurance over the impact on quality*
- *Safeguarding following COVID 19 lockdown – this will fall under safeguarding monitoring within the QAC*

3.2 Recommendations for 2020/21

| Source | *Recommendation* |
|---|---|
| Terms of Reference | *Revise the ToR ensure alignment with the work plan and appropriateness of agenda items.*<br>*To evaluate the membership of the Director of Finance or a representative for health and safety* |
| Work plan for 20/21 | *Revised the work plan for 2020/21 to ensure alignment with ToR and appropriateness of agenda items* |
| NHSI committee observation requiring on-going focus by the Committee | *Action log dates should always be fixed for review/completion.* |
| | *improvement of the presentation of papers and front sheets – including the strengthening of assurance provide in reports such as the CQC update and the learning from deaths paper* |
| | *Workforce data – Trust has aspirational target to reduce sickness rates however they are below what is seen in the country for mental health trust. Consider providing SPC with interval lines for national average and aspirational targets.* |
| | *On occasions not clear if the work required from discussions is being picked up. I.e. link between falls and riddor* |
| 2019/20 priorities not sufficiently addressed to be brought forward into 20/21 | *Promoting patient and staff viewpoint to agenda items where appropriate. To be discussed at the September 2020 joint QAC/FPC.* |
| Challenges in 2019/20 | Significant volume of work to be addressed in work plan revision |
| Developing governance | *Oversight of work plans and execution of the terms of reference* |
| | *Managing the quantity of assurance from the Quality Forum agenda* |
| | *Further embedding of governance structure* |

| | |
|---|---|
| | *Chair of QAC to attend the feeder level 2 committees once during the year* |
| Performance and assurance | *Strengthen the SI and complaint assurance from QAC to Board* |
| | *Performance on quality indicators* |
| | *Assurance mapping through the tiers* |
| Impact of COVID-19 | *Trust Board development session June 2020 to review recovery and restoration framework and sub-committee assurance process* |
| Further recommendations for the committee to discuss | *Reinstate bi-monthly committee meetings from September 2020* |
| | *Promote quality improvement through the buddy trust arrangement with NHFT to share and develop good practice.* |
| | *Review timings of the Committee and the Trust Board with a view to further alignment to strengthen flow of information.* |
| | *Review the adequacy of assurance received re Equality and Diversity from the EDI group (via SWC) and the patient experience group (via the Quality Forum).* |

3.3 The Committee will continue its oversight and scrutiny of priorities relating to COVID-19, the Step up to Great Strategy, regulatory standards, deep dives, and areas of strategic risk. It will also continue to maintain a focus on quality improvement across the work plan.

The overarching thematic priorities of the QAC for 20/21 include;

- Patient and staff viewpoint
- High standards
- Staff wellbeing
- Infection control
- Equality and diversity
- Leadership and Culture
- Quality improvement
- Oversight of the assurance related to COVID-19 recovery and restoration subject to discussion at the Board development session in June 2020.

## Appendix 1 – NHSI Committee Observation

# QAC

**QAC**

| Aspect | Good practice | Areas for development | Progress |
|---|---|---|---|
| Was the meeting well organised and well attended? | • Well attended and check for quoracy made | • Minutes not gone through page by page for corrections – asked the meeting if they were accepted.<br><br>• Items on the action log deferred but no dates were fixed for further discussion with a risk of slippage or lack of pace. | As papers are taken as read a page by page review is not the approach taken. Corrections are often received ahead of meetings and any further corrections received and captured at the meeting.<br><br>Noted and dates should always by fixed for review/completion. Increased oversight by the corporate governance function led by the Director of Corporate Governance and Risk will address this issue. |
| Were papers circulated in advance and is it evident members have read them and are conversant with the content? | • Papers taken as read | • Some papers were late being circulated and arrived in multiple emails. The Chair explained that this was because the meeting is a week early due to Xmas.<br><br>• There was not always evidence that papers had been read.<br><br>• It is clear that the new governance process is developing and therefore the presentation to various boards is out of sync. This was highlighted throughout the meeting | Noted as exception but to always be avoided.<br><br>Papers should always be read and this has been fedback to the Executives and NEDs.<br><br>New governance structures are now established and the enhanced role of corporate governance team support with Board and sub-committees' agendas will improve this situation. |

| | | | |
|---|---|---|---|
| Is there evidence of a golden thread between trust objectives and priorities, the content of the meeting and the supporting packs? | • New structure being developed for quality monitoring in the Trust. New quality forum TOR agreed. Positive change to structure.<br><br>• Good links to step up strategy by DON when presenting papers.<br>• Good presentation of the management of SIs through committee made.<br>• Good links between data and the exec walkabouts<br>• Good evidence of links to transformational work in the trust objectives<br>• Good link to 'safe ward' programme | • There appear to be actions on the action log for this meeting which are for the joint quality and finance meeting<br><br>• Some confusion about where some items will be discussed and in what time scale.<br><br>• Acknowledgement that new step up language needs to be in the papers as still using old language.<br><br>• CIP progress not reported clearly | The increased role of the corporate governance support team led by the Director of Corporate Governance and Risk is focused upon improving agenda management across all our level 1 committees ie Board and its sub-committees.<br><br>The new arrangements have also seen ownership of a central library of TORs, usage of common templates and more rigour for control of, and support to, the corporate governance committee environment.<br><br>Noted and included in papers<br><br>In the new committee structure a Transformation Committee has been created which is chaired by the Director or of Corporate Governance and Risk and attended by the Executive Directors. This will be supported by a new PMO function which is currently being recruited to. A set of programme management pro-formas and methodology has been developed. This includes the approach to QIA. |

| | | | |
|---|---|---|---|
| Are the objectives for the meeting clear? | | • There appears to be some confusion still about what goes to which Committee. The IQPR goes to FPC- Why are the quality elements not being taken through QAC? It was acknowledged that this is work in progress and being refined. | The increased role of the corporate governance support team led by the Director of Corporate Governance and Risk is focused upon improving agenda management across all our level 1 committees ie Board and its sub-committees.<br><br>The new arrangements have also seen ownership of a central library of TORs, usage of common templates and more rigour for control of, and support to, the corporate governance committee environment.<br><br>Further development work is underway across both Trusts to build on recent developments and further improve Governance and gain strength from the joint benchmarking of the two corporate governance teams respectively for NHFT and LPT , working together under the joint Executive Director lead for Governance<br>Performance report has always gone to QAC , new framework does and QAC will concentrate on quality metrics which have been expanded |
| Is there balance and proportionality between strategy, quality, finance, performance and people | • Good links between staffing paper and use of bank and agency and links to other work in the organisation. | • We observed quite a lot of discussion about how each Committee works eg. Discussion about the Operational Risk | It was a transition phase<br>The increased role of the corporate governance support team led by the Director of Corporate Governance and |

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| related issues on the agenda? Is there sufficient time allocated to each? | | Register flow and TOR's which did distract from discussion on assurance on key issues. Recognise this may be due to being in a transition phase. | Risk is focused upon improving agenda management across all our level 1 committees ie Board and its sub-committees.<br><br>The new arrangements have also seen ownership of a central library of TORs, usage of common templates and more rigour for control of, and support to, the corporate governance committee environment. |
| Are papers well presented, summarised and clear in their messages to the attendees? | • DON report presented well. Able to talk to data when asked but not presented in paper. Offer of explanation re cultural work in flu vaccination process.<br><br>• Links to national collaboratives made.<br>• Good challenge about the spot check process for CQC action plan by Trust chair.<br><br>• Good evidence that the Trust share learning from SI investigations and take action from the recommendations made.<br>• Good link to ne national SI process and the delays in implementation nationally.<br>• Good highlights of positive work between CCG and Trust re SI management. | • The DoN report could be strengthened by including outcome data. It is currently presented in an informal narrative style.<br><br>• Chair highlighted the need for improvement of the presentation of papers and front sheets as well as good housekeeping.<br><br>• CQC must and should do's – Detail of progress could be strengthened. Good challenge by non exec and chair agreed to bring the detail re medicines management to the meeting.<br>•<br>• The management of the must and should do's should be reviewed to ensure there is a sound process for spot checks and upward reporting of outcomes. The papers need to | Noted for Director of Nursing's consideration.<br><br>Governance workshops have been held for key corporate governance leads eg report authors and more are planned. Usage of common templates is improving.<br><br>CQC project manager has brought experience and improved rigour to the CQC progress reporting.<br><br>See above |

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| | • Chair does summarise at the end of each segment and rates each section to board reporting.<br>• Evidence that Trust chair and non execs understand spikes in data and can voice this.<br>• Good challenge by CCG around SIs that link to CQC report re crisis team with good explanation by execs<br>• Request for thematic review of community deaths as the numbers are creeping up. Agreed.<br>• Good health and safety link to riddor reporting from falls.<br>• Good presentation of staffing paper with good overview of issues, actions and progress points supported with triangulation of data. | give assurance.<br>•<br>• Assurance accepted re management of CQC action plan although there was little assurance offered.<br>• The Learning from Deaths paper was presented but the discussion was mainly around the fact that the format is changing rather than a thematic analysis of the learning from reviews of deaths. It will be important to ensure that this report becomes more focussed and provides the correct level of assurance.<br>•<br>• The front sheet lacks a Summary Section. | See above<br><br>Noted for feedback to the Medical Director<br><br>Governance workshops have been held for key corporate governance leads eg report authors and more are planned. Usage of common templates is improving. Increased oversight of papers by the corporate governance team will avoid such situations going forward. |
| Are clear actions, owners and timescales allocated? | | • Chair needs to ensure that agreed actions and timescales for work agreed in meeting to be undertaken. On occasions not clear if the work required from discussions is being picked up. I.e. link between falls and riddor. | Noted for Chairs. The presence of the Director of Corporate Governance and Risk at the QAC and FPC will bring clarity to outcome of discussions. |
| Is the Trust's approach to quality improvement evident in the approach to the meeting, including how information is | • Recognition that there will be risks that are overarching between quality and FPC.<br>• Good evidence of developing use of SPC in board papers | • Transformation risks moving to FPC this was challenged by a Non exec director using the new organisational structure chart. The chair offered clarification. However | The new corporate governance arrangements are now established and such issues should be eliminated ie clarity over risks and information ownership and flow. The oversight of |

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| presented? For example, appreciative enquiry, SPC, PDSAs of new approaches | • Evidence of improvement cycles<br>• Good evidence of move to digitisation for compliance audits<br>• Strong evidence of links to Quality Improvement Plan ( Step up to Great) in all papers. | further challenge around the quality oversight. There needs to be clarity around reporting structures around transformation.<br><br>• Workforce data – Trust has aspirational target to reduce sickness rates however they are below what is seen in the country for mental health trust. Consider providing SPC with interval lines for national average and aspirational targets. | the new Transformation Committee will allow the Director of Governance and Risk and Executive Director colleagues to identify if transformation programmes include a focus on quality which needs to be highlighted to QAC in addition to FPC.<br><br>Noted for feedback to Director of HR & OD. SPC is being used more widely in the Trust and experience is being gained. |
| Is there appropriate challenge including evidence of Executives challenging outside their remit? | | • There was limited executive challenge, this could be strengthened. Non – exec challenge was good | The new Governance process and ORR have supported the Executive Directors to provide appropriate challenge |
| Is there effective timekeeping, summation and involvement of the whole group by the Chair? | | • On occasions not clear if the work required from discussions is being picked up. I.e. link between falls and riddor | Noted for Chairs. The presence of the Director of Corporate Governance and Risk at the QAC and FPC will bring clarity to outcome of discussions. |
| Were the behaviours in the room constructive and professional? | There was good non-exec challenge and request for further assurance.<br>All behaviours appropriate.<br>Questions via the chair in the main | | |

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| Were new risks or changes to risks actively identified and logged? | • One non exec challenged the ORR risks in detail and clearly had read the papers. Little other discussions from the group, ? had they read the papers.<br>• 12,13,14 patient involvement to be reviewed in detail for assurance and impact on risks.<br>• Agreed risks to be presented to Board.<br>• New risks identified in the meeting highlighted and agreed. | • Formal de-escalation of risks on ORR 6,7,8 process needs clarifying<br>• Need to update risks to new language and update risks. This may happen as the risks move to FPC – risk of loosing the risk.<br>• The review of high risks discussion could have been strengthened if it had systematically focused on the high risks asking for information on the actions being taken. | The Organisational Risk Register has had an extensive re-work over the last 5 months to ensure full reporting of controls, actions and the context of Board agreed position on its Risk Appetite. The improved risk register received full (green) assurance from both the QAC and FPC level one committees in April. |
| Is there constructive reflection on the effectiveness of the meeting? | • Re-visiting of the ORR was discussed. | | |

**Joint FPC/QAC**

| Aspect | Good practice | Areas for development | Progress |
|---|---|---|---|
| Was the meeting well organised and well attended? | Well attended with team drawn from quality and finance and performance | | |
| Were papers circulated in advance and is it evident | As per observations in QAC meeting | | |

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| members have read them and are conversant with the content? | | | |
| Is there evidence of a golden thread between trust objectives and priorities, the content of the meeting and the supporting packs? | • Harm review process for patients on waiting list is developing. Time scales agreed for start of the review process.<br>• Good link to quality account<br>• Good links to external auditors reports and actions required to resolve issues highlighted by KPMG external audit | • CIP reporting is late because the trust turned the assurance meeting into financial turnaround meeting.<br>• CIP QIA process is still to be completed<br>• Recognition that there is a lack of assurance in the CIP QIA process. Link to FPC committee to oversee CIP and QIA in financial turnaround. | New corporate governance committee structure has re-focused the purpose of QAC and FPC and the timely and appropriate flow of information in the corporate governance structure. There is much more involvement of the Executive team functions for quality assurance and timings of papers to Board committees.<br><br>In the new committee structure a Transformation Committee has been created which is chaired by the Director or of Corporate Governance and Risk and attended by the Executive Directors. This will be supported by a new PMO function which is currently being recruited to. A set of programme management pro-formas and methodology has been developed. This includes the approach to QIA.<br><br>Headline transformation programmes including CIP have been agreed with Directors. |
| Are the objectives for the meeting clear? | • Good evidence that the data quality issues are overarching between the 2 committees. | • Discussion around development of harm review process was very quality driven despite starting as | New waiting list and harm review group (two former groups merged). On both the FPC and QAC agenda. |

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| | | an issue of performance. This felt like a quality item as it is about safety on the waiting list not reduction of the waiting list. Waiting list and harm prevention committee reports to FPC. | |
| Is there balance and proportionality between strategy, quality, finance, performance and people related issues on the agenda? Is there sufficient time allocated to each? | • Good discussion in the room about agenda items – more discussion than in QAC. | | |
| Are papers well presented, summarised and clear in their messages to the attendees? | | | |
| Are clear actions, owners and timescales allocated? | | | |
| Is the Trust's approach to quality improvement evident in the approach to the meeting, including how information is presented? For example, appreciative enquiry, SPC, PDSAs of new approaches | | | |
| Is there appropriate challenge including evidence of Executives challenging outside their remit? | | | |
| Is there effective timekeeping, summation and involvement of | • Good summation of discussion and agreed actions from lengthy | | |

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| the whole group by the Chair? | discussion around data quality and the Trusts assurance processes. | | |
| Were the behaviours in the room constructive and professional? | Behaviours appropriate. | | |
| Were new risks or changes to risks actively identified and logged? | | | |
| Is there constructive reflection on the effectiveness of the meeting? | | | |

Leicestershire Partnership NHS Trust

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|---|---|
| Meeting Name and date | Trust Board 7 July 2020 |
| Paper number | Paper G – Annex D |

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|---|
| Name of Report: FPC Annual Committee Review |

| | | | | | |
|---|---|---|---|---|---|
| For approval | | For assurance | ✓ | For information | |

| | | | |
|---|---|---|---|
| Presented by | Geoff Rowbotham<br>Non-Executive Director | Author | Kate Dyer, Head of Governance and Interim Company Secretary |

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

| Report previously reviewed by | |
|---|---|
| Committee / Group | Date |
| Finance and Performance Committee<br>Audit and Assurance Committee | 16 June 2020<br>3 July 2020 |

| Assurance: What assurance does this report provide in respect of the Organisational Risk Register Risks? | Links to ORR risk numbers |
|---|---|
| This report provides assurance regarding the oversight of all FPC related risks on the Organisational Risk Register (ORR). | |

| Recommendations of the report |
|---|
| To receive assurance that the Committee is operating within Trust governance arrangements.<br><br>To note the conclusions, recommendations and priorities for 2020/21 |

Leicestershire Partnership NHS Trust

# Finance and Performance Committee

# Annual review 2019/20

## Introduction

The Finance and Performance Committee (FPC) is chaired by a Non-Executive Director and meets on a monthly basis moving to bimonthly during 2020-2021. Its membership has key Executive Directors and three Non-Executive Directors including a Non-Executive from the Quality Assurance Committee. It is tasked with undertaking financial reviews, including capital planning and infrastructure developments, on behalf of the Trust Board, and considers actions to mitigate any major financial and performance risks facing our Trust. Business development opportunities form part of their considerations, as does the production of both the annual and longer term business plans. The Committee has a second major role being that of assurance of our operational performance to the Trust Board, which includes performance against the national priorities as set out in the NHS Operational Planning and Contracting Guidance 2019-2020.

## Discussion

An annual review has been presented to support the FPC discussion and subsequent approval of the conclusions, recommendations and priorities for the 2020/21 year.

Feedback

Due to the demands of the COVID-19 pandemic, the level 2 committees will not be undertaking an annual review; it is noted that this feedback is not therefore available to inform this committee review.

Feedback from committee members has been incorporated into sections 2.4, 2.5 and 2.6 which describe committee effectiveness in terms of the achievements and successes, challenges and the key priorities for 2020/21.

COVID-19

As at 1 April 2020 for the foreseeable future, due to the COVID-19 pandemic, Committees will be focusing on the following six areas as a priority;

- Quality and Safety
- Finance and impacts on performance
- Risk
- Covid-19
- The Health and Wellbeing of staff
- Statutory requirements

As a result, the draft work plan for 2020/21 has been adapted to prioritise these areas between April 2020 and August 2020, with a view to resuming a full remit from September 2020.

Due to COVID-19 the internal audit plan is due to be evaluated in June 2020. The FPC work plan includes internal audit reports which have a limited or no assurance opinion (or as part of a split opinion).

As the internal audit plans stands (at 05/06/20) those scheduled with FPC oversight include;

- Integrity of the GL and Financial Reporting
- Financial systems
- CIPs
- Data Quality Framework
- Data Security Standards

Policies

The FPC ToR makes reference to the oversight of two policies; accounting and treasury management out of a potential 8 identified by the Policy Team. As the next stage of the revised Governance framework program a review by FPC will be undertaken in 20/21 Q2 to recommend the most appropriate Committee to review policies within the new structure.

Review dates for policies due for a refresh in 20/21 have had deadlines extended until December 2020 (as a result of COVID-19). Rather than the Committee receiving eight policies (*subject to review) in January/March 2021, we are recommending that the Losses, and Special Payments Policy, and the Treasury Management Policy are scheduled on the 20/21 work plan. The remaining policies will be aligned to the recommendations proposed from the Q2 review.

- Access to Treatment Policy
- Fraud, Bribery and Corruption Policy
- Claims Management Policy
- Code of Business Conduct for Trust Staff
- Adoption and Implementation of an Income Management and Distribution Model for Commercial (Industry) Research Trials & Non-Commercial Research Grants
- Purchasing Card and Purchasing via the Internet Policy

Committee scheduling

The Committee is scheduled to move from a monthly to a bi-monthly meeting structure from September 2020.

Taking into consideration feedback received during the QAC Committee review '*back to back same day committee meetings are not conducive to health, well-being and attention';* the FPC will go back to a 1-3pm meeting time from July 2021.

**Conclusion**

A review of the FPC has been presented, with recommendations and priorities for 20/21 to be discussed by the Committee and approved.

# FPC Committee Review 2019/20

## 1. Fulfilling the Terms of Reference

1.1 Terms of Reference and Work Plan

*In the main, duties of the ToR were covered through delivery of the work plan during the year. There were a number of gaps; the Step up to Great strategy and regulatory feedback has resulted in on-going re-prioritisation of the original 2019/20 work programme for FPC.*

There are a number of areas as a result where the ToR and the work plan do not fully align, and a number of items listed in either the ToR and / or the work plan where a paper was not received during the year, these include;

- *Trust Five Year Plan / System Five Year Plan – This was delayed due to a re-focus on the Step up to Great strategic priorities*
- *360 Assurance Business Plan – reviews were presented to the FPC, it was agreed that a business plan would be an additional item at a future date. This has been included in the 2020/21 work plan.*
- *Premises Assurance Model – This was delayed due to re-focus on the Step up to Great strategic priorities.*
- *Flu Plan- this was included on the work programme and reviewed by QAC. This has been removed from the FPC work plan for 2020/21 and will be added to the QAC ToR and work plan.*
- *Innovation Strategy- This was delayed due to a re-focus on the Step up to Great strategic priorities*

A revised draft of the ToR will be presented to FPC in July 20. A draft work plan for 20/21 has been provided to FPC this month for comment. These revisions have addressed any items that the FPC would not be expected to receive going forward. The remaining items have been brought forward into the 20/21 work plan.

1.2 Membership

*Membership attendance has met the agreed levels. it has included clinical representation and each meeting was quorate.*

The membership listed in the ToR is;

- Three independent Non-Executive Directors.
- The Director of Finance who will hold executive responsibility for the Committee
- A Service Director
- The Medical Director or Director of Nursing, AHPs and Quality

The quorum shall be three members of the Committee and must include a Non-Executive. Each meeting was quorate.

| Director Member | Attendance: |
|---|---|
| NED chair (GR) | 10/12 (plus 2 deputies) |
| NED (FH) | 9/12 |
| NED from QAC (LR) from 1 March 2020 | 1/1 |
| Director of Finance, Business and Estates (DC) | 10/12 (plus 2 deputies) |
| Director of FYPC / LD Services (HT) | 11/12 (plus 1 deputy) |
| Director of CHS (RB) | 8/12 (plus 3 deputies) |
| Director of AMH Services (GK) | 4/7 (plus 1 deputy) |
| Director of Corporate Governance (CO) | 2/3 |
| Director of Strategy and BD (DW) | 1/1 |
| Medical Director (SE) | 7/12 |
| Chief Nurse (AMN / AS) | 5/12 |

1.3 External Assurance

*The committee receives external assurance from a number of sources; this year the committee has received direct feedback on committee effectiveness from NHSI which overall was positive. It contained a number of recommendations for further development which have been implemented.*

The committee receives external assurance from a number of sources including;

- Inspections from third party regulators such as CQC, NHSI etc. This year the committee received assurance over a visit from the Health and Safety Executive.
- Externally commissioned reviews including the Intensive Support Team (NHSI) and independent consultancy reports.
- NHSI observation and feedback of Board committees (December 2019). Overall feedback was positive. Detailed feedback for FPC and the joint FPC/QAC has been provided in appendix one with the latest progress against actions. NHSI recognised a lack of assurance in the CIP QIA process; this has had additional scrutiny throughout the year at joint FPC/QAC meetings.
- Internal Audit reports where limited or no assurance reports are received for finance and performance related items. During the 2019/20 year, five reports were issued with a split or limited assurance opinion and presented to FPC;
    - Risk management (18/19)
    - Data security and protection toolkit (18/19)
    - Risk management (19/20)
    - Estates management (19/20)
    - Waiting Times (19/20)
- External audit reports.
- The work of the Local Counter Fraud Specialist.

## 2. Committee Effectiveness

*Overall, the meetings have been considered as well-run. The Committee priorities responded to the Step up to Great strategy throughout the year; these overrode the original priority areas of enterprise and innovation. Significant changes have been made in 20/21, including a joint QAC/FPC meeting, and changes to governance and risk.*

### 2.1 Addressing Priorities

The committee's key priorities for the 2019/20 financial year were reviewed mid-year and directly linked to our Step up to Great priorities. Specifically these were:

- *Transformation – Overview of impact of service transformation programmes in AMH/LD and CHS in particular drilling down on financial and performance areas*
- *Environment – Focus on a Safe, clean and welcoming estate by overseeing the development of clear governance arrangements for reporting performance and progress in facilities management. Includes oversight of the development of the Mental Health Inpatient Business Case and delivery of the CAMHs new unit.*
- *Governance – Oversight of the implementation of the Trust's revised performance monitoring and management arrangements.*
- *Record – Oversight of delivery of the single electronic patient record.*
- *Access – Continued focus on delivery of improvement in our waiting times.*

*In addition, the committee committed to focus on:*

- *Continued improvement of data quality and monitoring the next stages of the DQIP*
- *Financial sustainability to achieve statutory and planned financial targets*
- *Review approach to the Enterprise Strategy to link with understanding and approach to service line sustainability.*
- *Maintain focus and scrutiny on the business development pipeline, IQPR, waiting times and finance report*

The majority of these priorities have been monitored throughout the year, with the exception of;

- Scrutiny of an enterprise / innovation strategy; This was not a Step up to Great priority and was therefore not received by the Committee.
- Oversight of system wide strategy; The Trust Board has assumed this remit; the FPC ToR will be amended to reflect this.

### 2.2 Deep Dives

In addition to the in depth presentations throughout the year on key agenda items, the following deep dives topics were discussed in the FPC during the year (additional deep dives were carried out at the joint FPC/QAC); these provide support for increased scrutiny of areas linked to key areas of risk;

- Deep Dive on Estates Strategy (August 2019)
- Organisational Risk Register (March 2020)

2.3 Key organisational changes during 2019/20

Governance and risk

- The Trust introduced a new, refocused strategy 'Step up to Great' with a new set of priorities for the Trust.
- The Trust's revised governance framework from October 2019 is leading to a streamlining of information flow throughout the organisation. Assurance and performance reports are received by FPC and QAC and assessed alongside risk identified on the ORR. An assurance rating is applied to each risk to summarise how assured we are based on the evidence from internal and external assurance sources, and how assured we are on the progress of the actions being delivered to mitigate the risks.
- Strengthening of the committee structures building upon the October 2019 Board approved structures, their focus, role and relationship with the Board and the Executive Team; including the timetabling and processes to support committees and flow of information. This was approved by the Trust Board in March 2020.
- The Director of Corporate Governance and Risk has been working with the Chairs of FPC and QAC to agree increased rigor around the functioning of the committees and corporate governance support to the committee chairs. A new escalation process for 20/21 has been agreed with chairs of FPC and QAC to support the collation of issue of papers
- A revised risk management strategy and policy which was approved by the Audit and Assurance Committee, and the Trust Board in September 2019.
- A review and update to the current organisational model, directors' roles and accountabilities across both corporate and operational directorates.
- Trust Board development session to understand the risks to delivery of the Step up to Great plan, including emerging risks, embeddedness and sustainability. This formed the basis of the revised ORR which has been developed to address the Step Up To Great strategic objectives for this year and has had a period of maturity and development over the last 6 months
- Our approach to determining risk appetite has been strengthened, and a new framework was approved by the Trust Board in October 2019

Joint meetings

- In 2019/20 the FPC and the QAC held quarterly joint meetings in recognition of areas of overlap in agenda items .This approach was approved by the Board and includes the following membership;
  - Five Non-Executive Directors (including the FPC and QAC Chairs)
  - Eight Directors (including the Director of Nursing, Director of Finance, Medical Director and Operational Directors).
- Joint QAC and FPC Agenda items have included the following; a number of these have previously been deep dives usually carried out by FPC or QAC;

- Elimination of Dormitory Accommodation
- CIP / QIA Report
- Estates Strategy
- Waiting times improvement and proposed harm assurance processes
- Progress on data quality improvement with specific reference to Quality account indicators
- Organisational Risk Register
- New Care Models (Forensic, CAMHS and Adult ED)

2.4 Achievements and successes

Feedback from Committee members primarily falls within the following three themes;

1. Revised Corporate Governance structure implemented
   - *Establishment of new sub-committee structures*
   - *NHSI/E external good practice review undertaken*
   - *Bi monthly meetings agreed from July 2020*
   - *New performance report and metrics introduced*

2. Triangulation of assurance across FPC and QAC
   - *Joint FPC/QAC quarterly meetings established for cross cutting themes which has strengthened assurance and improvement governance*
   - *Additional NED from QAC co-opted onto FPC*
   - *Chairs monthly review meetings introduced. Areas covered include sharing committee papers, cross referencing agendas and good practic*e.
   - *Joint scrutiny and oversight of quality and performance – for example the quality impact and priority waits in CAMHS and AMH*

3. Development and integration of the ORR
   - *Supported and engaged in its development*
   - *Launched and integrated it as a key tool to inform and develop committee assurance*

2.5 Challenges identified in 2019/20

Feedback from Committee members primarily falls within the following two themes;

1. Triangulation of assurance across FPC and QAC
   - *Time allotted for joint meeting not adequate to deal /interrogate key subject items on agenda (especially when sandwiched in between two existing meetings of QAC and FPC)*

   Action for 2020/21: Joint FPC/QAC to review at Governance workshop September 2020

2. The impact of the COVID-19 pandemic

   Action for 2020/21: Trust Board development session June to review recovery and restoration framework and sub-committee assurance process

## 3. Future Plans

*The future plans and priorities identified for the FPC will ensure that the Committee is focusing on the right agenda during 20/21*

3.1 Feedback from Committee members primarily falls within the following four themes;

1. Development of Governance Model
   - *Supporting and strengthening governance across level 2/3 committees*
   - *Scoping and implementation of lessons learnt and good practice with QAC*
   - *ORR integrated and established across tier 2/3 committees*
2. Performance
   - *Embed new performance report and metrics i.e. SPC into assurance and reporting methodology of the committee*
   - *Integrate and utilise across FPC governance structure as a key tool for assurance*
3. Step up to Great committee assurance priorities
   - *LPT strategy development (for items within the FPC ToR)*
4. Impact of the COVID-19 pandemic
   - *Ensuring harm review processes are embedded to mitigate the adverse impact of COVID-19 – this will be overseen by the QAC*
   - *Understanding the impact of COVID-19 on demand and capacity and oversight of restoration, recovery and reset plans – the Executive Team will have oversight of the restoration, recovery and reset plans.*
   - *Ensure focus on gains made on waiting time improvements are reset post COVID-19 pandemic – This will fall under the waiting times monitoring within the FPC*
   - *Ensure work on environment/ impact on quality is reset and improvements refocused post COVID-19 – This will fall under estates monitoring within the FPC. The QAC will have oversight of quality impact.*

*Nb To be reviewed/finalised following Trust Board Development meeting June 2020*

3.1 Recommendations for 2020/21

| Source | *Recommendation* |
|---|---|
| Terms of Reference | *Revise the ToR ensure alignment with the work plan and appropriateness of agenda items.* |
| Work plan for 20/21 | *Draft work plan for 2020/21 circulated to sub committee chairs for comment prior to approval in July and alignment with ToR* |
| Quality Improvement | *Promote quality improvement through the buddy trust arrangement with NHFT to share and develop good practice.* |

| | |
|---|---|
| Triangulation of assurance across FPC and QAC | *Joint FPC/QAC to review triangulation of assurance at governance workshop September 2020* |
| Impact of COVID-19 | *Trust Board development session June 2020 to review recovery and restoration framework and sub-committee assurance process* |
| Developing governance | *Supporting and strengthening governance across level 2/3 committees. To utilise the level 2 performance on a page for assurance to FPC* |
| | *Chair and or NEDs of FPC to attend the feeder level 2 committees once during the year* |
| | *Triangulation, scoping and implementation of lessons learnt and good practice with QAC* |
| | *Further embedding of the ORR including integrated and established across tier 2 committees* |
| Performance and assurance | *Embed new performance report and metrics i.e. SPC into assurance and reporting methodology of the committee* |
| | *Integrate and utilise performance reporting across FPC governance structure as a key tool for assurance* |
| Further recommendations for the committee to discuss | *Promoting patient and staff viewpoint to agenda items where appropriate. To be discussed at the September 2020 joint QAC/FPC.* |
| | *Bi monthly committee meetings from Sept 2020* |
| | *Review and clarify the policies received at FPC and its sub committees.* |
| | *Review timings of the Committee and the Trust Board with a view to further alignment to strengthen flow of information.* |

3.3 The Committee will continue its oversight and scrutiny of priorities relating to COVID-19, the Step up to Great Strategy, regulatory standards, deep dives, and areas of strategic risk. It will also continue to maintain a focus on quality improvement across the work plan.

The overarching thematic priorities of the FPC for 20/21 include;

- Patient and staff viewpoint
- Waiting times performance
- Estates and Facilities management
- Single electronic patient record
- Transformation
- Oversight of the assurance related to COVID-19 recovery and restoration subject to discussion at the Board development session in June 2020.

## Appendix 1 – NHSI Committee Observation

**FPC**

| Aspect | Good practice | Areas for development | Progress |
|---|---|---|---|
| Was the meeting well organised and well attended? | • Well attended | • Papers sent through in a number of emails. Ideally a complete set should be sent out 1 week before meeting . | New escalation process agreed with chairs of FPC and QAC to support the collation of issue of papers |
| Were papers circulated in advance and is it evident members have read them and are conversant with the content? | • Assumed papers read | | |
| Is there evidence of a golden thread between trust objectives and priorities, the content of the meeting and the supporting packs? | • Committee informed of the agreed actions from the combined meeting | | |
| Are the objectives for the meeting clear? | | • QI assurance process needs to be developed and a decision made which committee it reports to – taken outside meeting<br>• Evidence of evolving committee structure | Further work to strengthen committee structure – workshops with FPC / QAC chairs have been held. The Director of Corporate Governance and Risk is playing an increasingly influential role in the corporate management of Board committee agendas. |

| | | | |
|---|---|---|---|
| | | | A new governance structure has been agreed and the Director of Corporate Governance and Risk has been working with the Chairs of FPC and QAC to agree increased rigour around the functioning of the committees and corporate governance support to the committee chairs. |
| Is there balance and proportionality between strategy, quality, finance, performance and people related issues on the agenda? Is there sufficient time allocated to each? | • Where performance is not meeting the SPC expectation there was a link to transformation requirement and re plotting improvement trajectories<br>• Links back to using improvement monies to improve services. | • Links to quality of care /impact on patient not evidenced – felt a bit target driven | Revised Board committees/Board performance report<br><br>Please also see answers above on risk and performance reports. |
| Are papers well presented, summarised and clear in their messages to the attendees? | | | |
| Are clear actions, owners and timescales allocated? | • Good chairmanship ensuring there is an agreed date for return of action<br>• Good insistence from the chair on dates and expectations for | | |

| | | | |
|---|---|---|---|
| | improvement on delivery standards. | | |
| Is the Trust's approach to quality improvement evident in the approach to the meeting, including how information is presented? For example, appreciative enquiry, SPC, PDSAs of new approaches | • Evidence that performance improvement depends of transformation of services | | |
| Is there appropriate challenge including evidence of Executives challenging outside their remit? | • Yes leading to sending decision making back to exec operational board | | |
| Is there effective timekeeping, summation and involvement of the whole group by the Chair? | • Good summation and agreement of assurance by chair.<br>• Request and check to run 5 minutes over time to allow for effective discussion.<br>• Good amount of pace setting from Trust chair on areas of action plan that need to move forward before next formal review by auditors in Feb. | | |
| Were the behaviours in the room constructive and professional? | • Yes. All questions through chair.<br>• Good level of discussion in the room | • Some behaviours are ones of avoidance that was well managed by the chair. i.e. reducing waiting lists | Noted for future issues. Challenge to Executives expected to be met with full transparency. |

| | | | |
|---|---|---|---|
| | • Good challenge form non-execs. | | |
| Were new risks or changes to risks actively identified and logged? | • Review of risks pertinent to the committee. Good discussion. Agreed changes to risks and movement of risks between committees.<br>• Challenge to sub-committee to review risks that are not well described or rated.<br>• Good review of risks, new risks and those that need a refresh. | | |

**Joint FPC/QAC**

| Aspect | Good practice | Areas for development | Progress |
|---|---|---|---|
| Was the meeting well organised and well attended? | Well attended with team drawn from quality and finance and performance | | |
| Were papers circulated in advance and is it evident members have read them and are conversant with the content? | As per observations in QAC meeting | | |
| Is there evidence of a golden thread between trust objectives and priorities, the content of the meeting and the supporting | • Harm review process for patients on waiting list is developing. Time scales agreed for start of the review process. | • CIP reporting is late because the trust turned the assurance meeting into financial turnaround meeting. | New corporate governance committee structure has re-focused the purpose of QAC and FPC and the timely and appropriate flow of |

| | | | |
|---|---|---|---|
| packs? | • Good link to quality account<br>• Good links to external auditors reports and actions required to resolve issues highlighted by KPMG external audit | • CIP QIA process is still to be completed<br>• Recognition that there is a lack of assurance in the CIP QIA process. Link to FPC committee to oversee CIP and QIA in financial turnaround. | information in the corporate governance structure. There is much more involvement of the Executive team functions for quality assurance and timings of papers to Board committees.<br><br>In the new committee structure a Transformation Committee has been created which is chaired by the Director or of Corporate Governance and Risk and attended by the Executive Directors. This will be supported by a new PMO function which is currently being recruited to. A set of programme management pro-formas and methodology has been developed. This includes the approach to QIA.<br><br>Headline transformation programmes including CIP have been agreed with Directors. |
| Are the objectives for the meeting clear? | • Good evidence that the data quality issues are overarching between the 2 committees. | • Discussion around development of harm review process was very quality driven despite starting as an issue of performance. This felt like a quality item as it is about safety on the waiting list not reduction of the waiting list. Waiting list and harm prevention committee reports to FPC. | New waiting list and harm review group (two former groups merged). On both the FPC and QAC agenda. |

| | | | |
|---|---|---|---|
| Is there balance and proportionality between strategy, quality, finance, performance and people related issues on the agenda? Is there sufficient time allocated to each? | • Good discussion in the room about agenda items – more discussion than in QAC. | | |
| Are papers well presented, summarised and clear in their messages to the attendees? | | | |
| Are clear actions, owners and timescales allocated? | | | |
| Is the Trust's approach to quality improvement evident in the approach to the meeting, including how information is presented? For example, appreciative enquiry, SPC, PDSAs of new approaches | | | |
| Is there appropriate challenge including evidence of Executives challenging outside their remit? | | | |
| Is there effective timekeeping, summation and involvement of the whole group by the Chair? | • Good summation of discussion and agreed actions from lengthy discussion around data quality and the Trusts assurance processes. | | |
| Were the behaviours in the room constructive and professional? | Behaviours appropriate. | | |
| Were new risks or changes to | | | |

| | | | |
|---|---|---|---|
| risks actively identified and logged? | | | |
| Is there constructive reflection on the effectiveness of the meeting? | | | |

Leicestershire Partnership NHS Trust

# ANNUAL REPORT

Year 2019-20

| | |
|---|---|
| **Committee/Group** | Charitable Funds Committee |
| **Date** | 11 June 2020 |
| **Chair of Committee** | Cathy Ellis |

| | Yes | No |
|---|---|---|
| **Q1. All TORs covered in workplan?** | ☒ | ☐ |

*Any recommended changes to TORS please describe below.*

| Section/Term | Current wording | Proposed revised wording |
|---|---|---|
| | | |
| | | |

| | | |
|---|---|---|
| **Q2. External assurances?** | ☒ | ☐ |

*Please describe if any external assurances received.*

The 2018/19 annual accounts were subject to an independent examination. The auditors stated that they had no concerns and had come across no matters in connection with the examination (a formal opinion is not required as part of an independent examination).
A regularity audit was issued by internal audit in December 2019 which gave a significant assurance opinion.

| | | |
|---|---|---|
| **Q3. Membership Attendance Satisfactory?** | ☒ | ☐ |

*Please comment and for Level 1 committees please complete Table below*

| Trustee Member | Attendance: (Meetings attended/Total Meetings Held eg 4/5) |
|---|---|
| Cathy Ellis | 4/4 |
| Sharon Murphy | 4/4 |
| Frank Lusk | 1/4 |
| Geoff Rowbotham (to July 2019) | 2/2 |
| Ruth Marchington (From July 2019) | 2/2 |

| | | |
|---|---|---|
| Attendance has been satisfactory, all meetings have been quorate and Trust officers, including the Raising Health fundraising manager, have attended all meetings. | | |
| **Q4. Meetings well-run?**<br>*Consider quality of papers, how well-chaired, information flow reported in and up, quality of discussions.*<br><br>The agenda is agreed in advance of the meeting and is informed by the annual work plan.<br>Papers are of good quality, and shared at least a week in advance of each meeting.<br>The agenda is well managed and the use of a timed agenda ensures timeliness of discussions. Action points are summarised after each discussion and entered on an action log which is reviewed in each meeting.<br>A highlight report is prepared by the chair and executive lead after each meeting and is reported in to the Trust Board. | ☒ | ☐ |

Achievements and Barriers

- Please list top three achievements or successes

The committee has prioritised fundraising projects that support health and well-being for patients, particularly gyms and gardening.
Bids supported over the year include:

- Stewart House Road to Recovery Appeal – patient gym
- Beacon appeal – a new fundraising appeal to support the new CAMHS unit with sensory and sports equipment
- Early Years Therapy – Sensory Equipment Appeal
- Willows Gym Equipment
- Breast feeding peer supporters
- Let's Get Gardening Appeal for Bradgate Mental Health Unit
- Colour My Memories Appeal – Dementia wards at Evington Centre (including the Dementia Garden).

As part of last year's annual review, the committee agreed to focus on marketing for the charity. Work continues to enhance the charity's brand visibility on LPT sites, increase Raising Heath's presence at staff and public events and to implement a legacy strategy.

The committee also agreed to maintain focus on the charity's financial sustainability.
The income & expenditure run rate has been kept under review to assist in forecasting and management of financial risk.
The charity undertook a procurement process and appointed new investment managers, with effect from 1st January 2020.
The charity has reviewed its procedures, including SFIs, to ensure that they are clear and enhance efficiency and effectiveness.

No barriers were perceived to the work of the committee.

Future Plans

- What are the Committee's key priorities/focus/planned developments for next year?

Following the resignation of the current fund raising manager, the charity will recruit a replacement who can continue to build on the good foundations already in place.
The new fund raising manager will be responsible for implementing the 2020 - 2022 Raising Health fundraising strategy which has the following objectives:

  - Increase the depth of charity brand awareness and profile to all relevant audiences
  - Increase the level of donations to the charity using the appropriate fundraising mix
  - Invest in initiatives that support the vision of the charity
  - Develop partnerships which increase the reach of the charity

The committee will continue to focus on financial sustainability, particularly cash management. Recent volatility in stock markets could impact on future income for the charity and this risk will also need to be managed.

Raising Health has received significant donations in Q1 of 2020/21 as a result of Covid-19 local and national NHS fundraising campaigns. The committee are working hard to ensure that these are used in accordance with donor wishes to support patients and frontline staff.

Leicestershire Partnership NHS Trust

# Charitable Funds Committee
# Terms of Reference

## References to "the Committee" shall mean the Charitable Funds Committee

### 1 Purpose of Committee

1.1 Leicestershire Partnership NHS Trust (LPT) was appointed as a corporate trustee of charitable funds received under a Transfer Order from NHS Leicestershire County and Rutland Primary Care Trust on 22 December 2011.

1.2 The Trust Board will act on behalf of the corporate trustee in the administration of the charitable funds.

1.3 The purpose of the Committee is to manage, on behalf of the Trust Board, and in accordance with Standing Orders, charitable funds held and provide assurance to the Trust Board on the effective management thereof.

### 2 Clinical Focus and Engagement

2.1 The Trust considers clinical engagement and involvement in Board decisions to be an essential element of its governance arrangements and as such the Trust's integrated governance approach aims to mainstream clinical governance into all planning, decision-making and monitoring activity undertaken by the Board.

Comment [MS1]: New standard TOR

### 3 Status and Indemnity of Trustees

3.1 Where a NHS Trust is the sole corporate trustee of a charity, the individual persons who, from time to time, are responsible for the management of the corporate body, i.e. the members of the trust or other officers, are not themselves trustees of the charity. The duties, responsibilities and liabilities of trusteeship lie with the body corporate.

3.2 As LPT is the corporate trustee it will appoint/nominate appropriate representation from the Board to act as Corporate Trustees on its behalf on the Charitable Funds Committee.

## 4 Authority

4.1 The Committee is authorised by the Trust Board to conduct its activities in accordance with these terms of reference, and in statutory compliance with the Charity Commission regulations and charity law.

4.2 The Committee is authorised by the Trust Board to seek any information it requires from any employee of the Trust in order to perform its duties.

## 5 Membership

5.1 Membership will consist of two Non-Executive Directors, one of which will be the Trust Chair, and two Senior Managers (as nominated by the Director of Finance) one of which will be a senior finance manager.

5.2 The Chair of the Committee will be the Chairman of the Trust. In the Chair's absence the chairing of the Committee will be undertaken by another Non-Executive Director.

5.3 The Committee may require the attendance for advice, support, and information routinely at meetings from Trust staff and external advisors.

## 6 Secretary

**6.1** A member of the Corporate Affairs team shall act as secretary.

## 7 Quorum

7.1 The Committee quorum is one Non-Executive Director and one Senior Manager (as nominated by the Director of Finance)

7.2 Any meetings that are not quorate will continue and any decisions made will be ratified by those absent within 10 days of the meeting. A record of these agreements made to be held by the secretary of the meeting.

**Comment [MS2]:** This is in the new standard TOR – wasn't in the old CFC TOR

## 8 Frequency of Meetings

8.1 The Committee shall normally meet at least quarterly but not less than twice a year and at such other times as the Chairman of the Committee shall require at the exigency of the business.

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

## 9 Agenda/Notice of Meetings

9.1 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, and any other person required to attend, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to Committee members, and to other attendees as appropriate, at the same time.

9.2 The agenda for each meeting will include an item "Declarations of interest in respect of items on the agenda".

## 10 Record of Meetings

10.1 The secretary shall record the proceedings and resolutions of all Committee meetings, including the names of those present and in attendance.

10.2 Draft minutes of each meeting will be circulated promptly to the Chairman for review and then circulated to members for checking.

## 11 Duties

11.1 The Committee shall:

11.1.1 Pay Due Regard to Equality in all of its decisions. All reports include a Due Regard question. In order to ensure that the committee fulfils its statutory obligations it will use the Public Sector Equality Duty checklist attached at Appendix 2 in its decision making processes for agenda items.

**Comment [MS3]:** New standard TOR

11.2 The Committee is authorised to:

11.2.1 ensure that the income and property of the Charity are applied for the purpose set out in the governing document and for no other purpose.

11.2.2 have a general duty of protecting the property of the Charity and use the charitable monies proactively – i.e. for the benefit for which they were given.

11.2.3 ensure that the Trust's policies and procedures for charitable funds investments are followed.

11.2.4 ensure that the Trust's Standing Financial Instructions for funds held on trust are followed. The discharge of the Trust's corporate trustee financial responsibilities may not necessarily be discharged in the same manner as the Trust's financial responsibilities are, but there will still be adherence to the overriding general principles of financial regularity, prudence and propriety. Any departure from the Trust's SFIs will be clearly articulated in a separate document and approved by the committee each year.

11.2.5 manage the investments of the charitable funds pursuant to section 2 of the Trustee Act 2000 and, if necessary, appoint, as required, investment advisors. Day to day management on some or all of its investments to the investment advisors may be delegated with periodic reviews of the performance of the investment advisors.

11.2.6 approve expenditure, subject to agreed Raising Health procedures being followed, and on receipt of a completed bid form which has been approved by local fund managers and has received appropriate health & safety and estates advice.

11.2.7 ensure that the banking arrangements for the charitable funds are kept entirely distinct from the Trust's NHS funds.

11.2.7 receive any audit reports from internal or external Audit which relate to Charitable Funds.

11.2.8 receive the annual accounts of the Charity along with the Annual Trustees Report for the Charity Commission within the agreed timescales.

11.2.9 ensure that the Committee membership is reviewed after 2 years and refreshed every 3 years.

11.2.10 provide guidelines with respect to donations, legacies and bequests, fundraising and trading income.

## 12 Reporting Responsibilities:

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

12.2 The Committee shall produce a Highlight report for the Trust Board after each meeting that will give a level of assurance for key agenda items received.

12.3 The Committee shall produce for the Trust Board an annual report on the work it has undertaken during the course of the year.

## 13 Annual Review

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

## 14 Risk Responsibility

14.1 The risk areas the Committee has special responsibility for will be those that fall within the remit of this Committee.

14.2 Where any risks need escalation, the Committee will do so through its Highlight report.

**Comment [MS4]:** New standard TOR

## Appendix 1 – Membership of the Committee

**Core members of the committee include:**

Corporate Trustees:

Trust chair (chair of committee)

Senior finance manager

Senior Trust manager

Non-Executive Director

**Attendees of the committee include:**

Head of Communications

Raising Health fundraising manager

Raising Health assistant finance manager

Trust financial controller

**Appendix 2 - Public Sector Equality Duty check List**

The Committee should assure itself that for relevant agenda items the following checklist questions have been addressed in full (and where appropriate a "Due Regard" assessment has been carried out:

1. (a) Who will be affected by this decision? What information is there about its likely effects on them?
(b) Have you consulted with people who might be affected?
(c) Could this decision affect some groups of people more than others? In particular, is it likely to have a disproportionately bad effect on some groups?
(d) Could the proposal be amended to avoid or reduce this disproportionate effect?
2. Could the decision be seen as favouring a particular group or denying opportunities to another? Might it cause tensions or resentment between people? How could this be addressed?
3. Does this decision offer an opportunity to promote equality? Does it offer an opportunity to promote good relations between different groups of people?
4. Accessible environments
(a) Physical access: will the decision affect how and when different groups of people are able to use a room or building? Has the committee taken advice on improving access for disabled people?
(b) Access to information (E.g. Large Print, Digital/electronic, BSL, Non-English translations etc): does the decision involve communication or publication of information? Has the committee taken advice on producing accessible formats?
5. Decisions should be reviewed to see what effects they have actually had. Do you need to make arrangements now so that information will be available for this review?

Note: **Groups** refers to those protected under the Equality Act 2010 (age, disability, gender reassignment, Race, religion or belief, maternity or pregnancy, marriage or civil partnership, sexual orientation or sex).

Leicestershire Partnership NHS Trust

# ANNUAL REPORT

Year 2019-20

| | |
|---|---|
| **Committee/Group** | Remuneration Committee |
| **Date** | 19th June 2020 |
| **Chair of Committee** | Ruth Marchington |

| | Yes | No |
|---|---|---|
| **Q1. All TORs covered in workplan?** | X | |

*Any recommended changes to TORS please describe below.*

| Section/Term | Current wording | Proposed revised wording |
|---|---|---|
| | | |
| | Appendix 1 | The CEO added in as a permanent attendee |
| 1 Purpose | | Added detail on succession planning and executive objectives |
| 4.2 | 'Committee shall be made up of at least 3 members' deleted | Committee will be made up of five members. Addition and clarification of Chief Executive and Director of HR being permanent attendees. |
| 4.5 | | Director of HR added |
| 4.8 | 'Director of HR will deputise' deleted | In the event of the Chair of Committee not being available another Non Executive will deputise |
| 4.9 | | Added for clarity: Other staff will be invited |
| 6.1 | 6.1 'quoracy is 2' | 6.1 quoracy is 3 |
| 6.3 | Include wording around voting in cases of split | Where the committee has a split decision on |

| | | | | | |
|---|---|---|---|---|---|
| | | decisions. | a point the committee will move to a vote on the matter to be decided. | | |
| | 7.3 | Detail around virtual meetings procedures needed to be inserted | Where required and in response to urgent remuneration decisions required the committee shall meet virtually to undertake its business.<br><br>Where this occurs a clear date for a response will be given; if email responses indicate there is need for a debate or a split decision an ad hoc meeting will be called. | | |
| | 10 Duties | Group together similar duties in the description | Done- paragraphs renumbered as a result. | | |

**Q2. External assurances?**
*Please describe if any external assurances received.*

N/A

N/A

**Q3. Membership Attendance Satisfactory?**
*Please comment and for Level 1 committees please complete Table below*

X

| Director/Member | Attendance: (Meetings attended/Total Meetings Held) |
|---|---|
| Ruth Marchington | 3/3 |
| Cathy Ellis | 3/3 |
| Faisal Hussain | 2/3 |
| Geoff Rowbotham | 2/3 |
| Liz Rowbotham | 2/3 |
| Sarah Willis (in attendance) | 3/3 |
| | |

| | | |
|---|---|---|
| **Q4. Meetings well-run?**<br>*Consider quality of papers, how well-chaired, information flow reported in and up, quality of discussions.*<br><br>For a period of time lack of administrative support to the committee hampered efficiency and effectiveness but this has now been resolved satisfactorily. | x | |

Achievements and Barriers

- Progressed a number of rem com decisions due to significant new members of exec team.
- The delay of NHSI VSM pay framework means the benchmarking data being is not in date.
- Virtual meetings to take place where required with extra – ordinary session brought together if virtual is not suitable.

Future Plans

- Succession planning of Exec team
- Exec team Objectives
- Salary benchmarking

Leicestershire Partnership NHS Trust

# Remuneration Committee
# Terms of Reference

**NB Proposed additions/clarifications highlighted in yellow. Deletions highlighted in blue.**

## References to "the Committee" shall mean the Remuneration Committee

## 1 Purpose of Committee

The purpose of the Committee is to ensure there is a fair and transparent procedure for developing and maintaining policy on executive remuneration and terms and conditions, and for fixing the remuneration packages of individual directors. The committee will also receive information for assurance on succession planning and executive objectives/performance.

## 2 Clinical Focus and Engagement

2.1 The Trust considers clinical engagement and involvement in Board decisions to be an essential element of its governance arrangements and as such the Trust's integrated governance approach aims to mainstream clinical governance into all planning, decision-making and monitoring activity undertaken by the Board.

## 3 Authority

3.1 The Committee is authorised by Board to conduct its activities in accordance with its terms of reference.

3.2 The Committee is authorised by the Board to seek any information it requires from any employee of the Trust in order to perform its duties.

3.3 In connection with its duties the Committee is authorised by the Board to obtain, at the Trust's expense, any outside legal or other professional advice as is deemed necessary, following agreed Trust procedures.

## 4 Membership

4.1 Members of the Committee shall be appointed by the Board, in consultation with the Chair of the Remuneration Committee.

4.2 The Committee shall be made up of 5 members who are non-executive directors and the Chair of the Board, but shall not include the Chair of the Audit Committee. The Chief Executive and Director of HR will be in attendance.

4.3 The Chair of the Committee shall be appointed by the Chair of the Board of Directors and will be a non-executive director.

4.4 Only members of the Committee have the right to attend Committee meetings. However, other individuals such as external advisers may be invited to attend for all or part of any meeting as and when appropriate. (change made: reference to attendance of CEO and Director of HR moved and clarified in 4.2)

4.5 The Chief Executive, Director of HR or other directors shall not attend meetings where their remuneration is under consideration.

4.6 Appointments to the Committee shall be for a period of up to three years, which may be extended.

4.7 Membership of the Committee will be reviewed and agreed annually with the Board. .

4.8 The Chair of this Committee will be the nominated Non Exec Director. In the event of the Chair of the Committee not being available, the remaining members present shall elect one of themselves to chair the meeting. (Change made: deleted Director of HR will deputise)

4.9 Other staff of the Trust will be invited to attend for all or part of the meeting. (change made: added for clarity)

## 5 Secretary

5.1 The Trust Secretary's nominee shall act as secretary of the Committee.

## 6 Quorum

6.1 The quorum necessary for the transaction of business shall be 3 members. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

6.2 Any meetings that are not quorate will continue and any decisions made will be ratified by those absent within 10 days of the meeting. A record of these agreements made to be held by the secretary of the meeting.

6.3 Where the committee has a split decision on a point the committee will move to a vote on the matter to be decided.

## 7 Frequency of Meetings

7.1 The Committee shall normally meet not less than twice a year and at such other times as the Chairman of the Committee shall require at the exigency of the business.

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

7.3 Where required and in response to urgent remuneration decisions required the committee shall meet virtually to undertake its business.

Where this occurs a clear date for a response will be given; if email responses indicate there is need for a debate or a split decision an ad hoc meeting will be called

## 8 Agenda/Notice of Meetings

8.1 Meetings of the Committee shall be summoned by the Secretary of the Committee and at the request of its member in consultation with the Chair of the Committee.

8.2 Unless otherwise agreed, notice of each meeting confirming the venue, time and date together with an agenda of items to be discussed, shall be forwarded to each member of the Committee, and any other person required to attend, no later than 5 working days before the date of the meeting. Supporting papers shall be sent to Committee members and to other attendees as appropriate, at the same time.

8.3 The agenda for each meeting will include an item “Declarations of interest in respect of items on the agenda”.

## 9 Record of Meetings

9.1 The secretary shall record the proceedings and resolutions of all Committee meetings, including the names of those present and in attendance.

9.2 The record of Committee meetings shall be circulated promptly to all members of the Committee and the Chair of the Trust Board once agreed once agreed. The Committee's minutes will be open to scrutiny by the Trust's auditors.

## 10 Duties

10.1 The Committee shall:

10.2 Determine and agree with the Board the framework or broad policy for the remuneration of the Trust's Chief Executive, executive directors and any such other members of the executive management as it is designated to consider. This will include the individual starting salary and conditions of newly appointed Directors, as well as any annual salary uplift for existing directors. Determine any payment of management allowances for the Trust's Medical Director and Associate Medical Directors. No director or manager shall be involved in any decisions as to their own remuneration. To ensure the work of the Committee is seen as fair and transparent Directors will be able to make submissions to the Committee and seek feedback from the Chair on the decisions of the Committee.

10.3 Policy will be in line with the NHSI Very Senior Manager Pay Framework. Review the ongoing appropriateness and relevance of the remuneration policy in line with the very senior manager pay framework

10.4 Within the terms of the agreed policy and in consultation with the Chair and/or Chief Executive as appropriate determine the total individual remuneration package of each executive director and other designated senior managers including any incentive payments.

10.5 Review the delivery of the Chief Executive's performance objectives, and receive a review from the Chief Executive on the executive director performance objectives.

10.6 Approve the design of, and determine targets for, any performance related pay schemes operated by the Trust and approve the total annual payments made under such schemes.

10.7 Determine the policy for, and scope of, pension arrangements for each executive director.

10.8 Ensure that contractual terms on termination, and any payments made, are fair to the individual and the Trust, that failure is not rewarded and the duty to mitigate loss is fully recognised.

10.9 In determining such packages and arrangements, give due regard to any relevant legal requirements and to compliance with Department of Health/NHS England/NHS Improvement guidance.

10.10 Be exclusively responsible for establishing the selection criteria, selecting, appointing and setting the terms of reference for any remuneration consultants who may be required to advise the committee. The Committee shall have full authority to commission any reports or surveys which it deems necessary to help it fulfil its obligations.

10.11 Will receive a business case for consideration where a member of staff may receive a redundancy/ or other severance payment, in excess of their statutory and contractual entitlements, and/or in excess of £100k. The Committee will make its recommendation prior to submission to the NHS Improvement Remuneration Committee. A quarterly report providing an overview of all redundancies (including those under £100k) will also be received by the Committee for information.

10.12 Ensure that board/executive level succession plans are maintained and reviewed.

10.13 Pay Due Regard to Equality in all of its decisions. All reports include a Due Regard question. In order to ensure that the committee fulfils its statutory obligations it will use the Public Sector Equality Duty checklist attached at Appendix 1 in its decision making processes for agenda items.

## 11 Reporting Responsibilities:

11.1 Where no individual personal information or conflict of interest arises, the Committee Chair shall report formally to the Board, meeting in private session, on its proceedings after each meeting on all matters within its duties and responsibilities.

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

11.3 The Committee shall review the Trust's remuneration policy and practices, which may form part of the Trust's Annual Report, approved at the Trust's Annual General Meeting. To assist the Committee the Director of HR & OD will annually provide comparative data on director pay and conditions.

11.4 The Chair of the Committee shall attend the Trust's Annual General Meeting prepared to respond to any stakeholder questions on the Committee's activities.

11.5 The Committee shall produce a Highlight report for the (Parent Committee) after each meeting that will give a level of assurance for key agenda items received.

11.6 The Committee shall produce for the (Parent Committee) an annual report on the work it has undertaken during the course of the year.

## 12 Annual Review

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

## 13 Risk Responsibility

13.1 The risk areas the Committee has special responsibility for will be those that fall within the remit of this Committee.

13.2 Where any risks need escalation, the Committee will do so through its Highlight report.

## Appendix 1 – Membership of the Committee

**Non- Executive Directors**
**Chair of the Trust**

**In attendance:**
**Chief Executive Officer**
**Director of Human Resources and Organisational development**

## Appendix 2 - Public Sector Equality Duty check List

The Committee should assure itself that for relevant agenda items the following checklist questions have been addressed in full (and where appropriate a “Due Regard” assessment has been carried out:

1. (a) Who will be affected by this decision? What information is there about its likely effects on them?
(b) Have you consulted with people who might be affected?
(c) Could this decision affect some groups of people more than others? In particular, is it likely to have a disproportionately bad effect on some groups?
(d) Could the proposal be amended to avoid or reduce this disproportionate effect?
2. Could the decision be seen as favouring a particular group or denying opportunities to another? Might it cause tensions or resentment between people? How could this be addressed?
3. Does this decision offer an opportunity to promote equality? Does it offer an opportunity to promote good relations between different groups of people?
4. Accessible environments
(a) Physical access: will the decision affect how and when different groups of people are able to use a room or building? Has the committee taken advice on improving access for disabled people?
(b) Access to information (E.g. Large Print, Digital/electronic, BSL, Non-English translations etc): does the decision involve communication or publication of information? Has the committee taken advice on producing accessible formats?
5. Decisions should be reviewed to see what effects they have actually had. Do you need to make arrangements now so that information will be available for this review?

Note: **Groups** refers to those protected under the Equality Act 2010 (age, disability, gender reassignment, Race, religion or belief, maternity or pregnancy, marriage or civil partnership, sexual orientation or sex).

Leicestershire Partnership NHS Trust

| | |
|---|---|
| Meeting Name and date | Trust Board 7 July 2020 |
| Paper number | H |

# Report on documents signed under seal for quarter 4 2019/20 and quarter 1 2020/21.

| | | | | | |
|---|---|---|---|---|---|
| For approval | | For assurance | | For information | x |

| | | | |
|---|---|---|---|
| Presented by | Chris Oakes, Director of Corporate Governance and Risk | Author | Frank Lusk, Corporate and Legal Affairs |

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

| Report previously reviewed by | |
|---|---|
| Committee / Group | Date |
| Not applicable | |

| Assurance : What assurance does this report provide in respect of the Board Assurance Framework Risks? | Links to ORR risk numbers |
|---|---|
| Finance risk | 48 |

## Recommendations of the report

In accordance with Standing Order 8.3; "a report of the use of the seal shall be made to the Board at least quarterly". The documents shown below have been signed under seal during the period July to September 2019.

| Register Number | Type | Description | Date Sealed |
|---|---|---|---|
| 306 | Renewal Lease | 5 year renewal for property already used by Leicestershire Health Informatics Service for storage and assembly of IT equipment. | 6 March 2020 |
| 307 | Under Lease Plus | Part building occupancy lease for 360 | 6 March 2020 |

| | | | |
|---|---|---|---|
| | Agreement | Assurance and duration of lease linked to hosting of 360 Assurance by LPT. | |
| 308 | Dead of Easement | Provision of a gas pipeline to serve the new CAMHS unit and an uprated supply to the existing Bradgate Unit. | 10 March 2020 |

Leicestershire Partnership NHS Trust

# Mental Health Update

**Gordon King, Director for Mental Health**
**Michelle Churchard-Smith, Head of Nursing**

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compassion respect
integrity trust

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# Pre-covid…

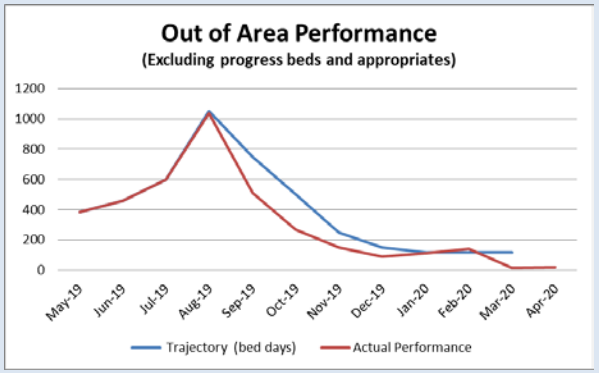
## Progress

**STEP up to GREAT Mental Health**

Staff launch of the implementation phase of transformation

**Inpatient Grip and Flow**

Large reduction in OOA placements




**Agreed plan for reducing dormitories**

Plan to turn dormitories into single rooms

## Key Challenges

**Waiting Times, caseloads & capacity**

- Capacity limitations in crisis & community
- High caseloads / waits in some teams

**Care Planning & documentation**

- Increased coproduction needed
- Increased need for collaborative care planning

**Sustaining quality improvement**

- Challenge maintaining the wide-range of improvements across services

# Managing through Covid

## Key Changes

| | |
|---|---|
| **Central Access Point** | • All age 24/7 direct contact point for mental health help |
| **Mental Health Urgent Care Hub** | • All age urgent mental health assessment and support outside of ED |
| **Isolation wards and inpatient flow** | • Established two isolation wards<br>• Temporary reduced beds<br>• Further reduction in out of area placement |
| **Community Rehab** | • Established a community transitory team<br>• Reduced rehab beds |
| **Maintaining majority of community activity** | • Adopted virtual and digital approaches<br>• Maintained majority of community activity<br>• Strong business continuity preparedness and IPC |
| **Integration with MHSOP and PIER** | • Successfully integrated MHSOP and PIER with AMH<br>• Strong joint working and cross-learning |

# Managing through Covid

## Quality and IPC

**Flexing workforce**

- Staff covering roles, services and new initiatives
- Matching staff to roles to minimise risk to their health

**Maintaining patient safety**

- Least restrictive practices and enhanced monitoring
- Increased management of new environmental risks

**Supporting patient experience**

- New methods of communication with patients, carers & visitors

**Maintaining patient care**

- Adapting practice to over 50 IPC changes affecting approaches to patient care

## Additional Challenges

**Increased Acuity**

**Widening gaps**

**Limitations in virtual working**

**Reduced Productivity**

# Recovery and restoration

## 5 Point Recovery Plan

| | |
|---|---|
| **Evaluate** | • Quarterly evaluation of key changes<br>• Quality improvement and support sustainability planning |
| **Sustain** | • Putting in place operational and financial sustainability of positive new changes. |
| **Recover** | • Objectives & trajectories being set for each key area<br>• Recovery plans aligned to Transformation<br>• Re-establishment of face to face activity where necessary |
| **Surge** | • Working with North CSU for surge modelling<br>• Local surveying to understand service gaps<br>• LLR MH system data group to increase depth of analysis<br>• Joint working with IAPT provider as targeted initiative |
| **Transform** | • Accelerating 4 key pathways<br>• Making necessary changes<br>• Starting groundwork for public consultation<br>• Working across system to put in place MHIS |

Leicestershire Partnership NHS Trust

**Leicestershire Partnership NHS Trust Public Trust Board Meeting 7th July 2020 – Video Presentation**

Video 3:

Agenda Item 14 - Coalville Community Hospital patient discharge video

https://youtu.be/vg_Dlj9r3uQ

J

Leicestershire Partnership NHS Trust

# QUALITY ASSURANCE COMMITTEE – 16th June 2020

## 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 Reference |
|---|---|---|---|
| ORR | High | 13 risks under QAC, 7 are high risk and 2 are at the highest risk score of 20. It was confirmed that with regards to access to treatment and patient safety, work is being strengthened around the harm review and this will have an impact on these risks. The group have strengthened their TORs and now have an increased clinical representation. This will lead to resources landing more appropriately to reduce harm.<br><br>The Chair confirmed that the waiting Lists and Harm Review Group will feed into FPC and any problems arising will be highlighted to QAC but as QAC had previously looked at the process it is important for it to now see the new, strengthened process.<br><br>Discussions were held around moving the ORR on with Covid-19 becoming business as usual. With the Covid-19 risks detailed in the red boxes will becoming part of the ORR and core risks redistributed to Directorate and Committee levels. The Chair and QAC members agreed that this would be a positive step and reporting on Covid-19 matters would be business as usual moving forward. | All |
| QAC Annual Report | High | The draft annual report will be presented at AAC on 4th July and then the Trust Board on 7th July. | 20, 40 |

| Report | Assurance level* | Committee escalation | ORR Risk Reference |
|---|---|---|---|
| | | KD confirmed that QAC had fulfilled most duties under the TOR and those that they had not fulfilled this was due to a change in their priorities. KD thanked members for their feedback which had informed the future priorities section. The committee approved the report subject to some factual amendments. | |
| CQC Update | Medium | There are focus groups planned to take place during the first 2 weeks of July. It is likely that a physical inspection will take place at some point in the future. Much work has been progressed to support our inspection and virtual focus groups supported with a robust communication strategy including posters and information packs for wards; time to shine Microsoft Teams sessions have been well attended by staff and the Foundations for Great Patient Care Forums continue to be well attended. The approach is 3 phased and the 3rd element focuses on the embedding of the changes. The action log currently contains 38 open actions.<br><br>The Chair suggested that NHFT's 'Reading Room' providing access to key documents would be a good idea for LPT and it was confirmed that this set up is currently in progress. | 5, 40 |
| Director of Nursing Update | Medium | The Quality Account has been approved by the Trust Board. Further instructions around the 20/21 CQUINS are expected shortly. A virtual Clinical Quality Review Group (CQRG) had been arranged for June; however this was subsequently cancelled but all LPT reports have been submitted as per the schedule timings.<br><br>The majority of the work for the Infection Prevention and Control (IPC) team continues to be in relation to Covid-19 and the requirements to support and protect patients and staff.<br><br>Work behind the scenes on the Hand Hygiene audits continues and an improvement plan is in place. The issue remains with the number of audits completed rather than the hand hygiene compliance . A proposal paper to plan for the next season's Flu campaign for staff is being developed and will be presented at the Strategic Executive meeting on the 3rd July. The number of safeguarding referrals are increasing and are being closely monitored. In relation to complaints, the current 'pause' will be lifted on 15th June 2020. Assurance was given on SI reporting and noted that in the last month there has been an | 1, 2, 3, 4, 5, 40 |

| Report | Assurance level* | Committee escalation | ORR Risk Reference |
|---|---|---|---|
| | | increase in the number of investigators available with prompt starting of investigations. The Patient Safety Improvement Group and the Incident Oversight Group continue to meet virtually, and the team continue to ensure Incident oversight of all incidents. The establishment of the weekly Incident Review Meeting continues to develop with the multi-professional review of incidents and decision making around levels of investigation.<br><br>The Chair raised the concerns raised by the Trust Board around patient safety, reporting and levels of harm and requested that the outcomes of this work are reported in the next bi-monthly report. | |
| R & D Quarterly Awareness Report | High | Susan Corr presented and detailed how much has changed since the Q4 report was written due to Covid-19 with many areas on pause and a resume date of October 2020.<br><br>The Chair commented that significant work goes into bids with a low rate of success, were any themes or learning arising from this. SC responded that part of the challenge is the lack of skill or calibre to be the leaders and steps that are being taken to get there are slow.<br><br>The Chair asked if any Covid-19 related research may become available and SC confirmed that initial Covid-19 studies were in acute settings but that a large national data input study is available as an opportunity for LPT to support. | 20, 25, 40 |
| Performance Report | Medium | This report has the Quality account metrics in for the first time in this month1 report. Tthis paper was in its new format and had been to Trust Board on 27th May 2020. The report confirmed that the Directorate performance reviews that had been postponed due to covid-19 have now re started. The next steps for the team working on the report involve work with Graham Jones and linking with the Trust's restoration framework – the three R's – Recover, Retain and Restore. This will be reflected in the report moving forward.<br><br>The Chair commented that we need to be clear when the time is right to start interrogating the data more and considering the restoration and recovery work. The Chair raised the issue of the timeliness of this report and the fact that we are seeing month1 data in month 3. LH confirmed that performance within directorates continues as normal and so the questions can still be asked | 5, 20, 28, 35, 40 |

| Report | Assurance level* | Committee escalation | ORR Risk Reference |
|---|---|---|---|
| | | around performance and in services where there have been pauses timelines for restart will need to be confirmed by the executives responsible.<br><br>The committee agreed that they received medium assurance from paper as whilst it was an improved format there were areas of deteriorating data and the timing of data receipt is also an issue. | |
| H&S Highlight Report | High | The Authorised Engineer had now been appointed. The emergency lighting work had been paused due to Covid-19. This was due to restart in the next 2 months. There have been delays in the risk assessment and training due to staff safety but it is anticipated that this will catch up during the restore and recovery stage. An additional H&S committee has been introduced to look at the impact of Covid-19 on certain areas of H&S including the staff who test positive and the investigation and reporting required around this. They will also be focusing on occupational dermatitis and supporting staff who are home working. The committee will be undertaking work around ensuring environments are Covid-19 secure as part of the restoration also. | 5, 9, 10, 11, 27, 40 |
| Quality Forum Report and Associated appendices | Medium | The report contained a comprehensive update on the quality improvement work, progress made and the strategy that has been agreed. The hand hygiene improvement plan was detailed. The report contains a clear plan for addressing the pause in complaints and also improving the quality of complaints. A new system has been purchased and the FFT will recommence from July 2020. The safe wards work has also restarted. The Legislative Committee updated the Quality Forum and although there have been an increase in admissions the QF felt assured around the Mental Health act work. MAPA training has been paused due to the close contact that is required to deliver this training. This training will need to be adapted to be Covid-19 safe. The safeguarding team continue to provide support and advice with lots of cases being very complex and very demanding on the staff.<br><br>The Chair confirmed that it was important that during the development of the Quality Forum it was clear which Step Up To Great metrics the forum were monitoring. | 1, 2, 3, 4, 5, 6, 24, 25, 26, 27, 35, 40 |

| Report | Assurance level* | Committee escalation | ORR Risk Reference |
|---|---|---|---|
| Strategic Workforce Reports | High | No SWC highlight report due to timing of the meetings. The EDI Workforce Group highlight report details the significant work around BAME staff risk assessments with over 1800 completed so far. The results have shown no change for the majority of staff and amended duties for a portion and some staff working from home due to the outcome of the BAME risk assessment. The EDI Workforce Group has also looked at workforce disability equality standards and steps have been taken to improve membership of the MAPLE group with a representative from MAPLE now sitting on the EDI Workforce Group.<br><br>It was requested that in future could HR feed into QAC how LPT is performing against all of the indicators and the Chair requested detail to next QAC around the progress on the Our Future Our Way initiative. | 25, 26, 27, 40, 41 |
| Seclusions Deep Dive | Medium | MCS presented a PowerPoint presentation. The improvement work had now moved into the phase 3 – embedding. This includes seclusion quality checks maintained on a spreadsheet; monthly statistically analysis to focus areas of improvement and weekly escalation process where seclusions do not fulfil practices. Work has been carried out to reduce restrictive practices and the number of hours in seclusion on the Belvoir Ward reduced initially followed by a slight increase during May 2020. De-escalation and other approaches to behaviour are now being employed more frequently. Post seclusion reviews are also being used to inform learning. The safe wards work has been paused due to Covid-19 and is resuming in the recovery phase. The annual Report is just being finalised and a revised strategy plan will accompany this report.<br><br>MCS confirmed that maternity leave cover is being arranged for the member of the team who is about to start maternity leave. The Chair offered thanks to the team for all their hard work. | 1, 2, 3, 6, 40, 42, 43, 47 |
| QAC Workplan review | NA | Workplan and TORs to return to 21st July meeting for approval | |

| | |
|---|---|
| Chair | Liz Rowbotham |

Leicestershire Partnership NHS Trust

| | |
|---|---|
| Meeting Name and date | Trust Board – July 7th 2020 |
| Paper number | K |

| |
|---|
| Name of Report: - Director of Nursing Quality Update |

| | | | | | |
|---|---|---|---|---|---|
| For approval | | For assurance | | For information | x |

| | | | |
|---|---|---|---|
| Presented by | Dr Anne Scott<br>Acting Director of Nursing AHP's and Quality | Author (s) | Dr Anne Scott<br>Acting Director of Nursing AHP's and Quality |

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

| Report previously reviewed by | |
|---|---|
| Committee / Group | Date |
| NA | |
| | |

| Assurance : What assurance does this report provide in respect of the Organisational Risk Register? | Links to ORR risk numbers |
|---|---|
| The report provides an update in respect of quality and safety | 18 |

| Recommendations of the report |
|---|
| The Board are asked to note the content.<br>Further clarification can be sought on any items |

Leicestershire Partnership NHS Trust

# Quality Update COVID-19

## Introduction

Leicestershire Partnership NHS Trust continues to conduct major incident procedures to coordinate and respond to the COVID-19 pandemic. Our main consideration continues to be that we deliver safe effective quality care to all our patients, whilst maximising the safety of all of our staff in exceptionally challenging and unprecedented times. Our approach continues to align with national guidance and focuses on maintaining the delivery of critical services, supporting recovery and enabling the Trust to safely staff and respond proactively to demand. Our approach also embraces transformation and sustainability of standards of care to align with the CQC Key Lines of Enquiry.

## Quality Summary

### Quality Account (QA) 2019/20

The Quality Account has been signed off at Trust board in May and uploaded to both the NHS choices and LPT Trust website as per the guidance. The priorities for 20/21 have been added to the board performance report to be monitored throughout the year and a feedback opportunity is being offered to our stakeholders for preparation for the 2020/21 QA.

### CQUINS

Continued monitoring agreed for the 19/20 CQUINS. Currently we are awaiting further instruction on the 20/21 CQUINS, discussions are expected to recommence at the end of July 2020.

### Quality Schedule/ CQRG

A virtual Clinical Quality Review Group (CQRG) had been arranged for June; however this has been cancelled by the CCG; however all LPT reports have been submitted as per the schedule timings. A mapping of the reports has been approved at Quality forum to ensure all reports have an internal approval committee for scrutiny prior to submission for CQRG.

### Workforce update on returning nurses, International nurses and student nurses/AHPs

Seven staff have returned to LPT under the 'bring back' scheme, mainly on the bank as staff not confident to return to substantive posts due to length of time out of clinical practice. We are currently trying to maximise deployment and retention during the next 12 months to consider clinical skills and the support programme. Whilst we have not had any international nurses requested to join the temporary register, we are reviewing the student model to ensure effective plans are in place for Autumn 2020. Pre work has been completed and there is an emerging risk in relation to nursing student placement capacity; as an organisation in response to COVID-19 we have reduced our placement capacity from 262 places to 90 places as the majority of placements were in community teams. This has been addressed with Lead Nurses/AHPs to collectively respond to the Universities requests to meet an increased demand of new cohorts and how to place cohorts paused whilst also considering AHP and medical student placements. We are developing an LPT strategic placement programme outlining revised capacity for all students in collaboration with Universities and partners to include a programme of IPC training, PPE selection and don and doff training etc.

### Infection Prevention Control

The majority of the work for the Infection Prevention and Control (IPC) team continues to be in relation to COVID-19 and the requirements to support and protect patients and staff. In April the Quality Forum noted that Hand hygiene and Bare Below Elbows audits were not collected timely across all community teams, mainly in light of changes to working practices due to the impact of COVID-19. Although where present, the audits did assure that the compliance rate of IPC practices was good. However, following targeted discussions with the senior nurses and the IPC team, a quality improvement work plan has been commenced to review and increase hand hygiene audits. In May 2020 there was a considerable increase with 548 audits submitted, compared to 310 audits submitted in April 2020. Work continues to improve and sustain increased auditing and reporting. This will continue to be monitored within the Infection Prevention and Control Group meeting and subsequently reported into the Quality Forum.

The IPC Board Assurance Framework (BAF) and 6 monthly IPC report was well received at Trust Board in May and a revised subsequent IPC BAF has also been completed and will be presented to Board as a separate agenda item. There are identified gaps in assurance which have been noted within the self-assessment and an action plan has been developed which is being monitored through our Quality Governance forums. All actions have been added to the CQC action tracker for monitoring. Processes for swabbing, track and trace and zoning for patient admissions is in place and under constant review within the ICC and the Clinical Reference Group. Regionally, surveillance of any hospital acquired COVID-19 and reporting of COVID-19 outbreaks has been requested by NHSI and work has been progressed to accurately report and monitor internally.

A proposal paper to plan for the next seasons Flu campaign for staff is being developed and will be presented at the Strategic Executive meeting on the 3rd July.

A proposal to increase capacity into the IPC team has been agreed by the Executive team in the Combined Executive meeting on the 19th June 2020 and a recruitment plan is now in place.

**Safeguarding**

There has been a significant increase in contact by LPT staff to the Safeguarding advice line. As reported previously, the duration of the contacts has increased due to the complexity of the enquiries. The team continue to have oversight on Child Criminal Exploitation with daily briefings, updates and referral of new cases into the hub. The daily Multi Agency Risk Assessment Conferences (MARAC) continues for Domestic Abuse issues and the latest data suggests that the numbers of referrals into the MARAC has returned to its pre-lockdown levels. Prevent referrals continue and Chanel Panels as business as usual and MAPPA meetings continue as business as usual. The Child Death Overview Process (CDOP) continues to be robust and an ECDOP process is being tested for LLR, which is a national reporting process; throughout June the data will be migrated across with a full ‘live’ date anticipated end of June 2020. Throughout COVID-19, home visits with the police have not been undertaken; into recovery face to face enquiries alongside police colleagues plan to resume.

Within the Adult Safeguarding arena, throughout May there has been a noted increase in the number of ‘allegations against professionals’; most unsubstantiated and closed relating to bank staff. Further analysis is ongoing to investigate and take appropriate action. Noted increase in Safeguarding adult referrals to all three local authorities within LLR; LPT have delegated responsibility under the Care Act (2014) to undertake s42 (Safeguarding Enquiries) for inpatient services; also noted a slight increase in the number of s42 enquiries. This is being monitored within LLR Safeguarding Board work.

Within the Child Safeguarding arena there has been a continued increase in the number of strategy calls across LLR, and noted decrease in child protection medicals, which does not correlate to the increased referrals and s47 enquiries noted. However, the local authorities’

early analysis indicates higher prevalence of Domestic Abuse cases, which therefore might indicate why children are not requiring medicals due to being emotional abuse and harm. This is being monitored within LLR Safeguarding Board work.

LPT's bi-monthly Legislative Committee, which incorporates all Safeguarding agendas and assurances for both Adults and Children, continues to be held in a virtual format covering the main current areas of assurance and risk. However, during the recovery phase of COVID-19, in months when there is no Legislative Committee, there has been a safeguarding group meeting. This will be mandated to authorise safeguarding changes and have oversight of the rapidly changing landscape. The governance of this meeting will be through the Legislative Committee.

The majority of the work for the LLR system Safeguarding Boards had initially been postponed or scaled back significantly, however work is now beginning to recommence from what was being undertaken pre-Covid (albeit virtually). The safeguarding focus within LPT working across the LLR system is to encourage the consideration Covid as a factor in multi-agency reviews, which is also being monitored through the LLR Safeguarding Board work.

**Mental Health Act Office**

We have responded positively to the challenges COVID-19 has presented for our Mental Health Act Office (MHA) work, and we have successfully implemented new ways of working aligned to stakeholder organisations activity. There has been a noted increase in MHA activity since the beginning of COVID-19 and we have agreed a three month retrospective study to be undertaken in July to analyse discharges and readmissions under section during COVID-19, to establish if a number of patients have been readmitted during that time. The Tribunal Service has also noted an increase in activity to reflect general increase in MHA activity; which has placed a requirement on services to respond to and successfully implement new working practices (remote hearings) at very short notice.

The Managers Panel Hearings which were initially suspended have since been implemented as remote hearings and successfully reducing a backlog which had built up. For any Second Opinion Appointed Doctors (CQC provision) there has been a successful implementation of directions for remote ways of working and Independent Mental Health Advocacy has continued to work with and refer all qualifying patients to the providers of the IMHA Service (POhWER).

**Complaints**

As at 28th May 2020 there are currently 20 live complaints, 4 are new complaints received during the current pause, which following clinical review has been commenced. It is noted that a huge amount of effort and support has been received from each directorate to reduce complaints and the current position is a notable improvement during the last 2 years.

As a result of the national 'pause', 17 new complaints have been received. All have been triaged by the complaints team and clinically where necessary. The breakdown of paused complaints as at 28th May 2020 is:

- AMH – 9 complaints
- CHS – 4 complaints
- FYPC – 4 complaints

The current 'pause' will be lifted on 15th June 2020; earlier than the 30 June deadline. In readiness to receive the paused complaints each directorate is reviewing all paused complaints and will identify a lead investigator. All new complaints will then be processed in the normal way. An improvement piece of work has been undertaken to review and update complaint final response letters; supported by the Director of Nursing, Quality and AHPs. This is to ensure that there is a consistency in the way in which complaint responses are

written and to help to reduce the variation in responses currently taking place. This has been agreed and welcomed by the members of the complaints review group.

**PALS**

The PALS team have commenced undertaking patient experience surveys of the new Central Access Point Service and feedback to date on the service has been positive. A survey to understand the experience of patients who have had either a telephone or video consultation is due to commence w/c 8th June 2020. Feedback from the evaluation of the introduction of ipads, on wards for patients to connect with their families and loved ones has demonstrated that these have been positively received by both staff and patients and are providing positive experience. One comment received 'They are used when requested by the patient or if we feel the patient needs a boost from home, they have been fab to allow the patients to keep in contact with their families and made a massive difference to those who choose to use it'.

**Patient Involvement**

Patient and carers involvement work has continued, and flourished during COVID-19, through adapting to using digital media and email and through weekly virtual involvement groups. These include Skype meetings and Teams meetings where patients and carers can join in discussions and activities in relation to patient engagement. In partnership with our CCG and UHL colleagues a weekly patient experience and engagement meeting is now also taking place. The aim of this group is to develop a Leicester. Leicestershire and Rutland approach to engagement to support the Recovery and Reset work. The group will work closely with our communications colleagues and will consider and develop system-wide engagement opportunities that will support the delivery of the 10 system expectations, with a clear focus on expectation 3, involve our patients and public. An example of other key patient involvement work includes:

- Development of a working group establishing patient-led questions, value statements and scenarios to be used within recruitment processes and will be based on the new behaviours framework for the Trust.
- Development of a People's Council is well underway and invitations of expressions of interest to join are being circulated to local voluntary and community sector groups and organisations and individual patients and carers. The Council will launch in September with a proposed membership of 6/8 organisations and groups representatives and 6 patient and carer leaders.
- The design of a patient/carer leader programme has been finalised, which will commence in September 2020, delivered online through an external provider; all patients and carers applying for the People's Council will be requested to undertake the training.
- A fortnightly newsletter has been developed and is sent out to our service users and carers involvement group, local stakeholders and our Trust membership.

**Buddy Forum**

NHS Improvement has a responsibility for the provision of the necessary support in improvement, and as part of securing this support for LPT, NHS Improvement enlisted Northamptonshire Healthcare NHS Foundation Trust as our Peer Support Trust. The Buddy Forum meets on a regular basis and the areas below have been completed as key focus areas during the buddy arrangement in 2019-2020:

- Organisational Development (OD) support to the Executive Team
- Ongoing 'confirm and challenge' of the Requires Improvement Trust's CQC action plan
- Clinical Review (as required)
- Support with improvements required to strengthen governance, in particular quality governance
- General 1:1/Relationship including Comms Support

Further support for 2020/2021 has been agreed by NHSI and the Buddy Forum and the MOU has been updated to reflect five further work-streams; plans on a page have been created to ensure progress of work is continued in the following areas:

- Support OD/Development and Governance Support to the LPT Executive Team
- Quality Support building on Confirm and Challenge of CQC action plan/Development of Quality Improvement Plan
- Chief Nurse NHFT providing supervision and support to Acting Executive Director of Nursing, AHPs and Quality LP
- Quality & Safety Work
- Communications Support

**CQC**

Following submission of the PIR in February 2020, an analysis has been undertaken by the Assurance Team which highlighted a number of areas of development in the content and formatting of the data provided. In response to this, these have been added to the CQC action log for on-going development and monitoring. There is a robust communication plan in place to support preparation for the CQC inspection, which includes the Foundations to Great Patient Care forums, which are well attended and our 'Time to Shine' sessions which are being delivered over Microsoft Teams and are being very well received across the Trust. Our 'Buddy Relationship' with NHFT also continues to support our journey on the road to being 'Good' and better.

**Patient Safety**

Initially, COVID-19 seemed to have affected the commencement of some Serious Incident (SI) investigations due to difficulties in identifying investigators; this led to some SI's reports being submitted late. In addition, SI's already under investigation pre-COVID-19, have been affected by delays in investigator's being able to meet with staff, family/patients involved and changes in services/staff working practices. However, currently overdue SI reports are no greater than at other times. In the last month we have seen an increase in the number of investigator's available with prompt starting of investigations, and we are working to recover the 60 working days since lockdown, in terms of reports that have occurred and been investigated fully in this period.

The Patient Safety Improvement Group and the Incident Oversight Group continue to meet virtually, with robust Incident oversight of all incidents. The establishment of the weekly Incident Review Meeting continues to develop with the multi-professional review of incidents and decision making on the levels of investigations and theme incidents and share these with the ICC for information/action. There is also robust analysis of evidence relating to incident reporting during the pandemic; notably an initial reduction at the start of the pandemic, however we have noted a slight improvement and this is expected to return within normal limits as services resume; this will continue to be monitored.

There has been an increase in incidents reported as 'moderate' harm and 'death', some of which is related to the accuracy of recording the degree of harm as a result of an 'incident'. The directorate teams are reviewing these and the figures will be reconsidered. There has also been a slight increase in community suicide. There is good engagement providing good governance to decision making. The Learning lessons exchange group has been paused; however the Learning from Deaths Group and the Suicide Prevention group continues virtually.

**Conclusion**

The Trust continues to respond well to the COVID-19 pandemic, proactively supporting recovery and maintaining a business as usual mentality towards quality and safety in very

unusual circumstances. This has ensured that we have capacity to be as effective and responsive to the fast changing landscape and clarity that quality of care and patient and staff safety is of paramount importance to the Trust.

Leicestershire Partnership NHS Trust

| | | | | | |
|---|---|---|---|---|---|
| Meeting Name and date | Trust Board – 7 July 2020 | | | | |
| Paper number | L | | | | |
| Name of Report<br>Infection Prevention and Control Board Assurance Framework | | | | | |
| For approval | x | For assurance | x | For information | |
| Presented by | Dr Anne Scott Acting Director of Nursing, AHP's and Quality | Author (s) | Emma Wallis Associate Director of Nursing and Professional Practice<br><br>Dr Anne Scott Acting Director of Nursing AHP's and Quality | | |

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

| Report previously reviewed by | |
|---|---|
| Committee / Group | Date |
| Trust Board | 27th May 2020 |

| Assurance : What assurance does this report provide in respect of the Organisational Risk Register? | Links to ORR risk numbers |
|---|---|
| Inability to maintain the level of cleanliness required within the Hygiene Standards | 9 |
| The ability of the Trust to deliver high quality care may be affected during a Coronavirus COVID-19 pandemic | 40 |

| Recommendations of the report |
|---|
| To note and receive an updated BAF. To note the progress with the action plan to improve assurance for the 6 KLOE's identified as need improving. This report contains embedded documents throughout. These documents are available to view if needed – please contact Kay Rippin Corporate Affairs Manager. |

## Introduction

The original Infection Prevention Control (IPC) Board Assurance Framework (BAF) self-assessment documentation received from NHSI, was completed during May 2020 and presented to the Leicestershire Partnership NHS Trust (LPT) Board on 27 May 2020. This consisted of 47 KLOEs, and following the self-assessment process, 6 KLOEs were identified as requiring additional actions to improve assurance and a subsequent action plan was developed.

On the 22 May 2020, a revised version of the IPC BAF self-assessment documentation was received by NHS organisations across the UK from NHSI; this included a further 19 KLOEs that each organisation was required to complete. A further self-assessment process was completed by our IPC team to include the 19 new KLOE's and this has been incorporated into the original version of the BAF, updated below.

Following the self-assessment of the 19 new KLOEs, a further 8 KLOEs were identified as requiring additional actions to improve assurance, which have been themed where possible. There are now collectively 14 KLOEs that have been identified which require actions to improve assurance; these have been translated into 10 themes overall and 4 of the KLOEs relate to increased cleaning requirements. A final action plan has been developed for the identified KLOEs requiring further action and improvement for assurance and is included within the appendix of this paper.

The action plan is a working document and we await clarification on contact tracing for patients with new onset of symptoms. A few actions have already been achieved and evidence has been embedded within the action plan. This will be monitored through the Trust IPC group and updates will be provided to the Quality Forum and then to Quality Assurance Committee and to Trust Board.

# Infection Prevention and Control board assurance framework – LPT self-assessment – Updated version 1.2 22.05.20

| **1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users** | | | |
|---|---|---|---|
| **Key lines of enquiry** | **Evidence** | **Gaps in Assurance** | **Mitigating Actions** |
| Systems and processes are in place to ensure:<br>• infection risk is assessed at the front door and this is documented in patient notes | Infection status is assessed on admission/'at front door' to all in patient wards. In response to COVID 19 an in-patient action card was developed with prompts for staff to assess the risk and actions to take to manage/mitigate the risk<br>  <br>IPC-Action-Card-Inpatient v6 17 march 2( | Audit of patient notes to check status is documented | Daily sit-reps from directorates of infection status and IPC daily clinical reviews |
| • patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of | Evidence as above, action card provides information for staff to source isolate and cohort patients with possible | None identified | |

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| transmission<br><br>• compliance with the national guidance around discharge or transfer of COVID-19 positive patients<br><br>• patients and staff are protected with PPE, as per the PHE national guidance | or confirmed COVID-19. The only exception is for AMH patients, there is a patient pathway for patients who are suspected or confirmed COVID-19 to transfer to Beaumont Ward to reduce the risk of transmission associated with non-concordance with source/self-isolation to due impaired understanding and reasoning.<br><br>Action card developed in response to the guidance<br>  <br>Action-card-discharge-and-transfer-v4-13<br><br>Initially action cards were developed for the use of PPE when caring for patients with suspected or confirmed COVID-19; these were updated in line with PHE guidance and updates. Subsequently posters were developed as an easy read/access format all in line with PHE guidance. In addition action cards were developed for | None identified<br><br>None identified | Staff are accessing updated action cards on staff net in line with guidance |

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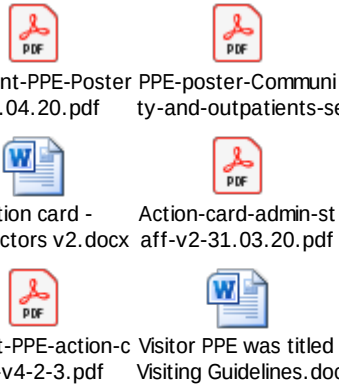
| • **all staff (clinical and non-clinical)** are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance | patients, visitors, admin staff & contractors.<br>  <br><br>Links to the above evidence | Training records<br><br>None identified | Local training records kept and from 22/06/20 to be linked through uLearn |
| • national IPC guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way | Establish training linked to the 2 mandatory levels of IPC training using video links and updating in line with COVID-19 | Identified within the individual risks | Identified within the individual risks |
| • changes to guidance are brought to the attention of boards and any risks and | Alerts in regard to updates to IPC guidance are sent through to the ICC inbox, the Trust Lead | | |

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| mitigating actions are highlighted<br><br>• risks are reflected in risk registers and the Board Assurance Framework where appropriate<br><br>• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens | for IPC also receives alerts. Any changes are then made to the relevant action card and communicated through the daily COVID-19 briefing<br><br>Changes have been highlighted through the ICC and ICC risk log for example shortage of PPE guidance and CAS alert<br><br>  <br>LPT response to PPE CAS ALERT 1.5.20.dc<br><br>COVID-19 Incident Control Centre (ICC) has a risk log, in addition all Organisational Risk Register (ORR) risks have all been reviewed in regard to the impact of COVID-19 with a specific ORR number 40 for COVID-19<br><br>IPC reporting systems for non-COVID-19 infections as per Trust policy and reported to the CQRG monthly and in the Trust IPC compliance reports | Introduction of the ICC has potentially created a gap in referrals noted to the IPC team for all infections | Receive weekly CDIFF data from the acute Trust, daily clinical patient reviews that picks up cases. Incident reporting system supports notification to the IPC team of any areas of infection. |
| **2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the** | | | |

| prevention and control of infections | | | |
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| **Key lines of enquiry** | **Evidence** | **Gaps in Assurance** | **Mitigating Actions** |
| Systems and processes are in place to ensure:<br><br>• designated teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas<br><br>• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas.<br><br>• decontamination and terminal decontamination | At the outset of the pandemic the Trust identified a number of COVID-19 suspected/confirmed wards;<br>• Beaumont<br>• Gwendolen<br>• East Ward<br>Priority training given for staff working in those wards including; don and doff and mask fit testing, available to all Trust staff both substantive and bank<br><br>Mask fit training is registered through uLearn<br><br>All cleaning teams have been trained in the use of PPE, donning and doffing of PPE and all dates of training are documented. Any new starter is trained as part of induction. Where possible we are rostering set teams to COVID-19 areas. | Training records for don and doff training delivered locally<br><br>None identified | Staff access to a uLearn video and don and doff posters |

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| of isolation rooms or cohort areas is carried out in line with PHE and other national guidance | Please see embedded documents which clarify cleaning procedures around isolation rooms and cohort areas in line with PHE guidance.<br>  SACLEBRA055 - Terminal Cleaning of I<br>  SACLEBRA056 - Isolation Cleaning of I<br>  SACLEOG010a - Cleaning Task Guidan<br><br>Developed an action card for cleaning and decontamination based on the PHE guidance<br>  Action-Card-Cleaning Decontamination.pdf | | |
| • increased frequency at least twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance | The Trust follow increased frequency for cleaning for any infection including COVID-19. Agency and temporary staff have been taken on to extend the hours of cleaning at the hospital sites in particular and to look at ensuring touch points and other high risk points are cleaned more frequently | None identified |  Poster - Back to basic Final.pdf |

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| attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas | See action plan and ICC actions on log to develop a cleaning specification for increased cleaning in light of updates on 22/05/20 | None identified | |
| • cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses | Chlorclean is used as per national guidance<br><br>Process established with procurement, IPC and Health and Safety to review any alternative products | | |
| • manufacturer s' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/products as per national guidance: | Followed as per guidance | | |
| • 'frequently touched' surfaces , eg door/toilet | See action plan and ICC actions | | |

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| handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice contaminated with secretions, excretions or body fluids | on log to develop a cleaning specification for increased cleaning in light of updates on 22/05/20 | None identified | |
| • electronic equipment, e.g. mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily | See action plan and ICC actions on log to develop a cleaning specification for increased cleaning in light of updates on 22/05/20 | | |
| • rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily) | The Trust does not currently have PPE removal rooms | | |
| • linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken | Linen is managed in line with PHE guidance and included in the clinical waste poster below<br>  <br>Clinical Waste Poster.pdf<br><br>Single use items are used | | |

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| • single use items are used where possible and according to Single Use Policy<br><br>• reusable equipment is appropriately decontaminated in line with local and PHE and other national Guidance<br><br>• review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission | where possible including gloves, aprons. Sessional use is also identified on the PPE poster and also reemphasised in the daily COVID-19 message on the 29 April 2020<br><br>Included within the action card for cleaning and decontamination and Trust policy<br><br>See action plan to address gaps in assurance | | |
| **3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance** | | | |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| Systems and process are in place to ensure:<br>• arrangements around antimicrobial stewardship are maintained<br>• mandatory reporting requirements are adhered to and boards continue to maintain oversight | Current arrangements are maintained.<br><br>AMR prescribing audit report presented to the last IPC group in February 2020<br><br>  <br>1778 T28D Antimicrobial Prescribi | None identified | |
| **4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion** | | | |
| **Key lines of enquiry** | **Evidence** | **Gaps in Assurance** | **Mitigating Actions** |
| Systems and processes are in place to ensure:<br>• implementation of national guidance on visiting patients in a care setting<br>• areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas clearly marked with | National guidance implemented and updated as per guidance changed<br><br>  <br>Visitor Guidance notice 13420.docx<br><br>Signage up in all areas, COVID-19 wards have specific signage | None identified | |

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| appropriate signage and have restricted access<br>• information and guidance on COVID-19 is available on all Trust websites with easy read versions<br>• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved | Yes, screenshot embedded<br>Screenshot of Trust web site.docx<br>Included in the in-patient, community and discharge and transfer action cards all previously embedded | None identified<br>We are not auditing this currently | National alert and major incident status, staff on high alert/ receiving services asking for status |
| **5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people** | | | |
| **Key lines of enquiry** | **Evidence** | **Gaps in Assurance** | **Mitigating Actions** |
| Systems and processes are in place to ensure:<br>• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross-infection as per national | Currently have designated COVID-19 wards with clear SOPs and arrangements in place to source isolate patients in single rooms where available and patients are cohorted in bays/dormitories if rooms not available and staff are cohorted where possible to minimise cross infection | | |

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| guidance<br><br>• mask usage is emphasized for suspected individuals |  SOP Isolation Ward (2).doc  COVID Entry Poster.pptx  Patient-PPE-action-card-v4-2-3.pdf | | Patient PPE action card developed with a risk assessment due to the potential risk of ligature/self-harm |
| • ideally segregation should be with separate spaces, but there is potential to use screens, eg to protect reception staff | Patient PPE action card developed with a risk assessment due to the potential risk of ligature/self-harm | | |
| • for patients with new-onset symptoms, it is important to achieve isolation an instigation of contract tracing as soon as possible | Advice and clarification being sought in line with NHS test and trace | | Advice and clarification being sought in line with NHS test and trace |
| • patients with suspected COVID-19 are tested promptly | All testing has been in line with PHE guidance and has been updated and changed as the testing model has changed. Action card for swabbing developed to support staff. | | |
| • patients that test negative | Yes, this is Trust procedure and has occurred on occasion as | | |

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| but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested<br><br>• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately | dictated clinically<br><br>Systems and process in place and rooms identified should this occur | | |
| **6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection** | | | |
| **Key lines of enquiry** | **Evidence** | **Gaps in Assurance** | **Mitigating Actions** |
| Systems and processes are in place to ensure:<br>• all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other guidance, to ensure their personal safety and working environment is safe | A programme of face to face don and doff training and mask fit test training for all staff commenced.<br><br>Staff have access to don and doff video training on uLearn<br><br>Mask fit testing must be face to face | Record of don and doff training | Posters and access to training video – to develop a don and doff audit |

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| • all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it<br><br>• a record of staff training is maintained<br><br>• appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed<br><br>• any incidents relating to the re-use of PPE are monitored and | Volunteering services ceased with the exception of community drivers<br><br>Action card developed for contractors – see embedded evidence section 1<br><br>As above<br><br>Donning & Doffing training carried out for staff by the IPC team, this was then cascaded to individuals in all areas so that the training can be rolled out.<br><br>Mask fit training register maintained on uLearn, a report is produced at the end of every week to identify pass and fails and the DNA (did not attend) rates.<br><br>Agreed the option of reuse of any equipment should be instigated only in extreme circumstances, instigated through the ICC with DoN, MD and IPC risk assessment and approval. | | Video for donning and doffing of PPE uploaded to uLearn<br><br>Staff training |

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| appropriate action taken<br><br>• adherence to PHE national guidance on the use of PPE is regularly audited | LPT response to PPE CAS ALERT 1.5.20.dc<br><br>Reuse not instigated at this point, see above<br>Risk assessment uploaded to ulysses | PPE audit form and assurance | PPE use is monitored through the daily PPE sitrep, that has trigger an IPC review if significant increased use noted or certain items unexplained increases |
| • staff regularly undertake hand hygiene and observe standard infection control precautions | Currently do not have an audit programme in relation to the use of PPE. | Noted decline in the number of hand hygiene audits and trust 5 marker audits during April however notable increase in May 2020 | Quality Improvement plan in place reporting through Quality governance route. |
| • hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance | Hand hygiene and Trust 5 markers of infection should be audited monthly<br><br>No hand dryers in clinical areas – exception is Charnwood Mill currently under review not accessed by patients. | | |

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| • guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas<br><br>• staff understand the requirements for uniform laundering where this is not provided for on site<br><br>• all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE and other national guidance if they or a member of their household display any of the symptoms. | See action plan poster under development<br><br>Uniform and work wear action card developed<br><br>  <br>Action Card Uniform and Work wear v 8.p<br><br>Information on staff net, action cards and daily COVID-19 briefings.<br><br>Evidence of this in the number of staff self-isolating due to themselves or a member of their household displaying symptoms, captured in the HR spread sheet and sitrep. | None identified<br><br>None identified | |

| **7. Provide or secure adequate isolation facilities** | | | |
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| **Key lines of enquiry** | **Evidence** | **Gaps in Assurance** | **Mitigating Actions** |
| Systems and processes are in place to ensure: | | None Identified | |

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| • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate<br><br>• areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance<br><br>• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement | Designated COVID-19 wards - source isolated with standard infection prevention and control precautions and transmission based precautions, also for patients displaying symptoms on any Trust inpatient area<br><br>The Trust is following PHE advice for cohorting compliant with environmental requirements. PPE posters and social distancing posters evidence the 2 metre distancing.<br>Review of bed base position and patient placement across the Trust – Feilding Palmer as an example<br><br>Patient reviews completed and risk based approach to patient placement. | | |
| **8. Secure adequate access to laboratory support as appropriate** | | | |

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| There are systems and processes in place to ensure:<br><br>• testing is undertaken by competent and trained individuals<br><br>• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance<br><br>• screening for other potential infections takes place | Action card to support staff<br>  <br>Action-Card-How to swab v1.pdf<br><br>Following national guidance that can be evidenced on ilab for patients and HR sitrep for staff<br><br>MRSA screening continues and staff following stool screening as per guidance | None Identified | |

| 9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections | | | |
|---|---|---|---|
| **Key lines of enquiry** | **Evidence** | **Gaps in** | **Mitigating Actions** |

| | | Assurance | |
|---|---|---|---|
| Systems and processes are in place to ensure that:<br>• staff are supported in adhering to all IPC policies, including those for other alert organisms<br>• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff<br>• all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance<br>• PPE stock is appropriately stored and accessible to staff who require it | Staff are supported to adhere to Trust IPC policies and the action cards developed in response to the COVID-19 pandemic<br><br>Actioned through the ICC, Clinical cell in conjunction with the IPC team. Communicated through the daily briefings or on the ICC calls<br><br>Yes<br>  <br>Clinical Waste Poster.pdf<br><br>Yes and daily sitrep is maintained and reported by procurement 7 days a week<br>All stock held centrally and figures managed to ensure the number of days stock is available | None Identified | |

| 10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection | | | |
|---|---|---|---|
| **Key lines of enquiry** | **Evidence** | **Gaps in Assurance** | **Mitigating Actions** |
| Appropriate systems and processes are in place to ensure:<br>• staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported<br>• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained<br>• consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national | Staff at risk groups have been identified including shielding staff, high risk or staff living with someone in that category. Information is held centrally with HR. A BAME risk assessment was issued to all BAME staff and line managers to be completed for all BAME staff.<br><br>We currently do not have any staff using a reusable respirator<br><br>See action plan<br><br>The Trust does not have planned and elective care pathways. Currently reviewing COVID-19 pathways for risk managed admitted pathway and relevant community non-admitted pathways | None Identified | |

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| guidance<br><br>• all staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas<br><br>• consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas<br><br>• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing<br><br>• staff that test positive have adequate information and support to aid their recovery and return to work. | Guidance for staff and posters on social distancing including in the staff briefings and at break/rest times. Review of areas in line with COVID-19 secure assessments. Trust have adopted face mask guidance issued on 13 June 2020<br><br>Monitored by HR and implementation of COVID-19 buddy system<br><br>Information available for staff whom test positive or a member of their household | | |

**Appendix: <u>IPC COVID-19 Board Assurance Framework – GAP analysis and actions</u>**

| KLOE identified gap in assurance | Action to improve assurance | Action owner | Date | Evidence | Progress |
|---|---|---|---|---|---|
| Infection risk is assessed on admission and documented in patient notes | Complete an audit of patient notes to check infection status is assessed | Amanda Hemsley<br><br>& Elena Relph | October 2020 | Audit report |  <br>IPC BAF gap analysis audits - Queries.msg |
| All staff clinical and non-clinical are trained in putting on (donning) and removing (doffing) PPE, what they should wear for each setting and a record of training maintained | Develop Trust PPE selection and donning and doffing training for clinical and **non-clinical staff**, **contractors, volunteers and students/learners**<br><br>**(Action on ICC log in relation to student training number 910)** | Greg Payne | 22/06/20 | Training resources<br>Training records | IPC team are preparing content for two e-learning courses, utilising Public Health England video clips. One course will match level 1 IPC requirements. The other will match level 2 requirements. These modules will be available as stand-alone courses and will also be attached to current IPC e-learning courses.<br><br>The courses will be defined as **<u>mandatory</u>** because IPC is listed as mandatory in the Core Skills Training Framework.<br><br>It is anticipated that 2 days of development will be required once |

| KLOE identified gap in assurance | Action to improve assurance | Action owner | Date | Evidence | Progress |
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| | | | | | the content has been received in Learning & Development.<br><br>There will be a communications campaign once a launch date is confirmed.<br><br>Anticipated launch date is Monday 22nd June 2020.<br><br>**Action complete 16.6.20** |
| Adherence to PHE national guidance on the use of PPE is regularly audited | Develop a system and process to monitor adherence | Laura Brown<br>And Elena Relph | 31/07/20 | System and process identified<br>Audit |  <br>IPC BAF gap analysis audits - Queries.msg |
| Staff regularly undertake hand hygiene and observe standard infection control precautions | Increase in the number of hand hygiene audits submitted monthly through the application | Heads of Nursing | 30/06/20 | Increased number of audits | Increase in May 2020 from 310 audits in April to 548 in May 2020 |
| Increased frequency, at least twice daily, of cleaning in areas that have higher environmental contamination rates<br><br>Attention to the | To develop a cleaning service specification to meet the PHE national cleaning guidance for in-patient areas<br><br>**(Action on ICC log number 907)** | Helen Walton/Amanda Hemsley<br><br>Helen | 30/06/20<br><br>30/06/20 | Updated cleaning service specification<br><br>Updated cleaning |  <br>Action Detail 907 (3).docx<br><br>Following the IPC group meeting 10/6/2020, Helen |

| KLOE identified gap in assurance | Action to improve assurance | Action owner | Date | Evidence | Progress |
|---|---|---|---|---|---|
| cleaning of toilets/bathrooms<br><br>Frequently touched surfaces such as door/toilet handles, patient call bells, over bed-tables, bed rails decontaminated at least twice daily and when known to be contaminated with secretions or body fluids<br><br>Electronic equipment, e.g. mobile phones, desk tops and keyboards should be cleaned at least twice daily | To identify cleaning roles and responsibilities for clinical staff and staff working in non-clinical areas that fall outside the cleaning specification | Walton/Amanda Hemsley | | service specification | Walton has agreed to set up a task and finish group to work through the actions required in order to achieve the action outcome – revised cleaning specification<br><br>**Task and Finish Group meeting on 18 June 2020** |
| Review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission | Review of ventilation in all admission and waiting areas actions to be divided;<br>a) Ventilation Authorised Engineer to develop a specification for the ventilation review<br>b) Contractor to review all admission and waiting areas | Helen Walton/Ventilation AE<br><br>Contractor to be procured following specification | 29/6/20<br><br>31/07/20 | Review specification<br><br>Review report | |

| KLOE identified gap in assurance | Action to improve assurance | Action owner | Date | Evidence | Progress |
|---|---|---|---|---|---|
| | | advised | | | |
| Ideally segregation should be with separate spaces, but there is potential to use screens | Current premises review and in-patient zoning plans | Heads of Nursing | 22/06/20 | Zoning plans<br>Zoning of Patients in Inpatient Settings.do<br>Option Appraisal to Implement Covid19 Z<br>FYPC Langley.docx<br>FYPC CAMHS.docx<br>Community Hospitals Option Appraisals RA | All presented to the executive team 12.6.2020<br><br>**Action complete** |
| Patients with new onset symptoms – instigation of contact tracing as soon as possible | Clarify expectations in line with the NHS Test and Trace programme<br><br>Develop a clear system and process to escalate to local public health experts to commence tracing for patients with new onset symptoms in health-care settings | Emma Wallis/Amanda Hemsley | 29/06/20 | | To contact CCG and PHE to clarify expectations and responsibilities in relation to contact tracing for patients with new symptoms |
| Guidance on drying should be displayed in | Identify a national poster for hand drying to be displayed | IPC team | 22/06/20 | Final poster in all areas | Poster in progress to incorporate hand |

| KLOE identified gap in assurance | Action to improve assurance | Action owner | Date | Evidence | Progress |
|---|---|---|---|---|---|
| all public toilet areas as well as staff areas | | | | | drying |
| Consistency in staff allocation is maintained, with reductions in the movement of staff between different areas | Staff teams allocated to zoning<br><br>Review of staff who cross wards/areas<br><br>Temporary staff impact | Heads of Nursing | 29/06/20 | Staff rotas for zoning/segregated areas<br><br>See zoning plans | **Action complete** |

Leicestershire Partnership NHS Trust

| | |
|---|---|
| Meeting Name and date | Trust Board 7th July 2020 |
| Paper number | M |

| |
|---|
| Name of Report: Patient Safety Incident and Serious Incident Learning Assurance Report for April and May 2020 |

| | | | | | |
|---|---|---|---|---|---|
| For approval | | For assurance | x | For information | x |
| Presented by | Dr Anne Scott<br>Acting Director of Nursing/AHP's & Quality | Author (s) | Tracy Ward<br>Head of Patient Safety | | |

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

| Report previously reviewed by | |
|---|---|
| Committee / Group | Date |
| | |
| | |
| Assurance: What assurance does this report provide in respect of the Organisational Risk Register? | Links to ORR risk numbers |
| That incidents are reported and escalated for appropriate investigation. Investigations are robustly undertaken and learning identified and shared. | 1 and 3 |

**Recommendations of the report**

Review and confirm that the content and presentation of the report of the incident provides assurance around all levels and categories of incidents.
Acknowledge that development of reporting is on-going and the presentation of the report may change as this develops.

- Be assured on the performance of SI report completion and the work to improve
- Be assured on the compliance with 'Being Open' and Duty of Candour'.
- Be assured systems and processes are in place to ensure effective investigations are undertaken that identify appropriate learning.
- Be assured that the quality assurance of these processes is continually reviewed

# Incident and Serious Incident Learning Assurance Report for April & May 2020

## Introduction

As we move into the Recovery phase of COVID19, the Corporate Patient Safety Team (CPST) continues to work to monitor the safety of all patients and meet virtually monthly. All reported incidents are reviewed to monitor for emerging themes and analysed as we see the changing guidelines and phases. Those that are COVID-19 related are actioned and shared with the Incident Control Centre (ICC) team each Friday to provide insight and to monitor for unintended consequences of COVID-19. All urgent incidents will be escalated immediately. Serious incidents (SI's) have continued to be investigated and submitted as close to the 60 working day deadline as possible. All SI's declared since COVID-19 has included a terms of reference question asking for the investigation to consider the impact of COVID-19 on the patient/family and service provision.

## Purpose of the Report

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

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

## Analysis of Patient Safety Incidents reported

Appendix 1 contains all of the Statistical Process Control (SPC) charts utilising the NHSI Toolkit that are shared to support the narrative and analysis below.

## All incidents reported across LPT in April and May 2020

Numbers are not seen as a good indicator of safety, however, these are monitored and in March there was a reduction considered to be related to changes in service delivery and staff moving in to 'major incident' mode and other lines of reporting. Staff continue to be reminded that incident reporting is important at this time to monitor for unintended consequences of actions. During April and May numbers have gradually increased.

## Review of Patient Safety Related Incidents

### 1. Pressure Ulcers

**Patients affected by pressure ulcers developed whilst in LPT care**

In April and May 2020, there were no 'hospital acquired' grade 4 Pressure Ulcers; those reported were acquired or deteriorated from a lesser grade in the community. The previous reports identified a reduction in patients affected by Grade 4 Pressure Ulcers however; there has been a slight increase in reporting and an upward trajectory. Evidence illustrates that the acuity of patients on district nursing caseloads is increasing due to the shift from inpatient hospital care. In addition, one post COVID-19 symptom, extreme fatigue, is affecting the mobility of some patients and their nutritional status thus increasing their risk of pressure damage.

**Learning identified:**

There has been a clear improvement with the focus on SSKIN Assessment compliance.

- There is a delay though in the formulation of these risks into a personalised care plan
- Waterlow scoring is not always accurately reflecting all patients risk factors and therefore not resulting in appropriately targeted preventative measures.

- There is an overarching “your skin matters” action plan that incorporates actions for all of these areas.

**Pressure Ulcers on Admission not attributable to LPT care**
The data continues to illustrate a consistence in reporting directly attributable to the focus and training becoming embedded since the process changed in April 2019. There is also increased scrutiny to support the monitoring by the CPST. Guidance released in April 2019 by NRLS, “Implementing the Revised 2018 Pressure Ulcer Framework in Your Local Reporting System” requires that pressure ulcers identified on admission are attributable to the reporting organisation and is now reported to NRLS (previously would have been reported as ‘no harm’).

**2. Falls**

Across the Trust there has been an increase in the number of falls reported, likely related to the acuity of patients. There has also been an increase in the number of patients who have fallen multiple times. The falls group continue to meet and monitor all falls and the CPST support this work offering additional scrutiny. In response, CHS are focussing on the quality of post falls huddles to encourage the identification of new interventions to reduce risk; highlighted as a ‘needs to improve’ in compliance.

In addition a wider weekly meeting acts as an intervention for the wider team to review patients who have fallen more than once to provide ‘fresh eyes’, expertise and challenge. The CPST team are part of the Falls Steering and scrutiny group providing additional analysis and professional challenge for patients who have repeatedly fallen regardless of diagnosis.

**3. All Self- Harm including Patient Suicide**

The suicide and self-harm reduction group have asked for a task and finish group to look at the Trusts approach to self-harm and recommend areas for development
There was a sharp rise in self-harm ‘moderate and above incidents’ in January 2020 along with a decline in February. May 2020 has seen a rise in self-harm incidents of moderate and above. To truly understand this and the category of patients it affects, i.e. adults and young people further work is required. Many incident investigations/reporting also included ‘COVID19’ as a contributory factor due to change in access/support/isolation. Nationally, this is an area of clinical focus in relation to the impact of COVID19 on patients living with mental health conditions.

**4. Suicide Reduction**

LPT are part of the LLR multi agency approach to suicide prevention which focusses on patients in the wider community as well as being under the care of LPT. During this unprecedented time the Suicide Prevention lead is ensuring that we are working with partner agencies to support patients/staff and the wider community. It is difficult to consider numbers of suicides in isolation however there does appear to have been an increase in community suicides of patients both under the care of LPT and not under the care of LPT.

**5. Zero Suicide for In-Patient Ambition Plan 2019/20**

NHSE have worked with NHS Trusts to support and develop a zero approach to in-patient suicides resulting with a Trust-wide plan. This includes patients on authorised and unauthorised leave. Whilst developing this and on review of our local data, the focus of this work has been extended to include patient’s within 10 days of discharge and patients under the care of the Crisis Team.

The group are aligning their work with the learning from the National Confidential inquiry into suicide and as such are concentrating on collaborative care planning with patients and including families were appropriate to create robust networks for patients. The plan will be governed by the Suicide Prevention Group and monitored against progress by the Learning from Deaths Group.

### 6. Violence, Assault and Aggression (VAA)

There has been an increase in overall VAA across the trust; this category of incident features in 2 out of 3 Directorate top 5 incidents due to changing in the directorates in May 2020. The Mental Health Directorate are developing an multi-faceted Quality Improvement approach to addressing this area and plan to share Trust-wide.

### 7. Medication incidents

Medication incidents are reviewed locally and the use of the BESS medication error tool to facilitate learning and a fair approach to supporting and managing staff following medication errors is well established. In May it was identified that over a period of 5 months the CPST has recognised an increasing number of insulin related incidents reported in CHS, both near misses and actual incidents. The Directorate are undertaking an analysis of these incidents along with best practice and professional drivers and will provide a report to PSIG in July 2020.

**Directorate Incident Information**

2 additional slides for information are included within Appendix 1, which detail the top 5 reported Incidents for each Directorate illustrating the level of diversity. Violence and Aggression has been reported in the top 5 reported incidents across the 2 clinical directorates, which demonstrates some of the challenges that the clinical teams face across the Trust.

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

There continues to be some identified time delays between submission and response related to 'non closure', the CPST are working closely with the CCG to facilitate and actively chase feedback following their sign off process. Coroners inquests are temporarily suspended. The CPST are liaising directly with the CQC to respond to queries as they arise and this is working well.

**Learning Lessons and Action Plan Themes**

### 1. Pressure Ulcers

The Pressure Ulcer Scrutiny Template enables the Nutrition and Pressure Ulcer Group to capture themes from lessons learnt for all pressure ulcers developed / deteriorated in 'our care'. The previous theme of completion and review of SSKIN has seen an improvement and has been a focus on the action plan. An ongoing review of any pressure ulcer serious incident investigation reports is routinely undertaken by lead nurses within the CHS Directorate and any key identified new issues are also added to the action plan.

### 2. Falls

There continue to be 5 key messages from the Falls Steering Group:

1. **Bed Rails / Low Bed Assessment** - Ensure assessments are completed for use of bed rails/low beds and consider the safest option for the patient Clinical reasoning must be completed and included in the patient's record. There is now Low Bed Assessment Tool that has had final consultation.
2. **Use of Crash Mats or Mattress** - For frail patients who are unlikely to try to get out of bed normally but at risk of rolling and falling from bed consider the use of a mattress rather than normal crash mats.
3. **Reassessment of Patients who Fall** - Consider reassessing a patient who has fallen, even if they did not incur harm, 24 hours after their initial fall to check for delayed pain or change of condition.
4. **Huddles - Post Fall Huddles** should be carried out as soon as practicality possible following a patient fall. The 'Remember—Huddles' campaign allows all staff, regardless of grade, to provide feedback and analyse why a patient fell. This is an area that is yet to be fully embedded.
5. **Falls CQUIN Goals (CHS)** - requires all patients to have a lying to standing Blood pressure recorded and a medication review during their stay and to ensure that each patient receives a mobility assessment within 24 hours of admission; a focus of the Falls Steering Group.

**Duty of Candour**

There were no declared Duty of Candour breaches for April/May 2020 from Directorates. The CPST continue to monitor the application of duty of candour and support staff to ensure this is compassionately applied.

**Incident Review Process**

The CPST has developed a new process that has been shared with all three directorate governance teams, Safeguarding Team, Health and Safety Team and the Patient Involvement and Experience Team which began in March 2020. Weekly meetings have been commenced to discuss incidents or complaints that may meet the criteria for a higher level of investigation. This is a process used in other organisations and encourages multi-professional discussion and a more structured approach to identifying appropriate investigation methodology. The multi professional input is positive.

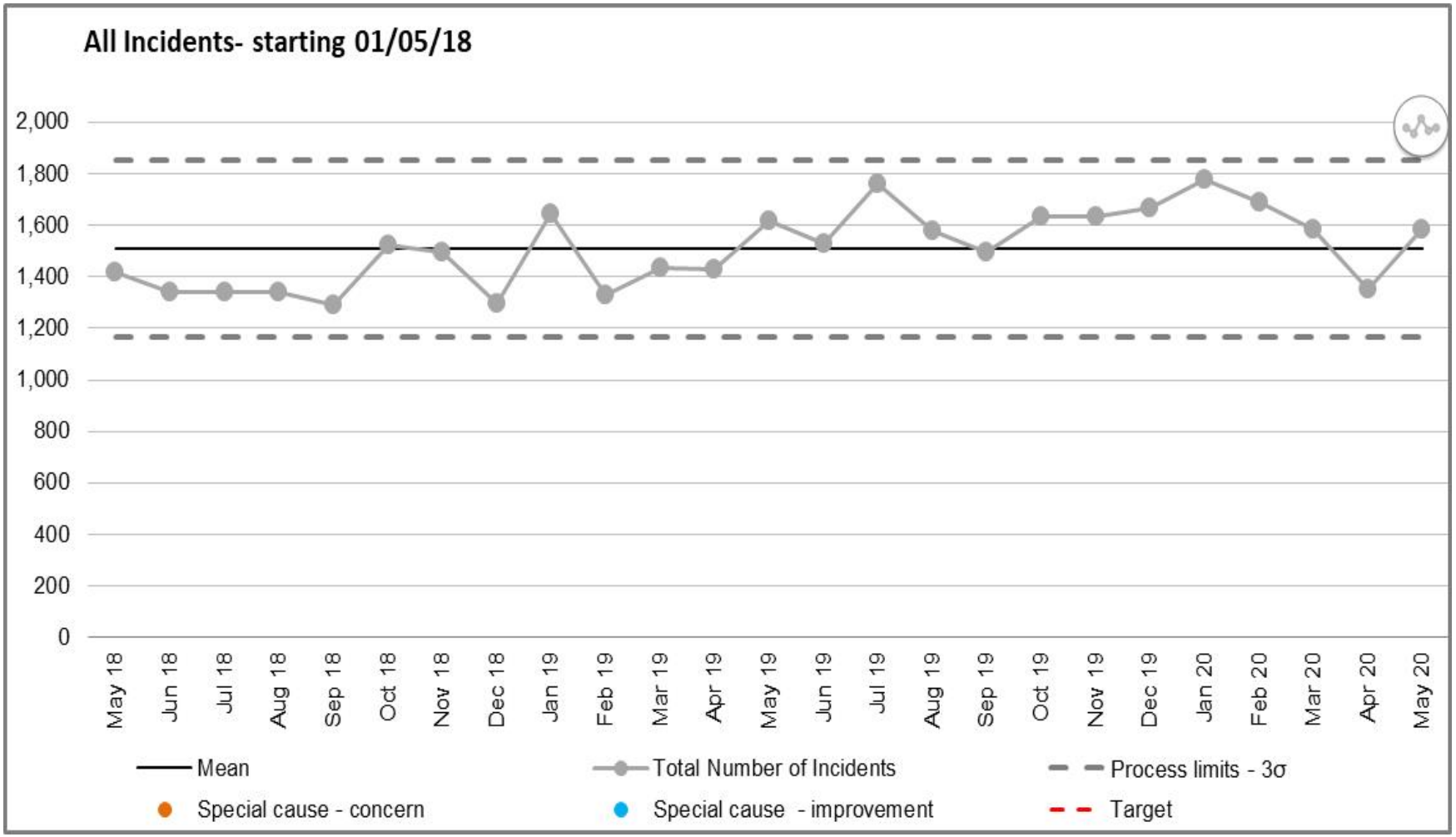
There has also been an introduction of new design to individualised 72hr Templates (ISMR) based on SBAR, human factors, Resuscitation Council/Sepsis Challenge and national suicide enquiry methods for gathering information to support the incident investigation decision. The incident oversight group has been monitoring the completion of serious incident action plans, there has been a deterioration in the position in relation to compliance which directorates are working to address ensuring robust oversight of action plan completion.

The new SI framework has been published (Patient Safety Incident Response Framework) which is different to previous frameworks and is encouraging a focus on inquisitive examination of a wider range of patient safety incidents in the spirit of “reflection and learning” rather than as part of a “framework of accountability” anchored in the principles of openness, accountability, learning and continuous improvement. The patient safety team are working through this guidance and will provide an executive briefing in relation to the key changes.

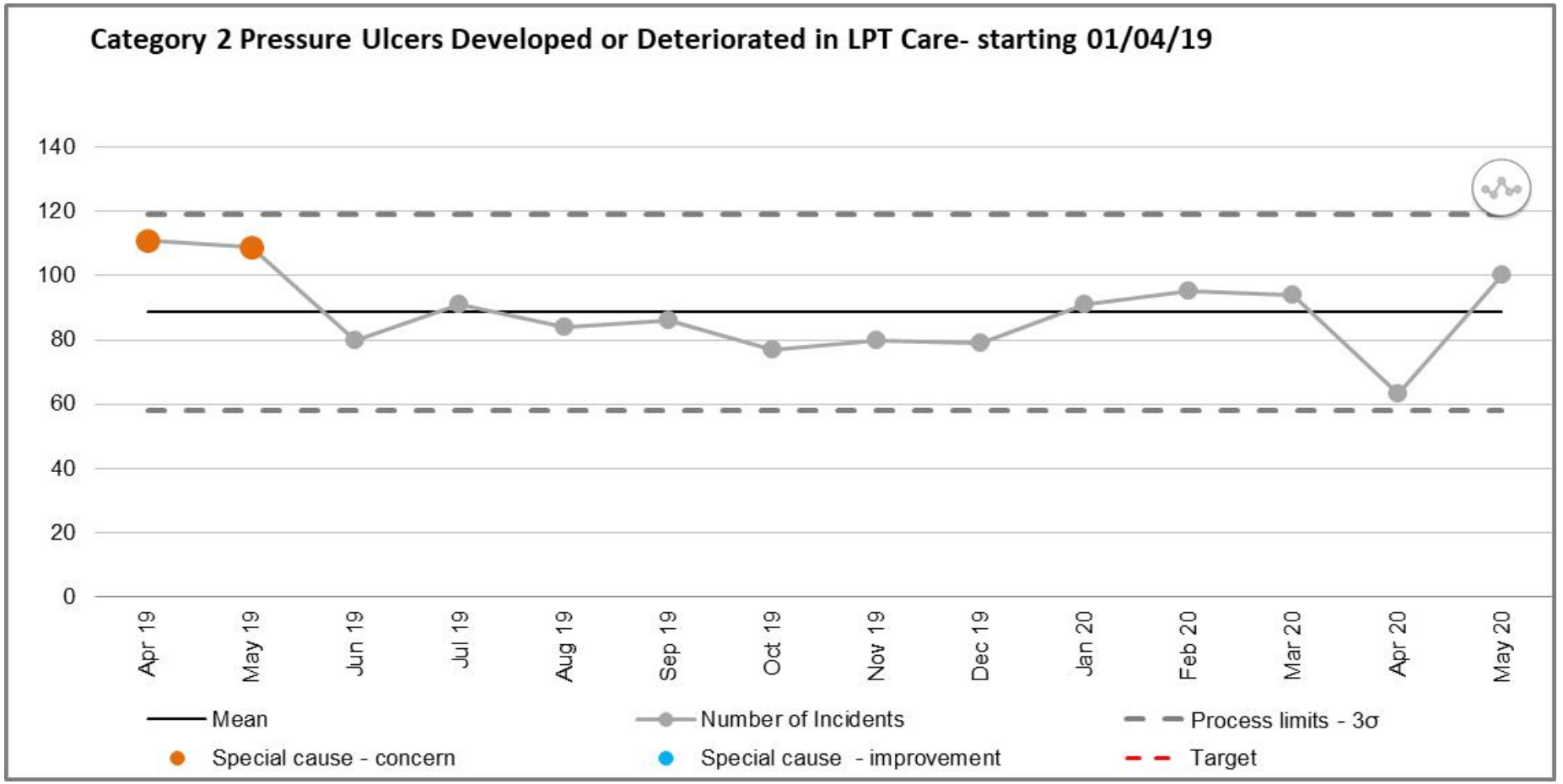
# Appendix 1

- The following slides show Statistical Process Charts of incidents that have been reported by our staff during April & May 2020 (there has been a change of specialities management during this time in relation to Top 5 incidents)
- Any detail that requires further clarity please contact the Corporate Patient Safety Team

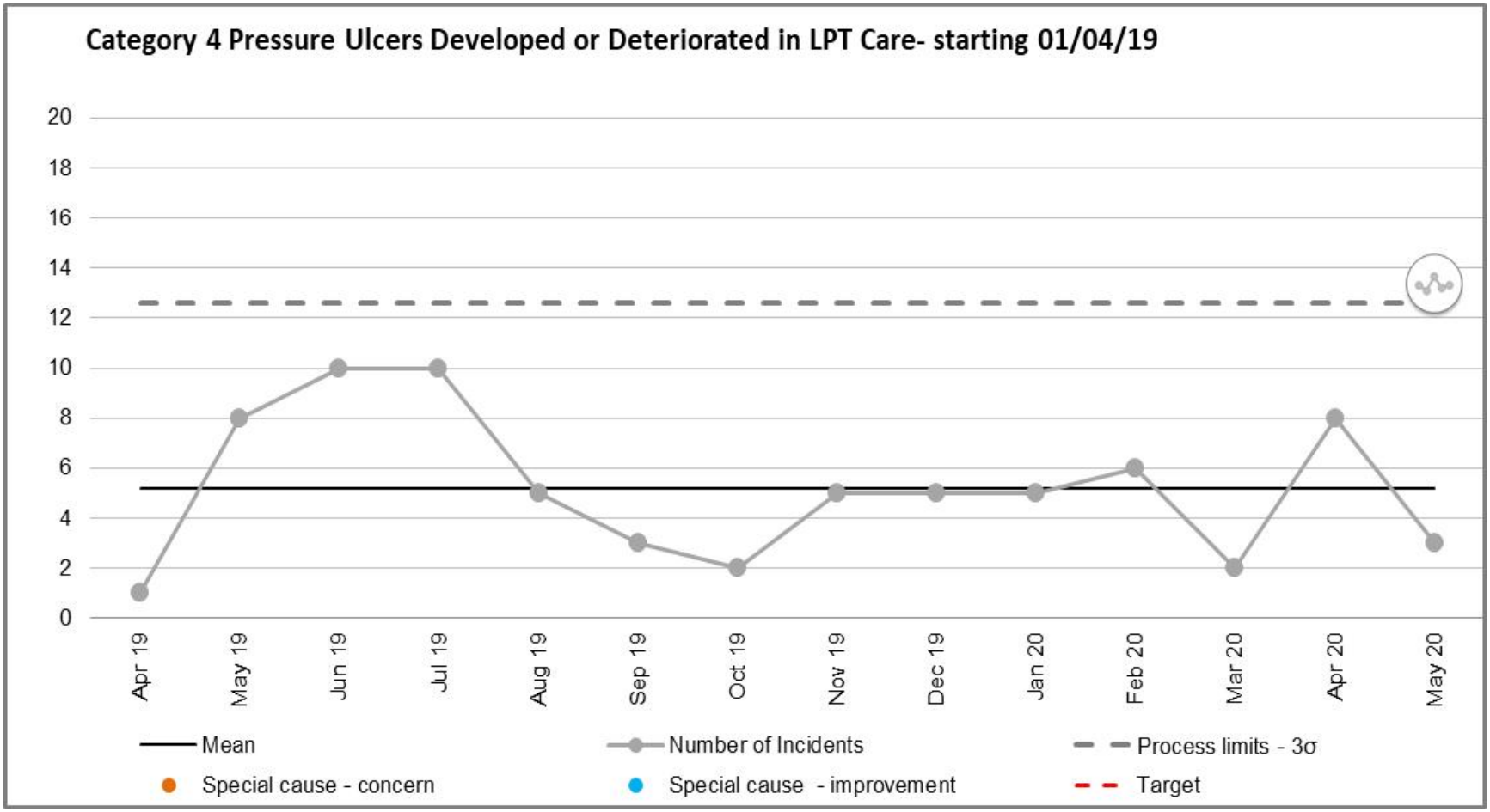
# 2 - All Incidents Reported



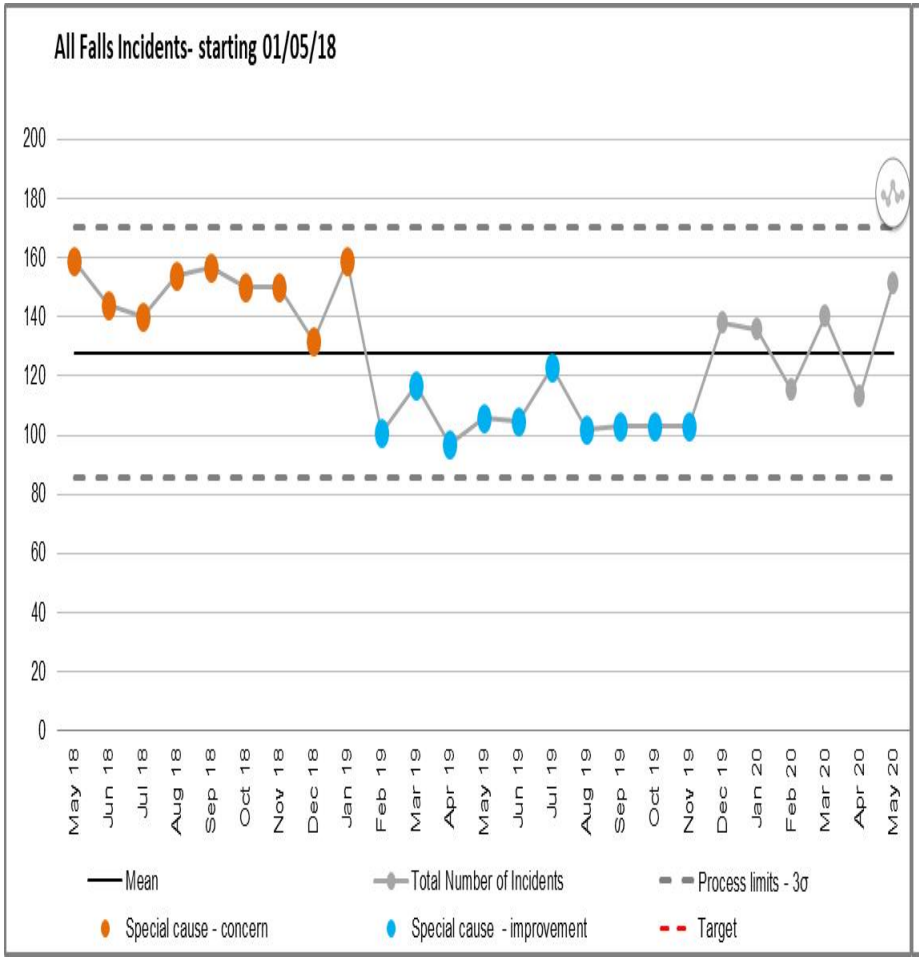
# 3a. Pressure Ulcers Grade 2

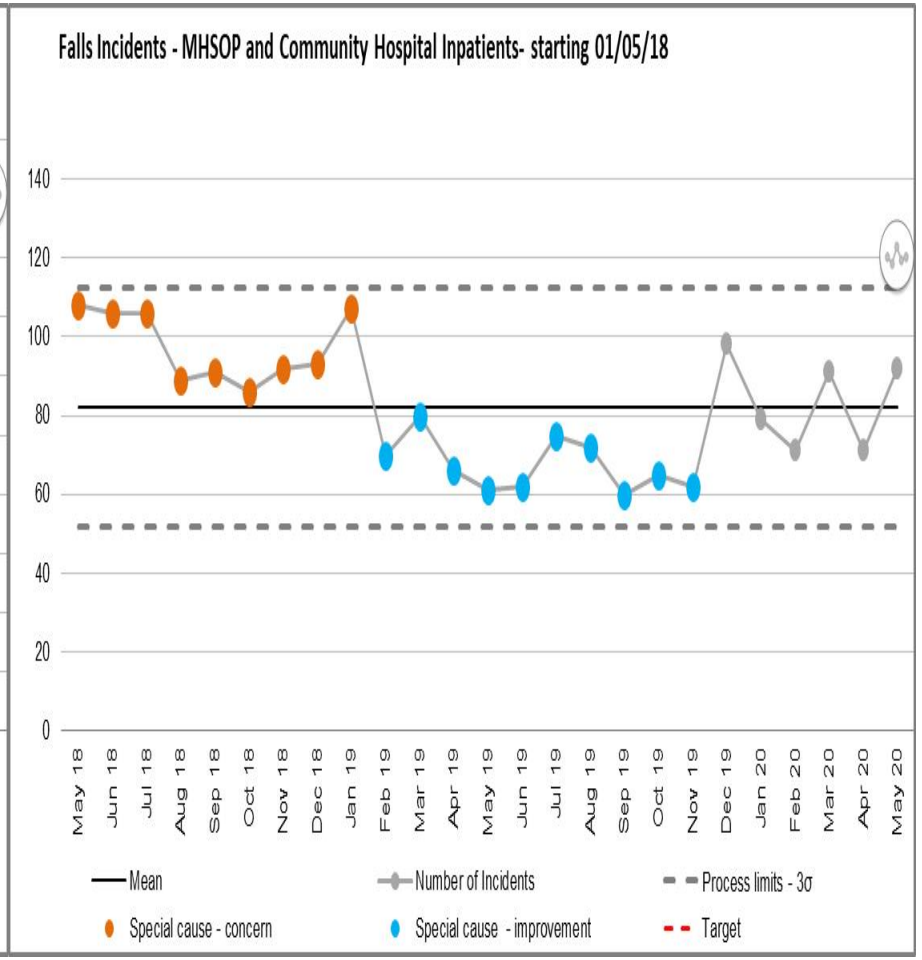


# 3b. Pressure Ulcers Grade 4

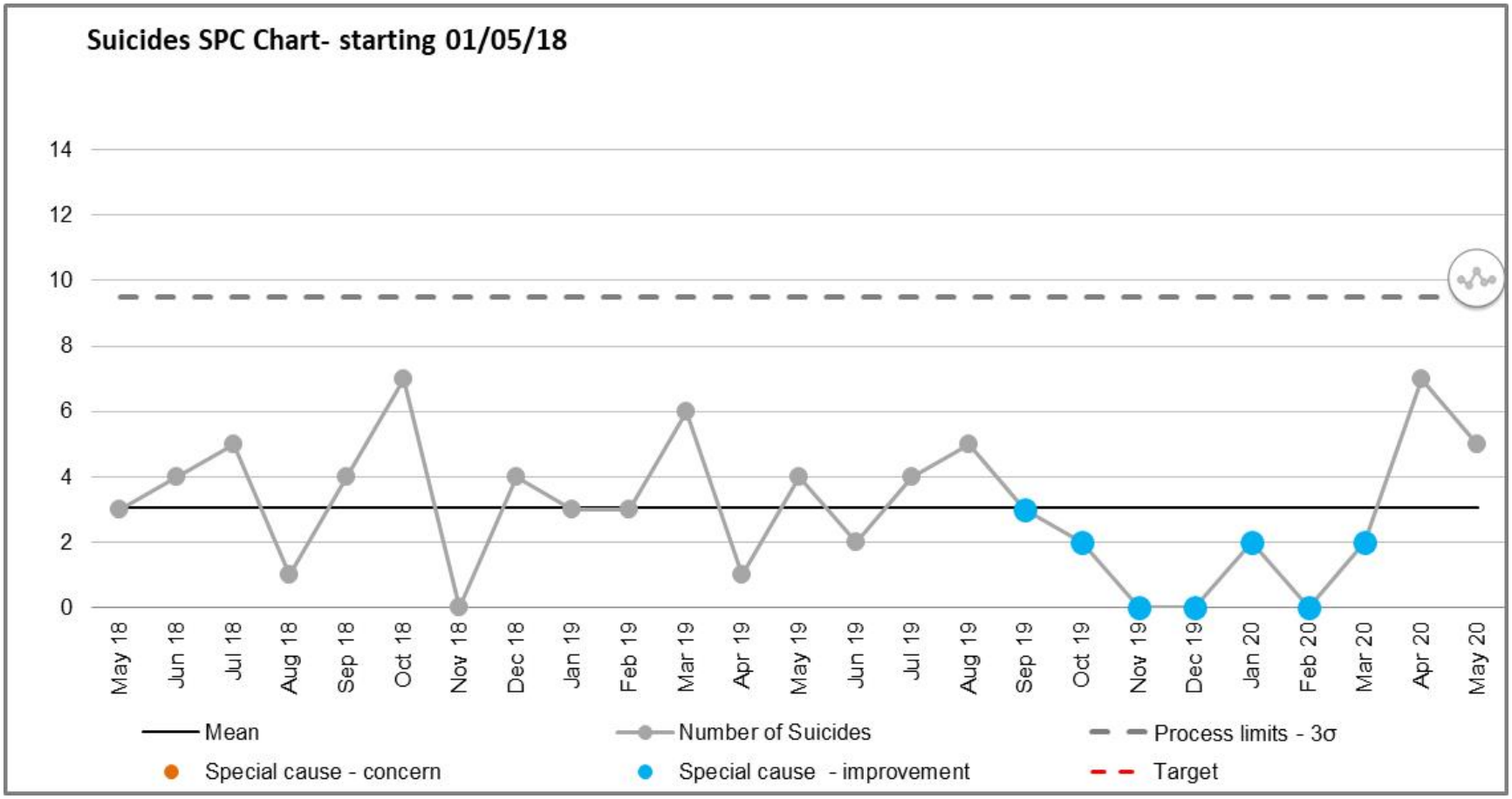


# 4. Falls

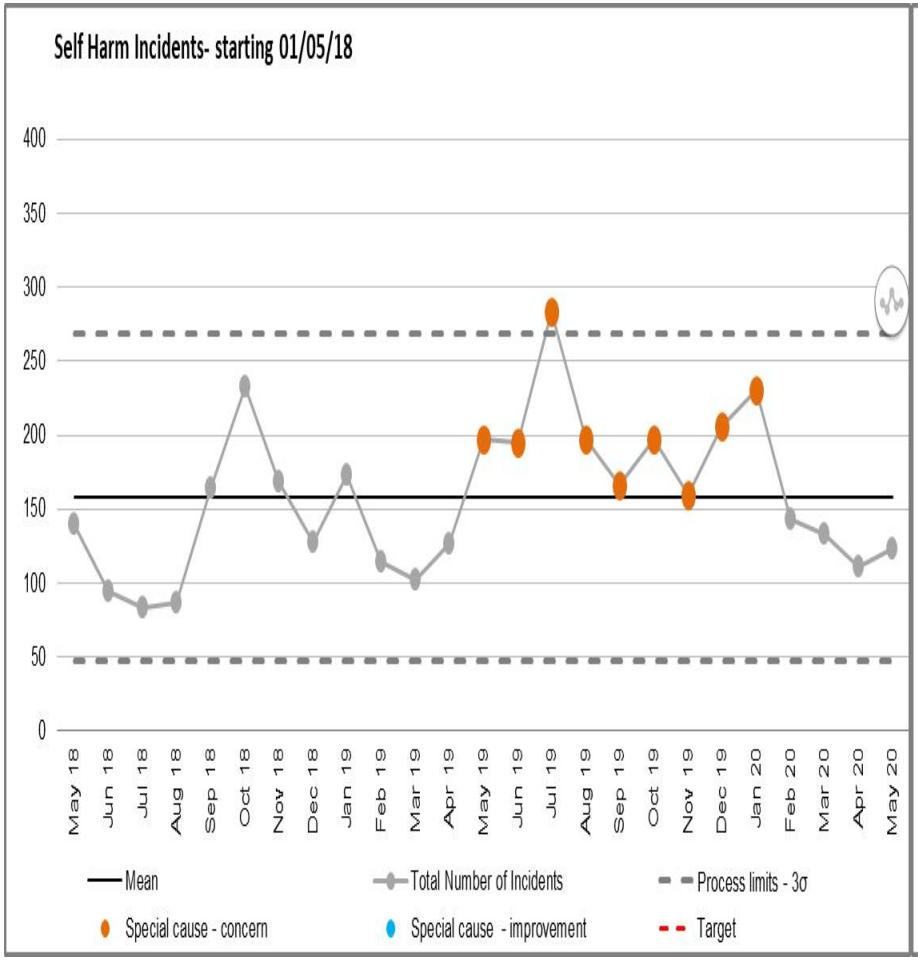

All Falls Incidents- starting 01/05/18
200
180
160
140
120
100
80
60
40
20
0
May 18
Jun 18
Jul 18
Aug 18
Sep 18
Oct 18
Nov 18
Dec 18
Jan 19
Feb 19
Mar 19
Apr 19
May 19
Jun 19
Jul 19
Aug 19
Sep 19
Oct 19
Nov 19
Dec 19
Jan 20
Feb 20
Mar 20
Apr 20
May 20
Mean
Total Number of Incidents
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

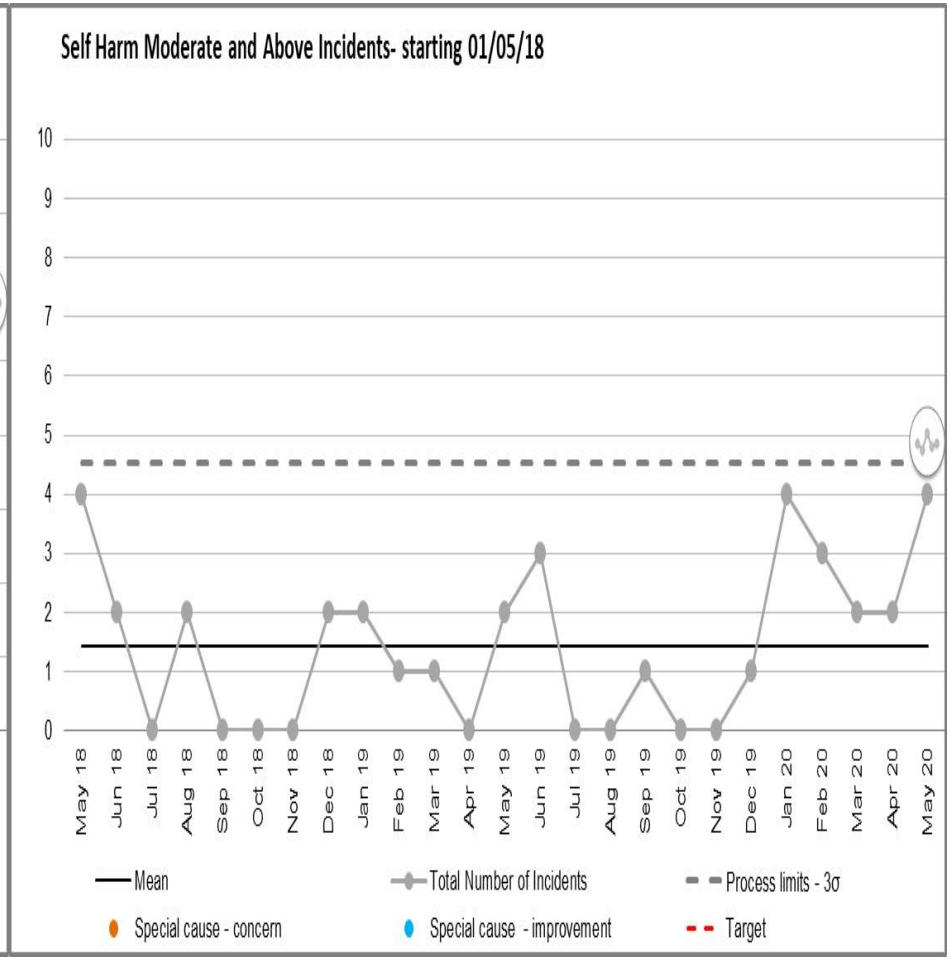

Falls Incidents - MHSOP and Community Hospital Inpatients- starting 01/05/18
140
120
100
80
60
40
20
0
May 18
Jun 18
Jul 18
Aug 18
Sep 18
Oct 18
Nov 18
Dec 18
Jan 19
Feb 19
Mar 19
Apr 19
May 19
Jun 19
Jul 19
Aug 19
Sep 19
Oct 19
Nov 19
Dec 19
Jan 20
Feb 20
Mar 20
Apr 20
May 20
Mean
Number of Incidents
Process limits - 3σ
Special cause - concern
Special cause - improvement
Target

# 5a. Top Reporting Incidents by harm 'not numbers' Patient Suicides

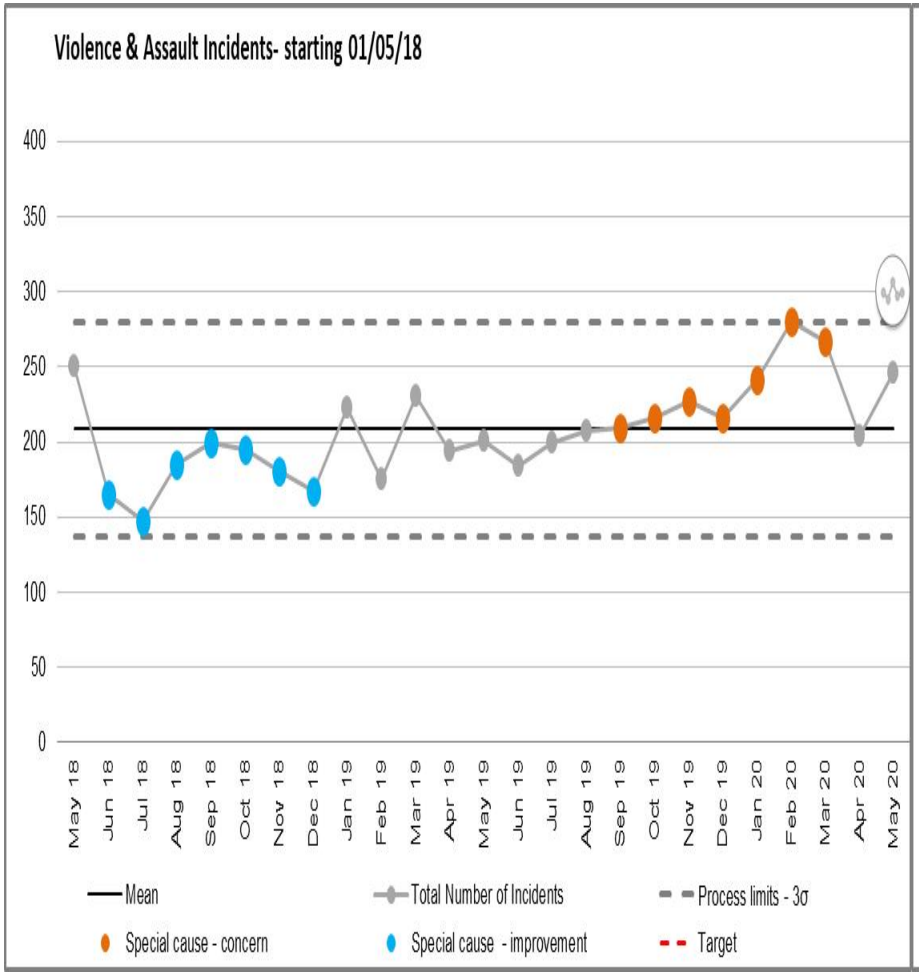


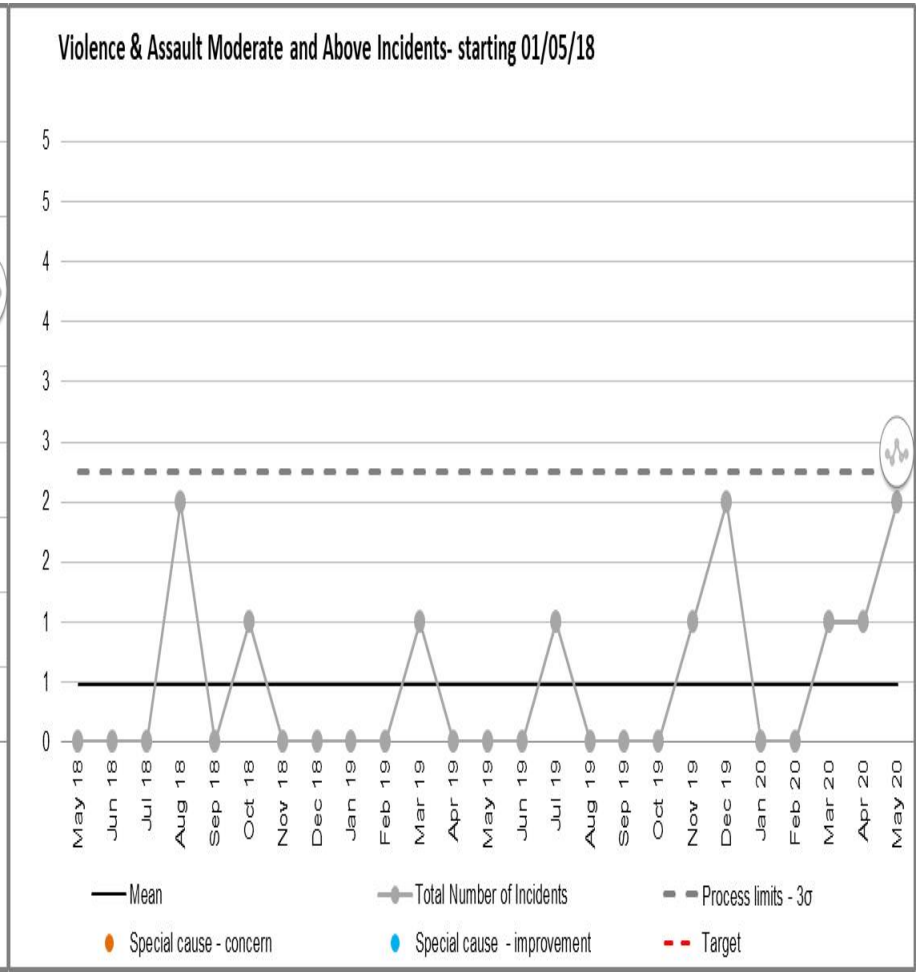
# 5b. Top Reported Incidents by harm 'not numbers'
# Self - Harm



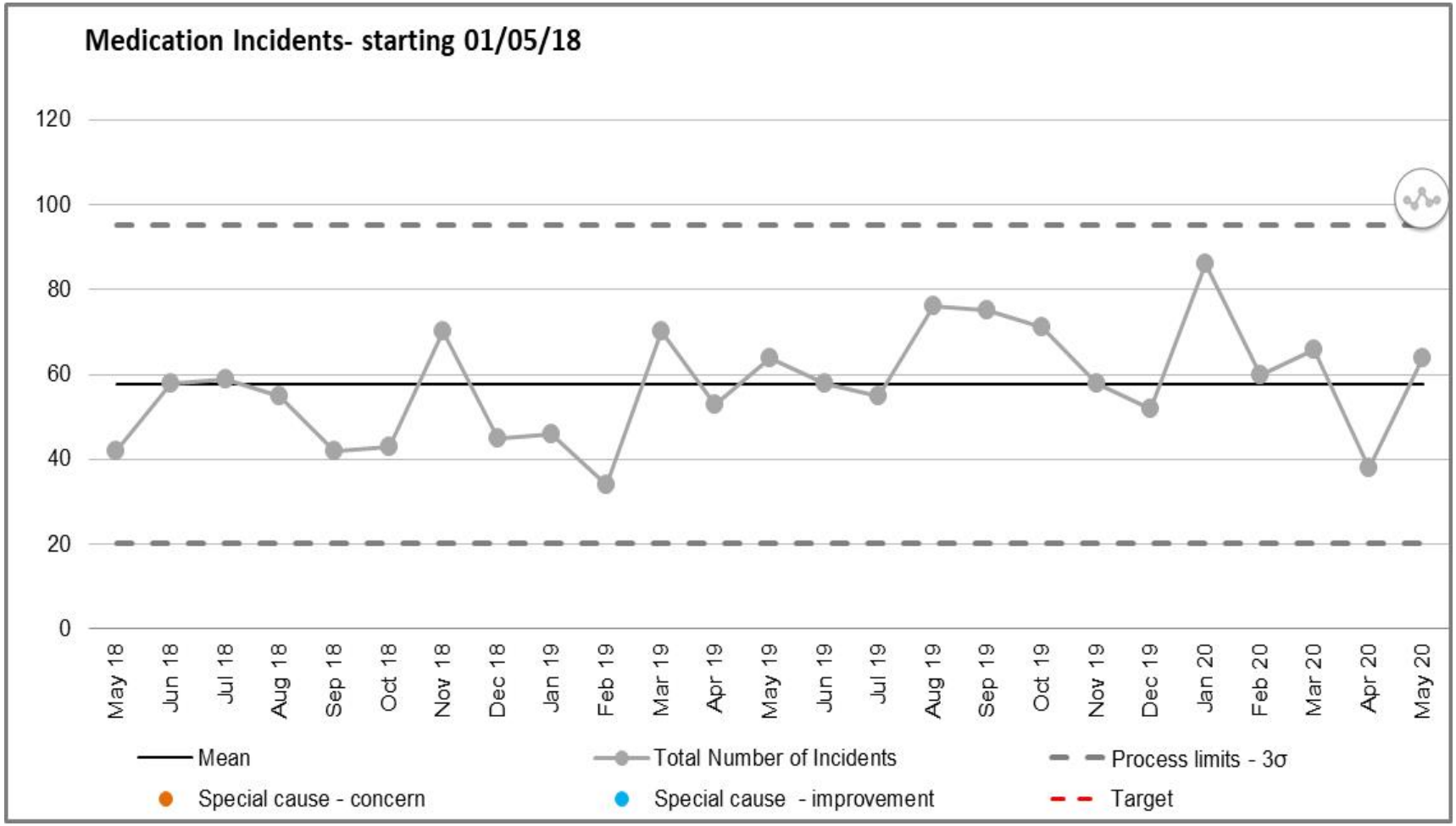



# 6a. Top Reported Incidents by harm ‘not numbers’ – Violence, Assault and Aggression



# 7a. Medication Errors across the Trust



# 8a. Directorates Top 5 Reported Incidents

**AMH/LD (became just MH at start of April 2020, then Mental Health start of May 2020**

| | |
|---|---|
| 1. Violence/Assault | ↓303 |
| 2. Patient Falls, Slips, And Trips | ↑131 |
| 3. Self Harm | ↔124 |
| 4. Missing Patient | ↓48 |
| 5. Clinical Condition | 45 |

**FYPC (became FYPC/LD at start of April 2020**

| | |
|---|---|
| 1. Violence /Assault | ↑114 |
| 2. Self Harm | ↑105 |
| 3. Communication | ↑17 |
| 4. Case Notes & Records | ↑16 |
| 5. IT Equipment/Systems | 16 |

# 8b. Directorates Top 5 Reported Incidents

**CHS (MHSOP moved to Mental Health Directorate at start of May 2020)**

| | |
|---|---|
| **Tissue Viability** | **↑881** |
| **Patient Falls, Slips, And Trips** | ↓122 |
| **Infection Control** | ↓61 |
| **Medication Incidents** | ↔55 |
| **Patient Death (all inpatient and Community)** | ↑54 |

# 9 StEIS Reportable Serious Incidents (SI's) and internal Investigations

| | | StEIS Notificatio | SI INVESTIGATIONS | | | | | | | Internal Root Cause Analysis Investigations | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Downgrade & removal requests | SIs declared AMH/LD | SIs declared FYPC | SIs declared CHS | Signed off within month | Within original deadline | SI Downgrade requests | Confirmed DoC breaches | AMH/LD | FYPC | CHS | Signed off within month | Within original deadline |
| 2019/20 Q1 | April | 0 | 3 | 0 | 0 | 3 | * | 0 | 0 | 9 | 4 | 1 | * | * |
| | May | 0 | 7 | 2 | 4 | 3 | | 0 | 0 | 2 | 4 | 0 | | |
| | June | 0 | 3 | 1 | 10 | 3 | | 0 | 0 | 4 | 2 | 0 | | |
| | | | | | | | | | | | | | | |
| 2019/20 Q2 | July | 0 | 6 | 0 | 11 | 2 | | 0 | 0 | | | | | |
| | August | 0 | 2 | 0 | 4 | 7 | | 0 | 0 | | | | | |
| | September | 0 | 3 | 1 | 22 | | | 2 | 0 | | | | | |
| | | | | | | | 31% | | | | | | | |
| 2019/20 Q3 | October | 0 | 2 | 2 | 4 | 5 | | 0 | 0 | 0 | 0 | 0 | | |
| | November | 1 | 10 | 1 | 4 | 9 | | 1 | 0 | 0 | 0 | 0 | | |
| | December | 1 | 4 | 4 | 1 | 9 | | 1 | 0 | 1 | 0 | 1 | | |
| | | | | | | | 32% | | | | | | | |
| 2019/20 Q4 | January | 0 | 3 | 2 | 10 | 8 | | 0 | 0 | 2 | 2 | 1 | | |
| | February | 0 | 5 | 2 | 10 | 2 | | 0 | 0 | 0 | 1 | 1 | | |
| | March | 6 | 3 | 0 | 5 | 27 | | 0 | 0 | 2 | 0 | 2 | | |
| | | | | | | | | | | | | | | |
| YTD | | 8 | 51 | 15 | 85 | 78 | | 4 | 0 | 20 | 13 | 6 | 0 | #DIV/0! |
| 2020/21 Q1 | April | 7 | 6 | 3 | 0 | 0 | | 0 | 0 | 6 | 0 | 2 | | |
| | May | 0 | 8 | 3 | 9 | 7 | | 0 | 0 | 3 | 1 | 2 | | |
| | June | | | | | | | | | | | | | |

# 10. Trust Wide Overall SI's Action Plan Status 2019/20 – awaiting April 2020 Data

| | ADULT MENTAL HEALTH & LEARNING DISABILITIES SI ACTION PLAN TOTALS | | | | | |
|---|---|---|---|---|---|---|
| | Total SI (Other) Action Plans due to be Implemented | Total SI (Other) Action Plans Implemented | Total SI (Pressure Ulcer) Action plans due to be Implemented | Total SI (Pressure Ulcer) Action plans Implemented | % Total SI Action Plans Implemented by Month | % Total SI Action Plans Implemented YTD |
| Apr-20 | 7 | 1 | 0 | 0 | 14.29% | 14.29% |
| May-20 | 7 | 1 | 0 | 0 | 14.29% | 14.29% |
| Jun-20 | 0 | 0 | 0 | 0 | - | 14.29% |
| Jul-20 | 0 | 0 | 0 | 0 | - | 14.29% |
| Aug-20 | 0 | 0 | 0 | 0 | - | 14.29% |
| Sep-20 | 0 | 0 | 0 | 0 | - | 14.29% |
| Oct-20 | 0 | 0 | 0 | 0 | - | 14.29% |
| Nov-20 | 0 | 0 | 0 | 0 | - | 14.29% |
| Dec-20 | 0 | 0 | 0 | 0 | - | 14.29% |
| Jan-21 | 0 | 0 | 0 | 0 | - | 14.29% |
| Feb-21 | 0 | 0 | 0 | 0 | - | 14.29% |
| Mar-21 | 0 | 0 | 0 | 0 | - | 14.29% |
| Total YTD: | 14 | 2 | 0 | 0 | 14.29% | 14.29% |

# 11 – Lessons Learned/Learning

- **Pressure Ulcer Themes/Trends and Learning -** Prevention strategies remain as area for improvement, in addition many patients recovering post acute stay from COVID19 in community, appear, to have higher multifactorial risk of developing pressure ulcers.

**Falls Themes/Trends and Learning**

- **Use of 'crash mats'/timely risk assessments with changes to wellbeing and use of 'Low Beds'** – there remains the need for education that as part of the assessments that these mats may not suitable for elderly, frail patients and to use a mattress. Project plan in place to drive the falls work as we have seen an increase in falls with and without 'harm'.
- **Post Fall huddles –** this continues to be a theme that is not being adhered to and is demonstrated by audit.

**Violence & Aggression Themes/Trends and Learning**

- Staff feedback continues to be that they consider a greater need for psychological input for patients and a strong model for patients with a diagnosis of personality disorder and many patients are proving to be challenge. MH directorate have a newly appointed psychologist to concentrate on this area. There have been some incidents in relation to the mental health hub and new ways of working are being developed. The MH directorate are pulling together a paper describing their approach for QAC in August

**Medication Incidents**

- Identified an increasing number of insulin related incidents. Review of these incidents from January to May 2020 along with best practice currently undergoing analysis

Leicestershire Partnership NHS Trust

| | |
|---|---|
| Meeting Name and date | Trust Board – 7th July 2020 |
| Paper number | Ni |
| Name of Report: Patient and Carer Experience and Involvement (PCEI) Quarterly Report (including Complaints) Quarter 4, year-end 2019/20 | |

| | | | | | |
|---|---|---|---|---|---|
| For approval | | For assurance | x | For information | |

| | | | |
|---|---|---|---|
| Presented by | Anne Scott, Director of Nursing, AHP's and Quality | Author (s) | Alison Kirk, Head of Patient Experience and Involvement |

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

| Report previously reviewed by | |
|---|---|
| Patient and Carer Experience Group | 5 May 2020 |
| Quality Forum | 4 June 2020 |
| Quality Assurance Committee | 16 June 2020 |

| Assurance : | Links to ORR risk numbers |
|---|---|
| • There is a risk that the Trust does not positively impact on the experience of services users , carers and families that use our service | 12 |
| • Patient do not always find it easy to share their experiences and the Trust does not as a result receive feedback | 14 |
| • The Trust does not increase the number of service users that are positively participating in their care, treatment and service improvement | 13 |

| Recommendations of the report |
| --- |
| • 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.<br>• 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. |

Leicestershire Partnership NHS Trust

**Quality Assurance Committee –**

**Patient and Carer Experience and Involvement (PCEI) Quarterly Report (including Complaints) Quarter 4, year-end 2019/20**

## 1. Introduction

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

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

- Frequent Feedback – comments, enquiries and concerns
- NHS Choices Feedback
- Friends and Family Test (FFT)
- Complaints
- Compliments

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.

Please note that this report covers all activity up to the end of March 2020. However due to the escalation of the Covid-19 pandemic during mid-March, numbers of feedback received toward the end of March declined significantly. This was due to a number of issues including staff capacity and availability and the national guidance on the pausing of the collection of the Friends and Family Test data.

## 2. Aim

To highlight work taking place Trust-wide to involve and consult with patients and carers and gather feedback on their experiences of our services to ensure robust systems are in place to manage and learn from complaints.

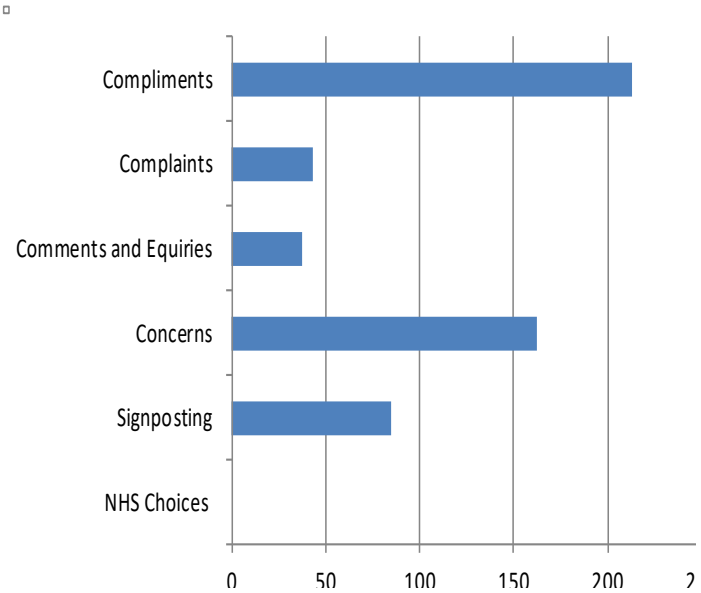
## 3. Recommendations

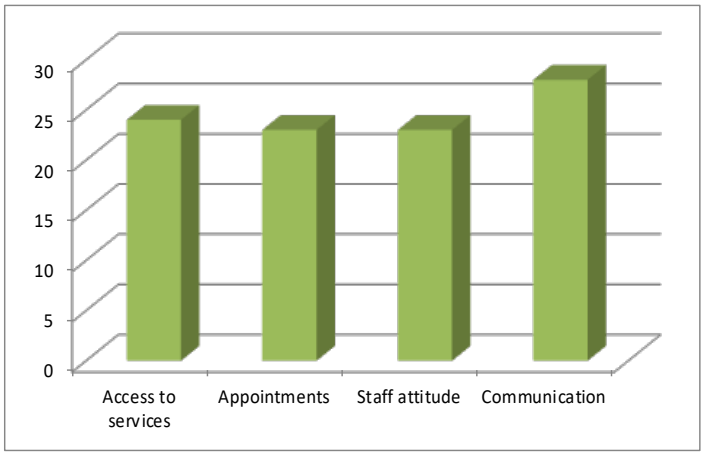
The Quality Assurance Committee (QAC) is recommended to:-

- 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.

## 4. Key highlights from the Patient Experience Report are as follows:

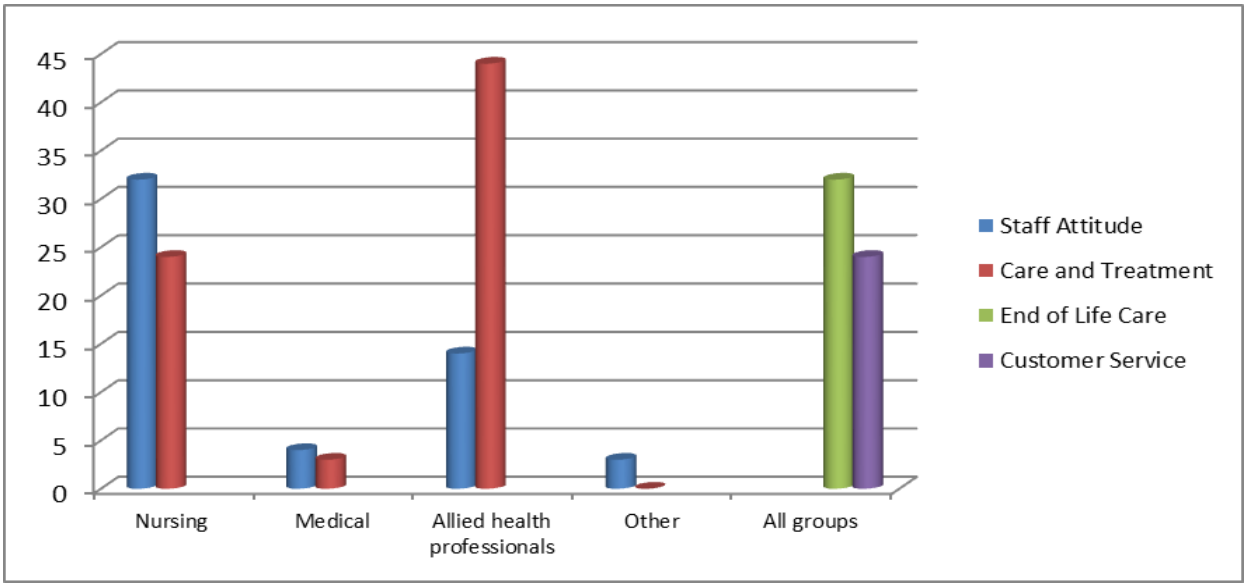
**Feedback Overview** shows that the Trust received 540 individual pieces of feedback in relation to complaints, comments, enquires, concerns, signposting and compliments. This is compared to 609 in Q3. 39% (n=213) were to provide positive feedback captured through compliments, which is a reduction of 5% from Q3. The remaining 61% of feedback received related to comments, concerns and enquiries 37%), complaints (8%) and the remaining 16% in relation to signposting to services both internal and external to the Trust.




Of the 242 pieces of negative feedback received during the period, there was no dominant trend in the themes of feedback. There was only a range of 2% amongst the key themes of where patients reported poor experience these are set out in the table opposite. These themes reflect those consistently received over previous quarters this year.

Compliments continued to be a key measuring for understanding where patients were reported positive experiences of care. As throughout previous quarters the number of compliments reported continues to be over a quarter of the total feedback received. For Q4 the key themes for positive experiences were consistent with those reported previously and include, staff attitude, customer service and care and treatment, however in Q4 we saw a jump in the positive number of compliments in respect of end of life care. This may be down to a number of factors including better reporting of compliments, however it is encouraging to see that our end of life services are meeting the needs of families and carers. A breakdown of the compliments received in Q4 has been provided below and have been separated into staff groups to show where patients and families are reporting positive experience by our staff.




This feedback is consistent to previous quarters in demonstrating that patients and carers reported the highest satisfaction on the emotional elements of their care, whereas those who reported poor experience in relation to appointments demonstrated dissatisfaction with the rational elements of care e.g. processes and systems that impacted on their care.

## NHS Choices patient feedback

During the period no comments were received through NHS Choices.

## Complaints

The Trust received 43 new complaints between 1 January and 31 March 2020 which included multi-agency complaints where we were asked to investigate specific elements of the complaint that relates to a person's care and treatment. The Trust saw a further reduction in the number of complaints formally registered compared to previous quarters at the same period last year. This has been a result of the team and continued efforts to support informal resolution and identify concerns that could be resolved swiftly and to the service user satisfaction.

There was a further reduction in the number of reopened cases in Q4 which has been a noticeable trend since the beginning of the financial year. The Trust also did not record any complaints that were escalated to the Parliamentary and Health Service Ombudsman for review of the case file and medical records or taken on for full formal investigation.

For this quarter 97.6% of all complaints were acknowledged within 3 working days, with one complaint not being acknowledged within the 3 days. 58% of all complaints were investigated with the timescale agreed with the complainant. Of this 38%, 44% (n=11) complaints were investigated within 25 working days, 66% (n=14) complaints were investigated within the timescale negotiated with the complainant, the negotiation may be impacted by a number of things including the complexity of the complaint which may require longer than 25 days for investigation or the fact that the complainant as requested that the investigation is paused for a personal reason.

The Complaints Team continue to support each directorate with familiarising staff with the amendments implemented to the Trust complaints process in October. Support was given on a case by case basis as well as delivering five further workshop events across directorates. The Complaints Team also recruited to their vacancies and a Senior Complaints Officer and Complaints Officer commencing in April 2020 and as a result will provide further support to the directorates.

Compassion in Healthcare event for staff was held in February 2020 in partnership with the patient experience and patient safety teams. The event focused on using empathy to see the emotional experience of complaints, and the use of recovery-based language when investigating and responding to complaints. The event was highly evaluated and there are plans to run additional events in 2020.

The Complaints Review Group continues in its early stages and the group are establishing their membership and core function. The Group has provided feedback on a draft version of the revised complaint policy and offered up positive comments to strengthen our processes and how we enhance the experience of raising a complaint for our users.

A review of the Trust's complaints policy was completed in March 2020 and resulted a new Complaints and Concerns Policy which has now been adopted by the Trust.

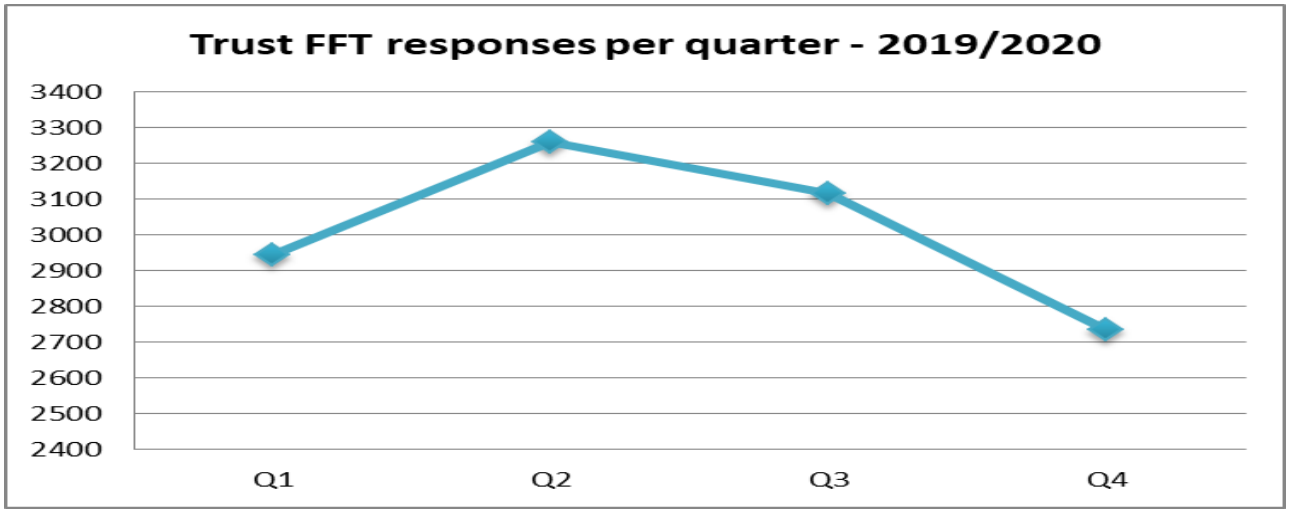
There has been a significant impact from the COVID-19 pandemic on the Complaints function within the Trust. In March the Trust, in line with national advice, placed a pause on its Complaints process to allow frontline staff capacity to focus on much needed patient care. The Trust is encouraging anyone to raise concerns about their care or treatment or, that of a loved one with the patient experience team and, where possible, in the first instance the team are working with complainants and the services to try and resolve matters informally. If this is not possible the Trust is registering, acknowledging and risk assessing all new complaints with the directorate prior to placing the complaint investigation on pause. This position is being reviewed regularly and the complaints team are communicating with complainants regularly during this period.

In Q1 of 202/21, the Complaints Team will implement a revised Complaint Management Document and support staff to utilise the documents when investigating a complaint. The Trust will look to implement an equality and diversity monitoring form to help enhance the data on those users accessing the service to help us to identify hard to reach or vulnerable groups that may need more support to raise their concerns.

A full breakdown of complaints data is available in Appendix 2

**Friends and Family Test**

2735 responses to the Friends and Family Test (FFT) were received in Quarter 4. This is a decrease of 12% compared to Quarter 3. This decrease reflects low numbers of FFT responses captured in January 2020 with a fall of 22% compared to January 2019 and the reduced number of 825 responses in March due to the pause and reporting of FFT data from 23rd March 2020 which meant any FFT data not inputted or received after this date is not included in the March data.




National figures for FFT are available for January and February 2020, March figures have not been published. Comparing the results for the Trust against the national average response rate for FFT the posting for January and February 2020 were:

| | Jan 2020 | Feb 2020 | National |
|---|---|---|---|
| CHS (including FYPC community services) | 1.4% | 1% | 4% |
| AMH (including CAMHS services) | 0.8% | 0.9% | 3% |

During the quarter the breakdown of ratings were 96% for recommendation and 1% for not recommend scores.

Agreement to fund a new automated FFT system was confirmed in March 2020. The new system will allow for the introduction to both text and individual voice messaging for the collection of FFT data. This additional functionality alongside the reconfiguration of the Trust's FFT iPads will greatly enhance the opportunities for the provision and recording of patient experience through FFT. The proposed increase in FFT responses using the new system and based on 2019/20 activity will range from potentially 12% in adult mental health services to 10% in community and children's services.

Due to Covid 19 the implementation plan for the new system has been delayed. Work is planned to commend on this in mid-May with a planned roll out of the new FFT question and additional patient experience questions in July 2020. As part of this work discussions with the CCG will need to be undertaken to agree FFT activity figures for 2020/21 based on planned activity figures and in line with the roll out of the new system.

In addition to the new FFT question a further 5 patient experience questions have been co-designed with a range of patients. These 5 questions will be asked alongside the FFT question across all services. The 5 questions are:

Two FFT workshops where held in early March with staff who have volunteered to act as Patient Experience and Involvement Champions in their service area, the workshops were attended by 45 staff. The aim of the workshop was to discuss the relaunch of the new FFT question and to share the proposed FFT system with staff. The new approach was well received by staff who also contributed to the design of the new FFT materials and FFT feedback cards.

# Directorate Feedback Breakdown

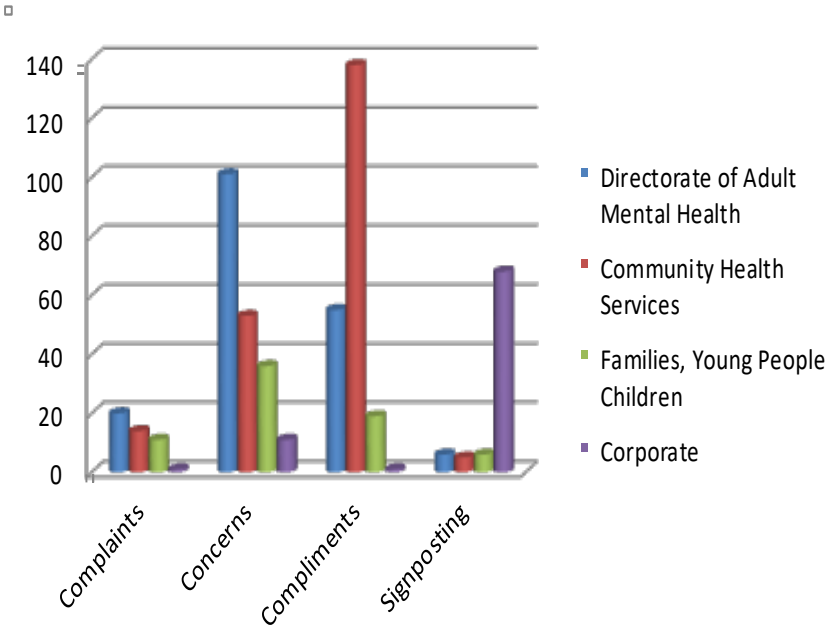
**Appendix 1**

## Individual Feedback Received Across All Directorates

| | | Complaints Q4 19/20 | PALS Q4 19/20 |
|---|---|---|---|
| Directorate of Adult Mental health | ADHD Services | 3 | 15 |
| | CMHT County | | 17 |
| | CMHT City | 2 | 25 |
| | Assertive Outreach | 1 | 1 |
| | Asperger Diagnostic Team | | 2 |
| | Dynamic Psychotherapy | | 1 |
| | Medical Psychology | | 2 |
| | Psychotherapy Oncology | | 1 |
| | Crisis Services | 3 | 8 |
| | Inpatient Wards | 6 | 21 |
| | Triage Services | 1 | 2 |
| | ART Nursing | | 1 |
| | Francis Dixon Lodge | 1 | 3 |
| | Bradgate Mental Health Unit | | 1 |
| | LD Referral Management | | 1 |
| Community Health Services | Inpatient Wards | 7 | 6 |
| | Community Integrated Neurology | | 2 |
| | Community Therapies | | 2 |
| | Continence Service | | 4 |
| | District Nursing – City | | 9 |
| | District Nursing – County | 2 | 9 |
| | District Nursing – Meridian | | 4 |
| | District Nursing – Inpatient | 3 | 2 |
| | MHSOP Community | 2 | 3 |
| | MSK Services | | 3 |
| | Physiotherapy Services | | 2 |
| | Podiatry Services | | 3 |
| | Tissue Viability Team | | 2 |
| | Care Home In-reach | 1 | |
| | SALT – Adult | | 1 |
| | Phlebotomy | | 1 |
| Families, Young People and Children | Asperger Diagnostic Team | | 1 |
| | Audiology | | 1 |
| | CAMHS – City | | 5 |
| | CAMHS – County | 4 | 12 |
| | Children's Occupational Therapy | | 3 |
| | FYPC Area 3 | | 1 |
| | FYPC Area 4 | | 1 |
| | FYPC Area 6 | | 1 |
| | FYPC North West Leicestershire | 1 | |
| | Healthy Together | | 2 |
| | School Nurses (inc immunisations) | 1 | 3 |
| | Health Visiting | | 2 |
| | Children's Therapies | 1 | 1 |
| | Langley Ward | 2 | |
| | PIER Team | 1 | |
| | SALT – Children's | 1 | |
| | Community Paediatrics | | 1 |
| | Diana Service | | 1 |
| | Continence Service | | 1 |
| Corporate and Enabling | Estates | | 1 |
| | Nursing and Quality | | 2 |
| | Covid-19 | | 3 |
| | Miscellaneous | | 5 |
| | | 43 | 201 |

During Q4 609 individual pieces were captured and recorded, of this feedback 39% was positive and 61% related to comments, concerns, enquiries and signposting.

Both graphs show all feedback received through website feedback and comments, concerns, enquiries received by directorate. Each comment can cover a range of themes and the analysis below is based on the themes covered in individual comments. During Q4, 201 comments, concerns, enquiries were received.



# Complaints

# Appendix 2

## Complaints Activity for Q4 – 1 January – 31 March 2020

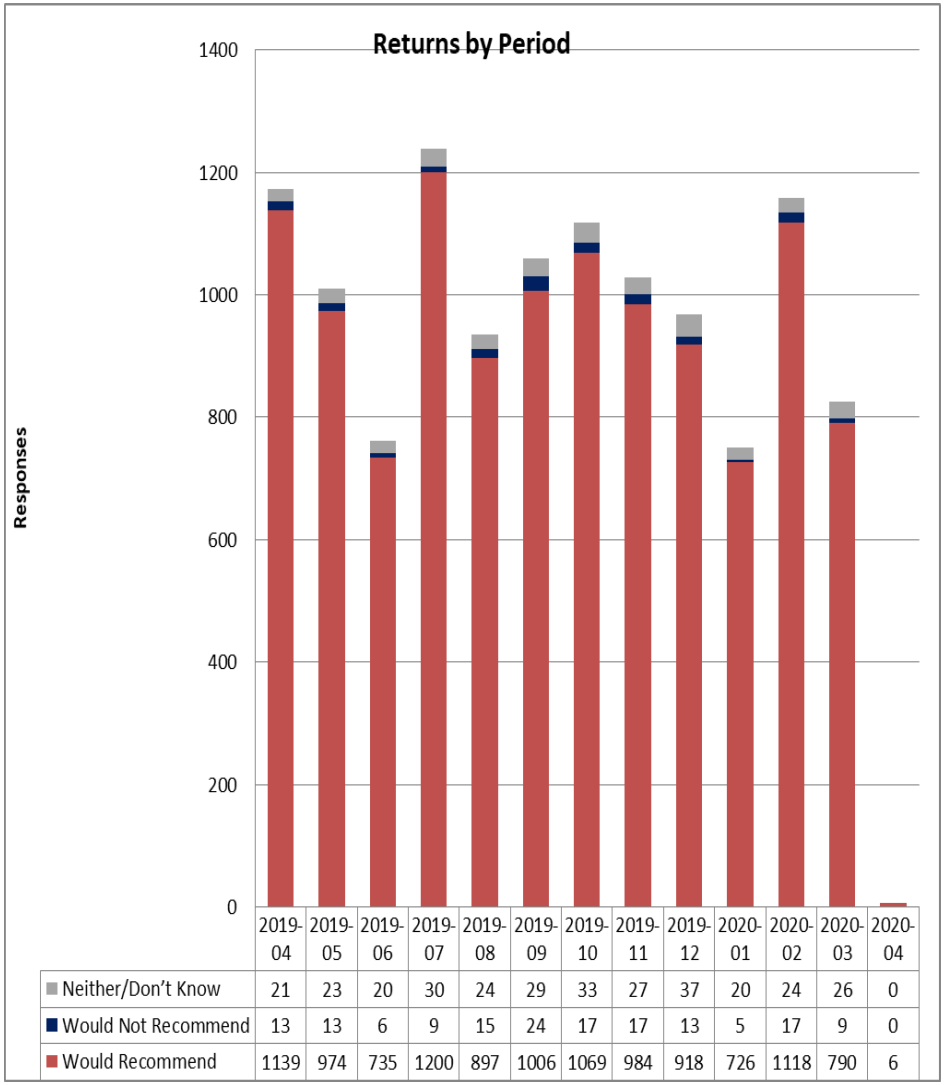
| | Q1 | Q2 | Q3 | Jan 2020 | Feb 2020 | Mar 2020 | Total Q4 | Total 19/20 |
|---|---|---|---|---|---|---|---|---|
| Adult Mental Health and Learning Disabilities | 36 | 24 | 20 | 6 | 7 | 8 | 21 | 101 |
| Community Health Services | 28 | 25 | 17 | 2 | 7 | 3 | 12 | 82 |
| Families, Young People and Children | 21 | 10 | 9 | 2 | 5 | 3 | 10 | 50 |
| Corporate/Facilities | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 2 |
| **Total Received** | **85** | **61** | **46** | **10** | **19** | **14** | **43** | **235** |
| Complaints vs Patient Activity (Complaints Rate as a %)* | 0.05 | 0.03 | 0.03 | 0.02 | 0.04 | 0.03 | 0.03 | 0.02 |
| % of complaints acknowledged within three working days | 99.3 | 100 | 97.6 | 100 | 100 | 93 | 97.6 | 98.6 |
| Number of complaints responded to within the negotiated timescale**** | 36 | 21 | 18 | 1 | 8 | 5 | 14 | 89 |
| Number of complaints responded to in 25 working days | 25 | 15 | 14 | 1 | 6 | 4 | 11 | 65 |
| Number of complaints upheld or partly upheld in quarter | 24 | 16 | 10 | 1 | 6 | 2 | 9 | 59 |
| Number of complaints ongoing after 3 months** | 13 | 9 | 6 | 0 | 0 | 0 | 0 | |
| Number of complaints ongoing after 6 months*** | 1 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Number of reopened complaints | 13 | 11 | 9 | 5 | 3 | 0 | 8 | 41 |
| Number of complaints reported to the PHSO | 2 | 1 | 1 | 0 | 0 | 0 | 0 | 4 |
| Number of complaints upheld or partly upheld by the PHSO | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |

**Complaints ongoing after 3 months at the end of Q1
***Complaints ongoing after 6 months at the end of Q1. These include those also included in the ongoing after 3 months section.
****Position statement as responses still under investigation

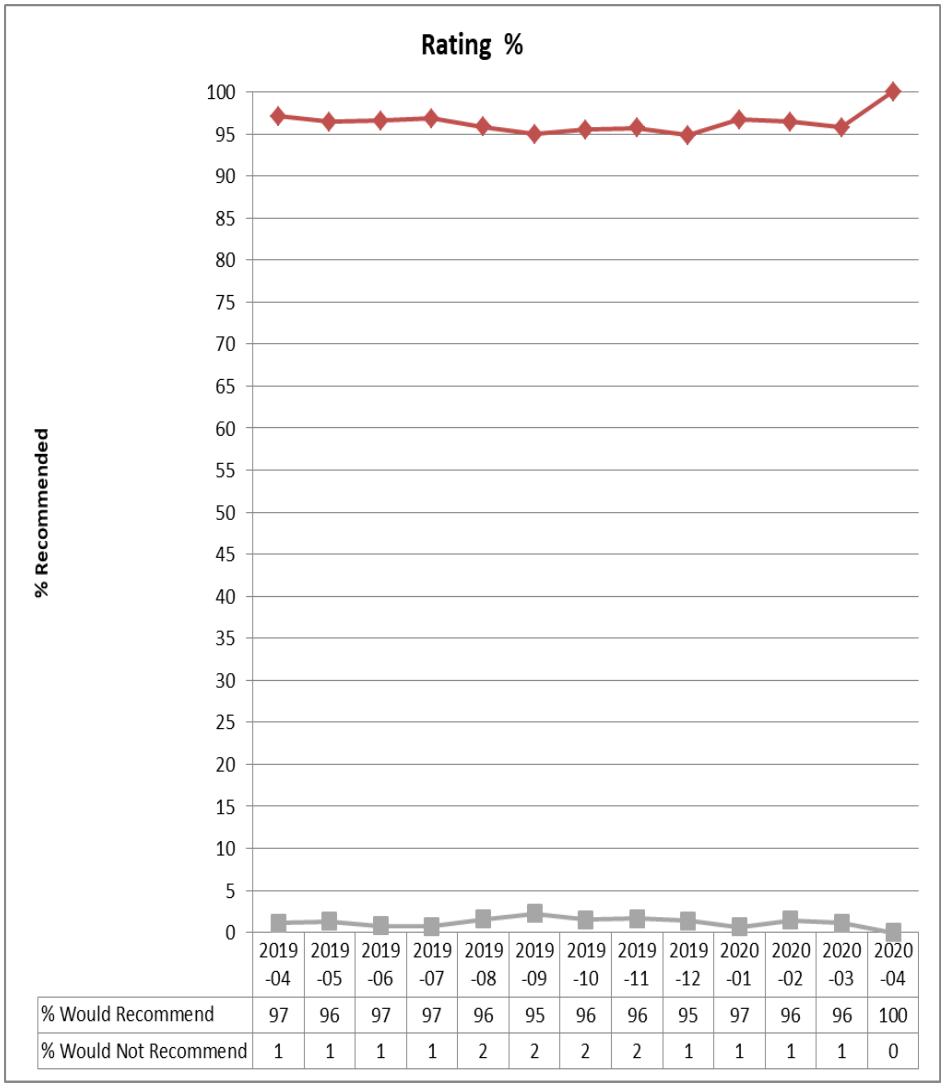
# Friends and Family Test

Appendix 3

## Trust-Wide Returns trend analysis

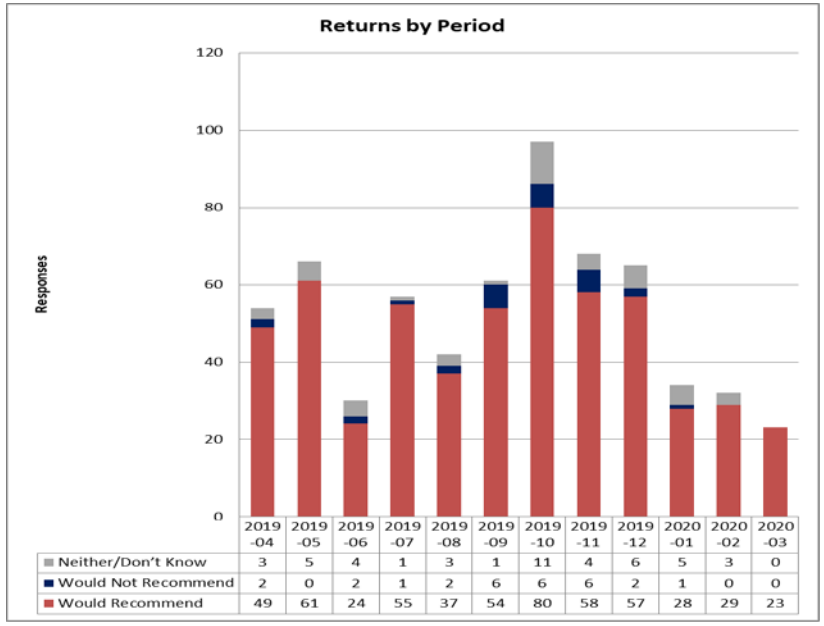



| | 2019-04 | 2019-05 | 2019-06 | 2019-07 | 2019-08 | 2019-09 | 2019-10 | 2019-11 | 2019-12 | 2020-01 | 2020-02 | 2020-03 | 2020-04 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Neither/Don't Know | 21 | 23 | 20 | 30 | 24 | 29 | 33 | 27 | 37 | 20 | 24 | 26 | 0 |
| Would Not Recommend | 13 | 13 | 6 | 9 | 15 | 24 | 17 | 17 | 13 | 5 | 17 | 9 | 0 |
| Would Recommend | 1139 | 974 | 735 | 1200 | 897 | 1006 | 1069 | 984 | 918 | 726 | 1118 | 790 | 6 |

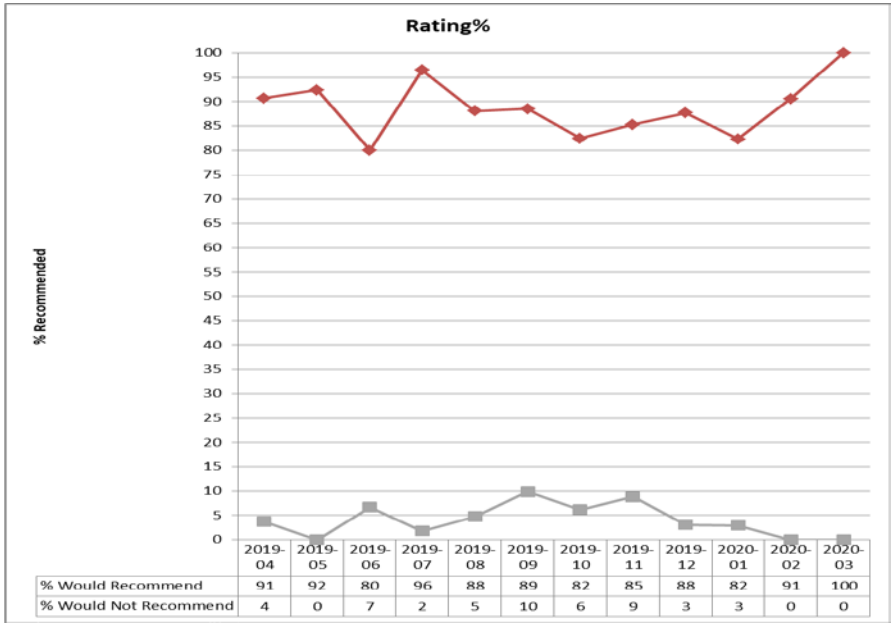



| | 2019-04 | 2019-05 | 2019-06 | 2019-07 | 2019-08 | 2019-09 | 2019-10 | 2019-11 | 2019-12 | 2020-01 | 2020-02 | 2020-03 | 2020-04 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % Would Recommend | 97 | 96 | 97 | 97 | 96 | 95 | 96 | 96 | 95 | 97 | 96 | 96 | 100 |
| % Would Not Recommend | 1 | 1 | 1 | 1 | 2 | 2 | 2 | 2 | 1 | 1 | 1 | 1 | 0 |

## Department of Adult Mental Health (including Learning Disabilities up to 31 March 2020)

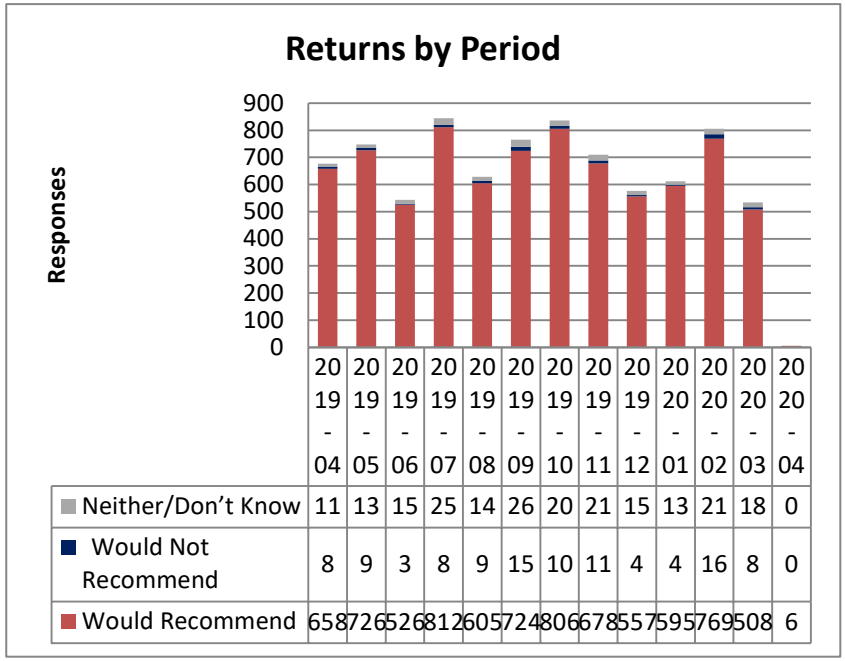



| | 2019-04 | 2019-05 | 2019-06 | 2019-07 | 2019-08 | 2019-09 | 2019-10 | 2019-11 | 2019-12 | 2020-01 | 2020-02 | 2020-03 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Neither/Don't Know | 3 | 5 | 4 | 1 | 3 | 1 | 11 | 4 | 6 | 5 | 3 | 0 |
| Would Not Recommend | 2 | 0 | 2 | 1 | 2 | 6 | 6 | 6 | 2 | 1 | 0 | 0 |
| Would Recommend | 49 | 61 | 24 | 55 | 37 | 54 | 80 | 58 | 57 | 28 | 29 | 23 |

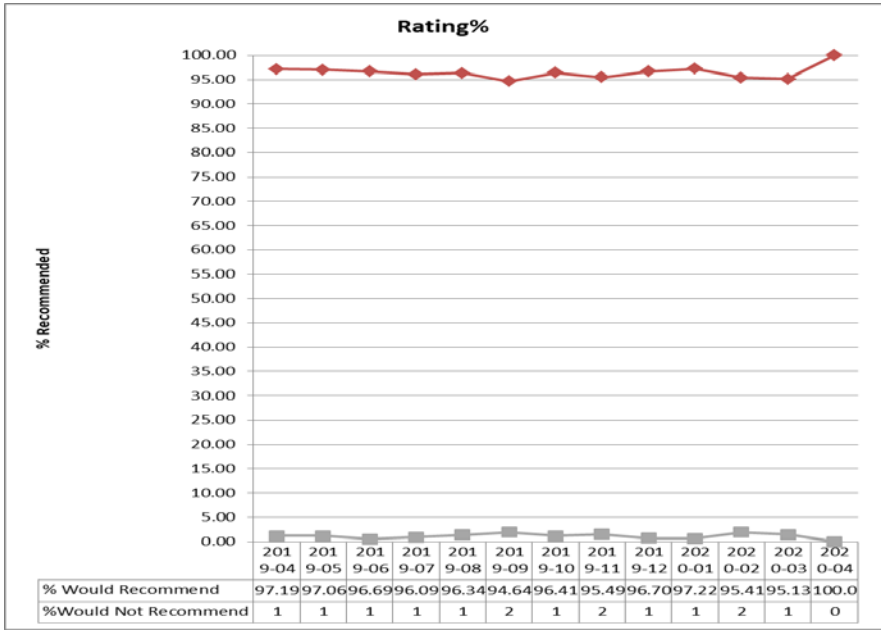



| | 2019-04 | 2019-05 | 2019-06 | 2019-07 | 2019-08 | 2019-09 | 2019-10 | 2019-11 | 2019-12 | 2020-01 | 2020-02 | 2020-03 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % Would Recommend | 91 | 92 | 80 | 96 | 88 | 89 | 82 | 85 | 88 | 82 | 91 | 100 |
| % Would Not Recommend | 4 | 0 | 7 | 2 | 5 | 10 | 6 | 9 | 3 | 3 | 0 | 0 |

## Community Health Services

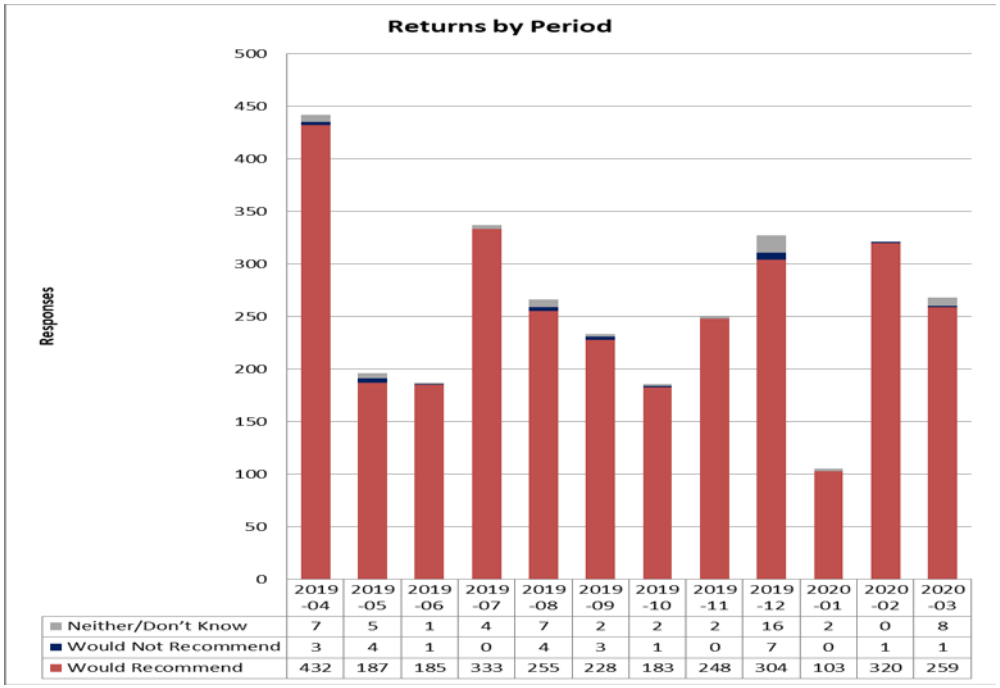



| | 2019-04 | 2019-05 | 2019-06 | 2019-07 | 2019-08 | 2019-09 | 2019-10 | 2019-11 | 2019-12 | 2020-01 | 2020-02 | 2020-03 | 2020-04 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Neither/Don't Know | 11 | 13 | 15 | 25 | 14 | 26 | 20 | 21 | 15 | 13 | 21 | 18 | 0 |
| Would Not Recommend | 8 | 9 | 3 | 8 | 9 | 15 | 10 | 11 | 4 | 4 | 16 | 8 | 0 |
| Would Recommend | 658 | 726 | 526 | 812 | 605 | 724 | 806 | 678 | 557 | 595 | 769 | 508 | 6 |

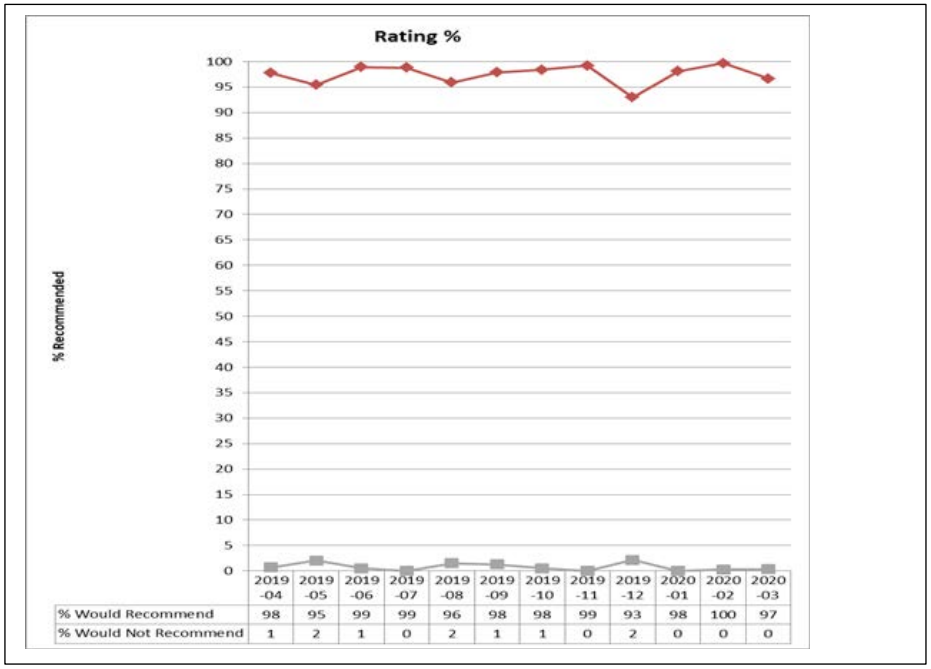



| | 2019-04 | 2019-05 | 2019-06 | 2019-07 | 2019-08 | 2019-09 | 2019-10 | 2019-11 | 2019-12 | 2020-01 | 2020-02 | 2020-03 | 2020-04 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % Would Recommend | 97.19 | 97.06 | 96.69 | 96.09 | 96.34 | 94.64 | 96.41 | 95.49 | 96.70 | 97.22 | 95.41 | 95.13 | 100.0 |
| %Would Not Recommend | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 2 | 1 | 1 | 2 | 1 | 0 |

## Families, Young People and Children




| | 2019-04 | 2019-05 | 2019-06 | 2019-07 | 2019-08 | 2019-09 | 2019-10 | 2019-11 | 2019-12 | 2020-01 | 2020-02 | 2020-03 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Neither/Don't Know | 7 | 5 | 1 | 4 | 7 | 2 | 2 | 2 | 16 | 2 | 0 | 8 |
| Would Not Recommend | 3 | 4 | 1 | 0 | 4 | 3 | 1 | 0 | 7 | 0 | 1 | 1 |
| Would Recommend | 432 | 187 | 185 | 333 | 255 | 228 | 183 | 248 | 304 | 103 | 320 | 259 |




| | 2019-04 | 2019-05 | 2019-06 | 2019-07 | 2019-08 | 2019-09 | 2019-10 | 2019-11 | 2019-12 | 2020-01 | 2020-02 | 2020-03 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % Would Recommend | 98 | 95 | 99 | 99 | 96 | 98 | 98 | 99 | 93 | 98 | 100 | 97 |
| % Would Not Recommend | 1 | 2 | 1 | 0 | 2 | 1 | 1 | 0 | 2 | 0 | 0 | 0 |

Leicestershire Partnership NHS Trust

| | |
|---|---|
| Meeting Name and date | Trust Board 7th July 2020 |
| Paper number | Nii |

| |
|---|
| Name of Report - Complaints Briefing |

| | | | | | |
|---|---|---|---|---|---|
| For approval | | For assurance | | For information | x |

| | | | |
|---|---|---|---|
| Presented by | Dr Anne Scott<br>Interim Executive Director of Nursing | Author (s) | Dr Anne Scott<br>Interim Executive Director of Nursing |

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

| Report previously reviewed by | |
|---|---|
| Committee / Group | Date |
| NA | |
| | |

| Assurance : What assurance does this report provide in respect of the Organisational Risk Register? | Links to ORR risk numbers |
|---|---|
| | All |

| Recommendations of the report |
|---|
| For Information |

Nii

**Briefing Paper to Trust Board on the Complaints service within Leicestershire Partnership Trust**

## Introduction

The experience that we offer when a person wishes to raise a concern or complaint about their care or that of a loved one has undergone significant change since April 2019. This paper outlines the advances in our policy and documentation and, importantly how we as a Trust have adopted an approach to work in collaboration with our complainants to provide a service-user led approach. This paper also updates on COVID-19 work since the end of March 2020 to date.

## Work Completed

Since April 2019, we have:

- Implemented a comprehensive set of categories to improve the identification of trends and themes; with sub-subjects allowing for a more granular dissection of the issues raised through complaints.
- Supported the Patient Experience Team to enhance triage of new concerns received and to communicate with the complainant from the outset to understand their expectation and help resolve their concerns swiftly through informal means. This has contributed to a 53% reduction in the number of formal complaints registered in 2019-20.
- Undertaken a full review of our complaint process to identify areas for improvement. This resulted in a reduction of the response timeframe, the consent process was strengthened and a robust approval and sign off process for final responses was introduced; all complaints are signed off by the Chief Executive and a local resolution meeting is encouraged.
- Delivered Complaint Workshops to staff on the changes to the complaint process.
- Streamlined our complaint management document to simplify for staff to complete and focused sections on Patient Safety in line with NHFT.
- Revised the complaints policy to reflect the changes made and to provide a greater clarity to staff on the expectations when managing concerns through the complaints process.
- Improved the quality of complaint responses and emphasised the importance of identifying actions to learn from the issues that have been raised. This included work to standardise letter templates, to improve the quality of response letters; resulting with a reduction in the number of complainants that returned unhappy with their response (59 in 2018-19 to 42 in 2019-20).
- Established a Complaint Review Group aligning with NHFT, with membership from all directorates to ensure accountability of complaints in line with regulations and effective embedding of learning.
- Introduced an equality monitoring form to help understand the demographics of people accessing the complaints process and to help shape future work on how we can encourage hard to reach groups to raise concerns and complaints.
- Improved the information provided to our service users. We have increased the information on our Trust website on how to raise a complaint and offered more methods to accessing the Complaints Service. The website also offer information to relevant support services and how we intend to handle their concerns and what will happen at each stage.
- Introduced an improved friendly and accessible Complaints Service.

## Challenges

The progress made has been extremely positive although not without challenge. There was an expected drop in compliance with the number of responses provided within the timeframe, whilst staff adjusted to the new shorter response timeframe. Unfortunately this

was a lot lower than anticipated, compounded by the absence of a key member of complaints staff within one Directorate. The Head of Patient Experience Involvement and the Complaints Team have been working closely with one Directorate to reduce the number of complaint responses. This work has continued and the directorate have commissioned a project to improve complaint management which has recently commenced.

Covid-19 has presented significant challenges and we have responded proactively to the way we investigate concerns and complaints raised. From the 26 March 2020, following national guidance, we placed a pause on all new and reopened complaints received. A process was put in place to ensure any concerns or complaints after this time were managed effectively and importantly, considered the wishes of the complainant, keeping them fully informed. Where possible to achieve a swift resolution, with the agreement of the complainant, the Complaints Team sought to resolve matters informally. When this was not possible, the concerns were registered formally. The complaint was clinically reviewed to ensure it was appropriate to place on pause and the complainant contacted to explain what the pause meant and if they had any questions; this was then followed up in writing.

The complaints process was restarted on 15 June 2020, after all directorates had been consulted at the Complaints Review Group. Prior to the restart, the Complaints Team contacted all complainants, to advise of the restart date, to ensure they understood the next steps and how their complaint would be progressed. All complaints on pause have now been processed for investigation and all complainants have been informed. These will now be managed in line with our current process.

**Targets**

The development of a user-led approach and provision of the best possible experience of raising concerns, requires significant further development. We will continue to acknowledge as many complaints as possible in 3 working days, with a commitment to high standards by aiming to achieve, for a second continuous year, a 10% reduction in the number of medical complaints received.

Previous targets in 2019-20 were to increase the number of complaints responded to within timeframe to 70% or above in Q2 and further improvement to 90% or above in Q4. Due to the pause on complaints, the response rate will impact the number of complaints that could be investigated in Q1. In 2020/21 we are projecting to respond to 70% or above with timeframe by the end of Q2, and by 90% or above by the end Q3 and then to maintain this by the end of Q4.

**Improvement Work planned for 2020/21**

Our aim in year is to:

- Develop training material and roll out training to Investigation Leads across the Trust.
- Devise a process for obtaining satisfaction levels from complainants on their experience of the complaint process.
- Implement a peer review process and how this can be implemented for the Trust.

These work streams will need to be considered in line with the implementation of the Parliamentary and Health Service Ombudsman standard frame work for complaints which is anticipated later this year. This publication will also have a positive effect on how we will manage complaints and provide a best practice framework for all organisations and how to manage complaints.

Leicestershire Partnership NHS Trust

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|---|---|
| Meeting Name and date | Trust Board 7th July 2020 |
| Paper number | O |

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|---|
| Name of Report: Learning from Deaths Report Q4 |

| | | | | | |
|---|---|---|---|---|---|
| For approval | | For assurance | x | For information | |

| | | | |
|---|---|---|---|
| Presented by | Dr Avinash Hiremath, Interim Medical Director | Author (s) | Prof Al-Uzri - Associate Medical Director (Quality)<br>Tracy Ward – Head of Patient Safety<br>Jo Nicholls – Patient Safety & Quality Manager |

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

| Report previously reviewed by | |
|---|---|
| Committee / Group | Date |
| QAC | 16/06/2020 |
| | |

| Assurance : What assurance does this report provide in respect of the Organisational Risk Register? | Links to ORR risk numbers |
|---|---|
| It is part of the control and assurance for the risk:<br>**The Trust does not learn from incidents and events and does not effectlvely share that learning across the whole organisation**<br>It is part of the assurance and learning for the Covid-19 risk:<br>**The Trust may not appropriately manage its patients with LD and Autism given the known disproportionate adverse impact of Covid-19 on this patient group** | 3<br><br>42 |

| Recommendations of the report |
| --- |
| 1. To assure the Board that there are robust mechanisms in place with regards to Learning from Deaths across the 3 Directorates<br>2. To note the mortality data. There has been no evidence of any significant changes or trends to be noted or to highlight concerns<br>3. To note that learning had been identified and that the Trust wide Learning from Deaths Group facilitates the sharing of this learning across services and directorates.<br>4. To note that newly appointed lead practitioner for Learning from Deaths is nbow in post and a more detailed report will be shared in Q1 |

Leicestershire Partnership NHS Trust

## 1. Introduction/Background

The trust's Learning from Deaths process was developed in line with the July 2017 NHS Improvement document, "Implementing the Learning from Deaths Framework: key requirements for trust boards". We have also joined a regional peer group and included shared learning in our approach. A recent internal audit report made some key recommendations which have now been fully implemented.

The report format will be changed for the next Q1 2020/2021 report further to reviewing other Trust's Learning from Deaths Board reports. This will standardise and streamline the information presented to Board.

## 2. Aim

The purpose of this report is to share key data and highlight any trends along with highlighting learning to the Board. Due to timings, the report shows data for the reporting quarter and learning from the previous.

## 3. Recommendations

To assure the Board that there are robust mechanisms in place with regards Learning from Deaths across the 3 Directorates.

To note the mortality data. There has been no evidence of any significant changes or trends to be noted or to highlight concerns.

To note that learning has been identified and that the Trust wide Learning From Deaths Group facilitates the sharing of this learning across services and directorates.

To note that newly appointed lead practitioner for learning from deaths is now in post and a more detailed report will be shared in Quarter 1

## 4. Discussion

## Mortality Data

### Mortality Figures 2019/2020

| Number of patients in scope who have died during 2019/20 | | | | | |
|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | Rolling total |
| Expected | 67 | 71 | 84 | 83 | 305 |
| Unexpected | 35 | 21 | 38 | 45 | 139 |
| Totals | 102 | 92 | 122 | 128 | 444 |
| **Number of Child Death Overview Panel (CDOP)** | | | | | |
| Totals | 8 | 8 | 10 | 8 | 34 |
| **The number of deaths subjected to a case record review** | | | | | |
| Numbers completed<br><br>Total | CHS – 58<br>AMH – 21<br>FYPC – 2<br>81 | CHS -40<br>AMH-9<br>FYPC-3<br>52 | CHS -47<br>AMH-14<br>FYPC-2<br>63 | CHS – 71<br>AMH - 14<br>FYPC- 3<br>88 | 216<br>48<br>12<br>276 |
| Numbers outstanding | CHS- 58<br>AMH – 0<br>FYPC – 0 | CHS – 19<br>AMH – 0<br>FYPC – 5 | CHS- 30<br>AMH – 4<br>FYPC – 0 | CHS - 53<br>AMH- 14<br>FYPC - 0 | N/A |
| **The number of unexpected deaths subjected to an SI investigation** | | | | | |
| Numbers completed | 8 | 12 | 7 | 11 | 38 |
| **The number and percentage of deaths subjected to an SI and case record review** | | | | | |
| Numbers completed | 0 | 2 | 1 | 0 | 3 |
| **The number of deaths more likely than not to have been due to problems in the care provided** | | | | | |
| | 0 | 0 | 0 | 1 | 1 |

The Learning from Deaths Policy has clear parameters for inclusion for case reviews. Given the demographics of our clinical services, CHS has a significantly larger proportion of expected deaths ( on average total deaths of 22 per month) but we are clear that we want all opportunities to learn so all deaths are included and will be reviewed. The timescales to do this will be reviewed to balance the need.

**Key Learning (Case Reviews, SI, CDOP,)**

| Themes & issues identified as part of the review/investigation including examples of good practice | Actions taken in response to identified themes & issues; actions planned and an assessment of the impact of actions |
|---|---|
| **AMH/LD** | |
| Need greater involvement of families in patients care when appropriate due to their risk | Working with staff around 'common sense confidentiality' to improve understanding of what and how to share |
| Need to strengthen the approach and compliance to policy in DNA of patients with severe mental health diagnosis to unsure DNA is not as a result in a deterioration | DNA policy reviewed and strengthened and application monitored |
| Patients are reported as non compliant with medication this is not always escalated to the prescriber | Educating support workers on escalation of health concerns when patients not compliant with medications for physical and mental health |

| Themes & issues identified as part of the review/investigation including examples of good practice | Actions taken in response to identified themes & issues; actions planned and an assessment of the impact of actions |
|---|---|
| **CHS**<br>End Of Life paperwork was initiated in 99% of all deaths considered this quarter<br><br>There has been a 19% drop in Same Day Admissions (SDA) to UHL<br><br>Gold Standard Framework (GSF) standards adhered to in over 95% of cases | SDA accountability has increased through better escalation plans and discussions with OOH providers<br><br>EOL champions working in better coordination with ward staff |

**Learning from FYPC**

| Themes and issues identified as part of the review/investigation including examples of good practice and Actions taken in response to identified themes and issues, actions planned and an assessment of the impact of actions |
|---|
| 1. If an outpatient is advised by adult eating disorder service (LAEDS) to attend A&E in future for medical reasons, consideration could be given to making a telephone call to the department and asking to speak to the senior clinician on duty. This would provide an opportunity to share any clinical information and to obtain feedback from LRI on any action taken. If appropriate, an accompanying letter could be sent with the patient.<br>2. Outpatients who may be asked to attend A&E . for urgent medical treatment could be asked to feedback to LAEDS the outcome of their visit. They could be offered a follow up appointment or phone call if appropriate. |

Leicestershire Partnership NHS Trust

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|---|---|
| Meeting Name and date | Trust Board – 7 July 2020 |
| Paper number | P |

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|---|
| Name of Report - **SAFE STAFFING - MAY 2020 REVIEW** |

| | | | | | |
|---|---|---|---|---|---|
| For approval | | For assurance | x | For information | |

| | | | |
|---|---|---|---|
| Presented by | Anne Scott Acting Director of Nursing, AHPs and Quality | Author (s) | Emma Wallis Associate Director of Nursing and Professional Practice |

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

| Report previously reviewed by | | |
|---|---|---|
| Committee / Group | Date | |
| NA | | |

| Assurance: What level of assurance does this report provide in respect of the Organisational Risk Registers? | Links to ORR risk numbers |
|---|---|
| Partial; Established processes are in place to monitor and ensure staffing levels are safe and that patient safety and care quality is maintained. Due to Covid-19 national and Trust data collection for safe staffing paused, no fill rates against planned staffing or CHPPD. | 1,4,26 |
| Recommendations of the report | |

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

Leicestershire Partnership NHS Trust

# TRUST BOARD – 7 JULY 2020

# SAFE STAFFING – MAY 2020 REVIEW

## Introduction/Background

1 This report provides an overview of nursing safe staffing during the month of May 2020, including an overview of staffing areas to note, updates in response to the COVID-19 pandemic, potential risks and actions to mitigate the risks to ensure that safety and care quality are maintained.

2 The report triangulates workforce metrics, quality and outcomes linked to Nurse Sensitive Indicators (NSIs) and patient experience feedback. A summary is available in Annex 1.

## Recommendations

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

## Discussion

## Trust level highlights for May 2020

## Right staff

- On 28 May 2020 the Chief Nursing Officer for England outlined second phase actions to be taken to support the nursing workforce in theCOVID-19 pandemic;

    - Deployment and then retention of returners during the next 12 months (and potentially beyond) to support the medium to long term system response to COVID-19. LPT had 7 staff return under the 'bring back' scheme, largely to the bank as staff were not confident due to length of time out of clinical practice.
    - Stepping up of non-COVID services into business-as-usual contacts under the healthy child programme and child safeguarding protocols.
    - Work alongside the Nursing and Midwifery Council (NMC) on the design and development of an approach to enable individuals to achieve full registration, particularly given the OSCE test centres remain closed. LPT does not currently have a programme to support full registration with the NMC and OSCE testing.

- Health Education England is managing the process for nursing and midwifery students to opt in to clinical practice. To date, around 27,000 students have opted in, of which 19,000 have been allocated to trusts, and 10,000 have started to work shifts. LPT have 27 aspirant nurses, from DeMontfort, Coventry and Open Universities working across our inpatient services in all three directorates.
- Student progression and review of placement opportunities to help make up for placement hours that have been lost to COVID-19 to minimise disruption to the workforce pipeline.

A separate report outlining LPTs response to the nursing workforce actions to be presented to the Strategic Workforce Committee in July 2020.

- Temporary worker utilisation rate decreased for the third consecutive month, a further 4.73% reduction reported at 15.27% overall. Trust wide agency usage also decreased this month by 0.90% to 2.10% overall. The decreased bank and agency utilisation in May 2020 reflects the reduced bed occupancy and flexed staffing levels to meet patient needs.

- This month Griffin and Rutland Ward utilised over 6% agency staff, the reduction in the number of wards utilising over 6% agency staff reflects the reduced overall temporary worker and agency use across the Trust.

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

- There are seven community team 'areas to note'. Staffing and case-loads are reviewed and risk assessed across service teams using patient prioritisation models to ensure appropriate action is taken to maintain patient safety.

**Right Skills**

- On 24 March 2020, the Trust made the decision to cancel all face to face courses until 30 June 2020 and all subject compliance dates have been extended by six months. As of 31 May 2020 Trust wide;
    - Appraisal at 91.7% GREEN
    - Clinical supervision improved at 81.3% AMBER

- FFP3 Mask Fit Test training continues. As of 10 June 2020;
    - 707 staff has been successfully mask fit trained.
    - 193 staff have had a fail result
    - 164 staff did not attend the session they were booked onto

Directorates have developed localised fit test training plans with trajectories focusing on achieving 80% of in-patient staff to be fit tested utilising local trainers.

**Right Place**

- The Trust three 'COVID-19' wards; Beaumont, Gwendolen and East Ward continue to operate to maintain separation between possible and confirmed COVID-19 patients and support patient and staff cohorting.

- Each directorate, led by the Heads of Nursing, has reviewed its inpatient settings and the clinical needs of the patients. Consequently the directorates have developed operational plans for zoning of wards to further support and maintain separation between possible and confirmed COVID-19 patients and staff allocated to care for patients, to eliminate the risk of nosocomial infection.

- The introduction of zones and adoption of COVID-19 non-admitted care pathways ensures that staff are in the right place, supporting vulnerable staff return to COVID-19 secure areas or Green in-patient areas following assessments for Health/ BAME staff.

- The trust made the decision to temporarily suspend admissions to Feilding Palmer Hospital (FPH) on the 14 May 2020 this was in response to national COVID-19: infection, prevention and control guidance and to ensure patient and/or staff safety is not compromised and safety is prioritised. Specific concerns at FPH include space constraints, which do not facilitate:
    - Social distancing of two meters, or
    - Requirement to cohort positive and/or symptomatic patients

- In response to increased COVID-19 incidents on Beech wood and Clarendon Wards, it was agreed to stop admissions to these wards in line with Trust policy and principles for managing increased incidences and outbreaks. A review was undertaken including baseline swabbing of all staff and patients, a full deep clean of each of the wards and review of adherence to PPE in practice.

## Staff leave data

- The table below shows absence captured by the HR isolation sheet as at 31 May 2020;

| | |
|---|---|
| Self-isolate – Household Carer | 9 |
| Self-isolate – Household WFH | 9 |
| Self-isolate – Symptomatic | 129 |
| Self-isolate – Vulnerable Group | 156 |
| Undefined | 3 |

| | |
|---|---|
| Covid related absence | 306 |
| General absence | 238 |

| | |
|---|---|
| Total Workforce | 5329 |

| | |
|---|---|
| Covid related absence | 5.74% |
| General absence | 4.47% |
| **Total absence** | **10.21%** |

**Table 1 – Trust COVID-19 and general absence – 31 May 2020**

In comparison to the previous month as reported on 30 April 2020, overall absence has decreased 2.14% and COVID-19 related absence has reduced by 1.6%.

| | AMH | Bank | CHS | Enabling | FYPC | Hosted | LD | MHSOP | Grand total |
|---|---|---|---|---|---|---|---|---|---|
| Self-isolation – Household carer | 3 | 2 | 3 | 1 | 0 | 0 | 0 | 0 | 9 |
| Self-isolation – | 3 | 0 | 2 | 0 | 3 | 0 | 0 | 1 | 9 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Household WFH | | | | | | | | | |
| Self-isolation – Symptomatic | 16 | 11 | 69 | 6 | 20 | 2 | 1 | 4 | 129 |
| Self-isolation – Vulnerable Group | 33 | 4 | 55 | 13 | 30 | 1 | 9 | 11 | 156 |
| Undefined | 1 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | 3 |
| **Totals** | **56** | **17** | **130** | **20** | **54** | **3** | **10** | **16** | **306** |

**Table 2 – COVID-19 absence by Directorate – 31 May 2020**

## In-patient Staffing

4 Summary of inpatient staffing areas to note;

| Wards | March 2020 | April 2020 | May 2020 |
|---|---|---|---|
| Hinckley and Bosworth - East Ward | X | X | X |
| Hinckley and Bosworth – North Ward | X | | |
| Beechwood | X | X | X |
| Clarendon | X | X | X |
| Feilding Palmer | X | X | |
| St Lukes Ward 1 | X | | |
| St Lukes Ward 3 | X | X | X |
| Coalville Ward 2 | | | |
| Rutland | | | X |
| Coleman | | | |
| Gwendolen | X | X | X |
| Welford | | | |
| Beaumont | X | X | X |
| Belvoir | X | X | X |
| Griffin | X | X | X |
| Watermead | | | |
| Agnes Unit | | | |
| Langley | X | | |
| Bosworth (CAMHS) | X | X | X |

**Table 3 – In-patient staffing areas to note**

4 Areas to note are identified either by the Head/Deputy Head of Nursing due to; high percentage of temporary worker/agency utilisation, or concerns relating to; increased acuity, high risk patients, staff sickness, ability to fill additional shifts and the impact to safe and effective care.Covid-19 wards are also identified as areas to note; East Ward Hinckley, Beaumont and Gwendolen Wards.

5 In response to increased COVID-19 incidents on Beech wood and Clarendon Wards, it was agreed to stop admissions to these wards in line with Trust policy and principles for managing increased incidences and outbreaks. A review was undertaken including baseline swabbing of all staff and patients, a full deep clean of each of the wards and review of adherence to PPE in practice.

6 The following wards utilised above 6% agency staff Griffin and Rutland.

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

## Community Teams

8 Summary of community 'areas to note';

| Community team | Mar 2020 | April 2020 | May 2020 |
|---|---|---|---|
| City East Hub- Community Nursing | X | X | X |
| City West Hub- Community Nursing | X | X | X |
| East Central Hub – Community Nursing | X | X | X |
| Hinckley and Bosworth – Community Nursing | X | X | |
| Healthy Together – City (School Nursing only) | X | X | X |
| Healthy Together – East | X | X | |
| Health Together - West | X | X | X |
| CAMHS County - FYPC | | | X |
| Diana service | X | X | X |
| Charnwood CMHT | | | |
| City West CMHT - MHSOP | | | |

**Table 4 – Community areas to note**

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

10 CAMHS County, Healthy Together City (School Nursing only), West Healthy Together and Diana teams are rated to be at Amber escalation level due to only 70% of the established team being available to work. Risks continue to be monitored within the Directorate on a weekly basis. The Diana service supported redeployment of the acute and MacMillan team to the acute Trust on 6 April 2020, returning to the Diana team on 29 May 2020.

11 There remain a number of vacancies across community planned care nursing hubs with City East, West and East Central carrying the largest number and key 'areas to note'. Due to the numbers of vacancies, the teams have an increased reliance on temporary workforce with a high agency use; there are associated challenges with continuity of the workforce, especially in City East. Interviews were held on the 18 May 2020 for Band 5 nurses in the City with a recruitment and retention premia attached under the Ageing Well banner. A total of three posts were offered with only one progressing to full recruitment. An advert has gone back out. Interviews have been held for nursing students due to qualify in 2020 with 13 candidates recruited and they will be placed into posts closer to their qualification date.

12 There are no 'areas to note' in AMH in May 2020. The impact of COVID-19 and social distancing measures continues to affect community teams. Non-essential community services have temporarily closed, and staff from the Mett Centre and Recovery College remain redeployed to inpatient areas. Within other community services, face-to-face

contacts have been suspended wherever possible, and telephone and video appointments are now offered. This has enabled staff in self-isolation to continue to work clinically. The exception to this is where face-to-face contacts are unavoidable, for example depot administration, Mental Health Act assessments and safeguarding management and care. Psychological therapists have therefore had some capacity, and they have been supporting outpatient departments with telephone follow ups.

Referrals and demand for our services have decreased over recent weeks, although the services are planning for an increase in clinical need as we move through the pandemic.

The Perinatal Mental Health Service is participating in a pilot of 'Attend Anywhere' video clinical consultation software. Feedback has been very positive and it is hoped that this resource will be rolled out to other areas.

The Central Access Point (CAP) developed in April 2020ncontinues to operate as a 24 hour telephone service which is collaboration between the community mental health teams and crisis resolution and home treatment teams. The CAP has a team manager, senior clinicians and an experienced administrative team.

## Conclusion

11 In light of the triangulated review of workforce metrics, nurse sensitive indicators and patient feedback, the Acting Director of Nursing, AHPs and Quality is assured that there is sufficient resilience across the Trust not withstanding some areas to note, to ensure that every ward and community team is safely staffed.

Presenting Director: Anne Scott – Acting Director of Nursing, AHPs and Quality

Author: Emma Wallis – Associate Director of Nursing and Professional Practice

## Annexe 1: Inpatient Ward triangulation staffing and NSIs.

Trust thresholds are indicated below;

- Temporary worker utilisation (bank and agency);
  - green indicates threshold achieved less than 20%
  - amber is above 20% utilisation
  - red above 50% utilisation

- Quality Schedule methods of measurement are RAG rating;
  - B – Less than 6% of clinical posts to be filled by agency staff
  - Red above 6% agency usage

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

### Acute Inpatient Wards

| Ward | Occupied beds | Temp Workers% | Agency % | Bank % | Medication errors | Falls | Complaints |
|---|---|---|---|---|---|---|---|
| Ashby | 94.8% | 13.03% | 1.58% | 11.45% | 2→ | 2↑ | 0 |
| Aston | 88.5% | 15.74% | 2.42% | 13.32% | 1↑ | 8↑ | 0 |
| Beaumont | 21.8% | 6.62% | 0.62% | 6.00% | 0↓ | 2→ | 0 |
| Belvoir Unit | 85.2% | 26.41% | 5.17% | 21.24% | 1→ | 2↑ | 0 |
| Heather | 94.8% | 15.04% | 0.30% | 14.74% | 2→ | 6↑ | 0 |
| Thornton | 96% | 25.34% | 2.48% | 22.86% | 1↑ | 0↓ | 0 |
| Watermead | 89% | 17.74% | 1.09% | 16.65% | 0↓ | 1↓ | 0 |
| Griffin F PICU | 82.8% | 32.34% | 9.88% | 22.46% | 1→ | 1↑ | 0 |
| **TOTALS** | | | | | **8→** | **22↑** | **0↓** |

Table 5 - Acute inpatient ward safe staffing

A review of the NSIs and patient has not identified any staffing impact on the quality and safety of patient care/outcomes. There was an increase in falls across the acute in-patient wards. Analysis has shown that the falls involved 12 different individuals. Ward teams have demonstrated a greater knowledge of the falls care pathway evidenced through reporting. Causes of falls have been linked to effects of physical health and mental health presentation and behaviours.

Learning and quality improvement themes have been identified including;

- Strengthening utilisation and recording of the post falls checklist and linking to the Falls Risk Assessment Tools and care plan.
- Involvement of medical teams to support clinical decision making.
- Lead physical health care nurse to continue to review the notes of any patients who have fallen to support teams and joint working.
- A plan to share falls training with ward teams during COVID-19
- Seek clarification on the falls process for those patients that are witnessed to be placing themselves onto the floor

## Learning Disabilities (LD) Services

| Ward | Occupied beds | Temp Workers% | Agency % | Bank % | Medication errors | Falls | Complaints |
|---|---|---|---|---|---|---|---|
| Agnes Unit | 50.0%(Pod 1)<br>91.1%(Pod 2)<br>66.9%(Pod 3) | 23.17% | 1.30% | 21.87% | 0 | 4↑ | 0 |
| The Gillivers | | | | | | | |
| The Grange | | | | | | | |
| **TOTALS** | | | | | **0** | **4↑** | **0** |

**Table 6 - Learning disabilities safe staffing**

No data for short breaks as temporarily closed.

A review of the NSIs and patient feedback has not identified any staffing impact on the quality and safety of patient care/outcomes for the Agnes Unit. The falls incidences have all been reviewed and analysed and no themes identified indicating concerns in relation to staffing or risk of harm.

## Low Secure Services – Herschel Prins

| Ward | Occupied beds | Temp Workers% | Agency % | Bank % | Medication errors | Falls | Complaints |
|---|---|---|---|---|---|---|---|
| HP Phoenix | 88.2% | 4.66% | 0.17% | 4.49% | 0 | 0 | 1↑ |

**Table 7- Low secure safe staffing**

There were no medication errors or falls in May 2020. One complaint not linked to staffing levels.

## Rehabilitation Services

| Ward | Occupied beds | Temp Workers % | Agency % | Bank % | Medication errors | Falls | Complaints |
|---|---|---|---|---|---|---|---|
| Skye Wing | 80.6% | 16.88% | 0.18% | 16.70% | 0 | 1↓ | 0 |
| Willows Unit | 1.2% (Cedar)<br>85.9% (Maple)<br>90.6% (Sycamore) | 10.09% | 0.45% | 9.64% | 1→ | 2↑ | 1↑ |
| Mill Lodge | 88.9% | 30.44% | 0.84% | 29.60% | 1↑ | 15↑ | 0 |
| **TOTALS** | | | | | **2↑** | **18↓** | **1↑** |

**Table 8 - Rehabilitation service safe staffing**

A review of the NSIs and patient feedback has not identified any staffing impact on the quality and safety of patient care/outcomes. Analysis of the falls incidents on Mill Lodge has identified that seven of the falls occurred with one patient with progressive deterioration of Huntingdon's disease. The patient has been consistently reviewed by the MDT and recently placed on the End of Life pathway due to rapid deterioration of disease. Five falls linked to one patient, following assessment and review has been referred to the wheelchair clinic and the team have ordered a helmet to reduce the risk of harm. Physio care plans amended to clarify seating and level of assistance staff should

offer for the patient to mobilise. Another key theme links to rolling out of bed and the team are reviewing use of sensor mats to support patients.

## Community Health Services (CHS)

### Community Hospitals

| Ward | Occupied beds | Temp Workers% | Agency % | Bank % | Medication errors | Falls | Complaints |
|---|---|---|---|---|---|---|---|
| FP General | 25.2% | 6.33% | 0.22% | 6.11% | 0↓ | 0 | 0 |
| MM Dalgliesh | 36.6% | 8.11% | 2.34% | 5.77% | 1↑ | 1→ | 1↑ |
| Rutland | 61.3% | 14.09% | 7.18% | 6.91% | 1↑ | 8↑ | 1↑ |
| SL Ward 1 | 81.4% | 11.06% | 3.00% | 8.06% | 1↓ | 2↓ | 0 |
| SL Ward 3 | 51.7% | 21.35% | 5.84% | 15.51% | 1↓ | 3↓ | 0 |
| CV Ellistown 2 | 67.7% | 1.36% | 1.32% | 1.04% | 1→ | 3↑ | 0 |
| CV Snibston 1 | 85.1% | 7.8% | 2.55% | 5.25% | 1↑ | 6↓ | 0 |
| HB East Ward | 46.9% | 7.32% | 4.20% | 3.12% | 2→ | 5↓ | 0 |
| HB North Ward | 57.7% | 10.23% | 3.60% | 6.63% | 0 | 7↑ | 0 |
| Swithland | 59.9% | 3.83% | 1.97% | 1.86% | 1↑ | 0↓ | 0 |
| CB Beechwood | 68.4% | 12.32% | 3.26% | 9.06% | 1↑ | 0↓ | 0 |
| CB Clarendon | 39.7% | 11.31% | 4.33% | 6.98% | 1→ | 5↑ | 0 |
| **TOTALS** | | | | | **11↑** | **40→** | **2↑** |

Table 9 - Community hospital safe staffing

Rutland Ward and St Lukes Ward 3 are hot spots associated with increased temporary workforce usage due to vacancies and sickness.

A review of the NSIs for the community hospital wards has identified that there was a slight increase overall in falls incidents from April 2020 to May 2020 on Rutland Ward, Ellistown Ward, North Ward and Clarendon Ward. Review of the increased incidences has not identified any direct correlation between staffing and the impact to quality and safety of patient care/outcomes.

The number of medication incidents for May 2020 is above the median of 10 for the inpatient wards. A review of these incidents has not identified any direct correlation with staffing.

### Mental Health Services for Older People (MHSOP)

| Ward | Occupied beds | Temp Workers% | Agency % | Bank % | Medication errors | Falls | Complaints |
|---|---|---|---|---|---|---|---|
| BC Kirby | 94.6% | 18.99% | 0.54% | 18.45% | 0 | 14↑ | 0 |
| BC Welford | 80.4% | 18.45% | 1.30% | 17.15% | 0↓ | 26↑ | 0 |
| Coleman | 50.9% | 24.95% | 0.81% | 24.14% | 0 | 8↑ | 0 |
| Gwendolen | 11.1% | 0.28% | 0.14% | 0.14% | 0 | 0↓ | 0 |
| **TOTALS** | | | | | **0↓** | **48↑** | **0↓** |

Table 10 - Mental Health Services for Older People (MHSOP) safe staffing

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

Gwendolen ward was the designated ward to nurse COVID 19 positive patients in MHSOP. As occupancy levels were low and at times there were no patients, the number of staff and skill mix has been adjusted resulting in a reduced number of requests temporary staff. Staff from Gwendolen ward was redeployed to other wards within MHSOP when occupancy was low.

Coleman ward was extended into Wakerley ward as part of the surge plan for mental health organic patients. This led to an increased use in bank and agency staff due to patient acuity and dependency, increased levels of observation and staff absence due to 'sheilding'.

Increased falls relate to one patient who had six falls, who loves to walk and walks continuously (lapping) on the ward. Levels of observation increased not for therapeutic benefit but for increased risk of falls.

Welford ward has patients with both functional and organic illness; this has resulted in increased acuity and levels of observations. Increased falls incidents are attributed mostly to one patient, twelve falls minor harm, falls risk assessment in place, MDT support and review and increased supervision. Falls associated with perceptual problems.

Kirby ward catered for patients with both functional and organic illness as admissions were restricted to Coleman ward as Coleman ward did not have any COVID -19 positives cases. The increased in falls relate to one patient who had 3 falls (Minor Harm). Although staff members were redeployed from Gwendolen ward, there was a reliance on temporary workforce to meet the safe staffing numbers due to increased acuity, 1:1 observations and staff members shielding.

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

| Ward | Occupied beds | Temp Workers% | Agency % | Bank % | Medication errors | Falls | Complaints |
|---|---|---|---|---|---|---|---|
| Langley | 91.6% | 32.97% | 2.45% | 30.52% | 1↓ | 0 | 0↓ |
| CAMHS | 75.1% | 19.13% | 4.07% | 15.06% | 0 | 2↑ | 0 |
| **TOTALS** | | | | | **1** | **2↑** | **0↓** |

**Table 11 - Families, children and young people's services safe staffing**

A review of the NSIs and patient feedback has not identified any staffing impact on the quality and safety of patient care/outcomes. The reduced temporary worker utilisation for CAMHS is reflective of utilisation of staff redeployed from outpatients and LD team.

Leicestershire Partnership NHS Trust

| | |
|---|---|
| Meeting Name and date | Trust Board – 7th July 2020 |
| Paper number | Q |

| |
|---|
| Name of Report Freedom to Speak Up Report |

| | | | | | |
|---|---|---|---|---|---|
| For approval | X | For assurance | | For information | |

| | | | |
|---|---|---|---|
| Presented by | Angela Hillery - CEO | Author (s) | Pauline Lewitt – Freedom to Speak Up Guardian |

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

| Report previously reviewed by | |
|---|---|
| Committee / Group | Date |
| NA | |
| | |

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

| Recommendations of the report |
|---|
| The Trust Board is recommended to:<br><br>• Confirm assurance that the Trust board is actively involved in creating a culture that embraces Freedom to Speak Up and supports the development of a culture where together “we are making speaking up business as usual”<br>• Support the current mechanisms and activities in place for raising awareness of the FTSU agenda.<br>• To approve the proposed actions thereby supporting the significant impact speaking up can have in supporting our Trust vision “Creating high quality, compassionate care and wellbeing for all”. |

Q

Leicestershire Partnership NHS Trust

# Trust Board – July 2020

## Freedom to Speak Up Report (6 monthly)

### Introduction/Background

1. The Freedom to Speak Up (FTSU) review led by Sir Robert Francis into speaking up in the NHS provided independent advice and recommendations on creating a more open and transparent culture in the NHS.

2. The role of the FTSU Guardian incorporates being an additional route for speaking up but extends well beyond, aiming to develop cultures where safety concerns are identified and addressed at an early stage. FTSU has three components: improving and protecting patient safety, improving and supporting staff experience and visibly promoting learning cultures that embrace continual development.

### Aim

3. This report provides an update from the Trust's FTSU Guardian on activities that strengthen the arrangements for staff to speak up, thereby creating a more open and transparent culture, and supporting improvements in patient care and the work experience for staff.

4. The report will also highlight updates from the National Guardian's Office.

5. In addition the report contains details of the concerns raised with the FTSU Guardian during the period January 2020 – 19th June 2020 (inclusive).

### Recommendations

The Trust Board is recommended to:

- Confirm assurance that the Trust board is actively involved in creating a culture that embraces Freedom to Speak Up and supports the development of a culture where together "we are making speaking up business as usual"
- Support the current mechanisms and activities in place for raising awareness of the FTSU agenda.
- To approve the proposed actions thereby supporting the significant impact speaking up can have in supporting our Trust vision "Creating high quality, compassionate care and wellbeing for all".

### Discussion

7. The FTSU Guardian has received support from Angela Hillery - Chief Executive and Sarah Willis - Director of HR & OD, through scheduled monthly meetings, and Cathy Ellis - Chair and Darren Hickman - Non-Executive Director to the Trust Board at quarterly meetings.

### Activity

8. *Freedom to Speak Up Partners* – The ongoing development of the FTSU Partner role meetings had temporarily stalled as a result of COVID-19 impacts and IPC guidelines. However, in June 2020 two virtual Partners' forums took place to enable wider attendance. These forums provided opportunities for partners to share their individual experiences, consider trends in barriers to

speaking up and reinforce FTSU messages across the network. It is intended that the FTSU Guardian and Executive leads for FTSU will meet quarterly with the partners to discuss and shape the work the Trust is doing to make 'speaking up business as usual'. The next forum is scheduled for September.

9. *FTSU Guardian visibility* – in response to the national working guidelines the FTSU Guardian has been unable to attend corporate induction, team meetings, community drop-ins and staff networking events. To continue to raise awareness of FTSU and visibility of the FTSU Guardian across the trust there have been articles in the COVID-19 bulletin, communications through social media, information in 'Wobble' rooms, access to MS Teams meetings including staff listening events and regular attendance at the staff support network meetings.

10. *Specialty and Associate Specialist (SAS) Doctors Conference* – In March 2020 the FTSU delivered a presentation to approximately 200 SAS doctors from across the midlands region about the role of the FTSU Guardian, highlighting information from the most recent FTSU report provided by the National Guardians Office. Leicestershire Partnership Trust employs between 30 and 40 SAS doctors and this provided a great opportunity to introduce key FTSU messages, facilitate and guide interactive discussions about the potential barriers to speaking up and promote networking with local Trust Guardians.

11. *Midlands Regional Network and the Nightingale Hospital Network* – The FTSU Guardian is an active member of the regional and national network of guardians and regularly supports colleagues from other trusts. In April, the FTSUG was invited by the NGO to talk to the Nightingale network about embedding the FTSU messages and potential barriers to speaking up within vulnerable groups**.**

**NGO updates**

12. *National Guardian's Office Annual Report (March 2020)* – This provides a summary of activities that National Guardian and the NGO's have undertaken during 2019 and identified case studies of positive learning experiences provided by a number of trusts. It reported that 19,331 cases had been raised to guardians in trusts over two years (between 1 April 2017 and 31 March 2019) and provided a percentage breakdown by professional group. In addition, the report identified future priorities and challenges which includes working closely with the Care Quality Commission to ensure that future Well Led PMS inspections have an appropriate focus on speaking up. It has appointed Regional Liaison Leads to identify and develop speaking up networks across primary care, including vanguard organisations that are developing the guardian role in primary care.

https://www.nationalguardian.org.uk/wp-content/uploads/2020/03/2019_ngo_annual-report.pdf

13. *NGO case review: Whittington Health NHS Trust (June 2020)* – This review took place as workers referral information indicated the trusts response to a number of speaking up cases had not been in accordance with its policies and procedures. The report contained recommendations relating to HR policies and procedures, internal communications, organisational development, audit, and the requirement to embed the FTSU role and messages across the trust. The report will be presented at the HR development session in order to complete a gap analysis in line with NGO guidelines.

https://www.nationalguardian.org.uk/wp-content/uploads/2020/06/casereviewwhittington.pdf

14. *Data Collection, Recording and Reporting* – Two new guidance documents were published by the NGO highlighting changes in the way data must be recorded and reported effective from 1st April 2020. The changes relate to the way professional groups are categorised and include a new

category to indicate the professional levels of individuals who speak up. The recording and reporting data document has been updated in line with the new requirements for data collection.

15. *Freedom to Speak Up and NHS Workforce Race Equality Standards (WRES)* - Dr Henrietta Hughes, National Freedom to Speak Up Guardian has sent a joint letter with the NHS Workforce Race Equality Standards (WRES) Team urging leaders in health to assure themselves that all workers feel free to speak up within their organisations, especially given the impact of COVID-19 on BAME workers.

The letter published recently from the WRES team and the National Guardian stated that freedom to speak up has never been more important than now.

https://www.nationalguardian.org.uk/wp-content/uploads/2020/06/c0582_ngo-and-wres-letter_15junerev.pdf

**Freedom to Speak Up activities in the Trust**

**Raising Concerns**

16. Thrust's Senior Executive Board receives a quarterly report which includes details themes of all concerns raised by workers in the Trust.

17. In the last 6 months (January 2020 – mid June 2020), 77 members of staff have raised concerns either individually or as a group. There is a wide cross-section of the Trust workforce that have contacted the Guardian and these have included, Medics, health care support workers, matrons, nurses, administrators, pharmacists, student nurses, practitioners and other Allied Health Professionals

18. The majority request that their issue be dealt with confidentially however with support and reassurance many have felt confident to be identified and further-more discuss issues openly with their senior managers and Human Resource business partners as part of a 'listening meeting'.

**Summary of speaking up cases in detail below: previous data provided for comparison**

| Month | No. of Contacts | Internal | FTSU | External | Anonymous |
|---|---|---|---|---|---|
| January | 7 | 7 | 7 | 0 | 0 |
| February | 12 | 12 | 12 | 0 | 0 |
| March | 18 | 14 | 14 | 4 | 4 |
| April | 11 | 10 | 10 | 1 | 1 |
| May | 17 | 17 | 17 | 0 | 0 |
| 19th June | 12 | 11 | 11 | 1 | 1 |
| **TOTAL** | **77** | **71** | **71** | **6** | **6** |

| Service Area | Jan 19 – June 19 | Jul 2019 – Dec 2019 | Jan 2020 – 19th June 2020 |
|---|---|---|---|
| AMH | 17 | 22 | 36 |
| CHS | 11 | 22 | 12 |
| Enabling | 6 | 3 | 5 |
| FYPC/LD | 10 | 16 | 22 |
| Hosted | 0 | 0 | 2 |
| **TOTAL** | **44** | **63** | **77** |
| | | | |

| Themes * | Jan 19 – June 19 | Jul 2019 – Dec 2019 | Jan 2020 – 19th June 2020 |
|---|---|---|---|
| Patient Safety | 13 | 35 | 41 |
| Staff Safety | 9 | 19 | 52 |

| | | | |
|---|---|---|---|
| Attitudes & Behaviours | 20 | 44 | 46 |
| Bullying/Harassment | 2 | 13 | 17 |
| System/Process | 21 | 35 | 41 |
| Infrastructure/Environment | 1 | 5 | 11 |
| Cultural | 10 | 24 | 32 |
| Leadership | 1 | 26 | 47 |
| Senior Management Issue | 1 | 6 | 6 |
| Middle Management Issue | 13 | 31 | 54 |

***Concerns often contain multiple themes***

19. The majority of issues raised with the Guardian did not instigate a formal investigation and therefore the categorisation has been based on the account given from the staff member's perspective and as such is not formally substantiated.

20. The nature of the role of the FTSU Guardian tends to lead to individual members of staff speaking up in relation to specific individual cases and therefore it is often difficult to see generalised themes within teams, departments, directorates or indeed across the Trust.

**Discussion of Themes**

**Pre COVID-19**

21. FYPC 0-19 service (Healthy Together) - concerns were raised by individuals and others collectively which may account for the high number of cases recorded for FYPC in the Q4 (2019-2020). These related to perceived issues around service delivery, safeguarding processes and the public health role. Listening meetings had been arranged to enable the senior leadership team to meet with those that were speaking up but it was agreed that these should be deferred due to the COVID0-19 response i.e. redeployment of staff and changes in services delivery.

22. AMH (CMHT) – issues were raised across the multidisciplinary teams in relation to service delivery, system processes and procedures, breakdown in team relationships and inappropriate attitudes and behaviors which were not consistent with the trust values. This issue was managed at a local level and it was expected that with the publication of the LPT Leadership Behaviors the team would have intervention from Organisational Development Team. This action has been deferred due to changes in teams, working environments and alternative work projects.

23. FYPC (LD) – a number of concerns were raised in relation to staff wellbeing and safety at the Agnes Unit. These were included in the wider Quality Summit for Learning Disability services held in January 2020 and led by the senior leadership team.

**Post COVID-19**

24. In the initial three weeks of the national pandemic there was a significant decrease in the number of cases that were referred to the FTSU Guardian and this appeared to mirror the experience of other Community Mental Trust Guardians. However since that time there has been a steady increase in the number of contacts.

25 *PPE, Service Delivery and Re-deployment* – a number of staff from a variety of services have spoken up both internally and externally to the CQC about their anxiety in relation to their own circumstances (home and work) and asking questions about the guidance regarding effective use of PPE in the community, changes to service delivery (telephone contacts and working from home) and redeployment. These were all managed locally through the publications and communications; Action Cards and COVID-19 staff bulletins and 1:1 or team meetings as appropriate.

26 *AMH (CMHT)* – issues have been raised from a group of individuals in relation to colleagues attitudes and behaviors not being consistent with the trust values. These matters are being managed through liaison with HR, senior manager and eventually through an OD intervention focused on the newly published Leadership Behaviors.

27 *Black, Asian and Minority Ethnic (BAME)* - The impact of COVID-19 on black, Asian and minority ethnic colleagues has been widely reported in the media and this created some anxiety with

individuals raising issues regarding their personal and work circumstances. These issues have been addressed individually and learning has been included in the work relating to the local BAME risk assessment, the staff engagement sessions for BAME colleagues and the movement for anti-racism. The FTSU Guardian is on the EDI Workforce Group and works closely with the Equality, Diversity and Inclusion (EDI) Team sharing information, highlighting significant themes and co-presenting the unconscious bias training across the trust. In addition the guardian regularly links in with the BAME staff support group. There are a number of BAME colleagues volunteering as FTSU Partners.

28. *Culture* – There has been a marked increase in the number of individual issues linked to staff experiencing incivility in the work place, reportedly creating strained relationships and resulting in work related stress. In most cases these have been resolved through conversation and resulted in signposting to other services including HR, occupational health and other mental health and wellbeing support agencies. It is anticipated that as speaking up is an intrinsic part of the (OFOW) programme, future actions will reference the Leadership Behaviours document and teams supported to access the OD interventions and resources.

29. All incidents and potential themes have been reported to the appropriate Directorate Management Teams or delegated representatives and managed at a local level. In all cases, staff that have spoken up have received ongoing feedback on the progress made to resolve issues or on the final outcome where appropriate, observing confidentiality. Concerns that are raised to external agencies by a staff member are included in the FTSU record log to ensure information is triangulated and provides opportunity for early recognition of any wider themes.

**Actions**

- Work with HR and Learning Lessons Exchange group to complete gap analysis on most recent NGO case review.
- Use guidance from WRES and NGO to review current practice, supporting colleagues from BAME heritage and ensure they have confidence in the speaking up processes available in LPT.
- Continue to develop the role of the FTSU Partners ensuring wider representation across the Trust.
- Maintain visibility across the wider trust to raise awareness of the speaking up role and embedding FTSU message.
- Maintain links with OD service to develop and support training (core, line and middle management, senior leader training) in line with NGO guidelines.
- Continue to engage in regional and national FTSU meetings and conferences thereby using updates, information and recommendations to inform best practice.

**Conclusion**

25. The Freedom to Speak Up agenda is building an environment where staff know their concerns, feedback and commentary are taken seriously and welcomed as an opportunity to guide service improvement and transformation.

26. Feeling free to speak up is a significant culture change across the NHS. Success is not only the responsibility of those in the guardian role. It is vital the Trust learn from concerns that staff raise and ensure changes or actions are implemented, otherwise there will be no value in the process and we would be missing out on some of the most valuable information that comes from these reports.

Presenting Director: Angela Hillery
Author(s): Pauline Lewitt

Leicestershire Partnership NHS Trust

| | |
|---|---|
| Meeting Name and date | Trust Board 7th July 2020 |
| Paper number | **R** |

| |
|---|
| Name of Report: Equality, Diversity and Inclusion Annual Report. |

| | | | | | |
|---|---|---|---|---|---|
| For approval | | For assurance | x | For information | |

| | | | |
|---|---|---|---|
| Presented by | Sarah Willis Director HR &OD Haseeb Ahmad, Equality, Diversity and Inclusion Lead | Author (s) | Haseeb Ahmad, Equality, Diversity and Inclusion Lead |

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

| Report previously reviewed by | |
|---|---|
| Committee / Group | Date |
| EDI Workforce Group | 20 May 2020 |

| Assurance: What assurance does this report provide in respect of the Organisational Risk Register? | Links to ORR risk numbers |
|---|---|
| Assurance that the Trust is meeting its statutory duties in relation to reporting and progressing EDI work and priorities. | 24 |

| Recommendations of the report |
|---|
| To recommend that the Trust Board is assured that:<br><br>1. LPT is complying with its legal and statutory obligations.<br><br>2. That the governance on EDI is working effectively to manage the wide ranging and |

complex agenda across workforce and service delivery.

3. The Trust has sufficient EDI plans in place which are responding to the needs and requirements of a diverse workforce and local population.

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Leicestershire Partnership NHS Trust

**Trust Board 7th July 2020**

# Annual Equality Diversity and Inclusion Report

## 1. Introduction/Background

LPT has been meeting its statutory and legal obligations under the Equality Act 2010 in accordance with EHRC Codes of Practice and NHS mandated Standards. The national focus on Workforce Race Equality Standard (WRES) data has grown since its introduction in 2015 and the Workforce Disability Equality Standard (WDES) was introduced in 2018.

In July 2019 Trust Board received the Annual Workforce EDI Report which presented the equalities workforce data and the significant work being undertaken to tackle gaps and advance equality of opportunity. This was the third year of reporting against our Workforce Race Equality Standard (WRES) data and the first year we reported against the Disability Workforce Equality Standard (WDES) data. WRES and WDES action plans were also presented and adopted and appropriate information published on Trust webpages as per statutory requirements.

LPT has been responding positively to the challenges which have emerged as a result of the findings of workforce data analysis and more recently the issues Covid19 have presented.

## 2. Aim

This report sets out an overview of the EDI work that has been undertaken over the past 12 months, LPT's current position and the plans for 2020/21 as LPT moves in to recovery phase of COVID 19.

## 3. Recommendations

To recommend that the Trust Board is assured that:

a. LPT is complying with its legal and statutory obligations.

b. That the governance on EDI is working effectively to manage the wide ranging and complex agenda across workforce and service delivery.

c. The Trust has sufficient EDI plans in place which are responding to the needs and requirements of a diverse workforce and local population.

## 4.0 Discussion



In line with the trust Step up to Great strategy and the priority within the strategy brick of Equality leadership and culture.

We have continued to progress our leadership culture and inclusion programme 'Our Future our Way' and the key actions we agreed related to WRES.


### 4.1 Current and Ongoing EDI Priorities

The following outlines key pieces of work implemented during the year some of which have had to be reframed in light of COVID 19.

- Launched our leadership behaviours of which the following specifically related to equality:
    - **Recognising and valuing people's differences**, described as, *"We respect everyone equally by helping to create a community that demonstrates unconditional positive attitudes; where people feel they belong, are valued, empowered and proud to work at LPT"*
- WRES – continued to progress work in the WRES action plan, actions of which were agreed in collaboration with our BAME Workforce.
- WDES – the Trust published its WDES data for the first time in 2019 as required and has an action plan which is regularly reviewed by the EDI Group and MAPLE our Staff disability network.
- EDI Governance – the governance on EDI has been strengthened in line with our revised governance arrangements. The trust has a workforce EDI Group and EDI patient experience and Involvement group to focus specifically on patient and service user issues.
- Delivered the Reverse Mentoring scheme with the first cohort successfully reviewed and well received.
- Cultural awareness training programme commenced and well received.
- Interview skills training and careers conversation programmes in place.
- Completed our third bank staff survey and ensured actions following feedback were aligned to existing EDI work streams.

**Actions during Covid19**

- LPT are one of the major partners on an LLR system wide EDI Taskforce convened to discuss and inform a system wide approach to issues arising from the Covid epidemic. Weekly meetings have taken place since April 2020 and communications developed and circulated to LPT staff.
- LPT have carried out 3 listening events with our BAME staff in response to concerns of the disproportionate impact of Covid on these communities. Over 200 staff have engaged with these sessions. Yvonne Coghill (WRES National Lead) joined us on one of the early listening events.
- A risk assessment tool has been developed in consultation with BAME staff and 3 workshops run with line managers. These have been very positively received. We are in the process of risk assessing our whole workforce.

- We are running regular OD sessions on having compassionate conversations with staff during COVID 19.

- Staff support networks have moved virtually through MS Teams which has enabled access and membership to grow considerably across our groups.

- Collaboration work on supporting our BAME workforce in place with NHFT buddy trust and Sussex partnership trust. This work has been shared across senior leader executive networks nationally.

- Senior leadership support and response to 'black lives matter' setting out our commitment to anti-racism. We are using the following framework moving to the growth zone in our weekly OD sessions with staff:
    - The fear zone – where people deny that racism is even a problem, avoid questions and don't feel comfortable talking about it.
    - The learning zone – where people recognise it is a problem and seek to educate themselves, and understand they are vulnerable to their own biases.
    - The growth zone –where you sit with discomfort, educate peers, you don't let mistakes deter you from being better, and identify where you unknowingly may benefit from racism.

**5.0 Statutory Duties**

**5.1 Publication of equality information in line with the Equality act 2010**

The Trust has a legal obligation to publish information on its access to services by its service users including complaints data. This information has been published annually by the Trust and the 2018/19 demographic and complaints information analysed by protected characteristics has been produced and presented at the EDI Patient Experience and Involvement Group. The main findings indicated that the trust needs to work on ensuring that it better captures the protected characteristics of its patients which will ensure a more accurate picture of which groups of patients are able to access services and identify gaps in service provision. In this respect work is progressing in updating the patient information template and issuing guidance to staff on ensuring that equalities monitoring questions are completed for patients and service users. The recording of patient and service user demography has been improving since the patient information templates have been updated in some service areas and the drive to collect more accurate information has been implemented.

The Service User demographic data and complaints report can be found on the trust EDI webpages from the following links:
https://www.leicspart.nhs.uk/wp-content/uploads/2020/01/equality-analysis-demographic-profile-of-service-users-18-19-REDACTED-FOR-PUBLICATION-v1_2.pdf
https://www.leicspart.nhs.uk/wp-content/uploads/2020/01/equality-analysis-service-user-complaints-18-19-REDACTED-FOR-PUBLICATION-v1_2.pdf

**5.2 Gender Pay Gap Reporting**

The Trust is required to produce Gender Pay Gap reporting annually. The Trust has produced its GPG analysis for 2018/19 and developed an action plan to address any gaps identified on gender pay. From the analysis it would appear that the main reason for the gender pay gap in the Trust is two-fold. Within the non-clinical areas there are a disproportionate number of full time senior roles occupied by male employees. Secondly the Clinical Excellence Awards have favoured male consultants (an issue which is being addressed nationally). The Trust has well established flexible working schemes in place and will continue to work towards providing access to further flexible working in areas where females are traditionally under-represented. The requirement to publish the GPG has been suspended for 2020 however LPT has completed the analysis and the Gender pay gap Report 2018/19 is available here:
https://www.leicspart.nhs.uk/about/equality-and-human-rights/publication-of-equality-information/

### 5.3 Equality Delivery System Grading

The Trust carried out its Trust wide Equality Delivery System grading for 2018/19. The Trust has historically graded against all of the objectives across all service areas. The EDS2 guidance advises that Trusts should pick a small number of services/areas in any given time period to ensure that a meaningful process is undertaken. To grade (and collect evidence) across all services consecutively is too onerous an exercise and is not a useful means to identify areas for improvement.

After discussion with Directorates our plan is that we will systematically manage a programme of future grading across a range of agreed services each year. This will be in accordance with the EDS guidance and any future iteration of it. This will be a much improved approach that will lead to identification of best practice where this exists, gaps where actions need to be addressed and involvement of patients/service users in the grading process. Additionally it is proposed that the rolling programme will be included in the revised EDI Strategy 2021 – 24 when this is developed and published.

### 6.0 Priorities 2020/21

The following are the main priorities for 2020/21:

- Continue to respond to COVID 19 impact through risk assessments and staff support for all protected characteristic groups.
- WRES and WDES metrics will be received at QAC in July 2020 for ongoing publication.
- Refreshed WRES and WDES action plans developed and published in response to listening events and data published.
- Deliver the WRES Culture change pilot programme once it is recommenced with the national Team (paused due to COVID).
- EDI strategy due for review.
- The role of staff support networks strengthened within governance and decision-making, staff networks membership forms part of this group.
- Ensure the full and meaningful implementation of NHSE&I EDS2, AIS.
- Renew Disability Confident status and assess progress to moving to level 3 (currently at level 2).
- Ensure consistent and systematic embedding of EDI across the system by working closely with the LLR Academy EDI Taskforce.
- Embed approaches to Equality Impact Assessments ensuring effective engagement with patients and service users with protected characteristics
- Continue to grow staff engagement through frequent listening events.
- Continue to develop 100% compliance with diverse interview panels
- Continue with interview skills training and career conversations for the BAME workforce delivered through virtual sessions during covid 19.
- Improve reporting of staff declaring disability in ESR.

## 7.0 Conclusion

The Trust is and has concentrated considerable focused work on delivering its EDI responsibilities over the past 12 months, particularly more so recently, given the challenges Covid19 has presented.

The EDI requirements for the NHS are substantial the Trust has been prioritising race equality during 2019/20. In addition to the focus on race equality LPT has ensured that it has continued to meet its statutory responsibilities across other protected characteristics.

Covid19 has highlighted significant inequalities nationally and locally in the delivery of services and the disproportionate impact on staff with protected characteristics that are older, male, and pregnant and from BAME backgrounds. These inequalities have enabled LPT and its system partners to identify opportunities to put in place additional measures to mitigate negative impacts such as risk assessment processes with supportive conversations as well as identify measures to promote and advance equality of opportunity.

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Leicestershire Partnership NHS Trust

# FINANCE AND PERFORMANCE COMMITTEE – 16 JUNE 2020

# 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 Reference |
|---|---|---|---|
| Matters Arising | NA | The Chair confirmed the focus of the meeting remained primarily on assurance around the 6 Covid-19 priority areas. As part of the transition from this to the restoration, recovery stages the committee agreed it would now start to consider appropriate items off its work plan.<br>Following discussion at QAC it was confirmed FPC would receive an update on the Harm Assurance policy with specific focus on the approach to the waiting list recovery process. | 38, 40, 48 |
| Director of Finance Report | NA | A verbal update was delivered. Restoration and recovery actions will be on a national, regional, LLR and LPT level. NHSIE Midlands have requested understanding of the services where significant changes have been made due to Covid-19, detailing those we wish to retain and make permanent. There are 3 major areas in terms of significant services we would like to keep. Rehabilitation – the community services that LPT discharge into; the Central Access Hub and the Mental Health Emergency Department. The NHSIE toolkit is being used to develop this piece of work.<br><br>Phase 3 of Covid-19 is expected to involve guidance around capacity requirements moving forward which will give clarity for operational and financial planning. This provides us with the opportunity to capture the stepping up of the capacity to deal with some of the issues that presented during the period including staff risk assessment including BAME staff risk assessments, IPC, quality and safety and finance and contracting. Early guidance is expected to be released at the beginning of July to discuss these items.<br><br>The H&S team are working to make LPT's sites Covid-19 secure during the restoration process and this is a critical enabler to re-establishing services. | |
| ORR | High | FPC has oversight of 14 risks. 10 of these are high risk, 3 of | All |

| Report | Assurance level* | Committee escalation | ORR/Risk Reference |
|---|---|---|---|
| | | those 10 being rated 20 the highest risk rate possible following Covid-19 impact reviews covering Finance, Access and quality of care.<br>As a result 7 new additional Covid-19 risks have been added to the register. These are being managed by the Executive Board. Risk 40 covering Covid-19, it was agreed, now has clearer focus as a corporate risk due to the addition of these additional specific 7 risks.<br>As part of this review Risk 38/39 Financial risks are being reviewed to reflect restoration and recovery. KD confirmed that the new financial risk will be presented at the 21st July FPC.<br>The committee supported 1 risk closure – risk 20 due to the out of area bed trajectory being met and a reduction in risk score to risk 22 Information systems following external reviews received at FPC.<br>The ORR would now reflect Covid-19 as the new normal and the committee approved as part of the transition the removal of the red boxes and the information contained within them. | |
| Annual Review of the FPC Committee | High | The Chair thanked everyone for their contribution in 19/20 and to the completion of the review. It recognised the significant change the committee had contributed to in improving triangulation with QAC, the development and embedding of new Governance, ORR processes and its flexibility and adaptability in response to Covid-19.<br>The committee discussed the importance in 20/21 of building on these foundations by embedding appropriate assurance and performance measures further within it and its subcommittees and continuing to develop its quality improvement focus including the patient and staff viewpoint.<br>The committee agreed with the proposal to use the 'buddy' relationship and next joint FPC and QAC workshop in September to develop these themes and appropriate actions further. | 20, 38, 40, 48 |
| Finance Report | Medium | LPT continues to operate under the Covid-19 regime – reimbursement, block payment and a top up for Covid-19 specific expenditure. LPT continues to report a break even position. To date there had been £1.2m Covid-19 expenditure and work was underway to refine understanding of our top-up. There is currently no assurance around normal income post Covid-19 as LPT await confirmation of when the covid-19 financial arrangements will cease. No planning guidance has been received from NHSEI nationally as yet and it remains difficult to plan financially without this. | 5, 38, 40, 48 |
| Combined Directorate Report | Medium | CHS had delivered CIPs for schemes that were in place at the beginning of the year and reported a 2 month underspend. FYPC&LD improved on month 1 with a small overspend. MH also benefitted from CIPs and an improvement on month1 resulting in a slight underspend<br>The Chair asked the committee following last month's discussion to note the revision to the Capital plan with a focus on new investment in Agile Working, the mental health outpatients SOC and improving disability access. The Chair questioned why the Covid-19 spend is so high in Mental Health and so low in Community Services. DC suggested that this was likely to be linked to the establishment of the Central Access Point and Emergency Department within the Mental | 5, 38, 40, 48 |

| Report | Assurance level* | Committee escalation | ORR/Risk Reference |
|---|---|---|---|
| | | Health Directorate and within Community Services the surge wards were not all used and the staff there were redeployed. PP confirmed that CHS had not processed all of the covid-19 spend yet due to bank code difficulties so the gap may not be as large as it shows currently.<br>The Chair requested some cross reference on spend to provide assurance and differentiate between one off and recurrent spends. DC confirmed that this is being done as part of the review of the underlying financial position across directorates.<br>The committee agreed a reasonable level of assurance as the financial position was reported as break even. Although significant progress was being made in understanding the underlying position it was still yet to be fully developed. | |
| Performance Report | Low | The Coivid-19 updates this month include reinstated Directorate reviews from May 2020, and the partnership work with both LLR and NHFT. Work is being progressed to give appropriate assurance in the performance report around restore, recover and retain during this next transitioning phase. Underpinning this work are recovery groups, local recovery work and STP recovery work. LH also explained that a plan is in place to identify what has happened due to Covid. The committee confirmed that the report process was now established but until FPC have the recovery and restoration principle in place they are not able to get full assurance on performance. It was noted the Trust Board had a development meeting scheduled to agree the approach, priorities and process.<br>The committee received and noted the report, the significant impact of Covid-19 and the work starting on restore, recovery and retain. Assurance around how and when performance would be recovered was now being undertaken. | 20, 35, 40, 38, 48 |
| Waiting Times Report | Low | The wait times dashboard shows lower levels of compliance with waiting times across the board as the impact of Covid-19 was now emerging. An increasing number is showing on the 52 week wait list. The slides in the pack detailed LPT wait times compared to national targets and PEIR targets. LPT wait times have further deteriorated but remain green against PEIR targets. It was confirmed that post Covid-19 there will be a different set of criteria and the range of services reporting on may be different moving forward. The Recovery Coordinating Group had a specific workstream for waiting times and recognized within its brief the potential impact of deferred referrals. The Chair confirmed that in the context of the Covid-19 position this report offers assurance around measuring performance and that it is important to consider how the Harm Assurance policy will support recovery. These are scheduled to be addressed at next month's FPC. DC confirmed that the recovery plans will form the basis of assurance for FPC. The committee received and noted the Internal Audit Report for waiting times which recognised the work undertaken. FPC would receive updates through the Waiting Time committees highlight report.<br>The committee recognised the significant improvement in reporting and work being undertaken to establish recovery plans. | 1, 5, 26, 28, 40, 44, 46, 47, 48 |
| Estates and | Medium | Preparation, equipping and commissioning of surge wards | 5, 10, 11, |

| Report | Assurance level* | Committee escalation | ORR/Risk Reference |
|---|---|---|---|
| Facilities Management Update | | are complete. CAMHs construction continues with a projected 9 week delay due to Covid-19. Elimination of dormitory accommodation and SOC works are progressing to plan. Facilities management contractual meetings with UHL have been suspended due to Covid-19 with informal work focused on Covid-19 progressing well. The last 3 months improvement data for FM remains below target.<br>All CQC actions from the last inspection have been completed. A data base for incidents now means that incidents can be prioritised and seen in real time which will help address the CQC's concerns around responsiveness in this area. PLACE Audits work is ongoing with colleagues in NHFT and Nottingham Healthcare to establish a cohort of assessors.<br>The committee agreed a medium level of assurance due to the continued performance issues around facilities management. | 40, 47, 48 |
| Facilities Business Case Proposal | Medium | The committee fully discussed the draft proposal. In particular balancing the need to progress the work when the full implications around the lift and shift principle are not clear. As a result the capital and revenue implications, cost benefits and risks cannot yet be fully defined. They felt that more information was required before it could be recommended for approval. It recognised and supported the need for a staged approach to the proposal and suggested the approach taken to the pay role contract was adopted.<br>Following some debate and discussion it was agreed that:<br>1) This document would be more clearly described as an outline business case. The key next steps would be highlighted for FPC and Trust Board agreement at each stage.<br>2) Further narrative would be developed to confirm the service proposition proposed around lift and shift and to highlight the planning risks assumed within the OBC.<br>3) That more detail around costs and benefits including any impact of TUPE and contract novation would be included in a full business case which would then come back to FPC to allow approval for the business transfer agreement for this service | 38, 40, 48 |
| IM & T Committee Highlight Report | High | The committee highlighted and confirmed that the Covid-19 impact and benefits review section were informative from an assurance perspective. The committee agreed that paper J provides high (green) assurance around the IM&T Committee and its work. | 22, 23, 40 |
| Estates Committee Highlight Report | High | All items listed in the report at amber have been reviewed. The committee agreed that paper K provides high assurance around the Estates Committee and its work. | 5, 10, 11, 40, 47, 48 |
| Transformation Committee Highlight Report | High | All projects are now agreed. Recruitment is ongoing for the PMO team. The community re-design work has now been signed off. The Agile Working Group now reports in to the Transformation Committee. | 6, 8, 40 |
| Capital Committee Highlight Report | High | An additional £1.3m in capital resource cover has been confirmed and a strategic approach has been agreed on its spend focused around the mental health inpatient outline business case; improving disability access, digital and agile working. The capital plan no longer assumes the sale of | 38, 40, 48 |

| Report | Assurance level* | Committee escalation | ORR/Risk Reference |
|---|---|---|---|
| | | Rubicon close in 20/21. | |
| FPC Workplan | NA | The draft work plan will now be circulated for final comment to Executive leads and then will be presented to FPC for approval at 21st July meeting. | |

| | |
|---|---|
| Chair | **Geoff Rowbotham, Non-Executive Director** |

Leicestershire Partnership NHS Trust

| | |
|---|---|
| Meeting Name and date | Trust Board meeting, 7th July 2020 |
| Paper Reference | T |

| |
|---|
| Name of Report: Month 2 Trust Finance Report |

| | | | | | |
|---|---|---|---|---|---|
| For approval | | For assurance | X | For information | X |

| | | | |
|---|---|---|---|
| Presented by | Danielle Cecchini, Director of Finance | Author (s) | Chris Poyser, Head of Corporate Finance; Jackie Moore, Financial Controller |

| Alignment to CQC domains: | | Alignment to LPT priorities for 2020/21 (STEP up to GREAT): | |
|---|---|---|---|
| Safe | | S – High Standards | |
| Effective | | T - Transformation | |
| Caring | | E – Environments | |
| Responsive | | P – Patient Involvement | |
| Well-Led | X | G – Well-Governed | X |
| | | R – Single Patient Record | |
| | | E – Equality, Leadership, Culture | |
| | | A – Access to Services | |
| | | T – Trustwide Quality improvement | |
| Any equality impact (Y/N) | N | | |

| **Report previously reviewed by** | |
|---|---|
| Committee / Group | Date |
| Finance & Performance Committee | 16 June 2020 |
| | |

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

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

T

Leicestershire Partnership NHS
NHS Trust

# Finance Report for the period ended
# **31 May 2020**

## For presentation at the
## **Trust Board**
## **7th July 2020**

# Contents

# Executive Summary and overall performance against targets

## Introduction

1. This report presents the financial position for the period ended 31 May 2020 (month 2). The report shows a year to date income and expenditure break-even for Trust budgets as a whole. As outlined in the report for month 1, the NHSI/E financial control total process and wider planning processes have been temporarily suspended for 2020/21. At present, Trusts are required to break even on a monthly basis, and additional financial support is provided by NHSE/I to enable Trusts to achieve this.

2. Within the Trust's overall M2 break-even position, operational budgets are currently overspending by £530k. Central reserves (which include the temporary national financial 'retrospective top-up' income accrual) are offsetting the operational overspend in order to achieve the overall break-even position.

3. Estates services report the largest overspend, standing at £481k (on a similar trajectory to 2019/20). Other overspends include Enabling Services (£172k), Learning Disabilities (£92k), Hosted (£91k) and FYPC (£16k). CHS are reporting an underspend of £223k, and AMH an underspend of £99k.

4. Closing cash for May stood at £36.3m. This equates to 46 days' operating costs.

| NHS Trust Statutory Duties | Year to date | Year end f'cast | Comments |
|---|---|---|---|
| **1. Income and Expenditure break-even.** | G | G | The Trust is reporting a break even position at the end of May 2020. Achievement of the statutory break-even duty by the end of the year is expected **[see 'Service I&E position' and *Appendix A*]**. |
| **2. Remain within Capital Resource Limit (CRL).** | G | G | The capital spend for May is £853k, which is within limits. |
| **3. Achieve the Capital Cost Absorption Duty (Return on Capital).** | G | G | The dividend payable is based on the actual average relevant net assets; therefore the capital cost absorption rate will automatically be 3.5%. |
| **4. Remain within External Financing Limit (EFL).** | n/a | G | The Cash level of £36.3m is above target due to temporary COVID-19 cash funding arrangements |

| Secondary targets | Year to date | Year end f'cast | Comments |
|---|---|---|---|
| **5. Comply with Better Payment Practice Code (BPPC).** | R | G | The target is to pay 95% of invoices within 30 days. Cumulatively the Trust achieved 3 of the 4 BPPC targets in May. |
| **6. Achieve Cost Improvement Programme (CIP) targets.** | n/a | n/a | As a result of the Covid-19 Financial arrangements, formal CIP reporting is currently suspended. |
| **7. Deliver financial plan surplus** | n/a | n/a | As a result of Covid-19 financial arrangements there is currently no control total surplus requirement. Trusts are expected to report income and expenditure break even on a monthly basis. |
| **Internal targets** | **Year to date** | **Year end f'cast** | **Comments** |
| **8. Achieve a Financial & Use of Resources metric score of 2 (or better)** | G | G | The Trust is currently scoring 2 for year-to-date performance. Whilst Trusts are responding to Covid it is not clear whether this target will formally monitored by NHSI/E. |
| **9. Achieve retained cash balances in line with plan** | G | G | A cash balance of £36.3m was achieved at the end of May 2020. **[See 'cash and working capital']** |
| **10. Deliver capital investment in line with plan (within +/- 15% YTD planned spend levels)** | G | G | Capital expenditure totals £853k at the end of month 2 **[See 'Capital Programme 2020/21']** |

# Temporary financial regime during Covid-19 pandemic

Nationally, the NHS response to the Covid pandemic has included a simplification of the finance/funding regime. This is primarily to ensure that providers have immediate access to adequate funding in order to properly respond to the many challenges that the pandemic brings.

The key changes are summarised below:

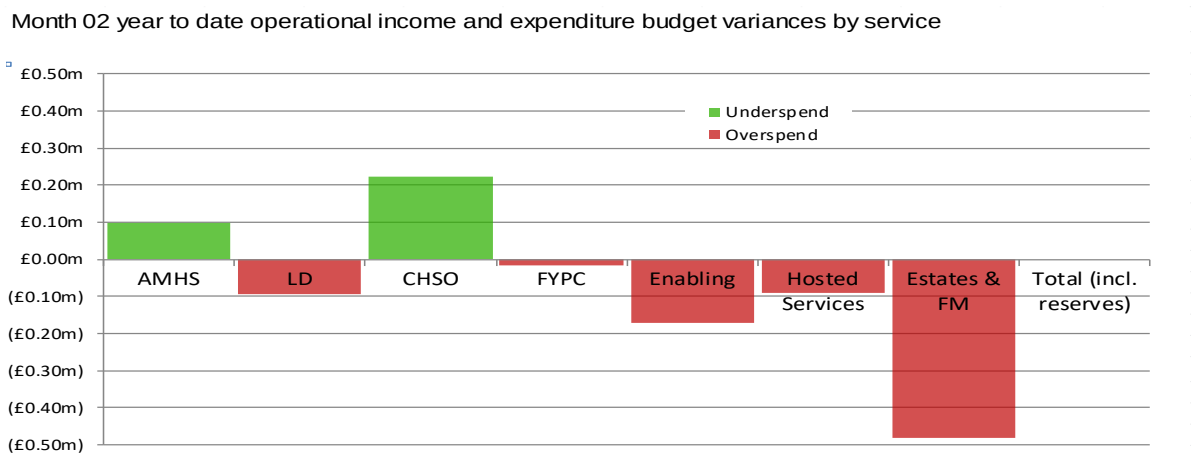
- Temporary suspension of formal 2020/21 planning / contracting round.
- Temporary suspension of tariff efficiency requirement.
- Simplification of main provider income streams via single fixed monthly payments made by commissioners (at least until 31 October 2020). These are based on 19/20 income levels, adjusted for gross inflation (i.e excluding the efficiency element). These amounts will not include any new investment, so where 'must-do' new investment remains a priority for the Trust, separate discussions with commissioners and possibly NHSI/E will be required.
- Temporary suspension of all Non-Contract Activity billing.
- Reclaim process to enable Covid direct expenditure to be reimbursed (now incorporated within the wider 'top-up' process outlined below).
- Retrospective financial 'top-up' process in place to ensure that Trusts disadvantaged by cost pressures and loss of income can still 'balance the books'.

Whilst the above processes satisfy the immediate requirement to ensure sufficient funding/cash is available, it remains imperative that the normal internal controls are maintained. Although it is likely that many of these changes will remain in force for the majority of this financial year, the Trust will still be required to accurately monitor and report financial performance, and to complete statutory returns including the final accounts at the end of the year. In addition, the NHSI funding returns are subject to separate audit review. In addition, when normal processes begin to be re-introduced, we will need to have a very clear understanding of what has transpired in the first part of the year so that this can be factored into future funding / contracting discussions.

## Income and Expenditure position

The month 2 position includes an operational overspend against underlying budgets that is currently offset by underspends and additional NHSI income included within central reserves.

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




Estates services are reporting an adverse variance of £481k in month 2. This overspend includes the recurrent underlying shortfall carried forward from last year plus further unfunded inflationary price increases on larger contracts from 1st April.

The Enabling 20/21 position marks a significant swing from the underspends reported last financial year, with budgets overspending by £173k. The overspend includes new costs which ordinarily would have been addressed through planning, budget setting and the cost improvement programme. The position is also missing the benefit of income over-recoveries which traditionally offset a number of cost pressures.

The temporary suspension of the planning, budget setting and CIP processes due to the current Covid-19 situation has reduced the scope of mitigation usually available to the Trust when managing cost pressures. At present, the national retrospective top-up process is being used to offset these pressures as well as to fund Covid costs. However, it is not yet clear how long the top-up will be available for, and consideration needs to be given to how the Trust's underlying position will be managed when the financial regime returns to something closer to 'normal' operations.

An additional appendix (***Appendix F***) has been included in the report this month. This seeks to analyse the underlying financial position by excluding the direct impact of Covid-19, and any top-up income. It also strips out any other one-off exceptional transactions that wouldn't normally be part of our operating position going forwards. The resulting position should begin to provide an indication of what the Trust's underlying financial position may look like post Covid-19. At present, this is likely to be a worst case position,

as at this stage none of our normal mitigations (CIPs, investment funding etc) can be assumed to be available to us.

We are developing a set of principles on how we can work to an appropriate cost based budget while we are operating under the Covid 19 financial regime. This might allow some planned investments to be implemented, while still working within the block payment value.

## Covid-19 expenditure and 'retrospective top-up'

The financial cost of the Trust's response to Covid-19 is recorded in order to provide accurate and timely monitoring of expenditure (both locally and nationally), and also to support the cost reclaim process.

The reclaiming of Covid-19 costs is now part of the wider monthly 'retrospective top-up' process. This mechanism has been put in place by NHSE/I to support Trusts through the wider Covid-19 phase and ensure that any cost pressures are fully offset by temporary support funding.

In addition to the direct costs of responding to Covid-19, the Trust is facing a number of other cost pressures, including (but not limited to) a large recurrent Estates overspend and significant shortfalls on a number of income streams (indirect effect of Covid-19 on the wider economy). All of these factors will contribute to our top-up requirement.

Covid-19 costs incurred in April were £563k. During May, Covid-19 costs were £691k. The increase in May is partly due to the payment of a large amount of backdated overtime claims related to March and April. (Estimated) March claims were provided for in the 2019/20 final accounts position, and this has partially reduced the impact on May costs that need to be reimbursed..

The total retrospective top-up claim for April was £983k (figure includes the £563k Covid-19 costs). This is due to be paid on June 15th – subject to final approval by NHSE/I. The top-up claim for May is still to be finalised, as considerable analysis work is required across each directorate to ensure that all assumptions built into positions are properly reflected in the total top-up value. However, as specific Covid-19 costs for May are already confirmed as £691k, it is anticipated that the overall May top-up will at least equal the April value, and may exceed it.

# Statement of Financial Position (SoFP)

| PERIOD: May 2020 | 2019/20 31/03/20 Audited £'000's | 2020/21 01/05/20 May £'000's |
|---|---|---|
| **NON CURRENT ASSETS** | | |
| Property, Plant and Equipment | 179,832 | 179,452 |
| Intangible assets | 2,473 | 2,418 |
| Trade and other receivables | 1,037 | 1,037 |
| **Total Non Current Assets** | **183,342** | **182,907** |
| **CURRENT ASSETS** | | |
| Inventories | 433 | 349 |
| Trade and other receivables | 12,162 | 15,603 |
| Cash and Cash Equivalents | 15,433 | 36,294 |
| **Total Current Assets** | **28,028** | **52,246** |
| **Non current assets held for sale** | **0** | **0** |
| **TOTAL ASSETS** | **211,370** | **235,153** |
| **CURRENT LIABILITIES** | | |
| Trade and other payables | (19,785) | (43,706) |
| Borrowings | (263) | (263) |
| Capital Investment Loan - Current | (189) | (189) |
| Provisions | (1,183) | (1,153) |
| **Total Current Liabilities** | **(21,420)** | **(45,311)** |
| **NET CURRENT ASSETS (LIABILITIES)** | **6,608** | **6,935** |
| **NON CURRENT LIABILITIES** | | |
| Borrowings | (7,761) | (7,761) |
| Capital Investment Loan - Non Current | (3,347) | (3,266) |
| Provisions | (647) | (621) |
| **Total Non Current Liabilities** | **(11,755)** | **(11,648)** |
| **TOTAL ASSETS EMPLOYED** | **178,195** | **178,195** |
| **TAXPAYERS' EQUITY** | | |
| Public Dividend Capital | 89,452 | 89,452 |
| Retained Earnings | 39,230 | 39,230 |
| Revaluation reserve | 49,513 | 49,513 |
| **TOTAL TAXPAYERS EQUITY** | **178,195** | **178,195** |

### Non-current assets

- Property, plant and equipment (PPE) amounts to £179.5m. This includes capital additions of £853k.

### Current assets

- Current assets of £52.2m include cash of £36.3m and receivables of £15.6m.

### Current Liabilities

- Current liabilities amount to £45.3m and mainly relate to payables of £43.7m.
- Net current assets / (liabilities) show net assets of £7m.

### Working capital

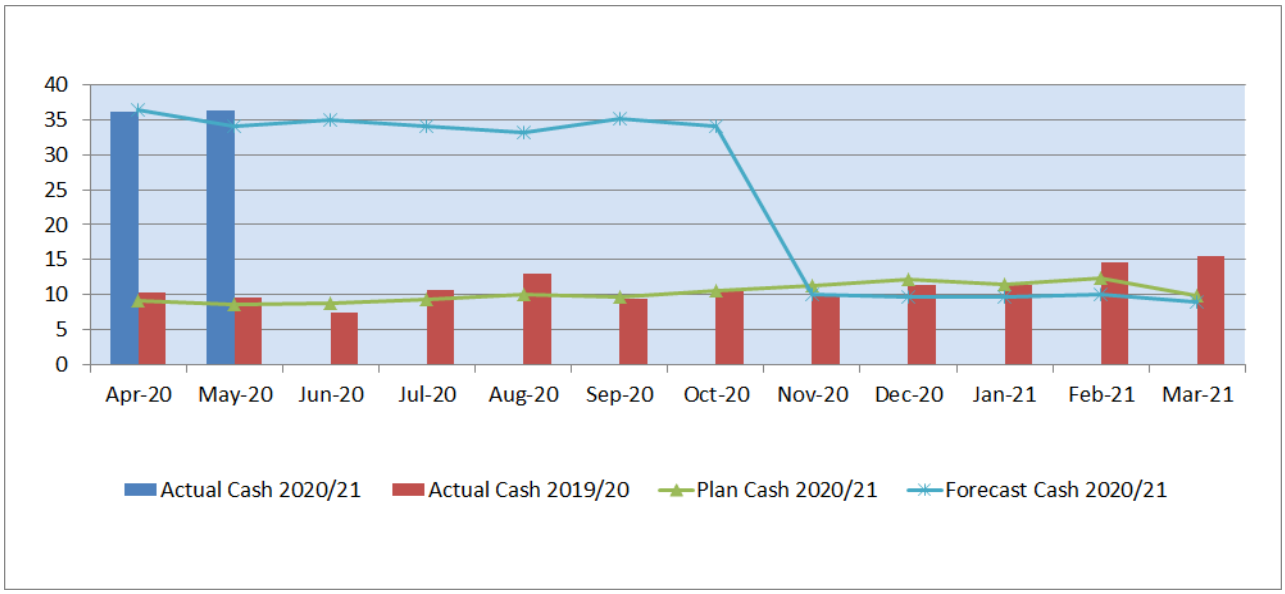
- Cash and changes in working capital are reviewed on the following pages.

### Taxpayers' Equity

- May's break-even position is reflected within retained earnings.

# Cash and Working Capital

## 12 Months Cash Analysis Apr 20 to Mar 21




### Cash – Key Points

The closing cash balance at the end of May was £36.3m, an increase of £202k during the month.

To assist provider organisations' cash-flow positions during the COVID-19 crisis, the Department of Health is issuing block contract income payments one month in advance. This has resulted in the receipt of June's block contract payments in May, benefiting the cash position by £23m. This advance payment has resulted in a corresponding liability (deferred income) on the balance sheet for the same amount. In 'real terms', excluding this advanced payment, the cash balance has reduced since the start of the year due to the payment of year end creditors.

A summarised cash-flow forecast is included at ***Appendix D.*** A year end closing cash balance of £9m is currently forecast. This is a reduction of £1.3m since the previous month's year end forecast of £10.3m due to an increase in this year's capital programme, to be funded from Trust cash reserves. This assumes:

- 2019/20 year end creditors will be paid in the first quarter of the year
- The Trust will breakeven at the end of the year (no I&E surplus is currently assumed, in line with national guidance)
- The monthly advanced block contract arrangement will continue until 31 October 2020
- The updated capital programme of £12.2m (previously £10.5m) will be delivered by the end of the financial year. The capital plan is £11.8m, however, the inclusion of PDC funded Covid capital claims takes the forecast outturn to £12.2m.

## Receivables

Current receivables (debtors) total £15.6m.

| Receivables | Current Month (May 2021) | | | | | |
|---|---|---|---|---|---|---|
| | NHS £'000 | Non NHS £'000 | Emp's £'000 | Total £'000 | % Total | % Sales Ledger |
| **Sales Ledger** | | | | | | |
| 30 days or less | 174 | 941 | (1) | **1,114** | **7.0%** | **20.3%** |
| 31 - 60 days | 44 | 118 | 8 | **170** | **1.1%** | **3.1%** |
| 61 - 90 days | 591 | 935 | 14 | **1,540** | **9.6%** | **28.1%** |
| Over 90 days | 2,010 | 476 | 179 | **2,665** | **16.7%** | **48.6%** |
| | 2,819 | 2,470 | 200 | **5,489** | **34.4%** | **100.0%** |
| **Non sales ledger** | 6,136 | 3,978 | 0 | **10,114** | **63.4%** | |
| **Total receivables current** | **8,955** | **6,448** | **200** | **15,603** | **97.7%** | |
| **Total receivables non current** | | 360 | | 360 | **2.3%** | |
| **Total** | **8,955** | **6,808** | **200** | **15,963** | **100.0%** | **0.0%** |

Debt greater than 90 days decreased by £130k since April and now stands at £2.7m. Receivables over 90 days should not account for more than 5% of the overall total receivables balance. The proportion at Month 2 is 16.7% (last month: 17.5%).

Due to the temporary arrangements put in place to simplify transactions with commissioners, the number of invoices raised to NHS customers has reduced significantly since the start of the year, hence the low value of '30 days or less' NHS debt.

The general bad debt provision for Non-NHS customers totals £391k. Formal debt chasing with Non-NHS organisations has been paused until July 2020 in light of the COVID-19 situation.

A review of our aged debt is being undertaken during June to identify those debts that need to be written-off. The details of those debts proposed for write-off will be included in next month's finance report.

## Payables

The current payables position in Month 2 is £43.7m; a small increase of £237k since the previous month. The advanced block contract payment of £23m is reported as deferred income within the overall payables balance. Excluding this amount the payables balance has increased by c£1m since the start of the year and mainly relates to accrued expenditure for the dividend payment to the Department of Health (payable in September).

| Payables | Current Month May 2020 | | | | |
|---|---|---|---|---|---|
| | NHS £'000 | Non NHS £'000 | Total £'000 | % Total | % Purchase Ledger |
| **Purchase Ledger** | | | | | |
| 30 days or less | 2,434 | 1,687 | **4,121** | **9.4%** | **59.3%** |
| 31 - 60 days | 471 | 124 | **595** | **1.4%** | **8.6%** |
| 61 - 90 days | 101 | 32 | **133** | **0.3%** | **1.9%** |
| Over 90 days | 2,046 | 57 | **2,103** | **4.8%** | **30.3%** |
| | 5,052 | 1,900 | **6,952** | **15.9%** | **100.0%** |
| **Non purchase ledger** | 24,965 | 11,789 | **36,754** | **84.1%** | |
| **Total Payables Current** | **30,017** | **13,689** | **43,706** | **100.0%** | |
| **Total Payables Non Current** | 0 | 0 | **0** | | |
| **Total** | 30,017 | 13,689 | 43,706 | **100.0%** | |

## Better Payment Practice Code (BPPC)

The specific target is to pay 95% of invoices within 30 days. Cumulatively the Trust achieved 3 of the 4 BPPC targets in May. The target not achieved related to the number of NHS invoices paid within 30 days (93.8%). Of the 38 invoices paid in May, two were outside of the target period. The achievement of the target has a very slim tolerance threshold due to the low number of NHS invoices actually paid each month. If the two late NHS invoices in May had been paid on time, the cumulative target of 95% would have been met.

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

## Capital Programme 2020/21

Capital expenditure totals £853k at the end of month 2 and continues to relate to CAMHS construction costs and IM&T staffing recharges. Following FPC approval last month, forecast expenditure has been adjusted to reflect changes in scheme delivery due to COVID-19 implications. These changes are now reflected in the table below.

The annual plan has been updated and now totals £11.85m. This is an increase of £1.3m since the original plan was approved at the start of the year, following agreement that the STP capital plan should be implemented. A revised LPT capital plan was submitted to NHSI in May. The Capital Committee meeting in June considered the strategic use of the additional funding. Predominantly, it will support the Bradgate Unit OBC fees and increase the IM&T rolling replacement programme and approach to resilience and agile working. The Trust will use its cash reserves (from previous years' I&E surpluses) to cover the extra spend. Cash reserves are also now being used instead of disposal proceeds from the sale of Rubicon Close (£250k) as it is now deemed unlikely to sell in this financial year.

A capital claim has been submitted to NHSI for capital COVID works totalling £390k. This includes the development of the surge wards in April and more recently the reconfiguration of Wakerley, Beaumont and Gwendolen wards. If funding is not approved the Trust will need to cover the additional £390k from its existing allocation.

| | Annual Plan Original | Annual Plan Adjts | Annual Plan Updated | May Actual Exp | Year End Forecast | Revision to Plan |
|---|---|---|---|---|---|---|
| **Sources of Funds** | **£'000** | **£'000** | **£'000** | **£'000** | **£'000** | **£'000** |
| Depreciation | 7,200 | (21) | 7,179 | 853 | 7,179 | 0 |
| STP capital for CAMHS (PDC) | 2,898 | 0 | 2,898 | 0 | 2,898 | 0 |
| PFI Agnes Unit capital lifecycle replacement | 100 | 0 | 100 | 0 | 100 | 0 |
| Cash utilisation of previous years' surpluses | 100 | 1,574 | 1,674 | 0 | 1,674 | 0 |
| Asset Sales | 250 | (250) | 0 | 0 | 0 | 0 |
| COVID-19 Central allocation - TBC | 0 | 0 | 0 | 0 | 390 | 390 |
| **Total Capital funds** | **10,548** | **1,303** | **11,851** | **853** | **12,241** | **390** |
| **Application of Funds** | **£'000** | **£'000** | **£'000** | **£'000** | **£'000** | **£'000** |
| **Estates & Innovation** | | | | | | |
| Service Improvements | (3,618) | 0 | (3,618) | (407) | (3,618) | 0 |
| Backlog (inc £302k contingency) | (1,785) | 0 | (1,785) | (49) | (1,917) | (132) |
| Rolling programme & other projects | (1,349) | 0 | (1,349) | (5) | (1,117) | 232 |
| Medical devices | (213) | 0 | (213) | 0 | (213) | 0 |
| COVID-19 | 0 | 0 | 0 | 0 | (390) | (390) |
| **Sub-total:** | **(6,965)** | **0** | **(6,965)** | **(461)** | **(7,255)** | **(290)** |
| **IT Programme** | | | | | | |
| Rolling programmes | (2,030) | 0 | (2,030) | (319) | (2,230) | (200) |
| Other projects (inc £50k contingency) | (1,553) | 0 | (1,553) | (73) | (1,453) | 100 |
| | **(3,583)** | **0** | **(3,583)** | **(392)** | **(3,683)** | **(100)** |
| **New funding - to be allocated** | **0** | **(1,303)** | (1,303) | 0 | (1,303) | 0 |
| **Total Capital Expenditure** | **(10,548)** | **(1,303)** | **(11,851)** | **(853)** | **(12,241)** | **(390)** |
| **(Over)/underspend against resource available** | **0** | **0** | **0** | **0** | **0** | **0** |

# APPENDIX A - Statement of Comprehensive Income (SoCI)

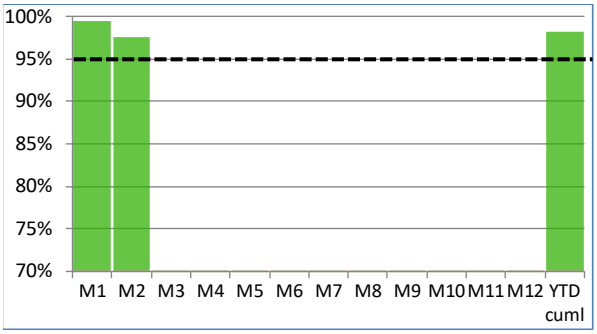
| Statement of Comprehensive Income for the period ended 31 May 2020 | YTD Actual M02 £000 | YTD Budget M02 £000 | YTD Var. M2 £000 |
|---|---|---|---|
| **Revenue** | | | |
| Total income | 49,494 | 47,906 | 1,588 |
| Operating expenses | (48,160) | (46,564) | (1,596) |
| **Operating surplus (deficit)** | **1,334** | **1,342** | **(8)** |
| Investment revenue | 7 | 0 | 7 |
| Other gains and (losses) | 0 | 0 | 0 |
| Finance costs | 0 | 0 | 0 |
| **Surplus/(deficit) for the period** | **1,341** | **1,342** | **(1)** |
| Public dividend capital dividends payable | (1,341) | (1,342) | 1 |
| **I&E surplus/(deficit) for the period (before tech. adjs)** | **0** | **0** | **0** |
| IFRIC 12 adjustments | 0 | 0 | 0 |
| Donated/government grant asset reserve adj | 0 | 0 | 0 |
| Technical adjustment for impairments | 0 | 0 | 0 |
| **NHSI I&E control total surplus** | **0** | **0** | **0** |
| **Other comprehensive income (Exc. Technical Adjs)** | | | |
| Impairments and reversals | 0 | 0 | 0 |
| Gains on revaluations | 0 | 0 | 0 |
| **Total comprehensive income for the period:** | **0** | **0** | **0** |
| **Trust EBITDA £000** | **2,259** | **2,267** | **(8)** |
| **Trust EBITDA margin %** | **4.6%** | **4.7%** | **-0.2%** |

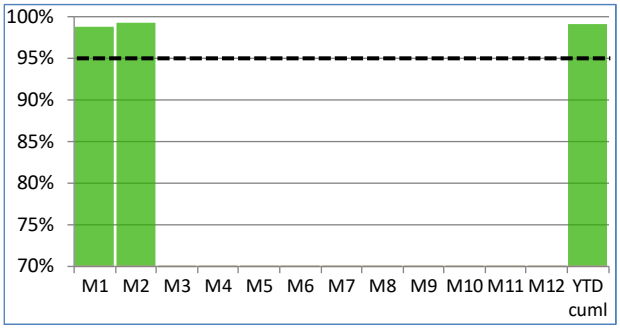
# APPENDIX B – BPPC performance

## Trust performance – current month (cumulative) v previous

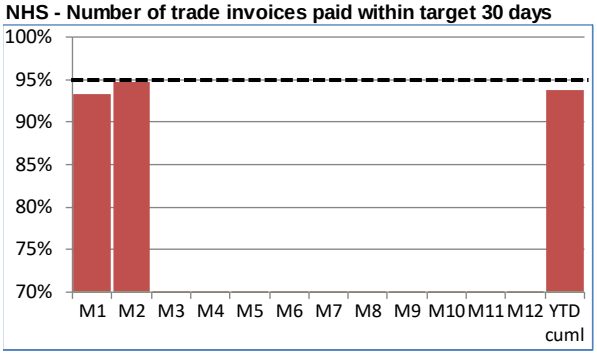
| Better Payment Practice Code | May (Cumulative) | | April (Cumulative) | |
|---|---|---|---|---|
| | Number | £000's | Number | £000's |
| Total Non-NHS trade invoices paid in the year | 4,214 | 16,072 | 1,536 | 5,049 |
| Total Non-NHS trade invoices paid within target | 4,140 | 15,930 | 1,527 | 4,988 |
| **% of Non-NHS trade invoices paid within target** | **98.2%** | **99.1%** | **99.4%** | **98.8%** |
| Total NHS trade invoices paid in the year | 128 | 8,648 | 90 | 2,432 |
| Total NHS trade invoices paid within target | 120 | 8,609 | 84 | 2,405 |
| **% of NHS trade invoices paid within target** | **93.8%** | **99.5%** | **93.3%** | **98.9%** |
| Grand total trade invoices paid in the year | 4,342 | 24,720 | 1,626 | 7,481 |
| Grand total trade invoices paid within target | 4,260 | 24,539 | 1,611 | 7,393 |
| **% of total trade invoices paid within target** | **98.1%** | **99.3%** | **99.1%** | **98.8%** |

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

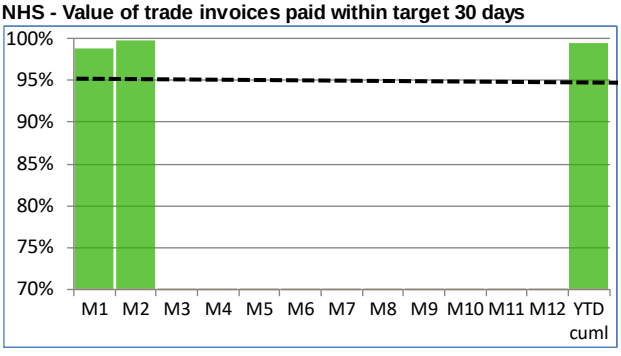



NHS - Number of trade invoices paid within target 30 days




NHS - Value of trade invoices paid within target 30 days



# APPENDIX C – Agency staff expenditure

| 2020/21 Agency Expenditure (includes prior yr comparators) | 2019/20 Outturn £000s Actual | 2019/20 Avg. mnth £000s Actual | | 2020/21 M1 £000s Actual | 2020/21 M2 £000s Actual |
|---|---|---|---|---|---|
| **AMH (19/20 includes LD)** | | | | | |
| Agency Consultant Costs | -1,008 | -84 | | -109 | -145 |
| Agency Nursing | -1,797 | -150 | | -145 | -129 |
| Agency Scient, Therap. & Tech | -213 | -18 | | -6 | -11 |
| Agency Non clinical staff costs | -241 | -20 | | -5 | -6 |
| **Sub-total** | **-3,259** | **-272** | | **-266** | **-291** |
| **LEARNING DISABILITIES (from 20/21)** | | | | | |
| Agency Consultant Costs | - | - | | 0 | 0 |
| Agency Nursing | - | - | | -7 | -7 |
| Agency Scient, Therap. & Tech | - | - | | 0 | 0 |
| Agency Non clinical staff costs | - | - | | 0 | 0 |
| **Sub-total** | **0** | **0** | | **-7** | **-7** |
| **CHS** | | | | | |
| Agency Consultant Costs | -107 | -9 | | 0 | 0 |
| Agency Nursing | -3,710 | -309 | | -234 | -249 |
| Agency Scient, Therap. & Tech | -517 | -43 | | -31 | -25 |
| Agency Non clinical staff costs | 0 | 0 | | 0 | 0 |
| **Sub-total** | **-4,334** | **-361** | | **-265** | **-273** |
| **FYPC** | 0 | | | | |
| Agency Consultant Costs | -440 | -37 | | -52 | -57 |
| Agency Nursing | -1,467 | -122 | | -120 | -136 |
| Agency Scient, Therap. & Tech | -70 | -6 | | 0 | 0 |
| Agency Non clinical staff costs | -82 | -7 | | 0 | 1 |
| **Sub-total** | **-2,059** | **-172** | | **-173** | **-192** |
| **Enabling, Hosted & reserves** | | | | | |
| Agency Consultant Costs | 0 | 0 | | 0 | 0 |
| Agency Nursing | 26 | 2 | | 0 | 0 |
| Agency Scient, Therap. & Tech | -142 | -12 | | -8 | 0 |
| Agency Non clinical staff costs | -425 | -35 | | -38 | -41 |
| **Sub-total** | **-541** | **-45** | | **-47** | **-41** |
| **TOTAL TRUST** | | | | | |
| Agency Consultant Costs | -1,555 | -130 | | -162 | -202 |
| Agency Nursing | -6,948 | -579 | | -506 | -520 |
| Agency Scient, Therap. & Tech | -943 | -79 | | -46 | -36 |
| Agency Non clinical staff costs | -747 | -62 | | -44 | -46 |
| **Total** | **-10,193** | **-850** | | **-757** | **-804** |
| Direct Covid-19 costs | 0 | 0 | | 27 | 50 |
| **Total excluding Covid-19 costs** | **-10,193** | **-850** | | **-730** | **-754** |

## **APPENDIX D** – Cash flow forecast (summarised)

| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Year |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Actual | Actual | Forecast | Forecast | Forecast | Forecast | Forecast | Forecast | Forecast | Forecast | Forecast | Forecast | Forecast |
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| | | | | | | | | | | | | | |
| **Opening cash** | **15,433** | **36,091** | **36,294** | **34,960** | **34,126** | **33,192** | **35,156** | **34,163** | **10,088** | **9,665** | **9,672** | **9,929** | **15,433** |
| CCG block income prepayments (deferred income re COVID) | 23,000 | 0 | 0 | 0 | 0 | 0 | 0 | (23,000) | 0 | 0 | 0 | 0 | 0 |
| Operating surplus before depreciation & financing activities | 701 | 739 | 701 | 701 | 701 | 3,314 | 701 | 739 | 701 | 701 | 701 | 3,308 | 13,708 |
| Movement in working capital | (2,666) | 447 | (1,000) | (500) | (500) | (500) | (500) | (500) | 70 | 500 | 750 | 1,000 | (3,399) |
| Cashflows from investing activities - capital programme | (183) | (670) | (841) | (841) | (941) | (1,331) | (1,000) | (1,000) | (1,000) | (1,000) | (1,000) | (2,434) | (12,241) |
| Cashflows from financing activities | (194) | (313) | (194) | (194) | (194) | 481 | (194) | (314) | (194) | (194) | (194) | (2,803) | (4,501) |
| **Closing cash** | **36,091** | **36,294** | **34,960** | **34,126** | **33,192** | **35,156** | **34,163** | **10,088** | **9,665** | **9,672** | **9,929** | **9,000** | **9,000** |

# APPENDIX E – Identified Covid-19 expenditure, May 2020

## COVID SPEND 2020/21

**M2 YEAR TO DATE** | **Run-rate**

| MONTH 2 YTD 2020/21 IDENTIFIED COVID SPEND | AMH £ | CHS £ | LD £ | FYPC £ | ESTS £ | ENAB £ | TOTAL M2 Cuml YTD £ | M1 run-rate £ | M2 run-rate £ |
|---|---|---|---|---|---|---|---|---|---|
| **PAY** | | | | | | | | | |
| Substantive staff | 120,564 | 10,948 | | 65,395 | | 12,993 | 209,900 | 37,051 | 172,849 |
| Bank staff | 149,416 | 42,174 | 34,921 | 22,515 | | 3,643 | 252,669 | 137,061 | 115,608 |
| Agency staff | 8,213 | 68,305 | | 551 | | 0 | 77,069 | 26,849 | 50,220 |
| **TOTAL PAY** | **278,193** | **121,427** | **34,921** | **88,461** | **0** | **16,636** | **539,638** | **200,961** | **338,677** |
| **NON-PAY** | | | | | | | | | |
| PPE | | | | | | 125,887 | 125,887 | 37,593 | 88,294 |
| Medical Oxygen Supplies / Gases | | | | | | 95,897 | 95,897 | 90,000 | 5,897 |
| Other med/surgical equipment | 125 | | | | | 9,146 | 9,271 | 1,761 | 7,510 |
| Cleaning services / materials | | | | | 1,250 | 7,469 | 8,719 | 1,742 | 6,977 |
| Staff uniforms & clothing | 495 | | | | | 87,785 | 88,280 | 41,107 | 47,173 |
| Staff accommodation | | | | | | 0 | 0 | 0 | 0 |
| Room hire | | | | | | 24,146 | 24,146 | 18,338 | 5,808 |
| Catering / provisions | 535 | | | | | 5,491 | 6,026 | 0 | 6,026 |
| IT Network security | | | | | | 76,070 | 76,070 | 34,014 | 42,056 |
| Other IT / Communications | 10,935 | 2,617 | | 8,426 | | 65,194 | 87,172 | 29,064 | 58,108 |
| Furniture, fittings, office equip | 2,360 | | | | | 112,758 | 115,118 | 78,876 | 36,242 |
| Revenue estates costs | 577 | | | | 24,000 | 29,488 | 54,065 | 22,937 | 31,128 |
| Travel/Transportation costs | 1,676 | | | | | 7,365 | 9,041 | 1,136 | 7,905 |
| Removal expenses | | | | | 1,134 | 3,859 | 4,993 | 1,346 | 3,647 |
| Drugs | | 1,863 | | | | 2,468 | 4,331 | 2,166 | 2,165 |
| Dressings | | 1,636 | | | | 0 | 1,636 | 818 | 818 |
| Other | 191 | | | | | 2,675 | 2,866 | 777 | 2,089 |
| **TOTAL NON-PAY** | **16,894** | **6,116** | **0** | **8,426** | **26,384** | **655,698** | **713,518** | **361,675** | **351,843** |
| | | | | | | | | | |
| **TOTAL IDENTIFIED COVID COSTS** | **295,087** | **127,543** | **34,921** | **96,887** | **26,384** | **672,334** | **1,253,156** | **562,636** | **690,520** |

**Note: only includes costs coded to specific Covid-19 cost codes. Does not include estimate for unclaimed overtime.**

# **APPENDIX F** – Underlying financial position

In order to assess the Trust's underlying financial position, a 'normalisation' analysis has been undertaken in respect of the M2 position.

This is summarised in the table below. The actual reported M2 year to date position is first shown for each directorate. This shows the current I&E break-even position, and the individual directorate variances that make up this total position. The effects of the normalising adjustments have then been applied to the figures on the right of the table, and so these show an estimated underlying M2 financial position:

| | | REPORTED YEAR-TO-DATE POSITION | | | | UNDERLYING YEAR-TO-DATE POSITION | | | |
|---|---|---|---|---|---|---|---|---|---|
| Directorate | Net YTD budget / CT £000 | Income £000 | Exp. £000 | Net I&E £000 | Variance £000 | Income £000 | Exp. £000 | Net I&E £000 | Underlying variance £000 |
| AMH | 2,605 | 15,319 | -12,615 | 2,704 | 99 | 14,929 | -12,531 | 2,398 | -207 |
| CHS | 3,213 | 14,110 | -10,674 | 3,436 | 223 | 13,723 | -10,483 | 3,240 | 27 |
| LD | 715 | 2,263 | -1,640 | 623 | -92 | 2,228 | -1,605 | 623 | -92 |
| FYPC | 1,043 | 9,123 | -8,095 | 1,028 | -15 | 9,026 | -7,731 | 1,295 | 252 |
| Estates | -4,527 | 511 | -5,519 | -5,008 | -481 | 485 | -5,493 | -5,008 | -481 |
| Hosted | 18 | 2,557 | -2,630 | -73 | -91 | 2,427 | -2,630 | -203 | -221 |
| Enabling | -3,429 | 2,404 | -6,006 | -3,602 | -173 | 1,414 | -5,003 | -3,589 | -160 |
| Reserves | 362 | 3,207 | -2,315 | 892 | 530 | 2,676 | -2,314 | 362 | 0 |
| **TOTAL TRUST:** | **0** | **49,494** | **-49,494** | **0** | **0** | **46,907** | **-47,790** | **-883** | **-883** |

## Normalising adjustments

The key normalising adjustments include:

- The exclusion of all Covid-19 costs and supporting top-up income (neutral I&E impact, but affects gross income and gross expenditure)
- The exclusion of other retrospective top-up income (estimated for May)
- The exclusion of any one-off gains/losses due to the release of 19/20 reserved creditors and debtors
- The exclusion of CAMHS investment costs on the basis that these are being treated as non-recurrent (provisionally shown as a gain to FYPC due to reducing expenditure, in lieu of a transfer of budget back to central reserves)
- The exclusion of any other exceptional gains or losses not expected to be part of the recurrent position.

This detail will be reported by service in future months' reports. The analysis will also show how our spend compares to the block payment received, to enable comparison against the underlying costs (as the block payment is based on 19/20 costs, these two figures should show our non-Covid impacted underlying positon).

# **APPENDIX F** – Underlying financial position **(cont'd)**

## Underlying directorate positions

The estimated underlying position at month 2 is a deficit of £883k. This represents a significant movement from the reported I&E break-even position. Key movements include:

- The removal of AMH, CHS and Hosted services income which in contractual terms is as yet unconfirmed (currently covered by the temporary block payments and the retrospective top-up)
- The removal of the balance of general retrospective top-up income shown within reserves
- The restoration of unallocated reserve budgets relating to the non-recurrent internal investment into CAMHS (£800k over the first six months of 2020/21)

## Forecasting

The analysis and reporting of the underlying position will be refined over the coming months, and is expected to also include monthly run-rates from month 3.

It is hoped that analysing the underlying position will also help to enable some form of financial forecasting to be undertaken. At present, the Covid-19 situation makes forecasting challenging, but the assumption has to be that at some point, the current temporary funding mechanisms will be stopped. At present, our assessment of the underlying position is our best forecast of what the Trust financial position would look like at that point in time, but excludes mitigations around investments, growth and CIP that would normally be included.

Leicestershire Partnership NHS Trust

# Performance Report – Month 2

# Paper U

Leicestershire Partnership NHS Trust

| Meeting Name and date | Trust Board - 7th July 2020 |
|---|---|
| Paper Reference | |

| Name of Report | Month 02 Trust Performance Report |
|---|---|

| For approval | | For assurance | | For information | X |
|---|---|---|---|---|---|

| Presented by | Danielle Cecchini - Director of Finance | Author(s) | Laura Hughes - Head of Information |
|---|---|---|---|

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

| Report previously reviewed by | |
|---|---|
| Committee / Group | Date |
| Operational Executive Team/ Strategic Executive Board | 15/06/2020 |
| | |

| **Assurance:** What assurance does this report provide in respect of the Board Assurance Framework Risks? | Links to ORR risk numbers |
|---|---|
| Provides assurance of the improving quality and availability of data reporting to inform quality decision making | 35 |

| Recommendations of the report |
|---|
| The Exec Team are recommended to receive the report and comment on the following:<br>• performance against targets (SPC)<br>• performance against plan (RAG) |

Leicestershire Partnership NHS
NHS Trust

# Leicestershire Partnership NHS Trust

# Performance Report (Month 02)

## Trust Board
## 7th July 2020

**Performance headlines – May 2020**

| Key: | | | |
|---|---|---|---|
| | The SPC measure has improved from previous month | **NEW** | The first assessment of a metric using SPC |
| | The SPC has not changed from previous month | **R** | Metric will be removed from future reports |
| | The SPC measure has deteriorated from previous month | **C** | Change in performance can be attributed to COVID-19 |

**Key standards being consistently delivered and improving or maintaining performance**

Inappropriate Out of Area bed days for Adult Mental Health services (inc progress beds)
**C** Length of stay - Community Services
Normalised Workforce Turnover rate
Core Mandatory Training Compliance for Substantive Staff

**Key standards being delivered but deteriorating**

Gatekeeping
**C** 6-week wait for diagnostic procedures
Staff with a Completed Annual Appraisal

**Key standards being delivered inconsistently**

Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral
CAMHS Eating Disorder – four weeks - (complete pathway)
Children and Young People's Access – four weeks (incomplete pathway)
Children and Young People's Access – 13 weeks (incomplete pathway)
**C** Occupancy rate – mental health beds (excluding leave)
**C** Occupancy rate – community beds (excluding leave)
**C** Length of stay (excluding leave) from Bradgate acute wards (SPC due March 2020)
Delayed transfer of care (DToC)
CPA 7 day
C Diff
Agency Cost

**Key standards not being delivered but improving**

Mental Health data submission - % clients in employment
Data quality maturity index
% of staff from a BME background

**Key standards not being delivered but deteriorating/ not improving**

Mental Health data submission - % clients in settled accommodation
CAMHS ED one week (complete)
Adult CMHT Access five day urgent (incomplete)
**C** Adult CMHT Access six week routine (incomplete)
CPA 12 month
STEIS action plans completed within timescales
Vacancy rate
Sickness Absence
% of staff who have undertaken clinical supervision within the last 3 months

**Key standard we are unable to assess using SPC**

Patient experience of mental health services
Readmissions with 28 days
Patient safety incidents
Patient safety incidents resulting in severe harm or death
Serious incidents (no target)
Quality indicators (no targets)
Cardio-metabolic assessment and treatment for people with psychosis
Admissions to adult facilities of patients under 16 years old
Safe Staffing

**Performance headlines – May 2020**

**COVID-19 Update(s)**
The Trust continues to prioritise its COVID-19 response in light of the worldwide pandemic. This report will identify where performance is known to be affected by COVID-19.

**Performance reviews:** Directorate performances reviews recommenced in May 2020. The reviews focussed on the introduction of the Trust's Restoration Framework; and discussion of how services may be required to adapt to new ways of working in the short, medium and long term.

**Improvement plans:** COVID-19 has compromised the delivery of improvement plans. Performance will be reviewed and prioritised for improvement as part of trustwide recovery plans.

**Data quality kite marks:** The data quality kite marks pertain to the previous six month period. Performance figures and SPC icons have been updated to reflect the latest available data.

**Known effects of COVID-19 on performance:**
- decline in **6-week wait for diagnostic procedures** performance due to national suspension of service;
- decline in **Adult CMHT Access Six weeks routine (incomplete pathway)**. The service is continuing to accept referrals during COVID-19 and utilising eContacts where possible. Expecting further deterioration of performance due to COVID-19;
- fluctuating average **length of stay** and o**ccupancy rates** due to changes in discharge protocol as a result of the COVID-19 response;
- increase in staff **sickness absence** since mid-March 2020 as expected due to COVID-19. In addition to actual staff sickness, the sickness absence rate reported for April 2020 will include staff who are self-isolating with suspected symptoms as well as those self-isolating with symptomatic members of their household. Early indications in April 2020, shows an increase of sickness absence to 11% of which 6% is attributed to COVID-19. These figures will be refined ahead of the next reporting period.

**Trust response:** Following the initial the COVID-19 emergency response, the Trust is now adapting towards COVID-19 recovery. To support this, a COVID-19 Recovery Co-ordinating Group and supporting COVID-19 Recovery Network Group and COVID-19 Data Cell has been set up to support the development of plans in relation to service restoration and recovery in line with the Trust's Restoration Framework currently under development.

The Trust is also working closely with LLR and regional partners to support the system wide recovery of services; with membership at system wide strategic and tactical operational cells as well as strategic and operational data cells.

**Improvement Plans**
• The Recovery Co-ordinating Group will be overseeing a programme of work to understand the impact of COVID-19 on performance. This will also extend to planning for recovery and agreeing how these will be prioritised and implemented going forward.

**Performance Framework**
• *see COVID-19 update(s) (above)*
• see COVID-19 update(s) (above)
**2020/21 Key Performance Indicators**
• New quality KPIs were approved by Board sub committees in March 2020 and the full Board in early April 2020.

• New indicators have been included to gather performance information for quality measures including repeat falls, restraint, seclusion and pressure ulcers.

• The 2020/21 KPI setting process includes KPIs linked to the Quality Account commitments which are reported to the Board through the Performance report.

**RAG rating against improvement plans**

A simple RAG rating is used to assess compliance to the recovery plan:

- Red – a target that is not being delivered
- Amber – a target that is not being delivered but has an approved recovery plan with trajectory that is being met or there is a query about delivery
- Green – a target that is being delivered

**Statistical process control (SPC) ratings against performance**

The Trust has introduced SPC icons to indicate assurance of whether the process is expected to consistently meet or fail the target; and if a process is in special cause or common cause variation.

| Icon | Performance Description |
|---|---|
| NO | The system is expected to consistently fail the target |
| YES | The system is expected to consistently pass the target |
| ? | The system may achieve or fail the target subject to random variation |

| Icon | Trend Description |
|---|---|
| UP | Special cause variation – cause for concern (indicator where high is a concern) |
| DOWN | Special cause variation – cause for concern (indicator where low is a concern) |
| NO CHANGE | Common cause variation |
| UP | Special cause variation – improvement (indicator where high is good) |
| DOWN | Special cause variation – improvement (indicator where low is good) |

Useful icon combinations to understand performance:

| Performance | Trend | Description |
|---|---|---|
| YES | UP/ DOWN or NO CHANGE | Key standards are being consistently delivered and are improving/ maintaining performance |
| YES | UP/ DOWN | Key standards are being delivered but are deteriorating |
| ? | Any trend icon | Key standards are being delivered inconsistently |
| NO | UP/ DOWN | Key standards are not being delivered but are improving |
| NO | UP/ DOWN or NO CHANGE | Key standards are not being delivered and are deteriorating/ not improving |

**Data Quality Kite Mark**

The Trust has introduced a data quality kite mark to help to assess priority wait time and key performance indicators (KPIs) against the six domains of data quality.

Each domain is rated using a standard assessment as being green (assured processes are in place), amber (room for improvement), red (issues identified for action).

| **Code** | **R** | **V** | **T** | **C** | **A** | **Rv** |
|---|---|---|---|---|---|---|
| **Domain** | Reliability | Validity | Timeliness | Completeness | Accuracy | Relevance |

The domain descriptions are as below:

**Reliability** - there are clear standard operating processes (SOPs) aligned to patient pathways
**Validity** - clinical systems, local reports and KPIs are in place to meet the needs of the service
**Timeliness** - data is entered in a timely manner – in line with the record keeping policy
**Completeness** - data quality is regularly checked in the service (patient tracking lists etc.)
**Accuracy** - KPIs/ reports are quality checked and authorised for external release
**Relevance** - KPIs/ reports are regularly reviewed through the performance process

The data quality kite marks have been applied to priority wait times and priority indicators – as agreed by the Trust Executive Team. The data quality kite marks are re-assessed every six months or when significant change warrants a review.

**1. Quality Account**

The following standards form the measures for the 2020/21 Quality Account

| Standard | Trust Performance | RAG/ Comments on recovery plan position | SPC Flag | |
|---|---|---|---|---|
| | | | Assurance of Meeting Target | Trend |
| The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period | Dec-19: 98.6%; Jan-20: 95.6%; Feb-20: 95.9%; Mar-20: 96.4%; Apr-20: 97.4%; May-20: 96.6% | | YES | DOWN |
| | | | Key standards are being consistently delivered but are deteriorating | |
| The percentage of patients on CPA (care programme approach) who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period | Nov-19: 96.1%; Dec-19: 98.1%; Jan-20: 97.0%; Feb-20: 96.3%; Mar-20: 98.3%; Apr-20: 100.0%<br>Awaiting national guidance on methodology for CPA 72hrs. This will be reflected in future reports. | Data quality improvements have been made by way of regular reporting and reminder to staff responsible for follow-ups | ? | UP |
| | | | Key standards are being delivered inconsistently | |
| The Trusts "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period | 2017/18: 7.4; 2018/19: 6.4; 2019/20: 7.1 | | n/a | n/a |
| | | | *Not applicable for SPC as reported infrequently* | |
| The percentage of patients aged:<br>(i) 0 to 15 and<br>(ii) 16 or over<br>readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period | **Age 0-15**: Dec-19: 0.0%; Jan-20: 28.6%; Feb-20: 66.7%; Mar-20: 0.0%; Apr-20: 0.0%; May-20: 25.0%<br>**Age 16 or over**: Dec-19: 35.7%; Jan-20: 32.8%; Feb-20: 36.8%; Mar-20: 38.0%; Apr-20: 32.9%; May-20: 31.0% | | n/a | n/a |
| | | | *SPC due October 2020* | |
| The number and, where available rate of patient safety incidents reported within the Trust during the reporting period | Dec-19: 1047, 62.8%; Jan-20: 1180, 66.3%; Feb-20: 1036, 61.5%; Mar-20: 1584, 62.2%; Apr-20: 801, 59.4%; May-20: 1037, 65.0% | | n/a | n/a |
| | | | *SPC due November 2020* | |

**1. Quality Account**

The following standards form the measures for the 2020/21 Quality Account

<table>
<tr><th rowspan="2">Standard</th><th rowspan="2">Trust Performance</th><th rowspan="2">RAG/ Comments on recovery plan position</th><th colspan="2">SPC Flag</th></tr>
<tr><th>Assurance of Meeting Target</th><th>Trend</th></tr>
<tr><td rowspan="4">The number and percentage of such patient safety incidents that resulted in severe harm or death</td><td><table><tr><td>Dec-19</td><td>Jan-20</td><td>Feb-20</td><td>Mar-20</td><td>Apr-20</td><td>May-20</td></tr><tr><td>2</td><td>7</td><td>1</td><td>6</td><td>11</td><td>14</td></tr><tr><td>0.2%</td><td>0.6%</td><td>0.1%</td><td>0.6%</td><td>1.4%</td><td>1.4%</td></tr></table></td><td rowspan="4"></td><td>n/a</td><td>n/a</td></tr>
<tr><td colspan="2">SPC due November 2020</td></tr>
<tr><td rowspan="4">Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral</td><td><table><tr><td>Dec-19</td><td>Jan-20</td><td>Feb-20</td><td>Mar-20</td><td>Apr-20</td><td>May-20</td></tr><tr><td>66.7%</td><td>72.2%</td><td>81.8%</td><td>63.2%</td><td>80.0%</td><td>95.8%</td></tr></table></td><td rowspan="4">Reducing service support to high risk psychosis.<br><br>Prioritised: Depot and assessment, urgent clinical reviews. Routine work by telephone</td><td>?</td><td>NO CHANGE</td></tr>
<tr><td colspan="2">Key standards are being delivered inconsistently</td></tr>
<tr><td rowspan="4">Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) Inpatient Wards b) EIP Services c) Community Mental Health Services (people on care programme approach)</td><td>Reported Bi-annually<br>Inpatient Wards<table><tr><td>Mar-20</td><td>Sep-20</td></tr><tr><td>60.0%</td><td></td></tr></table>EIP Services<table><tr><td>Mar-20</td><td>Sep-20</td></tr><tr><td>93.0%</td><td></td></tr></table>Community Mental Health Services on CPA (arrears)<table><tr><td>Mar-20</td><td>Sep-20</td></tr><tr><td>-</td><td></td></tr></table></td><td rowspan="4"></td><td>n/a</td><td>n/a</td></tr>
<tr><td colspan="2">Not applicable for SPC as reported infrequently</td></tr>
<tr><td rowspan="4">Admissions to adult facilities of patients under 16 years old</td><td><table><tr><td>Dec-19</td><td>Jan-20</td><td>Feb-20</td><td>Mar-20</td><td>Apr-20</td><td>May-20</td></tr><tr><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr></table></td><td rowspan="4"></td><td>n/a</td><td>n/a</td></tr>
<tr><td colspan="2">SPC under development</td></tr>
<tr><td rowspan="4">Inappropriate out-of-area placements for adult mental health services- (bed days)</td><td><table><tr><td>Dec-19</td><td>Jan-20</td><td>Feb-20</td><td>Mar-20</td><td>Apr-20</td><td>May-20</td></tr><tr><td>464</td><td>483</td><td>380</td><td>213</td><td>15</td><td>0</td></tr></table></td><td rowspan="4">The Trust continues to meet the reduction trajectory.<br><br>From April 2020, the number of progress beds reported will be zero</td><td>YES</td><td>NO CHANGE</td></tr>
<tr><td colspan="2">Key standards are being consistently delivered and are maintaining performance</td></tr>
</table>

**2. NHS Oversight**

The following targets form part of the new NHS Oversight Framework.

| Target | Trust Performance | RAG/ Comments on recovery plan position | SPC Flag | |
|---|---|---|---|---|
| | | | Assurance of Meeting Target | Trend |
| Early Intervention in Psychosis with a Care Co-ordinator within 14 days of referral<br><br>Target is >=56% | Dec-19: 66.7%; Jan-20: 72.2%; Feb-20: 81.8%; Mar-20: 63.2%; Apr-20: 80.0%; May-20: 95.8% | Reducing service support to High risk psychosis.<br><br>Prioritised: Depot and assessment, urgent clinical reviews. Routine work by telephone | ? | NO CHANGE<br><br>Key standards are being consistently delivered inconsistently |
| Inappropriate Out of Area bed days for Adult Mental Health services<br><br>Target is 0 by end March 2021 | Dec-19 / Jan-20 / Feb-20 / Mar-20 / Apr-20 / May-20<br>Total Inappropriate OAPs bed days: 464 / 483 / 380 / 213 / 15 / 0<br>Total Inappropriate OAPs bed days (excl progress beds): 92 / 114 / 141 / 18 / n/a / n/a<br>R / V / T / C / A / Rv | The Trust continues to meet the reduction trajectory.<br><br>From April 2020, the number of progress beds reported will be zero. | YES | NO CHANGE<br><br>Key standards are being consistently delivered |
| Mental Health data submission to NHS Digital: % clients in employment<br><br>Target is >=85% | 2018/19 Q2: 0%; 2018/19 Q3: 1%; 2018/19 Q4: 0%; 2019/20 Q1: 2%; 2019/20 Q2: 3%; 2019/20 Q3: 4% | Improvements are expected to follow the SystmOne go live - date TBC as a result of COVID-19 pandemic | NO | UP<br><br>Key standards are not being delivered but are improving |
| Mental Health data submission to NHS Digital: % clients in settled accommodation<br><br>Target is >=85% | 2018/19 Q2: 13%; 2018/19 Q3: 38%; 2018/19 Q4: 37%; 2019/20 Q1: 36%; 2019/20 Q2: 37%; 2019/20 Q3: 39% | Improvements are expected to follow the SystmOne go live - date TBC as a result of COVID-19 pandemic | NO | NO CHANGE<br><br>Key standards are not being delivered and are deteriorating/ not improving |
| 6-week wait for diagnostic procedures (incomplete)<br><br>Target is >=99% | Dec-19: 100.0%; Jan-20: 99.5%; Feb-20: 97.8%; Mar-20: 93.0%; Apr-20: 36.5%; May-20: 20.7%<br><br>This data refers to the Audiology Service only | In line with national COVID-19 guidance, this service has been suspended. Deteriorating waits throughout the COVID-19 lockdown period will be due to this suspension | YES | DOWN<br><br>Key standards are being delivered but are deteriorating |

**3. Access - wait time standards**

The following performance measures are key waiting time standards for the Trust:

| Target | Trust Performance | | | | | | RAG/ Comments on recovery plan position | SPC Flag | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Assurance of Meeting Target | Trend |
| CAMHS Eating Disorder – one week (complete pathway)<br><br>Target is 95% | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Due to COVID-19 response, high risk cases seen face to face. Routine appts completed by telephone | NO | NO CHANGE |
| | 100.0% | 50.0% | 100.0% | 75.0% | 100.0% | 100.0% | | Key standards are not being delivered and are not improving | |
| | R | V | T | C | A | Rv | | | |
| CAMHS Eating Disorder – four weeks (complete pathway)<br><br>Target is 95% | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | As above.<br><br>A funded interim improvement plan is on track to deliver the agreed trajectory. | ? | UP |
| | 100.0% | 57.1% | 100.0% | 91.7% | 100.0% | 100.0% | | Key standards are being delivered inconsistently but are improving | |
| | R | V | T | C | A | Rv | | | |
| Children and Young People's Access – four weeks (incomplete pathway)<br><br>Target is 92% | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Due to COVID-19 response, high Risk patients' Neurodevelopmental (ND) assessments temporarily reduced with priority for urgent ND assessments | ? | NO CHANGE |
| | 96.7% | 98.3% | 88.1% | 80.0% | 72.7% | 80.0% | | Key standards are being delivered inconsistently | |
| | R | V | T | C | A | Rv | | | |
| Children and Young People's Access – 13 weeks (incomplete pathway)<br><br>Target is 92% | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Due to COVID-19 response, high Risk patients' Neurodevelopmental (ND) assessments temporarily reduced with priority for urgent ND assessments | ? | DOWN |
| | 100.0% | 99.5% | 96.8% | 85.4% | 96.3% | 100.0% | | Key standards are being delivered inconsistently | |
| | R | V | T | C | A | Rv | | | |
| Adult CMHT Access Five day urgent (incomplete pathway)<br><br>Target is 95% | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Service offered via telephone/video support. Priority will be given to high risk patients during COVID-19 | NO | NO CHANGE |
| | n/a | 66.7% | 75.0% | 50.0% | 23.8% | 38.5% | | Key standards are not being delivered and are not improving | |
| | R | V | T | C | A | Rv | | | |
| | *'n/a' denotes no patients waiting as at last day of the month. There were two referrals made to the service in December 2019* | | | | | | | | |
| Adult CMHT Access Six weeks routine (incomplete pathway)<br><br>Target is 95% | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Service offered via telephone/video support. Priority will be given to high risk patients during COVID-19. Expected deterioration due to COVID-19 | NO | DOWN |
| | 43.7% | 46.8% | 50.9% | 43.1% | 24.3% | 27.9% | | Key standards are not being delivered and are deteriorating | |
| | R | V | T | C | A | Rv | | | |

**4. 52 week waits**

No patient should wait for more than 52 weeks from referral to the start of their treatment. From March 2020, the Trust will merge the existing Wait Times Group and the Harm Assurance Group to improve the governance and confidence of harm reviews for long waiting patients.

The following services have 52 week waits within their service:

| Target | | | | | | | Longest wait (latest month) | RAG/ Comments on recovery plan position | SPC Flag | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | Assurance of Meeting Target | Trend |
| Adult General Psychiatry - Community Mental Health Teams and Outpatients – Treatment (6 weeks) | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | 96 weeks | Service offered via telephone/video support. Priority will be given to high risk patients during COVID-19. No reduction in the number of 52 week waits. Audit of each patient taking place. | | |
| | 89 | 76 | 105 | 111 | 118 | 139 | | | *SPC icons due May 2020 when 12 months of data is available* | |
| Liaison Psychiatry (13 weeks) | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | 71 weeks | Service will be subsumed into new Core 24 service. This service has been decommissioned from 1st April 2020 | | |
| | 11 | 9 | 14 | 11 | 5 | 8 | | | *SPC icons due May 2020 when 12 months of data is available* | |
| | **R** | **V** | **T** | **C** | **A** | **Rv** | | | | |
| Cognitive Behavioural Therapy (13 weeks) | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | 120 weeks | Due to COVID-19 response, ongoing telephone/video support available to existing patients. New referrals will be triaged via the CAP. Long term plan to review Psychological Services. Shorter term plan is a case by case review. | | |
| | 28 | 33 | 35 | 34 | 41 | 43 | | | *SPC icons due May 2020 when 12 months of data is available* | |
| Dynamic Psychotherapy (13 weeks) | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | 116 weeks | Due to COVID-19 response, ongoing telephone/video support available to existing patients. New referrals will be triaged via the CAP. Long term plan to review Psychological Services. Shorter term plan is a case by case review. | | |
| | 47 | 46 | 40 | 46 | 47 | 62 | | | *SPC icons due May 2020 when 12 months of data is available* | |
| Personality Disorder (13 weeks) | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | 183 weeks | Due to COVID-19 response, ongoing telephone/video support available to existing patients. New referrals will be triaged via the CAP. Long term plan to review Psychological Services. Shorter term plan is a case by case review. | | |
| | 59 | 61 | 93 | 79 | 65 | 89 | | | *SPC icons due May 2020 when 12 months of data is available* | |
| Medical/ Neuropsychology (18 weeks) | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | 79 weeks | Recruitment to vacant posts have taken place. Recovery is expected but has yet to be delivered. No reduction or increase in March. Close performance management with UHL. | | |
| | 48 | 48 | 40 | 39 | 39 | 43 | | | *SPC icons due May 2020 when 12 months of data is available* | |
| CAMHS (13 weeks) | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | 60 weeks | Due to COVID-19 response the service has prioritised high risk patients for assessment. Significant improvement being delivered in line with improvement plan. | | |
| | 16 | 6 | 6 | 5 | 7 | 39 | | | *SPC icons due May 2020 when 12 months of data is available* | |

**5. Patient Flow**

The following measures are key indicators of patient flow:

| Target | Trust Performance | | | | | | RAG/ Comments on recovery plan position | SPC Flag | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Assurance of Meeting Target | Trend |
| Occupancy Rate - Mental Health Beds (excluding leave)<br><br>Target is <=85% | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Occupancy has decreased due to impact of COVID-19 with one ward used for isolation and focus on admissions using the mental health act | ? | DOWN |
| | 85.9% | 89.6% | 87.8% | 84.2% | 72.2% | 76.9% | | Key standards are being delivered inconsistently | |
| Occupancy Rate - Community Beds (excluding leave)<br><br>Target is >=93% | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Fluctuating vacancy rates will be attributed to ward changes as a result of implementing social distancing as part of the COVID-19 response | ? | NO CHANGE |
| | 89.2% | 91.9% | 87.5% | 83.4% | 54.9% | 57.4% | | Key standards are being delivered inconsistently | |
| Average Length of stay (excluding leave) from acute Bradgate wards<br><br>Target is <=33 days (national benchmark) | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Fluctuating LoS will be attributed to changes in discharge protocol as a result of the COVID-19 response | ? | NO CHANGE |
| | 41.9 | 36.9 | 35.5 | 44.6 | 49.6 | 42.4 | | Key standards are being delivered inconsistently | |
| Average Length of stay<br><br>Community hospitals<br><br>National benchmark is 25 days. | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Fluctuating LoS will be attributed to changes in discharge protocol as a result of the COVID-19 response | YES | DOWN |
| | 17.9 | 20.4 | 18.1 | 18.5 | 16 | 14.5 | | Key standards are being consistently delivered and are improving | |
| Delayed Transfers of Care<br><br>Target is <=3.5% across LLR | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | The target is being met as a wider LLR system.<br><br>NHS Digital has advised this national metric is being paused to release resources to support the COVID-19 response. We will continue to monitor locally | ? | DOWN |
| | 3.8% | 3.8% | 4.0% | 3.9% | 3.1% | 1.5% | | | |
| | R | V | T | C | A | Rv | | Key standards are being delivered inconsistently | |
| Gatekeeping<br><br>Target is >=95% | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | | YES | DOWN |
| | 98.6% | 95.6% | 95.9% | 96.4% | 97.4% | 96.6% | | | |
| | R | V | T | C | A | Rv | | Key standards are being consistently delivered and are maintaining performance | |
| Care Programme Approach – 7-day follow up (reported 1 month in arrears)<br><br>Target is 95% | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | Data quality improvements have been made by way of regular reporting and reminder to staff responsible for follow-ups | ? | UP |
| | 96.1% | 98.1% | 97.0% | 96.3% | 98.3% | 100.0% | | | |
| | R | V | T | C | A | Rv | | Key standards are being delivered inconsistently | |
| Care Programme Approach<br>12-month standard<br><br>Target is 95% | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Data quality improvements have been made by way of regular reporting and reminder to staff responsible for reviews | NO | NO CHANGE |
| | 94.5% | 93.5% | 93.6% | 91.1% | 89.3% | 89.3% | | Key standards are being delivered inconsistently | |

**6. Quality and safety**

| Target | Trust Performance | | | | | | | RAG/ Comments on recovery plan position | SPC Flag | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | Assurance of Meeting Target | Trend |
| C difficile<br><br>Full year ceiling is 12. | YTD | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Trust is below ceiling year to date with 1 case(s) year to date | ? | NO CHANGE |
| | 1 | 0 | 1 | 0 | 0 | 1 | 0 | | Key standards are being delivered inconsistently | |
| Serious incidents | | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | | N/A | UP |
| | | 9 | 16 | 13 | 5 | 20 | 17 | | Key standards are not improving | |
| STEIS - SI action plans implemented within timescales (in arrears)<br><br>Target = 100% | | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Awaiting validated data to assess achievement of measure | ? | DOWN |
| | | No Plans | 0.0% | 40.0% | 40.0% | 14.3% | 14.3% | | Key standards are being delivered inconsistently | |
| Safe staffing<br>No. of wards not meeting >80% fill rate for RNs<br><br>Target 0 | | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | This measure has been temporarily suspended during COVID-19 as staffing capacity is changing rapidly and continually to respond to the pandemic | NO | NO CHANGE |
| | Day | 3 | 2 | 2 | n/a | n/a | n/a | | AS AT FEB 2020<br>Key standards are not being delivered and are not improving<br>*SPC based on day shift* | |
| | Night | 1 | 1 | 1 | n/a | n/a | n/a | | | |
| No. of episodes of seclusions >2hrs<br><br>Target decreasing trend | | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | | N/A | NO CHANGE |
| | | 22 | 32 | 34 | 35 | 37 | 35 | | Key standard has no target; however performance is consistent | |
| No. of episodes of supine restraint<br><br>Target decreasing trend | | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | | N/A | NO CHANGE |
| | | 7 | 3 | 16 | 14 | 14 | 7 | | Key standard has no target; however performance is consistent | |
| No. of episodes of side-line restraint<br><br>Target decreasing trend | | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | | N/A | NO CHANGE |
| | | 19 | 26 | 29 | 21 | 17 | 19 | | Key standard has no target; however performance is consistent | |
| No. of episodes of prone (unsupported) restraint<br><br>Target decreasing trend | | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | | N/A | NO CHANGE |
| | | 0 | 0 | 0 | 0 | 1 | 0 | | Key standard has no target; however performance is consistent | |
| No. of episodes of prone (supported) restraint<br><br>Target decreasing trend | | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | | N/A | UP |
| | | 8 | 4 | 2 | 6 | 4 | 17 | | Key standard has no target; however performance is consistent | |
| No. of Category 2 and 4 pressure ulcers developed or deteriorated in LPT care<br><br>Target decreasing trend | | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | | N/A | DOWN |
| | Category 2 | 80 | 79 | 91 | 95 | 95 | 62 | | N/A | NO CHANGE |
| | Category 4 | 3 | 4 | 6 | 6 | 2 | 9 | | *Key standard has no target; however performance is improving for category 2 and consistent for category 4* | |
| No. of repeat falls<br><br>Target decreasing trend | | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | | N/A | UP |
| | | 37 | 51 | 49 | 45 | 60 | 54 | | *Key standard has no target; however performance is deteriorating* | |

**Additional quality measures**

• The new Quality KPI improvements will be reviewed at the end of 2020/21 quarter two.

**7. Data Quality**

The following measures are key indicators of the quality of data completeness. These should be read alongside the Mental Health Services Data Standards (MHSDS) set out in section one of this report.

| Target | Performance | | | | | | RAG/ Comments on recovery plan position | SPC Flag | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Assurance of Meeting Target | Trend |
| MH Data quality Maturity Index | Sep-19 | Oct-19 | Nov-19 | Dec-19 | Jan-20 | Feb-20 | The Trust is failing to deliver the 95% target. Improvement plan required. | NO | UP |
| | 92.5% | 92.7% | 92.4% | 91.5% | 92.0% | 92.6% | | | |
| Target >=95% | | | | | | | | Key standards are not being delivered but are improving | |

**8. Workforce/HR**

| Target | Trust Performance | | | | | | RAG/ Comments on recovery plan position | SPC Flag | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Assurance of Meeting Target | Trend |
| Normalised Workforce Turnover rate (Rolling previous 12 months)<br><br>Target is <=10% | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | The Trust is below the ceiling set for turnover. | YES | DOWN |
| | 9.3% | 8.8% | 8.6% | 9.1% | 9.3% | 9.4% | | Key standards are being consistently delivered and are improving performance | |
| Vacancy rate<br><br>Target is <=7% | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | | NO | UP |
| | 8.5% | 8.8% | 8.7% | 9.1% | 10.5% | 11.5% | | Key standards are not being delivered and are not improving | |
| Health and Well-being Sickness Absence (1 month in arrears)<br><br>Target is <=4.5% | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | The impact of COVID-19 has seen a significant increase in reported sickness absence during April and May | NO | NO CHANGE |
| | 5.2% | 5.3% | 5.5% | 5.3% | 5.4% | 5.6% | | Key standards are not being delivered and are not improving | |
| Health and Well-being Sickness Absence Costs (1 month in arrears)<br><br>Target is TBC | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | | n/a | n/a |
| | - | - | - | - | - | £727,410 | | SPC to be included once 13 data points have been provided | |
| Health and Well-being Sickness Absence YTD (1 month in arrears)<br><br>Target is <=4.5% | Nov-19 | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | | n/a | n/a |
| | - | - | - | - | - | 5.6% | | Not applicable for SPC as measuring cumulative data | |
| Agency Costs<br><br>Target is <=£641,666 (NHSI national target) | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | | ? | NO CHANGE |
| | £875,918 | £724,425 | £867,533 | £852,247 | £757,082 | £803,747 | | Key standards are being delivered inconsistently | |
| Core Mandatory Training Compliance for substantive staff<br><br>Target is >=85% | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | | YES | UP |
| | 95.3% | 95.4% | 95.2% | 98.0% | 97.9% | 97.8% | | Key standards are being consistently delivered and are improving performance | |
| Staff with a Completed Annual Appraisal<br><br>Target is >=80% | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | | YES | DOWN |
| | 93.0% | 93.8% | 93.5% | 93.0% | 91.3% | 87.5% | | Key standards are being consistently delivered and are maintaining performance | |
| % of staff from a BME background<br><br>Target is >= 22.5% | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | | NO | UP |
| | 22.7% | 21.9% | 22.9% | 22.9% | 23.0% | 22.9% | | Key standards are not being delivered but are improving | |
| % of staff who have undertaken clinical supervision within the last 3 months<br><br>Target is >=85% | Dec-19 | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | | NO | DOWN |
| | 81.7% | 83.0% | 83.9% | 79.4% | 67.4% | 72.8% | | Key standards are not being delivered and are deteriorating | |

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Leicestershire Partnership NHS Trust

# CHARITABLE FUNDS COMMITTEE– DATE 11th JUNE 2020

# 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 | It was agreed that the wording and scoring of the risk around declining donations impacting on the charity's objectives (4466) would be reviewed in light of the significant donations we have recently received and the recent significant assurance audit report. | 1911, 4367, 4466 |
| Strategic aims for 2020/21 | | The strategic aims for the charity for 20/21 were reviewed in light of the significant donations we have received and in preparation for the new fundraising manager starting in post. It was agreed that the paper would be updated to include links to the Raising Health strategy. The priority areas were agreed by the committee. | 1911,4466 |
| Promoting Charitable Funds and delivering the strategy - update | High | The outgoing fundraising manager had prepared a handover which included the status of fundraising appeals. It was agreed that this would be updated with the latest financial values & discussed with the new fundraising manager as part of their induction. | 1911 |
| Finance Report (Q4) | High | An update on the charity's financial position was provided. The investment value had decreased by £247k in quarter 4, as a result of the impact of the coronavirus on stock markets. Donations, fundraising and legacy income were higher than expected for this period, this was | 1911 |

| Report | Assurance level* | Committee escalation | Risk Reference |
|---|---|---|---|
| | | due to the receipt of £100k from the Coalville League of Friends and two legacies (totaling £19k).<br>Total income for the year was £49k lower than plan, due to the unrealized loss on the investment value.<br>Expenditure for the year was £112k lower than plan, and reflects the need to manage the charity's cash balances.<br>The cash balance was £165k at the end of March, an increase of £76k since December and £34k since the start of the year. The £100k donation from the League of Friends contributed towards this closing position. | |
| Three year financial plan | Medium | The committee discussed the 3 year financial plan. The recent material donations were included in the cash forecasts for 20/21 and 21/22. It was agreed that the underlying cash position still needed to be managed, and that the new fundraising manager would need to ensure that donations continue to provide funding for future bids, as the charity wanted to avoid any further drawdowns from the investment fund. | 1911, 4466 |
| Investment Managers Performance report (Q4) | High | The new investment manager, Cazenove, had provided their first quarterly report. The investment value had decreased to £1.6m since it was transferred from Sarasin on the 7th January 2020 due to the general market conditions following the coronavirus pandemic.<br>The committee accepted the report and agreed to request more narrative and analysis to be provided for future reports, as had been demonstrated during the company's tender presentation to committee members. | 1911, 4466 |
| Annual review of investment managers | High | As the investment managers had been in place for three months, it was agreed to change the timing of the annual review to March 2021. Cazenove would be invited to present their review to the committee. | 1911 |
| Approval of the investment strategy | High | The Raising Health investment strategy had been revised as part of the annual strategy review. It had been updated to include the new investment manager's investment details and to tidy up Trustee Act 2000 references.<br>The committee agreed that, subject to some minor revisions, the strategy was approved. | 1911 |
| Update on previous bids | High | • Hawthorn Centre – it was agreed the new fundraising manager would follow up with the service<br>• Syringe drivers – the service need to provide more information on purchases | 1911 |
| New bids approved | High | Bids were approved by the committee:<br>• R & D, Masters in research matters (£6k)<br>• R & D ,Masters in research matters (£6k)<br>• Frontline Covid-19 support : Fruit for staff on all LPT sites for 3 weeks (£3k) | 1911,4466 |

| Report | Assurance level* | Committee escalation | Risk Reference |
|---|---|---|---|
| | | • Astro turfed sports area with interactive wall (Beacon CAMHS unit, from major donation) (£41k)<br>• Staff rooms (£ TBC) – it was agreed that this bid would be linked with the Trust's capital plan which also includes funding for staff rooms. Raising Health to fund additional wellbeing aspects of these refurbishments which were in excess of NHS core funds. | |
| Benefits realization – assessing VFM of long term projects | High | An update report on research funding schemes previously approved was received. The committee was assured of progress with the schemes. | 1911 |
| New funds created | High | The creation of new funds was approved:<br>• Perinatal Mental Health Fund<br>• COVID 19 staff well being<br>• Valentine Centre youth improvement fund<br>• A specific fund for a major donor | |
| Work plan | High | The work plan was reviewed and amendments were agreed to ensure timing of items was appropriate. | |
| Review of risk register | High | No further amendments were required above those agreed at the start of the meeting | 1911,4367, 4466 |
| AOB | | • SFI update was reviewed & agreed<br>• It was agreed the committee's annual report would be circulated & agreed in advance of the Audit & Assurance Committee review date<br>• Discussions took place around the most appropriate way to mark the NHS Birthday celebration now that the national planned tea party would not take place. It was agreed that a proposal would be prepared for committee members<br>• The committee reviewed an internal audit proposal to undertake a specific Covid 19 audit. The committee didn't think that this was needed, as Covid 19 transactions are processed in line with the existing financial control procedures, and would be picked up as part of the routine assurance audit.<br>• It was agreed to accept the donation of an IPad from the freemasons for Hinckley hospital.<br>• There was potential for another significant donation from the major donor. It was agreed we would look at how we could fund significant community projects from this funding. | 1911 |

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