NHS

Leicestershire Partnership

NHS Trust

quality account 2016-2017

compassion • respect • integrity • trust

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Part 1 – Introduction

1.1 Statement on quality from the Chief Executive

On behalf of the board of LPT I am proud to be able to present our 2016/17 quality account. The report presents the quality of the services that we provide and continues to develop our open and transparent culture that we are developing as a trust.

We welcome external scrutiny of our services and in November 2016 we welcomed 86 CQC inspectors into the trust to provide a comprehensive assessment of our services. This account presents those findings. Overall we were rated as 'requires improvement' however the CQC recognised improvement in many areas and I was particularly pleased to see the improvement in overall safety for the trust. It was also great to see the outstanding rating for caring for our community children's services.

The CQC rated our community CAMHS service as inadequate on two domains, safety and responsive. This was primarily related to the number of young people that were waiting for treatment. We will be working with all our partners and commissioners over the coming year to address this issue.

It is a priority of the trust board to establish a process and commitment to self-regulation, to ensure that we know first if there are any risks to the quality of service, and during this past year we have worked with all of our services to embed this approach. We are committed to ensuring our services are focused around the needs of people, families, and local communities.

The experience of our patients, and their carer's, is critical in providing patient centred services. This report gives details of how we understand this experience. The Board is proud of our FFT scores, with 97% of people who responded saying they would recommend our service to friends and family.

As a board we put quality and continuous improvement first, but are conscious of the financial demands on the NHS. We must ensure that any savings that are made do not have an impact on the safety of our services.

Dr Peter Miller, Chief Executive, By Order of the Board

26/05/2017

1.2 Statement of Directors' responsibilities in respect of the Quality Account

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered;

- The performance information reported in the Quality Account is reliable and accurate; with the exception of the matters raised in section 3.3.8 on the Gatekeeping indicator and the CPA 7 day follow data.

- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;

- Reliable, accurate and relevant high quality data is a key organisational requirement. LPT is committed to improving data quality across all of its services and undertakes regular data quality audit reviews. The Trust continues to implement a Data Quality Improvement Programme (DQIP) which is supported by performance monitoring systems to ensure its continual improvement;

- The data underpinning the measures of performance reported in the Quality Account are subject to appropriate scrutiny and review. To ensure continued adherence to prescribed definitions, the trust has implemented actions to improve and assure the quality and consistency of reporting of CRHT gatekeeping data. The trust has also taken account of the need to change the way CPA 7 day follow up information is reported to ensure national definitions are met as well as local clinical arrangements and this reporting will be changed from 2017/18.

- The Quality Account has been prepared in accordance with Department of Health guidance.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

Dr Peter Miller

Chief Executive

By Order of the Board 26/05/2017

Cathy Ellis

Chair

26/05/2017

1.3 Statement of responsible person on behalf of Leicestershire Partnership NHS Trust

To the best of my knowledge the information included in this Quality Account is accurate.

Professor Adrian Childs

Chief Nurse/ Deputy Chief Executive

26/05/2017

Part 2 – Priorities for improvement and statements of assurance

2.1 Priorities for quality improvement in 2017/18

Improving quality is about making healthcare safer, more effective, patient centred, timely, efficient and equitable. Our central purpose is to provide the highest quality healthcare and promote recovery and hope to our patients. We are committed to improving the quality of our care and the services we provide. Our patients value clinical outcomes together with their overall experience of our services. We want to provide the very best experience for every person using our services. Our priorities will focus on three key areas:

- Improve clinical recording and care planning to support safe and effective patient centred care.
- Improve discharge planning and follow up to support safe transfer of care.
- Evidence improved engagement in clinical supervision for all staff delivering care.

Our quality plan for 2017/2018 is detailed below;

Figure 1: Quality Plan 2017/2018

The priorities are important to our service users, carers, patients and staff. The Quality Account (QA) clinical priorities for 2017/18 will remain consistent with the clinical priorities 2016/17 for the next two years and are included in the two year plan which was approved by the Trust Board in December 2016. See further details on each priority in Appendix 1. Our three priorities are further developed locally to establish directorate specific clinical priorities and detail specific areas that will demonstrate the improvements (See fig 2) made.

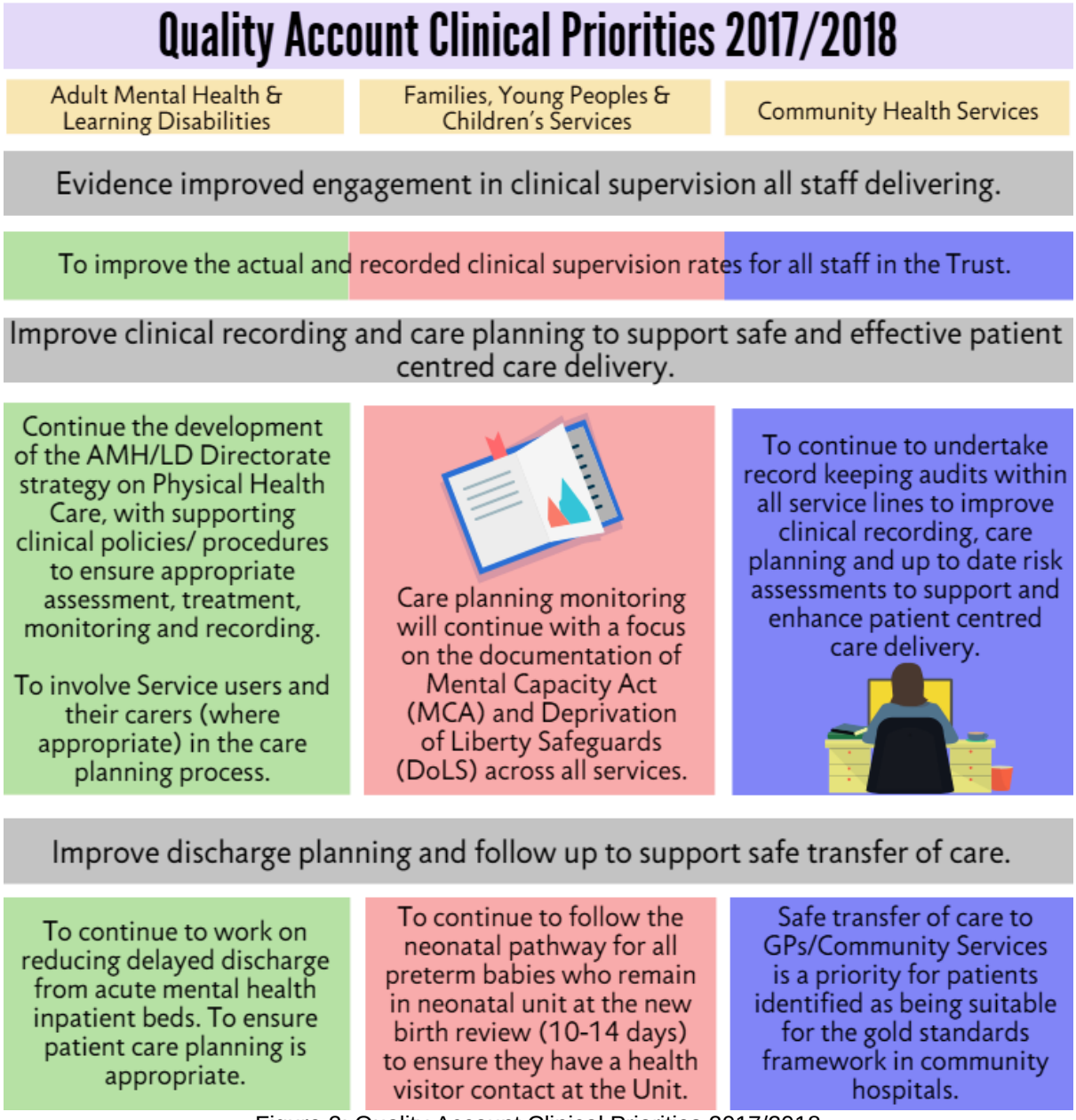
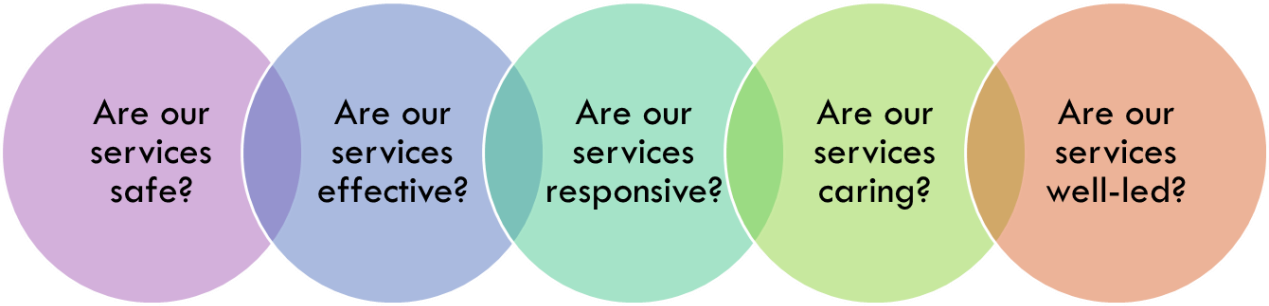


Figure 2: Quality Account Clinical Priorities 2017/2018

2.2 Self-Regulation

To support the delivery of improvement across LPT we have continued to strengthen our approach to Self-regulation which is encapsulated in our model, the 'Step-up' approach. This approach enables teams to identify areas for improvement and demonstrate compliance with the expected regulatory requirements referred to as the Fundamental Standards (2015). It is based around the CQC's five key questions;



Our Self-regulation model empowers teams to self-assess at team level to identify areas for improvement using a variety of different approaches. Led by their Team Leader, their outcomes are subject to challenge and scrutiny, which can be supported by members of the senior management team, peers or staff working across other services. Our approach to Self-regulation involves a four-step process.

Figure 3: Self-Regulation

During 2016/17 in excess of 109 services/teams participated in self-regulation and our external auditors confirmed that '*the model does have the capacity and the capability of delivering the necessary outcomes and embedding self-regulation as a governance process within the Trust'.*

2.3 Delivering our quality improvement priorities

The Trust Board is committed to achieving excellence and members discuss quality performance at every Trust Board meeting. We will report and monitor our progress against delivery of the clinical priorities at the Quality Assurance Committee (QAC), which is a Trust Board Committee. The QAC provides advice and assurance to the Board in relation to quality performance. The QAC shapes, influences and provides overall assurance about the quality of our services and reports any concerns to the Board.

2.4 Review of services

During 2016/17 LPT provided and/or subcontracted 109 NHS services. Mental Health and Learning Disabilities account for 46 services and Community Health Services make up the remaining 63. See full list in Appendix 2.

LPT has reviewed all the data available on the quality of care of these NHS services, both for services directly provided and for those services subcontracted. Robust monitoring both externally with commissioners (via contractual requirements to monitor over 50 clinical quality performance indicators) and internally (via performance reviews and quality reports) ensures the highest standards are adhered to in the areas of infection control, patient safety, service user and carer experience, safeguarding, clinical effectiveness and compliance with regulatory requirements.

The income generated by the NHS services in 2016/17 represents 100 per cent of the total income generated from the provision of NHS services by LPT for 2016/17.

2.5. Examples of how we reviewed our services in 2016/17

Board members remain visible in our services

During 2016/17 we made some changes to our Trust Board and welcomed two new Non-Executive Directors. Healthwatch representatives from the City and County continue to contribute at Trust Board meetings as participating observers.

We run a programme of Board Walks where Board Members visit services to see the day to day activities of frontline staff and meet with patients to hear about their experiences. This builds communication and engagement between the board and staff whilst highlighting areas of good practice and where changes may be needed. During 2016-17, Board members completed 94 visits to our services; FYPC received 23, CHS received 31, and AMH/LD received 40 Boardwalks.

Commissioners are visible in our services as they undertake quality visits

During 2016/17 there were 4 Commissioner-led and 2 NHS England 'quality visits' to some of the places where we provide services. The commissioning teams included senior managers and doctors from the commissioning groups. The visits were undertaken to gain assurance of 'quality', for example good leadership, staff supervision and patient records. The methods used included observing the care environment, talking to nursing staff/patients and reviewing care records. The visits took place at a variety of services including; the District Nursing Service, local prisons, community hospitals and inpatient centres.

2.6 Participation in clinical audits

During 2016/17, five national clinical audits and two national confidential enquiry covered NHS services that LPT provides.

During that period LPT participated in 100% national clinical audits and 50% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that LPT was eligible to participate in during 2016/17 are as follows.

Title
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme
Prescribing Observatory for Mental Health (POMH-UK) / Monitoring of patients prescribed lithium (POMH Topic 7 e)
Prescribing Observatory for Mental Health (POMH-UK) / Prescribing antipsychotic medication for people with dementia (POMH Topic 11c)
Prescribing Observatory for Mental Health (POMH-UK) / Rapid tranquilisation (POMH Topic 16a)
Sentinel Stroke National Audit Programme (SSNAP)
National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)

The national clinical audits and national confidential enquiry that LPT participated in and for which data collection was completed during 2016/17 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audit Title	Number of cases submitted as a percentage of the number of registered cases required
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	100%
Prescribing Observatory for Mental Health (POMH-UK) / Monitoring of patients prescribed lithium (POMH Topic 7 e)	100%
Prescribing Observatory for Mental Health (POMH-UK) / Prescribing antipsychotic medication for people with dementia (POMH Topic 11c)	100%
Prescribing Observatory for Mental Health (POMH-UK) / Rapid tranquilisation (POMH Topic 16a)	100%
Sentinel Stroke National Audit Programme (SSNAP)	100%
National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	100%

The reports of three National Clinical Audits were reviewed by LPT in 2016/17 and the following actions are planned to improve the quality of healthcare provided.

Audit Title	Actions to be taken
Prescribing for Attention deficit hyperactivity disorder (ADHD) children, adolescents and adults: POMH Topic 13b	To contact the three trusts with the highest compliance level in the use of structured tools to assess/manage adults with learning disabilities & ADHD to find out about the tools that they have used. Discuss the aforementioned tools with the medical members of the LD teams to develop a single tool for use in Adult LD Service. To discuss with FYPC staff the correct intervals regarding measuring physical parameters and provide centile charts for weight, height and blood pressure.
Antipsychotic prescribing in people with a learning disability: POMH Topic 9c	To develop an 'antipsychotic and care plan registry' on RiO to rationalise antipsychotics use in LD patients with challenging behaviours. To develop systems to ensure that antipsychotics and care plans are reviewed periodically and key medications information is communicated to patients and carers.
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme	To develop a Standard Operating Procedure for the service. To set up a database for our outcome measures. Implement walking speeds into every class to improve exercise training element. Re-audit locally after each programme.

The reports of 94 local clinical audits were reviewed by LPT in 2016/17 and LPT intends to take the following actions to improve the quality of healthcare provided.

Audit Title	Actions to be taken
Prescription of Benzodiazepines & Hypnotics at the time of admission for service users admitted onto Beaumont Ward (#822) The aim of this audit was to determine whether clear indications are documented and whether benzodiazepine and/or hypnotic drugs are prescribed, administered and reviewed appropriately in the first week of commencement.	To include current LPT guidance on the use of benzodiazepines & other hypnotics for the management of insomnia as part of the LPT Pharmacy briefing for junior doctors To add a warning to the e-Prescribing system: On initiation of Benzo/Z drug: “Prescription will be automatically discontinued after 14 days if not administered within that period.” “Sleep Packs” containing Patient Information Leaflets to be developed and made available on the wards for service users.
Speech and Language Therapy Quality Standards in Practice for Children with Cleft Palate (#832) The aim of this audit was to determine the quality of service delivery in terms of assessments and management decisions.	To carry out regular (6 monthly) spot checks of case notes (using the audit tool) in order to ensure standards are upheld. To feedback results of 6 monthly spot checks at local team meetings.
Physical Assessment & Investigations (Mental Health Services for Older People [MHSOP]) (#1098) To establish if physical assessments and investigations are completed within 24 hours of admission.	To raise awareness of importance of physical exams in junior doctors' induction. Posters to be displayed in Junior Doctor Rooms at Bennion Centre, Evington Centre & Bradgate Mental Health Unit.
Implementation of Frequency of Intervention (FIR) Charts (MHSOP) (#1199) The FIR chart has been designed to record interaction and interventions including; fluid balance, bowel management, safety measures, and personal care and hygiene. This audit measured the implementation of FIR Charts within MHSOP Wards.	A revised FIR chart to be devised and circulated to the New Ways of Working Meeting, the Ward Matrons and Senior Management for review. Wards to trial the revised chart for 1 month. Comments to be collated, amendments to be made and finalised chart to be launched.
Prescription of Antipsychotics Above the Maximum Dose Recommended by the British National Formulary (#1226) This audit measured the appropriateness of antipsychotic prescribing.	Pharmacy to alert prescribing doctors and discuss appropriate monitoring when the dose is above BNF limits To design simple, eye catching posters conveying key requirements for best practice. To be displayed within BMHU.
Leicester, Leicestershire & Rutland Neonatal Care Visits (#1239) The aim of this audit was to ensure that 100% of families of babies born between 23-28 weeks gestation were receiving a face to face contact by the Health Visitor (HV) on the Neonatal Unit (NNU) between 10-14 days.	All new staff starters to be offered current training session devised on the NNU Pathway policy.

Children Over 5 Continence Pathway (#1325) The Continence (Healthy Bladder and Healthy Bowel) Pathway for children 0 to 19 years old was introduced in LPT in January 2015 to affect clear, timely, safe, evidence based, robust and standardised practice across Leicestershire, Rutland and Leicester City (LLR). The Pathway aims to promote healthy bladder and bowel by early intervention and timely identification and management of continence needs. This audit was to assess the delivery of the standardised continence treatment /management offer across LLR.	Pathway to be reviewed and clarified following service specification changes and commissioning arrangements. To share and cascade information via promotion of the Pathways, training, Healthy Bladder and Bowel Special Interest Group (SIG) at the following forums: Health Visitor and School Nurse Development Meetings , Healthy Bladder and Bowel quarterly Newsletter and Leicester Clinical Assessment Tool (LCAT) contacts.
Person Centred Care (MHSOP) (#1392) This audit was undertaken to assess whether practice has been sustained and improved in relation to quality of the assessment and intervention process through a patient's journey, the quality of care planning and evaluation and the translation of care into practice.	A supporting information sheet to be produced to aid patients, relatives, carers and staff in understanding the value of having the information contained in the 'who am I' document. Clinical trainer to develop and deliver Bite Size training session using an anonymised 'who am I' document and consider how this would be included in care planning. To establish a task and finish group to explore current issues and actions required.

2.7 Participation in clinical research

LPT continues to provide our service users and carers the opportunity to participate in research in the knowledge that this enhances care, enables services to deliver innovative interventions and contributes to the development of staff.

We are committed to developing, hosting and collaborating with local, national and international research through our partnerships with academic and other NHS organisations as part of the National Institute of Health Research (NIHR), in particular with the Clinical Research Network: East Midlands (CRN: EM), Collaboration for Leadership in Applied Health Research and Care: East Midlands (CLAHRC: EM) and East Midlands: Academic Health Science Network (EM: AHSN). Our research profile includes projects adopted across a number of areas including Children, Dementia and Neurodegenerative Diseases, Diabetes, Learning Disabilities, Heart Failure and Mental Health.

The number of patients receiving NHS services provided or sub-contracted by LPT in 2016/17 that were recruited to participate in portfolio studies approved by a research ethics committee was; Portfolio Recruitment: 505 (reported on EDGE); 526 (Reported in national Open Data Platform).

The portfolio studies hosted by the trust in 2016/17 are listed in the table below:

Sample Portfolio Studies Title/Acronym	Key aim/principle of study
ACTIFCare	ACTIFCare: Access to timely formal care
AD Genetics	Detecting Susceptibility Genes for early onset Alzheimer's disease
Adult Autism Spectrum	Autism Conditions in Adulthood – Learning about lives of adults on the autism

Cohort	spectrum and their relatives
AFFECT	A randomised controlled trial of calcium channel blockade with **A**mlodipine **F**or the treatment o**F** subcortical ischa**E**mic vas**C**ular demen**T**ia
AQUA	A randomised controlled trial comparing the effects of providing clinicians and patients with the results of an objective measure of activity and attention (QbTest) versus usual care on diagnostic and treatment decision making in children and young people with ADHD
Attachment and metallisation of predictors of family therapy outcome	Attachment and metallization as predictors of outcome in family therapy for adolescent anorexia nervosa
BDR	Brains for Dementia – Longitudinal assessment of potential brain donors
CADL	Changes in the motivation and performance of activities of daily living in dementia and their relationship to well-being
Cardiac rehab and Stroke	A feasibility study to identify attitudes, determine outcome measures and develop an intervention to inform a definitive trial that will determine the effectiveness of adapted cardia rehabilitation for subacute stroke patients
CATCH-US	Children with ADHD in transition to adult services
CIRCLE	Randomised controlled trial of the clinical and cost effectiveness of a contingency management intervention for reduction of cannabis use and of relapse in early psychosis
DAPA	Physical activity programmes for community dwelling people with mild to moderate dementia
DEME 3728 LEGATO-HD	A multicentre, multinational, randomised, double blind, placebo controlled, parallel group study to evaluate the efficacy and safety of Laquinimod (0.5, 1.0 and 1.5 mg/day) as treatment in patients with Huntington's Disease
ENROLL-HD	Enroll-HD: A Prospective Registry Study in a Global Huntington's Disease Cohort
EpAID	Improving outcomes in adults with epilepsy and intellectual disability: A cluster randomised controlled trial of nurse-led epilepsy management (EpAID)
ESMI	The effectiveness and cost effectiveness of mother and baby units versus general psychiatric inpatient wards and crisis resolution team.
EXCEED	Extended cohort for e-health, environment and DNA (EXCEED) Study
EQUIP	EQUIP: Enhancing the quality of user involved care planning in mental health services Evaluation of the efficacy and cost effectiveness of user/carer involved care planning
EUPATCH	The role of feedback on Adherence to Amblyopia treatment version
FLUENZ	Enhanced safety surveillance
HIND	Hypertension in Dementia
Journeying Through Dementia	A randomised controlled trial of the clinical and cost-effectiveness of the Journeying through Dementia intervention compared to usual care
LISTEN UP	Understanding and helping looked after young people who self-harm
LYNC	Improving health outcomes for young people with long term conditions: the role of digital communication in current and future patient-clinician communication for NHS providers of specialist clinical services (long term, young people, networked digital communication technology, clinical communication
MADE	Minocycline in Alzheimer's disease efficacy trial: The MADE Trial. (Professor Robert Howard: Kings College & SLAM)
mATCH	People with autism detained within hospitals: defining the population, understand aetiology and improving care pathways.
MARQUE	The quality of life of people with memory problems who live in care homes
MOCHA-R	Understanding and optimising hospital ward card in the NHS
MOLECULAR	A national study investigating the genetic basis of Bipolar Disorder.
MOLGEN	Molecular Genetics of Adverse Drug Reactions
Passive Fluenz Tetra Safety Surveillance	Passive enhanced safety surveillance (ESS) of the Quadrivalent live attenuated influenza vaccine (QLAIV) fluenz tetra in children and adolescents during the early

	2015/16 influenza season in England.
PBS	Clinical and cost effectiveness of staff training in Positive Behaviour Support (PBS) for treating challenging behaviour in people with intellectual disability (Angela Hassiotis – UCL).
PPIP2	Prevalence of neuronal cell surface antibodies in patients with psychotic illness
PRIDE	Promoting Independence in Dementia (PRIDE) project
OTSUKA-Sz	Recent onset psychosis survey
RADAR	Reducing pathology in Alzheimer's Disease through Angiotensin taRgeting. The RADAR Trial. A phase II, two arm, double-blind, placebo-controlled, randomised trial to evaluate the effect of losartan on brain tissue changes in patients diagnosed with Alzheimer's disease
REACT	An online randomised controlled trial to evaluate the clinical and cost effectiveness of a peer supported self-management intervention for relatives of people with psychosis or bipolar disorder: Relatives Education And Coping Toolkit
REGISTRY 3 (ENROLL-HD)	A Prospective Registry Study in a Global Huntington's Disease Cohort
Servier S38093	Efficacy and safety of 3 doses of S38093 (2, 5 and 20mg/day) versus placebo in co-administration with donepezil (10mg/day) in patients with moderate Alzheimer's Disease. A 24 week international, multi-centre, randomised, double-blind, placebo-controlled phase IIb study
The use of guided self-help in Anorexia Nervosa	A study of feasibility and effectiveness of the addition of self-help aid and recovery guide for eating disorders (SHARED) to treatment as usual for anorexia nervosa.
SPRING	The Study of psychosis and the role of inflammation and GABA/Glutamate
Star	Feasibility and efficacy of resistance training in CP
STOP	Diabetes screening and prevention for people with Learning Disabilities
Support Heart Failure	Home monitoring with integrated risk---stratified disease management support versus home monitoring alone in patients with heart failure
SUICIDE	Study of Suicide in the Criminal Justice System: Nested Case-Control (Prof Jenny Shaw (Manchester))
	In-patient suicide whilst under non-routine observation (Prof Jenny Shaw, Manchester)
Surviving Crying	Development and Preliminary Evaluation of an Intervention Package to Support Parents of Excessively Crying Infants
TEQ	Therapeutic Engagement Questionnaire Developing and testing a tool to measure Therapeutic Engagement (TE)
TIARA	A sham-controlled randomised feasibility study of repetitive transcranial magnetic stimulation (rTMS) as an adjunct to treatment as usual (TAU) in adults with severe and enduring anorexia nervosa (SEED-AN)
Triangle	A novel patient and carer intervention for Anorexia Nervosa

Seventeen clinical staff members participated as Principal Investigators in portfolio research approved by a research ethics committee at LPT during 2016/17. These staff participated in research covering a range of specialities including old age psychiatry, adult mental health, children, learning disability, child and adolescent mental health and public health.

In the last three years we have not had any National Institute of Health Research (NIHR) funded Chief Investigators within the trust. However our staff have been disseminating their research through various publications, showing commitment to transparency and desire to improve patient outcomes and experience. Twenty three articles have been published in 2016 in a wide range of journals.

A full list of all research activity is available upon request via email to: research@leicspart.nhs.uk

2.8 Goals agreed with Commissioners

2.8.1 Use of contractual arrangements

Local authorities, West Leicestershire Clinical Commissioning Group, East Leicestershire and Rutland Clinical Commissioning Group and Leicester City Clinical Commissioning Group (CCGs) commission services on behalf of people living in Leicester, Leicestershire and Rutland. As part of our relationship with the three Clinical Commissioning Groups we have agreed quality targets and goals and these are translated into a Quality Schedule and a Commissioning for Quality and Innovation (CQUIN) payment framework. Progress against delivery has been monitored by our Commissioners on a monthly basis through formal meetings and visits to review our services in 2016/17.

The Trust's Quality schedule for 2017/18 has been agreed with our commissioners. Further details of the Quality Schedule for 2016/17 can be requested via email to: feedback@leicspart.nhs.uk

2.8.2 Use of the CQUIN payment framework

The amount of £4,977,529 of LPT's income in 2016/17 was conditional on achieving quality improvement and innovation (CQUIN) goals between West Leicestershire Clinical Commissioning Group, East Leicestershire and Rutland Clinical Commissioning Group and Leicester City Clinical Commissioning Group for the provision of NHS services, through the CQUIN framework. In 2016/17 we agreed 8 CQUIN goals with our Commissioners and we partially achieved 3 and fully achieved 5 CQUIN goals. Therefore the trust achieved £4,099,287.

The table below outlines our CQUIN goals for 2016/17.

	CQUIN	DESCRIPTION OF GOAL
1a	Staff health & well being	National CQUIN to implement a physical activity and mental health scheme and improve staff access to physiotherapy
1b	Healthy food for NHS staff, visitors and patients	National CQUIN to reduce the availability of sugary drinks and foods high in fat, sugar and salt
1c	Improving the uptake of flu vaccinations for front line clinical staff*	National CQUIN with a target to immunize 75% of front line staff
2a	Cardio Metabolic Assessment and treatment for patients with psychosis	National CQUIN to improve the assessment, documentation and action on cardio metabolic risk factors in patients with psychosis
2b	Communication to General Practitioners	National CQUIN to improve discharge summaries for patients on CPA
3	Nutrition and Hydration	Local CQUIN to develop and implement a Nutrition and Hydration Improvement Plan across all LPT inpatient areas

4	LD Medicines Optimization	Local CQUIN to ensure that adults with L D and challenging behavior, who are prescribed antipsychotics have their medication reviewed in line with best practice guidelines
5	Participate in the Gold Standards Framework (GSF)	Local CQUIN to implement the GSF for End of Life in two Community Hospitals
6	Shared care medication agreement	Local CQUIN to improve adherence to shared care medication agreements with primary care
7	Reduce non-attendance (DNA) at appointments with Mental Health Services*	Local CQUIN to reduce non-attendance at appointments for Mental Health Services
8	Effective Care and Crisis and Discharge Management and its impact on length of stay*	Local CQUIN to improve impatient management and reduce length of stay and prevent relapse in the community for patients with mental illness

*LPT did not demonstrate full compliance with this CQUIN. Further discussed in Section 2.8.3

2.8.3 Improved patient outcomes as a result of CQUINs

As a result of the 2016/17 CQUIN programme the following are some examples of improved patient outcomes:

- CQUIN 3 - All inpatient areas met the nutritional screening targets and implemented innovative quality improvement plans.
- CQUIN 4 – 76% of adults with LD and challenging behavior, who were prescribed antipsychotics had their medication reviewed and information shared with carers and health provides (40% in Quarter3)
- CQUIN 5 – Two community hospitals have completed The Gold Standard Framework which involved measuring positive changes in clinical practice
- CQUIN 6 - 80.5% of patients discharged with shared care drugs initiated by LPT had a Shared Care Agreement with primary care that was 90% complete

We could not demonstrate full compliance with 3 CQUINs in 2016/17 and therefore received partial payment. The CQUINs that we partially met were:

- CQUIN 1c - The uptake of flu vaccinations for front line clinical staff increased from 49% in 2015/16 to 61% in 2016/17 (CQUIN target 65%). In order to meet the 2017/18 CQUIN target we will further develop our peer vaccinator scheme as this was effective this year.
- CQUIN 7 – Three out of the six services met the CQUIN target however all services reduced non-attendance (DNA) at first appointments to some degree. The Trust wide DNA communication campaign is expected to have an ongoing positive impact on all DNAs
- CQUIN 8 - Although there has been significant improvement in crisis care planning for patients with mental illness, a continued focus on discharge pathways is required in order to reduce length of stay in the Bradgate Unit.

Further details of the CQUIN programme for 2016/17 and 2017/19 can be requested via email to: feedback@leicspart.nhs.uk

2.9 What others say

2.9.1 Care Quality Commissioners

The Care Quality Commission (CQC) was established by the Health and Social Care Act 2008 to regulate the quality of Health and Adult Social Care. From 1 April 2010 all NHS providers were required to register their services with the CQC. The trust received notification of full registration without any conditions on 1 April 2010. During 2016/17 LPT maintained an accurate Statement of Purpose as set out in the Health and Social Care Act 2008 regulatory requirements. LPT currently has a total of 17 registered locations.

Chief Inspector of Hospitals
Comprehensive Inspection of Services

The Trust underwent a comprehensive inspection in November 2016 the results of which were received during February 2017. The Trust received sixteen reports covering 15 'Core Services' and an overarching 'Provider level' report. The Trust was rated as 'Requires Improvement' overall. Within these reports the CQC have issued a total of 83 'Requirement Notices'. Work is underway in all areas identified to address the findings. The overall 'Provider Level' rating is detailed in figure 4.

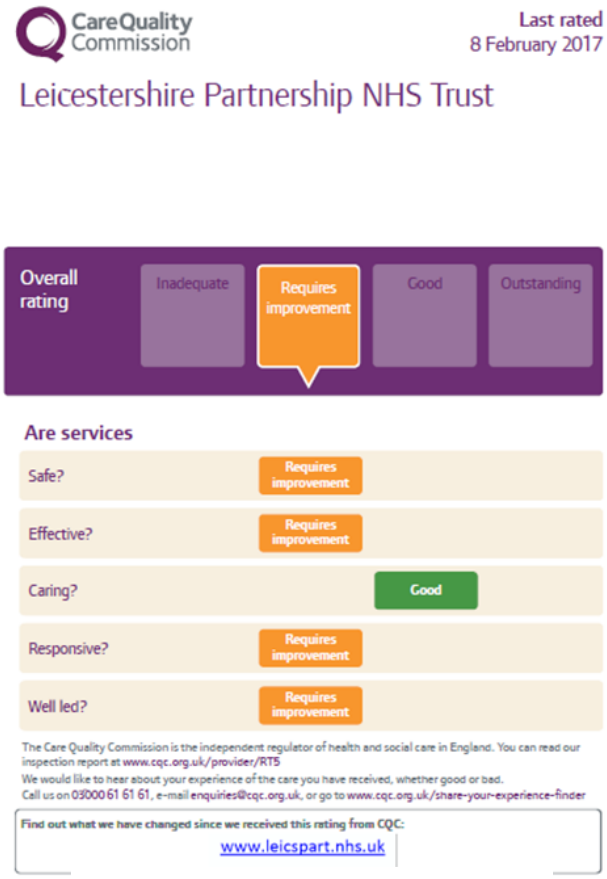


Figure 4: CQC ratings November 2016

The CQC identified many 'good' areas within our practice and services; we are particularly proud of the 'outstanding' rating we have received for the care we provide children, young people and families in the community. Their report highlights the progress and improvements we have made in many areas across our services since the previous inspection in March 2015, including a 'good' rating for our Child and Adolescent Mental Health Service (CAMHS) inpatient ward and an appreciation of the progress we have made in our adult mental health services. However, they have highlighted some areas for improvement, which means that we have received a **'Requires Improvement'** rating overall. While we have made good progress in the eighteen months since our last inspection, we still have more to do.
The CQC report has identified a number of areas for further focus; these areas will be included in our improvement plan.

- Continuing to improve the safety of our ward environments
- Reduce reliance on bank and agency staff to reach the required numbers of staff needed on wards
- Reduce out of area mental health placements

- Reduce long waiting times for patients to access their treatment
- Improve staff understanding of the Mental Capacity Act
- Improve our mental health Place of Safety
- Greater involvement of patients in care planning

CAMHS

Our rated specialist community mental health service for children and young people as inadequate overall and key areas for improvements in this service include;

- Care planning and risk assessment
- CAMHS assess and waiting times

CQC inspection reports can be accessed at http://www.cqc.org.uk/provider/RT5

CQC Ratings Grid

A Summary of all the ratings (as determined by the CQC) is shown as Appendix 3. A comprehensive action plan is being drawn up and improvement actions will then be implemented. Our progress is monitored monthly through our Trust Board and Quality Assurance Committee through a task and finish group.

CQC Mental Health Act Commissioner visits in 2016/17

The CQC continue to monitor application of the Mental Health Act (MHA) 1983 for patients whose rights are restricted under the Act. These visits are normally unannounced.

Each visit generates an action plan from the CQC which requires a response within a defined time frame. The CQC use the MHA Code of Practice as their monitoring tool and identify concerns on the action plan using quotes from the Code.

In 2016/17 the **CQC Mental Health Act Commissioner** visited the following locations:

LOCATION:	DATE OF VISIT:
Watermead Ward	23/06/16
Langley Ward	28/06/16
Ashby Ward	27/07/16 & 02/08/16
Aston Ward	02/08/16
Beaumont Ward	08/08/16
Belvoir Ward	10/08/16
Griffin Ward	23/08/16
Bosworth Ward	02/09/16

Heather Ward	06/09/16
Mill Lodge	15/09/16
Phoenix Ward	26/09/16
The Willows – Acacia Ward	27/09/16
Kirby Ward	04/10/16
Ward 3 - CAMHS	18/10/16
The Willows – Maple Ward	26/10/16
The Willows – Sycamore Ward	04/11/16

Services are responsible for the continued management of the action plans.

2.9.2 HM Coroner

The Trust has received three Prevention of Future Death (PFD) Reports under Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. The Regulations provide the Coroner with a duty not just to decide how somebody came about their death but also where appropriate to report the death with a view to preventing future deaths.

The concerns raised by the Coroner for each inquest are considered and responded to by the Chief Executive within the timeline set-out by the Regulation Report. Any emerging themes are also considered for actions to be considered wider than the specific team or service provision.

2.9.3 Health Education East Midlands

The General Medical Council (GMC) Regional Educational Review of Leicester and Nottingham in November 2016 did not include a site visit to LPT as no significant educational risks were identified in GMC and Health Education East Midlands (HEE-EM) trainee surveys or in the Leicester Medical School annual quality return.

Following publication of the Health Education England Quality Framework in April 2017, it is anticipated that the HEE-EM annual quality management visits going forward will become targeted and focussed on specific issues highlighted by local and GMC trainee surveys.

2.10 What do our staff say?

Freedom to speak up

Our Raising Concerns (Whistleblowing) Policy and Procedure is designed to provide a way for staff to speak out safely if they have concerns about issues which are affecting patient care or safety.
The policy is being supported by, Leicestershire Partnership NHS Trust's Freedom to Speak Up Guardian who reports directly to our Chief Executive

and is required to provide an impartial overview of all concerns raised and how they are investigated and handled.

We want LPT to be a safe environment that encourages a culture of openness and transparency and allows our staff to speak up if they feel things aren't right.

The Raising Concerns (Whistleblowing) Policy and Procedure includes the following messages:

- **If in doubt, raise it.** Do so as early as possible and preferably to your line manager
- **It doesn't matter if you are mistaken**, or if there is an innocent explanation, as long as you were acting honestly and in the public interest
- **The Trust will not tolerate harassment or victimisation** of anyone who raises a concern, and recognises that individuals may want to do so in confidence
- I**nvestigations will be focused on improving the service we provide to patients**, will be objective and evidence-based, and will produce a report that focuses on identifying and rectifying issues, and learning lessons to prevent problems recurring
- The policy, and Freedom to Speak Up Guardian, are there to help.

We have appointed our Freedom to Speak Up Guardian, who will be using the LiA approach to hear staff views on raising concerns and speaking up in LPT.

National Staff Survey

Staff experience of harassment, bullying or abuse from other staff (Staff Survey Key Finding KF 26)

Overall, 21% of staff told us, through the 2016 NHS Staff Survey, that they had experienced harassment, bullying or abuse from staff in the last 12 months. This is the same as in 2015 and average for similar trusts. With respect to the Workforce Race Equality Standard, similar percentages of White and BME staff told us that they had experienced harassment, bullying or abuse from staff in the last 12 months (20% and 21% respectively). This represents an improvement for BME staff since 2015 (when 25% of BME staff told us that they had experienced harassment, bullying or abuse from staff in the last 12 months) and is lower than the average for similar trusts in 2016 (amongst whom 24% of BME staff reported having experienced harassment, bullying or abuse from staff in the last 12 months). We continue to work closely with staff representatives to seek early resolutions to bullying and harassment issues, aided by the provision of an Anti-Bullying and Harassment Advice Service, trained mediators and the use of facilitated conversations as well as appropriate training and awareness raising for line managers.

Staff belief that the Trust provides equal opportunities for career progression and promotion (Staff Survey Key Finding KF 21)

Overall, 89% of staff responding to the 2016 NHS Staff Survey indicated that they believe we provide equal opportunities for career progression and promotion. This is

similar to the position in 2015 and is in line with the national average for similar trusts. With respect to the Workforce Race Equality Standard, a higher percentage of White than BME staff indicated that they believe we provide equal opportunities for career progression and promotion (93% and 75% respectively). Compared to the average for similar trusts in 2016, this is slightly higher for White staff (89% in similar trusts) and slightly lower for BME staff (78% in similar trusts), but is similar to the position for our trust in 2015. We continue to work with BME staff to identify issues that affect them and to implement targeted interventions, e.g., Listening into Action, focussed staff surveys, and the development of an action plan with a "task and finish" group to address career development issues for BME staff in particular areas.

2.11 Data quality

The Trust is taking action to improve data quality through a significant programme of work which commenced in 2016/17 to review and improve all aspects of the information lifecycle. This solution includes the development of a new fit for purpose data model and a rolling programme of Key Performance Indicator (KPI) reviews incorporating clinical systems training, system configurations and reviews of how our services enter information onto clinical systems and use their performance data to improve patient care.

The Trust continues to build self-service on-line web-based reporting of core indicators to support staff to deliver high quality care and continually reviews its Information Management and Technology Strategy to ensure it underpins the Trust's objectives and service development plans.

2.12 Use of NHS number

LPT submitted records from April 2016 to March 2017* to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's **valid NHS number** for LPT was:

100.0 % for outpatient care
99.8 % for inpatient care

The percentage of records in the published data which included the patient's **valid General Medical Practice Code** was:

99.7 % for admitted patient care
100 % for outpatient care

2.13 Information Governance Toolkit attainment levels

The Information Governance Assurance Framework (IGAF) is the national framework of standards that bring together all statutory, mandatory and best practice requirements concerning information management. The standards are set out in the NHS Digital Information Governance Toolkit (IGT) as a roadmap enabling

organisations to plan and implement standards of best practice and to measure and report compliance on an annual basis.

LPT's Information Governance Assessment Report score overall for 2016/17 was 88% against the information governance toolkit grading scheme', and was graded satisfactory (Green) against the Information Governance Toolkit grading scheme. 360 Assurance completed an audit of a sample of IGT requirements to assess the robustness of LPT's approach to its self-assessment scoring, establishment of an information governance control framework and a review of compliance against the recommendations of Caldicott 2: 'To Share or not to Share', having been embedded into the toolkit.

The review was completed in accordance with the internal audit standards for the NHS and was performed to provide an objective and unbiased opinion. The outcome of this review was the achievement of 'significant assurance'.

The Trusts' Information Governance Team continues to work with the Leicestershire Health Informatics Service IT Assurance Manager on information and cyber security. The Trust has registered as part of NHS Digitals CareCERT Programme, receiving alerts relating to known threats to the NHS and any identified specific threats in order to ensure that appropriate actions are taken to mitigate risks.

2.14 Clinical coding error rates

Clinical Coding is the medical terminology used by clinicians to record a patient's diagnosis and treatment in a standard, recognised code. The accuracy of this coding is a key quality standard, to help us ensure that patient's records are accurate.

The Mental Health Minimum Dataset (MHMDS) is a mandatory requirement for all providers of specialist adult mental health services in a secondary care setting. The requirement is to collect person focused clinical data which includes all relevant treatment and care for service users in a mental healthcare setting using ICD-10 for diagnoses and OPCS-4 for procedures. The coded clinical data inputted helps provide local clinicians and managers with better quality information for clinical audit, and service planning and management.

The principal aim of the IGT Clinical Coding requirements is to ensure all mental health trusts are providing accurate and concise quality data and continue to do so into the future. By providing a standard development framework it is possible to outline what is considered to be best practice and drive the production of good quality data inputted by staff using the application of national standards. This will ensure consistent, meaningful and comparable data.

An Annual Audit is undertaken in order to conform to the IGT requirement 514, which states that all Mental Health Trusts should have an audit of a minimum of 50 Finished Consultant Episodes (FCEs) undertaken each year. The trust achieved a Level 3 for the IGT Clinical Coding standards, which is reflective of the outstanding work that our clinical coders do. The challenges for the Trust moving forward, is the transition to complete electronic records and the requirement to ensure that systems are SNOWMED compliant.

Internal Audit Clinical Coding Audit

In March 2016, the Trusts' Internal Audit function was commissioned to undertake an audit of aspects of the Information Governance Toolkit Clinical Coding Audit that were identified as weakness in the report. The Trust has generally performed well with regards to coding accuracy, as evidenced in from external information governance clinical coding reports: 100% accuracy rate for primary diagnoses, and 93% for secondary diagnoses codes (the recommended accuracy for a level 3 attainment is 90% for primary diagnosis and 80% for secondary diagnosis.

The weaknesses identified in the report, whilst not impacting the overall results in information governance terms, could impact on the overall accuracy of the information on which coding is based. The audit review opinion was 'Limited Assurance', and identified areas for improvement which included levels of clinical engagement with the coding validation work; technical obstacles with the electronic patient record, RiO; the quality and timeliness of clinical coding in community services; and the logic in using different Electronic Patient Records (EPRs) across the Trust. Relevant actions have been included in the Data Quality work plan for the Trust, with recognition that a number of actions were dependent on progress of work outside of the Trust's control.

2.15 Duty of Candour

The Trust has a Being Open/Duty of Candour Policy in place. This policy ensures that we are always open and honest with patients and/or their families following an incident where a patient has been harmed. We have a duty to contact the patient and/or their family within 10 days of the incident. Where an investigation has taken place we arrange to meet with the patient and/or their family to share the findings with them. The policy contains a flow chart guide, crib sheet and assurance template document which captures information related to the discussions that we have with patients and/or families. The Trust reports to commissioners each month on our compliance with Duty of Candour.

Duty of Candour training has been delivered to all senior managers. Staff training is delivered and an e-learning package is available on line.

2.16 Sign up to Safety Plan

LPT has pledged to strengthen patient safety within its services with an aim to deliver harm-free care for every patient, every time and everywhere. The campaign champions openness, honesty and supports everyone to improve the safety of patients.

To deliver our safety programme, we have agreed an improvement plan to deliver improvements across the three areas as follows;

- Reduce harm from medication errors
- Reducing the risk of harm from medical devices
- Reduce harm from falls

Part 3 – Review of quality performance in 2016/17

Our Quality Strategy takes account of the local and national context of service change that we know will critically affect the quality of care for all our patient and delivery will be supported through our governance arrangements so that we can be assured that the care and treatment delivered by our services is safe, effective, and focused on positive outcomes for the people that use our services.

Improving quality is about making healthcare safer, more effective, patient centred, timely, efficient and equitable. Our central purpose is to provide the highest quality healthcare and promote recovery and hope to our patients. To do this we need to actively seek out the views of patients, carers, staff and work hard to build a culture of openness, honesty and support.

Our quality priorities take account of staff requests to have focused and meaningful priorities that are simple to understand and relate to. In line with the CQC approach we acknowledge that achieving safe, effective and person centred care can only be sustained when a caring culture, professional commitment and strong leadership are combined to provide responsive accessible services for our patients.

The agreed LPT quality priorities are;

1. Ensuring our service users are safe (Safe care)
2. Ensuring are care is effective (Effective care)
3. Ensuring Person Centred care

Our three quality priorities are underpinned by our approach to self-regulation which is reliant on good leadership and accountability at every level of the organisation for delivering high quality services. It is all of our responsibilities to be curious about our work and to create a culture of improvement that is patient focused.

Improving safety, effectiveness and patient and carer experience aligns with our 'Sign up to Safety' pledges and workforce and leadership plans. We are passionate about creating a culture that supports learning where people are comfortable asking questions, asking for and receiving feedback and are encouraged to innovate.

A key part of leadership and a safety culture is listening to our patients and carers as well as staff so that we are informed and learn from them. We are building a culture in which patients and staff can be confident their views matter and will be heard; and where all staff has what they need to provide the best possible care for patients whether through direct patient care or in the supporting services.

3.1 Progress on quality priorities for 2016/17

3.1.1 Our local priorities – our achievements in 2016/17

Our progress to date as measured against the local priorities that we set out to achieve in 2016/17. We will continue to monitor progress with these priorities, where some have been achieved but need to be sustained and in others where we have achieved some improvement, but they still require further work and this will be monitored by the groups responsible for monitoring the quality of our services.

Some of the key achievements:

- Adult Mental Health/Learning disabilities: Recording of clinical supervision has improved over the year from 37.7% in February 2016 to 57.7% in January 2017.
- Community Health Services: Current record keeping and care planning training for the service as of 1st January 2017 is above 85% compliance.
- Families, Young People and Children's: The standard for first Episode Psychosis since April 2016 is that 50% of cases accepted for treatment have been seen and allocated within 2 weeks. This has been monitored through weekly Patient Tracking List meetings. The compliance rate for 2016/17 to date is 78%.
- Clinical Supervision rates have increased from July 2016 to 64% March 2017.

For further details see Appendix 4.

3.1.2 Mandatory reporting criteria 2016/17

These national mandatory figures provide comparable benchmarks between similar Trusts. Data is made available to LPT by NHS Digital. A comparison of the numbers, percentages, values, score or rates of the Trust, for the reporting period, will need to be included for each of the mandatory national measures listed in the table, including

I. The national average, and
II. The highest and lowest percentages

NHS Digital provides links to the latest data for each of the indicators that trusts are required to report upon. NHS Digital will refresh the links to the most current data annually each March.

These figures have been reported in either the Integrated Quality or Performance Report (IQPR) which is presented to the Trust Board on a monthly basis or through the sub committees of the Trust Board.

The Trust submits some mandatory national measures on a quarterly basis either through the Omnibus Survey data collection system on behalf of NHS digital for the Crisis Resolution Home Treatment measure and via the Unify2 web portal on behalf of the Department of Health Information Centre for Care programme approach seven day follow up. The Trust submits data to the National Reporting and Learning System (NRLS) which is published bi-annually by the NHS Commissioning Board.

• The Trust monitors and discusses the performance of all performance measures on a routine basis to ensure continuity and enable services to provide high quality care.

Mandatory National Measure	Quarter Period Totals/ Percentage				Year End	National Average
	Q1	Q2	Q3	Q4		
*The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period; Source *National Reporting and Learning System Organisational Patient Safety Incident Report, Reported incidents between 01 April 2016 to 30 September 2016, published April 2017.	2511 psi out of 4364 incidents reported	2557 psi out of 4458 incidents reported	2771 psi out of 4623 incidents reported	2708 psi out of 4501 incidents reported	10547 psi out of 17946 incidents reported *Rate = 72.02 per 1000 bed days *(Data only available for April – September 2015)*	*Median = 42.45 per 1000 bed days *(Data only available for April – September 2016)*
*The number and percentage of such patient safety incidents that resulted in severe harm or death. Source: Trust - published data for 2017 is not yet available *These incidents are subject to further validation through the serious incident investigation process which may result in a variation in the number of incidents as investigations conclude.	05 0.2%	19 0.74%	08 0.29%	08 0.30%	40 0.38%	0.8%
KF 1 INDICATOR Staff recommendation of the trust as a place to work or receive treatment. (the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.) Source: *NHSstaffsurveys.com*	2015 Staff Survey 3.58 - LPT 3.7 - all organisations 4.06 Highest 3.4 Lowest				2016 Staff Survey Trust's position is 3.61	3.93 Highest 3.47 Lowest average 3.71

Mandatory National Measure	Quarter Period Totals/ Percentage				Year End	National Average
	Q1	Q2	Q3	Q4		
The "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. Source: *nhssurveys.org*	2015 National NHS Community Mental Health Service User Survey 7.6 Score				2016 National NHS Community Mental Health Service User Survey 7.3 Score	8.1 score Highest 6.9 score Lowest

See appendix 5 for data definitions*

3.1.3 Waiting Times

We are focused on improving waiting times for our services and monitor this through the IQPR. Directorates continue to prioritise the roll-out of best practice weekly patient tracking lists (PTLs) which enable us to focus on reducing waiting times.

3.2 Listening into Action (LiA)

Listening into Action is one of the key ways that the Trust empowers staff to make changes that improve working life and patient care. The programme enables staff to take bold steps to deliver better outcomes for our patients, staff and the Trust as whole 76 teams have now undergone the 7 step process and it is expected another 12 will join cohort 8 in March 2017.

LiA managing change enables staff engagement in an organisational change and leaders have used this to help inform the process (examples of these being the 5 year plan, the people strategy and creating rotational posts across UHL/LPT).

LiA is now an essential part of our programme to improve the quality of care across all of our services. More and more teams are recognising the programme as a way to make improvements to their areas and are requesting to use the methodology. In the past year there have been 38 big conversation held, around a variety of topics, giving staff the chance to contribute their opinions and ideas, engaging them in potential change and improvement.

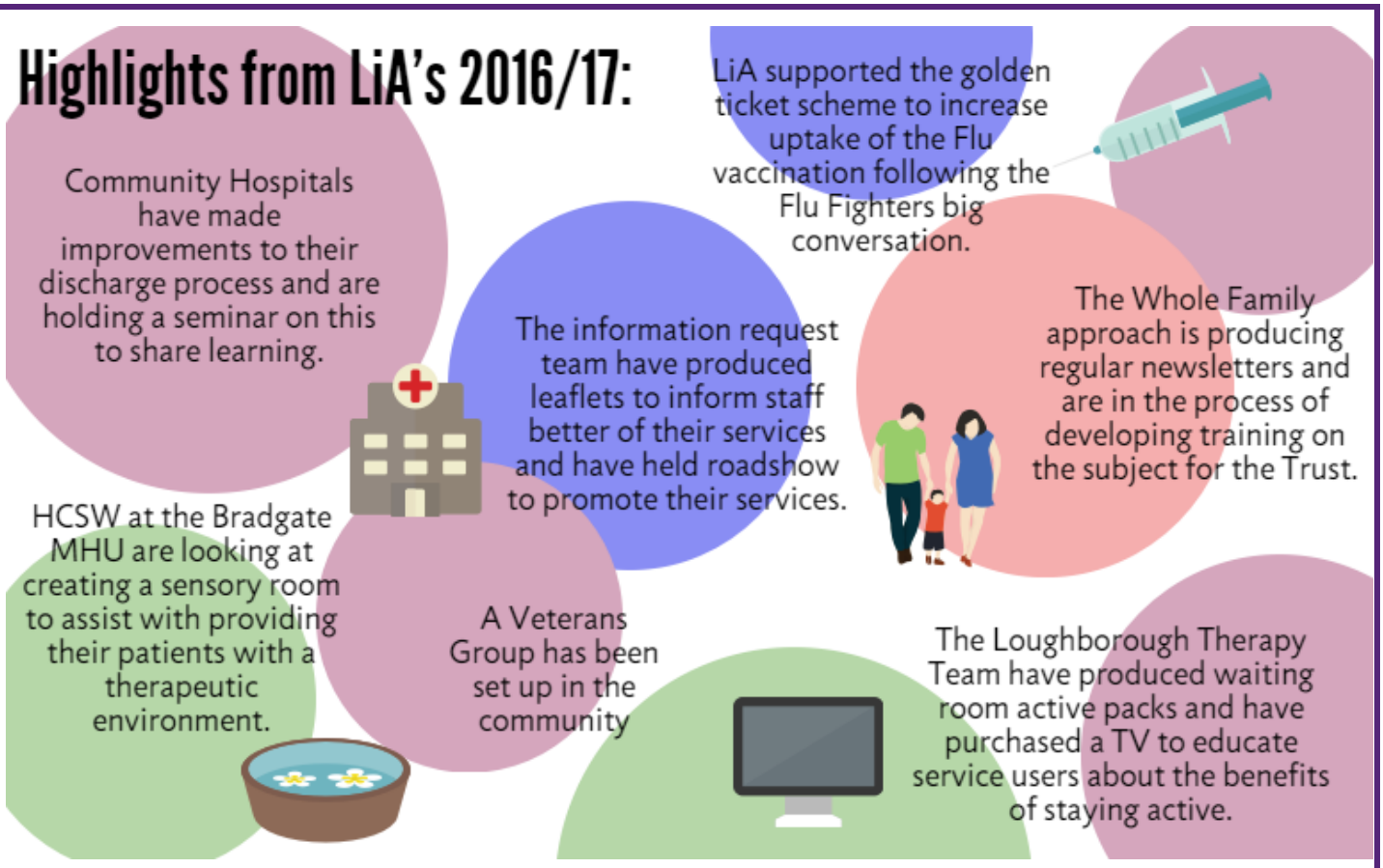


Figure 5: Highlights from LiA 2016/2017

On March the 21st 2017 the pass it on event has been held to celebrate the improvements of teams in Cohort 7 and welcome all the new teams about to begin their LiA journey.

3.3 Quality of services 'Safe Care'

3.3.1 Supporting our workforce

Workforce recruitment and retention continue to pose a risk to the quality of services being provided across the trust. During 2016/17 we have put in place a number of strategic actions to proactively attract people to our vacancies.

We continue to explore further avenues of candidate attraction and develop our employment proposition to attract new staff through developing a range of incentives for services to use to help attract candidates to their roles.

The recruitment and retention of staff remains a challenge for us, we continue to monitor and report our compliance with safer staffing requirements. This ensures

that we have sufficient have nursing staff to deliver our services. We have in place an ongoing recruitment programme and a professional development programme to enable us to maintain safer staffing levels. This includes establishing new roles such as assistant practitioners and activity co-ordinators to work as part of the multi-disciplinary team.

Figure 6: Staffing strategic actions

3.3.2 Learning from incidents

During 2016/17 our staff reported a total of 17,678 incidents, of these 69 incidents were considered serious, 3 of these were prison SIs. The definition of a serious incident is: 'any reportable event which could have, or did lead to unintended harm, loss or damage (including reputation)'.

Trained staff investigates every serious incident to identify the root causes and share lessons learnt with all staff to prevent recurrence. Our commissioners also review our investigations to ensure that they have been rigorous.

Serious incidents reported this year include suspected suicide, sudden unexpected deaths; pressure ulcers; attempted suicides; slips, trips and falls resulting in serious injury; safeguarding vulnerable adults and children and confidential information breaches which require a full root cause analysis investigation.

From the 69 serious incident investigations completed in 2016/17, we have identified lessons to be learnt and shared them with staff to ensure that the risks associated with similar occurrences are reduced.

The trust has in place an improvement plan to reduce the number of avoidable pressure ulcers that occur in our care.

The Trust has developed a framework for mortality governance which includes identification of learning lessons from deaths which take place within the care of trust. We continue to embed our mortality review framework and improve the quality of incident investigation and subsequent learning and actions. The Trust will participate in the annual publication of avoidable deaths in line with the agreed guidance.

Each directorate has a spot-check audit programme to revisit closed serious incident action plans and ensure that learning and change has been embedded and maintained. This provides assurance that change has been sustained. Locally learning boards are utilised to share learning from serious incidents amongst staff

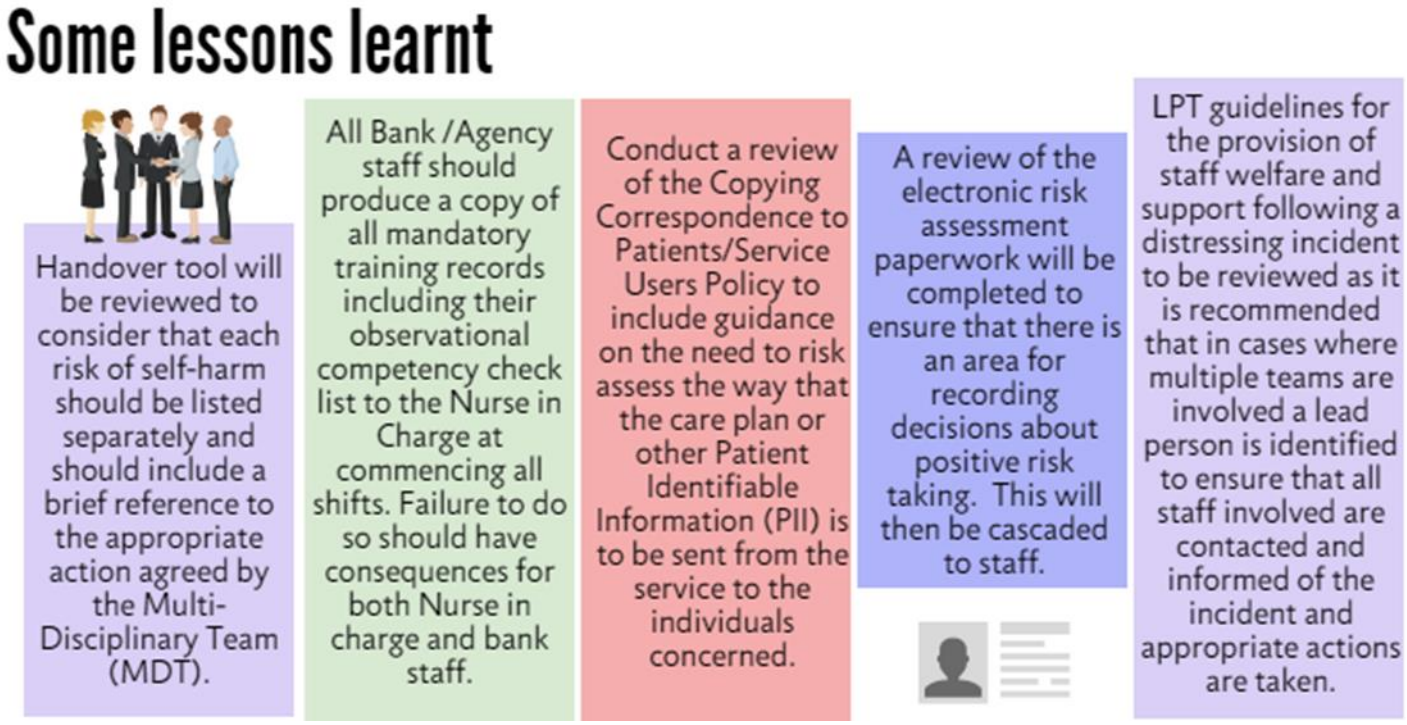


Figure 7: Some lessons learnt

3.3.3 **Never Events**

Never Events are defined as ‘serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers’.

The Department of Health has outlined 25 Never Events which aim to ensure the safety of patients and further information about these is available at www.dh.gov.uk

During 2016/17 zero Never Events occurred.

3.3.4 Patient Safety Collaborative

The Trust continues to participate in the East Midlands Academic Health Sciences Network local Patient Safety Collaborative. The approach offers staff, service users, carers and patients the opportunity to work together to tackle specific patient safety problems, improve the safety of systems of care, build patient safety improvement capability and focus on actions that make the biggest difference using evidence based improvement methodologies. We continue to focus on developing a safety culture and measurement for improvement across the areas of, falls, medication errors and medical devices.

3.3.5 Infection Prevention and Control/ Healthcare Associated Infections (HCAIs)

Our dedicated infection prevention and control team of nurses continue to work closely with our clinical services and support our stringent and robust infection prevention and control suite of policies. Networking across Leicester, Leicestershire and Rutland continues to be a priority with specific work on antimicrobial stewardship to benefit the wider healthcare economy.

During 2016/2017, we reported no cases of MRSA bacteraemia attributed to our care delivery. Our trajectory of 7 cases of Clostridium difficile has not been achieved; we reported 11 Clostridium Difficile cases. We have embedded all the improvements that had been identified and continue to review each case through a robust and stringent root cause analysis process. We have also triangulated each of these events to ensure lessons for learning and outcomes are met.

In October 2016 the Infection Prevention and Control team hosted a day conference entitled ‘Stop… Let’s Talk Infection Control’ with guest speakers. It was very well attended from all divisions within the trust and the feedback was really positive.

We continued to support the annual Flu campaign/ vaccination programme, maintaining peer vaccinators and introducing prize incentives.

The uptake to date has been 62 % and by close of the campaign in February 2017 is aiming for 65%.

3.3.6 Safeguarding Children and Vulnerable Adults

The Trust is committed to safeguarding children and vulnerable adults and ensures that services meet with statutory requirements, including Working Together to Safeguarding Children 2015 and the Care Act 2014. The Trust conducts inpatient safeguarding enquires, on behalf of Leicester, Leicestershire and Rutland (LLR) Local Authorities who hold statutory responsibility to oversee safeguarding enquiries carried out by health providers. The Trust continues to work in partnership with the Safeguarding Adults Boards to ensure LPT is ‘Care Act Compliant’.

In 2016 the CQC undertook a review of health services for Children Looked After and Safeguarding in Leicester City. The review made a number of cross organisational recommendations; an improvement plan has been implemented to ensure the all recommendations are being completed.

The number of Safeguarding Children Learning review processes involving LPT has decreased over the past year with 8 in total being conducted in 2015 and 5 in 2016. There has been an increase in Safeguarding Adult Reviews; this is due to the continued developments associated with the application of the Care Act 2014 in 2015. 2016 also saw an increase in Domestic Homicide Reviews and alternative reviews with the total number of reviews in 2016 increasing from 4 to 8 in 2015.

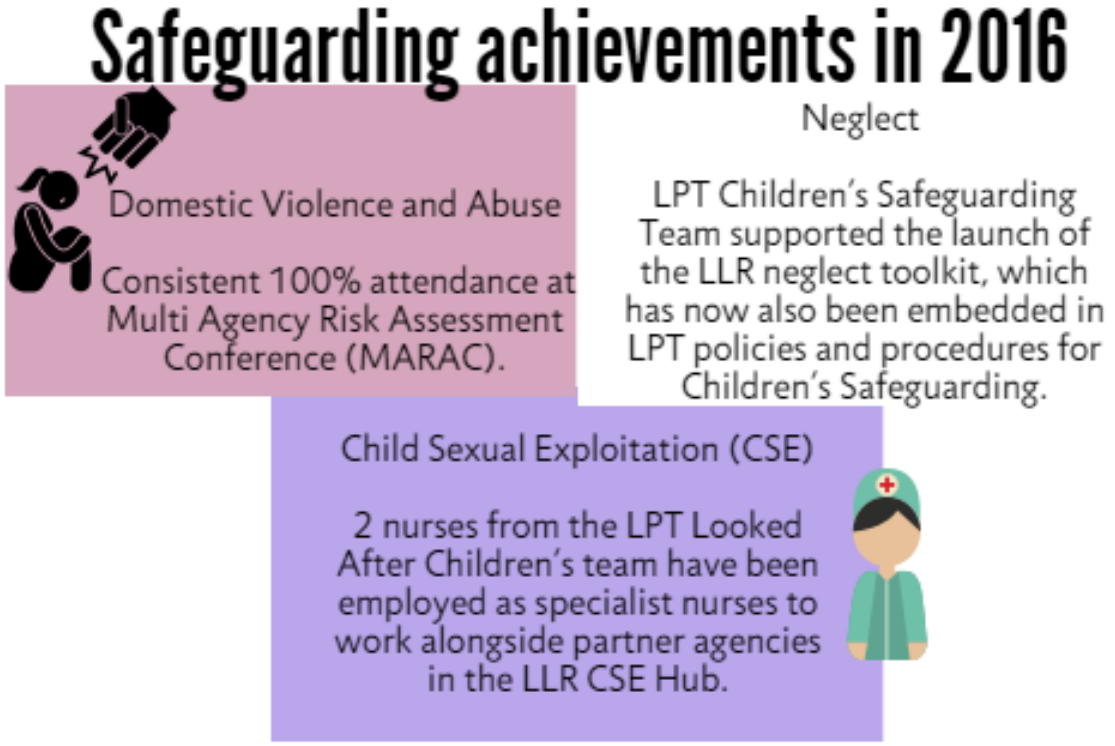


Figure 8: Safeguarding achievement in 2016

3.3.7 Safer medications

All patients who are prescribed Clozapine and/or Lithium during their stay in any LPT in-patient facility now receive counselling on their therapy from a member of the pharmacy team.

The Trust prescribing group have developed several strategies to reduce the likelihood of patients becoming dependant on sleeping tablets whilst in our care. These include sleep hygiene packs being made available in all in-patient areas and the development of a patient group direction for Zopiclone making it clear who was responsible for the patient receiving a sleeping tablet and making it less likely that the drug would be prescribed on discharge.

3.3.8 External assurance on quality indicator testing

Two mandated indicators were subject to external audit as follows:

- The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.

- The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period (gatekeeping).

CPA 7 day Follow up indicator (see table below)

Mandatory National Measure	Quarter Period Totals/ Percentage				Year End	National Average
	Q1	Q2	Q3	Q4		
*The percentage of patients on Care Programme Approach who were follow-up within 7 days after discharge from psychiatric in-patient care during the reporting period. Source: *NHS Digital – mental health community teams activity*	96.9%	96.6%	98.1%	98.3%	98.3%	96.7% Average 99.4% Highest 84.6% Lowest *As at Q4*

The assurance review was unable to provide a limited assurance opinion for CPA 7 day follow up data due to LPT using a local process that does not reflect the national definition.

LPT considers that this data is as described for the following reasons;

- The data reported in this quality account reflects the current LPT CPA clinical procedure which is results in a patient review prior to inpatient discharge whereby a clinical decision can be made to take the patient off the CPA.

- In this instance the patient will be reviewed and classified as not on CPA. Where a service user is discharged and not on CPA, the rationale for this decision is recorded, thus not all patients discharged from a psychiatric ward are regarded as being on CPA.

- All patients on CPA at discharge do have a follow up within 7 days and this is the data that is monitored and recorded in the Trust IQPR and the quality account.

The national definition requires that all patients discharged from a psychiatric in-patient ward are regarded as being on CPA (see appendix 5).

LPT intends to review the reporting arrangements from 2017/18 to ensure that reporting includes all patients in line with the national definition

Gatekeeping indicator (see table below)

Mandatory National Measure	Quarter Period Totals/ Percentage				Year End	National Average
	Q1	Q2	Q3	Q4		
*The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team (CRHT) acted as a gatekeeper during the reporting period. Source: *NHS Digital– mental health community teams activity*	99.2%	100%	99.6%	100%	99.7%	98.8% average 100% Highest 90.0% Lowest *As at Q4*

See appendix 5 for data definitions*

The assurance review was unable to provide a limited assurance opinion for CRHT Gatekeeping due to LPT including exclusions within their data that do not reflect the expectations detailed in the national guidance.

LPT considers that this data is as described for the following reasons;

- The data reported in this quality account reflects the current LPT CRHT Gatekeeping procedures.
- The data reflects what has been reported in the Trust IQPR and the quality account.

LPT intends to review the information reporting system to ensure that exclusions are not included in the reporting and for 2017/18.A validation process will be established to test accuracy in line with the guidance.

3.3.9 Directorate service improvements

Adult Mental Health and Learning Disabilities

We have completed a schedule of remedial works at the Herschel Prins Centre in order to create a safer environment for patients by removing ligature points and improving the seclusion facilities. We are also undertaking some additional actions at the Bradgate Unit to address any remaining ligature risks. The withdrawal of plastic bin bags in inpatient areas and use of plastic carrier bags has led to an initial reduction in attempted ligatures via this method.

We have established a new staff newsletter in AMH to improve learning from serious incidents. It details key lessons learned and is written in a very accessible style for staff. Feedback from the first 3 issues has been very positive and it prompted a trust wide version which has also been launched recently.

Families, Young People and Children's

CAMHS Eating Disorder Team (EDT)

The CAMHS EDT has developed significantly in 2016/17 and is now offering a wide-range of therapy options for its patients. The team has been actively involved in

training other professionals outside of CAMHS to increase awareness of eating disorders and the importance of early intervention for treatment outcomes. The service offers specialist outpatient assessment and treatment to young people and their parents who are affected by eating disorders such as anorexia nervosa, bulimia nervosa and binge eating disorder. The team manages around 100 new referrals each year, and treatment usually lasts between 12 and 18 months.

Our multi-disciplinary team is based at Mawson House in Leicester, and includes psychiatry, psychology, nursing, psychotherapy staff and staff trained in family therapy. We offer a wide range of evidence-based therapies so that we can provide more choice for our patients over the care they receive. Our approach is always to work closely with parents and carers to maximise the support for the young person throughout their recovery.

Care Navigation

The care navigators within the trust FYPC's families, young people and children's service carry out a valuable administrative role supporting clinicians working in neighbourhoods across Leicester City, Leicestershire and Rutland. They work collaboratively with health and partner agencies and co-ordinate the care provided to children and families, ensuring they are able to access the right services at the right time. Our Looked after Children (LAC) team and CAMHS each have a dedicated care navigator.

Care navigators help families' access different services and get the best health outcomes. They organise multi-agency meetings where professionals working with a child or family come together to explore the appropriate pathways of care. Between Oct - Dec 2016. 42 Locality Hubs were attended across Leicestershire. A total of 487 cases were discussed, an average of 40 per week. Working in this way supports a 'whole family' approach and ensures a comprehensive picture of a child's needs is available. It also prevents children and young people becoming 'lost in the system'. We have recently recruited care navigators based in our adult mental health service and with the deliberate self-harm team at Leicester Royal Infirmary.

CAMHS Access Model

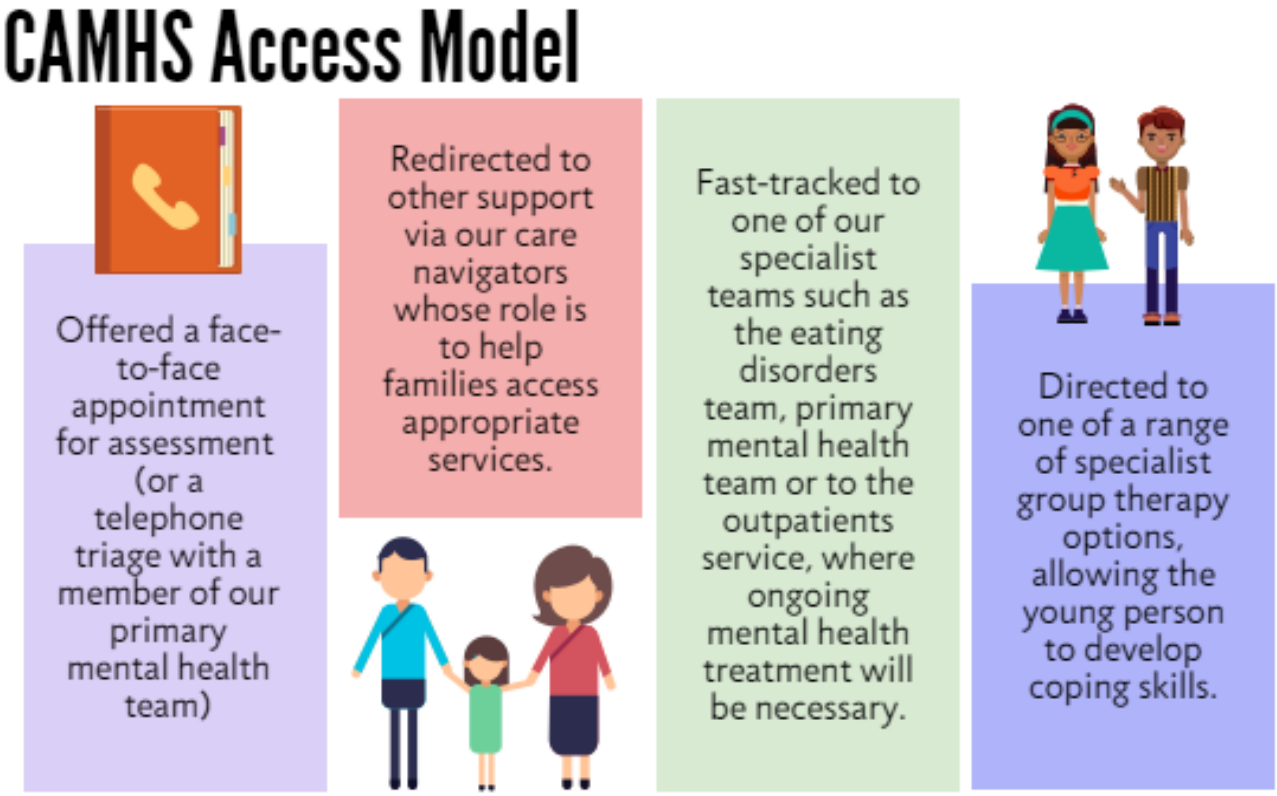
In May 2016 CAMHS implemented an innovative new model for responding to referrals, ensuring service users receive a more timely and comprehensive first contact with the service, and that our 13 week target for initial referral is met consistently. This development represents the first phase of our work with commissioners and partners to respond to the Future in Mind strategy.

The CQC also found that our waiting lists from assessment to treatment are too long for our community child and adolescence mental health service; this disappointingly resulted in an 'inadequate' rating for safety and responsiveness. We continue to work with our commissioners to improve our service. Our new crisis and home treatment service was launched in April 2017 and will contribute to ensuring we respond the need to ensure our local children and young people get the best mental health care in the community.

This new model enables closer working relationships with social care, universal health services and the voluntary sector. Daily multidisciplinary meetings with colleagues in social care help to speed up the inter-agency referral processes, ensuring children and young people with mental ill health are able to receive the right care from the right agencies as quickly as possible.

Under the new model, our central access team contacts families by telephone at the earliest opportunity to confirm they have received with the referral. Following the call, the numbers of options are offered (see Figure 9).

Figure 9: CAMHS Access Model



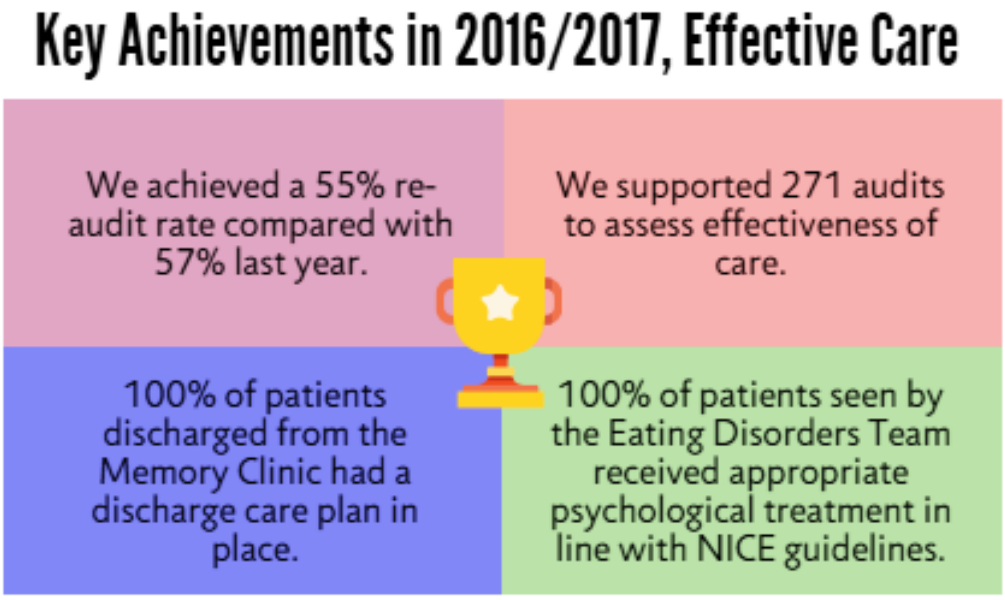
Community Health Services (CHS)

Within Community Hospitals, North & Clarendon wards were involved in the national specialling project to improve the understanding of staff and experience for patients who may require special 1:1 support, we call this 'specialling'. This programme has now been rolled out across all CHS inpatient wards. Staff are all now utilising the appropriate risk assessment tool prior to identifying the need for specialling. The tool also supports the stepping down of specialling as the patient's condition changes.

Our Mental Health Services for Older People (MHSOP) have introduced regular Schwartz Centre Rounds; these are 1 hour events which allow all staff to discuss the emotional and social dilemmas that arise in caring for patients.

Across the whole of CHS we have introduced the production of learning boards from all serious incidents to enable the sharing of learning amongst staff. This initiative has been adopted from an original idea at Newcastle NHS Foundation Trust.

3.4 Quality of services 'Effective care'



3.4.1 Clinical audit key achievements

Providing high quality care means making the best clinical decision to achieve the best patient outcomes. Undertaking clinical audit provides us with an opportunity to assess the effectiveness of clinical care and also enables continuous quality improvement.

During 2016/17 the Trust's Clinical Audit Team supported 271 audits and achieved a 55% re-audit rate. Over 400 audit criteria have been used to re-audit whether standards have been applied to practice, for the benefit of patients in our care.

Re-auditing after changes have been made enables clinical staff to demonstrate change and identify those areas where further improvement is required.

3.4.2 Quality improvement as a result of clinical audit

Audit results are communicated to staff in a variety of ways including team meetings, staff briefings and communication posters which provide staff with a snapshot of the key results.

We held our annual clinical audit conference in March 2017. The focus of the day was clinical audit for patient safety. Presentations included Patient Safety, Positive and Proactive Care, and Falls. The day ended with a revalidation and reflection session and the presentation of the poster competition prizes.

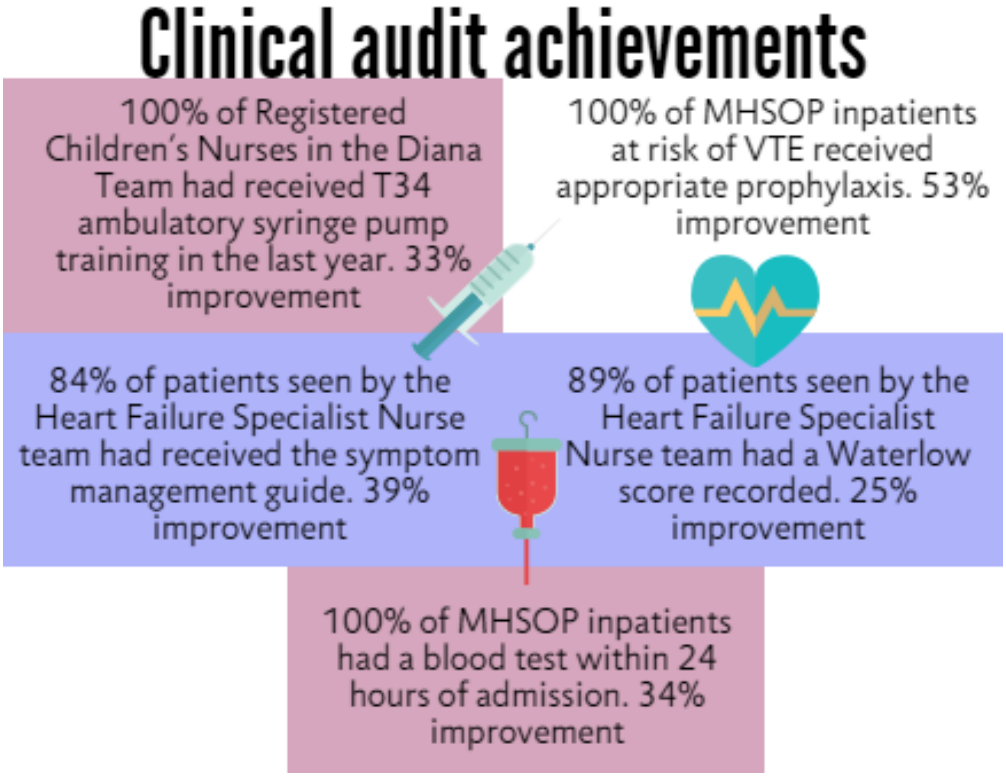


Figure 10: Clinical audit achievements

3.4.3 Quality improvement as a result of research and development

We utilise research to improve the quality of care for our service users.
There are a number of examples of how research has improved the quality of care for service users. For example, within CHS, we have implemented the 'Physical Care' project aiming to integrate and improve the quality of assessments in identifying and addressing the physical care needs of patients admitted onto the Dementia Assessment wards. Improvements to date are demonstrating more responsive reviews and treatment for long term conditions such as diabetes and heart conditions, proactive end of life discussions and decisions which involve communication with the patients' family and an increase in collaborative family decision making improving the perception of a joint professional – carer care approach

Within FYPC, we have changed the way assessments on children who have complex physical and neurological disabilities are undertaken, helping to prevent long-term postural complications. Parents reported improved confidence in their own ability to support and self-manage their children's care, and feeling in a stronger position to secure the right equipment to support their child.

Within AMH/LD, a study on the association of congenital deafness/blindness and autism in adults with LD, found that being born blind increased the risk of autism in people with learning disability, independent of degree of brain damage and gender. Training days were set up for staff and a training CD-ROM was made available to some families whose children had autism, congenital blindness and challenging behaviour. As a result, several vulnerable service users with profound and multiple

LD received a detailed and holistic assessment which resulted in diagnosing conditions otherwise missed and benefited from specialist input during home visits.

3.4.4 Mill Lodge Relocation

With the relocation of Mill Lodge from Kegworth to the Stewart House site we opened the new purpose-built facilities, which include 14 bedrooms with on suite facilities. Two members of the Huntington's disease support group were instrumental to getting the first HD service developed more than 25 years ago were there for the opening by Cathy Ellis, Trust Chair.

Feedback from service users, families and other visitors was overwhelmingly positive, with one relative later posting on our Facebook page: "What a lovely home this will be for the patients living there. Congratulations to everyone involved in the planning and building of this splendid unit. Thank you to all the staff at Kegworth who has done a marvellous job for many years."

3.4.5 Perinatal mental health service

We expanded our perinatal mental health service and a film was released highlighting the expansion of specialist psychiatric support for mothers who experience mental illness. Two young mothers and their partners shared their personal experiences in a new film introduced at a special event for health professionals to raise awareness of the work of our specialist perinatal mental health service. The team provides support at or close to home for mothers with moderate to serious mental health needs, both before and following delivery of their babies. Last year the service provided care and support for nearly 600 women in the community.

The perinatal team is made up of a consultant psychiatrist, specialist perinatal mental health nurses, medical trainees and administrative support. As well as providing direct care for women at or close to home, including group support, they provide training for midwives and

health visitors to help them identify women who need psychiatric care. The film can be accessed here:
https://www.youtube.com/watch?v=e8b7xjXy1z4&feature=youtu.be

3.4.6 Flu Vaccinations

Locally, the trust was commissioned to offer and provide vaccination to children between year 1 and year 6 in primary schools, or aged from around 5 years to 11 years. There are occasions where children, for whom we have a positive consent form, cannot be vaccinated in school because they are unwell, absent on the day or were unable to have the vaccine within the school setting. In the past we have used community clinics to offer these children a second opportunity to be vaccinated, but these community clinics have proven cumbersome to set up and staff and there has been a poor uptake.

In 2015/2016, a pilot was set up whereby parents were offered a second opportunity to have their child vaccinated in a community pharmacy if they did not receive it in school. Community pharmacies are conveniently located, open outside of school hours and in some cases extended hours including weekends. This represents easier access for parents and the young person. This pilot proved hugely successful and parental feedback was very positive.

We have built on the success of last year and continued to offer this in 2016/17. This year, we have already exceeded the uptake compared to last year (379 vaccinations so far compared to 240 last year). In terms of success rate, around 70% of parents that have expressed an interest in having their child vaccinated in this way went on to take their child.

3.5 Quality of services 'Patient Experience'

3.5.1 The NHS Friends and Family Test

All NHS Trusts providing Mental and Community Services are required to give patients the opportunity to comment on their care saying how likely they would be to recommend the care they have had to Family and Friends. They can also leave follow up comments.

Figure 11: Friends and Family Test (FFT) Feedback wordall

In 2016/17 the trust has increased opportunities for people to respond by providing surveys on electronic devices and using accessible formats for children, young people and people with learning disabilities.

In 2016-17 97 % of service users who responded would be extremely likely or likely to recommend our services. However the most valuable aspect of the feedback is the comments that service users leave. The majority of these are compliments about the caring, compassion and professionalism of staff and services. A word collage to display where service users have given comments about things that didn't go so well this gives us the opportunity to put things right.

Figure 12: Family and Friends Test improvements 2016/2017

3.5.2 Patient Feedback – Complaints, PALS and Compliments

Complaints are an essential source of information for the trust, highlighting our patients' view of the services we provide. They present a crucial opportunity to identify ways of improving patient care and the Trust is committed to capturing this feedback to ensure lessons are learnt. The Complaints Team supports service staff to ensure that all patient complaints are dealt with effectively, promptly and in accordance with national regulation.

In April 2016 the trust launched its new complaints process. This places the complainant at the centre of the investigation. The investigator makes early contact with the complainant, and agrees the timescale for completion along with the scope of the investigation.

During the year the trust has undertaken two Complaint Peer Review Panel events. Reviewing anonymised complaints using the Patient Association Toolkit, the events have been highly successful, supported by internal staff and external stakeholders. In addition complaints are undertaking satisfaction surveys of recently closed complaints. This combined improvement work has allowed us to strengthen our complaint handling processes.

During 2016/17 we received 372 complaints, and in addition we input to 58 complaints that were led by other organisations. Two complaints were partially upheld by the Parliamentary and Health Service Ombudsman (PHSO), five complaints were not upheld. The complaints that were not upheld were initially received by the Trust in March 2014, October 2014, August 2015 and September 2015. The two that were partially upheld were received in December 2013 and February 2014.

We monitor our complaints and look for themes and trends, so that we can ensure that appropriate changes are made to improve services and improve the experience of our patients.

Trust Wide Complaint Themes:-

- Nursing care
- Patient expectations and service delivered
- Attitude of staff – Nursing
- Clinical advice/treatment
- Attitude of staff – Medical

It is recognised that there have been issues with the cancellation of Community Mental Health Team (CHMT) outpatient appointments. Patients for some services in AMH/LD have also experienced long waiting times for outpatient clinics as the demand for services is outweighing capacity. Actions have been put in place to address these issues including the recruitment of permanent staff and changes to the booking process for outpatient appointments.

Patient Advice and Liaison Service (PALS) concerns about appointment issues and attitude of staff have both shown improvement on figures from 2015/2016.
There has been a reduction in concerns about appointments of 34% and 19% for attitude of staff. This may reflect improved staffing levels in some clinical areas and the use of concerns for reflective learning in clinical supervision.

The PALS service is accessible to people who wish to raise concerns or enquiries. It offers confidential support and advice to meet people's individual needs. PALS also enables people to access information about trust services and information about health and social care issues.

During the 2016/17 we received 931 concerns, 552 enquiries and 1707 compliments.

PALS monitor themes and trends and have reporting systems in place to share with services and make these findings known as part of routine monitoring in order to facilitate change.

Trust Wide Concern Themes:-

- Patient expectations and service delivered
- Appointments (delays/cancellations)
- Patient safety - medications
- Attitude of staff
- Clinical advice and treatment

There has been an increase in issues raised about the Podiatry Service on decisions to decline home visits. This year the commissioners funding for podiatry has changed, therefore changes in service processes have been fully explained to people who have been unhappy about eligibility criteria for home visits.

The Customer Services Safeguard web allows staff to log concerns that they have resolved locally. This has led to an increase in recording of concerns handled by the prison healthcare staff during 2016/17. The issues logged include concerns about medication. Examples of action taken by healthcare staff to resolve these concerns include scheduling of a GP appointment for a patient who raised issues about their pain management and booking a medication review for a patient raising concerns about sleeping tablets.

3.5.3 Mental Health Surveys

Inpatient Mental Health Survey 2016

The Inpatient Mental Health Survey is not part of the nationally mandated survey programme however to understand our patients experience of inpatient mental health services the trust along with 19 other Trusts undertook this survey on a voluntary basis.

The service users surveyed in the 2016 survey were a sample of those discharged after receiving inpatient care from Mental Health Services during July to December 2015.

The Trust response rate was 19% with 78 service users from a sample of 404.

When compared to the Trust's 2015 results, there have been improvements in the scores for 26 questions, most notably in sections relating to service user rights, hospital staff, care and treatment and leaving hospital. These included being listened too, given enough time, having confidence and trust in and being treated with respect and dignity by staff, having access to talking therapy and knowing who to contact and having contact from staff after discharge.

By looking at questions where there has been deterioration against the 2015 scores and where in 2016 the scores are "worse than" other trusts in the range, the following areas for improvement were identified:

- reducing disturbance due to noise at night
- delivering single sex accommodation standards
- improving cleanliness of wards and bathrooms
- improving contact from the mental health team within 1 week of discharge

A Trust wide action plan is being implemented to drive improvement in these areas.

National Community Mental Health Service Users Survey 2016

The CQC published the results of the 2016 national community mental health survey in November 2016. Patients who received care between September and December 2015 were surveyed.

There were 256 completed surveys received from the usable cohort of 831 surveys, giving a Trust response rate of 31%. The response rate of all Trusts was 28%.

The results were compared with the Trust's results from the 2015 survey alongside the results of the other 58 trusts who participated in the 2016 survey. The Trust scored "about the same" as other trusts in the 10 areas of care measured. This is an improvement on 2015 when the Trust had scored 'worse than' in Planning care and Other areas of life.

The Trust moved from "worse than" in 2015 to "about the same" in the following 3 questions:

- How well care and services are organised
- Involvement in agreeing what care will be received
- Involvement of family or someone else close as much as desired

In 2016 there were 3 questions where the Trust received the lowest scores received by all Trusts.

- Knowing who to contact out of hours if in crisis
- Obtaining support to take part in activity
- Being provided information about support from people who have experience of the same mental health needs

The Trust has put in place an action plan to drive improvement informed by the results of this survey.

3.5.4 Involving patients and carers in the infrastructure of the organisation

The Trust has a Patient, Carer Experience and Involvement Strategy 2015-17 which includes three promises:

- We will listen and learn from our patients, their carer's and families about their experiences of our services and ask for their suggestions about how services can be improved.
- We will do this by systematically gathering and analysing qualitative and quantitative evidence in a range of different ways and use this evidence to continuously measure and improve our services in order to provide our patients, carers and families with the best possible experience.
- We will involve our stakeholders, especially those from vulnerable or seldom heard groups, in the planning, development and delivery of our services. We

will demonstrate how we have involved our stakeholders, listened to their feedback and taken action on what we have learned.

In 2016/17 we have asked staff and patients for feedback on our strategy so that we can refresh it and make sure it reflects their priorities and concerns. This revised strategy will be used to guide the work that we do in 2017/18 to involve and listen to patients and carers.

Listening into Action

We invited staff, patients and external stakeholders to a LiA Big Conversation to talk about what barriers there are to patients being involved in improving services and being listened to about their experience of care. Based on these discussions we are developing a central resource and data base to support staff to involve patients, to share good practice and to monitor and celebrate activities and improvements made by working with patients and carers.

A LiA was held by Community Mental Health teams and involved patients and carers. The Big Conversation was held as part of the process and was a chance to understand the experiences of service users, carers and staff, during the planning of their care. With staff, service users and carers face to face, the honest discussion led to some important actions, which are already underway. These included

- Raise awareness of the wide definition carers
- Have clear procedures about recording carers' information
- Identify gaps in materials and develop Identify gaps in materials
- Publicise the availability of resources and monitor take-up
- Develop register of service user groups and contact details
- Develop cohort of people who can engage and provide information sessions

Patient Stories

The Patient Experience Team is building a library of patient stories held securely on YouTube. The stories can be used for a variety of purposes, e.g. staff training and induction, team meetings and service development sessions.

Patient video stories are shown routinely to the Trust Board as part of the Patient Voice agenda. These have included feedback from young people on our digital offer of Chat Health, Health for Teens and Health for Kids websites, as well as patient experience stories from patients struggling with mental health cuts in the community and positive stories of support and early discharge.

Co-Design of services

The FYPC is using a co-design approach to design services. This includes a wide variety of face to face and digital involvement of individuals and community and patient groups. This approach provides diverse communities and individuals the opportunity to determine the way they contribute to the design, evaluation or delivery of services. We engage individuals in conversations about what is important to them and people can be involved as simply as providing feedback through to ongoing relationships with us to influence more complex work.

An example of this approach is the involvement of young people in co-designing a young people's crisis and home treatment service. The young people formed a young advisors group called 'Evolving Minds' who meet on a monthly basis and are available through social media to work with staff to make service more young people friendly.

Whole family approach

The success of a Listening into Action event has enabled the 'Whole Family Approach' to safeguarding to be commenced. Whole Family Approach is an essential requirement in order to effectively support families and safeguarding children, young people and vulnerable adults. It is recognised that no single service can focus on the whole family and meet the needs of all family members. Multi-disciplinary collaboration is necessary in order to achieve this.

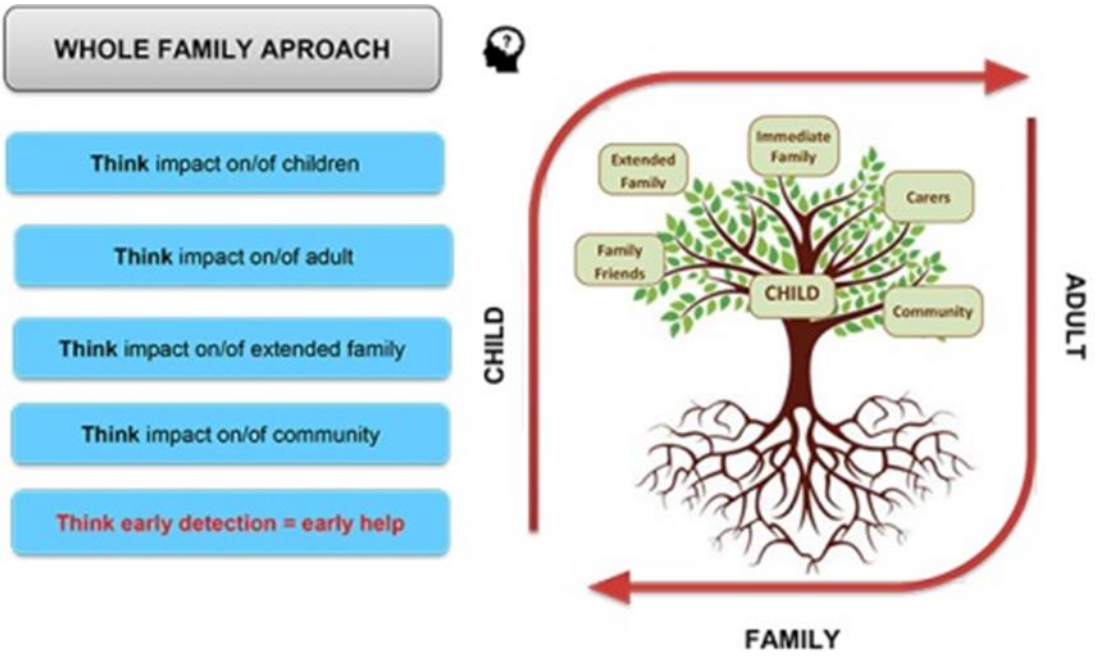


Figure 13: Whole Family Approach Diagram

3.5.5 Volunteers

We have over 400 members of the local community, including service users, volunteering in our services for the benefit of patients. In 2016 we recruited an additional 165 volunteers. Our volunteer drivers completed 562 journeys per month on average during the year, enabling service users and patients to access services across the Trust.

Using the formula recommended by National Council of Voluntary Organisations (NCVO) the financial value of this volunteering to the Trust in 2016 was over £500,000.

The engagement of our local community directly with services through volunteering can be energising and creative. For example

- The use of volunteers by the Diana Service to play with siblings while other children receive services, and sensitive issues are quietly discussed with parents.
- Work around supporting women with breastfeeding, with around 80 peer volunteers presently recruited across the Trust; such that a flexible, personal and matched service can be offered both over the telephone and 'one to one'.
- The use of volunteers to support Trust staff at the Mett Centre has brought music, computing, jewellery making and sewing, in addition to staffing the centre tea bar, together to enhance the overall recovery of service users.

The voluntary services team raised just over one thousand pounds this year through fundraising events and plan to spend this money to better equip and develop volunteers.

3.5.6 Delivering same sex accomodation

We have converted the one remaining traditional mixed sex ward at the Bradgate Unit to female only. This was highlighted as an area for improvement in the 2016 inpatient survey (of patients who were in hospital during the last 6 months of 2015) and so we hope to see an improvement in next year's survey results.

3.5.7 Community Hospitals

Within community hospitals activity co-ordinators continue to support patients in meaningful activities and encourage patients to interact in groups to reduce isolation. Community hospitals have introduced changes to increase the flexibility of visiting times on the wards. Also family & relatives are given the opportunity to participate and be more involved in influencing care delivery.

Musculoskeletal (MSK) services have undertaken a LiA event to improve the patient understanding of the service. The outcome of this event has resulted in the service setting up a patient forum.

3.5.7 Getting Children Moving

Primary School children were asked to complete an online adventure game which encouraged them to take part in a physical activity every day. Children recorded their activity from a pre-determined list of 8 activity types. Each activity recorded allowed them to move one step further in the story world. Positive health messages and digital achievement badges were given to them when they entered their activities. From June to October 2016, a total of 47,053 activities were undertaken from children and 218 primary schools took part.

In 2015/2016 the Move it Boom won best website at the Northern Digital Awards in Leeds, fighting off fierce competition from the likes of the Great Ormond Street Hospital and Greater London Authority websites, receiving praise for the fact that it had been co-designed with children.

3.6 Commentary received from stakeholders

LEICESTERSHIRE COUNTY COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

COMMENTS ON THE LEICESTERSHIRE PARTNERSHIP NHS TRUST QUALITY ACCOUNT FOR 2016-17

APRIL 2017

The Health Overview and Scrutiny Committee welcomes the opportunity to comment on the Leicestershire Partnership NHS Trust (LPT) Quality Account for 2016-17. The Committee accepts LPT's Quality Account as a balanced representation of the Trust's work over the past year and is not aware of any major issues omitted from the report. However, we would point out that the Quality Account was not the most reader friendly document due to an overreliance on diagrams and tables. It was difficult to ascertain from the diagram on page 5 of the Quality Account what the priorities were, and confirmation of those priorities in non-diagrammatical form was not provided until appendix 1. The Quality Account also contained many acronyms not all of which were written in full. It also makes it difficult for us as a Committee to comment when so much of the data is recorded at this draft stage as 'to be confirmed'.

Nevertheless, the Committee welcomes the priorities for improvement during 2017/18 of improving discharge planning, improved engagement in clinical supervision for all staff delivering care, and improving clinical recording and care planning to support safe and effective patient centred care delivery. Areas of concern or of particular interest to the Committee are set out below.

The Committee particularly welcomes the planned emphasis on improving the actual and recorded clinical supervision rates for all staff in the Trust. At our most recent Committee meeting we were reassured by LPT that the culture had now changed towards providing more support for staff. We were informed that records were now being kept of the amount of support that had been provided to individual staff members and where it was identified that an inadequate level of support was being provided team managers were being spoken to. It is therefore pleasing to note that for adult mental health/Learning disabilities the recording of clinical supervision has improved over the year from 37.7% in February 2016 to 57.7% in January 2017, and for Community Health Services current record keeping and care planning training for the service as of 1 January 2017 is above 85% compliance. We look forward to continuing improvements in this area.

We fully support the improvement of Discharge planning as a priority for 2017-18 and wish to emphasise that discharge planning should begin as soon as the patient enters the care of LPT to ensure that all necessary arrangements are in place by the time the patient is ready to leave hospital. We are aware that a proportion of discharge delays are due to patients having to wait for medication and we hope that this issue can be addressed. We note that LPT continues to be involved with patients after discharge and we welcome the acknowledgement in the Quality Account that contact from the mental health team within 1 week of discharge needs to be

improved. We welcome the Trust-wide action plan which is being implemented to drive improvement in these areas.

We are aware that the CQC identified that LPT needed to reduce reliance on bank and agency staff to reach the required numbers of staff needed on wards. At a recent Committee meeting we raised concerns that reliance on bank and agency staff had a negative effect on staff morale, although we were pleased to note that there was no effect on patient safety. We therefore welcome the action being taken by LPT to improve staffing levels such as holding recruitment events and increasing activity with local universities, making the recruitment section of the LPT website more visible and informative, and implementing a staff referral scheme to encourage staff to actively engage in recommending the Trust as a place to work. We look forward to receiving an update on the success of these initiatives in future. It is unfortunate that LPT has little scope to improve the terms and conditions of its staff thereby encouraging greater staff retention but we are aware that terms and conditions must be in line with the National Agenda for Change.

We note that the CQC rated the community Child and Adolescent Mental Health Service (CAMHS) services as inadequate on two domains, safety and responsive and this was primarily related to the number of young people that were waiting for treatment. We were informed by LPT at our Committee meeting on 1 March that there had been a 20% increase in specialist CAMHS referrals which in the view of LPT was not sustainable. This is of great concern to the Committee and action needs to be taken to prevent a backlog of patients waiting to receive treatment. At our recent Committee meeting LPT also informed us that there had been an improvement in the waiting times for patients receiving a first CAMHS appointment however this had led to a longer waiting list for patients to start treatment. We hope that further progress can be made in this area and that the CAMHS Access Model is a success.

It is of concern that the CAMHS Early Help service has not been recommissioned yet due to a provider not yet coming forward. We agree with LPT that early intervention is important to prevent Mental Health problems escalating and hope that a suitable provider of the Early Help Service can be found.

It is also disappointing to note from the Quality Account that there have been issues with the cancellation of Community Mental Health Team outpatient appointments. The Quality Account states that actions have been put in place to address these issues such as changes to the booking process for outpatient appointments and we would be interested to learn more about these. It is pleasing to note that LPT has started telephone consultation to be able to offer advice over the phone to patients whilst they are on the waiting list.

In conclusion, the Committee is of the view that the Quality Account is accurate and provides a just reflection of the healthcare services provided. The Committee is looking forward to the improvements to be made in the year 2017-18 to the LPT's healthcare provision in line with the priorities set out in the Quality Account for 2016-17.

Healthwatch Leicestershire Statement

4 May 2017

LPT Quality Account 2016-17
Healthwatch Leicestershire response

Healthwatch Leicestershire acknowledge the receipt of the Leicestershire Partnership Trust (LPT) draft Quality Account (QA) and for the opportunity to comment. Healthwatch gives people a powerful voice locally and nationally. Whether it's improving them today or helping to shape them for tomorrow.

Overview
We would like to provide some general observations and comments to the QA.

As we mentioned last year we are mindful that there is a prescriptive framework for Quality Accounts that does not allow greater accessibility by the public to engage with the document.

We noted that last year's priorities were aligned to the CQC's 2015 findings and that this appeared challenging which is borne out by the 3 key areas - Clinical Risk Assessment, Care Planning; Mental Capacity Assurance Compliance and Assessment of Capacity require further follow up and are being rolled forward to 2017.

We are disappointed that the agreed 'robust improvement plan' did not secure the ambition of a CQC rating of Good by 2017-18 and expect that new plans following the Quality Summit (16 February 2017) reflect on lessons learnt for improvements. In particular, many of the improvements specified by the CQC are based on the standard of care in an environment that is unsafe for patients, which is deeply concerning to Healthwatch and the people we represent.

The inspection report showed that care was not always delivered in line with the Trust's policies e.g. particularly relating to handling and prescribing medication, clinical supervision care planning and record keeping. We are however, pleased to note the following updates on priorities:

Adult Mental Health /Learning Disability Priority

- Senior nurses receive reports monthly for their areas in order to support teams with increasing uptake.
- Managers now monitor uptake of clinical supervision within their teams, systems are in place for staff to enter their sessions on to uLearn and Poor performance is followed up.
- Recording of clinical supervision has improved over the year from 37.7% in February 2016 to 57.7% in January 2017.

Children Health Service Priority

- Mental Health Services for Older People - Inpatient weekly record keeping/care planning surveys established. Care planning survey has been introduced to Community Mental Health Teams
- Training for the service as of 1st January 2017 is above 85% compliance.

Family Young People Community Priority

- Practice/pathway development. Offer parents a new birth visit at the NNU as an alternative to home contact.
- The re audit and evaluation of the change will be assessed to support any improvements
- FYPC will develop an audit tool and complete an audit during 2017/18.

HWL also has concerns regarding staff demonstrating poor understanding of some aspects of the Mental Capacity Act. It is vital that the staffing levels including appropriately qualified staff are brought up to full capacity as soon as possible with the right training, skills and supervision.

We do understand that recruitment and retention is a challenge and that the Trust has different ways to address this such as Staff Wellbeing - Staff health & wellbeing initiatives and Improving the uptake of flu vaccinations- 7,437 staff - 65% of their frontline staff.

We are unable to provide feedback on performance on a number of areas as the draft QA sent on 27 March 2017 did not provide the relevant data on all area – some illustrative examples below:

- Page 15 Improved patient outcomes as a result of Commissioning for Quality and Innovation (CQUINs)
- Page 18 Use of NHS patient number
- Page 20 Duty of Candour compliance rate
- Page 38 Patient Feedback – Complaints, PALS and Compliments

In the future, it would be much better to have the draft QA with updated figures to enable Healthwatch to provide both scrutiny and reflective feedback.

Specific Questions and Responses

Questions	**Responses**
Does the draft QA reflect people's real experience told to local Healthwatch by service users and their families and carers over the past year?	When comparing the Draft Quality Account to this feedback, including the CQC overall rating of 'requires improvement', appears to accurately reflect the reality of patients' experiences.
From what people have told local Healthwatch, is there evidence that any of the basic things are not being done well by the provider?	We are particularly disappointed with the findings for the Bradgate Mental Health Unit namely ligature points, same sex accommodation, staffing skill mix and record keeping.

	Our evidence from patients highlighted that handling and prescribing medication, clinical supervision care planning and record keeping were areas that could be improved.
Is it clear from the draft Quality Account that there is a learning culture within the provider organisation that captured and used to enable the provider to get better at what it does year on year?	From an examination of the Quality Account and from our dealings with LPT at regular Quarterly meetings with the CEO and representation at the LPT Board meetings, it is clear that a learning culture is being embedded and more accessible and transparent communication in simple language, avoiding jargon and acronyms in different formats to share with patients and the public would be beneficial.
Are the priorities for improvement as set out in the draft Quality Account challenging enough to drive improvement and it is clear how improvement has been measured in the past and how it will be measured in the future?	We welcome the focus on the clinical priorities remaining the same for the next two years as these reflect the concerns of patients : - Discharge planning and follow up to support safe transfer of care - Evidence improved engagement in clinical supervision - Clinical recording and care planning to support safe and effective care delivery

Healthwatch Leicestershire acts as a critical friend to organisations and we support the Quality Account for 2016 -17, the achievements and the challenges facing LPT for the future.

We will continue to work and support LPT to gather patients and service users perspective on what will work best to involve local people in determining priorities going forward.

Rick Moore

Chair
Healthwatch Leicestershire

Chris Faircliffe

LPT Lead Board member
Healthwatch Leicestershire

Healthwatch Leicester City and Rutland Statement

May 2017

LPT Quality Account 2016-17

Joint Response from Healthwatch Leicester and Healthwatch Rutland

We are very pleased to respond to this Leicester Partnership Trust Quality Account which looks back to achievements in 2016-17 and forward to plans for 2017-18.

External scrutiny was dominated in 2016-17 by the re inspection of LPT by the CQC. Its inspection took place in November 2016 and its report was issued in February 2017. Our comments should therefore be read in conjunction with that report.

This Quality account is a very comprehensive review of the extensive range of services provided by the Trust and its Directors. It also lays out the aims and actions they propose to achieve their objectives across the three national domains of patient experience, clinical effectiveness and patient safety.

We support the Directors in their clinical priorities for the year gone which are set out in Appendix 4 and their priorities for 2017-18 which are set out in Appendix 1.In particular, we welcome improved discharge planning as the first three priorities.

We were particularly pleased to see the Trust's CEO, Dr Miller, promote both a culture of continuous improvement and transparency. These are welcome.

In order to assess the year from a patient and public perspective, we adopted the four tests recommended by Healthwatch England

- *Does the draft Quality Account reflect people's real experience as told to local Healthwatch by service users and their families and carers over the past year?*
- *From what people have told local Healthwatch is there any evidence that any of the basic things are not being done well by the provider?*
- *Is it clear from the draft Quality Account that there is a learning culture within the provider organisation that allows people's real experiences to be captured and used to enable the provider to get better at what it does year on year?*
- *Are the priorities for improvement as set out in the draft Quality Account challenging enough to drive improvement and is it clear how improvement has been measured in the past and how it will be measured in the future?*

- **Does the draft QA reflect people's real experience told to local Healthwatch by service users and their families and carers over the past year?**

The Trust's Friends and Family Test has achieved a positive result of 97% which is an excellent endorsement. The CQC judgement ranged from outstanding for community health families, young people and children service to urgent regulatory action for others .it gave the Trust the following overall ratings :-

- Are services safe? Requires improvement
- Are services effective? Requires improvement
- Are services caring? Good
- Are services responsive? Requires improvement

- Are services well-led? **Requires improvement**

We believe this account captures the majority of patient experiences. In addition, we meet the CEO on a quarterly basis which enables us to feedback what we have learned from patients and public and we welcome this.

- **From what people have told local Healthwatch, is there evidence that any of the basic things are not being done well by the provider?**
  The comments we have received mirror those of the CQC including:-

  Mental Health – apart from concerns given to the CQC which are shared by patients and public, a study by Healthwatch revealed concern about evidence from patients about handling and prescribing medication, clinical supervision care planning and record keeping as areas that could be improved.

  We also hear many concerns about the adequacy of discharge arrangements for patients, as evidenced by the Healthwatch Enter and View visit to the Evington Centre and are pleased this has been given high priority for action.

  We also hear concerns about the speed of implementation of new services for young people's mental health.

  Community Services - We hear reports of community nursing staff being extremely stretched by increasing demand from an ageing population.

  For community services effective integrated discharge is also a continuous concern.

- **Is it clear from the draft Quality Account that there is a learning culture within the provider organisation that captured and used to enable the provider to get better at what it does year on year?**
  The quality account documents contain many initiatives to learn from experience. Healthwatch has supported the quarterly peer review of the handling of complaints by the Trust. Initiatives such as this demonstrate a willingness to learn from experience. We have also been pleased to be asked to provide a patient and public perspective on whether the Trust's information is accessible.

- **Are the priorities for improvement set out in the draft Quality Account challenging enough to drive improvement and it is clear how improvement has been measured in the past and how it will be measured in the future?**
  The priorities for 2017-18 are set out in Appendix 1 and we support them. As STP plans progress, we also support the inclusion of discharge and community support. For all services, we recommend that staffing levels and skill mix are kept under review as patterns of care change.

  Proof of the pudding as to whether the Quality Accounts are challenging enough will come with the next CQC inspection.

In conclusion we praise the very determined efforts and hard work by both staff and directors of LPT. They are achieving worthy improvements and we support their forward plans through this Quality Account.

Karen Chouhan

Chair of Healthwatch Leicester

healthwatch Leicester

Jennifer Fenelon

Chair of Healthwatch Rutland

healthwatch Rutland

Clinical Commissioning Groups Statement

Comments from NHS East Leicestershire & Rutland, Leicester City and West Leicestershire Clinical Commissioning Groups

NHS East Leicestershire & Rutland Clinical Commissioning Group (CCG) is the lead commissioner for Leicestershire Partnership Trust on behalf of a number of commissioners and in this role the CCG is responsible for monitoring the quality and performance of services at Leicestershire Partnership Trust throughout the year. We welcome the opportunity to provide the narrative on the Quality Account for 2016/17 on behalf of West Leicestershire and Leicester City Commissioning Groups in Leicestershire. We have reviewed the account and would like to offer the following comment:

This is a wide ranging report and covers the key elements that are required within a quality account. CCG Commissioners would like to note in particular a number of areas of good practice and achievement:

- The rating of Good for the domain of Caring in the recent CQC inspection report.
- Better engagement with patients and the use of technology in order to improve patient feedback and experience.
- Increase of staff groups using 'Listen Into Action' methodology as a quality improvement tool.
- Investment into Trust premises and estates to improve environments for patients and staff members.

We fully support the Trust's focus in this coming year on improving staff engagement in clinical supervision, clinical recording and care planning, and improvement on discharge planning and follow up. However, we would like to note that that two of these clinical priorities were included in the previous year's, so it is unclear as to whether there has been sufficient progress made by the Trust in order to progress these during this time.

We note that the Trust's strategy is aimed at learning from the 'Requires improvement' rating, and working towards achieving 'good' and ultimately 'outstanding'. This is indicative of the aspiration and commitment from the organisation and its staff members to work towards improving quality and patient safety.

However there are a number of areas that commissioners believe could further augment this Quality Account to provide a more balanced representation of the Trust's performance:

Further emphasis and detail on the results of the CQC inspection with the actions and improvement priorities for these.

It is noted that the Specialist Community Mental Health Services for Children and Young People services was rated 'inadequate' – further narrative is required on the key areas of concern identified through the CQC inspection, and the actions taken to address these, as well as mitigation of any clinical risks.

Throughout 2016/17, the Trust has faced considerable pressure to maintain safe staffing levels within inpatient and community services. The Trust has taken a number of measures to maintain and increase the number of registered nurses including regular job fairs and utilising other healthcare professionals that are employed in the services. Although there is a section within the report, the Quality Account would benefit from more detail to outline the specific pressure points, clinical risks and actions taken to address these.

The Trust continues to report positively against a number of national quality indicators including CPA 7 day follow up and crisis gatekeeping as well as locally agreed quality indicators within the contract quality schedule; however there should be acknowledgment of

some of the areas requiring improvement within this, such as waiting times and offer of 30 hours of meaningful activity for inpatients on rehab units. The monitoring of the local quality schedule has also enabled identification of key areas of concern such as increased number of grade 4 avoidable pressure ulcers, so enabling utilisation of work streams to explore and address these. Continual clinical development over the past 12 months is also reflected in the outcomes of the contract quality schedule, so again narrative on the Trust's progress on this would be useful to obtain a balanced perspective on this.

We believe that we have a highly positive relationship with the Trust and we look forward to further development of this and continued collaborative partnership working in the pursuit of high quality mental health and community services for the people of Leicestershire. We will continue to work with the Trust in the monitoring of progress against the priorities outlined in this Account, as well as providing continued support with the improvement actions outlined within this Quality Account.

INDEPENDENT AUDITORS LIMITED ASSURANCE REPORT TO THE DIRECTORS OF LEICESTERSHIRE PARTNERSHIP NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required to perform an independent assurance engagement in respect of Leicestershire Partnership NHS Trust's Quality Account for the year ended 31 March 2017 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope .and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following indicator:

- CPA 7 days follow up (CPA); and
- The percentage of admissions to acute wards for which the Crisis Resolution Home

Treatment Team acted as a gatekeeper during the reporting period (Gatekeeping). We refer to these two indicators collectively as "the indicators".

Respective responsibilities of the Directors and the auditor

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;

in the NHS Quality Accounts Auditor Guidance ("the Guidance"); and

- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2016 to May 2017;
- papers relating to quality reported to the Board over the period April 2016 to June 2017;
- feedback from the Commissioners dated May 2017;
- feedback from Local Healthwatch dated 4 May 2017;
- feedback from Overview and Scrutiny Committee dated April 2017
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 21 February 2017;
- feedback from other named stakeholder(s) involved in the sign off of the Quality
- Account;
- the 2016 National Patient Survey dated 4 January 2017;
- the 2016 National Staff Survey dated 7 March 2017;
- the Head of Internal Audit's annual opinion over the trust's control environment datedMay 2017;
- the annual governance statement dated 26 May 2017;
- the Care Quality Commission's Inspection Report dated 8 February 2017; and
- any other relevant information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information,

This report, including the conclusion, is made solely to the Board of Director of Leicestershire

Partnership NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Leicestershire Partnership NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Leicestershire Partnership NHS Trust.

Basis for adverse conclusion

As set out in the Statement on Quality from the Chief Executive of the Trust on pages 3 to 5 of the Trust's Quality Report, the Trust currently has concerns with the accuracy of data of the CPA 7 day follow up indicator and the accuracy of the data of the Gatekeeping indicator.

As a result of these issues, we have concluded that we are unable to test sufficiently the 'CPA

7 days follow up indicator' and 'Gatekeeper' indicators for the year ended 31 March 2017.

CPA

Our testing of the calculation of the CPA indicator found that the Trust does not follow the national definition but follows its own clinical CPA process. The national definition requires that all patients discharged from a psychiatric inpatient ward are regarded as being on CPA. We therefore, cannot conclude that we have sufficient assurance as to the accuracy, reliability or validity of the indicator. For this reason we are unable to issue a limited assurance opinion on this indicator.

The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period (Gatekeeping)

Our testing of the calculation of the Gatekeeping indicator identified that data extracted from RiO included patients that were exempt per the national guidance. As a consequence we are unable to conclude on the accuracy, relevance and reliability of the Gatekeeping indicator included in the published Quality Report.

Adverse conclusion

Based on the results of our procedures, except for the effects of the matters described in the

'Basis for adverse conclusion' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations; and
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
One Snowhill Birmingham
B4 6GH

31 May 2017

Appendix 1: Clinical Priorities for 2017/18

	What is the priority?	Division	Why we have chosen this priority?	How we will measure this?
1	**Improve discharge planning and follow up to support safe transfer of care-** To continue to follow the neonatal pathway for all preterm babies who remain in neonatal unit at the new birth review (10-14 days) to ensure they have a health visitor contact at the Unit.	Families, Young People and Children's	Benefits for parents and perinatal mental health. To ensure transition from hospital to home remains seamless. Increased communication between the neonatal team and health visitors across LLR.	FYPC will develop an audit tool and complete an audit of neonates who receive a birth visit whilst on the unit during 2017/18. We will monitor feedback from the staff delivering the pathway and the people using our services. Progress will be monitored via the FYPC Patient Safety & Experience Group.
2	**Improve discharge planning and follow up to support safe transfer of care-** Safe transfer of care to GPs/Community Services is a priority for patients identified as being suitable for the gold standards framework in community hospitals	Community Health Services	Following the introduction of the Gold Standard Framework (QSF) as part of the 2016/17 CQUIN programme, the priority is to ensure that the GSF status of the patient is communicated via the ICE discharge letter to ensure a seamless transition to primary care/community services	GSF compliance audit to be undertaken in Quarter 4 of 2017/18. We will report progress through The transfer of care group
3	**Improve discharge planning and follow up to support safe transfer of care -** To continue to work on reducing delayed discharge from acute mental health inpatient beds to ensure patient care planning is appropriate	Adult Mental Health and Learning Disabilities	This will be building on the Length of Stay project which included work streams focussing enhancing capacity, supporting staffing numbers and operational resilience and quality improvement. This is important as we aim to support people to stay well at home and only come into hospital when they are too unwell to stay safe at home	Continue to build on the progress made via the project in identifying solutions to support patients to be discharged when they no longer require an acute mental health bed. Progress with the project plan and on-going monitoring by our Commissioners
4	**Evidence improved engagement in clinical supervision for all staff delivering care -** To improve the actual and recorded clinical supervision rates for all staff in the Trust.	ALL	This priority has been highlighted by feedback from the CQC and Commissioner visits and Trust Audits. Also essential for maintaining registration with regulatory bodies such as the HCPC, NMC, GMC.	An improvement in the rate of recorded clinical supervisions. Examine the implementation of clinical supervision structures in each clinical area including responsibilities, scheduling and recording. Where recording levels of clinical supervision are the lowest initially in order to identify and plan to overcome obstacles to ensuring all staff access the clinical

				supervision appropriate to their role. Frontline visits will show evidence of clinical supervision being embedded in practice through the self-regulation process. Clinical supervision will be rated as good or excellent on U-learn or through clinical audit. Frontline visits will show evidence of clinical supervision being embedded in practice. A focus has been on improving compliance with clinical supervision. A review of the quality of the supervision experience is planned for 2017/18. We will report progress to monthly Clinical Effectiveness Group.
5	**Improve clinical recording and care planning to support safe and effective patient centred care delivery** Clinical recording keeping and care planning • Embed the approved standards for record keeping and care planning • Embed the record keeping and care planning escalation process • Establish a monitoring process to identify areas for improvement and enable reporting against standards of record keeping and care planning **FYPC** FYPC will continue to undertake record keeping audits within all service lines to improve clinical recording, care planning and up to date risk assessments to support and	ALL	FYPC have identified a need to improve clinical record keeping, care planning and risk assessments Care planning remains a priority for the directorate building on the roll out of the care planning monitoring across all service lines. Following the 2016 CQC visit, MCA/DOLS and person centred dementia care is a key focus of review. This priority has been highlighted by the national research showing the comorbidity of serious physical health issues for people with MH and LD, trend in incidents and feedback from	Continuous record keeping audits with analysis and implementation of improvement actions Progress will be monitored via the FYPC Clinical Audit, Service Evaluation and Research Group for the Directorate (CASER group). An improvement in record keeping as a theme demonstrated through complaints and incidents in Quarter 4 of 2017/18 An improvement in the reporting of MCA/DOLS through audit and spot checks Continuation of the MCA/DOLS Champions forum to build staff confidence and competence. Completion of the MCA/DOLS overarching action plan. Establish a Physical Health Strategy with supporting policies and procedures and implement any changes

	enhance patient centred care delivery **CHS** Care planning monitoring will continue with a focus on the documentation of MCA/DOLS across all services **AMHLD** Continue the development of the AMH/LD Directorate strategy on Physical Health Care, with supporting clinical policies/ procedures to ensure appropriate assessment, treatment, monitoring and recording. To involve Service users and their carers (where appropriate) in the care planning process.		commissioner and CQC visits. In July 2016 all NHS funded care providers received a National Patient Safety Alert (NPSA) requesting a review of their resources to support safer care for the deteriorating patient. Follow this key actions were taken. Appointment of physical health nurses in acute mental health services increased training for mental health staff in some physical health conditions. Commencement of a review of the monitoring tool used for assessing deterioration in patients' physical healthcare; including a review of Sepsis Pathway. (This work has commenced target for completion end qtr. 1 (2017/18). This is in response to the lack of improvement in this area as reported as part of the annual community mental health patient survey and local care plan monitoring results in inpatients.	to existing monitoring tools or develop a new tool incorporating the Sepsis Pathway, across all AMH/LD inpatient areas (As this is likely to involve staff training across all areas likely target date quarter 4) • Production of a strategy with policies/ procedures • Implementation of new or adapted physical health monitoring tool dependent on approval from Clinical Effectiveness Group • Adaptations to training programmes • Training compliance • Monitoring and lessons learned from EIRF's We will report progress to Quality Monitoring Group and Clinical Forums. Progress will be highlighted to the Directorate Assurance Group. Increase the number of service users who have actively contributed to their community care plan. With service user agreement we will also aim to increase the number of carers involved in the service users care plan. We will also ensure that all registered staff attends the LPT care plan training in 2017. Annual CPA audit which will look at service user and carer involvement in the care planning process. We will review the findings of the next community mental health patient survey and inpatient care plan monitoring. CPA audit results, staff training records and progress will be feedback at the Directorate Quality Monitoring group and Clinical Effectiveness Group.

Appendix 2 List of LPT Services 2016/17

During 2016/17 LPT provided and/or subcontracted 109 NHS services. Mental Health and Learning Disabilities account for 46 services and Community Health Services make up the remaining 63.

Mental Health and Learning Disabilities Services

Inpatients

Adult Low Secure
Assertive Outreach
CAMHS Tier 4
District Forensic - Non Secure
Eating Disorder Tier 4
General Psychiatry
Huntington's disease Service
Learning Disabilities - Agnes Unit
Learning Disabilities - Short Breaks
MHSOP - Functional Assessment
MHSOP - Organic Assessment
Psychiatric Intensive Care
Rehabilitation

Non Inpatient Services

Acquired Brain Injury
Adult ADHD Service
Asperger's
Assertive Outreach
CAMHS
Clinical Neuropsychology
Cognitive Behaviour Therapy
Community Forensic Team
Court Liaison and Diversion
Crisis House
Crisis Resolution
Dynamic Psychotherapy
Early Intervention (PIER)
Eating Disorders
Employment Services
General Psychiatry
Huntington's (Neuro Psychiatry)
Learning Disabilities
Liaison Psychiatry
Liaison Psychiatry - Del Self Harm
Liaison Psychiatry - Mother & Baby
Liaison Psychiatry - Psycho Oncology
Liaison Psychiatry - Urgent Care
Medical Psychology
Memory clinic
MH Homelessness
MH Integrated Nurses
Older Persons
Personality Disorder Service
Place of Safety
SPA Assessment
Triage Car
Triage Nurse

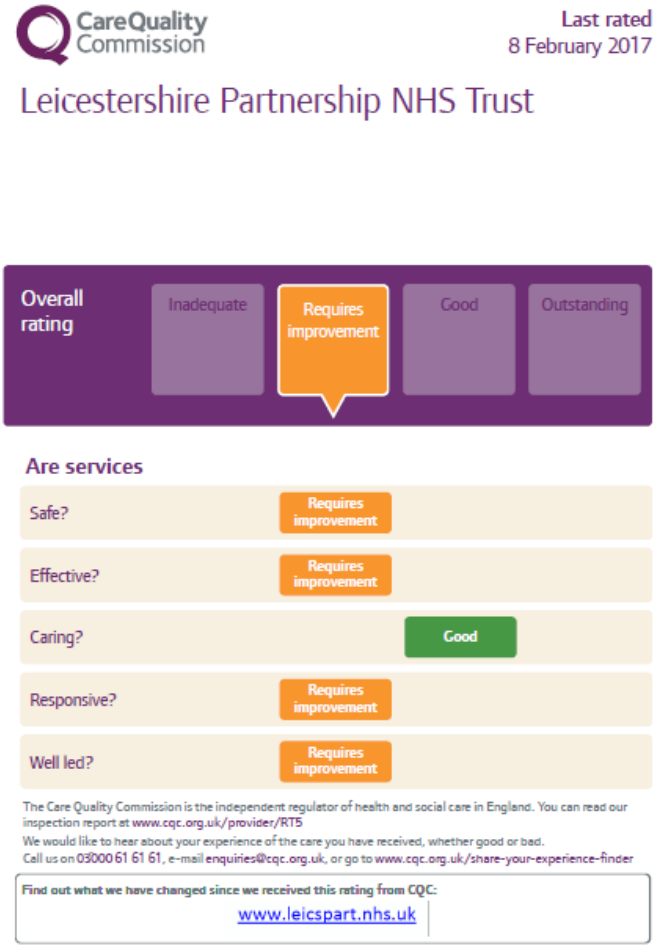
Community Health Services

Inpatients
ICS Beds
Intermediate Care and Community Hospital Beds

Non Inpatient Services

Adult MSK Physiotherapy
Adult Weight Management Services
Child and Family Support Service (CAFSS)
Child Death Overview Panel
Child Sexual Abuse Exam Service
Children's Audiology
Children's Occupational Therapy
Children's Physiotherapy
Childrens Rapid Assessment Follow-up Team
Children's SALT
Children's Weight Management Services
Children's Physiotherapy
Chronic Obstructive Pulmonary Disease Service
Community Clinic
Community Health Volunteer Scheme
Community Infection Control and Prevention
Community Integrated Neurology and Stroke Rehabilitation Service
Community Therapy
Community Wellness Service
Continence Nursing Service
Diana Children's Services
District Nursing
Food & Activity Buddies
Generalist Community Matrons
Health Improvement Specialist Service
Health Visiting
Heart Failure Service
Home Visit
Integrated Crisis Response Night Nursing Service (ICRS)
Integrated Health & Social Care
Intensive Community Support
Intermediate Care and RIT
Lifestyle Eating and Activity
Looked After Children
Macmillan - Adult
Macmillan - Childrens
Mic-Key Buttons
Nutrition and Dietetics services
Out of Hours District Nurse Visit
Overnight District Nurse Service
Oxygen Service
Paediatric Medical Services
Palliative - Hospice at Home
Phlebotomy Service
Phlebotomy services
Podiatry
Primary Care Coordinators
Prison Healthcare Services
Regalement
Safeguarding Children
School Nursing
School-Aged Immunisations Services
SEND
Single Point of Access (SPA)
Specialist Domestic Violence Nurse
Speech and Language for Adults
Technology Dependent Children
The Falls Clinic Program
Tissue Viability
Travelling Families Services
Ujala Resource Centre

Appendix 3 CQC Grid



	Safe:	Effective:	Caring:	Responsive:	Well-Led:	**Overall:**
Community health inpatient services						
Child and Adolescent Mental Health Wards						
Community based services for People with Learning Disabilities or Autism						
Acute Wards for Adults of Working Age and Psychiatric Intensive Care Units						
Forensic Inpatient/Secure Wards						
Community based Mental Health Services for Adults of Working Age						
Community based Mental Health Services for Older People						
Long stay/Rehabilitation Mental Health wards for working age adults						
Community Health Services for Children, Young People and Families						
Community Health Services for Adults						
Wards for People with Learning Disabilities or Autism						
Mental Health Crisis Services and Health based places of safety						
Specialist Community Mental Health Services for Children and Young people						
Wards for Older People with mental health problems						
Community End of Life Care						
LPT – Overall Provider Report						

Appendix 4: Clinical Priorities for 2016/17

	What is the priority?	Division	How we will measure this? (Actions)	Q4 Position
1	Improve clinical recording and care planning to support safe and effective patient centred care delivery.- First Episode Psychosis – Nationally there is a need for people to have access to NICE compliant treatment within two weeks of their first episode of psychosis.	FYPC	Waiting times from referral to first episode of treatment.	The standard for first Episode Psychosis since April 2016 is that 50% of cases accepted for treatment have been seen and allocated within 2 weeks. This has been monitored through weekly Patient Tracking List meetings. The compliance rate for 2016-17 to date is 78%. The PTL meetings are now monthly and compliance against target for 2016-17 is currently 80.3%
2	Improve discharge planning and follow up to support safe transfer of care- To launch and establish a neonatal pathway for all preterm babies who remain in neonatal unit at the new birth review (10-14 days) to ensure they have a health visitor contact <u>at the Unit.</u>	FYPC	We will develop an audit of neonates who receive a birth visit whilst on the unit.	Pathway has been launched. HV SOG 'Health Visiting Standard Operating Guidance' in 2015. The HV SOG (2015) states that the HV should offer the parents a new birth visit at the NNU as an alternative to home contact.
			We will monitor feedback from the staff delivering the pathway and the people using our services.	The re audit needs to reflect the number of new birth reviews offered at the unit and those that received them at the unit and those that had them at home. A meeting has been arranged between the Governance Lead and Health Visiting lead to discuss governance arrangements prior to developing the toolkit to ensure the questions fit practice and record keeping practice. The audit will be completed during 2017/18.
3	Improve clinical recording and care planning to support safe and effective patient centred care delivery- To enable the safety of patients on MHSOP Wards (including those who suffer from falls) via good assessment of patient strengths and needs and good standard care-planning.	CHS	The number of staff who have attended the training.	50 qualified MHSOP staff in 2016 have received the following training: Assessment and Care-Planning for MHSOP Staff using RIO' (full day) Bite-size record keeping and care-planning Bite-size Assessment using outcome measures
			Continual monitoring of the assessment and care-planning. Maintenance of 85% to be achieved across all domains.	A task and finish group established to support driving PCC planning. The service has delivered 85% across the domains during 2016.

			75% of qualified staff to have attended sessions during 2016/17.	1st March 2017 training compliance was at 88%. Care planning survey introduced across the service line.
4	Improve clinical recording and care planning to support safe and effective patient centred care delivery- Review record keeping documentation for community hospitals in line with the introduction of nerve centre and Trust objectives around improved record keeping and personalised care planning.	CHS	Establish a task and finish group to review and consider duplication.	Community Hospitals • A joint community and in-patient record keeping and care planning task and finish group has been established for Community Hospitals and Community to review and update the nursing assessment, including review of the nursing models of care. There are 3 phases to the work; review of the nursing assessment model, review of the core care plans and review of the Frequency of Intervention record (FIR chart).
			An improvement in record keeping audit results undertaken in Quarter 4 of 2016/17.	Community hospitals the trust standards for record keeping, quality performance and escalation process have been shared with all ward teams across the service. Monthly audits of 5 sets of records per in-patient area have commenced, which though sporadic, has demonstrated improvements in assessments and care planning compliance. A quarterly review is currently being undertaken for consideration in April.

			An improvement in record keeping as theme demonstrated through complaints and incidents in Quarter 4 of 2016/17.	• The key themes for improvement include ensuring that the patient needs are identified in the nursing assessment and care plans are updated/ evaluated as a minimum weekly. Community A new community record keeping and care planning survey was launched in October 2016 focusing on all key aspects of the nursing process. The results will be reviewed in line with the trust quality performance and escalation process and matrons will support the Operational Leads and District Nurses to identify a robust improvement plan, with oversight by the lead nurse to be reviewed within service at the community governance meeting.
5	Improve discharge planning and follow up to support safe transfer of care- Transition of patients through our hospitals is a key priority to improve the flow of patients and ensure that patients are cared for in the most appropriate setting.	CHS	Undertake an LIA event to discuss discharges and the documentation that goes with it. Implement agreed actions.	Community Hospitals The new discharge planner as a result of the LIA, has been implemented across the service, from November 2016 compliance with the planner is now audited as part of the record keeping and care planning audit.
			Development and implement of an e-learning package around discharge which will be for all the multi-disciplinary (MDT).	Help to Live at Home went Live on 7th November with packages of care in for social services. The new process is now embedded on the wards and is supporting timely discharges.
			We will report progress through The transfer of care group	MHSOP Within MHSOP Inpatient weekly record keeping/care planning surveys have been in place for a significant period. Questions within the survey are reviewed regularly and there is a focus on Discharge planning. Fortnightly delayed transfer of care (DtoC) meetings are in place. Patients with complex needs are discharged on CPA,

				hence having a 7 day follow up post discharge
			We will ensure the physical check on admission for all MH and LD patients takes place within 48 hours, with exceptions managed via the ward MDT.	Documentation reviewed and developed a 72 assessment pack on admission that then supports further interventions for physical health.
			Spot checks will be carried out, to ensure actions are completed on a regular basis.	Physical health assessments and care planning are part of the care planning are monitored by the monthly spot checks in LD and will be included in the spot checks for Rehabilitation services.
6	Improve clinical recording and care planning to support safe and effective patient centred care delivery. - Improving the physical health care planning and recording of progress in support of the Parity of Esteem Agenda.	AMH/LD	We will increase the number of registered general nurses to support physical health assessment and care.	We have focused on practical improvement and have employed 2 band 7 and 3 band 5 Registered General Nurses (RGN) to focus on improving physical health of patients in acute areas. They have reviewed documentation and developed a 72 assessment pack on admission that then supports further interventions for physical health.
			We will ensure the physical check on admission for all MH and LD patients takes place within 48 hours, with exceptions managed via the ward MDT.	There is currently a recommendation for the appointment of RGNs to support the presence of 1 on each ward at the Bradgate Unit.
			Spot checks will be carried out, to ensure actions are completed on a regular basis.	Physical health assessments and care planning are part of the care planning are monitored by the monthly spot checks in LD and will be included in the spot checks for

				Rehabilitation services.
			A change in our staffing and skill mix an increase in RGN appointments, the development of a tracking system via RiO to monitor completion of the physical health assessment on admission. We will report progress to ICL's Clinical Governance Group and Clinical Forums. Progress will be highlighted to Divisional Assurance Group (DAG).	The Head of Nursing has linked with the Trust lead for the physical health CQUIN to discuss opportunities for joint working and relevant policy development. Senior Matrons for Prison Healthcare and Rehabilitation are leading the "Deteriorating Patient" work across the service. AMH Rehabilitation services are exploring options for recruiting a physical health nurse across the services.
7	Improve clinical recording and care planning to support safe and effective patient centred care delivery - Improving patient and carer involvement in care planning (inpatients and community)	AMH/LD	A new care plans being available to patients. Patient feedback on the new care plan.	The Bradgate Unit has implemented a 'My Care Plan' which is offered within 7 days of admission. The purpose of this care plan is to incorporate patient's views on what is important to them regarding care and treatment. Care plan monitoring continues to be progressed across services. Additional action is also being taken in response to the recent CQC inspection.
			Audit of Care Plans – patient agreement.	Within LD: Agnes Unit "Care plan and My Care plan" include patient and carer involvement and within LD and Rehabilitation services recording of patient involvement is included in the monthly care planning spot checks Recent record keeping audit (Oct 2016) demonstrated Mill Lodge were 100% compliant with patient involvement. Care plan monitoring continues to be progressed across services.

			For community LiA event to be carried out and progress the outcomes to improve the level of involvement/engagement in care planning.	The LiA event was held on the 17th June 2016 and the Pass it On event on the 30th September. The key actions identified were: • Communication to support a culture of involvement • Informing and empowering patients, carers and the public • Creating a central database and resource around involvement The work is still progressing and a document library has been set up and run by the LiA lead. He has made contact with the VCS to help promote of awareness of CPA, there have been improvements to the recording carers' details and he has started to look into value based recruitment involving patients and carers.
			Outcome measures from the LiA and the directorate Community Mental Health Survey. We will report progress to the Clinical Governance Group and Clinical Forums. Progress will be highlighted to DAG	MH survey results under review and actions are being developed. Additional training on patient involvement in care planning is being provided to registered nurses during RN training days in January and February 2017. The latest Community Mental Survey showed improvement in: •Involvement in agreeing what care will be received •Involvement of family or someone else close as much as desired. The results of the inpatient mental health survey were presented in February 2017 and showed and showed a 19% improvement in the question re involvement in decisions about care and treatment.

8	Improve discharge planning and follow up to support safe transfer of care - To understand the reasons for and delays in high complex transfers of care including those who may require a hospital to hospital transfer	AMH/LD	Appoint the final member of the complex discharge planning team (May 16). We will conduct a deep dive analysis into long Length of Stay (LoS) patients and complex DToC's to improve our understanding of the outstanding issues and to improve effective escalation of issues.	We have carried out detailed reviews of the longest staying patients [over 100 days] have identified a number of clinical and social complications which means they would be unsuitable for an acute patient pathway. These include ✓ complex physical co-morbidities from which they would never fully recover ✓ those who could never live independently again ✓ vascular dementia ✓ patients requiring detox from drug and/or alcohol as well as treatment for their mental illness ✓ extensive previous and active forensic history ✓ polysubstance abuse ✓ co-existing LD ✓ treatment resistant conditions
			An improvement in the number of DToCs on our wards, a reduction in the LoS of DToC patients and a reduction in mean LoS across our wards. We will report progress to ICL's Operational Group. Progress will be managed by AMHLD Finance & Performance Committee.	In addition the following barriers to discharge were identified: ✓ Availability of accommodation ✓ Time to secure a Community Treatment Order(CTO) ✓ Time to secure a Community Psychiatric Nurse (CPN) ✓ Time to apply for AHP/nursing/residential care ✓ Social work assessment ✓ Risk Factors The average mean for the Length of Stay for Dec 16 – 59.5%. Clinical audit of patients with treatment resistant depression and schizophrenia respectively to determine nature of pathways to be designed • Value stream mapping exercise to take place to determine 'Always' events for patients in first 3 weeks of stay. • Step-down housing model in design in partnership with CCG
9	Evidence improved engagement in clinical supervision for all staff delivering	ALL	An improvement in the rate of recorded clinical supervisions.	CHS

	care - To improve the actual and recorded clinical supervision rates for all staff in the Trust.		We will develop a bite size training programme to improve knowledge and understanding of those receiving supervision. (CHS) Numbers of staff undertaking training. Clinical supervision will be rated as good or excellent on U-learn or through clinical audit. (FYPC) Frontline visits will show evidence of clinical supervision being embedded in practice. (FYPC) We will report progress to Clinical Effectiveness Group (CEG).	The position for CHS has stagnated at 54.6% as of 1st March. A task and finish group has been established to take a wide pronged approach to improving clinical supervision across CHS and will incorporate any additional training requirements. AMH/LD Recording of clinical supervision has improved by nearly 20% from Feb 16 to Jan 17. Managers are asked to monitor uptake of clinical supervision within their teams, and ensure that systems are in place for staff to enter their sessions on to uLearn and that poor performance is followed up. This is formally discussed in the workforce agenda of local Ops meetings. All actions are continuing and additional action is also being taken in response to the recent CQC inspection. Clinical supervision rates are improved from the start of 2016 but current performance is at 54.4% The Head of Nursing will be reviewing Clinical Supervision arrangements within the service and a system set up to ensure all staff receive clinical supervision in line with the Trust Policy by June 2017 FYPC Past 6 months Supervision Rates for FYPC show a steady rise from 1st July 2016 – 63.4% to 1st December 2016 – 79.1%. A focus has been on improving compliance with clinical supervision. A review of the quality of the supervision experience is planned for 2017/18.

Appendix 5: Data definitions

Test numerator and denominator: A manual quality assurance process is undertaken by the service to cross check a patient who had discharge recorded on RiO against what is recorded on either electronic or manual paper notes of staff.

CPA – 7 day follow-up

The indicator definition is: The number of people under adult mental illness specialties on CPA who were followed up (either by face to face contact or by phone discussion) within 7 days of discharge from psychiatric in-patient care.

LPT CPA clinical procedure is that prior to discharge a patient review may result in a clinical decision to take the patient off the CPA and in this instance the patient will be reviewed and placed on non CPA at the point of discharge. Where a service user is discharged and not on CPA, the rationale for this decision is recorded, ***thus not all patients discharged from a psychiatric ward are regarded as being on CPA.***

Trust inpatient policy: "Where a service user is discharged and not on CPA, the rationale for this decision must be recorded. Those not on CPA will have a Lead Professional identified. (Unless the service user is discharged from the services)."

The National guidance: "Everyone Counts: Planning for Patients 2014/15 - 2018/19: Technical Definitions for Clinical Commissioning Groups and Area Teams" details the denominator for this indicators as: *The total number of people under adult mental illness specialties on CPA who were discharged from psychiatric in-patient care*. ***All patients discharged from a psychiatric in-patient ward are regarded as being on CPA.***

CRT Gatekeeping

The indicator definition is: In order to prevent hospital admission and give support to informal carers, CRHT are required to gatekeep all admission to psychiatric inpatient wards and facilitate early discharge of service users. An admission has been gatekept by a crisis resolution team if they have assessed the service user before admission and if the crisis resolution team was involved in the decision making-process, which resulted in an admission.

Patient safety incidents

The indicator definition is: National Reporting and Learning System (NRLS) define a patient safety incident as 'any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS funded care'.

Glossary

Adult Mental Health Services (AMH)
This is the division which provides adult mental health services.

Adult Mental Health - Learning Disabilities (AMH-LD) A sub-division of AMH responsible for the provision of Learning Disability Services.

Better Care Together (BCT)
A programme of work which will transform the health and social care system in LLR by 2019, by ensuring that health and social care services in LLR are capable of meeting the future needs of the local population. BCT brings together partners, including local NHS organisations and councils, to ensure that services change to meet the needs of local people, and future challenges.

Black and Minority (BME)
Black and Minority Ethnic or Black, Asian and Minority Ethnic is the terminology normally used in the UK to describe people of non-white descent.

Care Pathways
These determine the locally-agreed, multi-disciplinary practice based on guidelines and evidence, where available, for each specific service user group.

Care Programme Approach
(CPA) A system of delivering community services to those with a serious mental illness, based upon the four principles of assessment, care plan, care co–ordination and review.
Implicit in all of them is involvement of the person using the service, and where appropriate, their carer.

Care Quality Commission
(CQC) The Care Quality Commission replaced the Healthcare Commission, Mental Health Act Commission and the Commission for Social Care Inspection in April 2009. The CQC is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. Local application of the Mental Health Act is now included as part of the CQC's Comprehensive Inspection Programme.

Child and Adolescent Mental Health Services (CAMHS)
CAMHS is a range of services for children and young people aged up to 18. Young people between 16 and 18 years can access CAMHS or other adult services, depending on which is felt to be more useful for their needs.

Clinical audit
Clinical audit measures the quality of care and services against agreed standards and suggests or makes improvements where necessary.

Clostridium difficile (CDiff)
CDiff is a species of bacterium that causes diarrhoea and other intestinal disease when competing bacteria are wiped out by antibiotics.

Commissioning for quality and innovation (CQUIN)
The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of healthcare providers' income to the achievement of local quality improvement goals.

Commissioners
Commissioners are responsible for ensuring adequate services are available for their local population by assessing needs and purchasing services. Clinical Commissioning Groups are the key organisations responsible for commissioning healthcare services for their area. They commission services for the whole of their population, with a view to improving their population's health.

Community Health Services and Mental Health Services for Older Persons (CHS/MHSOP)
This is the division which provides inpatient community services, community services, and mental health services for older people.

Deprivation of Liberty Safeguards (DoLS)
These are part of the Mental Capacity Act 2005. They aim to make sure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom.

Families, Young People and Children's Services (FYPC)
This is the division which provides services to families, young people and children.

Friends and Family Test (FFT)
FFT is a patient metric to test likelihood of recommending our ward / service to friends and family if they were to need similar care or treatment. Scores are now shown as the percentage of people who express 'extremely likely' and 'likely' to recommend the service to their friends and family (from a 5 point range from; 'Extremely likely' to 'Extremely unlikely').

GEM (Arden and Greater East Midlands Commissioning support Unit.
One of the largest Commissioning Support Units

in the country, serving 37 Clinical Commissioning Groups, with a population of around 6.3 million; they deliver commissioning support.

Health & Social Care Information Centre (HSCIC)
A national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care; HSCIC is an executive non-departmental public body, sponsored by DoH.

Healthcare Associated infections (HCAI)
HCAI are infections acquired as a consequence of a person's treatment by a healthcare provider, or by a healthcare worker in the course of their duties. They are often in a hospital setting, but can also be associated with clinical care delivered in the community.

Healthwatch
Healthwatch is the consumer champion for Health and Social Care. A local Healthwatch is an independent organisation, able to employ its own staff and involve volunteers, so it can become the influential and effective voice of the public. It keeps accounts and makes its annual reports available to the public. It replaced LINKs (Local Involvement NetworK), has taken over their responsibilities and has implemented additional services around advice and guidance.

The aim of local Healthwatch is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their community.

Integrated quality and performance reports (IQPR)
A monthly report which gives levels of compliance with our improvement priorities, the Monitor Compliance Framework and CQC registration requirements. The report also provides the current monthly data and trend analysis across each of the Trust strategic objectives including all local commissioning targets and internal Trust targets.

ICD-10
the 10th revision of the International Statistical Classification of Diseases and Related Health Problems, a medical classification list by the World Health Organisation.

Information Governance Toolkit
The framework by which the NHS assesses how well we meet best practice for collecting, storing and sharing information about people. These standards cover information governance management, confidentiality and data protection, information security, information quality and the keeping of all records.

Leicester, Leicestershire and Rutland (LLR)
Our local healthcare area.

Learning Disabilities Services
This is the division which provides services for adults with learning disabilities.

Listening into Action (LiA)
LiA is one of the key ways that the Trust empowers staff to make changes that improve working life and patient care. The scheme works to bring people together to share their thoughts and ideas, and to make improvements together. It is now an essential part of our programme to improve the quality of care across all of our services.

Mental Capacity Act 1983 (MCA)
This is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over.

Mental Health Act (MHA)
Amended in 2007, the MHA sets out treatments, rights, etc., for those with mental disorders, and also the legal powers of detention of doctors and Approved Mental Health Professionals. It outlines a legal framework which must be followed to ensure rights are protected.

Mental Health Minimum Dataset (MHMDS) A mandatory requirement for all providers of specialist adult mental health services in a secondary care setting, to collect person focused clinical data which includes all relevant treatment and care for service users. The coded clinical data inputted helps provide local clinicians and managers with better quality information for clinical audit, service planning and management, with the aim of ensuring provision of accurate and concise quality data.

Methicillin-Resistant Staphylococcus Aureus (MRSA)
A common skin bacterium that is resistant to a range of antibiotics. 'Methicillin-resistant' means the bacteria are unaffected by Methicillin, a type of antibiotic that used to be able to kill them.

Multi-Disciplinary Team (MDT)
MDTs are composed of members from different healthcare professions with specialised skills and expertise, who collaborate together to make treatment recommendations that facilitate quality patient care.

NHS number

The NHS number is the mandated national unique identifier for patients. It must be used alongside other demographic information to identify and link the correct records to a particular patient.

National Institute for Health and Clinical Excellence (NICE) The National Institute for Health and Clinical Excellence provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health.

National Institute of Health Research (NIHR) A national body established to commission and fund NHS and social care research in public health and personal social services. Its role is to develop the research evidence to support decision making by professionals, policy makers and patients, make this evidence available, and encourage its uptake and use.

National Patient Safety Agency (NPSA) A national agency which leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector.

National Reporting and Learning System (NRLS)
A central database of patient safety incident reports. Since the NRLS was set up in 2003, over four million incident reports have been submitted. All information submitted is analysed to identify hazards, risks and opportunities to continuously improve the safety of patient care.

Non-portfolio Research
The majority of these studies are relatively small-scale, local studies (formerly known as "own account" research).

Patient Safety Thermometer
A point of care survey instrument, the Patient Safety Thermometer measures local and system progress in providing a care environment free of harm for patients. It allows clinical teams to measure the proportion of patients that are 'harm free' during their working day.

Portfolio Research
These are studies that are of "high quality", as determined by being awarded funding on a competitive basis from an eligible funding body (such as MRC, NIHR, HTA, SDO, RfPB etc.). In most cases these are multi-centre studies aiming to recruit large numbers of participants, so as to produce the best possible evidence. The majority of these studies are "adopted" by Topic Specific Networks such as MHRN (Mental Health Research Network), CRN (Cancer Research Network), DRN (Diabetes Research Network) or directly on to the UKCRN Portfolio through the NIHR-CSP (Central Sign-off for NHS Permission) system managed by the Comprehensive Local Research Networks (CLRN).

Quality Schedule
LPT's Quality targets and goals as agreed with the three local Clinical Commissioning Groups. Progress against delivery is monitored by Commissioners on a monthly basis through formal meetings, and by visits.

Secondary Users Service (SUS)
A single source of comprehensive data, available to the NHS, to enable a range of reporting and analysis.

Summary Hospital Level Mortality Indicator (SHMI)
An indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as an official statistic by the Health and Social Care Information Centre (HSCIC) with the first publication having been in October 2011. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

Trend
A trend refers to the concept of collecting information and attempting to spot a pattern, or trend, in the information. A trend line presents the 'trend'.

360 Assurance
Established in July 2013, 360 Assurance brings together two long standing internal audit services. They assist LPT in the identification of key business risks and in the gaining of assurances that these are being managed effectively.

Feedback your views

This is the Quality Account and we want this report to be used to inform discussions about how we could improve our services. The Trust welcomes your questions or comments on the issues raised in this document or any of its services.

Comments should be sent to:
Chief Executive , **Leicestershire Partnership NHS Trust, Riverside House/Bridge Park Plaza**, **Bridge Park Road**, **Thurmaston**, **Leicester**, **LE4 8PQ.**

Telephone: 0116 295 0994 and ask for the communications team
Email: feedback@leicspart.nhs.uk

This document is also available on our website at www.leicspart.nhs.uk
(After 30th June 2017)