NHS
Leeds Community Healthcare
NHS Trust

Board Meeting (held in public)
Friday 6 October 2017, 9.00am – 12noon
Trust Headquarters, Stockdale House, Victoria Road, Leeds LS6 1PF

AGENDA				
Time	**Item no.**	**Item**	**Lead**	**Paper**
		Preliminary business		
9.00	2017-18 (39)	Welcome, introductions and apologies	Neil Franklin	N
9.05	2017-18 (40)	Declarations of interest	Neil Franklin	N
9.10	2017-18 (41)	Questions from members of the public	Neil Franklin	N
9.15	2017-18 (42)	Patient's story: Children's services	Marcia Perry	N
9.30	2017-18 (43)	Minutes of previous meeting and matters arising: a. Minutes of the meeting held on 4 August 2017 b. Actions' log c. Committees' assurance reports: i. Quality Committee: 25 September 2017 ii. Business Committee: 27 September 2017 d. Minutes of the annual general meeting held on 14 September 2017	 Neil Franklin Neil Franklin Tony Dearden Brodie Clark Neil Franklin	 Y Y Y Y Y
		Quality and delivery		
9.50	2017-18 (44)	Chief Executive's report	Thea Stein	Y
10.05	2017-18 (45)	Care Quality Commission inspection report	Mandy Thomas	Y
10.20	2017-18 (46)	Third sector in health and care in Leeds	Sam Prince	Y
10.30	2017-18 (47)	Performance brief and domain reports	Bryan Machin	Y
10.45	2017-18 (48)	Serious incidents report	Marcia Perry	Y
		Strategy and planning		
10.55	2017-18 (49)	Review of operational plan including financial plan 2017/18	Bryan Machin	Y
		Reports		
11.10	2017-18 (50)	Emergency preparedness and resilience report and major incident plan report 2016/17	Sam Prince	Y
11.20	2017-18 (51)	Infection prevention and control annual report 2016/17	Marcia Perry	Y
11.30	2017-18 (52)	Safeguarding annual report 2016/17	Marcia Perry	Y
		Governance		
11.40	2017-18 (53)	Significant risks and assurance report	Thea Stein	Y
11.50	2017-18 (54)	Board workplan	Thea Stein	Y
		Minutes		
11.55	2017-18 (55)	Approved minutes (for noting): a. Quality Committee: 24 July 2017 b. Business Committee: 26 July 2017 c. Leeds Safeguarding Children Board: 21 March 2017	Neil Franklin	 Y Y Y
12.00	2017-18 (56)	Close of the public section of the Board	Neil Franklin	N

Date of next meeting (held in public)
Friday 1 December 2017, 9.00am -12noon
Trust Headquarters, Stockdale House, Leeds LS6 1PF

AGENDA ITEM 2017-18 (43a)

Leeds Community Healthcare NHS Trust
Trust Board Meeting (held in public)

Boardroom, Stockdale House, Victoria Road, Leeds LS6 1PF

Friday 4 August 2017, 9.00am – 12.00noon

Present:	Neil Franklin	Trust Chair
	Thea Stein	Chief Executive
	Brodie Clark	Non-Executive Director
	Dr Tony Dearden	Non-Executive Director
	Jane Madeley	Non-Executive Director
	Richard Gladman	Non-Executive Director
	Bryan Machin	Executive Director of Finance and Resources
	Marcia Perry	Executive Director of Nursing
	Sam Prince	Executive Director of Operations
	Dr Amanda Thomas	Executive Medical Director
	Sue Ellis	Director of Workforce
Apologies:	Professor Ian Lewis	Non-Executive Director
In attendance:	Vanessa Manning	Company Secretary
	John Walsh	Freedom To Speak Up Guardian (for item 27)
Minute taker:	Liz Thornton	Board Administrator
Observers:	Steve Keyes	Head of Organisational Development
	John Walsh	Organisational Development Lead (for all items apart from item 27)
	Farah Hameed	HR Advisor
Members of the public:		

Item	Discussion points	Action
2017-18 (18)	**Welcome and introductions** The Trust Chair welcomed Trust Board members and extended a welcome to members of staff from the Trust who were in attendance or attending as observers. The Trust Chair welcomed the appointment of Professor Ian Lewis to the Board as a Non-Executive Director and noted that he had offered his apologies for this meeting. He also noted that the Director of Workforce was attending her last meeting before taking up a new post at the Leeds Health and Social Care Academy. **Apologies** Apologies were noted from Non-Executive Director (IL). **Chair's opening remarks** The Trust Chair said he wished to make some opening remarks in order to provide a strategic context for the Board's deliberations during the course of the meeting, he set out a number of key strategic issues for the Trust, these being:	

	• ***Meeting the requirements of the Trust's regulators, particularly the Care Quality Commission (CQC):*** ensuring and evidencing that the Trust's services are safe, caring, effective, responsive and well-led for patients, for staff and for the organisation as a whole. The formal feedback and report from the CQC's inspection in January 2017 was still awaited. • ***Financial performance***: meeting the challenges in the short term. The Trust satisfactorily met its financial duties in 2016/17 and financial performance remained satisfactory in the early months of 2017/18 but the Chair said in the longer term that focus needed to be on maintaining a viable and sustainable organisation. • ***Leadership:*** meeting the need to grow and retain good leaders to build on achievements in 2016/17 and to continue to address the quality, financial and workforce challenges in 2017/18. Although recruitment and sickness absence rates were improving, alongside retention they remained the Trust's most significant risks. • ***Working within the wider Leeds health and social care economy***: working co-operatively with partners in the best interests of patients and their families to achieve change strategically and operationally in the context of the Leeds Health and Care Plan would be a top priority.	
2017-18 (19)	**Declarations of interest** The Non-Executive Director (JM) declared an interest in item 30 in relation to the Trust's research links with the University of Leeds and item 31 in relation to the involvement of the University of Leeds in the development of the Leeds Health and Social Care Academy. The Director of Workforce declared an interest in item 31 in relation to her future role at the Leeds Health and Social Care Academy.	
2017-18 (20)	**Patient's story** This item was withdrawn from the agenda.	
2017-18 (21)	**Questions from members of the public** There were no members of the public in attendance.	
2017-18 (22) **(22a)** **(22b)** **(22c)**	**Minutes of the previous meeting held on Wednesday 31 May 2017 and matters arising** **Minutes of the previous meeting held on Wednesday 31 May 2017** The minutes were reviewed for accuracy and agreed to be a correct record. **Items from the actions' log** ***Item 2016-17 (94) Annual staff survey 2016:*** This action referred to a report of on the data outcomes and impact of the staff health and wellbeing initiatives. It was agreed that the completion of this action would be progressed through a report to the Business Committee in October 2017. The completed actions from previous meetings were noted. **Assurance reports from sub-committees** **Item 22c(i) – Charitable Funds Committee 23 June 2017** The Committee Chair and Non-Executive Director (BC) provided a verbal update and highlighted the key issues discussed, namely: • ***Fundraising*** – new initiatives included a potential partnership arrangement with Leeds Teaching Hospitals NHS Trust (LTHT) and discussions were progressing well.	

- ***More than a welcome*** – work was continuing including improvements linked to customer service training and wider 'front of house' initiatives. The Committee had agreed that in future oversight of the 'more than a welcome' initiative would be considered as business as usual and a handover plan was being developed.
- ***Model Health Centre*** – work was underway to pilot the model at Beeston Health Centre and the St George's Centre.

Item 22c(ii) – Nominations and Remuneration Committee 23 June 2017
The report was presented by the Trust Chair and Committee Chair (NF) who highlighted the key issues, namely:

- ***Class (bank staff) hours*** – the Committee had received assurance that checks were in place to ensure that the hours worked by staff who may have more than one job role within the Trust or work as agency staff were not compromising their health and the care and safety of patients.
- ***Chief Executive's and directors' performance uplift*** – the Committee had approved in principle a 1% salary uplift for 2017/18, subject to guidance and approval from NHS Improvement. The Director of Workforce confirmed that this was in line with the pay award for other NHS staff agreed by the government following the recommendations made by the health pay review bodies for 2017/18.

Item22c(iii) – Audit Committee 21 July 2017
The report was presented by the Committee Chair and Non-Executive Director (JM) who highlighted the key issues discussed, namely:

- ***Internal audit –*** The Committee had received a follow up report on an audit on statutory and mandatory training which had received a limited assurance opinion. Urgent recommendations had been addressed and future compliance with targets would be included in the quarterly workforce reports to the Business Committee. The Committee had received reports on the first two audits completed in 2017/18; neighbourhood teams (demand and capacity management) and board and committee effectiveness. Both audits had received a reasonable assurance opinion.
- **Counter fraud –** the Committee had received NHS Protect's focused quality assessment of compliance against NHS Protect's standards for NHS provider organisations. The Trust had been identified as being non-compliant and rated as 'red' related to the 'hold to account' standards. The Committee would receive a detailed report on the Trust's self-assessment and compliance against all four standards in October 2017.
- ***Cyber security*** **–** The Committee had received a 'lessons learnt' report related to the cyber security incident that the NHS experienced on 12 May 2017 and also a de-brief report following an emergency planning exercise run in the neighbourhood teams during June and July 2017. Overall, teams felt confident that they would be able to maintain essential service delivery if an incident occurred but consideration needed to be given to the time required to recover and for systems to return to full capacity.

Item22c(iv) – Quality Committee 24 July 2017
The report was presented by the Committee Chair and Non-Executive Director (TD) who highlighted the key issues discussed, namely:

- ***Falls prevention –*** the falls prevention steering group had been established and the Committee had agreed that there was reasonable assurance on the work being carried out. A revised falls action plan would be shared with the Committee in October 2017 containing more specific actions, identification of and progress against themes and evidence of the impact of the action plan in relation to falls reduction in the Trust.

	• ***Children's services –*** the Committee had been briefed on a programme of enhanced support to Hannah House and had received reasonable assurance of the plans and progress. • ***Neighbourhood teams –*** The Committee had discussed the difficulties in measuring complexity and intensity in community services and the challenges the teams faced on a daily basis. The Committee would receive a further report in October 2017 regarding the definition and measurement of complexity and the potential to approach commissioners for additional funding for specific cases. The Executive Director of Operations advised that she was contributing to work at a national level with the aim of developing a tool to measure complexity. **Item22c(v) – Business Committee 26 July 2017** The report was presented by the Committee Chair and Non-Executive Director (BC) who highlighted the key issues discussed, namely: • ***Children's strategy –*** the Committee was briefed on the initial work to develop a strategy for children's services; the aim being to ensure that this would fit with the overarching Leeds children's and young people's plan. A first draft of the plan would be available for the Business Committee meeting in September 2017. • ***Organisational development strategy –*** the Committee had received an update which provided assurance of the alignment of the strategy with other key strategies but remained very keen to see more measurable actions with clear timescales for delivery. • ***Estates strategy –*** work continues to deliver against the strategy's objectives. Services had already been relocated from three bases and a further nine projects were in the pipeline. • ***Business and commercial developments –*** the Committee had been briefed on a number of business developments and tendering exercises for which the Trust was well placed to compete. The Trust had recently been successful in bidding to NHS England to take on devolved commissioning responsibility and budget for the mental health in-patient services for West Yorkshire's children and young people. **Outcome:** The Board noted the updates reports from the committee chairs and the matters highlighted.	
2017-18 (23)	**Chief Executive's report** The Chief Executive presented her report, the items highlighted included: • the improvements in community dental services • winter planning • initiatives linked to the health and wellbeing of the workforce • joint work across the city to address workforce issues Referring to the *Ask Thea* analysis, a Non-Executive Director (TD) asked about why staff chose to raise issues and concerns or make comments direct to the Chief Executive rather than their line manager. In response, the Chief Executive said that *Ask Thea* provided an alternative route but the percentage of staff raising issues through the *Ask Thea* approach was relatively small in relation to the total number of staff employed by the Trust. She felt that most had tried other avenues to raise a concern before resorting to a direct approach to the Chief Executive. In response to a request from Non-Executive Director (TD) for more detailed information on the development of the Leeds Health and Care Plan, the Chief Executive agreed to circulate the most recent version of the plan to non-executive directors.	

	Action: The most recent version of the Leeds Health and Care Plan to be circulated to non-executive directors. The Chair observed that last winter had been a challenging period for the Trust and asked what preparations were being made for winter 2017/18. The Chief Executive reported that a significant amount of work had already been undertaken. The Trust was working with primary care colleagues and wider health and social care system partners both in Leeds and across West Yorkshire to prepare for service pressures during the winter period. A local delivery plan had been drawn up and two workshops involving all partner organisations had been held in recent weeks. Referring to the review of NHS performance during winter 2016/17 published by NHS England and NHS Improvement, a Non-Executive Director (BC) asked if the government had made any commitment to additional funding to support trusts in 2017/18. The Chief Executive explained that £1bn had been allocated in the Spring Budget 2017 for the purposes of meeting adult social care needs; reducing pressures on the NHS including supporting more people to be discharged from hospital when they are ready; and ensuring that the local social care provider market was supported. This funding would remain with local government, however, the Trust was in discussion with the Director of Adult Social Care at Leeds City Council with a view to agreeing the use of the funding. A Non-Executive Director (JM) asked about opportunities to facilitate timely movement of patients through the system. The Chief Executive explained that the local delivery plan, drawn up with all partner organisations, comprised some nationally mandated components and local priorities including approaches to: • A&E streaming and interface with other providers • 111: greater clinical involvement in the assessment of patients through greater deployment of emergency care practitioners • management of patient flow including hospital discharge provisions In addition, a new Leeds frailty unit is to be trialled at St James University Hospital's emergency department for three weeks from 14 August 2017 and an urgent care centre would be established at the St Georges Centre in Leeds. A Non-Executive Director (TD) reflected on the learning from 2016/17 and emphasised the importance of partnership working and a mutual understanding of the consequences of deferring routine surgery and other elective procedures during periods of high pressure. A Non-Executive Director (BC) suggested that the Board workshop on 1 September 2017 should discuss winter planning, with a primary focus on: • current and likely service pressures • the Trust's response • working with partners The Executive Director of Finance and Resources reflected on the discussion and the initiatives already in place to support local systems through the winter months. He said that it was important for partner organisations across the city to recognise that the initiatives that had been developed to build more resilience into the system for winter 2017/18 could not be funded from 'core capacity'.	**Company Secretary**

	The Chief Executive advised that a 'Board to Board' event was scheduled for 8 August 2017 and it was appropriate to raise issues around winter planning funding at that event. **Action:** Winter planning funding to be raised at Board to Board event on 8 August 2017. In summary, the Trust Chair said that it was clear that the system remained under pressure and for many of the Trust's staff in neighbourhood teams and other services the level of demand related to winter pressures had not ceased and was now the 'new normal'. He said that it was crucial for the Trust to ensure that proper planning and discussion with local partners took place to enable the Trust to meet the challenges of the forthcoming winter. **Outcome**: The Board noted the Chief Executive's report and the matters highlighted particularly the discussion on winter planning.	**Executive Director of Finance and Resources**
2017-18 (24)	**Performance brief and domain reports** The Executive Director of Finance and Resources presented the report, which comprised: • high level performance summary • more detailed domain reports: safe, caring, effective, responsive, well-led and finance The Executive Director of Finance and Resources said that the report provided a focus on key performance areas that were of current concern to the Trust and a summary of performance against targets and indicators in these areas. He highlighted the following: ***Safe*** The Trust was achieving all of its targets within the safe domain. Safe staffing stands at 95% against a target of 95%. All other measure were green; including duty of candour and the Trust's 5% reduction in falls target. ***Caring*** The Trust was meeting all of its targets in the caring domain and the Trust expected this to be the position at the end of the year. The Board noted that the percentage of staff recommending care (staff friends and family test) was reported as 81% in June 2017, which was above the target of 73%. ***Effective*** Compliance with clinical supervision was reported at 80% in line with the year to date target. The Executive Director of Finance and Resources reported that there had been no increase in the number of services reporting outcome measures centrally but this was expected to increase and consequently had been given an amber rating. ***Responsive*** The Trust continued to perform well in respect of responsive indicators for example waiting times; all seven were rated as green for June 2017. The volume of clinical activity for the first three months of 2017/18 was 6.4% below profile and was rated as amber. The Executive Director of Finance and Resources said that activity levels would continue to be monitored and were expected to meet the target at the end of the year.	

	Well-led The Director of Workforce advised that the Business Committee had received the first quarterly workforce report which contained information on trends and progress in addition to the monthly performance data. She explained that the report provided high level data across all business units. New arrangements were being introduced to allow managers easier access to live workforce data through the electronic staff record business intelligence suite. Monthly performance reports on workforce data were also being uploaded to the performance information portal. A Non-Executive Director (JM) asked about data on the level of staff compliance on safeguarding training and why this was not routinely presented to the Board under the well-led domain report. The Director of Workforce advised that statutory and mandatory training reporting to Quality Committee, Business Committee and the Board would be reviewed. **Action:** Reporting on staff compliance with safeguarding training to be reviewed for inclusion with statutory and mandatory training reporting to the Quality Committee, Business Committee and Board. ***Financial position*** The Executive Director of Finance and Resources reported that, in the third month of the year, the Trust was meeting its financial targets for most of the indicators with the exception of capital expenditure in comparison to plan and cost improvement plan delivery. He advised that, based on the current forecast outturn, additional savings of £0.5million would be required to deliver the £3.034million control total set by NHS Improvement. The Executive Director of Finance and Resources said that this was a manageable risk at this stage in the year based on current forecast and the control total requirement. A Non-Executive Director (JM) said she was satisfied that the Trust had effective financial management processes in place and supported the approach of continued vigilance in monitoring the budget without the need for more stringent financial measures to be introduced at the present time. She added that it was important that mitigation plans were developed to ensure that the control total was delivered at the end of the year. ***Single point of urgent referral (SPUR)*** The Trust Chair noted the key area of focus in the paper related to the single point of urgent referral (SPUR). The report provided an update on the changes in the neighbourhood team referral process. Evidence showed improved outcomes in terms of bed usage than had previously been the case. **Outcome:** The Board noted the Trust's performance for June 2017.	**Director of Workforce**
2017-18 (25)	**Serious incidents report** The Executive Director of Nursing introduced the report which provided an update on the outcomes, themes and learning from serious incident investigations closed during May and June 2017. The Executive Director of Nursing reported that there had been a total of 16 serious incidents reported in May and June 2017 taking the total for the year to date to 22. This was a 21% reduction overall in serious incidents compared to the same time last year. 15 of the serious incidents related to pressure ulcers; with one other related to a fall resulting in a fracture.	

	Outcome: The Board received and noted the contents of the report.	
2017-18 (26)	**Safe staffing report** The Executive Director of Nursing presented the report which set out progress on maintaining safe staffing over the previous six months. The report outlined where the Trust was meeting safe staffing requirements and where there was further work to be undertaken. Updates were also included on the additional key areas of agency expenditure and the development of the e-rostering tool. The Executive Director of Nursing advised that safe staffing had been maintained across all inpatient units for the time period of the report and units had continued to provide safe and caring high quality care. Recent concerns had focused on the increasing challenges resulting from the community intermediate care beds tender process and its impact on staffing. Referring to the data on health visiting, the Chief Executive noted that good progress had been made in relation to the caseload size but asked about the measures by which unsafe staffing levels were identified and managed. The Executive Director of Nursing explained that staffing levels were RAG rated and carefully scrutinised and monitored. When staffing levels became a concern, steps were taken to review the caseloads with a view to moving or amalgamating caseloads if appropriate. The Executive Director of Nursing advised that progress in relation to caseload size would be challenging in the future. Locally, a very effective caseload waiting tool had been developed alongside an allocation tool. A Non-Executive Director (RG) asked about the staff perception of staffing levels across the Trust. The Executive Director of Nursing said that staff were more aware and had developed a greater understanding of the data produced in relation to staffing levels. Referring to the information on key quality indicators for Hannah House and Little Woodhouse Hall, a Non-Executive Director (TD) asked about the lack of data entered for either unit under the friends and family test (FFT) indicator. The Executive Director of Nursing agreed to investigate and report back to the Quality Committee. **Action:** Data related to FFT response rates and FFT care recommendation to be reconciled and included in a report to Quality Committee in October 2017. In response to a question from Non-Executive Director (TD), the Executive Director of Nursing confirmed that the Trust had a statutory responsibility to report on safe staffing levels across in-patient units but many elements in the current guidance could be applied to other services. **Outcome:** The Board noted the report and welcomed the assurance that staffing levels were being monitored to maintain safe staffing.	**Executive Director of Nursing**
2017-18 (27)	**Freedom to speak up annual report** The Freedom to Speak Up Guardian presented the report which provided an overview of his work, basic activity data and recommendations on the role and its development.	

	The Freedom to Speak Up Guardian said that he had received strong support from the Chief Executive and the wider Trust. A clear approach had been established and was working well. In response to a question from Non-Executive Director (BC), the Freedom to Speak Up Guardian explained that the 26 members of staff, whom he had met directly, had raised a combination of individual and team specific issues and possible solutions had been discussed. A Non-Executive Director (TD) noted the ongoing work to develop the Trust's whistleblowing policy and suggested that consideration should be given to the links and interaction between the role of the Freedom to Speak Up Guardian and the whistleblowing policy. **Action:** Consideration to be given to the interaction between the role of the Freedom to Speak Up Guardian and the whistleblowing policy.	**Director of Workforce**
2017-18 (28)	**Guardian for safe working hours annual report** The Executive Medical Director declared a conflict of interest in presenting the report to the Board and advised that she was not in a position to take any questions in relation to its content. She explained that the role of guardian for safe working hours had been introduced as part of the 2016 junior doctors' contract as an assurance that the protections included in the contract regarding working hours and training would be honoured in practice. The Trust's Guardian for Safe Working Hours had resigned from the role in June 2017 and a new appointment to the post was expected to be made in September 2017. The Executive Medical Director provided a brief overview of the background and context to the report and drew Board members attention to the annual data summary. The Trust Chair thanked the outgoing Guardian for Safe Working Hours for the report and, on behalf of the Board, expressed support for the work across the Trust. **Outcome:** The report and activity to date was noted.	
2017-18 (29)	**Digital strategy** The Executive Director of Finance and Resources presented the strategy report which provided an overview of the key information management, technology and capabilities and infrastructure required by the Trust in the timeframe 2016-2020. A Non-Executive Director (BC) advised that the paper had been considered in detail by the Business Committee. The strategy met the Trust's immediate needs and priorities linking to the Trust's strategy and progress against the strategy would be reviewed by the Business Committee on a six monthly basis from November 2017. The Business Committee recommended that the Board approve the strategy. The Board discussed the degree to which the strategy fully met future aspirations and recognised that the Trust would need to continue to consider innovative approaches; including working with partner organisations. In reply to a question from Non-Executive Director (RG), it was confirmed that the Executive Director of Nursing had been assigned as the Trust's Chief Clinical Information Officer.	

	Outcome: The Board approved the digital strategy 2016-2020.	
2017-18 (30)	**Research and development strategy: implementation update** The Executive Medical Director presented the paper which reported on the progress of the research and development strategy (2015-2018) implementation plan from November 2016 to June 2017. The Executive Medical Director advised that after an initial period of significant change both locally and nationally, which had slowed momentum and anticipated progress, work was now progressing well. The Chief Executive said that more work should be done to raise the profile of the research work undertaken by the Trust. . **Outcome:** The Board noted the report.	
2017-18 (31)	**Leeds Health and Social Care Academy** The Director of Workforce presented the paper which provided an update on the progress made to develop the concept of the Leeds Health and Social Care Academy. The Director of Workforce noted that, in June 2017, the full Local Academic Health Partnership Board (LAHP) Board had agreed to progress to the next stage of developing a city-wide academy to support learning and development for all NHS and social care staff. The host organisation in the initial stage was to be Leeds Teaching Hospitals NHS Trust (LTHT), and a transition team was being established. The next step thereafter would be the establishment of a project board, of which the Trust would be a member **Outcome:** The Board noted the update report.	
2017-18 (32)	**Medical director's report: medical revalidation** The Executive Medical Director introduced the report which was a requirement for revalidation of doctors and provided assurance to the Board on the appraisal process. The report covered the period 1 April 2016 to 31 March 2017. The report followed the guidance: *Framework of Quality Assurance for Responsible Officers and Revalidation, June 2015.* The Board was asked to approve the statement of compliance which had been considered by the Quality Committee. **Outcome:** The Board approved the Executive Medical Director's report, noted the requirements by NHS England for inclusion in the statement of compliance and approved the sign off of the statement of compliance.	
2017-18 (33)	**Nurse revalidation** The Executive Director of Nursing introduced the report which provided an overview of the first full year since the introduction of nurse revalidation as a mandatory requirement in April 2016. The information covered the year from 1 July 2016 to 30 June 2017. The first quarter of 2016 had been covered in a report to the Trust Board in October 2016. Informal feedback from nurses employed by the Trust had been that the revalidation process had been a straightforward process.	

	It was noted that two individuals employed by the Trust had failed to comply with the requirement but the systems in place appeared to be effective in that there was an early and timely alert to notify the Trust. **Outcome:** The report was welcomed and noted.	
2017-18 (34)	**Significant risks and risk assurance report** The Chief Executive presented the report which comprised: • The summary report which provided the Board with information about risks scoring 15 or above, after the application of controls and mitigation measures. It also provided a description of any risk movement of risks scoring 12 (high risks) since the last register report was received in May 2017. • The board assurance framework (BAF) summary report which gave an indication of the current assurance level for each strategic risk. The Board noted there were three risks with a current score of 15 (extreme) or above relating to: • reduction in funding for neighbourhood teams as a result of community intermediate care beds re-tender • reduced level of care due to the prevalence of staff sickness in particular services and/or across the Trust • difficulties recruiting to and retaining staff within neighbourhood teams The Board discussed the new extreme risk related to a reduction in funding for neighbourhood teams as a result of the community intermediate care beds re-tender. The Executive Director of Operations provided further information about the risk and the financial implications involved. **Outcome:** The Board noted the revisions to the risk register and the current assurance levels provided by the BAF summary.	
2017-18 (35)	**Corporate governance update** The Chief Executive presented the report which covered: • a new appointment to the Board of Directors • updated membership of the Board sub-committees • updated committees' terms of reference: Nominations and Remuneration Committee. **Outcome:** The Board received the report and: • noted changes to the non-executive membership of the Board • noted membership of Board sub-committees • approved changes to the terms of reference of the Nominations and Remuneration Committee.	
2017-18 (36)	**Board work plan** The Chief Executive presented the Board work plan (public business) for information and noted that the work plan would be revised, as and when required, in line with outcomes from the Board meetings. **Outcome**: The Board noted the work plan.	

2017-18 (37)	**Approved minutes of Board committees** The Board noted the following final approved committee meeting minutes and reports presented for information. a. Audit Committee: 28 April and 26 May 2017 b. Quality Committee: 24 April, 22 May and 26 June 2017 c. Business Committee: 26 April, 24 May and 28 June 2017 e. Leeds Safeguarding Adult Board minutes: 21 February and 19 April 2017 d. Leeds Health and Wellbeing Board minutes: 20 April 2017	
2017-18 (38)	**Close of the public section of the Board** The Trust Chair thanked everyone for attending and concluded the public section of the Board meeting.	
Date and time of next meeting **Friday 6 October 2017, 9.00am – 12 noon.** **Boardroom, Trust Headquarter, Stockdale House, Victoria Road, Leeds LS6 1PF**		

Signed by the Trust Chair: Neil Franklin
Date: 6 October 2017

AGENDA ITEM 2017-18 (43b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) actions' log: 6 October 2017

Agenda Number	Action Agreed	Lead	Timescale	Status
4 August 2017				
2017-18 (23)	**Chief Executive's report:** most recent version of the Leeds Health and Care Plan to be shared with NEDs.	Company Secretary	September 2017	Completed
2017-18 (23)	**Chief Executive's report:** winter planning funding to be raised at Board to Board on 8 August 2017.	Executive Director of Finance and Resources	August 2017	Completed
2017-18 (24)	**Performance brief and domain reports:** well-led domain – reporting on staff compliance with safeguarding training to be reviewed for inclusion with statutory and mandatory training reporting to the Quality Committee, Business Committee and Board.	Director of Workforce	September 2017	Completed
2017-18 (26)	**Safe staffing report:** data related to FFT response rates and FFT care recommendation to be reconciled and reported to Quality Committee.	Executive Director of Nursing	October 2017	
2017-18 (27)	**Freedom to speak up annual report:** consideration to be given to the interaction/links between the role of the Freedom to Speak Up Guardian and the whistleblowing policy.	Director of Workforce	October 2017	

Key		
Total actions on action log	**5**	
Total actions on log completed since last Board meeting: 4 August 2017	**3**	
Total actions not due for completion before 6 October 2017; progressing to timescale	**2**	
Total actions not due for completion before 6 October 2017; agreed timescales and/or requirements are at risk or have been delayed	**0**	
Total actions outstanding as at 6 October 2017; not having met agreed timescales and/or requirements	**0**	

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (43ci)

Report to: Trust Board 6 October 2017
Report title: Quality Committee 25 September 2017: Committee's Chair assurance report
Responsible Director: Chair of Quality Committee **Report author:** Executive Director of Nursing
Previously considered by: Not applicable

Purpose of the report
This paper identifies the key issues for the Board from the Quality Committee held on 25 September 2017 and indicates the level of assurance based on the evidence received by the Committee where applicable.

Service spotlight: Integrated service for children with additional needs (ICAN)
The Committee received a presentation from the ICAN service and heard about the wide range of services provided to children and families with physical disability and/or learning difficulties. The service had instigated a number of quality improvements, including: an enhanced triage service with all referrals triaged within two days, introduction of multi-agency rapid access clinics and sharing of lessons learnt from serious incidents. The service was well-regarded; with families giving the service a recommendation of care rating of over 97%. The service was not without challenge and was encountering an increase in and greater complexity of referrals, the impact of which was particularly felt in complex communication assessments and neuro-disability care where staffing and sickness issues reduced capacity to meet demand.

Director of Nursing (DoN) and quality governance report
Incident reporting
The Committee discussed the need to continue to focus effort on incident reporting and noted that whilst the Trust continues to make progress in relation to reducing the incidence of avoidable pressure ulcers and falls, recent review meetings had highlighted some repeating areas of concern. During October to December 2017, the Trust will run focused months on falls prevention, reducing avoidable pressure ulcers and reducing medication incidents. This will reiterate learning, good practice and key messages.

Assurance level							
Substantial		**Reasonable**	X	**Limited**		**No**	

Pressure ulcers
As noted in the performance brief, during August 2017 there had been four avoidable category 3 pressure ulcers and one avoidable category 4 pressure ulcer. The total number of all pressure ulcers reported in August 2017 was 61. This is the highest number reported by month since the end of 2016. Category 2 ulcers accounted for 51% of the overall total. During August 2017, two pressure ulcers occurred in the Trust's inpatient services; one was a category 2 ulcer (CICU) and one was an unavoidable unstageable ulcer (SLIC). The need to sustain significant systematic effort on pressure ulcer avoidance and management was reinforced as the Committee felt that the greater incidence of pressure ulcers in August 2017 needed to be addressed to avoid emergence of a continuing trend.

Assurance level							
Substantial		**Reasonable**	X	**Limited**		**No**	

Outcome measures

The Committee received a progress report on clinical outcome measures and particularly noted the five services for which the commissioners seek progress with reporting on clinical outcome measures. These services are: ICAN, musculo-skeletal services, neighbourhood teams, podiatry and cardiac services. In addition, there is work to identify and target the outcome measures most widely used by services. The Committee welcomed the deployment of additional resource to rolling out outcome measures but asked that the Committee be further assured as to how the Trust's initiative (largely relating to patient-reported outcomes) related to the national outcomes framework (incorporating a wider range of outcomes for example including mortality).

Assurance level							
Substantial		**Reasonable**	X	**Limited**		**No**	

Whistleblowing incident

Periodically, the Committee receives reports on any incidents raised under the auspices of the Trust's whistleblowing policy. A recent incident was reported to the Committee. The anonymised report indicated that the matter had been thoroughly investigated in line with the policy and the Committee took substantial assurance that due process had been followed and an operational decision had been taken in relation to the level of tolerable risk.

Assurance level							
Substantial	X	**Reasonable**		**Limited**		**No**	

Care Quality Commission: inspection report

The Committee received a report arising from the inspection of the Trust in January 2017; the inspection had resulted in an overall rating of 'good' for the Trust's services. The future challenge being to sustain or improve upon the rating of 'good' for the constituent services rated as 'good' and to attain a rating of 'good' for the smaller number of constituent services requiring a degree of improvement. The Committee noted proposals for monitoring and reporting involving the Committee which would begin with receipt of a quality improvement plan in October 2017. The Committee also agreed the proposal whereby the Quality and Business Committees would consider and maintain oversight of compliance with the new key lines of enquiry developed by the CQC. The Committee gained reasonable assurance on the process in relation to carrying forward the inspection outcomes.

Assurance level							
Substantial		**Reasonable**	X	**Limited**		**No**	

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (43cii)

Report to: Trust Board 6 October 2017

Report title: Business Committee 27 September 2017: Committee's Chair assurance report

Responsible director: Chair of Business Committee
Report author: Executive Director of Finance and Resources

Previously considered by: Not applicable

Purpose of the report
This paper identifies the key issues for the Board from the Business Committee 27 September 2017 and indicates the level of assurance based on the evidence received by the committee.

In depth service focus: Improving Access to Psychological Therapies Service (IAPT)
A presentation was made by the service; a consortium of the Trust and three third sector organisations which provides psychological interventions for common mental health problems. The Committee heard about the challenges presented by the access and waiting times' targets and the achievements in relation to the recovery rate target whereby the 50% recovery rate for those completing treatment had been exceeded over the past two quarters. The Committee noted the recruitment and retention challenges and particularly amongst step 2 therapists (psychological wellbeing practitioners). The Committee heard about current commissioning and contractual discussions and noted: discussion about the level of resource committed to frontline clinical staff and the requirement to operate shadow 'payment by results' from 2018/19. It was a very useful and broad ranging discussion and raised some important questions, challenges and clarifications.

Children's strategy
The Committee welcomed a first draft strategy for children's services; the aim being to ensure that this would fit with the overarching Leeds children's and young people's plan. Committee members indicated a number of suggestions to be included in a subsequent draft, relating to: the wider external context, commissioners' priorities, options for partnership working, a greater child and family-centric focus, innovation and digital developments. The Committee would also be keen to see articulation of key changes (over the life of the strategy) and an implementation plan. Further development would be incorporated in a subsequent draft prior to receipt by the Board; the core of the document was also intended to be shared at a children's service celebratory event in December 2017.

Community child and adolescent mental health services
The Committee was updated on the waiting times challenges within this service and actions to understand and manage referrals and the onward impact that the volume and complexity of referrals had on waiting times and activity. A focus on consistent assessment and allocation processes was felt to be essential to maximising productivity to meet demand.

Operational plan 2017/18: in year progress report
The Committee received a report recording progress with corporate objectives and debated those items rated as 'amber' ie where progress had been delayed or achievement was at risk, namely: e-rostering project, waiting times in a minority of children's services, service resilience within neighbourhood teams, recruitment in neighbourhood teams and a shift towards strengths based new models of care. The Committee asked that the amber rating for e-rostering be reviewed and invited further individual comments on the detail to be provided.

Assurance level							
Substantial		**Reasonable**	X	**Limited**		**No**	

Key projects
The Committee received progress reports on the Trust's three key projects (electronic patient record, e-rostering and review of patient administration).

E-Rostering
The Committee received an update on the roll out of e-rostering and noted its concerns around this programme and particularly the continuing delays in meeting the project milestones. Urgent follow up actions were discussed including ongoing discussions with the system supplier.

Assurance level							
Substantial		**Reasonable**		**Limited**	**X**	**No**	

Patient administration
The Committee was briefed on the commencement of the review of patient administration services across the Trust with the aim of providing a modern and consistent service that made best use of digital approaches. The project initiation document was to be circulated in readiness for a further look at the project in November 2017.

Assurance level							
Substantial		**Reasonable**	**X**	**Limited**		**No**	

Performance report
Areas of satisfactory performance and some improvements across areas of previous challenge were noted.

Activity Levels
Whilst the Trust generally continues to perform well in respect of its responsive indicators, there continues to be a variance from activity profile (-10.9% August 2017) which is rated as red for August 2017 (activity for the year to date is 7.2% below profile and is rated amber). Pending further investigation the Committee drew only limited assurance.

Assurance level							
Substantial		**Reasonable**		**Limited**	**X**	**No**	

Patient experience: friends and family test response rates
There is further deterioration in the response rates (inpatients 12.6% and community 5.2%) and both indicators are rated as red. Inclusion of further explanation in future reports was sought.

Assurance level							
Substantial		**Reasonable**		**Limited**	**X**	**No**	

Workforce
Staff turnover (15.1%), staff stability index (83.8%), staff appraisals rate (85%) and statutory and mandatory training (91.5%) remain below target.

Assurance level							
Substantial		**Reasonable**		**Limited**	**X**	**No**	

Finance
In the fifth month of the year, the Trust is meeting its financial targets for most of the indicators with the exception of cost improvement plan delivery and the Committee took reasonable assurance from the finance report.

Assurance level							
Substantial		**Reasonable**	**X**	**Limited**		**No**	

NHS
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Leeds Community Healthcare NHS Trust
Annual General Meeting – 2016

AGENDA ITEM 2017-18 (43d)

Thackray Medical Museum, Beckett Street, Leeds LS9 7LN

Thursday 14 September 2017, 2.00pm – 3.30pm

Present:	Neil Franklin	Trust Board Chair
	Thea Stein	Chief Executive
	Professor Ian Lewis	Non-Executive Director
	Dr Tony Dearden	Non-Executive Director
	Bryan Machin	Executive Director of Finance and Resources
	Sam Prince	Executive Director of Operations
	Dr Amanda Thomas	Executive Medical Director
	Marcia Perry	Executive Director of Nursing
Apologies:	Brodie Clark	Non-Executive Director
	Richard Gladman	Non-Executive Director
	Jane Madeley	Non-Executive Director
	Sue Ellis	Director of Workforce
In attendance:	Vanessa Manning	Company Secretary
Minutes:	Liz Thornton	Board Administrator
Observers and members of the public:	75 members of staff and members of public attended	

Item	Discussion item
1.	**Welcome and introductions** The Chair welcomed everyone to the Trust's 2016/17 Annual General Meeting on behalf of the Board of directors. The Chair said that the Trust's vision was to provide the best possible care to everyone across the community in Leeds. He emphasised that this vision remained firmly in sight despite the financial challenges and the immense changes taking place within the NHS. The Chair said that 2016/17 had been a very challenging year for the NHS generally and particularly for the Trust. He said he was immensely proud of the staff and their achievements and he wished to take the opportunity to thank all staff for their dedication and commitment to providing high quality compassionate care to the people of Leeds, through one of the most difficult winters the city had faced.

	The Chair said he was pleased to report that, as a result of an inspection by the CQC in January 2017 the overall Trust rating had been upgraded from 'Requires Improvement' to 'Good'. He said this would not have been possible without the hard work and dedication of both clinical and corporate colleagues and their relentless focus on quality, during a time of unprecedented demand. The Chair briefly outlined the format for the formal part of the meeting. The Chief Executive would present a review of the 2016/17 year and the Executive Director of Finance and Resources would present the Trust's 2016/17 annual accounts. A number of the Trust's Executive and Non-Executive Directors were present and there would be an opportunity for questions at the end of these presentations. The Chair advised that, as the Annual General Meeting was a formal meeting of the Leeds Community Healthcare NHS Trust Board, it would minuted in the same way as all Board meetings, the minutes would be published on the Trust's website in the papers for the Board meeting on 6 October 2017. The Chair said that following the end of the formal session representatives of the adult, children's and specialist services would be showcasing some of the innovative work they were involved in across the city.
2.	**Chief Executive's presentation – reviewing the year 2016/17** The Chief Executive presented a review of the previous 12 months. She said that she particularly welcomed this opportunity to reflect on the past year and to recall her aspirations when she had joined the Trust three years ago as Chief Executive; when she had welcomed the opportunity to be part of an organisation which had a clear vision and was used every day to guide the Trust. During the last year, the Trust had focused on what was called 'our 11'; one vision, three values and seven magnificent behaviours. The Chief Executive said that at staff induction meetings every month she spoke about how everyone should find a way to connect to the vision and values to help them understand that these values and behaviours were at the heart of how the Trust delivered care. The Chief Executive said there were many highlights she wanted to speak about and focused on some of the Trust's significant achievements over the past year. The Chief Executive said she and other Board members were impressed by the feedback from the Care Quality Commission about the outstanding compassionate care provided by the Trust. The Chief Executive referred to the UNICEF mark of outstanding care for babies received by the health visiting service; the excellent work undertaken to improve waiting times for first assessments by the child and adolescent mental health service (CAMHS) and the innovative work in the neighbourhood teams which was being considered as best practice by other organisations. She expressed her thanks to all community staff and their managers for the resilient manner in which they had faced the challenges during the winter period. This year the Trust had been nominated for a number of Health Service Journal (HSJ) awards including; two nominations in the clinical leader of the year category and two nominations for compassionate care.

	The Chief Executive said that she was proud of the work that the Trust had undertaken as a partner with other organisations across the city including Leeds Teaching Hospitals NHS Trust, Leeds and York Partnership NHS Foundation Trust, the Council and the third sector. In conclusion, the Chief Executive said that 2016/17 had been an exciting year and she looked forward to even greater progress in 2017/18. The Chair thanked the Chief Executive for her report.
3.	**Executive Director of Finance and Resources** **Presentation of annual report and accounts 2016/17** The Executive Director of Finance and Resources provided a presentation and overview of the Trust's annual report and accounts for 2016/17. The Executive Director of Finance and Resources was pleased to report that although the national financial position in the NHS had been placed under considerable pressure, the Trust had maintained financial stability and had met all its key financial duties. The Trust had achieved a surplus of income over expenditure of £3,346,000 in 2016/17, exceeding the income and expenditure surplus target set by NHS Improvement by £0.49 million. The Executive Director of Finance and Resources said that the Trust's financial results were only achieved through the hard work of all the staff in the Trust and the support of commissioners and other partners. Early in the financial year, the Trust had had to make some difficult decisions to achieve the £2.9 million surplus of income over expenditure target agreed with NHS Improvement. He reported that, in June 2016 additional controls were introduced on the use of agency staff and overtime, recruiting staff and restrictions on spending on goods and services that did not directly impact on patient care. The early identification of the risk of not achieving the financial target, the quick action to correct the position and the co-operation of managers and staff across the Trust meant that the Trust had improved its financial position by the end of the financial year. The Executive Director of Finance and Resources observed that 2017/18 would be another challenging year financially for the NHS but the Trust was determined to retain good financial health in order to focus on the delivery of quality of care. The Chair thanked the Executive Director of Finance and Resources for his presentation.
4.	**Question and answer session** The Chair opened this section of the meeting by inviting questions and comments. He said that Trust Board members were in attendance and would assist in answering questions. A member of the audience asked about the Trust's approach to procurement. The Executive Director of Finance and Resources explained that as a provider of services the Trust did not issue a significant number of invitations to tender for contracts. Where it was necessary to buy goods and services the Trust was subject to EU public procurement rules which govern the way goods, services and works were purchased. He went on to explain that for small contracts the usual practice was to seek three competitive quotations. Larger high value tenders were advertised publically and bids were assessed on price and quality.

	A member of the Trust said that in the past he had been offered opportunities to actively engage with the Trust in answering surveys, completing questionnaires and reviewing publications, however, over recent months, the number of requests for involvement from members had significantly reduced. The Chief Executive said that the Trust was committed to genuine and meaningful involvement of patients, carers and the public and she agreed that listening and responding to members was an essential part of shaping how the Trust's services were provided and developed. She said that a recent appointment to support activities during 2017/18 would re-new the focus on this important area. A member of the audience asked how the Trust was working proactively with other organisations across the city to improve care for the people of Leeds. The Chief Executive said that the Trust was an active healthcare partner within the West Yorkshire and Harrogate area and was working within the scope of the Leeds Health and Care Plan to set out a vision and direction of travel for services over the next five years. She explained that this involved working with GPs, social care, the third sector and other NHS providers across the city which would see services working in a more integrated way. No further questions were raised and the Chair closed this section of the meeting.
5.	**Close of the 2016/17 Annual General Meeting** The Chair thanked everyone for attending and closed the formal part of the meeting and introduced a series of presentations which formed the next part of the meeting.
6.	**Partnership with primary care – Dr Andy Sixsmith GP partner** Dr Sixsmith, spoke about his role as Chair of the Armley Community Wellbeing Leadership Team which had been established with the aim of bringing together different providers within the local area, building relationships between the professional teams who care for people within the community and allowing easier access for patients to the care and support they needed. He explained that the people who worked in individual localities understood the specific needs and challenges faced by their population and were best placed to play a leading role in shaping how services were provided in the future. Dr Sixsmith said that Armley was the first group to be set up, in March 2016 with other locality groups then following in late 2016 and early 2017. He said there were now five community wellbeing programmes established and each had a community wellbeing leadership team made up of GPs, practice nurses, community nursing (Leeds Community Healthcare NHS Trust), adult social care (Leeds City Council) and mental health teams (Leeds and York Partnership NHS Foundation Trust), as well as representatives from voluntary sector organisations active in those communities. Together they had established key priorities and were building relationships between teams within their localities. The Chief Executive thanked Dr Sixsmith for his presentation.
7.	**Partnership and innovation - presentations from adult, children's and specialist services** • *Adult business unit* Colleagues from the adult business unit presented information on end of life care; the introduction of electronic patient records and the Live Well Leeds project.

	• *Children's business unit* Colleagues from the children's business unit presented information on the latest digital developments including the 'baby buddy app' designed as a guide through pregnancy and the first six months of a baby's life. • *Specialist business unit* Colleagues from the nutrition and dietetic service presented information and a short video on the oral nutrition passport which had been designed to manage stable dietetic patients on oral nutrition supplements. Colleagues from the community intravenous antibiotic service (CIVAS) presented information including a short video on the work the CIVAS team do to support early discharge for patients who need an extended course of intravenous antibiotic therapy. The Chief Executive thanked the teams for their excellent presentations which showcased some of the innovative projects staff were working on to enhance the care and support the Trust was able to offer to people across the city of Leeds.
	Date, time and venue of the Leeds Community Healthcare NHS Trust 2017/18 Annual General Meeting: **To be confirmed**

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AGENDA ITEM 2017-18 (44)

Meeting: Trust Board 6 October 2017	**Category of paper**	
Report title: Chief Executive's report	**For approval**	
Responsible director: Chief Executive **Report author:** Chief Executive	**For assurance**	√
Previously considered by Not applicable	**For information**	

Purpose of the report

This report sets out the context in which the Trust works and helps to frame the Board's consideration of the Board meeting's papers.

Main issues for consideration

On this occasion, the report focuses on a number of local and national developments some of which are covered in more depth in later items. The main features of the report are:

- Care Quality Commission inspection outcome
- Community care beds
- Frailty unit
- Seasonal resilience: planning for winter
- Flu vaccination campaign
- Planning for emergency situations
- Staff health and wellbeing
- Celebrations: awards, annual general meeting and staff conferences
- Leeds health and social care developments
- The Trust's overall performance

A further verbal update will be provided at the Board meeting.

Recommendation

The Board is recommended to:

- Note the contents of this report

Chief Executive's report

1 Purpose of this report

1.1 This report sets out the context in which the Trust works and helps frame the Board papers. The paper describes a number of local developments and, in addition, refers to a small number of external or national announcements that have the potential to impact on the Trust.

2 Care Quality Commission: inspections of services

2.1 'Good' news for all!

2.2 During the week commencing 30 January 2017, the Trust was inspected by the Care Quality Commission (CQC). In addition to a range of interviews and focus groups involving directors, service leads and a wide cross section of staff, the inspectors reviewed:

- Adult inpatient units: Community Intermediate Care Unit, South Leeds Independence Centre and the Community Rehabilitation Unit
- Adult community services: neighbourhood teams and some specialist services across eight health centres
- Children's community nursing inpatient unit: Hannah House
- Child and adolescent mental health services inpatient unit: Little Woodhouse Hall
- Specialist services: sexual health services
- Trust-wide review of well-led domain

2.3 The formal feedback and report on the inspections were received on 29 August 2017 and the Trust was delighted to learn that the inspection had resulted in an overall rating of the Trust as 'good'. This is excellent news and reflects the commitment and hard work of all staff to provide the highest standards of care to the people of Leeds.

2.4 A fuller report appears as a separate agenda item; the CQC paper celebrates success and areas of outstandingly good practice but also indicates that the Trust has some important work to undertake in certain services to ensure that the quality and safety of care is of a comparable high standard across all areas.

3 Community care beds

3.1 Over recent months, a competitive tendering exercise has been underway whereby bids were sought to run inpatient community care bed services for Leeds. The tender, led by Leeds South and East Clinical Commissioning Group, on behalf of the city, followed a comprehensive review of existing community intermediate care inpatient services that included South Leeds Independence Centre (SLIC) and the Community Intermediate Care Unit (CICU – J31).

3.2 The Trust led an alliance bid (Leeds Community Bed Alliance) with Leeds City Council and Leeds Teaching Hospitals NHS Trust and was successful in winning 72 of the 190 available beds. The bed bases hosting community care beds will be 40 beds at South Leeds Independence Centre (renamed Recovery Hub @ South Leeds) and 32 beds at Suffolk Court (renamed Recovery Hub @ North West Leeds). A further 12 beds have been awarded at Pennington Court and these will be subcontracted via the alliance initially on a temporary six months basis.

3.3 This makes the Leeds Community Bed Alliance the biggest provider of community care beds in the city. The Trust is pleased to be able to enhance the existing relationship with the local authority, building on work already started with the integrated neighbourhood teams.

3.4 The Trust will be playing to its strengths, bringing health and social care expertise together to provide a range of holistic services that aim to promote independence in people between hospital and home. Beds will be used flexibly between intermediate care and discharge to assess dependent on need. There will be a key focus on recovery, rehabilitation and re-ablement.

3.5 The service goes live on 1 November 2017.

4 Frailty unit at St James' Hospital

4.1 A Leeds frailty unit was trialled at St James's University Hospital's accident and emergency department in August 2017.

4.2 Following initial triage within the department, every medical patient over 80, plus any patient between 70 and 80 years old with frailty needs who would benefit from an alternative to hospital admission, was triaged to the frailty unit.

4.3 The initiative was jointly-led by Leeds Community Healthcare NHS Trust, Leeds Teaching Hospitals NHS Trust, Yorkshire Ambulance Service NHS Trust, the Leeds Clinical Commissioning Groups (CCGs) as part of their 'One Voice' approach and Leeds City Council.

4.4 The trial is the latest example of collaborative working between trusts ahead of the winter period and aims to help elderly patients remain in their normal place of residence by providing timely clinical intervention and avoid unnecessary overnight stays in hospital. The pilot was devised to test the concept of a frailty unit to gain a greater understanding of how the unit may impact upon winter pressures and the management of frail, elderly patients.

5 Seasonal resilience: planning for winter

5.1 The Trust and the wider health and social care system is well-advance in preparing for the service pressures that will be encountered through the winter months.

5.2 A local delivery plan has already been drawn up. The plan comprises some nationally mandated components and local priorities and covers approaches to:

- A&E streaming and interface with other providers
- Management of patient flow including hospital discharge provisions
- Community capacity including referral management and capacity in neighbourhood teams and community beds
- Mental health services
- 111: greater clinical involvement in the assessment of patients
- GP access and extended hours and other primary care provider services
- Care homes: access to clinical advice for care homes
- Public health including health promotion and the prevention of infection
- Communications, escalation procedures and achieving mutual aid

5.3 Internal work includes:

- Ensuring the referral pathway (particularly from hospital to neighbourhood teams) is as efficient as it can be and does not add any unnecessary delay to a patient's access to the service
- Mobilisation of the health case management service from 9 October 2017
- Further work on the trusted assessor model
- Several schemes to increase capacity in the neighbourhood teams, including: use of bank and agency staffing; development of a self-care team to support early discharge; contracts for pharmacy technicians etc

5.4 The internal winter plan is overseen by a fortnightly steering group and progress discussed with SMT on a monthly basis.

6 Flu' vaccination campaign

6.1 The Trust has launched its seasonal flu campaign as part of the Trust's approach to planning for additional service pressures this winter.

6.2 Year on year, the Trust wishes to see more frontline staff vaccinated to help protect staff, families, communities and vulnerable patients. Last year, the Trust achieved 76.6% uptake; in excess of the 75% national target and the highest figure of any community trust.

6.2 This year's campaign started with a drop-in day on 29 September 2017, Thereafter, there is a programme of three vaccination 'clinics' on each of 25 days between 2 October 2017 and 3 November 2017. This represents a huge effort by the Trust's infection prevention and control team to keep everyone safe and well this winter.

7 Emergency planning exercises

7.1 At the last Board meeting, the Board heard about the Trust's continuing drive to ensure the security of all its electronic-based information systems including a cyber security exercise to test the resilience of the Trust's systems. The exercise was designed to test the resilience of the neighbourhood teams in the event of the loss of multiple systems and to provide a rehearsal opportunity in place of a real incident.

7.2 The Senior Management Team has also undertaken an exercise to test access to business systems 'out of hours'.

7.3 In addition, a further exercise was undertaken in August 2017 based on a scenario whereby there was no access to Trust headquarters.

7.4 Each of these three exercises has been instructional in terms of identifying refinements to Trust-wide and local business continuity plans. The Emergency Planning Manager and line managers are working to ensure lessons learnt are incorporated into response plans.

8 Health and well-being

8.1 At previous meetings, the Board has discussed the fact that, at the heart of the Trust's work to recruit and retain talented staff, is a range of initiatives linked to the health and well-being of the workforce. Staff who are physically healthy, mentally well and well supported at work provide the best care.

8.2 The staff survey results in 2016 showed that the Trust has more to do in this respect. To fully understand matters, the Trust has listened to staff, talked to staff side representatives, asked the '50 Voices' groups and asked all leaders for feedback; the Trust is continually working on making changes to make the Trust the employer that provides the working lives staff want.

8.3 The Trust has launched a 'Feel Good' pledge:

'We will have a working environment that supports our physical and mental health and well-being'

8.4 The latest edition of Community Health Matters, the Trust's newsletter, has provided signposting advice to the range of services available to support staff with physical and emotional wellbeing. Also, for those who came forward with suggestions for improving the working environment, the Trust is well on the way to fulfilling the majority of these requests.

8.5 The Trust will use the results of the staff survey again this year, continual conversations and other feedback mechanisms to check how the Trust is doing against this pledge.

9 Staff success: national awards

9.1 The Trust continues to receive external acknowledgement in respect of its many excellent services.

9.2 On this occasion, the Board should note that the Trust's had been successful in being shortlisted for the national Health Service Journal awards:

- In the Compassionate Patient Care category, two shortlisted entries for An Integrated Neighbourhood Team Approach to Improving Palliative Care for Patients and Carers and Outstanding Breast Feeding Standards
- Cardiac Service Clinical Lead and Consultant Clinical Psychologist are both shortlisted in the Clinical Leader of the Year category
- the Leeds Health and Care System is shortlisted in the Improved Partnerships between Health and Local Government category for Using a Health Coaching Approach across the Leeds Health and Care System

9.3 In terms of next steps, presentations by the nominees are to be made during October 2017 and then the awards are announced at a national awards ceremony in London on 22 November 2017.

10 Celebrating at the annual general meeting

10.1 It was pleasing to hear so much good news at the Trust's annual general meeting (Thursday 14 September 2017) hosted by the Trust's Chair, Neil Franklin. Over 80 attendees (comprising Board members, managers, staff and members of the public) heard that:

- the Trust's services had been rated 'good' by the CQC and that inspectors had talked about 'outstanding compassionate care'
- health visiting had received the UNICEF 'baby friendly initiative' mark of 'outstanding care for babies'
- there were countless examples of staff 'going the extra mile' to provide excellent care amidst significant service pressures and, in doing so, demonstrating the Trust's vision, values and behaviours in action
- the Trust had achieved all its financial targets and achieved excellent performance across a whole range of national and local performance indicators

10.2 The annual general meeting was an inclusive affair this year and attendees heard presentations from:

- Thea Stein, Chief Executive
- Bryan Machin, Executive Director of Finance and Resources
- Andy Sixsmith, General Practitioner
- Sarah McDermott, Fiona Allport and Mary Tyrell Place from adult services
- Shelley Robson and Benita Powrie looking at digital developments in children's services
- Mark Simpson, David Magson and Simone Beedle - oral nutrition passport

- Lee Maloney and Charlotte Ward described a day in the life of the community intravenous antibiotics service

11 Conferences for staff

11.1 The Trust is proud to sponsor three conferences for staff, these are:

- ***Let's integrate – the five year forward view! 5 October 2017:*** a Leeds practice nurse and community nurse combined conference which will include:
    - How we're integrating in Leeds
    - Identifying priorities in population health management
    - A shared approach to wound care management
    - Coordinating supported self-care: diabetes
    - Shared learning from excellence
    - Community and practice nurse networking
    - The Trust's first ever nursing awards
- ***Next steps conference 2 November 2017:*** a conference for all non-registered staff to recognise the contribution made by this group of staff; on the day there will be the opportunity to:
    - Hear inspirational stories from individuals who began their careers in non-registered roles and have gone on to more senior positions both inside and outside of the Trust
    - Hear from service users about the difference the non-registered workforce make to their lives on a daily basis
    - Discuss ideas with like-minded people and inspire each other
- ***Medical and dental conference 6 November 2017:*** this annual conference will cover:
    - New models of care
    - Medical and dental leadership
    - PReP for dental appraisals
    - European Data Protection Directive
    - Resilience – an interactive session

12 Associated teaching trust agreement

12.1 An important agreement has been signed between the Trust and the University of Leeds' School of Medicine.

12.2 The agreement enables the Trust to continue to provide placements for medical students over the course of the next five years in a number of key specialties, for example: paediatrics, gynaecology and sexual health.

12.3 The arrangement marks the strong relationship between the two organisations and the joint commitment to education and learning as the foundation for providing the best possible care in community settings.

13 Health and social care organisations: working together

13.1 Representatives of the Board continue to forge strong partnerships across the city in pursuit of the ambition to be 'the best city for health and wellbeing'.

13.2 In September 2017, Board members met with colleagues from the other NHS trusts in Leeds, the City Council, clinical commissioning groups, Healthwatch, third sector bodies and regional partners to address a number of common issues. Working together in this manner provided an opportunity for partners to come together to share progress around key system priorities, ensuring that there is a focus on the short-term whilst also maintaining focus on the long-term vision set out in the Leeds Health and Wellbeing Strategy.

13.3 The 'board to board' meeting discussed:

- ***Leeds Local Delivery Plan (winter 2017/18)***: whilst there is a national focus on the resilience of local health and care systems, partners in Leeds are sponsoring a number of initiatives, including:
    - Long term condition management
    - Community capacity: neighbourhood team/practice nurse development, seven day services, action with care homes
    - Community beds procurement: additional intermediate beds capacity and transfer to assess beds
    - Acute 'front door': GP streaming in A&E, frailty unit, integrated discharge service
    - Mutual aid: align organisational triggers for escalation
    - High level system indicators, management of risk and communications
- ***Leeds Health and Care Plan:*** following discussions at the Health and Wellbeing Board on June 2017, the plan has been further refined as a basis for future financial and business planning and conversations with elected members and the public
- ***West Yorkshire and Harrogate Health and Care Partnership*** (formerly known as the sustainability and transformation partnership): the wider context for the Leeds Plan
- ***One commissioner voice:*** progress with aligned city-wide commissioning arrangements
- ***Accountable care – population health management:*** the city's vision is to develop and implement a model of accountable care. Commissioners may create the conditions for accountable care to happen at pace and scale by moving to commissioning providers to deliver population level outcomes. Commissioning for outcomes will mean that providers can work together in integrated, innovative ways to most effectively deliver the outcomes. This overall approach for both commissioning and providing accountable care is captured as population health management

14 Performance and finance overview

14.1 Despite the current sustained pressures being experienced within the NHS both nationally and locally, the Trust has continued to maintain a focus on ensuring it delivers a range of performance targets and therefore evidencing it provides safe, caring, effective, responsive and well-led services.

14.2 From a quality perspective, the following remain the main areas of focus and are covered in more detail in the performance report:

- Safe staffing 'fill rate' in inpatient units: currently 97.5% against a target of 95%
- Reducing the incidence of avoidable pressure ulcers; regrettably, after good performance in the first quarter of the year, the Trust recorded both avoidable category three and category four pressure ulcers in August 2017
- The target reduction in falls in inpatient units has been achieved in the year to August 2017
- On-going work in relation to incident reporting continues
- Work to ensure that the recording of duty of candour reporting matches the practice of staff is proving successful; 100% of applicable incidents received an appropriate apology
- Percentage of patients recommending care: is 100% for inpatient settings and 96.1% for community patients against target of 95%

14.3 The Trust continues to perform well in respect of the responsive indicators with continuing good performance against all statutory and non-statutory waiting times. There has, however, been an increase in the negative variance from profile in relation to the number of patient contacts in August 2017 (minus 10.9%); the year to date figure is minus 7.2%.

14.4 A number of workforce related indicators remain a concern, for example staff turnover (15.1%) remains high. Staff appraisal rates are below target at 85% (target 90%) and compliance with statutory and mandatory training requirements stands at 91.5%; further detail is contained in the performance report.

14.5 The finance measures remain satisfactory as at the end of August 2017, although capital expenditure and cost improvement plan delivery are behind plan. The use of resources risk rating (1) represents the lowest risk position.

15 Recommendation

15.1 The Board is recommended to:

- Note the contents of this report

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (45)

Meeting: Trust Board 6 October 2017	**Category of paper**	
Report title: Care Quality Commission (CQC) Inspection Report	**For approval**	
Responsible director: Executive Medical Director **Report author:** Executive Medical Director	**For assurance**	
Previously considered by Not applicable	**For information**	√

Purpose of the report

This paper provides a report to the Board on the Care Quality Commission (CQC) inspection findings set out in the final reports published on 29 August 2017.

Main issues for consideration

The CQC carried out an announced follow up inspection of the Trust between 31 January 2017 - 2 February 2017, assessing the leadership and governance arrangements at the Trust and inspected core services that required improvement at the last inspection. In addition, the CQC inspected Sexual Health services and Hannah House.

CQC published the final reports on its inspection of the Trust on 29 August 2017 and rated the Trust overall as '**Good**'.

This paper provides an overview to the Trust Board on the CQC inspection findings published on 29 August 2017 and a progress report on the development and delivery of the organisational response to the CQC's inspection findings and reporting requirements. The report has been considered by Quality Committee on 25 September 2017.

Recommendation

The Board is recommended to:

- Receive the information with regard to the CQC inspection and ratings published on 29 August 2017
- Approve the proposed monitoring and reporting arrangements through the SMT and Quality Committee to Board
- Agree the proposal for consideration of the CQC's new key lines of enquiry

Care Quality Commission (CQC) Inspection Report

1.0 PURPOSE OF THIS REPORT

1.1 The purpose of this paper is to provide an overview to the Trust Board on the Care quality Commission (CQC) inspection findings published on 29 August 2017 and a progress report to the Trust Board on development and delivery of a robust organisational response to the CQC's inspection findings and reporting requirements.

2.0 BACKGROUND

2.1 Previous CQC inspection 2014

2.1.1 The CQC carried out an announced inspection of the Trust 24 - 27 November 2014 to include the following core services:

- Community services for children and families (universal services and specialist community children's services) to include Hannah House
- Child and adolescent mental health wards, Little Woodhouse Hall
- Specialist community mental health services for children and young people
- Community services for adults with long-term conditions (district nursing services, specialist community long-term conditions services and community rehabilitation services)
- Services for adults requiring community inpatient services
- Community dental services
- In addition, the CQC carried out unannounced visits to twilight and child development services.

2.1.2 The Trust received an overall rating of 'Requires Improvement' in the published reports issued in March 2015.

2.1.3 The Trust strengths were: caring staff, effective and innovative practice, good incident reporting culture, and good patient feedback.

2.1.4 The Trust areas for improvement were: staffing levels, quality of records particularly risk assessments, management of falls, planning and delivery of care, waiting times, clinical supervision, governance and risk management processes, and risks associated with unsafe or unsuitable premises.

2.2 CQC Inspection 2017

2.2.1 The CQC carried out an announced follow up inspection of the Trust 31 January – 2 February 2017. In addition, there was a further unannounced inspection of Hannah House, Leeds Sexual Health Service and a visit to the single point of urgent referral (SPUR) on 15 February 2017.

2.2.2 As part of the inspection, the CQC assessed the leadership and governance arrangements at the Trust and inspected core services that required improvement at the last inspection. In addition, the CQC inspected sexual health services because of a whistle blowing concern and Hannah House due to medicines management concerns.

The CQC inspected the following services:

- Community health services for adults to include a range of specialist services;
- Community services for children, young people and families (Hannah House)
- Adult community inpatient services;
- Sexual health services
- Child and adolescent mental health wards (Little Woodhouse Hall)

2.2.3 The Trust submitted comments relating to any factual inaccuracies in the draft reports and a ratings challenge on 29 June 2017. A number of changes were accepted although some were rejected but, as a result, the changes made did impact on the ratings contained within the final report.

2.2.4 The CQC published the final reports on its inspection of Leeds Community Healthcare NHS Trust on 29 August 2017. The CQC overall rating for the Trust was '**Good**'. The individual ratings are shown in the table below.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires Improvement	Good	Good	Good	Good	Good
Community Adults	Good	Good	**Outstanding**	Good	Good	Good
Community Inpatients	Good	Good	Good	Good	Good	Good
Sexual Health	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
Little Woodhouse Hall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Hannah House	Requires Improvement	Requires Improvement	Good	Requires Improvement	Inadequate	Requires Improvement

2.2.5 The CQC found that the Trust had successfully addressed many issues which required improvement since the CQC undertook its comprehensive review in November 2014 and had found several areas of outstanding practice particularly within community health services for adults.

2.2.6 Overall the CQC found that that the Trust provides services that are caring, effective, responsive and well-led, although further improvements are still needed in the safety of some services.

2.2.7 The CQC rated Hannah House, Leeds Sexual Health Service, and Little Woodhouse Hall as Requires Improvement. Hannah House was rated at location level and not as part of the overall provider because the CQC did not inspect the whole of the community children, young people, and families' service.

3.0 Current Position

3.1.1 An action plan was developed immediately following the inspection for Hannah House and following the receipt of the draft reports for the other services. Following the published reports the action plans are being revised by the services and signed off by the Executive Director of Nursing and Executive Medical Director.

3.1.2 The services rated as ‘requires improvement’ were visited by a director and provided with verbal feedback when the reports were published.

3.1.3 Parents/carers of children and young people in Hannah House and Little Woodhouse Hall were sent letters on the date of publication to inform them of the inspection outcomes and provide them with contacts if they had questions.

3.1.4 All staff were informed by email and on the Trust’s intranet (Elsie). Stakeholders were informed by letter.

3.1.5 The CQC has advised the Trust that they no longer call a Quality Summit to present findings of the inspection reports to commissioners and stakeholders but will instead organise a meeting with members of the Trust and representatives from commissioners to discuss the report findings. The date has yet to be confirmed.

3.1.6 The Trust has been allocated a new CQC engagement team. The new team has advised that there is a new engagement process which, in addition to monitoring progress with the Trust’s CQC action plan, will also include the engagement team visiting services, observing high level meetings such as board meetings and governance meetings, holding focus groups and stakeholder engagement.

3.1.7 The CQC has published their next phase of regulation, June 2017. There is a new assessment framework for healthcare (replacing multiple healthcare provider handbooks) with revisions and additions to key lines of enquiry (KLOE)/prompts. New KLOEs relate to medicines management, end-of-life care, use of technology, response to external alerts/reviews and involvement of families and carers. In addition, the CQC has a new monitoring, inspection and ratings regime for NHS trusts which is a risk based approach. All trusts can expect to have a well-led assessment and at least one core service inspection each year (with frequency of core service inspections subject to how services were rated at the last inspection). The CQC has a new 'CQC Insight' system for data collection to include the new annual provider information requests that will enable the CQC to target inspections. The ‘CQC insight’ system and quarterly relationship management meetings will help inform the CQC's regulatory planning. This more targeted and responsive system should see previously ‘good’ or ‘outstanding’ trusts inspected less frequently.

3.1.8 The CQC set out a number of actions (requirement notices) the Trust is required to take. The Trust is required to submit a written report of the actions to the CQC by the 30 October 2017.

3.2 Trust Approach

3.2.1 The Trust intends to take a similar approach to the CQC action plan (Quality Improvement Plan, QIP) as this proved successful for monitoring and informing the Trust internally at Senior Management Team, Quality Committee and Trust Board, in addition to the CQC engagement team.

3.2.2 The QIP plan will address the CQC's Requirement Notices (must-do's and should-do's) in addition to the concerns ('could do's') flagged in the body of the reports.

3.2.3 A lead Director and lead manager is accountable for each QIP action and there is an expectation that the QIP will evidence the impact and embeddedness of improvement actions. For many actions this will be achieved by the requirement to evidence 3 consecutive 'clean' spot checks / audits. Wherever appropriate, this will be incorporated into existing audit activities e.g. environmental audit, documentation audit.

3.2.4 An internal audit of CQC compliance will be carried out in Quarter 3, 2017.

3.3 Requirement Notices

3.3.1 The tables in Appendix 1 outline the 'Requirement Notices' for each service or Trust-wide

3.4 Strengths

3.4.1 The CQC confirmed the position of the Trust in that it had made significant improvements across our services resulting in amending the Trust's overall rating from Requires Improvement to Good.

3.5 Notable achievements include:

- The CQC visited during the period of 'unprecedented challenges to capacity and patient demand' (silver command) and rated the Trust as overall **Good**, acknowledging the Trust for 'applying appropriate strategies' during this period.
- Adult services were rated overall **Outstanding** for caring and all other services were rated as **Good** for caring.
- CQC saw several areas of outstanding practice including speech and language therapy, musculoskeletal services, the project to improve patient flow and the development of pharmacy technicians which had supported staff and improved patient compliance.

- Staff are passionate about providing good care and treat patients with dignity and compassion, involve patients in their care, promote independence and self-care, meet the individual needs of patients including meeting the needs of vulnerable people, and work well together for the benefit of our patients across all disciplines.
- The Trust has a stable and cohesive leadership with accessible, visible leaders who work collectively.
- The Trust has an open and transparent culture and staff articulate the Trust's values and strategy.
- The Trust has good staff engagement and good patient feedback.
- The Trust has a stronger governance process and a 'maturing safety culture'.

3.6 **New Key Lines of Enquiry (KLOEs)**

3.6.1 The Trust will need to consider the new KLOEs developed by the CQC within their new assessment framework for healthcare and incorporate them in terms of reporting where appropriate.

3.6.2 The proposal would be for Quality Committee to consider new KLOEs in Safe, Caring and Effective and for Business Committee to consider new KLOEs in Well Led and Responsive.

3.6.3 Senior Management Team (SMT) will then consider any required changes to reporting and potentially incorporate into the performance brief at the time of the performance brief annual review

4.0 IMPACT

4.1 **Quality**

4.1.1 SMT and Quality Committee will monitor the quality improvement plans with exception reporting to the Trust Board.

4.2 **Risk and assurance**

4.2.1 A robust and effective approach to addressing the improvement actions set out in the CQC's inspection report will support mitigation of the following board assurance framework risks:

- ineffective systems and processes for assessing the quality of service delivery and compliance with regulatory standards
- failure to implement and embed lessons learned from internal and external recommendations
- lack of internal capacity to secure quality and drive transformational change

4.3 **Legal/regulatory**

4.3.1 There are no legal implications that the Board needs to take into account.

5.0 NEXT STEPS

5.1 SMT and Quality Committee will sign off the action plan for improvement actions prior to submission to the CQC on 30 October 2017.

5.2 SMT will receive monthly progress reports which will inform bi-monthly progress reporting to Quality Committee and exception reporting in the intervening months. The Board will receive assurance from Quality Committee on progress with implementation of the plan.

5.3 The Trust will link with the CQC to establish regular engagement meetings.

6.0 RECOMMENDATIONS

6.1 The Board is recommended to:

- Receive the information with regard to the CQC inspection and ratings published on 29 August 2017
- Approve the proposed monitoring and reporting arrangements through the SMT and Quality Committee to Board
- Agree the proposal for consideration of the new KLOEs

Appendix 1

Tables indicating actions LCH must or should take to improve.

Trust-wide	
Must improvements: **LCH must ensure:**	**Should improvements** **LCH should ensure:**
	Review systems to ensure consistency in meeting the fit and proper person requirements.
	Ensure consistency in recording risks on the risk register in all services.

Community Adults	
Must improvements: **LCH must ensure:**	**Should improvements** **LCH should ensure:**
	To ensure dementia awareness is incorporated into mandatory training.
	To clarify in safeguarding children training records which level has been attained
	To continue to monitor environmental issues in community clinics

In Patient Units	
Must improvements: **LCH must ensure:**	**Should improvements** **LCH should ensure:**
	Replace the patient call system and the patient falls sensor system at South Leeds Independence Centre, to ensure it meets the needs of the people using the service
	Make sure all patients are assessed in line with the Mental Capacity Act
	Provide and maintain up-to-date dementia training for staff caring for patients living with dementia.
	Introduce audits to assure the quality of patient records.
	Work to improve response rates for patient feedback through the Friends and Family test.
	Improve patient participation in self-medication at CICU and SLIC.
	Consider improving the variety of food and timings of meals at South Leeds Independence Centre.
	Consider improving the environment/maintenance of the community intermediate care unit.

Hannah House	
Must improvements: **LCH must ensure:**	**Should improvements** **LCH should ensure:**
All registered staff have Level 3 safeguarding training and recorded supervision	Processes in place for environmental safety checks
There is a Safe management of medicines & there is documentation to support this	Safeguarding supervision is completed
Staff are appropriately skilled and trained to meet the care needs of children at HH	Learning from incidents and complaints is shared with staff
There are governance procedures to ensure risks are identified and escalated appropriately and any actions are shared with staff	Daily records of care are completed
	Consider how the service engages with families to enable them to contribute to service development.
	Reduce number cancelled short break stays and review reasons for cancellations

Little Woodhouse Hall	
Must improvements: **LCH must ensure:**	**Should improvements** **LCH should ensure:**
All temporary bank or agency staff, complete the required mandatory training and that this is recorded and monitored appropriately.	Young people are able to access therapies whilst admitted to the unit
Systems and processes are operating effectively and are sufficiently embedded to ensure the quality and safety of the unit. This includes safeguarding alerts and notifications to the Local Authority and the Care Quality Commission, an appropriate seclusion policy, protocols to support staff in the roll-out and the use of new restraint methodology, a clear mandatory training system for temporary staff, and that responses and actions are completed in response to action plans and reviews, for example the ligature risk assessment and the assessment of the lift, in a timely manner	Staff receive specialist training and induction in relation to child and adolescent mental health in line with the quality network standards for inpatient child and adolescent mental health.
	All informal patients are aware of their rights as outlined by Mental Health Code of Practice.
	It has clear processes in place for communication with carers and ensures it responds to their concerns in a timely manner.
	The use of temporary staff does not impact on the safety and quality of patient care.
	It follows guidance in relation to the monitoring of the use of prescriptions

Sexual Health	
Must improvements: **LCH must ensure:**	**Should improvements** **LCH should ensure:**
The service meets the training target for staff having the required level of safeguarding training.	Key performance indicators for the service are met
	Continue to improve the rate of clinical supervision and support for staff groups across the service
	Mandatory training compliance and that all staff have received CSE awareness training.
	Consider communicating waiting times in clinics
	Processes are in place to consistently monitor refrigeration temperatures.
	Risks are recorded on the risk register.
	Review and establish clear systems and processes for documenting checks for the emergency oxygen checklist

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (46)

Meeting :Trust Board 6 October 2017	**Category of paper**	
Report title: Third Sector in Health and Care in Leeds	**For approval**	
Responsible director : Executive Director of Operations **Report authors:** Business Unit Business Managers	**For assurance**	
Previously considered by SMT 20 September 2017	**For information**	√

Purpose of the report

This paper aims to provide an overview of the breadth and diversity of the third sector in Leeds, the partnerships and joint working already in place with Leeds Community Healthcare NHS Trust (LCH) and the potential for further developments that will support LCH and the third sector to play their key roles in the future health and care landscape

Main issues for consideration

The health and care third sector in Leeds is extensive and mature, including a very diverse range of local, regional and national voluntary, community and faith organisations as well as small unconstituted groups all contributing to the health and wellbeing of the people of Leeds.

Recommendation

The Board is recommended to:

- receive the report

THIRD SECTOR IN HEALTH AND CARE

1. INTRODUCTION

The 'third sector' is the sector-preferred term for voluntary, community and faith sectors. This report follows responses to public questions regarding Leeds Community Healthcare NHS Trust's (LCH) relationship with the third sector at LCH's Annual General Meeting in 2015 and the Leeds Scrutiny Board's work schedule for 2016 around the involvement of the third sector in the provision of health and social care services.

Chapter 2 of the Five Year Forward View identifies that 'a new relationship with people and communities' is essential to NHS reform – better health, better care and greater financial sustainability. NHS England's 'Realising the Value' programme has increased and strengthened the existing evidence base for this and the People and Communities Board calls for a "fully engaged scenario" to move from being 'nice to have' to 'business and usual'.

This paper aims to provide an overview of the LCH's of the breadth and diversity of the third sector in Leeds, the partnerships and joint working already in place with Leeds Community Healthcare NHS Trust (LCH) and the potential for further developments that will support LCH and the third sector to play their key roles in the future health and care landscape

2. HEALTH AND SOCIAL CARE THIRD SECTOR IN LEEDS

The health and care third sector in Leeds is extensive and mature, including a diverse range of local, regional and national voluntary, community and faith organisations as well as small unconstituted groups all contributing to the health and wellbeing of the people of Leeds.

Forum Central is the health and social care third sector network for Leeds, with a combined membership of nearly 300 health and social care organisations. Their work is delivered through the following partnerships: Leeds Older People's Forum: Physical and Sensory Impairment (PSI) Network: Tenfold (the Learning Disabilities Forum) and Volition (the Mental Health Forum).

3. STRATEGIC INVOLVEMENT OF THE HEALTH AND CARE THIRD SECTOR IN LEEDS

The third sector is involved in the planning and delivery of the Sustainability and Transformation Plan (STP), as it:

- works with and is part of communities with the greatest health inequalities creating trust, reach, culturally sensitive services, intelligence about gaps, engagement with people
- works with people in an asset-based, person centred ways, designed to empower and support people to recovery, to self- management, to staying in the community
- provides interventions that holistically address and understand the wider determinants of health and wellbeing, employment, housing, debt, education
- operates in a flexible way, both to meet the person's needs but in addition able to organise flexibly to address unmet needs
- delivers evidence-based cost effective health and care services
- has the potential to deliver additional new roles and responsibilities such as care coordination, community builders, medicine prompts, social work

The Third Sector is represented on key strategic groups including:

- Health and Wellbeing Board (St Gemma's Hospice)
- Community Providers Network (Age UK Leeds and Moor Allerton Elderly Care)
- STP Board of Boards

- Workforce Development (People Matters, Aspire, Home-Start Leeds, Leeds CIL)
- Data and Digital (Forum Central)

4. PARTNERSHIPS AND JOINT WORKING BETWEEN LCH AND THE THIRD SECTOR

LCH works with and subcontracts/contracts in partnership with the third sector, spending over £1m annually with the voluntary and independent sectors. Organisations from whom we commissioned services in the last three years included:

- Advonet – Advocacy Services for Children & Young People in CAMHS Inpatient Unit
- Armley Helping Hands
- Basis (formerly Genesis)
- Black Health Initiative
- Carers Leeds
- Community Links Ltd
- Kissing it Better
- Leeds Counselling
- Leeds Involving People
- Marie Curie Cancer Care
- Partnerships For Wellbeing
- St George`s Crypt
- Touchstone
- Yorkshire Mesmac Ltd

4.1 PARTNERSHIPS AND JOINT WORKING WITH THE ADULT BUSINESS UNIT

Neighbourhood Teams work closely with Neighbourhood Network Schemes, which are community based, locally led organisations that enable older people to live independently and pro-actively participate within their own communities by providing services that reduce social isolation, provide opportunities for volunteering, act as a “gateway” to advice/information/services, promote health and wellbeing and thus improve the quality of life for the individual. The Neighbourhood Network Schemes provide a range of services, activities and opportunities promoting the independence, health and well-being of older people throughout Leeds. The first Neighbourhood Network Scheme was established in Leeds in 1985 and now there are over forty Schemes working throughout the city. The Neighbourhood Network Schemes support over 25,000 older people every year.

4.2 PARTNERSHIPS AND JOINT WORKING WITH THE CHILDREN’S BUSINESS UNIT

A wide range of work takes place across Children’s Services, with the third sector as a partner, lead provider or commissioner of numerous joint initiatives. Every service has a story to tell about this way of working, examples of which include:

0-19 Services

- Best Start Peer Support Project – three year contract, in partnership with Women’s Health Matters and Touchstone (as the lead provider). The Health Visiting Service provides clinical input to courses delivered by third sector partners to parents/carers of 0-2 year olds across Leeds South & East CCG area. The service primarily provides an advisory role to the partnership and provides clinical oversight to the development of training materials and the delivery of the peer education programme.
- The School Nursing Service is currently working with the marketplace in the development of their care pathway for Alcohol and Drugs.

- There are multiple opportunities to be explored about how our services can work in partnership with the third sector to deliver 0-19 services for the future, when these are recommissioned in 2018/19.

Watch It

The service works in partnership with DAZL and Leeds Health for All (ACE) in the delivery of the service.

ICAN (Integrated services for Children with Additional Needs)

Children's Occupational Therapy, Physiotherapy Services and Community Paediatrics worked in partnership with third sector partners Sunshine and Smiles and Leeds Mencap (Hawthorne Family Support Centre) to co-produce services improvements with parents/carers to the Downs Syndrome pathway.

In the future, as local third sector organisations such as Leeds MENCAP develop purpose built facilities for young people with additional needs, there are opportunities for ICAN services to work in partnership with them to think differently about where services are provided to ensure the best user experience for children and their families.

The National Deaf Children's Society is the only third sector organisation which specifically supports deaf children and their families, and has worked with the Audiology Service for several years on pathway improvement work for deaf children. It is also an integral part of the local multiagency Children's Hearing Services Working Group.

Speech & Language Therapy

The service provides Makaton training to all parents with Downs Syndrome. In the future this training could be delivered through parent led third sector networks such as Sunshine and Smiles.

CAMHS

- Staff from Northpoint and the Marketplace are contracted to work in Mindmate Single Point of Access (SPA), to ensure the most effective triage of children and young people and best use of available support services across health, education and the third sector. Co-delivery of Mindmate SPA alongside third sector and education partners is an area where there is ambition to extend as the function develops further.
- The service works alongside Community Links (ASPIRE) to provide psychiatry input to services for Early Intervention in to Psychosis
- The service is contracted by BARCA Leeds to provide psychology input to the Family Drug and Alcohol Court

4.3 PARTNERSHIPS AND JOINT WORKING WITH THE SPECIALIST BUSINESS UNIT

Partnership work with third sector organisations contributes significantly to delivery of a number of services within the Specialist Services Business Unit. Examples of which include

IAPT

The Leeds IAPT Services is delivered as an innovative consortium model that sees LCH work with three local third sector partners: Community Links, Northpoint Wellbeing and Touchstone. Together the four agencies work together to provide the Leeds IAPT service, as part of the Improving Access to Psychological Therapies programme.

The service is intended to help NHS patients with common mental health problems such as depression, anxiety and panic attacks, and stress. Each partner brings its own expertise that contributes to the delivery of an effective service for IAPT that meets the needs of Leeds patients. Northpoint Wellbeing, formerly Leeds Counselling, is a registered charity with a mission to help people experiencing emotional distress and provides specific Cognitive Behavioural Therapy (CBT) element of the service. Community Links is an award winning non-profit provider of mental health and wellbeing services in Yorkshire and the Humber who provide support for people with a wide range of mental health issues. Within the Leeds IAPT service this is achieved through the provision of a variety of IAPT therapies. Touchstone is a third sector organisation that is a major provider of mostly BME services. For Leeds IAPT Touchstone also provide a range of IAPT therapies, specialising in providing services for people from a Black or Ethnic Minority background.

Leeds Sexual Health

Leeds Sexual Health offers Sexually Transmitted Infection (STI) screening and treatment, HIV testing and contraception services. Following a procurement exercise in July 2015 the Contraception and Sexual Health Service (CaSH), Genito-Urinary Medicine service (GUM) and third sector partners Yorkshire MESMAC came together as Leeds Sexual Health to provide a new, improved and easy to access sexual health service. MESMAC offer services to various communities including men who have sex with men, BME groups, people misusing drugs, sex workers and LGB&T young people and adults and as such are an integral part of the Leeds Sexual Health service.

HALP

Homeless Accommodation Leeds Pathway (HALP) works with the homeless people in Leeds to improve the quality of inpatient stay and discharge from hospital, coordinate integrated care following hospital discharge to prevent readmission to hospital and improve access to health services in order to reduce morbidity and mortality. To deliver the service the HALP team work closely with third sector partner St Georges Crypt who provide accommodation for homeless people when they are discharged from hospital.

4.4 PARTNERSHIPS AND JOINT WORKING WITH CORPORATE SERVICES

Corporate services also have partnerships and procure from the third sector, including:

- Inclusion
    - Stonewall
    - Black Health Initiative
    - Forum Central LGBT+ mapping

- Involvement and public accountability
    - Healthwatch

- Venues
    - SHINE
    - Thackray Museum
    - Stanningley Rugby Club

- Consultation on strategy and policy

5. FUTURE PLANS

Partnerships with the third sector contribute to fulfilment of our corporate social responsibility and sustainability. They support us to provide the best possible care within the resources available, develop services that meet people's needs and get as much impact for every health 'pound' we spend. Our future plans are to continue to add value through existing partnerships and proactively seek out new opportunities for partnerships with the third sector.

6. RECOMMENDATION

The Board is requested to receive this briefing paper

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2017-18 (47)

Meeting Trust Board 6 October 2017	**Category of paper**	
Report title Performance Brief and Domain Reports	**For approval**	
Responsible director: Executive Director of Finance and Resources **Report author:** Head of Business Intelligence	**For assurance**	✓
Previously considered by: Senior Management Team, 20 September 2017 Quality Committee, 25 September 2017 Business Committee, 27 September 2017	**For information**	

Purpose of the report

This report provides a high level summary of performance within the Trust during August 2017.

It highlights any current concerns relating to contracts that the Trust holds with its commissioners.
It provides a focus on key performance areas that are of current concern to the Trust. It provides a summary of performance against targets and indicators in these areas, highlighting areas of note and adding additional information where this would help to explain current or forecast performance.

More detailed narrative on each of the individual indicators will be available in the domain reports.

Main issues for consideration

Safe
The Trust is currently achieving all but one of its targets within the safe domain for the year to date. The exception is avoidable category 4 pressure ulcers of which there has been one during August 2017.

Green is forecast for all indicators with the exception of category 4 pressure ulcers.

Caring
The measures in the caring domain are rated green. All indicators are expected to be rated green at year end.

Effective
The effective domain is reported quarterly only; as such there is no update.in this report.

Responsive
The Trust continues to perform well in its indicators relating to waiting lists of which there are six. All are rated as green for August 2017.

The Trust is, however, more than 10% outside of its activity profile in August 2017 resulting in a red rating in month and an amber rating year to date. A working group has been set up to examine reasons for decreased activity in the neighbourhood teams and further analysis will be carried out to determine why activity levels are lower. Activity levels are expected to meet the target at year end.

Well-led
Sickness absence rates have fallen in August 2017 (5.5%) and have returned to a green rating.

The category for 'reason for leaving' in the electronic staff record recorded as 'other/unknown' has also improved and returned to a green rating.

The staff appraisal rate has dropped to a red rating for August 2017. Also rated red are the response rates for the inpatient and community Friends and Family Test. These latter two measures are expected to be red at year end.

Finance
The Trust remains at a green rating for net surplus/deficit for the year to date and for the use of resources risk rating.

Cost improvement plans delivery and capital expenditure in comparison to plan remain rated red for the year to date.

Each of the measures are forecasted to be achieve their targets by year end with the exception of delivery of cost improvement plans.

Recommendation

The Board is recommended to:

- Note present levels of performance
- Determine levels of assurance on any specific points

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust

Performance Brief, August 2017

Senior Management Team – 20th September 2017
Quality Committee – 25th September 2017
Business Committee – 27th September 2017
Trust Board – 6th October 2017

Executive Summary

This report provides a high level summary of performance within Leeds Community Healthcare (LCH).

It highlights any current concerns relating to contracts that LCH holds with its commissioners.

It provides a focus on key performance areas that are of current concern to the Trust. It provides a summary of performance against targets and indicators in these areas, highlighting areas of note and adding additional information where this would help to explain current or forecast performance.

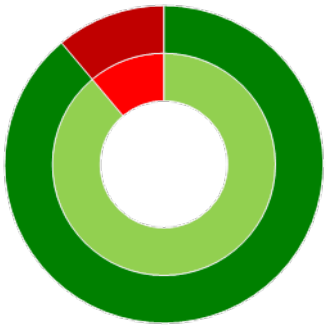
Contents

1. High Level Performance Summary

1.1 Summary of Performance Against High Level Indicators

Please note that the charts included below do not represent the CQC key lines of enquiry. They do reflect the Trust's high level indicators which are aligned to the CQC domains.

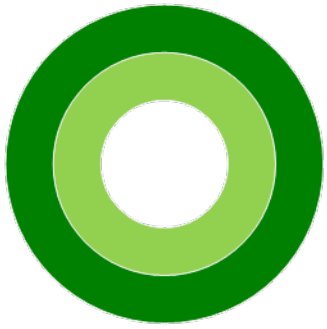
1.1.1 Safe



The Trust is currently achieving all but one of its targets within the safe domain for the year to date. The exception is avoidable category 4 pressure ulcers of which there has been 1 this month reported in Chapeltown NT. This is the first since October 2016. Learning from the management of these continues to be discussed at pressure ulcer review meetings

Green is forecast for all indicators with the exception of category 4 pressure ulcers.

1.1.2 Caring

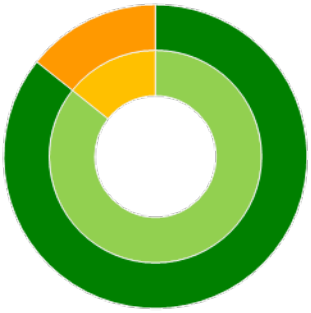


The measures in the caring domain are rated green. All indicators are expected to be rated green at year end.

1.1.3 Effective

The Effective domain is reported quarterly only as such there is no update this month.

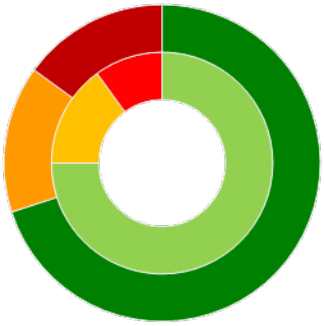
1.1.4 Responsive



The Trust continues to perform well in its indicators relating to waiting lists of which there are six. All are rated as green for August

The Trust is more than 10% outside of its activity profile in August resulting in a red rating in month and an amber rating year to date. A working group has been set up to examine reasons for decreased activity in the Neighbourhood Teams and further analysis will be carried out to determine why activity levels are lower.

1.1.5 Well Led



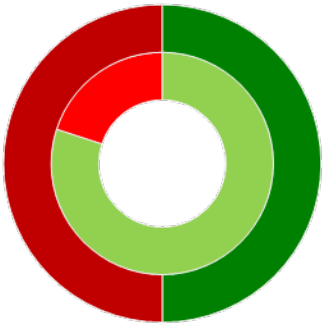
Sickness absence rates have fallen in August and have returned to a green rating.

The Category for Reason for Leaving in ESR Recorded as "other/unknown" has also improved and returned to a green rating this month and is now rated amber.

The AfC staff appraisal rate has dropped to a red rating for August. Also rated red are the response rates for the inpatient and community

Work with services continues in order to improve response rates to FFT. Quality Leads and the FFT Lead worked in partnership in Q1 to agree a plan. Baseline data was established for both response rates and equality data in Q1. A report will be provided on FFT equality data at the end of Q2. Services are encouraged to input their own FFT and to date this has been taken up by the IAPT, MSK and LSH services. Support is offered to services in developing bespoke surveys, through the Clinical Governance Team.

1.1.6 Finance



The Trust remains at a green rating for Net surplus/Deficit for the year to date and for the Use of Resources Risk Rating.

CIP delivery and capital expenditure in comparison to plan remain rated red for the year to date.

Each of the measures are forecasted to be achieve their targets by year end with the exception of delivery of CIPs.

1.2 Statutory Breaches

Leeds Community Trust is currently performing within all nationally set targets.

At the end of August five patients were waiting more than 18 weeks for treatment in consultant-led services. 3 patients were waiting for the Paediatric Neuro Disability Service (PND), one for Child Development Centres and one for Community Paediatrics. All but one of these waits (one in PND) were due to the initial appointments being cancelled by the service and subsequent appointments being cancelled by the parent.

The service is meeting its targets for wait times in IAPT. 96.0% of patients were seen within the 6 week waiting target for IAPT and 99.1% of patients were seen within 18 weeks. These are comfortably above the national targets.

2. Contract Related Performance Highlights

2.1 CAMHS Consultation Clinic Waiting List

The number of patients waiting more than 12 weeks to access CAMHS Consultation Clinics has increased in comparison to last month. There are currently 63 patients waiting more than 12 weeks for Consultation Clinics. 11 of these patients have exercised patient choice and chosen an appointment at a later date. This situation was expected to get worse over August due to the holiday period. The CAMHS service are trying to respond to this issue and are looking at freeing up clinician time to address this.

2.2 National Child Measurement Programme

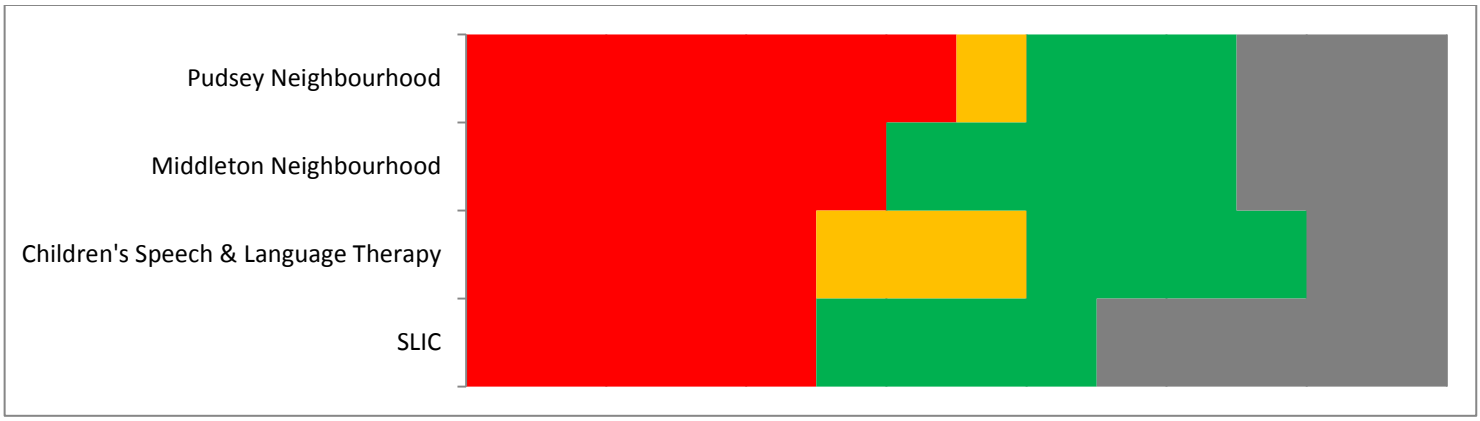
Leeds City Council raised some concerns that the current coverage of Year 6 pupils was not at the expected level. Assurance has been provided that the required level will be reached.

2.3 School Nursing Service

School Nursing contacts to children on the Universal Plus offer are down on last year, specifically contacts relating to Universal Plus advice and support, emotional health and wellbeing, enuresis and continence and healthy weight. The commissioners (Leeds City Council) are concerned over the significant fall in activity, particularly in the light of high level of staffing vacancy.

3. Heat Map

The graph below shows the four services with the most red ratings in the Heat Map. This information is from June 2017.



3.1 Neighbourhood Teams

Two of the neighbourhood teams have the greatest number of red rated measures. Both Pudsey and Middleton neighbourhood teams are rated red for patient safety incidents, patient contacts, friends and family score, extent of overspend, appraisals and statutory and mandatory training. In addition Pudsey is rated red for serious incidents.

The picture in the Neighbourhood Teams in relation to patient contacts is described in section 4.1.1, however neither Pudsey nor Middleton are the worst performing teams in this area. The analysis around activity levels has shown that there has been a spike in the percentage of vacancies in the Neighbourhood Teams which has remained at the same level since approximately April 2017. The level of vacancies in Middleton reflects this pattern, which would explain the red ratings for the other measures.

Despite a spike in vacancies in April the percentage of vacancies in Pudsey has returned to a low level. However, there has been a recent spike in sickness with levels up to 12.8%. This will undoubtedly have had an impact on the service and could therefore cause the red ratings for other measures.

3.2 Children's Speech and Language Therapy

The Children's Speech and Language Therapy service is rated red for patient contacts, DNA'd appointments, the percentage of patients treated within 18 weeks, extent of overspend, appraisals and statutory and mandatory training. It is known that the service has been under pressure for some time with recruitment of Speech and Language Therapists proving difficult. The service has action plans in place to address waiting times and held initiatives over the summer holidays in order to improve waiting times. In addition there is working going on to examine the DNA rate and activity levels more closely with a view to implementing action plans to resolve these issues.

3.3 SLIC (South Leeds Independence Centre)

The measure rated red in SLIC all relate to staffing levels. They are; shift fill, sickness absence, extent of overspend, appraisals and statutory and mandatory training. Sickness within the therapy team in the service and higher levels of vacancies are being reported. This would mean that is it difficult to maintain regular appraisals and completion of statutory and mandatory training and back fill of staff with agency or bank staff would account for increased spending.

The full heat map is provided for information in Appendix 1.

4. Key Areas of Focus

4.1 Patient Contact – Variance from Profile

The Trust continues to miss its target for patient contacts. August's variance is the lowest monthly variance since April. It is thought that this relates to a decrease in contacts in some Children's Services due to the school holiday period. It is expected that these services will recover in September and that the shortfall will be made up over the remainder of the year.

This provides an explanation for why August is lower than other months, but activity has been lower than profile for the majority of this year. The major contributors to this short fall are:

4.1.1 Neighbourhood Teams

The Adult Activity Review Group continues to meet fortnightly to understand the reasons for the fall in activity and to implement appropriate action plans.

The information gathered so far seems to indicate that these drops in activity levels are a positive story. It is thought that the neighbourhood teams are seeing fewer inappropriate patients since referrals were routed through SPUR and that as case management initiatives progress in individual neighbourhoods teams contacts are managed more efficiently. For example in Armley, caseload reviews have meant that they are discharging patients at the right time and they have performed a review of care plans examining which care plans can be delivered in the same contact. In some cases this has bought the number of contacts down from 4 or 5 a week to 1 or 2.

These hypotheses explain why the number of contacts delivered to each patient might have decreased, but not why teams aren't seeing more patients as this capacity is freed up. Certainly the number of vacancies in the neighbourhood teams has spiked in recent months so this will affect the teams' ability to use this new capacity. Also it may be that additional, non-patient facing activities are now taking place; for example, appraisals, more effective hand overs, attendance at admission avoidance meetings. Further evidence to support these hypotheses is being sought.

In addition the four Neighbourhood Teams with the largest drop in activity levels are being investigated in detail to elicit the reasons for this drop and with a view to sharing best practice. These teams are Armley, Beeston, Kippax and Morley.

4.1.2 IAPT

This year the IAPT service's activity levels have been between 48% and 60% below profile. The service is assessed on KPIs that relate to service outcomes rather than the quantity of contacts delivered and therefore the focus is not on low activity levels. That said, a review of the activity profile is necessary and has been started. The new profile will be related to the other KPIs and will reflect the number of contacts necessary to achieve those KPIS.

4.1.3 School Immunisations

This service is currently 58% below their activity profile which is split equally across the year. However, the nature of the School Immunisation services is that they process immunisations in large batches. Delivery of these batches will start again in September and activity is expected to reach the profile by year end.

4.1.4 Leeds Sexual Health Service

The Leeds Sexual Health Service is a service produced through the integration of the old CASH and GUMCAD services. One of the main aims of the service was to deliver more dual contacts; i.e. contacts that require input from staff with expertise previously associated with either the CASH service or GUMCAD. It was therefore expected that activity levels would drop significantly once the service was set up and we have seen this.

Again this service is assessed on a number of different services outcomes rather than solely on activity levels. This is why this apparent under performance has not been focussed upon. The commissioner, Leeds City Council, is now expressing an interest in how we are recording and counting activities in the service and this provides us with an ideal opportunity to review the current activity profile, one that we will take.

4.1.5 Early Start Service (Health Visiting)

The Health Visiting Service ended 2016/17 with activity 3.9% above profile. They are 9.6% behind profile for this year to date. The Early Start Service commissioner (Leeds City Council) does not assess the number of contacts the service delivers in relation to a profile and hence there is little focus on this area. However, there may be reason to focus on this. The service is due to be re-procured and due to go to the market later this year with a view for delivery of the new contract to start in 2019. In addition the service has been impacted by cuts in Public Health budgets. The views of the Children's Business Unit Business Manager will be sought in relation to this.

Leeds Community Healthcare NHS Trust

Director of Nursing Report

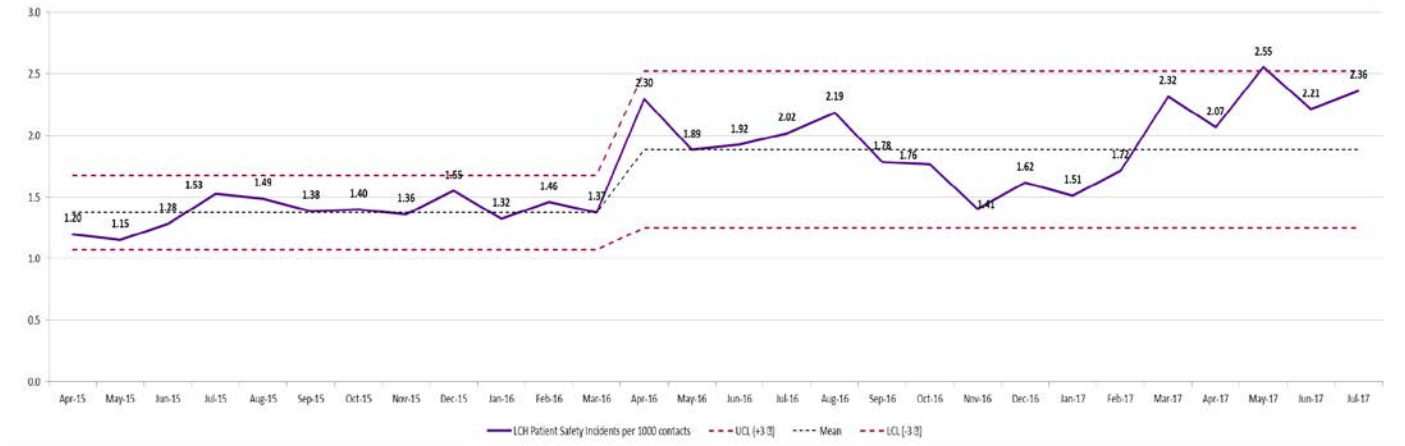
Safe and Caring Domain Report

Safe - people are protected from abuse and avoidable harm		YTD Target	YTD	Q1	Jul	Aug	Forecast
Overall Safe Staffing Fill Rate - Inpatients	2017/18	>=95%	-	97.7%	102.5%	97.5%	●
	2016/17		-	100.9%	100.0%	100.7%	
Patient Safety Incidents Reported in Month Reported as Harmful	2017/18	0.62 to 0.99	0.91	0.94	0.74	0.99	●
	2016/17		0.77	-	0.71	0.87	
Potential Under Reporting of Patient Safety Incidents	2017/18	1.36 to 2.63	2.29	2.28	2.31	2.31	●
	2016/17		2.47	-	2.80	2.93	
Serious Incident Rate	2017/18	0 to 0.13	0.05	0.05	0.00	0.08	●
	2016/17		0.05	-	0.04	0.02	
Percentage VTE Risk Assessment Completed	2017/18	>=95%	88.7%	96.3%	60.0%	95.1%	●
	2016/17		83.4%	81.0%	87.5%	95.5%	
5% Reduction in Falls Resulting in Avoidable Harm in our Community Inpatient Units	2017/18	5	5	3	0	2	●
	2016/17		13	-	-	-	
10% Category 3 Avoidable Pressure Ulcer Reduction Target	2017/18	7	7	2	1	4	●
	2016/17		24	12	1	0	
0 Avoidable Category 4 Pressure Ulcers	2017/18	0	1	0	0	1	●
	2016/17		0	1	1	0	
Percentage of Incidents Applicable for DoC Dealt with Appropriately	2017/18	100%	100.0%	100%	100%	100%	●
	2016/17		57.8%	79%	81%	71%	

Caring - staff involve and treat people with compassion, kindness, dignity and respect		YTD Target	YTD	Q1	July	Aug	Forecast
Percentage of Staff Recommending Care (Staff FFT)	2017/18	>=73%	-	81.0%			●
	2016/17		-	77.5%	73.7%		
Percentage of Inpatients Recommending Care (FFT)	2017/18	>=95%	-	100.0%	100.0%	100.0%	●
	2016/17		-	100.0%	96.7%	87.0%	
Percentage of Community Patients Recommending Care (FFT)	2017/18	>=95%	-	95.3%	94.5%	96.1%	●
	2016/17		-	96.3%	96.0%	94.0%	
Written Complaints - Rate	2017/18	No Target	50	50	23	18	
	2016/17		217	77	34	9	

1. Patient Safety Incidents (LCH only)

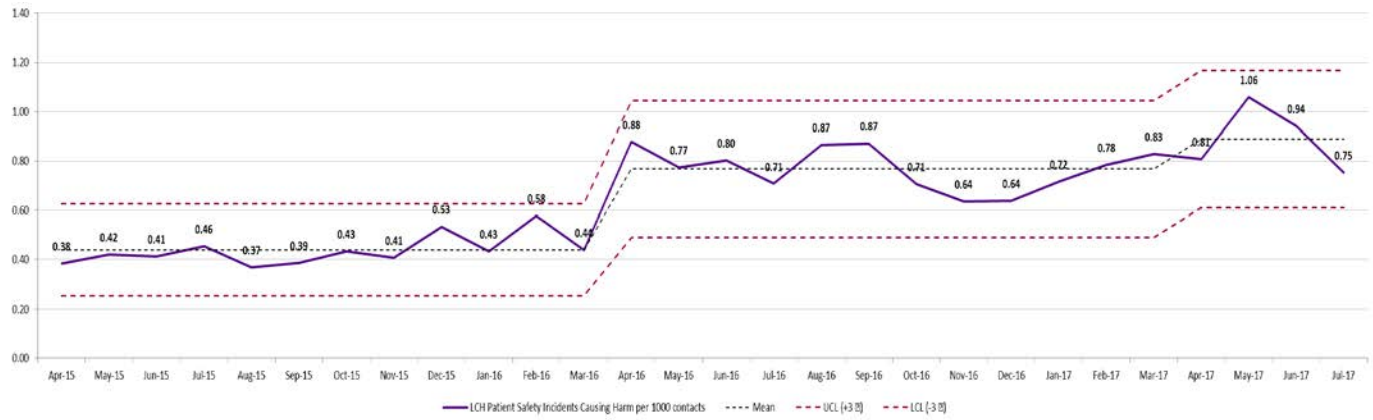
LCH PSIs per 1000 contacts (July 2017) currently remain within the control variation limits.



**data available to July 2017 only*

2. Incidents Causing Harm (LCH only)

The number of **LCH *patient safety incidents causing harm per 1000 contacts*** remains within the variation limits at this time.

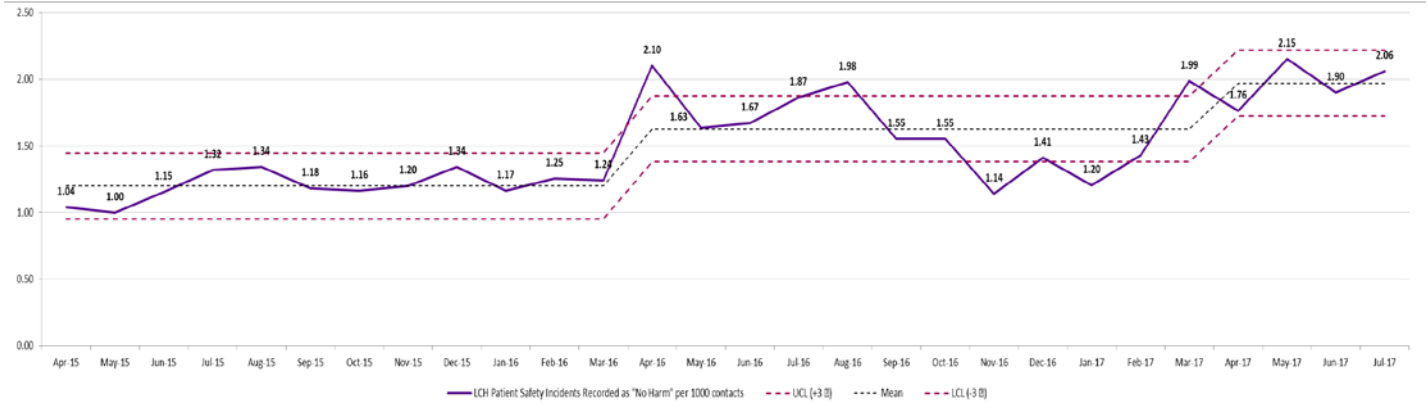


**data available to July 2017 only*

Analysis of associated data shows that activity is stable for August. There is no significance at this time.

3. No Harm Incidents

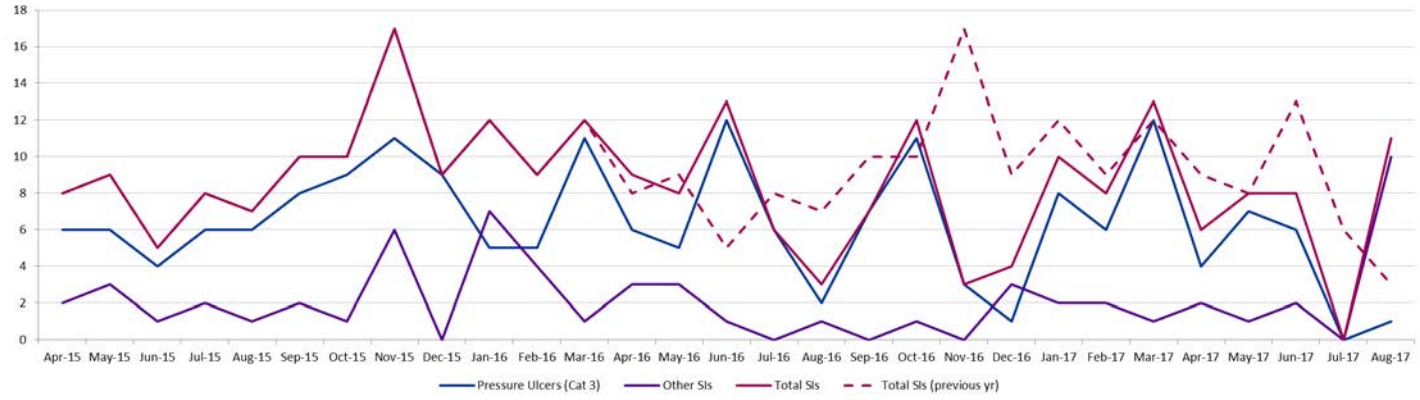
The number of LCH patient safety incidents causing no harm per 1000 contacts is currently within the upper and lower control variation limits.



**data available to July 2017 only*

4. Serious Incidents

The pattern of reported SIs has changed and is consistent with the new process for reporting avoidable only pressure ulcers as SI's. There were 11 SI's in August of which 73% related to unstageable ulcers.



5. Quality Account Priorities

5.1 Protecting Patients from harm

Protecting patients from harm that happens in our care is a Quality Account quality improvement priority for 2017/18. Areas of focus are:

- reduce the number of patients who have a fall resulting in avoidable harm whilst in our care
- reduce the number of patients who develop an avoidable pressure ulcer

Progress against the quality improvement priorities for 2017/18 is reported in full on a quarterly basis to the SMT. Any concerns regarding progress against the relevant priorities will also be escalated to the PSEGG by the Clinical Governance Team.

6. Never Events

No Never Events were reported in August.

7. Safety Alerts (CAS)

There were no Safety Alert response breaches in August.

8. Duty of Candour

At the end of August a total of 43 incidents were closed which had triggered the Duty of Candour. Of these:

- 39 (91%) were identified as not being as a result of the healthcare intervention following a 3 day fact find or SI investigation.
- 4 (9%) were avoidable harm attributable to LCH where the patients received an appropriate apology*

**verified as actual moderate + harm and attributable to an LCH PSI*

These results followed a review by the Quality lead for Specialist Services who identified a number of cases where the incident record on Datix had not been updated to reflect the outcome of the 3 day fact find or SI review.

The Quality Lead for Specialist Services is working with Business Unit counterparts to ensure incident handlers are accurately capturing the outcome of the fact find/SI on Datix.

In conclusion, Duty of Candour was applicable in 74 incidents where 100% received an appropriate apology.

Note of good practice: on discovery of a patient safety incident, Staff are having an early conversation with the patient and giving a verbal apology before the 3 day review has taken place. This is demonstrating a move towards a culture of openness with patients.

9.0 Infection Prevention Control (IPC)

9.1 MRSA bacteraemia and C difficile Infection

During August there were no reported cases of MRSA bacteraemia or C Difficile Infection assigned to LCH.

9.2 Sharps Safety Issues

The IPC Team continues to monitor all incidents relating to needle stick injuries within LCH and have a programme to review for all injured staff for a period of 6 months following injury. There were no cases of sharps injury reported in August (5 in April, 4 in May, 2 in June, and 2 in July). Work with CCGs regarding the provision of safe insulin pen needles continues and all clinical teams have been equipped with appropriate devices and training to deliver care.

9.3 Outbreaks

No outbreaks were reported during August.

Leeds Community Healthcare NHS Trust

Effective Domain Report

The indicators in the effective domain are assessed quarterly. As such there is no information to report this month.

Leeds Community Healthcare NHS Trust

Responsive Domain Report

Responsive - services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care		YTD Target	YTD	Q1	July	Aug	Forecast
Patient Contacts - Variance from Profile	2017/18	0 to ± 5%	-7.2%	-5.8%	-7.7%	-10.9%	●
	2016/17		0.0%	1.2%	-3.2%	5.0%	
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	2017/18	>=92%	-	99.6%	99.4%	99.6%	●
	2016/17		-	100.0%	99.8%	99.9%	
Number of patients waiting more than 52 Weeks (Consultant-Led)	2017/18	0	0	0	0	0	●
	2016/17		0	0	0	0	
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	2017/18	>=99%	-	99.5%	100.0%	100.0%	●
	2016/17		-	100.0%	100.0%	94.4%	
% Patients waiting under 18 weeks (non reportable)	2017/18	>=95%	-	98.8%	98.6%	99.0%	●
	2016/17		-	98.8%	98.8%	98.9%	
IAPT - Percentage of people treated within 18 weeks of referral	2017/18	>=95%	-	100.0%	98.7%	99.1%	●
	2016/17		-	99.9%	99.8%	99.2%	
IAPT - Percentage of people treated within 6 weeks of referral	2017/18	>=75%	-	96.1%	93.6%	96.0%	●
	2016/17		-	98.3%	97.8%	97.7%	

Please see section 1.2 for narrative information on those measures relating to statutory waiting times and section 4.1 for detail on patient contacts – variance from profile.

Leeds Community Healthcare NHS Trust

Well Led Domain Report

Well Led - leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture		YTD Target	YTD	Q1	July	Aug	Forecast
Workforce Race Equality Standard	2017/18	>=14.7%	-	-	-		
	2016/17		-	-	-		
Staff Turnover	2017/18	<=15%	-	15.2%	15.2%	15.1%	●
	2016/17		-	14.6%	14.5%	13.8%	
Executive Team Turnover	2017/18	<=15%	-	0.0%	0.0%	0.0%	●
	2016/17		-	0.0%	0.0%	0.0%	
Stability Index	2017/18	>=85%	-	83.8%	83.8%	83.8%	●
	2016/17		-	-	-	-	
Short term sickness absence rate (%)	2017/18	<=1.94%	-	1.8%	2.0%	1.9%	●
	2016/17		-	1.3%	1.3%	1.7%	
Long term sickness absence rate (%)	2017/18	<=3.6%	-	3.5%	3.8%	3.6%	●
	2016/17		-	4.5%	5.0%	3.8%	
Total sickness absence rate (%)	2017/18	<=5.54%	-	5.2%	5.8%	5.5%	●
	2016/17		-	5.6%	6.3%	5.5%	
AfC Staff Appraisal Rate (12 Month Rolling - %)	2017/18	>=90.4%	-	86.6%	86.7%	85.0%	●
	2016/17		-	89.1%	88.4%	87.2%	
Medical staff appraisal rate (%)	2017/18	100%	-	100.0%	-		●
	2016/17		-	86.4%	93.3%		
6 universal Statutory and Mandatory training requirements	2017/18	>=91.7%	-	91.0%	91.0%	91.5%	●
	2016/17		-	88.9%	88.2%	87.8%	
Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	2017/18	>52.0%	-	54.0%	-		●
	2016/17		-	49.0%	42.8%		
Percentage of staff who are satisfied with the support they received from their immediate line manager	2017/18	>60.0%	-	62.0%	-		●
	2016/17		-	-	-		
Response Rate for Staff FFT	2017/18	>22.0%	-	22.0%	-		●
	2016/17		-	22.2%	21.0%		
Sustain the time between placing adverts and filling vacancies							
Qualified Nurses		<= 112 Days	-	97	-		●
Police Custody		<=145 Days	-	124	-		●
Administration		<=83 Days	-	83	-		●
Reduce the number of staff leaving the organisation within 12 months	2017/18	<=22%	-	16.3%	14.2%	13.5%	●
	2016/17		-	-	-	-	
Category for Reason for Leaving in ESR Recorded as "other/unknown"	2017/18	<=10%		0.0%	10.3%	0.0%	●
	2016/17		-	-	-	-	
Response Rate for Inpatient FFT	2017/18	>=23.1%	-	15.4%	15.4%	12.6%	●
	2016/17		-	-	19.5%	2.0%	
Response Rate for Community FFT	2017/18	>=6.8%	-	6.9%	6.6%	5.2%	●
	2016/17		-	-	5.4%	4.2%	
Total agency cap	2017/18	£2,917k	£2,585k	£1,544k	£416k	£625k	●
	2016/17		£6,366k	1,926k	553k	532k	
Percentage Spend on Temporary Staff	2017/18	None	8.0%	8.1%	6.8%	9.1%	
	2016/17		7.5%	9.6%	8.4%	8.2%	

1. Appraisal

As at the end of August 2017 85.0% of available staff were registered as having had an appraisal within the last 12 months. This has seen a decrease on last month's figure of 86.7%.

To support appraisers, 8 sessions have been planned for October and November 2017 which concentrate on the skills appraisers need to have a courageous conversation. These have been commissioned to support the 200 appraisers that did not attend last year's sessions. The sessions are for 25 people and places are still available to be booked via ESR self-service.

We continue to work on a number of key priorities and this is now beginning to show results. These areas include; embedding values, feedback and involvement, personal development and appraisal, as repeated via the NHS National Staff Survey and the Staff Friends and Family.

2. Statutory & Mandatory Training

The level of staff compliance with universal statutory & mandatory training 91.5% has slightly increased from last month position of 91.0% compliance.

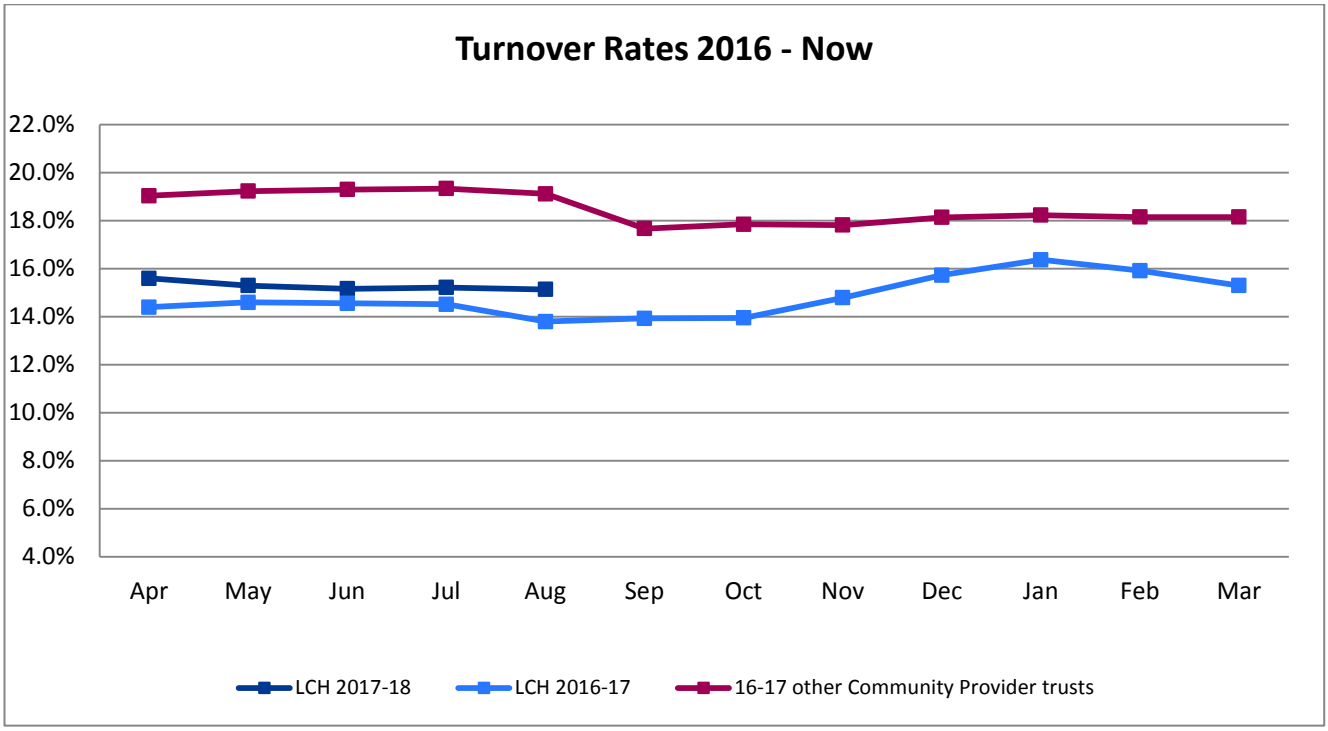
The individual topics report as follows:

- Information Governance training is at 93.8%
- Equality and Diversity training is above target with a compliance rate of 96.4%
- Health and Safety (Slips, Trips and Falls) training is 94.12%
- Fire Training, Infection Prevention and Control and Moving and Handling are all below target compliance rate at 87.1%, 88.4% and 89.29%.

The new portal to ESR has been made available from the end of august this will be easier for employees and managers to review information.

3. Turnover

The figure of 15.1% for the rolling year has slightly decreased from last month position of 15.2% this remains above the target of 15%.



In August 2017 there were 24 leavers across the Trust.

Business Unit	August 2017 Leavers
833 Adult Business unit	9
833 Children's Business Unit	6
833 Corporate Directorate	1
833 Operations	3
833 Specialist Business Unit	5

Staff Group	August 2017 Leavers
Nursing	12
Administrative and Clerical	4
Allied Health Professionals	6
Add Prof Scientific and Technic	0
Support Services	2
Medical and Dental	0

The top 3 reasons for leaving were:

- Voluntary Resignation - Better Reward Package (6)
- Voluntary Resignation - Work Life Balance (6)
- Retirement Age (3)

There has been a reduction in the number of leavers who left the trust in the first year of their employment and the number recruited since August 2016. The number of leavers within the first 12 months has continued on downwards trend from April 17 (18%) to the August 2017 (13%)

Business unit	< One yr	> One Yr	Grand Total	%
833 Adult Business unit	25	134	159	16%
833 Children's Business Unit	8	116	124	6%
833 Corporate Directorate	6	31	37	16%
833 Operations	6	25	31	19%
833 Specialist Business Unit	17	92	109	16%
Grand Total	**62**	**398**	**460**	**13%**

Work continues on staff engagement and 'Creating the Working Life We Want' and 'Building the Workplace We Want' and remains the focus of our retention effort. Each of the Business unit plans also has a specific section about their focus on staff. We continue to monitor impact to reduce turnover, and there is now some feedback from frontline staff that they are seeing improvements in their workload.

4. Workforce Race Equality Standard (WRES)

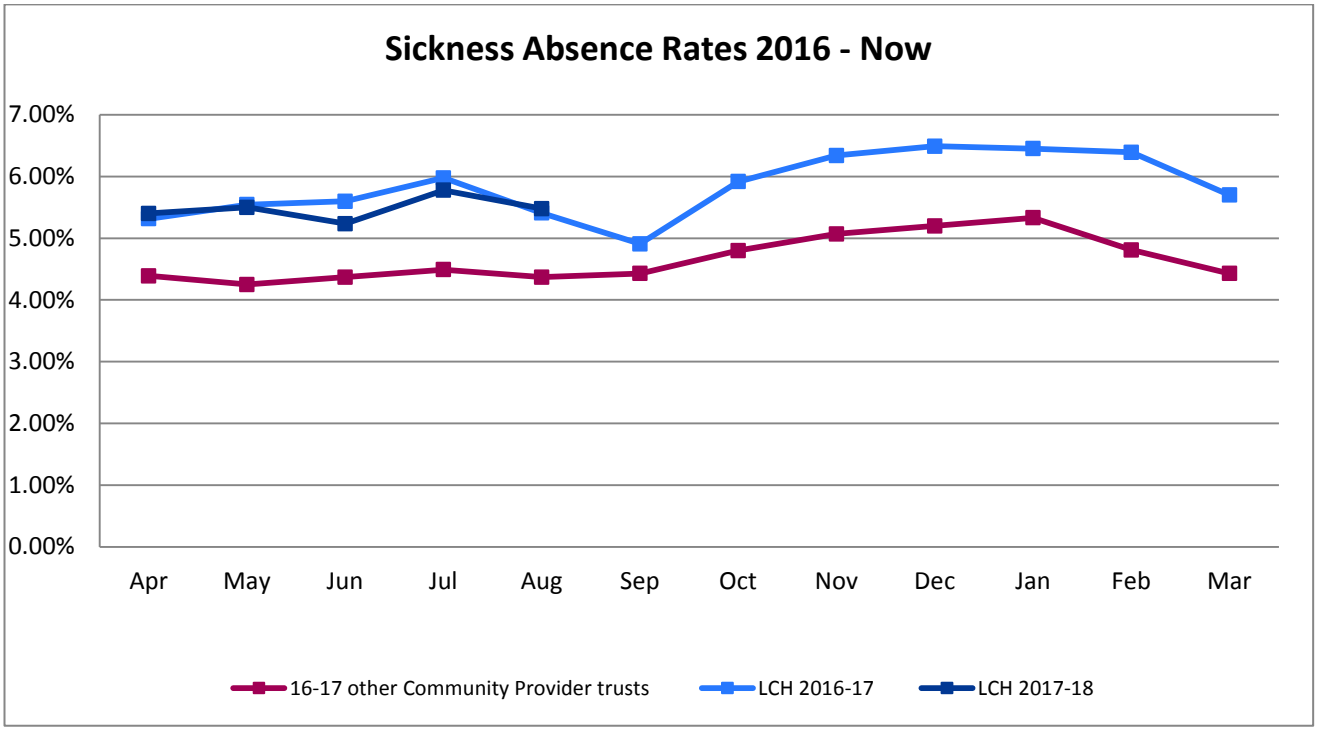
Building on from the workshops held with BAME staff, a BAME staff network has been launched, with the first meeting taking place in October 2017. As well as being a forum for support, this group will help drive the BAME agenda of the Trust.

The WRES data for year 2016/17 was submitted to NHS England in August 2017 and an action plan is now in development to help build on improvements. The Director of the WRES implementation team from NHS England, met with senior trust representatives in September to offer focused and bespoke support to implement workforce race equality, and was very supportive in her praise of the journey the Trust is on with this work.

5. Sickness Absence

The Sickness absence target for August is 5.45%. Sickness absence rate for August was 5.5%, which is broken down into Long-term absence 3.6% and Short-term absence at 1.9%.

Business Unit	August 2017 absence rate
Adult	6.9%↑
Children	4.5%↓
Specialist	4.6%↓
Corporate and Executive Directorate	5.4%↔
Estates & Ancillary Staff (Operations)	5.2%↔



The areas of HWB focus during September include:-

- Launch of Feel Good pledge
- Sickness absence training for managers – co-delivered in partnership with Staffside representative
- Progression of HWB Action Plan that was signed off at SMT
- Drop-in sessions for managers continue for managers to meet with an HR Advisor for support and guidance in managing absences

Leeds Community Healthcare NHS Trust

Finance Report

Finance		YTD Target	YTD	Q1	July	Aug	Forecast
Net surplus (-)/Deficit (+) (£m) - YTD	2017/18	-£1.7m	-£1.9m	-£0.9m	-£1.2m	-£1.9m	●
	2016/17			-£0.1m	-£0.7m	-£0.4m	
Net surplus (-)/Deficit (+) (£m) - Forecast	2017/18	-£3.0m	-£3.0m	-£3.0m	-£3.0m	-£3.0m	●
	2016/17		-	-£2.9m	-£2.9m	-£2.9m	
Forecast underlying surplus	2017/18	-£1.4m	-£1.4m	-£1.4m	-£1.4m	-£1.4m	●
	2016/17		-	-£1.5m	-£1.5m	-£1.5m	
Capital expenditure in comparison to plan (£k) - YTD	2017/18	£0.2m	£0.3m	£0.2m	£0.2m	£0.3m	
	2016/17		-	£354k	£439k	£452k	
Capital expenditure in comparison to plan (£m) - Forecast	2017/18	£1.8m	£1.8m	£1.8m	£1.8m	£1.8m	●
	2016/17		-	£3.2m	£3.2m	£3.2m	
CIP delivery (£m) - YTD	2017/18	£1.3m	£1.0m	£0.6m	£0.9m	£1.0m	
	2016/17		-	£0.2m	£0.2m	£0.3m	
CIP delivery (£m) - Forecast	2017/18	£3.4m	£2.9m	£3.4m	£2.8m	£2.9m	●
	2016/17			£0.7m	£0.7m	£0.7m	
Use of Resources Risk Rating (from Oct 2016)	2017/18	2	1	1	1	1	●
	2016/17		-	-	-	-	

1. Summary & KPIs

The Trust is £0.2m ahead of the planned surplus at the end of August. Pay expenditure has been in line with budget in August indicating substantive vacancies and been covered by use of agency staff which has increased this month. The year to date overspend on pay has been mitigated by the release of uncommitted reserves and underspending on non-pay. The expenditure on agency staff is 11% below the agency cap at the end of August. Cost savings plans are 25% below expected levels year to date; any shortfall has been included in the reported forecast expenditure outturn position. The Trust has spent £0.3m on capital assets for the year to date this is marginally more than planned. Cash is running £2.9m ahead plan and the use of resources risk rating continues to be 1.

Table 1 Key Financial Data	Year to Date	Variance from plan	Forecast Outturn	Performance
Statutory Duties				
Income & Expenditure retained surplus	(£1.9m)	(£0.2m)	(£3.034m)	G
Remain with EFL of £2.941m			£2.941m	G
Remain within CRL of £1.816m	£0.3m	£0.1m	£1.816m	G
Capital Cost Absorption Duty 3.5%			3.5%	G
BPPC NHS Invoices Number 95%	98%	3%	95%	G
BPPC NHS Invoices Value 95%	99%	4%	95%	G
BPPC Non NHS Invoices Number 95%	95%	0%	95%	G
BPPC Non NHS Invoices Value 95%	96%	1%	95%	G
Trust Specific Financial Objectives				
Use of Resources Risk Rating	1	-	1	G
CIP Savings £3.0m recurrent in year	£0.9m	-21%	£2.6m	R
CIP Savings £0.5m planned non recurrent in year	£0.1m	-44%	£0.3m	R
CIP Savings other non recurrent in year	£0.2m	NA	£0.5m	G

2. Income & Expenditure

The Trust's income continues to run in line with the August plan. Expenditure is underspending by £0.3m for the year to date; with pay costs £0.1m more than expected the overspending is being mitigated by under-spending on non pay and release of un-committed reserves. The Trust has 142 wte or 5.4% less staff in post than funded in August; this is after the planned vacancy factor reduction. Temporary staffing costs are £789k for the month. Non pay expenditure is £0.2m less than planned and £0.3m of reserves are un-utilised.

Table 2 Income & Expenditure Summary	August Plan	August Actual Contract	YTD Plan	YTD Actual	Variance	Annual Plan	Forecast Outturn	This Month Variance	Forecast Variance last month
	WTE	WTE	£m	£m	£m	£m	£m	£m	£m
Income									
Contract Income			(56.9)	(56.9)	0.0	(134.2)	(134.1)	0.1	0.1
Other Income			(4.1)	(4.1)	0.0	(8.8)	(8.8)	0.0	0.1
Total Income			***(61.0)***	***(60.9)***	***0.1***	***(143.0)***	***(142.9)***	***0.1***	***0.2***
Expenditure									
Pay	2,654.2	2,511.7	43.1	43.2	0.1	101.5	103.1	1.5	1.5
Non pay			14.3	14.1	(0.2)	33.8	33.2	(0.6)	(0.5)
Reserves & Non Recurrent			0.9	0.6	(0.3)	2.1	1.2	(0.9)	(1.0)
Savings Requirement							(0.1)	(0.1)	(0.3)
Total Expenditure	***2,654.2***	***2,511.7***	***58.3***	***58.0***	***(0.3)***	***137.5***	***137.4***	***(0.1)***	***(0.3)***
EBITDA	**2,654.2**	**2,511.7**	**(2.7)**	**(2.9)**	**(0.2)**	**(5.5)**	**(5.5)**	**0.1**	**(0.1)**
Depreciation			0.7	0.7	0.0	1.7	1.8	0.0	0.0
Public Dividend Capital			0.3	0.3	(0.0)	0.8	0.8	0.0	0.0
Profit/Loss on Asset Disp			0.0	0.0	0.0	0.0	(0.1)	(0.1)	0.0
Interest Received			(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	0.0	0.0
Retained Net Surplus	**2,654.2**	**2,511.7**	**(1.7)**	**(1.9)**	**(0.2)**	**(3.0)**	**(3.0)**	**(0.0)**	**0.0**
	Variance =	**(142.5)**							

2.1 Income

Both contract and non-contract income to be achieved as planned. The figures include accruals for CQUIN income paid in arrears. The income figure assumes the STF monies for 2017/18 will be achieved. The forecast income is consistent with last month and assumes the Trust will deliver all the CQUINs agreed with commissioners; following the quarter 1 review of progress there could be a shortfall circa £250k. This is not included in the position reported at table 2.

2.2 Pay

Table 3 below illustrates the total pay costs by category. Expenditure on substantive staff in post continues to underspend in August; the overall year to date position at month 5 is the same as month 4.

Table 3 Annual Pay Costs by Category	YTD Plan £k	YTD Actual £k	YTD Variance £k	Last Month YTD Variance £k	Forecast Outturn Variance £k
Cost of staff directly employed	42,649	39,484	**(3,166)**	**(1,917)**	
Seconded staff costs	246	281	**35**	**35**	
Vacancy Factor	(2,747)		**2,747**	**2,198**	
Sub-total Direct Pay	**40,148**	**39,764**	**(384)**	**316**	
Bank Staff	36	889	**853**	**696**	
Agency Staff	2,915	2,585	**(329)**	**(875)**	
Total Pay Costs	**43,099**	**43,238**	**140**	**137**	**1,548**

Specialist services: -£139k (July -£111k, June -£56k) underspent, this is after delivery of the vacancy factor savings.

Children's services: £402k (July £338k, June £251k) overspending being mostly the non delivery of the vacancy factor.

Adult services: £49k (July £96k, June £145k) overspending due to non-delivery of vacancy factor, agency costs were more than underspending on substantive posts, overspending on admin and clerical posts.

QPD Clinical: £318k (July £188k, June £194k), overspending on bank and agency costs not mitigated by savings on substantive staff.

Senior review panels for all vacancies continue; these consider the quality impact of holding vacancies, look for alternatives to recruitment and the financial impact if the post is deemed essential.

Table 4 Month on Month Pay Costs by Category	April £k	May £k	June £k	July £k	August £k	YTD Actuals £k
Directly employed staff	7,816	8,037	7,831	7,817	7,982	39,484
Seconded staff costs	72	111	117	92	-111	281
Bank staff	182	175	212	156	164	889
Agency staff	563	474	507	416	625	2,585
Total Pay Costs	**8,633**	**8,798**	**8,668**	**8,480**	**8,659**	**43,238**

Agency costs overall are £625k this month; a significant increase on last month. This is mostly as a result of additional agency staff for the CICU and SLIC inpatient services where substantive staffing have been impacted by the uncertainty as a result of the Commissioners tendering these services; additional agency staffing have been utilised to maintain safe staffing levels.

The main areas of agency expenditure and associated staffing positions are:

- Specialist BU £699k 21.46 wte less than planned
- Children's BU £377k 3.30 wte less than planned
- Adult's BU £853k 42.77 wte less than planned
- QPD Clinical £316k 4.22 wte less than planned
- Corporate £151k 28.59 wte less than planned
- Estates £97k 29.53 wte less than planned

Overall there are 142 vacancies for August which is 9 more than last month.

The Trust planned for agency expenditure of up to £7,000k for the year the agency cap for 2017/18 set by NHS Improvement is £7,386k. Agency staff are recruited to replace essential substantive staff vacancies they are funded from under-spending on substantive staff as they provide the alternative capacity to enable services to continue care provision.

2.3 Non Pay

Non pay expenditure continues to run less than planned. The overspending in clinical supplies is in respect of continence products. The movement in the other non pay expenditure this month is reduction in the bad debt provision as £37k of outstanding aged debts have been recovered. The overspending is as a result of the procurement, estates and course fees savings targets where the savings have yet to be identified.

Table 5 Year to Date Non Pay Costs by Category	YTD Plan £k	YTD Actual £k	YTD Variance £k	Last Month YTD Variance £k	Forecast Outturn Variance £k
Drugs	423	475	52	40	
Clinical Supplies & Services	3,641	3,741	100	97	
General Supplies & Services	1,076	1,027	(49)	(47)	
Establishment Expenses	2,775	2,570	(206)	(176)	
Premises	5,730	5,489	(242)	(163)	
Other non pay	654	811	157	203	
Total Non Pay Costs	**14,299**	**14,112**	**(187)**	**(45)**	**(613)**

3 Reserves & Non Recurrent

The Trust has £2.1m in reserve at the end of the month; all un-committed reserves have been released into the forecast outturn position. Based on the forecast at this point in the year the Trust will require an additional £0.1m of savings to achieve the control total agreed with NHSI for the year. The Trust continues to hold a contingency reserve; the first call on this will be to mitigate any shortfall in CQUIN income.

4 Service Line & Contract Performance

Table 6 Service Line	Annual Budget £m	Budget WTE	Actual Contract WTE	Variance WTE	YTD Budget £m	YTD Actual £m	YTD Variance £m	YTD Plan Activity	YTD Actual Activity	YTD Variance Activity	Corr-elation
Specialist Services	35.5	614.9	593.4	(21.5)	14.9	14.5	(0.4)	192,997	179,655	(13,342)	•••
Childrens Services	27.8	682.2	678.9	(3.3)	11.6	12.0	0.3	150,679	137,353	(13,326)	•••
Adults Services	33.6	849.4	806.6	(42.8)	14.2	14.1	(0.1)	354,000	332,139	(21,861)	•••
QPD Clinical	4.6	87.5	83.2	(4.2)	2.6	3.0	0.4	12,428	9,784	(2,644)	•••
Ops Management & Equipment	1.2	58.3	45.7	(12.6)	0.5	0.6	0.1				••
Service Line Totals	**102.8**	**2,292.2**	**2,207.9**	**(84.4)**	**43.8**	**44.2**	**0.4**	**710,104**	**658,931**	**(51,173)**	•••
Corporate Support & Estates	26.6	362.0	303.9	(58.1)	11.3	10.8	(0.4)				••
Total All Services	**129.4**	**2,654.2**	**2,511.7**	**(142.5)**	**55.0**	**55.0**	**(0.0)**	**710,104**	**658,931**	**(51,173)**	•••

This month operational services have 84.4 wte (July 81.0 wte) less in post than planned. The services are a net £0.4m overspent for the year to date; £0.1m more than last month. Specialist and Adult services are underspending for the year to date; the other clinical services are over spent.

The overall activity is 7.2% (July 6.9%) behind plan, as all business units continue to deliver less activity than planned for the year.

- Specialist services activities are 6.9% less than planned, (July 7.1%),
- Children's services activities are 8.8% less than planned, (July 6.1%),
- Adult NT services activities are 6.1% less than planned, (July 6.6%) and
- QPD Clinical services activities are 21.3% less than planned, (July 21.3%).

5 Cost Improvement Plans

Table 7 has the Trust's performance against the cost savings plan for 2017/18. Overall the plan is £310k or 25% behind at the end of August (19% for July). It is anticipated actions will, where possible, be taken to recover the shortfall and this is reflected in the forecast outturn CIP delivery and expenditure. The CIP requirement for CAMHS has been removed following discussions with Commissioners.

The forecast CIP delivery has been updated to reflect current plans this month. Any shortfall in the delivery of a recurrent CIP will be a cost pressure for 2018/19.

Table 7 Savings Scheme	2017/18 YTD Plan £k	2017/18 YTD Actual £k	2017/18 YTD Variance £k	2017/18 Annual Plan £k	2017/18 Forecast Outturn £k	2017/18 Forecast Variance £k	2017/18 Forecast Variance %
Child Health Admin	8	4	(3)	20	20	0	0%
Night Nursing	21	0	(21)	50	0	(50)	-100%
JCMT	83	0	(83)	200	31	(169)	-85%
Admin Review	0	0	0	250	250	0	0%
CAMHS	104	0	(104)	250	0	(250)	-100%
Corporate Support	63	63	0	150	150	0	0%
LSH	63	62	0	150	150	0	0%
Orthotics	8	8	(0)	20	20	0	0%
Child Health Continence Products	10	0	(10)	25	0	(25)	-100%
Geriatricians Overhead Charge	21	21	0	50	50	0	0%
Training	83	74	(10)	200	200	0	0%
Procurement	75	0	(75)	180	180	0	0%
Travel	63	63	0	150	150	0	0%
Drugs	21	0	(21)	50	0	(50)	-100%
Non pay inflation	150	150	0	360	360	0	0%
Mobile/data line charges	42	42	0	100	100	0	0%
Rents	58	58	0	140	140	0	0%
Estates other	42	42	0	100	100	0	0%
Contribution to overheads/fixed costs	135	135	0	325	325	0	0%
IT kit	104	104	0	250	250	0	0%
Release of reserves	167	167	0	400	400	0	0%
Total Efficiency Savings Delivery	**1,321**	**994**	**(327)**	**3,420**	**2,876**	(544)	**-16%**

6 Capital Expenditure

The Trust's capital resource limit for 2017/18 has been set at £1.816m by NHS Improvement. The Trust has capital expenditure planned for this amount.

Expenditure has been incurred in respect of the EPR project £176k to the end of August of which £116k is staffing costs for the project and £50k for IT equipment. Other capital expenditure to the end of August includes £85k for estates maintenance St George's Centre.

Table 8 Scheme	YTD Plan £m	YTD Actual £m	YTD Variance £m	Annual Plan £m	Forecast Outturn £m	Forecast Variance £m
Estate maintenance	0.0	0.1	0.1	0.5	0.5	0.0
Equipment/IT	0.0	0.0	0.0	0.8	0.8	0.0

Electronic Patient Records	0.2	0.2	(0.0)	0.5	0.5	0.0
Totals	**0.2**	**0.3**	**0.1**	**1.8**	**1.8**	**0.0**

7 Statement of Financial Position

Table 9 has the statement of financial position as at the end of August; the year to date position reflects that the Trust is £0.2m ahead of the planned surplus and the forecast outturn for 2017/18 includes the additional £0.5m STF monies which increased the surplus last year that wasn't in the planned position submitted to NHS Improvement in March 2017.

Trade receivables total £5.6m at the end of month 5. The largest debtor is Leeds City Council which owes £0.9m. Accrued income totals £2m, made up of £0.5m for CQUIN income and £0.3m for NHS England/CCG non-contract income. Non NHS non contract income is £0.4m and STF accruals for 2017/18 total £0.3m.

Trade payables total £12.3m at the end of August. Accrued expenditure totals £6.7m, made up of £2.9m for property charges and various other smaller accruals.

As a result of the above the cash position is £2.9m more than planned, with cash and cash equivalents totalling £23.1m.

Table 9 **Statement of Financial Position**	**Plan 31/08/17 £m**	**Actual 31/08/17 £m**	**Variance 31/08/17 £m**	***Opening 01/04/17 £m***	**Planned Outturn 31/03/18 £m**	**Forecast Outturn 31/03/18 £m**	**Forecast Variance 31/03/18 £m**
Property, Plant and Equipment	26.8	26.7	(0.1)	*27.1*	27.5	27.0	(0.4)
Intangible Assets	0.0	0.1	0.0	*0.1*	0.0	0.1	0.0
Total Non Current Assets	**26.8**	**26.7**	**(0.0)**	***27.2***	**27.5**	**27.1**	**(0.4)**
Current Assets							
Inventories	0.0	0.0	0.0	*0.0*	0.0	0.0	0.0
Trade and Other Receivables	6.3	5.6	(0.7)	*6.7*	6.6	6.6	0.0
Cash and Cash Equivalents	20.2	23.1	2.9	*19.1*	20.7	21.6	0.9
Sub-Total Current Assets	**26.5**	**28.7**	**2.2**	***25.8***	**27.3**	**28.2**	**0.9**
Non-Current Assets held for sale	0.2	0.2	0.0	*0.2*	0.0	0.0	0.0
Total Current Assets	**26.7**	**28.9**	**2.2**	*26.0*	**27.3**	**28.2**	**0.9**
TOTAL ASSETS	**53.5**	**55.6**	**2.1**	***53.2***	**54.8**	**55.2**	**0.5**
Current Liabilities							
Trade and Other Payables	(10.9)	(12.4)	(1.5)	*(11.1)*	(11.1)	(11.1)	0.0
Provisions	(0.8)	(1.2)	(0.4)	*(1.4)*	(0.4)	(0.4)	0.0
Total Current Liabilities	**(11.6)**	**(13.6)**	**(1.9)**	***(12.5)***	**(11.5)**	**(11.5)**	**0.0**
Net Current Assets/(Liabilities)	**15.0**	**15.1**	**0.2**	***13.5***	**15.8**	**16.7**	**0.9**
TOTAL ASSETS LESS CURRENT LIABILITIES	**41.8**	**42.0**	**0.2**	***40.7***	**43.2**	**43.7**	**0.5**
Non Current Provisions	0.0	0.0	0.0	*0.0*	0.0	0.0	0.0
Total Non Current Liabilities	**0.0**	**0.0**	**0.0**	***0.0***	**0.0**	**0.0**	**0.0**
TOTAL ASSETS LESS LIABILITIES	**41.8**	**42.0**	**0.2**	**40.7**	**43.2**	**43.7**	**0.5**
TAXPAYERS EQUITY							
Public Dividend Capital	0.3	0.3	0.0	*0.3*	0.3	0.3	0.0
Retained Earnings Reserve	14.2	14.1	(0.1)	*12.8*	15.6	16.1	0.5
General Fund	18.2	18.2	0.0	*18.2*	18.2	18.2	0.0
Revaluation Reserve	9.2	9.5	0.3	*9.5*	9.2	9.1	(0.0)

TOTAL EQUITY	41.8	42.0	0.2	40.7	43.2	43.7	0.5

8 Working Capital

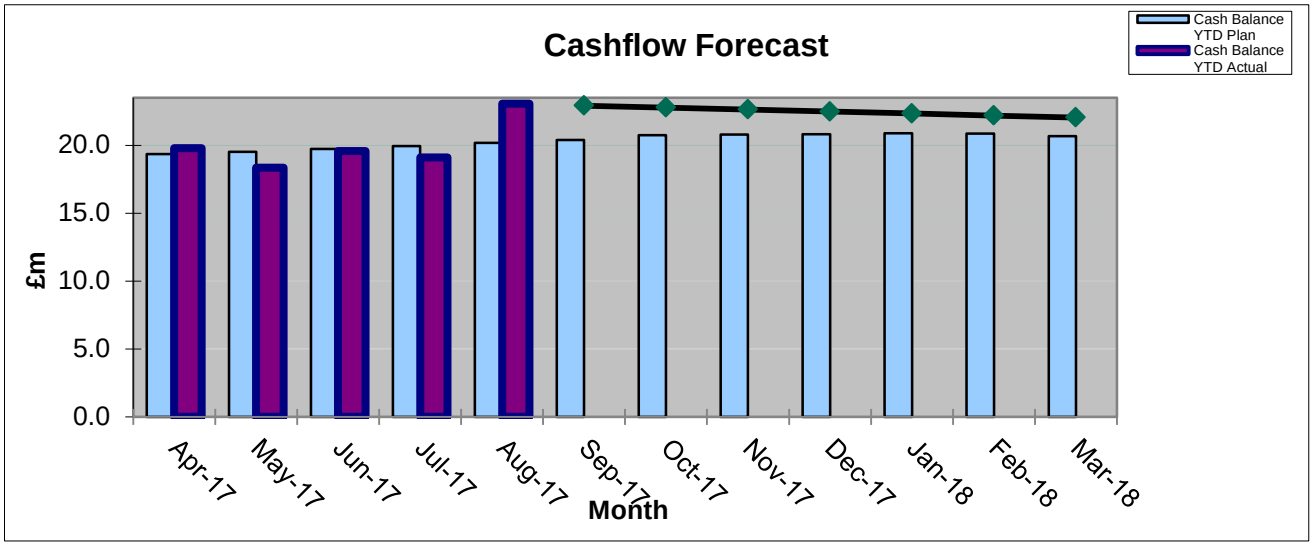


Chart 1 reflects the Board approved financial plan submitted to NHS Improvement March 2017. The planned, actual and forecast cash positions for the year are illustrated.

The Trust's cash position is strong at £23.1m which is £2.9m more than planned. In August Leeds City Council have paid more of the outstanding invoices than expected; this has increased the cash position this month but the forecast outturn for the end of the year remains consistent with last month's report.

Table 10 Measure	Performance This Month	Target	RAG
NHS Invoices			
By Number	98%	95%	G
By Value	99%	95%	G
Non NHS Invoices			
By Number	95%	95%	G
By Value	96%	95%	G

Table 10 demonstrates the Trust's performance in respect of the Better Payment Practice Code. Performance on non NHS invoices has recovered since the delays in paying agency invoices until employment status checks had been undertaken earlier in the year.

9 Use of Resources Risk Rating

Table 11 reports the Trust's financial performance calculated using the single oversight framework; which has revised criteria to determine an overall use of resources risk rating.

For August the Trust's overall result continues to be 1, which is the lowest risk.

Table 11 Criteria	Metric	Performance	Rating	Weighting	Score
Liquidity	Liquidity ratio (days without WCF)	39	1	20%	0.2
Balance Sheet sustainability	Capital servicing capacity (times)	7.6	1	20%	0.2
Underlying performance	I&E margin	2%	1	20%	0.2
Variance from plan	Distance from plan	0	1	20%	0.2

Agency spend above ceiling	Agency	-16%	1	20%	0.2
Overall Use of Resources Risk Rating					**1**

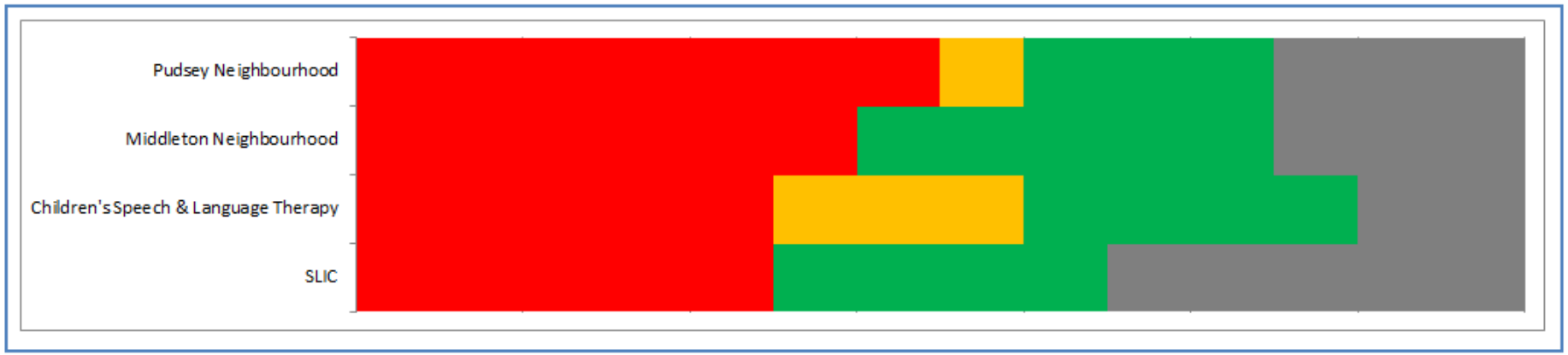
10 Conclusion on Financial Performance

The Trust's financial performance at the end of August continues to run slightly ahead of the planned control total surplus. CIP delivery continues to be a concern and pay overspending has been mitigated by the release of reserves. Staffing levels are below funded WTEs for all business units; temporary staffing is in place to mitigate service risks. Activity levels are 7.2% less than planned for the year month and year to date; this is a worse position than last month and is being driven by Children's services.

Based on the current forecast outturn additional savings circa £0.1m are required to deliver the £3.034m control total set by NHSI. Further financial risks such as the non delivery of CQUINs may have a negative impact on the Trust's performance as the year continues and the Trust has limited resources available to mitigate these should they arise.

Appendix 1 – Heat Map

Services with the most red ratings



Performance Assurance / Service	Safe				Effective			Caring		Responsive	Well Led					
	1.1	1.2	1.3	1.4	2.1	2.2	2.3	3.1	3.2	4.1	5.1	5.2	5.3	5.4	5.5	5.6
	Patient Safety Incidents Reported in Month Reported	Serious Incidents	Shift Fill	Temporary: Permanent Staffing Ratio	Patient Contacts	1st:FU Ratio	DNA Appointments	Number of Complaints	Friends & Family Score	Percentage of patients treated within 18 weeks	Sickness Absence	Extent of Overspend	% Leavers (permanent staff)	Staff Appraisal (12mth rate)	Staff Morale	6 universal statutory and mandatory training
	Monthly	Monthly	Monthly		Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	YTD	Monthly	YTD		YTD
Pudsey Neighbourhood																
Middleton Neighbourhood																
Children's Speech & Language Therapy																
SLIC																
Community Neurology																

Services with the most green ratings

Performance Assurance / Service	Safe				Effective			Caring		Responsive	Well Led					
	1.1	1.2	1.3	1.4	2.1	2.2	2.3	3.1	3.2	4.1	5.1	5.2	5.3	5.4	5.5	5.6
	Patient Safety Incidents Reported in Month Reported as "Harmful"	Serious Incidents	Shift Fill	Temporary: Permanent Staffing Ratio	Patient Contacts	1st:FU Ratio	DNA Appointments	Number of Complaints	Friends & Family Score	Percentage of patients treated within 18 weeks	Sickness Absence	Extent of Overspend	% Leavers (permanent staff)	Staff Appraisal (12mth rate)	Staff Morale	6 universal statutory and mandatory training requirements
	Monthly	Monthly	Monthly		Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	YTD	Monthly	YTD		YTD
Community Stroke Team																
MSK																
Podiatry																
Community Gynaecology																
TB Liaison																

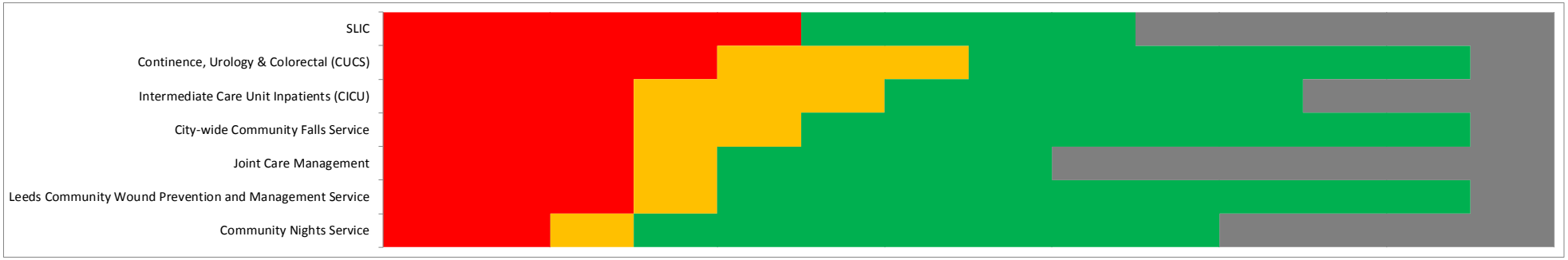
Performance Assurance Heat Map **Jun-17**

Early Warning Heat Map - Adult Services

On target | Approaching target | Cause for Concern | N/A or No Data Found | Under Development

The Heat Map below is configured to identified those services with the greatest pressure points and cause for concern

Adults



Performance Assurance / Service	Safe				Effective			Caring		esponsiv	Well Led					
	1.1	1.2	1.3	1.4	2.1	2.2	2.3	3.1	3.2	4.1	5.1	5.2	5.3	5.4	5.5	5.6
	Patient Safety Incidents Reported in Month Reported as "Harmful"	Serious Incidents	Shift Fill	Temporary: Permanent Staffing Ratio	Patient Contacts	1st:FU Ratio	DNA Appointments	Number of Complaints	Friends & Family Score	Percentage of patients treated within 18 weeks	Sickness Absence	Extent of Overspend	% Leavers (permanent staff)	Staff Appraisal (12mth rate)	Staff Morale	6 universal statutory and mandatory training requirements
	Monthly	Monthly	Monthly		Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	YTD	Monthly	YTD		YTD
Adult Services																
City-wide Community Falls Service																
Community Nights Service																
Continence, Urology & Colorectal (CUCS)																
Intermediate Care Unit Inpatients (CICU)																
Joint Care Management																
Leeds Community Wound Prevention and Management Service																
SLIC																

Early Warning Heat Map - Neighbourhood Teams **Jun-17**

On target | Approaching target | Cause for Concern | N/A or No Data Found | Under Development

The Heat Map below is configured to identified those services with the greatest pressure points and cause for concern

Neighbourhood Teams

Performance Assurance / Service	Safe				Effective			Caring		esponsiv	Well Led					
	1.1	1.2	1.3	1.4	2.1	2.2	2.3	3.1	3.2	4.1	5.1	5.2	5.3	5.4	5.5	5.6
	Patient Safety Incidents Reported in Month Reported as	Serious Incidents	Shift Fill	Temporary: Permanent Staffing Ratio	Patient Contacts	1st:FU Ratio	DNA Appointments	Number of Complaints	Friends & Family Score	Percentage of patients treated within 18 weeks	Sickness Absence	Extent of Overspend	% Leavers (permanent staff)	Staff Appraisal (12mth rate)	Staff Morale	6 universal statutory and mandatory training requirements
	Monthly	Monthly	Monthly		Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	YTD	Monthly	YTD		YTD
Neighbourhood Teams																
Armley Neighbourhood																
Beeston Neighbourhood																
Chapeltown Neighbourhood																
Holt Park Neighbourhood																
Kippax Neighbourhood																
Meanwood Neighbourhood																
Middleton Neighbourhood																
Morley Neighbourhood																
Pudsey Neighbourhood																
Seacroft Neighbourhood																
Wetherby Neighbourhood																
Woodsley Neighbourhood																
Yeadon Neighbourhood																

Performance Assurance Heat Map **Jun-17**

Early Warning Heat Map - Children & Families

On target | Approaching target | Cause for Concern | N/A or No Data Found | Under Development

The Heat Map below is configured to identified those services with the greatest pressure points and cause for concern

Children & Families

Performance Assurance / Service	Safe				Effective			Caring		Responsi	Well Led					
	1.1	1.2	1.3	1.4	2.1	2.2	2.3	3.1	3.2	4.1	5.1	5.2	5.3	5.4	5.5	5.6
	Patient Safety Incidents Reported in Month Reported as "Harmful"	Serious Incidents	Shift Fill	Temporary: Permanent Staffing Ratio	Patient Contacts	1st:FU Ratio	DNA Appointments	Number of Complaints	Friends & Family Score	Percentage of patients treated within 18 weeks	Sickness Absence	Extent of Overspend	% Leavers (permanent staff)	Staff Appraisal (12mth rate)	Staff Morale	6 universal statutory and mandatory training requirements
	Monthly	Monthly	Monthly		Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	YTD	Monthly	YTD		YTD
Children & Families																
CAMHS Inpatient Unit																
CAMHS Specialist Services																
Child Development Centres (CDC)																
Child Development Centres (CDC) - Health Visiting																
Child Protection Medical Service																
Children's Audiology																
Children's Community Eye Service																
Children's Learning Disability Team (CLDNT)																
Children's Nursing & Butterfly Team																
Children's Occupational Therapy																
Children's Physiotherapy																
Children's Speech & Language Therapy																
Community Paediatric Service																
Continuing Care Nursing Team (CCNT)																
Early Start Service (Health Visiting)																
Hannah House																
Inclusion Nursing Service																
Looked After Children (CLA)																
Paediatric Neuro Disability Clinics																
School Immunisation																
School Nursing																
Short Breaks																
Sickle Cell & Thalassaemia																
SLT Traded Activity																
Watch It																

Performance Assurance Heat Map **Jun-17**

Early Warning Heat Map - Specialist Services

On target | Approaching target | Cause for Concern | N/A or No Data Found | Under Development

The Heat Map below is configured to identified those services with the greatest pressure points and cause for concern

Specialist Services

Performance Assurance / Service	Safe				Effective			Caring		Responsi	Well Led					
	1.1	1.2	1.3	1.4	2.1	2.2	2.3	3.1	3.2	4.1	5.1	5.2	5.3	5.4	5.5	5.6
	Patient Safety Incidents Reported in Month Reported as "Harmful"	Serious Incidents	Shift Fill	Temporary: Permanent Staffing Ratio	Patient Contacts	1st:FU Ratio	DNA Appointments	Number of Complaints	Friends & Family Score	Percentage of patients treated within 18 weeks	Sickness Absence	Extent of Overspend	% Leavers (permanent staff)	Staff Appraisal (12mth rate)	Staff Morale	6 universal statutory and mandatory training requirements
	Monthly	Monthly	Monthly		Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	Monthly	YTD	Monthly	YTD		YTD
Specialist Services																
Adult Nutrition & Dietetics																
Adult Weight Management																
Cardiac Services																
Children's Nutrition & Dietetics																
Chronic Spinal Pain Management (SpineFit)																
CIVAS																
Community Dental Services																
Community Gynaecology																
Community Neurology																
Community Rehab Unit Inpatients																
Community Rehab Unit Outpatients																
Community SLT (Speech & Swallowing)																
Community Stroke Team																
Diabetes Services																
Healthy Lifestyle Service																
Leeds Sexual Health																
MSK																
Podiatry																
Leeds IAPT Service																
Prison Healthcare																
Respiratory Services																
Stop Smoking Service																
TB Liaison																

Performance Assurance Heat Map Measures Key

Measure	Metric					
Measure 1 - Safe	1.1	Patient Safety Incidents Reported in Month Reported as "Harmful"	Monthly	<30%	30%-35%	>35%
	1.2	Serious Incidents	Monthly	0		1+
	1.3	Shift Fill	Monthly	100%	95>%- and <100%	<95%
	1.4	Temporary:Permanent Staffing Ratio				
Measure 2 - Effective	2.1	Patient Contacts	Monthly	95%-105%	94%-95% or 105%-106%	<94% or >106%
	2.2	1st: Follow Up Ratio	Monthly	Meeting / Better than expected	5% of expected	Less then Expected
	2.3	DNA Appointments	Monthly	<=0%	0 to 5% of expected	>=5% of expected
Measure 3 - Caring	3.1	Number of Complaints	Monthly	0%	<2% to >5%	>5%
	3.3	Friends & Family Score	Monthly	>95%	90%-95%	<90%
Measure 4 - Responsive	4.1	Percentage of patients treated within 18 weeks	Monthly	>95%	90%-95%	<90%
Measure 5 - Well Led	5.1	Sickness Absence	Monthly	<4.6%	4.6%-9.7%	>9.7%
	5.2	Extent of Overspend	YTD	<0%	0%-5%	>5%
	5.3	% Leavers	Monthly	<13%	13%-18%	>18%
	5.4	Staff Appraisal (12mth rate)	YTD	>95%	95%-90%	<90%
	5.5	Staff Morale				
	5.6	6 universal statutory and mandatory training requirements	YTD	100%	95% > and <100%	<95%

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (48)

Meeting Trust Board 6 October 2017	**Category of paper**	
Report title Serious Incidents Summary Report	**For approval**	
Responsible director Executive Director of Nursing **Report author** Incident and Assurance Manager	**For assurance**	√
Previously considered by	**For information**	

Purpose of the report

This report provides the Board with an update and assurance in relation to the management of serious incidents. It summarises the outcomes, themes, actions and learning from SI investigations closed within the organisation during July and August 2017; as well as progress against action plans.

Main issues for consideration

A total of 11 serious incidents (SIs) were reported in July and August 2017 taking the total for the year 2017/18 to 34. This is a 10.5% reduction overall in SIs compared to the same period in the previous year.

Ten (90.9%) of the SIs in this reporting period related to pressure ulcers; with one other related to complex catheter management.

Outcomes of serious incident investigations completed in July and August 2017 are included in the report along with any themes identified through investigations. The themes remain consistent with previous reports and generally fall into four overarching categories: documentation, communication, processes and equipment.

There have been no pressure ulcer SIs being 'de-logged' from the strategic executive information system (StEIS). This is a positive reflection of accurate initial categorisation and recording.

Section 9 of the report details a summary of inquests. It is assuring to note that none of the inquests concluded year to date have resulted in recommendations for the Trust.

Recommendations

The Board is recommended to:

- receive this report and note the current position with regards action plans and learning
- receive assurance regarding the management of serious incidents and handling of inquests

Serious Incidents Summary Report

1.0 Purpose of this report

1.1 The purpose of this report is to provide the Trust Board with an overview of Serious Incidents (SIs) managed within LCH in the period 1 July 2017 – 31 August 2017.

1.2 The report provides a summary of the outcomes, themes, learning and actions from completed incident investigations. An update of service improvements and actions taken to prevent recurrence of the incident is also included in the report.

1.3 The report provides an overview of Coroner's Inquests held in relation to Serious Incidents, along with the outcomes of those.

2.0 Background

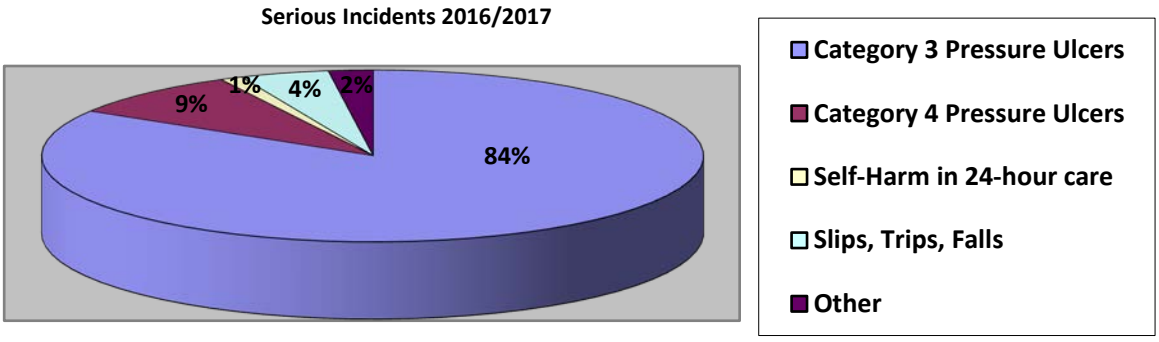
2.1 The Trust reports all incidents meeting the Serious Incident criteria, according to the NHS England Serious Incident Framework (DoH March 2015), via the Leeds West CCG Strategic Executive Information System (StEIS).

2.2 Serious Incidents (SIs) are reported on StEIS within 2 working days of the incident being confirmed as a Serious Incident. They are allocated to the relevant commissioner via the StEIS report.

2.3 SIs occurring in services with additional commissioning arrangements (for example HMP Wetherby YOI, Policy Custody, Leeds IAPT) are also reported to the relevant body, such as NHS England.

2.4 A monthly summary of SIs and any exceptions is included within the monthly Clinical Governance Exception report; part of the Trust's Executive Director of Nursing's Report. This is submitted to the Quality Committee.

2.5 In 2016/2017 LCH recorded 92 SIs. The pie chart below illustrates the percentage of each category.



2.6 The category "other" represents two incidents. One related to an unexpected death of a patient under LCH (community) services and one was related to an intervention error (incorrect patient identification). The latter was subsequently de-logged as an SI.

2.7 The reduction of pressure ulcers is a Quality Account quality improvement priority for 2017/18; and is part of the Trust's Sign up to Safety Pledge. The aim is to reduce avoidable category 3 pressure ulcers by 10% and have no avoidable category 4 pressure ulcers. Progress against this priority is reported on a quarterly basis to the SMT.

2.8 Sixteen SIs were recorded in May and June 2017; these were reported to Board in July.15 (93.7%) of these related to pressure ulcers and one to a fall resulting in a fracture.

2.9 A further SI (fracture from fall) was recorded subsequent to the last report. This was a historical fall that had initially not fulfilled SI criteria but had undergone investigation. Following a review the case was recorded as an SI and and this is represented in the table that follows in 3.2.

3.0 Current position

3.1 Eleven SI's were reported in July and August.

3.2 The table below provides a summary YTD within the reporting period.

2017 - 2018	Apr	May	Jun	Jul	Aug	Total
Pressure ulcer - Cat 3	4	7	6	0	1	18
Pressure ulcer - Cat 4	0	0	2	0	1	3
Pressure ulcer - Unstageable	Not previously SI criteria			0	8	8
Slips, trips, falls and collisions	1	1	1	0	0	3
Other	1	0	0	0	1	2
Total	6	8	9	0	11	34
Delogged SI's						0
Previous year 2016 - 2017	8	8	13	6	3	92

3.3 The implementation of the new process for SIs, as agreed with the CCG and outlined in the previous report, means that data from July 2017 will be incomparable to subsequent months, and also to the same reporting period from previous years. This is due to changes in process for certain categories of pressure ulcers i.e. unavoidable category 3 pressure ulcers are no longer recorded as SIs (fewer SIs); however, avoidable unstageable pressure ulcers do now fulfil the SI criteria (more SIs).

3.4 One SI in August was harm sustained to a community patient in relation to the delivery of complex catheter care and is currently under investigation.

3.5 There have been no pressure ulcer SI's being 'de-logged' from StEIS. This is a positive reflection of accurate initial categorisation and recording.

4.0 Completed Investigations

4.1 During July and August 2017 17 SI investigations were completed and closed. These included 13 category 3 pressure ulcer investigations, which are reported to the CCG within a quarterly summary report.

4.2 Of four SIs submitted individually to the CCG, two category 4 pressure ulcers, and two were falls resulting in a fracture. A synopsis is provided below:

Ref	Type	Status	Root Cause(s)
15185	Category 4 pressure Ulcer	Unavoidable	Patient with complex health needs and some concordance issues developed a category 4 pressure ulcer. Early involvement of wound care and health professionals provided as much care and education as possible. All possible prevention strategies implemented.
14836	Category 4 pressure Ulcer	Avoidable	Patient with co-morbidities had a deteriorating condition with capacity to make own informed decisions. However there were missed opportunities to fully screen and assess the patient to identify risks and deterioration in the patient's condition.
16092	Fracture sustained	Avoidable	Patient with a history of falls suffered a fall in a care home and sustained a fractured hip and bleeding to the brain. Although prevention equipment was in place, some assessments could have been conducted in a more timely way.
13317	Fracture sustained	Unavoidable	Inpatient with a history of falls, and at high risk of falls, had an unwitnessed fall in their room. The patient was mobilising alone without recommended assistance. All care was appropriate to the plans in place at the time.

4.3 The themes and learning from the closed investigations have been extracted and included in section 5.0.

4.4 All open SI's are currently within CCG investigation timescales.

5.0 Outcomes and Themes

5.1 Themes emerging from all the SI investigation reports completed in July and August identify the areas of concern to be:

5.1.1 **Documentation:**

- Accurate and specific documentation of care needs (accurate care plans) not always evident or updated in a timely way
- Specific risk assessments (relating to pressure ulcers) not always complete in timely manner/re-assessment not clearly documented
- Documentation of skin inspection and purpose T in line with policy not always as frequent as it should be
- Non-concordance issues not always clearly documented

5.1.2 **Communication:**

- Teams and departments need clear communication channels to ensure consistency, accuracy, accountability and effective working – communication problems are often highlighted

- The importance of keeping clear records of communication with patients/ family/carers is often highlighted and the need to involve carers in education and holistic assessment
- Improved communication between teams and services is an ongoing issue; particularly where other organisation/agencies are involved in the care provision
- Improved communication when there are concordance issues highlighted to ensure understanding and decisions are appropriately informed

5.1.3 **Care Delivery/Process:**

- Proactive case management not always evident – missed opportunities for risk identification of deteriorating conditions
- Weekly case manager reviews not always conducted
- Holistic assessment not always completed or reviewed frequently
- Timeliness of reviews and skin inspections not always evident
- Timeliness of referrals / visits / assessment and subsequent documentation frequently highlighted as contributing to pressure ulcer development

5.1.4 **Equipment:**

- Assessment and documentation of equipment not always complete fully
- Initial provision of equipment not always timely

5.2 Themes are reflective of those identified in previous reports, which relates in part to the cause of the SI's being of the same theme i.e. pressure ulcers and the complexities involved in reducing these incidents.

5.3 The targeted programme of education, led by the Pressure Ulcer Steering Group, continues.

6.0 Action Plans and Learning

6.1 All SI reports require an action plan to be developed alongside completion of the investigation. Action plans are reviewed at a validation panel to ensure they are SMART and fully address the recommendations.

6.2 The Business Units provide a monthly update of progress for open action plans. These are scrutinised and monitored via Patient Safety, Experience and Governance Group (PSEGG) and any issues are escalated to the Quality Committee. Access to action plans will also support the PSEGG to triangulate learning from incidents, patient experience and inclusion along with patient, carer and public involvement and feedback from staff (via workshop meetings). The action plans are overseen by the Business Unit Quality Leads.

6.3 Outcomes and experience from the management of SI's is shared with other organisations at the regional SI network meeting. This network will be used to develop benchmarking and identify areas for improving how learning is embedded.

7.0 CCG response

7.1 All SI investigations are sent to the CCG to review at a validation panel. The panel will authorise closure of an incident; or request further assurance with regards to the management of and learning from it.

7.2 The CCG requested further assurance in relation to three SI reports in July and August.

7.2.1 Two requests related to the quality of the reports and the action plans. These were reviewed and re-submitted with improved action plans and are awaiting CCG panel review for closure.

7.2.2 One request related to further information regarding the safeguarding process. Following submission of an amended response this SI was closed.

7.3 Partnership work continues between LCH and the CCG to cross reference all open SI's to ensure consistent records are held and that all completed investigations are closed on the StEIS database.

8.0 Inquests

8.1 Twenty-two inquests registered with LCH as an interested party were concluded in 2016/17.

8.2 Since 01 April 2017 there have been 7 inquests registered for LCH. The table below provides a real time update on the status of these inquests:

	Synopsis	Inquest Date	Outcome	Recommendations
1	Prisoner at HMP Leeds was found hanging in his cell in December 2013. Known to the drug misuse service but not to the mental health service in HMP.	20 Mar 2017 *(concluded April)*	Narrative Conclusion	PFD report (Reg 28) issued to prison. No criticism of LCH
2	Prisoner at HMP Leeds was found hanging in cell in November 2015.	02 May 2017	Narrative Conclusion	No Coroner recommendations for LCH
3	Prisoner at HMP Leeds was found hanging in cell in November 2015.	03 Jul 2017	Mis-adventure – pressure to neck	No Coroner recommendations for LCH
4	Patient in CIC bed developed infected pressure ulcers. Died November 2015.	19 Jul 2017	Narrative Conclusion	No Coroner recommendations for LCH
5	Prisoner at HMP Leeds was found hanging in cell in May 2015.	04 Sep 2017		
6	Inpatient died following accidental event	25 Sep 2017		
7	Prisoner at HMP Leeds was found hanging in cell in February 2016.	09 Oct 2017		

NB: There will be other inquests held for LCH patients. Those listed are for inquests where LCH is officially registered with the Coroner's office as a Properly Interested Party (PIP) and/or where LCH witnesses are required to provide information/evidence.

8.3 There have been no Prevention of Future Death (PFD) reports served by the Coroner to LCH under the Coroners Regulation 28 (Reg 28).

9.0 Impact

9.1 *Quality*

9.1.1 The process of SI management has an impact on quality in the following areas:

- Quality and safety of patient care
- Meeting statutory/regulatory requirements
- Supporting services with the local governance arrangements relating to serious incidents
- The organisations reputation with external and internal stakeholders

9.1.2 These priorities are addressed by ensuring the continuation of good governance of the Serious Incident process; identifying feedback from Commissioning bodies; and ensuring the opportunity for continuous improvement is embedded the SI management process.

9.2 *Risk and assurance*

9.2.1 All previously identified risks are being positively addressed to ensure that governance systems are in place to mitigate any risk in relation to good SI management.

10.0 Next steps – monitoring & improvements

10.1 Quality Committee will continue to receive assurance regarding SI management and learning as part of agreed monthly and quarterly reporting arrangements.

10.2 An annual themed report will be produced combining incidents (including SI's) and complaints with an interim (6 monthly) report of themes.

10.3 The Clinical Governance Team will continue to monitor the quality of SI action plans as previously advised.

10.4 The PSEGG will bring together themes, actions and learning and evidence the sharing of learning across the organisation.

11.0 Recommendations

11.1 The Trust Board is recommended to:

- receive this report and note the current position with regards action plans and learning
- receive assurance regarding the management of Serious Incidents and handling of inquests

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (49))

Meeting Trust Board 6 October 2017	**Category of paper**	
Report title Delivery of 2017/18 Operational Plan Priorities	**For approval**	
Responsible director Executive Director of Finance and Resources **Report author** Business Planning Manager	**For assurance**	✓
Previously considered by Senior Management Team 20 September 2017 and Business Committee 27 September 2017	**For information**	

Purpose of the report

This report provides an overview of progress towards achieving the corporate objectives and priorities set out in the 2017/18 operational plan at the end of month 5 and a forecast for the year-end.

Main issues for consideration

The 2017/18 Operational Plan set out four corporate objectives and a number of priorities for each objective. Each priority has one or more success measures, described in SMART terms where possible and appropriate. Each priority is given an overall RAG rating, as is each success measure. The RAG rating of priorities reflects an overall assessment of progress and performance in relation to the priority, not solely the component success measure RAG ratings.

Quarter 2 year performance

The month 5 / year to date position is:

- 13 of the 21 priorities (62%) are on track: green
- 6 (29%) priorities show slight adverse performance and / or risk of not achieving requirements: amber
- 2 (9%) priorities show significant adverse performance / not expected to achieve requirements at year end: red

For the year-end forecast:

- 16 of the 21 priorities (75%) on track for the year-end: green
- 4 (21%) priorities at risk of not achieving at year-end: amber
- 1 (4%) priority will not / not expected to achieve requirements at year end: red

The following priorities have amber or red RAG ratings:

Corporate objective 1: ensure consistent delivery of high quality care

Priority 1.2: deliver Quality Account priorities
The month 5 and year-end RAG ratings have changed from amber in quarter 1 to red as a result of:

- Protect patients from harm: 0 avoidable category 4 pressure ulcer target for 2017/18. There was one avoidable category 4 pressure ulcer in August 2017
- E-rostering roll-out being significantly behind schedule. Discussions with the supplier are continuing
- Patient friends and family test (FFT) response rate being below target in July and August 2017. Plan agreed to improve response rates

Priority 1.3: develop use of tools and provision of information supporting quality improvement
Month 5 position amber reflecting delays implementing safety huddles and quality boards however there is confidence that they will be established and embedded before the year-end.

Priority 1.5: improve access
The CAMHS and ICAN Quality Account priority access targets remain amber at quarter 2 reflecting continuing challenge for in achieving waiting time targets. Recovery plans are being implemented and closely monitored: CAMHS autism spectrum disorder assessment patients waiting over 12 weeks has improved since quarter 1.

Priority 1.8: improve patient feedback information
The RAG rating at month 5 is red due to FFT response rates in July and August 2017 being below the quarter 2 target (September 2017 data awaited). The year-end forecast is amber reflecting a plan for improving response rates having been agreed but there nevertheless being risk in relation to achieving the year-end target.

Corporate objective 2: create sustainable services

Priority 2.1: consolidate and develop sustainable integrated neighbourhood teams: as in quarter 1 the priority is rated amber reflecting the overall assessment of current service resilience. There is continued focus on caseload review, recruitment and retention and providing support to teams through team coaching. The success measures reflect workstreams (skills competency development and rolling out the electronic patient record and new ways of working) key building blocks to support service sustainability.

Priority 2.2: develop organisational approach to assessing and driving service sustainability
The Senior Management Team (SMT) proposes revising the success measure from:

- all services to complete a service self-assessment by 31 March 2018, to:
- complete self-assessments for services being tendered in 2017/18 by 31 March 2018

SMT has reflected that the organisational priority is ensuring processes supporting services preparing for tenders are robust. Self-assessments are now completed systematically as part of tender-ready activities. Self-assessments for other services are proposed to extend through 2018/19.

Corporate objective 3 Continue to improve staff engagement and morale

Priority 3.3: fill substantive posts required for effective delivery

The amber rating continues to reflect inability to recruit to all vacancies due to insufficient supply and the expectation that this will remain challenging; neighbourhood teams and adult in-patient units being particularly impacted. Adult in-patient unit turnover and recruitment has been exacerbated by the uncertainty of the community care beds tender process. Slight delay in finalising the adult services workforce plan.

Priority 3.5: Shift the way we work with patients and carers to a strengths and asset based approach aligned with social care model and health

The year-end forecast has changed from amber in quarter 1 to green reflecting funding having been approved for a city-wide proposal to drive a to a strengths based approach across health and care staff city-wide. A shift to a strengths based approach underpins the reduction in demand necessary to achieve the Leeds Health and Care Plan ambition and targets.

Recommendations

The Board is recommended to:

- Note the assessment of progress at the end of month 5 and the forecast for the year-end
- Consider SMT's proposal to revise the success measure: all services to complete a service self-assessment by 31 March 2018 in order to reflect the priority being ensuring support services preparing for tenders
- Consider the level of assurance provided about achievement of priorities

Key	On track	Slight under performance & / or risk of not achieving the priority / success measure	Significant under performance/ not expected to achieve at year-end

Corporate objective 1: Ensure consistent delivery of high quality care

Priority	Success Measure	Status at end of month 5	Year end forecast
1.1 Act on agreed recommend-ations from external reviews: CQC, Ofsted, HMIP	Implement agreed recommend-ations within timescales agreed by Board / sub committees	Overall: GREEN ❑ CQC Inspection: GREEN. Trust's CQC inspection report published, trust overall rating: 'good'. Finalising action plan to address 'must-do' and 'should-do' recommendations to send to the CQC by the 30th October 2017 ❑ CQC Ofsted joint SEND inspection: action plan implementation remains on track. Moderation panel introduced to assure quality of information in the Education Health and Care Plans ❑ HMIP Inspection March 2017. Draft report received and action plan submitted. Implementation on track	GREEN ❑ CQC: Mechanisms to provide assurance about progress implementing the action plan: Progress reporting to SMT and Quality Committee and Board Regular engagement meetings with the CQC Internal audit planned for November ❑ HMIP Formal response to the draft action plan and final approval not expected until December 2017. Completion of some actions dependent on prison co-operation and resource
1.2 Deliver Quality Account priorities and remedial action plans in place where any deviation	Delivery against Quality Account SMART indicators	Overall: RED Of the 10 Quality Account priorities 2 report quarterly and 4 not on track: ❑ Protect patients from harm: includes 0 avoidable category 4 pressure ulcers. 1 in August. ❑ e-rostering roll-out: behind schedule. Detailed discussions with the supplier to resolve system issue effecting roll-out continuing. ❑ FFT response rate: below target (>=6.8%) in July and August: 6.6% and 5.2 respectively ■ Improvement in access to CAMHS and ICAN: risk in relation to achieving targets. See pg 3	RED Reflects: ❑ Protect patients from harm: 0 category 4 pressure ulcers - red given zero tolerance ❑ e-rostering roll-out. Recovery plan being developed with the supplier ■ FFT response rate:risk of not achieving year-end target ■ CAMHS and ICAN access: rate: risk of not achieving year-end target

Key	On track	Slight under performance & / or risk of not achieving the priority / success measure	Significant under performance/ not expected to achieve at year-end

Corporate objective 1: Ensure consistent delivery of high quality care

Priority	Success Measure	Status at end of month 5	Year end forecast
1.3 Develop use of tools & provision of information supporting quality improvement: • Outcome reporting (QA priority) • Use of Quality Boards • Roll out safety huddles	• Increase in teams reporting outcomes • Sexual Health & agreed Childrens services using Quality Boards • Monthly safety huddles	Overall:AMBER ❑ Outcomes: AMBER. Resources to underpin a Trust-wide approach have been agreed by SMT. To include outcomes measures detailed in SDIPs, outcome measures with an application beyond one single service i.e. TOMs and EQ5D, and support to CQIN 5: patient activation Measures. Recruitment of a Project Manager will now proceed. ❑ Quality Boards: AMBER. Children's Bus Unit: Hannah House and LWH using and updating Quality Boards daily, Board ordered for ICAN. Specialist Business Unit: implementation across services delayed to ensure boards reflect key quality indicators and can be reported through monthly quality metrics. Revised timescale for implementation: 31 October. ❑ Safety huddles: Children's Bus Unit: not progressed at Hannah House due to changes in leadership. Daily huddle takes place at LWH. Specialist Business Unit to identify by 31 October services to adopt this approach and implement by the end of December.	Overall: GREEN ❑ Outcomes: GREEN. Likely will achieve an increase in number of services reporting outcome measures ❑ Quality Boards: GREEN: focus on establishing and embedding use. ❑ Safety huddles: GREEN. To be implemented at Hannah House. Use of Quality Boards and Safety huddles are part of LWH and Hannah House Quality Improvement Plans
1.4 Develop leadership throughout the organisation (Quality Account priority)	• Evaluate Lead programme • Deliver further LEAD programme and 4 Manager as Coach programmes	Overall: GREEN ❑ 1st LEAD programme completed June '17. Immediate impact evaluation very positive; 6 months evaluation post completion planned. ❑ Schedule agreed for further LEAD programme and 4 MAC programmes	Overall: GREEN ❑ Deliver further LEAD programme (start October 17) and 4 MAC programmes

Key	On track	Slight under performance & / or risk of not achieving the priority / success measure	Significant under performance/ not expected to achieve at year-end

Corporate objective 1: Ensure consistent deliver y of high quality care

Priority	Success Measure	Status at end of month 5	Year end forecast
1.5 Improve access (QA priority)	• CAMHS Autism Spectrum Disorder (ASD) and ICAN • CUCS initial assessment, Specialist Nursing Review • Understand waits and agree priority interventions	Overall: AMBER ❑ CAMHS and ICAN: AMBER. CAMHS: continuing high level of CAMHS ASD waiters >12 weeks:134 as at 14-Sept-2017; down from 168 at end of Q1. Implementation of additional core and temporary clinics, outsource assessments. Redesign of neuro pathways underway. ICAN: reduced SHV and medic capacity creating waiting time challenges. Co-working across SLT and ICAN; developing nurse competencies and pathways to reduce reliance on medics. ■ CUCs targets met - quarter 2 data not available yet. Met in quarter 1	Overall: AMBER ❑ AMBER reflects risk in relation to both CAMHS ASD and ICAN access targets. CAMHS trajectory indicates plans will enable 12 week waiting time target to be achieved by year-end. The focus on ASD may cause other CAMHS waiting times to increase. ICAN weekly wait time and access review. Breach risk flagging system operational
1.6 Improve workforce continuous improve-ment capability	• Review leadership development programme content • Participation in QI training: Improvement Academy, LIQH, Core Improvement Concepts training	Overall: GREEN ❑ Review leadership development programme content: GREEN. Workshop held in July. Development of QI sessions August – September. Assessment of QI leadership programmes through NHS Improvement underway. ❑ Participation in QI training: GREEN. Several leaders participating in LIQH programmes. Q1 assessed Improvement Academy on-line QI training: being promoted to Business Units. Agreed QI training to be incorporated within preceptorship programme.	Overall: GREEN ❑ Incorporate leadership for Improvement within Trust leadership programmes by Autumn. Leadership for QI to be delivered within LEAD programme from Autumn 2017. ❑ Launch and promotion of online QI training by Oct 2017. August 17 commence QI training within the preceptorship programme

Key	On track	Slight under performance & / or risk of not achieving the priority / success measure	Significant under performance/ not expected to achieve at year-end

Corporate objective 1: Ensure consistent delivery of high quality care

Priority	Success Measure	Status at end of month 5	Year end forecast
1.7 Maintain safe staffing in in-patients and develop safe staffing in community teams in line with national guidance	• Inpatients safe staffing target 97% • Achieve national agency cap • National guidelines compliance	❑ Inpatients safe staffing target: target achieved April – August with the exception of June when very narrowly missed: 96%. ❑ National agency cap: achieved ❑ National guidelines compliance: GREEN. As reported at Q1, SMT reviewed National Quality Board guidance about District Nursing safe caseloads and staffing levels and determined that there is no additional work arising	GREEN
1.8 Improve patient feedback information (Quality Account priority)	Quarterly increase in FFT response rates and equality data against 16/17 baseline	Overall: RED ❑ FFT response rate: RED. Below target (>=6.8%) in July and August: 6.6% and 5.2% respectively. Await September data. Plan for increasing FFT response rates and establishing the impact of the change in law regarding requirement for explicit permission to use mobile number to collect FFT responses by the end of quarter 2. Producing a report on FFT equality data by the end of quarter 2.	AMBER reflecting risk of not achieving quarterly target at year-end
1.9 Compliance with Duty of Candour requirements (QA priority)	Q1: target 90%, Q2 onwards: 100% compliance	GREEN ❑ Duty of Candour compliance: Green. Quarter 2 data not yet available. 100% target achieved consistently April – August	GREEN

Key	On track	Slight under performance & / or risk of not achieving the priority / success measure	Significant under performance/ not expected to achieve at year-end

Corporate objective 2: Create sustainable services

Priority	Success Measure	Status at end of month 5	Year end forecast
2.1 Consolidate and develop sustainable integrated NTs: • Fully implement EPR & new ways of working (NWOW) • Roll out e-rostering	• Improvements in NT staff FFT vs Q1 baseline • By year-end 80% of workforce in each NT competent in key clinical skills including EPR / mobile working • EPR and new ways of working rolled out to all NTs • Clear rotas in place	Overall: AMBER reflecting continued capacity and demand pressures due to high levels of sickness and turnover and difficulty recruiting to vacancies. The success measures reflect key developments required to support service sustainability going forward, not current service sustainability. The service has also introduced a capacity and demand tool and commenced work to identify a meaningful indicator(s) of service resilience. ▪ Staff FFT: quarter 2 data not available yet ▪ Skills competency GREEN. On track. Staff skills and competency development on track: September audit identified lower rates for non registered staff. Focus of new temporary competency sign-off roles will be deployed accordingly ▪ EPR/NWOW – GREEN. On track. Last NT to go live with mobile working on 9 October; all teams working towards migrating fully to electronic patient records . Readiness assessment for NWoW being undertaken with all teams to identify schedule for NWoW ▪ E-rostering – RED. e-rostering roll-out: behind schedule. Detailed discussions with the supplier to resolve system issue effecting roll-out continuing.	Overall : AMBER reflecting risk re balancing capacity and demand including winter pressures. Continue focus on prioritising and reviewing team caseloads and recruitment and retention alongside skills competency development and implementing EPR and NWoW. ❑ Skills competency– AMBER. Risk of not achieving for Band 3's for specific competencies ❑ EPR/NWOW – AMBER. Confident that all teams will migrate to full electronic patient record by year-end. NWoW roll-out scheduled to commence in November (on track), however dependent on implementing e-rostering. ▪ E-rostering – RED.

Key	On track	Slight under performance & / or risk of not achieving the priority / success measure	Significantlunder performance/ not expected to achieve at year-end

Corporate objective 2: Create sustainable services

Priority	Success Measure	Status at end of month 5	Year end forecast
2.2 Develop organisational approach to assessing and driving service sustainability. • Expand services where we excel and are the provider of choice • Support services to be ready to respond to tenders	• All services complete service self-assessment by March ’18 • Confirm services we want to expand by end of June ’17 • Expansion strategy in place by end of September ‘17	Overall: AMBER: ■ Complete all service self-assessments by March 18: RED. SMT propose revising this success measure to completing self-assessments only for services being tendered in 17/18 as this is the organisational priority. Self assessment for all other services proposed to complete by to March 19. Self-assessments are now completed systematically as part of tender-ready activities – completed for forthcoming tenders: Community Dental, Health Visiting and School Nursing. ❑ Confirm services we want to expand: AMBER. Business Development strategy states which services we want to expand. To be re-submitted to Business Committee October ‘17 for sign off ❑ Expansion strategy in place: AMBER expansion strategy included in the Business Development strategy	Overall: GREEN
2.3 Commence estates rationalisation	Delivery of key milestones monitored by Business Committee: • financial savings • reduction in estate • increase in space utilisation	Overall: GREEN 17/18 deliverables on track. On track to withdraw from James Reid House and Shaftesbury House in October ’17. Sale of Garforth clinic completed in September ’17.	GREEN: on track to deliver key milestones for 17/18. Project plan aligned to key deliverables to be completed in October.

Key	On track	Slight under performance & / or risk of not achieving the priority / success measure	Significant under performance/ not expected to achieve at year-end

Corporate objective 2: Create sustainable services

Priority	Success Measure	Status at end of month 5	Year end forecast
2.4 Develop a clear Children's services offer	Clear strategy by end of June 2017	AMBER: ❑ Reflects slight delay due to changes and gaps in Childrens Business Unit senior leadership team. Childrens Strategy submitted to September Business Committee and approved	GREEN
2.5 Meet financial targets	Achieve the Control Total and Capital Resource Limit	GREEN: On track. ❑ The Trust is slightly ahead of I&E plan at the end of Q2 and underspending against the capital resource limit	GREEN: On track The Trust is forecasting to achieve the control total and not exceed the capital resource limit

Key	On track	Slight under performance & / or risk of not achieving the priority / success measure	Significant under performance/ not expected to achieve at year-end

Corporate objective 3: Continue to improve staff engagement and morale

Priority	Success Measure	Status at end of month 5	Year end forecast
3.1. Further embed Our Working Lives Star and team effectiveness model • targeted team coaching • continue using coaching strategy to support Better Conversations	Improvements in 2017 national staff survey results • Ability to contribute to improvements at work • Staff motivation at work • Recommend LCH as a place to work. Target >52% Achieve turnover target: 15%	Overall: GREEN ❑ Staff survey results not expected until January 2018. Rated green to reflect SMT assessment of current preparatory work which includes tailoring team coaching to meet teams' needs, cultural mapping informing targeted support for teams and enabling identification and spread of good practice in high performing teams with strong culture. Plans in place to deliver LEAD and MAC programmes (see 1.4). Health coaching plan developed (see 4.1) ■ Turnover target: AMBER. 15% target narrowly missed: 15.1% throughout April – August. Continues to be below the community provider average	GREEN: ❑ Turnover: GREEN. Turnover has reduced throughout the 1st 5 months of the financial year and marginally above target. Based on the trend, and continued focus in this area, expect to achieve the turnover target in quarters 3-4.
3.2 • Strengthen management of regular short-term sickness absence when no underlying health condition • Provide earlier supported intervention for long term absences	• Achieve 17/18 sickness trajectory (Q4: 5.2%) CQUINs: • 5% improvement over 2 years on staff survey questions on health and well-being, stress, MSK • staff flu immunisation target: 70%	Overall: GREEN ❑ Sickness absence: GREEN Q2 trajectory achieved in August: 5.5% CQINs: ❑ Health and Well-Being: GREEN. SMT agreed a Health and Well-Being action plan and next steps in September ❑ Staff flu immunisation: GREEN. Campaign launching 29 September	GREEN ❑ On track to achieve year-end sickness absence and staff flu immunisation targets. ■ Staff health and well-being CQUIN: AMBER. Risk of not being achieved as the improvement target is challenging

Key	On track	Slight under performance & / or risk of not achieving the priority / success measure	Significant under performance/ not expected to achieve at year-end

Corporate objective 3: Continue to improve staff engagement and morale

Priority	Success Measure	Status at end of quarter 1	Year end forecast
3.3 Fill substantive posts required for effective delivery	• Sustain time from placing advert to filling vacancies by role / service • Recruit in line with Adult Workforce Plan	Overall: AMBER reflecting not currently able to recruit to all vacancies due to insufficient supply. ■ Time taken to fill vacancies : GREEN. Q2 data not available yet, Q1 targets met . The recruitment team are currently recruiting to vacancies and will be fully staffed by the end of quarter 3 and able to improve recruitment times and quality of recruit further. ❑ Recruit in line with Adult Workforce Plan: AMBER. Interim recruitment intelligence informing recruitment planning pending finalisation of Adult Workforce Plan. Adult Workforce Plan slightly delayed: due to be completed by end of quarter 2, Adult Bus Unit senior management team to review the draft early October. Continuing to work with local universities in preparation of new qualified nursing graduating September 2018. LCH continues to have a presence at national career events to continue attraction work.	AMBER reflecting challenge in recruiting to vacancies.
3.4 Reduce the number of staff leaving within 12 months of start date	• Use stability index metric to measure retention of staff: 85% • Leavers in first 12 months: target 19-22%	Overall: GREEN ❑ Stability index AMBER: May – August : 84%, very narrowly missing the 85% target. ❑ Leavers within 12 months: GREEN: target met. Progressive reduction since April: over quarter one reduced from 18% to 16%, in July and August further reduced: 14%, 13.5%. Each Bus Unit is below target. Deep dive by the recruitment and retention steering group to understand reasons for leaving alongside culture mapping work which will inform retention strategies.	GREEN: current trajectory and intelligence suggests targets will be achieved

Key | On track | Slight under performance & / or risk of not achieving the priority / success measure | Significantly under performance/ not expected to achieve at year-end

Corporate objective 4: Take a lead role in delivering new models of care in the city through system integration

Priority	Success Measure	Status at end of month 5	Year end forecast

3.5 Shift the way we work with patients and carers to a strengths and asset based approach aligned with social care model and health	• Secure commitment from partners city-wide to a plan that will drive a shift in the way we work to a strengths based approach at the pace required to deliver the Leeds Plan
	• Deliver health coaching training
	  • NTs: 10 x 2 hour introductory sessions - approx 30 per session
	  • 5 x 2-day - max 20 staff per session
	• Positive evaluation of 2-day training
		Overall: GREEN.
		❑ September Health and Wellbeing Board approved £300k funding for 2017/18 – 2019/20 to drive a shift city-wide to a common strengths based approach at pace
		❑ Schedule for NT introductory sessions agreed: commences September '17
		❑ Resource to deliver 5 2-day sessions agreed; sessions booked.
			GREEN

3.6 Develop new models of care (NMoC) • Work with primary care and LYPFT to redesign and implement the community based mental health offer • Contribute to develop't of LTC pathways and models for the city	• Integrated mental health pathway designed and implemented • Participate in developing and implementing new models for Diabetes, MSK, Respiratory, Cellulitis	Overall: GREEN. ❑ MH pathway: leadership for redesigning mental health pathways in Leeds has moved to the commissioner. The change in leadership and direction has delayed pathway redesign. Work continues at service level to improve current models such as developing groups for patients cared for by LYPFT. ❑ NMoC developments include: 1. Diabetes structured education model agreed, 2. Continuing delivery of 3 MSK pilots, 3. Progressing integrated Gynaecology service pathway redesign with LTHT and commissioners, 4. Seven day Respiratory Service went live April 17, 5. Progressing work on developing additional IV pathways and identifying estate for CIVAS community hubs, *6.* Implementing the Foot Protection pathway. Cellulitis pathway on hold while medication piloted.	GREEN ❑ NMoC development: continue influencing citywide discussions: Diabetes and MSK

Key	On track	Slight under performance & / or risk of not achieving the priority / success measure	Significantlunder performance/ not expected to achieve at year-end

Corporate objective 4: Take a lead role in delivering new models of care in the city through system integration

Priority	Success Measure	Status at end of month 5	Year end forecast
4.1 Engage pro-actively in STP and Leeds Plan development and implementation including: • multispecialty community provider hubs building on NT New Models of Care pilots • Develop LCH as the under-arching structure and ready for '18/19 alliance commissioning	• All NTs working with clusters of GPs in the developing locality models • Clarity about alliance model / ACO governance • Roll out leadership work around neighbourhoods • Virtual budgets starting to be held and understood at cluster/cohort level	Overall: GREEN ❑ All NTs are working with clusters of GPs in the developing locality models ❑ Alliance model: MOU signed with GP federations, One Medical Group and Local Care Direct to form an alliance. This alliance will be the provider of GP Streaming in A&E but seen as a crucial step in development of ACS. LCH to hold contract. ❑ Leadership work around neighbourhoods: Accountable Care Development Board established, jointly chaired by Thea and Nigel Gray. Group to steer and roll out the leadership model around NTs established. ❑ GP leader on virtual budgets in place and starting in July. The first population health management segment has been decided: frailty. Work is now starting to define this. Internal steering group established reporting to SMT Work has started to review all strategy alignment against direction of travel. Staff engagement started A clear project plan leading to development of an integrated LCH LTHT nursing workforce is in place	GREEN LCH remains on track to work at the heart of the changes and take this work forward. This is, however a multi-agency programme and success is not simply down to LCH alone. Work will continue to iterate and develop throughout the year. The work we can control will be overseen by the new LCH models of care group established. Through city wide working developing a project plan aligned to the Leeds health and care plan.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (50)

Meeting Trust Board 6 October 2017	**Category of paper**	
Report title Emergency Preparedness Annual Report 2016/17	**For approval**	√
Responsible director Executive Director of Operations **Report author** Resilience Manager	**For assurance**	√
Previously considered by n/a	**For information**	

Purpose of the report

This paper is designed to provide the Board with an overview of emergency preparedness, resilience and response (EPRR) activity over the last year and identifies priorities for 2017/18. In addition, the Trust is required to undertake a self-assessment against the 2017/18 national emergency planning, resilience and responsiveness (EPRR) core standards and complete the statement of compliance identifying the organisation's overall level of compliance. This process is overseen by NHS England to ensure that the NHS is prepared to respond to an emergency and has resilience in relation to continuing to provide safe patient care.

Main issues for consideration

This paper presents the Board with the outcome of the self-assessment of the Trust's position against the EPRR standards. In summary the self-assessment proposes:

- The Trust is fully compliant (green) with 51 of 54 core standards and five of the six governance standards
- The Trust is not fully compliant with three of the core standards - the improvement plan at appendix B sets out how the Trust will become fully compliant within the next 12 months.
- The Trust has identified a non-executive director to oversee the portfolio but this information is not yet publicised appropriately. This governance standard has been rated as amber – not fully compliant
- There are no standards where the Trust is not compliant

The Board is recommended to:

- Note the EPRR activity over the last year and the priorities for 2017/18
- Note that the emergency planning team has completed a self-assessment against the EPRR core standards
- Note that there are three core standards and one governance standard considered 'not fully compliant'
- Approve the recommendation to submit an overall assessment of 'substantially compliant' against the standards (in line with national guidance)
- Review and approve the Trust's associated improvement plan

Leeds Community Healthcare NHS Trust

EMERGENCY PREPAREDNESS ANNUAL REPORT

October 2016 - September 2017

1. Overview

The Trust continues to fulfil the requirements placed upon it as detailed in the Civil Contingencies Act 2004 as a provider of NHS-funded healthcare. These requirements ensure that the organisation is operationally resilient to any form of disruption to normal service provision as well as being able to respond to major incidents.

As in previous years, all services both operational and corporate have been required to review and update their Business Continuity Plans as required to ensure that their arrangements for mitigating the effect of and dealing with the impact of disruptive events are fit for purpose.

The Trust has held a number of emergency planning-related exercises throughout the year designed to test the effectiveness of our plans and to provide an opportunity for staff to share knowledge and expertise with each other.

2. EPRR Core Standards Assurance Process

The Trust is required to adhere to the requirements of the NHS England Emergency Preparedness, Resilience and Response **(**EPRR) Assurance Process. The purpose of this process is to assess the preparedness of the NHS, both commissioners and providers, against common NHS EPRR Core Standards in order to provide assurance that both the NHS in England and NHS England are prepared to respond to emergencies, and are resilient in relation to continuing to provide safe patient care.

As an organisation we must:

- Undertake a self-assessment against the relevant NHS England Core Standards for EPRR. This comprehensive assessment is attached at Appendix A
- Complete an Improvement Plan which details further actions required to achieve full compliance (see Appendix B)
- Complete a Statement of Compliance identifying the Trust's overall level of compliance with the standards (see Appendix C)
- Present this to the Trust Board for sign-off prior to submission to NHSE by Friday 6th October 2017

Self-assessment

There is a new requirement this year (standard DD3 in the governance section) to identify a non-executive director who holds the EPRR portfolio for the organisation. It has been agreed that Brodie Clark will fulfil this role and the Business Committee will have oversight of this portfolio. There is an expectation that the organisation publicly identifies the non-executive Director/ that holds the EPRR portfolio via their public website and annual report. As this is a recent change the information has not been included in the annual report nor is it yet on the public website – for these reasons the standard is rated as amber

There are three amber rated standards in the core standards section:

Standard 26 - Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical. Good progress has been made on this standard; however a final definition of "critical" services is still required. This will agreed within the next month (Action – Resilience Manager)

Standard 37 - Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents. This work is in progress and is anticipated to be complete by the end of the calendar year (Action – Head of Communications)

Standard 49 - Arrangements include a current training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents. Having reviewed current arrangements there is a need for further trained loggists by end of December (Action – Resilience Manager)

Actions from the previous year have either been completed or have elements of ongoing work (included in appendix B)

3. Escalation Planning

A significant workstream this year has been around developing the OPEL (Operational Pressures Escalation Levels) plan for escalation, both internally to the Trust and externally with our partner organisations. An organisation-wide OPEL plan is now in place which has been developed alongside a working group comprised of representatives from key organisations across the healthcare community.

This plan identifies the key triggers and associated values which would determine our OPEL escalation level. Within each level a number of internal and external actions have been defined which, when actioned, should enable the Trust to recover from the period of pressure and de-escalate.

4. Exercises

Emergency planning and business continuity exercises are required as part of our obligations under the CCA and as part of the NHSE Core Standards. The Trust is required to hold a desk-top exercise at least annually and a live exercise at least once every three years.

This year the Trust has held the following exercises:

- Mass casualty desk-top exercise
- Two cyber-security exercises
- A live building denial exercise

The mass casualty exercise scenario mirrored the recent Manchester Arena attack and required our on-call managers to play out the scenario as though it had happened out of hours at the Leeds Arena. A number of actions were identified throughout the course of the exercise and, as a result, the Trust's Major Incident Plan has had a full review and refresh, resulting in a much more user-friendly and fit for purpose document.

The two cyber-security exercises were run on separate occasions, once with Chapeltown Neighbourhood Team and again with Armley Neighbourhood Team. It was designed to test the resilience of both teams in the event of the loss of all IT systems for an extended period of time. This was in response to the recent cyber-security incident which affected a number of NHS organisations nationally. The feedback from the participants of both exercises was that it was hugely beneficial and that the teams are confident in their ability to maintain essential service delivery. A number of actions were identified and an action plan produced.

The live exercise was held at Stockdale House and the scenario was based around the denial of access to the building. All staff were required to leave the premises and access was then denied to all staff and visitors for a number of hours. This exercise was a test of the Business Continuity Plans of all affected staff and services. This exercise was very successful and all services were able to maintain service delivery.

Debrief reports have been produced for all exercises and include details of the action plan, along with feedback from participants and lessons learned.

5. Future Priorities

The emergency preparedness and resilience priorities for the forthcoming year are:

- Continued development of the OPEL plan
- Specific identification of critical elements of the Trust's key services and how these will be maintained in the event of disruption
- Identification and training of additional Loggists to ensure resilience within the Emergency Management Team

NHS England Core Standards for Emergency preparedness, resilience and response

v5.0

The attached EPRR Core Standards spreadsheet has 6 tabs:

EPRR Core Standards tab: with core standards nos 1 - 37 (green tab)

Governance tab:-with deep dive questions to support the EPRR Governance'deep dive' for EPRR Assurance 2017 -18(blue) tab)

HAZMAT/ CBRN core standards tab: with core standards nos 38- 51. Please note this is designed as a stand alone tab (purple tab)

HAZMAT/ CBRN equipment checklist: designed to support acute and ambulance service providers in core standard 43 (lilac tab)

MTFA Core Standard: designed to gain assurance against the MTFA service specification for ambulance service providers only (orange tab)

HART Core Standards: designed to gain assurance against the HART service specification for ambulance service providers only (yellow tab).

This document is V50. The following changes have been made :

• Inclusion of EPRR Governance questions to support the 'deep dive' for EPRR Assurance 2017-18

	Core standard	Clarifying information	Community services providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance								
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		Y	• Ensuring accountaable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergeny Preparedness Resilience and Response, and Business Continuity Management agendas • Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible. • Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles. • Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles. • Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation. • That there is an approporiate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.	Green	None	N/A	N/A
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and changes in the organisations - changes in key personnel - changes in guidance and policy	Y		Green	None	N/A	N/A
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent unambiguous terminology, • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place. • Include references to other sources of information and supporting documentation	Y		Green	None	N/A	N/A
4	The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.	Y		Green	None	N/A	N/A
Duty to assess risk								
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver its functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages;	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages	Green	None	N/A	N/A
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.	• surges and escalation of activity; • IT and communications; • utilities failure; • response a major incident / mass casualty event • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites) There is a process to consider if there are any internal risks that could threaten the performance of the organisation's functions in an emergency as well as external risks eg. Flooding, COMAH sites etc.	Y	• Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed	Green	None	N/A	N/A
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.	Y		Green	None	N/A	N/A
Duty to maintain plans – emergency plans and business continuity plans								
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Y	Relevant plans: • demonstrate appropriate and sufficient equipment (inc. vehicles if relevant) to deliver the required responses • identify locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; • take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres; • include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met.	Green	None	N/A	N/A
9		corporate and service level Business Continuity (aligned to current nationally recognised BC standards)	Y		Green	None	N/A	N/A
10		HAZMAT/ CBRN - see separate checklist on tab overleaf	Y		Green	None	N/A	N/A
11		Severe Weather (heatwave, flooding, snow and cold weather)	Y		Green	None	N/A	N/A
12		Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions)	Y		Green	None	N/A	N/A
13		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)	Y		Green	None	N/A	N/A
14		Mass Casualties	Y		Green	None	N/A	N/A
15		Fuel Disruption	Y		Green	None	N/A	N/A
16		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)	Y		Green	None	N/A	N/A
17		Infectious Disease Outbreak	Y		Green	None	N/A	N/A
18		Evacuation	Y		Green	None	N/A	N/A
19		Lockdown	Y		Green	None	N/A	N/A
20		Utilities, IT and Telecommunications Failure	Y		Green	None	N/A	N/A
24	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions (including action cards) of support staff including communications • Location of incident co-ordination centre (ICC) from which emergency or business continuity incident will be managed • Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents • Complementary generic arrangements of other responders (including acknowledgement of multi-agency working) • Stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • Contact details of key personnel and relevant partner agencies • Plan maintenance procedures (Based on Cabinet Office publication Emergency Preparedness, Emergency Planning, Annexes 5B and 5C (2006))	Y	• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency plans • Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down • Version control and change process controls • List of contributors • References and list of sources • Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).	Green	None	N/A	N/A
25	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision - Specify who should be consulted before making the decision - Specify who should be informed once the decision has been made (including clinical staff)	Y	• Oncall Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.	Green	None	N/A	N/A
26	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities	Y	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control/co0ordination centre	Amber	Further work is on-going to identify critical functions of key services	Emma Lydon	Oct-17
27	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management	Y		Green	None	N/A	N/A
28	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content		Y	• Specifiy who has been consulted on the relevant documents/ plans etc.	Green	None	N/A	N/A
29	Arrangements include a debrief process so as to identify learning and inform future arrangements	Explain the de-briefing process (hot, local and multi-agency, cold) at the end of an incident.	Y		Green	None	N/A	N/A
Command and Control (C2)								
30	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Y	Explain how the emergency on-call rota will be set up and managed over the short and longer term.	Green	None	N/A	N/A
31	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England publised competencies are based upon National Occupation Standards .	Y	Training is delivered at the level for which the individual is expected to operate (ie operational/ bronze, tactical/ silver and strategic/gold). for example strategic/gold level leadership is delivered via the 'Strategic Leadership in a Crisis' course and other similar courses.	Green	None	N/A	N/A
32	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	This should be proportionate to the size and scope of the organisation.	Y	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control/co0ordination centre and manage any events required.	Green	None	N/A	N/A
33	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.		Y		Green	None	N/A	N/A
34	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.		Y		Green	None	N/A	N/A
Duty to communicate with the public								

	Core standard	Clarifying information	Community services providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
37	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off site implications) - include the process of communication with internal staff - consider what should be published on intranet/internet sites - have regard for the warning and informing arrangements of other Category 1 and 2 responders and other organisations.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous information campaigns to inform the development of future campaigns • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'. • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes. • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work.	Amber	Crisis Comms Plan in development	Jayne Murphy	Dec-17

	Core standard	Clarifying information	Community services providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
38	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		Y	• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.	Green	None	N/A	N/A
Information Sharing – mandatory requirements								
39	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and inclue DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supercedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance.	Y	• Where possible channelling formal information requests through as small as possible a number of known routes. • Sharing information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups. • Collectively developing an information sharing protocol with the Local Resilience Forum(s) / Borough Resilience Forum(s). • Social networking tools may be of use here.	Green	None	N/A	N/A
Co-operation								
40	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)		Y	• Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and memebership is quorat. • Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups • Taking lessons learned from all resilience activities • Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives • Establish mutual aid agreements • Identifying useful lessons from your own practice and those learned from collaboration with other responders and strategic thinking and using the Local Resilience Forum(s) / Borough Resilience Forum(s)	Green	None	N/A	N/A
41	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA		Y		Green	None	N/A	N/A
42	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	NB: mutual aid agreements are wider than staff and should include equipment, services and supplies.	Y		Green	None	N/A	N/A
45	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc.	Y		Green	None	N/A	N/A
48	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level		Y		Green	None	N/A	N/A
Training And Exercising								
49	Arrangements include a curent training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • A training needs analysis undertaken within the last 12 months • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate • Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective • Arrangements include providing training to an appropriate number of staff to ensure that warning and informing arrangements are effective	Y	• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice • Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles • Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises • Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs. • Developing and documenting a training and briefing programme for staff and key stakeholders • Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidentshave been taken forward • Programme and schedule for future updates of training and exercising (with links to multi-agency exercising where appropriate) • Communications exercise every 6 months, table top exercise annually and live exercise at least every three years	Amber	Identification and training of additional Loggists required	Emma Lydon	Dec-17
50	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties. • Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years. • If possible, these exercises should involve relevant interested parties. • Lessons identified must be acted on as part of continuous improvement. • Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing arrangements are effective	Y		Green	None	N/A	N/A
51	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises		Y		Green	None	N/A	N/A
52	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		Y		Green	None	N/A	N/A

	Core standard	Clarifying information	Community services providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
2015 Deep Dive								
DD1	The organisation's Accountable Emergency Officer has taken the result of the 2016/17 EPRR assurance process and annual work plan to a pubic Board/Governing Body meeting for sign off within the last 12 months.	• The organisation has taken the LHRP agreed results of their 2016/17 NHS EPRR assurance process to a public Board meeting or Governing Body, within the last 12 months • The organisations can evidence that the 2016/17 NHS EPRR assurance results Board/Governing Body results have been presented via meeting minutes.	Y	• Organisation's public Board/Governing Body report • Organisation's public website	Green	None	N/A	N/A
DD2	The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report.	• There is evidence that the organisation has published their 2016/17 assurance process results in their Annual Report	Y	• Organisation's Annual Report • Organisation's public website	Green	None	N/A	N/A
DD3	The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.	• The organisation has an identified Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio. • The organisation has publicly identified the Non-executive Director/Governing Body Representative that holds the EPRR portfolio via their public website and annual report • The Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio is a regular and active member of the Board/Governing Body • The organisation has a formal and established process for keeping the Non-executive Director/Governing Body Representative briefed on the progress of the EPRR work plan outside of Board/Governing Body meetings	Y	• Organisation's Annual Report • Organisation's public Board/Governing Body report • Organisation's public website • Minutes of meetings	Amber	identify Non-executive Director on their public website and annual report	Emma Lydon	2017/18 annual report
DD4	The organisation has an internal EPRR oversight/delivery group that oversees and drives the internal work of the EPRR function	• The organisation has an internal group that meets at least quarterly that agrees the EPRR work priorities and oversees the delivery of the organisation's EPRR function.	Y	• Minutes of meetings	Green	None	N/A	N/A
DD5	The organisation's Accountable Emergency Officer regularly attends the organisations internal EPRR oversight/delivery group	• The organisation's Accountable Emergency Officer is a regular attendee at the organisation's meeting that provides oversight to the delivery of the EPRR work program. • The organisation's Accountable Emergency Officer has attended at least 50% of these meetings within the last 12 months.	Y	• Minutes of meetings	Green	None	N/A	N/A
DD6	The organisation's Accountable Emergency Officer regularly attends the Local Health Resilience Partnership meetings	• The organisation's Accountable Emergency Officer is a regular attendee at Local Health Resilience Partnership meetings • The organisation's Accountable Emergency Officer has attended at least 75% of these meetings within the last 12 months.	Y	• Minutes of meetings	Green	None	N/A	N/A

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Community services providers		Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Q	**Core standard**	**Clarifying information**		**Evidence of assurance**				
	Preparedness							
53	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Arrangements include: • command and control interfaces • tried and tested process for activating the staff and equipment (inc. Step 1-2-3 Plus) • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • communications planning for public and other agencies • interoperability with other relevant agencies • access to national reserves / Pods • plan to maintain a cordon / access control • emergency / contingency arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving arrangements • Version control	Green	None	N/A	N/A
54	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Decontamination trained staff can access the plan	Y	• Site inspection • IT system screen dump	Green	None	N/A	N/A
55	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Documented systems of work • List of required competencies • Impact assessment of CBRN decontamination on other key facilities • Arrangements for the management of hazardous waste	Y	• Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7)	Green	None	N/A	N/A
57	Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7.	• For example PHE, emergency services.	Y	• Provision documented in plan / procedures • Staff awareness	Green	None	N/A	N/A
	Decontamination Equipment							
58	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	• Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	• completed inventory list (see overleaf) or Response Box (see Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities (NHS London, 2011))	Green	None	N/A	N/A
	Training							
64	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/ CBRN command and control training • Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus • Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	• Show evidence that achievement records are kept of staff trained and refresher training attended • Incorporation of HAZMAT/ CBRN issues into exercising programme	Green	None	N/A	N/A
66	Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	• Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf)	Y		Green	None	N/A	N/A

HAZMAT CBRN equipment list - for use by Acute and Ambulance service providers in relation to Core Standard 43.

No	Equipment	Equipment model/ generation/ details etc.	Self assessment RAG Red = Not in place and not in the EPRR work plan to be in place within the next 12 months. Amber = Not in place and in the EPRR work plan to be in place within the next 12 months. Green = In place.
	EITHER: Inflatable mobile structure		
E1	Inflatable frame		
E1.1	Liner		
E1.2	Air inflator pump		
E1.3	Repair kit		
E1.2	Tethering equipment		
	OR: Rigid/ cantilever structure		
E2	Tent shell		
	OR: Built structure		
E3	Decontamination unit or room		
	AND:		
E4	Lights (or way of illuminating decontamination area if dark)		
E5	Shower heads		
E6	Hose connectors and shower heads		
E7	Flooring appropriate to tent in use (with decontamination basin if needed)		
E8	Waste water pump and pipe		
E9	Waste water bladder		
	PPE for chemical, and biological incidents		
E10	The organisation (acute and ambulance providers only) has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required. (NHS England published guidance (May 2014) or subsequent later guidance when applicable).		
E11	Providers to ensure that they hold enough training suits in order to facilitate their local training programme		
	Ancillary		
E12	A facility to provide privacy and dignity to patients		
E13	Buckets, sponges, cloths and blue roll		
E14	Decontamination liquid (COSHH compliant)		
E15	Entry control board (including clock)		
E16	A means to prevent contamination of the water supply		
E17	Poly boom (if required by local Fire and Rescue Service)		
E18	Minimum of 20 x Disrobe packs or suitable equivalent (combination of sizes)		
E19	Minimum of 20 x re-robe packs or suitable alternative (combination of sizes - to match disrobe packs)		
E20	Waste bins		
	Disposable gloves		
E21	Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe		
E22	FFP3 masks		
E23	Cordon tape		
E24	Loud Hailer		
E25	Signage		
E26	Tabbards identifying members of the decontamination team		
E27	Chemical Exposure Assessment Kits (ChEAKs) (via PHE): should an acute service provider be required to support PHE in the collection of samples for assisting in the public health risk assessment and response phase of an incident, PHE will contact the acute service provider to agree appropriate arrangements. A Standard Operating Procedure will be issued at the time to explain what is expected from the acute service provider staff. Acute service providers need to be in a position to provide this support.		
	Radiation		
E28	RAM GENE monitors (x 2 per Emergency Department and/or HART team)		
E29	Hooded paper suits		
E30	Goggles		
E31	FFP3 Masks - for HART personnel only		
E32	Overshoes & Gloves		

	Core standard	Clarifying information	Community services providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance								
1	Organisations have an MTFA capability at all times within their operational service area.	• Organisations have MTFA capability to the nationally agreed safe system of work standards defined within this service specification. • Organisations have MTFA capability to the nationally agreed interoperability standard defined within this service specification. • Organisations have taken sufficient steps to ensure their MTFA capability remains complaint with the National MTFA Standard Operating Procedures during local and national deployments.						
2	Organisations have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability.	• Deployment to the Home Office Model Response sites must be within 45 minutes.						
3	Organisations have the ability to ensure that ten MTFA staff are released and available to respond to scene within 10 minutes of that confirmation (with a corresponding safe system of work).	• Organisations maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA capability matrix. • Organisations ensure that, as part of the selection process, any successful MTFA application must have undergone a Physical Competence Assessment (PCA) to the nationally agreed standard. • Organisations maintain the minimum level of training competence among all operational MTFA staff as defined by the national training standards. • Organisations ensure that each operational MTFA operative is competent to deliver the MTFA capability. • Organisations ensure that comprehensive training records are maintained for each member of MTFA staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the MTFA skill sets.						
4	Organisations ensure that appropriate personal equipment is available and maintained in accordance with the detailed specification in MTFA SOPs (Reference C).	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable. • All MTFA equipment is maintained to nationally specified standards and must be made available in line with the national MFTA 'notice to move' standard. • All MTFA equipment is maintained according to applicable British or EN standards and in line with manufacturers' recommendations.						
5	Organisations maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability.	• Organisations ensure that Control rooms are compliant with JOPs (Reference B). • With Trusts using Pathways or AMPDS, ensure that any potential MTFA incident is recognised by Trust specific arrangements.						
6	Organisations have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.							
7	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.							
8	Organisations maintain an appropriate register of all MTFA safety critical assets.	• Assets are defined by their reference or inclusion within the National MTFA Standard Operating Procedures. • This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).						
9	Organisations ensure their operational commanders are competent in the deployment and management of NHS MTFA resources at any live incident.							
10	Organisations maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).							
11	In any event that the organisations is unable to maintain the MTFA capability to the interoperability standards, that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.							
12	Organisations support the nationally specified system of recording MTFA activity which will include a local procedure to ensure MTFA staff update the national system with the required information following each live deployment.							
13	Organisations ensure that the availability of MTFA capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.							
14	Organisations maintain a set of local MTFA risk assessments which are compliment with the national MTFA risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.							
15	Organisations have a robust and timely process to report any lessons identified following an MTFA deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.							
16	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.							
17	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.							
18	FRS organisations that have an MTFA capability the ambulance service provider must provide training to this FRS	Training to include: • Introduction and understanding of NASMed triage • Haemorrhage control • Use of dressings and tourniquets • Patient positioning • Casualty Collection Point procedures.						
19	Organisations ensure that staff view the appropriate NARU training and briefing DVDs	• National Strategic Guidance - KPI 100% Gold commanders. • Specialist Ambulance Service Response to MTFA - KPI 100% MTFA commanders and teams. • Non-Specialist Ambulance Service Response to MTFA - KPI 80% of operational staff.						

	Core standard	Clarifying information	Community services providers	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance								
1	Organisations maintain a HART Incident Response Unit (IRU) capability at all times within their operational service area.	• Organiations maintain the four core HART capabilities to the nationally agreed safe system of work standards defined within this service specification. • Organiations maintain the four core HART capabilities to the nationally agreed interoperability standard defined within this service specification. • Organiations take sufficient steps to ensure their HART unit(s) remains complaint with the National HART Standard Operating Procedures during local and national deployments. • Organiations maintain the minimum level of training competence among all operational HART staff as defined by the national training standards for HART. • Organiations ensure that each operational HART operative is provided with no less than 37.5 hours protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven week period). • Organiations ensure that all HART operational personnel are Paramedics with appropriate corresponding professional registration (note s.3.4.6 of the specification). • As part of the selection process, any successful HART applicant must have passed a Physical Competence Assessment (PCA) to the nationally agreed standard and the provider must ensure that standard is maintained through an ongoing PCA process which assesses operational staff every 6 months and any staff returning to duty after a period of absence exceeding 1 month. • Organiations ensure that comprehensive training records are maintained for each member of HART staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the HART skill sets.					
2	Organisaions maintain a HART Urban Search & Rescue (USAR) capability at all times within their operational service area.							
3	Organisations maintain a HART Inland Water Operations (IWO) capability at all times within their operational service area.							
4	Organisations maintain a HART Tactical Medicine Operations (TMO) capability at all times within their operational service area.							
5	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	• Four HART staff must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. Note: This standard does not apply to pre-planned operations or occasions where HART is used to support wider operations. It only applies to calls where the information received by the provider indicates the potential for one of the four HART core capabilities to be required at the scene. See also standard 13. • Organisations maintain a minimum of six competent HART staff on duty for live deployments at all times. • Once HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations can ensure that six HART staff are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised. • Organisations maintain a HART service capable of placing six competent HART staff on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). Competence is denoted by the mandatory minimum training requirements identified in the HART capability matrix. • Organisations maintain any live (on-duty) HART teams under their control maintain a 30 minute 'notice to move' to respond to a mutual aid request outside of the host providers operational service area. An exception to this standard may be claimed if the live (on duty) HART team is already providing HART capabilities at an incident in region.					
6	Organisations maintain a criteria or process to ensure the effective identification of incidents or patients at the point of receiving an emergency call that may benefit from the deployment of a HART capability.							
7	Organisations ensure an appropriate capital and revenue depreciation scheme is maintained locally to replace nationally specified HART equipment.	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should have processes in place to use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable.						
8	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.							
9	Organisations ensure that the HART fleet and associated incident technology are maintained to nationally specified standards and must be made available in line with the national HART 'notice to move' standard.							
10	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.							
11	Organisations maintain an appropriate register of all HART safety critical assets. Such assets are defined by their reference or inclusion within the National HART Standard Operating Procedures. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).							
12	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the HART estate specification.							
13	Organisations ensure their incident commanders are competent in the deployment and management of NHS HART resources at any live incident.							
14	In any event that the provider is unable to maintain the four core HART capabilities to the interoperability standards,that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.							
15	Organisations support the nationally specified system of recording HART activity which will include a local procedure to ensure HART staff update the national system with the required information following each live deployment.							
16	Organisations maintain accurate records of their compliance with the national HART response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).							
17	Organisations ensure that the availability of HART capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.							
18	Organisations maintain a set of local HART risk assessments which compliment the national HART risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.							
19	Organisations have a robust and timely process to reportany lessons identified following a HART deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.							
20	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.							
21	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.							

Appendix B - Yorkshire and the Humber EPRR core standards improvement plan 2017-18

Organisation: Leeds Community Healthcare

ACTIONS AND PROGRESS FROM 2016 / 2017

Core standard reference	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Update on progress since last year
11	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as practical	Critical services have been identified. Business Impact Analysis completed for all critical services. REAP Plan in place for critical services. Identify what is the acceptable level of service in the event of an emergency or business continuity incident	Audit of completed BIAs for critical services. Work with critical services across the three business units to develop REAP plans.	Detailed work completed in adult business unit - further work on-going with critical services
34	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	Training need analysis to identify required level of training	Produce training needs analysis Develop and deliver appropriate training for all staff with named role within major incident plan	Training needs analysis completed and action on training undertaken. The exercise has identified need for further loggists – see 2017/18 action plan
DD2	Organisation has explicitly identified its Critical Functions and set Minimum Tolerable Periods of disruption for these	BIAs for all critical services	Audit of completed BIAs for critical services. Ensure all services have completed BIA and included minimum tolerable period of disruption.	Detailed work completed in adult business unit - further work on-going with critical services

Add further rows as required

Appendix B - Yorkshire and the Humber EPRR core standards improvement plan 2017-18

ACTIONS ARISING FROM 2017 / 2018 ASSURANCE PROCESS

Core standard reference	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
26	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Need to be able to identify critical functions of key services	Further work is on-going to identify critical functions of key services Meeting scheduled for end of sept to look at this	October 2017
37	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Procedures and actions identified in relation to communications in the event of a major or business continuity incident	Crisis comms plan to be developed to add to Major Incident Plan	December 2017
49	Arrangements include a current training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	2nd on-call managers to be confident in their ability to perform role of Incident Manager Identification and training of more Loggists	Where required, 2nd on-call managers to attend Strategic Leadership in a Crisis training Following the 'Perfect Week' exercise at LTHT, identify and provide training for extra loggists	December 2017
DD3	The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.	Identify NED with oversight of this agenda in the annual report and on website	Inclusion in 2017/18 annual report	March 2018

Appendix C - Yorkshire and the Humber Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2017-2018

STATEMENT OF COMPLIANCE

Leeds Community Healthcare has undertaken a self-assessment against required areas of the NHS England Core Standards for EPRR v5.0.

Following assessment, the organisation has been self-assessed as demonstrating the Substantial compliance level (from the four options in the table below) against the core standards.

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place and the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Partial	Arrangements are in place however the organisation is not fully compliant with six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board or Governing Body and will be monitored on a quarterly basis in order to demonstrate future compliance.

Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the organisation's EPRR governance arrangements.

I confirm that the organisation has undertaken the following exercises on the dates shown below:

A live exercise (required at least every three years)	23rd August 2017
A desktop exercise (required at least annually)	13th June 2017
A communications exercise (required at least every six months)	23rd August 2017

I confirm that the relevant teams in my organisation have considered the debrief reports and actions required from the cyber incident at North Lincolnshire and Goole NHS FT and The Leeds Teaching Hospitals NHS Trust Pathology Incident. A plan for the identified actions arising is available.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

_____

Signed by the organisation's Accountable Emergency Officer

06/10/2017
Date of board / governing body meeting

06/10/2017
Date signed

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (51)

Meeting Trust Board 6 October 2017	**Category of paper**	
Report title: Infection Prevention and Control Annual Report 2016/17	**For approval**	√
Responsible director: Executive Director of Nursing **Report author:** Lead Infection Prevention Nurse	**For assurance**	
Previously considered by: Quality Committee 25 September 2017	**For information**	

PURPOSE OF THE REPORT

The purpose of this report is to provide information and assurance to the Board relating to infection prevention and control (IPC) activities within Leeds Community Healthcare NHS Trust and to provide assurance that the organisation is compliant with current legislation, best practice and evidenced based care.

The report covers the period 1 April 2016 to 31March 2017 and provides information on:

- IPC activities undertaken within the organisation
- Description of the IPC arrangements
- Healthcare associated infection (HCAI) statistics
- IPC programme 2017/18

MAIN ISSUES FOR CONSIDERATION

Notable successes within this period include:

- Achieving 76.9% uptake in the staff flu campaign and awarded to the top community Trust in England. The IPC Team were shortlisted for a number of awards at the recent NHS Employers Flu Fighter Conference
- Team members representing the organisation in national conferences and giving expert testimony's at National Institute for Health and Care Excellence (NICE)
- The Trust has organisationally remained within commissioned targets for CDI and MRSA bacteraemia. No cases of MRSA bacteraemia had been assigned to LCH within the report period. One case of C difficile infection (CDI) had been reported on the South Leeds Independence Centre (SLIC) during October 2016. A review of the case did not identify any "lapses in care" related to case acquisition, but did identify learning related to the timeliness of stool sampling
- Development of surveillance system to monitor "alert organism" infections and new acquisition MRSA colonisation to create an early warning system identifying periods of increased incidence (PII) within geographical areas of city
- Ongoing development of a group of IPC Champions from different Business Units and the facilitation of targeted training
- Enhancement of engagement opportunities with the General Public and Trust membership to enable completion of Patient Led Assessments of the Care Environment (PLACE) Inspections

- The Trust's Team was central in the identification of an outbreak of MRSA infection within a drug misusing cohort and also worked closely with partner agencies in the investigation and management of a large scale outbreak at a visitor centre in the south of the city
- Modification of the referral system for the management of head lice infestations, providing a more robust and evidenced based response to patients with infestation
- The development and implementation of a SEPSIS management algorithm within the Adult Business Unit and evidence of improved detection and subsequent patient management
- Facilitation of an Infection Prevention Week during November 16 which focussed on current IPC issues

RECOMMENDATION

The Board is recommended to:

- Approve the IPC Annual Report 2016/17

Leeds Community Healthcare NHS Trust

Infection Prevention and Control

“Changing Hearts and Minds”

ANNUAL REPORT 2016/17

and

IPC PROGRAMME FOR 2017/18

Executive Summary

This document forms the Infection Prevention and Control (IPC) annual report on Healthcare Associated Infections (HCAI) within Leeds Community Healthcare NHS Trust (LCH).

The aim of this report is to provide information and assurance to the Board that the Infection Prevention and Control Team (IPCT) and all staff within the Trust are committed to reducing HCAI and that LCH is compliant with current legislation, best practice and evidenced based care.

The report covers the period 1st April 2016 to March 31st 2017 and provides information on:

- IPC activities undertaken within the organisation
- Description of the (IPC) arrangements
- HCAI statistics
- Forthcoming IPC programme 2017/18

Notable successes within this period include:

- Achieving 76.9% uptake in the staff Flu campaign and awarded to the top community Trust in England. The IPC Team were shortlisted for a number of awards at the recent NHS Employers Flu Fighter Conference
- Team members representing the organisation in national conferences and giving expert testimony's at National Institute for Health and Care Excellence (NICE)
- LCH has organisationally remained within commissioned targets for CDI and MRSA bacteraemia. No cases of MRSA bacteraemia had been assigned to LCH within the report period. One case of C difficile infection (CDI) had been reported on the South Leeds Independence Centre (SLIC) during October 2016. A review of the case did not identify any "lapses in care" related to case acquisition, but did identify learning related to the timeliness of stool sampling
- Development of surveillance system to monitor "alert organism" infections and new acquisition MRSA colonisation to create an early warning system identifying periods of increased incidence (PII) within geographical areas of city
- Ongoing development of a group of IPC Champions from different Business Units and the facilitation of targeted training
- Enhancement of engagement opportunities with the General Public and LCH membership to enable completion of Patient Led Assessments of the Care Environment (PLACE) Inspections
- The LCH Team were central in the identification of an outbreak of MRSA infection within a drug misusing cohort and also worked closely with partner agencies in the investigation and management of a large scale outbreak at a visitor centre in the south of the city
- Modification of the referral system for the management of head lice infestations, providing a more robust and evidenced based response to patients with infestation
- The development and implementation of a SEPSIS management algorithm within the Adult Business Unit and evidence of improved detection and subsequent patient management

- Facilitation of an Infection Prevention Week during November 16 which focussed on current IPC issues

Infection Prevention and Control Annual Report

1.0 Introduction

This document provides the seventh annual report on IPC activity within LCH. The primary focus throughout this year has been to raise the profile of infection prevention practice, both within LCH teams and also across the wider community health economy. Central to this strategy has been a subtle changing of perceptions about the importance of infection control and the use of an increasing wealth of evidence relating to the rise of antimicrobial resistance and patient vulnerability to change “hearts and minds” and increase compliance with safe practice.

At the time of the report the Infection Prevention and Control service consisted of the LCH Infection Prevention and Control Team (IPCT), the Communicable Diseases Control Team (CDC) and IPC commissioned service provision to care homes with nursing.

This annual report captures some of the developments and achievements made during the last year, with progress being mapped against the 2016/17 work plan (see appendix 1). Performance management information as well the IPC programme for 2017/18, which sets out objectives to meet the needs of the organisation to ensure patient and staff safety (appendix 2) is also included.

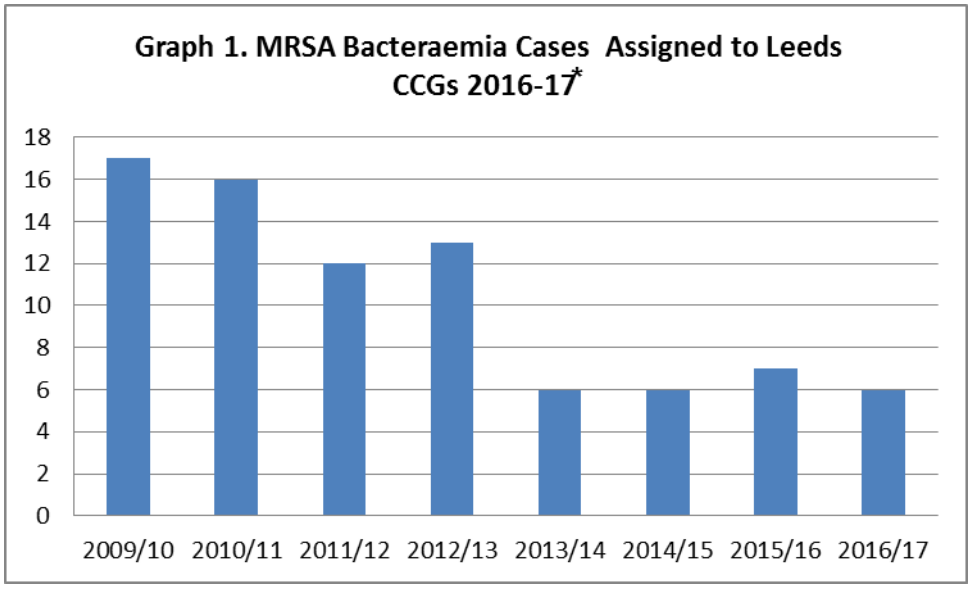
2.0 Healthcare Associated Infections (HCAIs)

2.1 Surveillance of Alert Organisms

Although there are no specific government mandatory targets for individual community care organisations for the incidence of Meticillin Resistant Staphylococcus aureus (MRSA) and Clostridium difficile infection (CDI), locally agreed targets were developed for LCH. These targets included no more than 2 cases of MRSA bacteraemia and 3 cases of CDI being directly attributed to LCH where a multiagency review identifies lapses in care that have directly contributed to the infection episode.

2.1.1 Meticillin Resistant Staphylococcus aureus (MRSA)

During the report period there have been no cases of MRSA bacteraemia directly assigned to LCH. The last case attributed to LCH was reported in 2014 and so the organisation has consistently demonstrated effective MRSA bacteraemia prevention strategies.



*MRSA Bacteraemia cases identified within 48 hours of admission to Secondary Care

During the report period a total of 13 cases of MRSA bacteraemia have been reviewed by the Leeds IPC Team. Following a comprehensive Post Infection Review 6 cases were finally assigned to Leeds CCGs. As stated previously no case had been assigned to LCH. The IPCT have also worked collaboratively with Leeds Teaching Hospital Trust to review a further 10 cases having a provisional Secondary Care assignment.

Within the community cohort 3 bacteraemia cases were related to patients who were noted to be involved in IV drug usage

2.1.2 Learning from Post Infection Reviews

All reported cases of MRSA bacteraemia within the wider community health economy are subject to a full Post Infection Review (PIR), with the contributing factors and root causes of the infection identified. Significant work has been done to improve interagency collaboration with reviews where cases have received care from both Primary and Secondary Care providers.

As stated earlier, no cases of MRSA bacteraemia have been assigned to LCH during the report period. Some elements of learning have, however been identified and integrated into care delivery within LCH. These include:

- Improvements in communication between GP's and LCH services , along with more extensive documentation on SystmOne from both GP and LCH services in relation to treatment rationale and patient needs
- A more robust use of urine sample submission for the effective diagnosis of Catheter associated urinary Tract Infection (CAUTI)
- Improvements in the documentation of patient risk assessments

Within the wider community health economy there have been a variety of predisposing risk factors identified in MRSA bacteraemia acquisition. These have primarily related to soft tissue damage due to Intravenous drug usage, surgical site infection and also eczema.

Deficiencies in the communication of patient's infection status between healthcare providers have also featured as an issue in a number of cases.

2.13 Clostridium difficile Infection (CDI)

Within the report period there was one case of CDI assigned to an LCH in-patient area. This case was identified in October 2016 and related to a patient admitted to the South Leeds Independence Centre (SLIC). A comprehensive multiagency PIR was completed on the case, with conclusion that the patient was symptomatic on admission to the unit. The review did not identify any lapses in care that directly contributed to the infection episode, but lapses were noted in relation to the timeliness of sampling. This learning has been addressed by the care team and appropriate actions taken to prevent future occurrences.

Within the wider community healthcare economy the common themes and risk factors relating to CDI included:

- Patients having had recent secondary care in-patient treatment
- The use of antibiotic treatments
- Elderly patients with multiple pathologies
- Patients receiving Proton Pump Inhibitor treatments.

Multi agency work has been ongoing throughout the report period to address the incidence CDI infection within the Leeds area and a city wide action plan is in place. This work has focussed on:

- The active review of antibiotic prescribing related to each case with follow up remedial action being taken when practice has deviated from guidance
- Ongoing distribution of a CDI patient information leaflet and alert card
- Bringing together key stakeholders to form a collaborative forum which enables cross boundary reviews of cases where secondary/primary care interface issues are identified.

The IPCT contact all patients diagnosed with CDI at or around nine days following their positive sample result day. This enables the identification of patients with unresolved symptoms and ensures clinical intervention to prevent relapsing of the primary condition.

Throughout the report period the team have struggled with issues relating to the quality of CDI data provided from the Laboritory. Investigation is ongoing and work to rectify this issue aims to be completed in 2017-18

2.2 Outbreaks of Communicable Infection

During the report period there have been 4 outbreaks of infection within LCH –inpatient areas.

Hannah House October 16

An outbreak of gastric illness occurred at Hannah House during October 16.

Following a review it was evident that the index case was a child who became ill with diarrhoea and vomiting on the 22/10/16. There then followed by a second child and multiple staff members. The outbreak followed a classical viral gastro presentation, but no

positive viral result was obtained. The unit was closed for 3 days, with 2 children and 5 staff suffering gastric illness.

An IPC review of the environment identified issues with the standards of cleaning and equipment management. An action plan has been developed. The learning arising from this incident included:

- The requirement to review the cleaning resource available to the unit and a rationalising of the cleaning products used
- Importance of regular decluttering and effective equipment management
- For staff to fully understand their individual responsibilities relating to equipment and environmental decontamination
- The need for a more robust internal auditing process for environmental cleaning
- Development of enhanced hand hygiene observational audits

South Leeds Independence Centre (SLIC) November 16

An outbreak of respiratory illness was reported at SLIC during November with the cause being related to Respiratory Syncytial Virus (RSV). At the time of the incident RSV was circulating widely within the local community and 4 positive results were obtained from the patient group. A total of 8 patients and 1 staff member were symptomatic. Control measures enabled the facility to remain open, but restrictions had been placed on patient movement within the orange corridor which is one of the four wings on the unit.

Community Intermediate Care Unit (CICU) Episodes January and February 17

Two separate episodes of gastric illness were reported on CICU during the periods identified above. In both of the situations the outbreak management strategy involved the closure of individual bays, whilst the unit remained operational. Although stool samples were submitted, no causative agents were identified. Both incidents were indicative of a viral gastro infection.

2.3 Management of Panton Valentine Leukociding (PVL) Cases

PVL is a toxic substance produced by some Staphylococcus aureus strains which has been implicated in severe infection and invasive disease. Throughout the year the IPCT have responded to 37 cases identified within the community economy to provide advice and information to patients and healthcare workers on appropriate management strategies. This represents a significant increase in numbers in comparison to the 24 cases reported in the previous year. This increase may partly be related to a general increased awareness of the agent and more proactive testing being undertaken.

3.0 Learning for Patient Safety

3.1 Systems

The IPCT continue to work with managers and clinical staff to support learning for patient safety. Systems are in place to ensure incidents are recognised, recorded, analysed and learning shared across services.

3.2 Incidents

Incidents are categorised into four areas;

- Environment
- Exposure to infection
- Sharps
- Other infection control incidents.

3.2.1 Sharps

Wherever a medical sharp device is used there will always be risk of sharps injury associated with these devices. The Infection Prevention and control Team strive to reduce this risk as far as possible by following LCH risk management strategies and ensuring that all teams are provided with adequate education, safer sharps equipment, adhere to standard infection control precautions and follow relevant LCH policy.

There was a total of **75** Infection Control related incidents reported from April 2016 to March 2017

- **13** related to Treatment/procedure
- **62** were Sharps related, **23 (37%)** of which resulted in a sharps injury with minimal harm.

This highlights that sharps related incidents remain the greatest reported infection control related incident.

Breakdown of reported sharps incidents with harm;

The majority of sharps injuries reported were related to non-safety insulin pen needles (29%) and non-safety Blood Glucose Lancets (17%)

The majority of sharps injuries with harm were reported by the Adult Business Unit **(75%)**. All of these, excluding one which was reported by the End of Life Care Team, were reported by the Neighbourhood Teams.

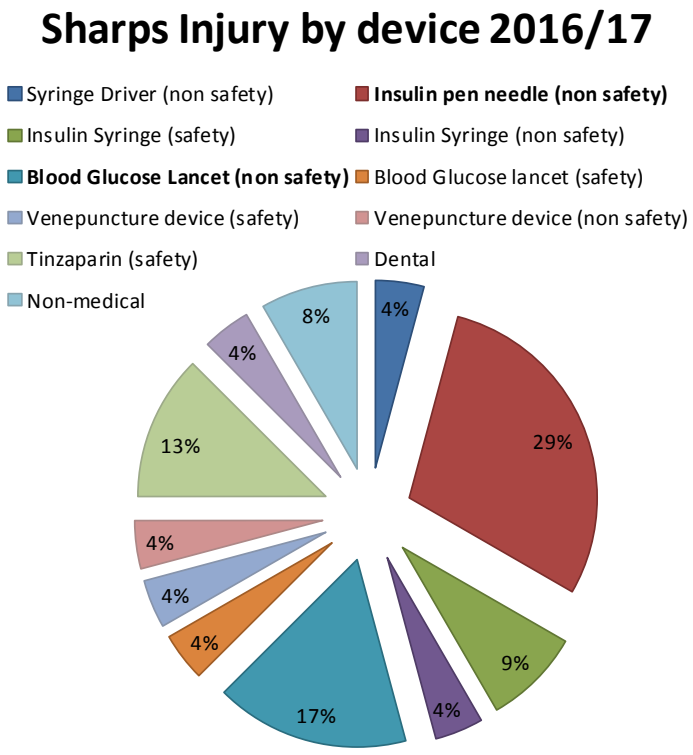
Each injury that is reported is followed by an individual specialist review and any learning is disseminated locally and wider if appropriate.

The significant themes that emerge from the review of the injury data indicate that a number of the injury episodes are related to the use of non-safety insulin pen needles as shown in Graph 2. A comprehensive work stream has been established to address this burden and includes:

- Multiagency working with CCGs to review the availability of safety equipment. The Leeds CCGs have developed a “commissioning statement” which indicated that they will not prescribe safety needles or syringes for administration of insulin by LCH staff. An organisational decision has been made by LCH to provide an appropriate safety device to all staff engaged in the use of insulin delivery pens

during patient care. Further work is required with the CCGs and informal carers administering injections

- The production and distribution of posters and leaflets to staff, outlining safe practice requirements
- Joint working with the Diabetes Team to increase awareness of safety system usage within care teams
- Enhanced awareness raising at IPC Mandatory Training sessions
- Effective post injury review and investigation with the dissemination of learning throughout the organisation
- Audit of equipment use within neighbourhood Teams



Graph 2 Sharps Injury Incidence by device 2016-17

3.2.2 Environmental Matters

During the report period there have been a variety of incidents reported in this category. As seen during the previous year, a high proportion of these reports related to environmental conditions within patients own home setting and included flea infestation and cleaning issues

Other incidents have related to the identification of poor water quality at an LCH managed health centre and deficits in the condition of the environments of facilities used but not managed by LCH. Actions have been put in place to resolve all identified issues.

3.2.3 Exposure to infection

No particular themes or trends have been identified and actions have been implemented following each investigation. Typical examples of incidents within this category are exposure of staff to body fluids from burst abscesses, bleeding following injection etc.

All incidents reported via the DATIX system will continue to be monitored on a daily basis. Quarterly reports and action plans will be fed into the Infection Prevention and Control Group (IPCG).

4.0 Decontamination

LCH has a robust decontamination process for the management of reusable surgical equipment used in dentistry, podiatry and offender health. The organisation continues to utilise a central reprocessing system from and external provider with "state of the art" facilities. The Infection Prevention Team continues to monitor decontamination standards with regular meetings and "Duty of Care" visits to the facility.

Within the report period there have been no reported untoward incidents relating to the provision of sterile medical devices from this source.

5.0 Estates/ Facilities

The IPCT have continued to foster integrated working arrangements with the Estates/Facilities teams to reduce the risk of infection in LCH care environments.

The Facilities team are actively linked into the audit activity to enable effective monitoring and response to environmental issues identified during the audit process

A more integrated approach with IPC and Estates has been made, which has ensured that IPC requirements are included at the outset of all refurbishment work.

The IPCT has contributed to the development of environmental policies and also provided advice in the event of water quality issues or other problems relating to the healthcare environment. A Legionella positive sample was found within Morley health centre which was effectively dealt with by cohesive team working between the estates and IPC teams.
Working collaboratively with the Estates Project Team, the IPCT contributes by ensuring the proposed sites are fit for purpose ergo safe delivery of services continues when teams move to new sites.

6.0 Clinical Governance

6.1 Governance Structure

Governance is assured through the Infection Prevention and Control Group (IPCG) and its reporting mechanisms via the organisational governance structure. Throughout the year further work has been done to ensure a robust communication pathway is available via the Patient Safety and Experience Group and Quality Committee. The monthly Director of Nursing Briefing also reviews infection prevention and control issues/status.

6.2 IPC Policies

The IPCT are responsible for a suite of policies and have continued to develop and review clinical policy documents and best practice clinical guidelines to support front-line staff. A number of “key note” policies have been updated throughout the year and the team continue to “horizon scan” to ensure that practice in concurrent with current evidence and best practice.

The IPC policies and guidelines are directly related to patient, staff and visitor safety and to the consistency of quality of care a patient receives. They ensure compliance with the standards outlined by the Health and Social Care Act (2008), National Health Service Litigation Authority (NHSLA) and Health and Safety at Work Act. A number of “key note” policies have been updated during the report period. These have included, Food safety, Respiratory Virus Policy, Toys Policy etc.

6.3 Audit

The Infection Prevention & Control (IPC) team is at the end of their sixth year of a Health and Social Care Act compliant environmental audit programme.

6.3.1 Process

Due to a lack of suitable products being available the IPCT has yet to acquire an effective tablet-based tool that will allow paper free auditing and reporting, however work is ongoing with this goal. On the completion of audits, feedback is provided to the relevant team leader(s) via the action plan.

Areas or systems of good practice are highlighted as well as areas / issues of concern that required addressing. Time specific, ameliorative recommendations are included for the highlighted areas of concern. Recommended actions are agreed with the staff identified as being responsible and the progress of any improvements is monitored by subsequent follow up visits.

Simultaneously, the action plan is registered on the organisational data base and sent to relevant departments, for example facilities which include external cleaning agencies.

6.3.2 Audit Results

During the report period a total of 61 environmental audits have been completed by the Infection Prevention Team. This represents 100% of the areas identified in the LCH audit programme for the year.

Audit activity is reducing as LCH continues its drive to reduce the estate. Refurbishment work has recently been completed allowing Paediatric services to move out of Ashley wing in SJUH to St George’s Centre in Beeston. Community Gynaecology and CASH services have been withdrawn from James Reid House and moved to Beeston Hill HC.

Regrettably a number of recurrent themes also become apparent which include:

- Varying standards of cleaning in a small number of areas
- Sharps bins not signed and / or dated correctly, although improvement has been noted.

- Isolated issues related to the standards of equipment cleaning.
- Staff knowledge and compliance.

Current audit findings are incorporated into the mandatory IPC training sessions to improve staff appreciation of IPC risks as well as their role in prevention of incidents resulting from practice that deviates from policy and safe practice.

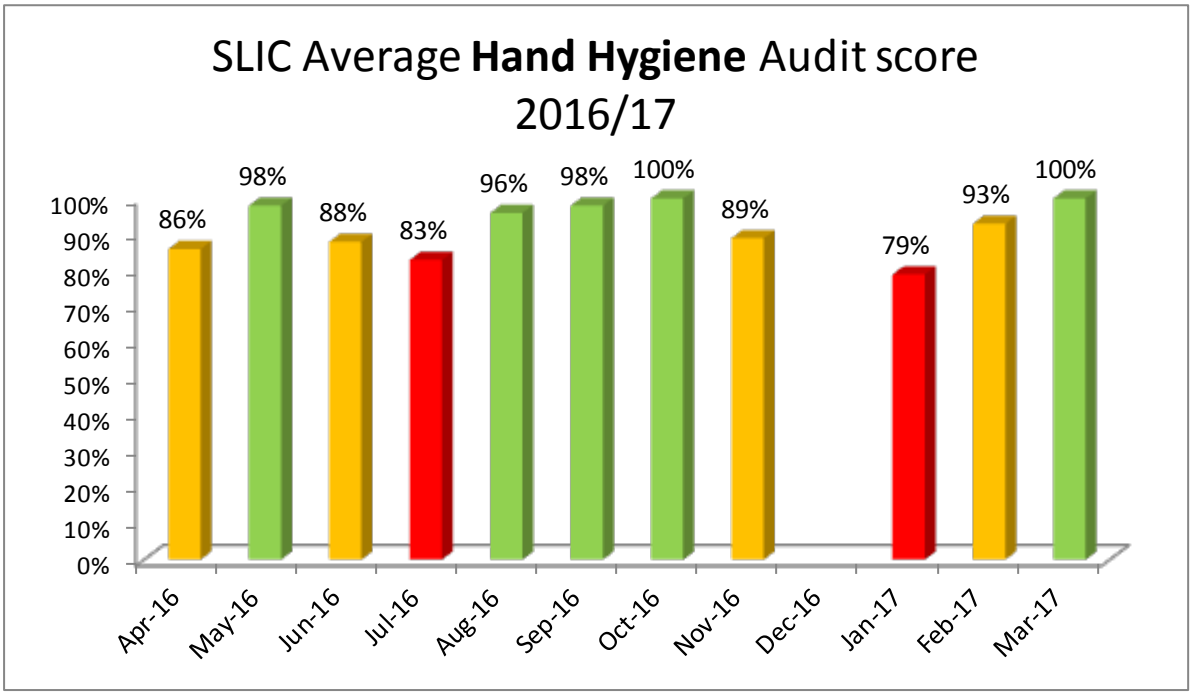
6.3.3 Dental Water Lines (DWL) Audit

A programme of systematic testing of dental waterlines has continued with 6 monthly reports on water quality results being submitted to the IPCG. On the identification of elevated bacterial levels within lines, specific remedial action is implemented to assure patient safety.

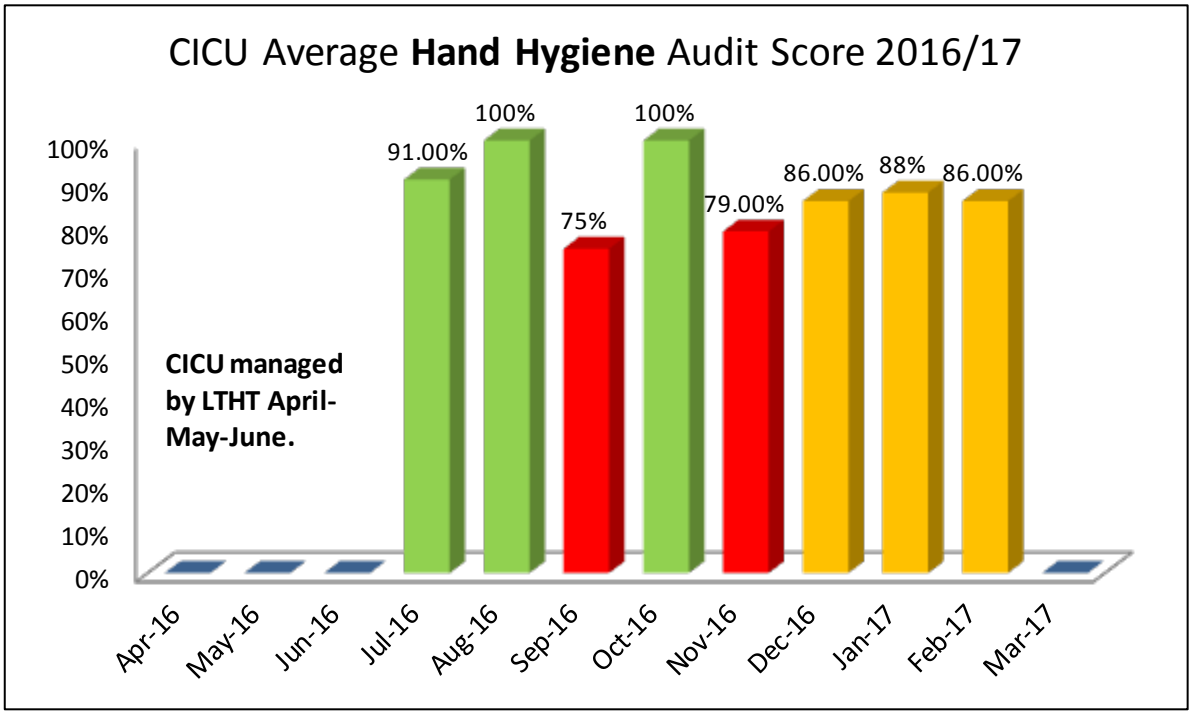
The surveillance and monitoring process identified high bacterial counts within the equipment at LTHT Clarendon Wing Theatres. Rapid intervention and modification of the disinfection regime prevented any risk to patient safety and enabled resolution of the problem.

6.3.4 Hand Hygiene Compliance Audits

The process provides an element of assurance that clinical staff members have an appropriate level of competence in relation to hand hygiene and the basic principles of IPC. A process of weekly hand hygiene compliance monitoring has been established at the South Leeds Independence Centre (SLIC) , Community Rehabilitation Unit (CRU), Community Intermediate Care Unit and Little Woodhouse Hall. Work is ongoing to establish a formalised process for Hannah House. Within the wider community economy peer assessment observations have been ongoing within care delivery teams. Compliance information generated as a result of The Essential Steps observational process is submitted by teams to the Quality Challenge + programme. This process has been quite problematic over the report period and measures have been put in place to modify the process for the forthcoming year.



Graph 3 Hand Hygiene Compliance SLIC 2016/17



Graph 4. Hand Hygiene Compliance CICU 2016/17

6.4 Quality

6.4.4 Quality Challenge plus

In order to provide robust quality assurance pathways, IPC features on the organisational Quality Challenge + Framework. This involves all care providing teams giving assurance that they are compliant with important infection prevention criteria such as; having appropriate hand hygiene materials available at all times. That IPC features on job descriptions, is reviewed during appraisal and performance review and that staff have peer led assessments of individual hand hygiene compliance. As stated previously data collection and review has been difficult and measures to improve the process will be integrated into the activity during the 2017-18 year.

7.0 User Engagement

7.1 Patient Public Involvement (Safe Clean Care and PLACE projects)

The Infection Prevention Team (IPCT) continues to closely work with a group of Public Members to appraise the standards of infection prevention practice within health centres and in-patient areas. The IPCT reflects the organisational philosophy of putting the patient at the centre of the care delivery process. In order to develop sustainable links with patients and the general public the IPCT have recruited a group of Public members to help with IPC and environmental standards monitoring. A core group of six individuals have now been actively involved for the last three years with their individual experiences/ views used validate assessments of the quality of the environments in a number of LCH health centres. The team also are closely involved in the mandatory Patient Led Assessment of the Care Environment (PLACE) inspections which were completed on SLIC, CRU and at Little Woodhouse Hall.

7.1.1 PLACE Inspection Results 2016-17

The PLACE results for the 2016 inspections of SLIC, J31, CRU and Little Woodhouse Hall were published by the Department of Health (Health and Social Care Information Centre) on the 11th August 2016.
The graphs shown below have been modified centrally to provide a comparison with the country wide average for each category inspected.

The reviews were led by representatives of the LCH Public Membership who assessed standards relating to:-

- Cleanliness
- Food quality
- Privacy and dignity
- Environmental condition

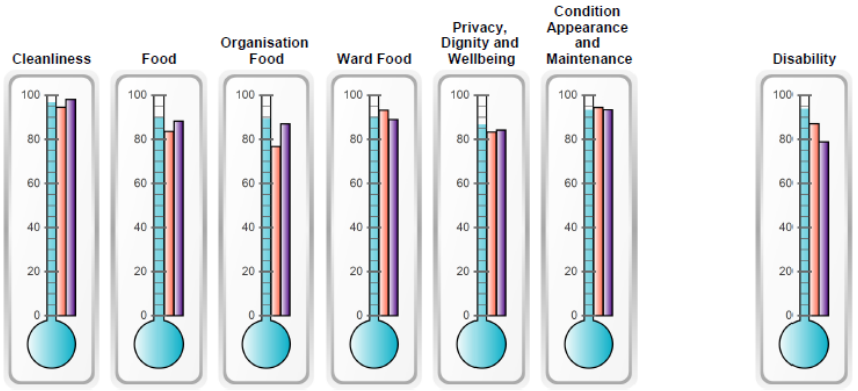
- Dementia care
- Disability

• The overall food standards rating for SLIC were lower than the defined national average. This may have resulted, partly from local misinterpretation of the question set related to organisational food controls.

• The average environmental cleanliness result for the three areas visited (94.47%) was lower than the national average (98.06%)

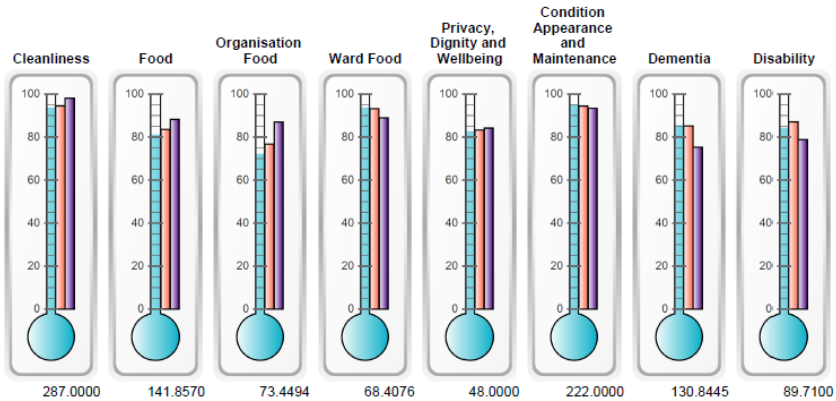
• The results for criteria related to Condition and appearance, Dementia Care and Disability were well above the national average for all areas a reviewed

LITTLE WOODHOUSE HALL- Collection: 2016



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Disability
Achieved Score (Actual)	304.0000	170.5412	96.7889	73.7523	62.5000	155.0000	55.4128
Available Score (Actual)	314.0000	189.9264	108.2567	81.6697	72.0000	166.0000	58.9908
Site Score	96.82%	89.79%	89.41%	90.31%	86.81%	93.37%	93.93%
Organisation Average	94.47%	83.61%	76.75%	93.19%	83.30%	94.39%	87.06%
National Average	98.06%	88.24%	87.01%	88.96%	84.16%	93.37%	78.84%

SOUTH LEEDS INDEPENDENCE CENTRE- Collection: 2016



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	287.0000	141.8570	73.4494	68.4076	48.0000	222.0000	130.8445	89.7100
Available Score (Actual)	306.0000	174.6385	101.7309	72.9076	58.0000	234.0000	152.8571	106.3697
Site Score	93.79%	81.23%	72.20%	93.83%	82.76%	94.87%	85.60%	84.34%
Organisation Average	94.47%	83.61%	76.75%	93.19%	83.30%	94.39%	85.16%	87.06%
National Average	98.06%	88.24%	87.01%	88.96%	84.16%	93.37%	75.28%	78.84%

The standards for cleanliness within the three areas were noted to be below the national average. The combined average organisational score was 94.47%, compared to a national average of 98.06%. Issues relating to environmental cleaning standards have previously featured in Infection Prevention audits of SLIC and Little Woodhouse Hall. Sub optimal standards have resulted in the implementation of improvement plans that have seen a temporary, but not sustained improvement in standards. This is also compounded by the fact that the cleaning services in each of the areas is provided and managed by external agencies. On identification of the deficits outline the IPCT immediately instigated remedial action plans and undertook compliance re audited 1 month later. These demonstrated significant progress in the identified areas

The challenge remains that a robust and sustained improvement in cleaning is required. Central to this must be the introduction of internal LCH ongoing monitoring and consideration given to the development of a "Strategic Cleaning Group," where by all key stakeholders periodically meet to discuss issues relating to cleaning standards and have sufficient influence to address the root causes of poor standards. This must include the external providers and senior management from LCH.

The Infection Prevention Team continue to undertake monthly cleaning audits at SLIC, CRU and more recently follow up IPC reviews at Little Woodhouse Hall. The Team at Little Woodhouse Hall have been provided with an IPC self-audit tool and so will be undertaking periodic self-audits of their area. A further challenge within the areas with "outsourced" cleaning services is to improve the internal communication between the cleaning and clinical staff, with the sharing of information relating to standard monitoring

7.2 Information Technology

The IPCT continues to review its activity in relation to available Information Technology systems.

The Flu campaign saw the team use Social Media in a more advanced nature, linking professionally using Twitter and Facebook. As a result of this the Team were shortlisted for an NHS Employers Media Award.

7.3 Patient and Public Information

A dedicated infection prevention and control information resource page for patients and public is maintained on the Leeds Community Healthcare NHS Trust website. This site provides easily accessible IPC resources and tools suitable for use by the general public or healthcare professionals. Staff can also access these resources via the IPC pages on the LCH intranet system ELSIE.

A number of items have been added and/or updated over the course of the year. Revised items include the sharps awareness poster, Norovirus FAQ, Isolation guidance, and CDC leaflet. New information added includes Zika, Catheter Associated Urinary Tract Infection, (CAUTI) poster, WHO 5 Moments catheter poster, flu leaflet, and 'How to use HiBi SCRUB leaflet.

7.4 Collaborative Working

The IPCT have continued to work hard to improve engagement and collaborative working with other agencies/ stakeholders in the Leeds health economy. Throughout the year, the LCH Team have actively contributed to the city wide promotion of infection prevention, working on such initiatives as pandemic Influenza planning, antibiotic resistance and winter planning.

The IPCT have actively engaged with the Local Authority Social Care provider Teams and deliver bespoke IPC training to the care providers. Work has been done within a number of schools and children's centres along with involvement in the Leeds Venture Programme, where the team provided a number of IPC awareness sessions. The team have also worked with the local hospices, gaining highly acclaimed feedback following attendance at a conference hosted by Martin House Hospice.

Throughout the year the IPCT have worked with LTHT on cases of MRSA and C difficile infection where joint involvement has been noted. This joint review process has enabled a more integrated approach to identifying causes and solutions to infection related issues.

7.5 Staff Influenza Vaccination Campaign

The Infection Prevention and Control Team (IPCT) have been responsible for the co-ordination and delivery of the 2016/17 LCH staff influenza campaign which ran from the 3rd October 2016 until January 2017. The programme was delivered by the Infection Prevention Team, supported by the LCH Class Bank.
The campaign philosophy was, "To change hearts and minds" as in previous years to directly empower staff members to access vaccination at local "Flu Clinic" sessions advertised and held throughout the Leeds Community area. The team also facilitated vaccination events at staff team meetings, Induction, staff bases and other suitable locations.

Central to the campaign has been a communication strategy which has included the dissemination of information to staff on individual wage slips, ELSIE Intranet Updates/Alerts, regular articles and updates in the Community Talk e magazine, Text Messaging and Community Health Matters, Team Brief and posters sent to each staff base. There is a strong emphasis on a top down approach from the Senior Management Team, ensuring they are visible during the programme with a strong, consistent empowerment messages being sent to all staff. We worked with Leeds United Football Club and an article was published in the Evening Post.

New for 2016 the team used characters Flo and Frankie to brand the campaign. These added fun, focus and a face to the campaign, and they were launched at the Trust medical conference which was also 'Jabathon day'. This was strongly supported by the use of social media from the Twitter account. Community staff are often difficult to find and clinics are difficult to get to, therefore Jabathon identified a clear message for patient facing staff, if they cannot get to us we will get to them. During the Jabathon day we engaged with Leeds Rhinos and used this as a great opportunity for social media. BBC Radio Leeds also used as an opportunity to share the public health messages and this was heard across West Yorkshire. NHS employers were particularly impressed with the teams enthusiasm and were part of their media campaign with Yorkshire Post coverage.

At the end of the programme 2016/2017 campaign a total of 2291 (76.9%) LCH staff had received flu vaccination; LCH came first in the country for Community Healthcare Trusts for uptake of vaccines.

For 2017-18 the flu programme is subject to a CQINN target of 70%. Planning has begun to ensure organisational readiness for the 2017 - 2018 campaign.

The IPCT have been invited to present at 2 conferences for the NHS Employers Flu Fighters and provided an expert testimony on NICE guideline on Flu vaccination: increasing uptake - Health Care Workers and flu vaccination uptake.

The top three community trusts are:

Trust	1 Sept 2016 - 28 Feb 2017 (%)	1 Sept 2015 - 28 Feb 2016 (%)
LEEDS COMMUNITY HEALTHCARE NHS TRUST	76.9	64.8
HERTFORDSHIRE COMMUNITY NHS TRUST	75.7	46.2
LIVERPOOL COMMUNITY HEALTH NHS TRUST	75.6	59.8

7.6 Student Learning Opportunities

For several years, the IPCT has been providing placements for 1-3rd year nursing as well as Allied Health Professional Students. The IPCT works closely with the practice learning facilitators to ensure that placements are stimulating and meaningful. A wide range of exposure to IPC is provided, including visits to the acute and mental health trusts, offender health and related teams within LCH.

Students are provided with a current, comprehensive workbook, microbiology work sheets and case studies to complete prior to placement commencement. These are updated as the placement and their insight into IPC priorities and education progresses. Students are allocated a primary and secondary mentor with whom to work as well as support from the wider IPCT members.

Verbal, written and student portal feedback is consistently excellent. Student feedback is woven into workbook and placement honing.

It is a pleasure to host professionals of tomorrow.

8.0 IPC Training

8.1 Programme

The IPC mandatory training programme has undergone further modification through the year.

8.2 Attendance

The proportion of staff that have attended IPC training as set out in the statutory and mandatory training grid had remained at around 87% (source ESR) throughout the report period. This figure is below the 90% organisational threshold and so the IPCT have implemented a host of local measures to increase uptake. These have included::

- Providing bespoke training within staff bases, including sessions out of hours for night and twilight staff
- Reviewing individual team/neighbourhood performance and providing targeted sessions to areas of low compliance
- Reviewing data quality issues with the Workforce Information Team
- Increasing the availability of generic training sessions

The issue remains on the organisational Risk Register and the issue is identified on the IPC programme for 2017-18, with an expectation that the training target will be achieved by March 2018.

8.3 Infection Control Week November 2016

The team developed and facilitated an Infection control Week during November of which the Flu Jabathon was a key element. Other initiatives included show casing hand hygiene requirements in line with the 5 Moments, sharps device safety and needle stick injury prevention, along with important Norovirus messages. The team launched the Community nursing sepsis tool this week. The event once again raised the profile of IPC within the organisation especially as the used social media and Twitter to highlight key messages. All the Adult Neighbourhood Teams were visited during the week along with a number of teams form other specialisms.

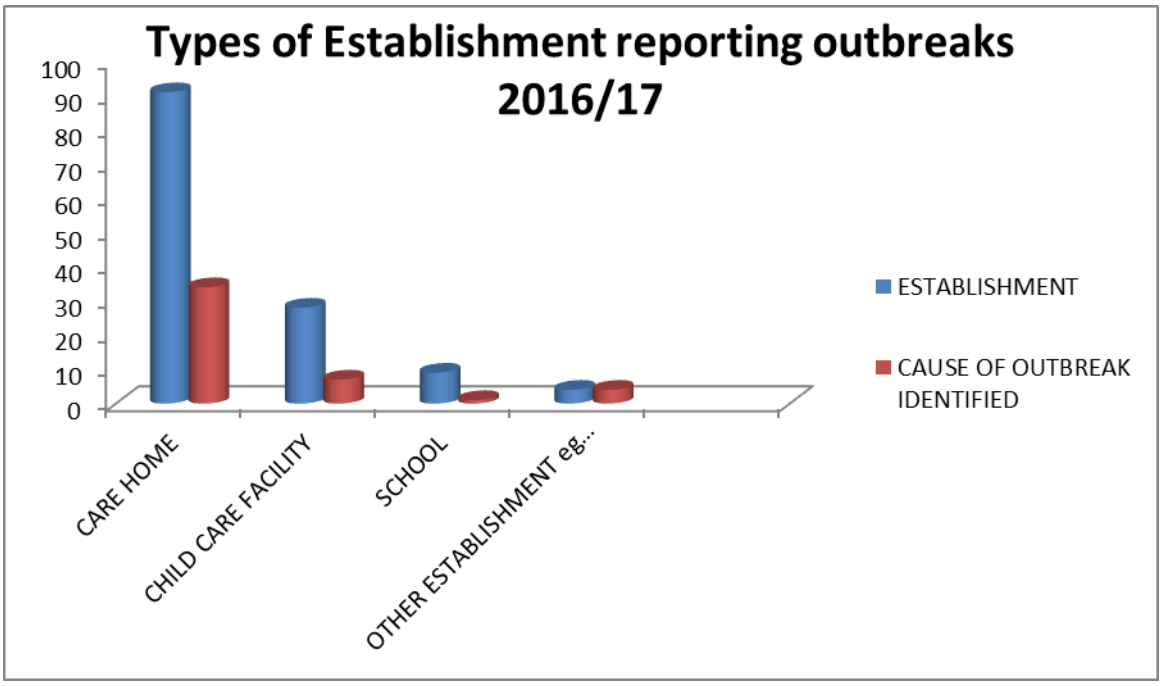
9.0 Communicable Disease Control (CDC)

9.1 The CDC Team

The CDC Team consists of 1.2 WTE nurses and is based with Leeds City Councils (LCC) Environmental Health Food and Health Team. Their purpose is to investigate, act and report on all individual cases and larger outbreaks of notifiable gastric diseases within the population of Leeds. They investigate confirmed and suspected food poisonings and also manage outbreaks of viral gastroenteritis within any establishment including care homes, child care settings, schools, day centres, etc. They work closely with partner agencies including Leeds City Council and Public Health England (PHE) and have continued to work with PHE and West Yorkshire local authorities to review and standardise key principles of managing Gastro intestinal illnesses across West Yorkshire.

Outbreak management details (Wider Leeds community health Economy) 1/4/16 to 31/3/17.

Total outbreaks 132.



Graph 5. Overview of Outbreak Settings 2016-17

The chart provides an overview of the types of facilities that have reported outbreaks of gastro intestinal illness during the report period. Each of the identified outbreaks have been visited, advised and managed by the CDC nursing team. The graph shows that a variety of settings have reported incidents, ranging from Care Homes, Schools, Child Care facilities, and other establishments including food premises and a local farm. The majority of causative organisms identified have been identified as viral in nature with Norovirus being identified as the main cause of many outbreaks. Other viruses such as Astrovirus, Rotavirus, Sapovirus and Salmonella, Cryptosporidia and E.coli 0157 were also identified in other establishment outbreaks.

The CDC Team identified and were involved in a large outbreak of Cryptosporidia and E.Coli 0157 at a Leeds farm. There were a total of 33 confirmed and 11 probable cases of cryptosporidia and 3 confirmed and 5 probable cases of E.coli 0157. This outbreak was a good example of partnership working involving CDC nurses, Leeds City Council Health and Safety and Animal Health Teams and Public Health England. Input from all controlled the outbreak and prevented further cases.

The CDC Team also had a large part to play in the management of cases from a large Norovirus outbreak at a Leeds restaurant in February. A total of 46 parties reported symptoms with 120 cases being contacted and advised accordingly.

In December 2016 the CDC team identified an outbreak of salmonella and following investigation, eggs were identified as being the source which were also implicated in an outbreak in the North West of England.

Enteric Illness

Reported cases 1/4/16 to 31/3/17

Suspected food poisoning - 338 individual reports of illness after eating from establishments in Leeds which were all responded to and advised accordingly.

Organisms identified through Notification of Infectious Diseases reporting 1/4/16 to 31/3/17

ORGANISM	NUMBER OF CASES
CAMPYLOBACTER	836
CRYPTOSPORIDIA	112
GIARDIA	133
TYPHOID/PARATYPHOID	11
ENTAMOEBA HISTOLYTICA	13
YERSINIA	5
SHIGELLA (including sonnei, boydii, flexneri, and dysenteriae)	44
VIBRIO	2
E.COLI 0157	14
CYCLOSPORA	8
SALMONELLA	140
CHOLERA	1
TOTAL POSITIVES	1319

9.2 Ectoparasitic Management

The IPCT provide a specialist service for the management of head lice (Headstart) and scabies infestations within the community. The service offers advice and support in cases of persistent head lice infestation. The main sources of referrals come through school staff, school nurses or social workers.

During the 2016/2017 report period 60 new referrals were received into the Headstart service. These were assessed and appropriately managed by the team. The head lice flow chart, check list, referral form, posters and flyers produced last year with the aim of providing better information to clients and improving the quality of referrals received, has resulted in significantly reducing the number of referrals this year.

Furthermore, queries and referrals from schools and families in the west of the city have seen a marked reduction since Leeds West CCG joined with the other 2 CCGs last year in providing free Hedrin via the Pharmacy First Minor Ailments Scheme. This has resulted in more equitable access across the city to free head lice treatment (for those exempt from prescription charges) to all affected families across the city.

The service continues to encounter some complex and challenging cases where children have presented with severe head lice infestation in addition to other issues, which have occasionally led to safeguarding concerns. These families are often hard-to-engage and repeatedly fail to check their children's hair and/or apply a pharmacy-approved head lice product in accordance with the instructions. In one example a young girl presented with a sore scalp and was found to be heavily infested. She was referred on to social services for input due to neglect.

In other cases, difficulties with head lice management have arisen due to family breakdown, parental illness or disability. Support and advice has been provided in these circumstances to help the parent acquire the necessary knowledge and skills to take on the responsibility of managing their children's head lice.

Headstart visits continue to take place in the school environment wherever possible. This has enabled better engagement with parents/guardians through closer collaborative working with the school staff, particularly the learning mentors/child protection leads, who are the main source of referrals into the service. Moreover, seeing referred cases in the school environment has all but eliminated the problem of unattended appointments and minimised the potential risks associated with lone working. Visits are only conducted in the home when this is the only remaining viable option.

10 CCG Commissioned Services

Much progress has been made to engage, advise and provide quality assurance for the commissioned services (care homes and Local Authority) within the Leeds healthcare economy. Specific work streams have been implemented to improve IPC compliance in these areas.

10.1 Care Homes

The IPC nurse visits Care homes with nursing (CHWN) to perform periodic IPC audit visits. During the year 16/17 the IPC team commissioned the Infection Control Audit Technology (ICAT) Company to use their comprehensive auditing tool for the auditing activity.

The purpose of auditing is to appraise the activities of IPC in CHWN against national standards. From this non-compliant areas are identified and advice and an action plan is given to support care homes work towards compliancy.

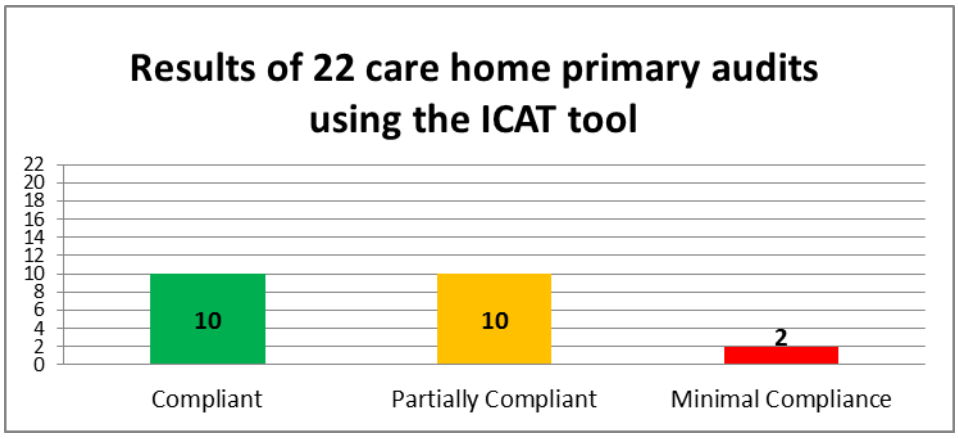
Each CHWN should receive a primary audit visit minimally every 3 years. Care home visits are followed up again in 3 months to review progress and further advice is given as

needed. In the year 16/17 the auditing activity exceeded the minimum commissioned requirement numbers.
The audits are scored in line with the Department of Health scoring system which provides a clear indication of compliance for each audit criterion and of the overall audit score:

Compliance score	Compliance rating	Risk rating
85% or above	Compliant	Minimal Risk
76-84%	Partial Compliance	Medium Risk
75% or less	Minimal Compliance	High Risk

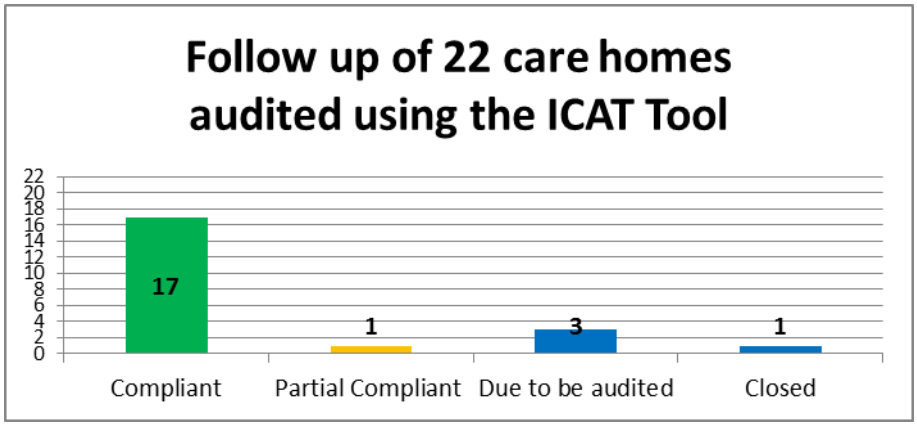
Audit Results for the year 16/17

During 16/17, 27 CHWN received a primary audit and out of these 22 care homes received a primary audit using the ICAT tool. 20 care homes received a follow up visit(s). The graph below show the overall compliancy ratings of primary audits of the care homes audited using the ICAT tool.



Follow up visits results of 22 care homes audited with the ICAT tool

By the end of year 16/17, 18 CHWN audited using the ICAT tool had a review visit, 1 had closed and 2 were due to be followed up early in the year 17/18. See the graph below for the overall compliancy results on follow up.



Further support will be provided in year 2017/18 for the CHWN who had a partial compliancy score.

Additional Support
IPC support to the care home economy has is provided in the form of:

- Telephone/email/face to face advice
- Visits and meetings at care home premises
- 4 monthly IPC champions training
- Biannual IPC newsletter
- Speaking at care home forums and events
- A dedicated care home IPC information web page which includes guidelines and promotional material.
- Sharing IPC new updates via the web page, email and meetings
- Developing supportive material as necessary .i.e. best practice posters and fact sheets
- Invitations to LCH events such as annual catheter day and the IPC conference
- IPC visits to areas where outbreaks of communicable disease or untoward infection episodes have been identified.
- Inclusion in shared learning cascades of HCAI's untoward incidents

Residential care home support
Residential care homes have access to and are included in the list of additional support above.
Support to the residential care homes in year 16/17 has included:

- 4 premises inspections at the request of the care home managers/stakeholders
- 1 visit to give advice on managing clostridium difficile infections
- 1 premises inspection following MRSA bacteraemia infection
- 1 visit following urinary catheter related MRSA colonisation. This was followed by a second visit to provide an education session on basic catheter care.
- Telephone and email advice to 1 care home who had widespread use of false nails amongst the care staff. On review the staff had all stopped waring false nails in the work environment.

Further to the auditing activity and support provided above, the IPC nurse acts as a link for care homes to the wider health and social care agencies, services and commissioning teams. Consequently this provides a pathway for escalations of concerns and sharing of good practice.

11 Medicine's Management Report (Medicines Management Team)

NICE Guidance NICE NG 15 (Antimicrobial Stewardship)
In November 2016, updates on the implementation of NICE guidance NG 15 – antimicrobial stewardship, were presented to the Infection Prevention and Control Group.

Antibiotic resistance poses a significant threat to public health. Introduced in 2011, the national antimicrobial stewardship guidance aims to improve the safety and quality of patient care and to contribute to reduction in the emergence and spread of antimicrobial resistance. The principles of antimicrobial stewardship include prescribing antibiotics only when they are needed (and not for self-limiting mild infections such as colds, coughs, sinusitis, earache and sore throats) and reviewing the continuing need for antibiotic when they are prescribed.

Antimicrobial stewardship embodies an organisational and system-wide approach to promoting and monitoring the judicious use of antimicrobials by:

- optimising therapy for individual patients;
- preventing overuse and misuse; and
- minimising the development of resistance at patient and community levels.

A baseline assessment of the organisational position against the NICE guidance in February 2016 identified of the 51 recommendations, 34 were relevant to Leeds Community Healthcare NHS Trust. A number of areas of good practice were identified and also some gaps which require close working across the health and social care economy, including:

- developing local networks across all care settings to communicate information and share learning on antimicrobial prescribing, antimicrobial resistance and patient safety incidents.
- use of electronic systems to support decision making for prescribers

An action plan was compiled alongside the emerging city-wide antimicrobial stewardship action plan, overseen by the Leeds Antimicrobial Strategy Group, chaired by the Director of Public Health, Leeds City Council.

A re-assessment of the implementation of relevant actions was undertaken in October 2016. This identified that one recommendation (1.1.13) was no longer relevant to LCH. Twenty of the 33 applicable recommendations have been implemented, with 13 outstanding.

Four key LCH work streams have been developed to work towards compliance:

- Roles and responsibilities (1 recommendation);
- Audit (6 recommendations);
- Benchmarking (1 recommendation); and
- Electronic prescribing support (2 recommendations).

In addition, contribution to city-wide plans will support compliance with three further recommendations.

NICE – NG 63 (Changing Risk Related Behaviours in General Population)

In January 2017, NICE published additional guidance: NG 63 - antimicrobial stewardship: changing risk-related behaviours in the general population. This guideline covers making people aware of how to correctly use antimicrobial medicines (including antibiotics) and the dangers associated with their overuse and misuse. It also includes measures to prevent and control infection that can stop people needing antimicrobials or spreading

infection to others. It aims to change people's behaviour to reduce antimicrobial resistance and the spread of resistant microbes.

A joint baseline assessment has been undertaken by the Medicines Management Team with the Infection Prevention and Control Team. Of the thirty-five recommendations, six are relevant to LCH. A city-wide antimicrobial steering group, led by Leeds City Council, is taking forward work in this area. The implementation of city-wide plans will support compliance with relevant recommendations.

Audit of antibiotic prescribing
In April 2017 we presented the results of a case note review, data collection and analysis of antibiotic prescribing for patients at HMYOI Wetherby between March 2016 and January 2017. Twenty-two prescribed courses of antibiotics were included in the audit.

Results showed that:

- 21 of the 22 cases (95.4%) had a clearly documented indication for prescribing the antibiotic recorded.
- 20 of 21 cases (94.1%) demonstrated that the antibiotic chosen was appropriate for the indication
- All cases where the antibiotic was appropriate for the indication (20 out of 20, 100%) had a dose regimen in line with local guidance as published on Leeds Health Pathways.
- 19 of 20 cases (95%) had durations of treatment in line with guidance as published on Leeds Health Pathways. One patient had been receiving lymecycline treatment (for acne) for three years (Leeds Health Pathways advises six monthly review to ensure continuing treatment appropriate).

Feedback from the audit has been presented to the clinical team, and also to the Infection Prevention & Control Group.

12 Conclusion

Throughout the year, The IPCT have continued to raise the profile of Infection Prevention and Control and to ensure that safe IPC practice is a fundamental element of all care delivery activities. The team have worked hard to foster relationships with internal and external partners, developing collaborative working arrangements to form the foundation of a "single economy" approach to the prevention and management of communicable disease.

To ensure continued quality improvements and to support the organisations zero tolerance to HCAIs, further work has been indentified throughout this report which will form the basis of the IPC programme and priorities for 2017-18 as set out in the 2017-18 Infection Prevention and Control Programme (Appendix 3).

LCH IPCT
July 17

Appendix 1

Infection Prevention and Control Programme 2016-17

In addition to existing IPC activities this programme describes activities that meet the needs of the organisation to ensure patient safety

Work plan element	Lead	By	RAG Rating					Comments
			Q1	Q2	Q3	Q4	PEYS*	
Policies								
Update existing LCH policies due for expiry 2016-17 • CPE MRB • C difficile • Food Safety • Respiratory Viruses • Needlestick Policy • Toys in Community	DH	March 17						
Training								
Ensure compliance levels for IPC Mandatory training reaches 90% target	DH	Interim results to IPCG Quarterly						*Compliance 86% march 17*
Produce and deliver training package for identification and management of Sepsis cases in Community	DH	July 16						
Undertake Target training sessions for GPs relating to IPC Issues	DH	November 16						
Develop and implement IPC Champions programme for LCH care teams	DD	January 17						
IPC Performance and Quality Assurance								
Convert surveillance data into performance information for neighbourhood and specialist teams. Utilise this as early warning for practice compliance deficits.	KT	June 16						
Develop and implement computer based Audit Tool for environmental audit process. • Care homes • LCH environments • GP	DHep	July 16						*Provider IPC solutions identified. Tool not suitable for GP and LCH. Works well in care home economy*

Work plan element	Lead	By	RAG Rating					Comments
			Q1	Q2	Q3	Q4	PEYS*	
Assist clinical teams through the completion of IPC elements of Quality Challenge.	DH/DS	Sept 16						
Enhance the dissemination and monitoring of local and organisational learning arising from MRSAb incidents	DD/DH							*No cases attributed to LCH. Learning associated with competency assurance ongoing*
Undertake and Coordinate PLACE reviews of : • Little Woodhouse Hall • CICU J31 • South Leeds Independence Centre	DH	June 16						*Results disappointing. Action plan produced for each area and report to QC to be produced end of November 16*
Produce an Annual Report and release it publically	DH	June 2017						*Annual Report 15-16 completed and published*
Review and implement (if appropriate) the use of IT technology to enhance the IPC audit process	D Hep	August 16						*Review of Electronic Audit process completed.. ICAT purchased*
Review efficacy of outcome monitoring programme for staff who have sustained harm from needle stick injuries	DD	September 16						*All staff injured are now monitored by team*
Audit adherence to Start Smart and Focus principles relating to antibiotic stewardship on SLIC	DD/CN	August 16						*NG 15 compliance report produced by CN. Ongoing audits*
User Engagement								
Coordinate staff influenza vaccine campaign 2016-17 achieving CQUINN target of 75% frontline uptake	DH	Feb 17						*End of programme result 76.82%*
Further develop and expand work of patient representatives in the Safe Clean Care assessment process. To include	DH	Dec 16						*LISH audited October 16*

Work plan element	Lead	By	RAG Rating					Comments
			Q1	Q2	Q3	Q4	PEYS*	
• Sexual Health Unit Merrion Centre • St Georges Centre Hunslet								
Undertake Hand Hygiene awareness Campaign within LCH	LG/DW	Sept 16						*Completed as part of IPC week*
Develop FFP3 Mask Fit Testing programme for LCH in response to potential Pan Flu risks	DH	March 17						*Fit testing educational activity undertaken for IPC Team October 16*
Develop case study of appropriate CDI and MRSAb episode to be used as organisational learning	JW/DD	March 17						*Ongoing*
Service Improvement								
Facilitate IPC Team Building Event	DH	Dec 17						*Team Building session completed June 16. And November Focus on communication*
Reviewing and updating the Headstart referral pathway and referral form	JW/DS	June 16						*New referral algorithm created and published. Distributed thorough LCH and Public Health communication channels*
Establish programme for Pan Leeds Collaborative HCAI Group, Developing work streams relating to; • Improving compliance with the use of Catheter Passport	DH/ LTHT/LYPFT	August 16						*Pan Leeds Group established and chaired DH. Action plan produced. Fed into HCAI Improvement*

Work plan element	Lead	By	RAG Rating					Comments
			Q1	Q2	Q3	Q4	PEYS*	
• Single economy approach to CDI review								*Group Oct 16*
Undertake review of Insulin Delivery Pens and associated Safety Engineered Devices. To identify appropriate alternative device for use within LCH	DD	March 17						*Review undertaken by DD. Safety Duo identified. Whole economy meeting held Oct 16 to develop city wide position statement*
Development of "Infection Prevention First Choice Product List" This provides LCH staff with a list of products and devices that are compliant with current IPC requirements.	DD	April 16						*Completed by DD. Interfacing with LCH internal procurement forum*
Support teams through a process of environmental risk reduction in areas with deficits in the fabric or cleaning of care environment has been identified through audit. Ashley Wing Paediatric Child development Unit SJUH Little Woodhouse Hall St Georges Outpatients	DH	Update Nov 16						*Ashley Win g CPO / CDU improvements noted in cleaning standards.* *LWH ongoing*
Facilitate a themed IPC Week November 16, including Sharps safety Hand hygiene Sepsis Norovirus and winter pressures Influenza								

Appendix 2

Leeds Community Healthcare NHS Trust

Infection Prevention and Control Programme 2017-18

In addition to existing IPC activities this programme describes activities that meet the needs of the organisation to ensure patient safety

Work plan element	Lead	By	RAG Rating					Comments
			Q1	Q2	Q3	Q4	PEYS*	
Policies								
Update existing LCH policies due for expiry 2017-18 • Overarching IPC Policy • Isolation Policy • Standard Precautions Policy	LG	March 18						
Training								
Ensure compliance levels for IPC Mandatory training reaches 90% target	DH	Interim results to IPCG Quarterly						
Develop organisational algorithm for management of Sepis in Children and young people	DH	Dec 17						
Facilitate a one day IPC conference	LG	November 17						
Collaborative working to support AMR Agenda in GP economy	LG	September 17						
Develop and implement IPC Training for GP and Practice based Teams	Team	Nov 17						
Review and refresh IPC mandatory training programme	LG	Dec 17						
IPC Performance and Quality Assurance								
Work collaboratively with CCG partners to develop surveillance and investigation process of Gram negative	LG/ JR	October 17						

Work plan element	Lead	By	RAG Rating					Comments
			Q1	Q2	Q3	Q4	PEYS*	
bacteraemia episodes in line with DH Mandatory requirements								
Standardise IPC assessment and assurance framework in Custody Suite areas	JR	Nov 17						
Assist clinical teams through the completion of IPC elements of Quality Challenge Plus and integrate into IPC Assurance Framework	DS	Sept 17						
Undertake structured audit activity within GP practices as part of commissioned service	LG and Team	April17						
Undertake and Coordinate PLACE reviews of : • Little Woodhouse Hall • CICU J31 • South Leeds Independence Centre	DH	June 18						
Produce an Annual Report and release it publically	DH	June 2018						
Modify and refresh LCH Internal Audit Tool	JW/ LG	August 18						
Review IPC Overarching Assurance Framework	DH	August 17						
Review and undertake audits of antimicrobial usage as directed by Medicines Management Team	LG/CN	Jan 18						
User Engagement								
Coordinate staff influenza vaccine campaign 2016-17 achieving CQUINN target of 75% frontline uptake	TBC	Feb 18						
Foster engagement with cohort of membership with PLACE induction training session	DH	Dec 17						

Work plan element	Lead	By	RAG Rating					Comments
			Q1	Q2	Q3	Q4	PEYS*	
Undertake Hand Hygiene awareness Campaign within LCH	TEAM	Nov 17						
Further develop FFP3 Mask Fit Testing programme for LCH in response to potential Pan Flu risks	DH	Dec 18						
Service Improvement								
Facilitate IPC Team Building Event	DH	Dec 17						
Work with CCG partners to review and improve the wider community CDI review process	LC/DH LTHT/LYPFT	Nov 17						
Work with facilities and Estates to support team/service relocation activities	DH	Dec 17						
Work with CCG partners and other stakeholders to review the MRSA decolonisation protocols	DH LC	Feb 18						

IPC Team
July 17

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (52)

Meeting: Trust Board 6 October 2017	**Category of paper**	
Report title: Safeguarding Annual Report 2016-17	**For approval**	✓
Responsible director: Executive Director of Nursing **Report author:** Safeguarding Head of Service	**For assurance**	
Previously considered by: Quality Committee 25 September 2017	**For information**	

PURPOSE OF THE REPORT

Review of the key achievements and challenges addressed by the safeguarding team on behalf of the Trust throughout 2016-17.

MAIN ISSUES FOR CONSIDERATION

The report reflects close partnership working with our front line services and across the multi-agency partnership, particularly with our colleagues in commissioning, Leeds Safeguarding Children Board, Leeds Safeguarding Adults Board and Safer Leeds.

Safeguarding is a complex and dynamic environment and this is reflected in the sub-sections of the report, with contributions from each of the key areas the safeguarding team is accountable for.

Significant achievements in 2017-17 and ambitions for 2017-18 are identified at the head of each section.

Most notable for the future are:

- The impact the Sexual Assault Referral Centre (SARC) has had on reducing referrals to the Specialist Child Protection Medical Service – commissioning intentions are likely to cause further impact if/when historic cases are also directed to the SARC
- The impending change to how the strategic partnership will work in the light of the Wood Review into the role of the Leeds Safeguarding Children Board and Child Death Overview Panels
- Internal review of safeguarding levels of training and competence to bring the electronic staff record in line with Intercollegiate guidance

RECOMMENDATION

The Board is recommended to:

- Approve the safeguarding annual report 2016-17

Leeds Community Healthcare
NHS Trust

Safeguarding
Annual Report 2016-17

Contributing authors:
Safeguarding Adults
Prevent
Mental Capacity, Deprivation of Liberty Safeguards (DoLS) and Dementia
Safeguarding Children
Specialist Child Protection Medical Services
Sudden Unexpected Death in Infancy and Childhood (SUDIC)
Children Looked After and Care Leavers

Contents Page:

Introduction and Executive Summary

LCH places high priority on the safety of all children and adults at risk who are or whose parents or carers are in receipt of services. The Safeguarding Team ensure LCH meets its statutory requirements outlined in Working Together 2015, The Care Act 2014 and the Mental Capacity Act 2005.

The purpose of this suite of reports is to provide the Quality Committee and LCH Board with a brief overview of the Safeguarding achievements and challenges in 2016 – 2017 and outline those areas requiring further development.

Team Structure

The Safeguarding Team based at Armley Moor Health Centre provides both corporate and operational functions and sits within the corporate directorate providing safeguarding advice, guidance, support, supervision and training for all LCH employees. Staff can contact the safeguarding team Monday to Friday for specific advice in relation to new and ongoing cases where a safeguarding concern is under consideration. The team also undertakes Health Needs Assessments (HNAs) and health interventions for Children Looked After (CLA) and Care Leavers for Leeds children and those children placed in Leeds from other areas across the country.

The Team works closely with the designated and named professionals within community paediatrics, the Clinical Commissioning Groups (CCGs) and across other health care providers as well as colleagues in Social Care to ensure our work force have the skills and support they need to safeguard all those in our care.

Governance Arrangements

The Safeguarding Team sit with the Quality and Professional development unit under the Executive Director of Nursing (the board member with responsibility for safeguarding). The Safeguarding Committee, a subcommittee of the Quality Committee meets bi-monthly to both drive and oversee the safeguarding agenda

The Safeguarding Nurses meet with operational service lead practitioners on a bi-monthly basis (safeguarding operational groups) to develop and implement objectives identified in the safeguarding work plan. We currently have three safeguarding operational groups:

- Safeguarding Adults Champions,
- Safeguarding Children Operational Group, and
- Health and Justice Operational Group,

Safeguarding reports go on a quarterly basis to the Quality Committee via the LCH Safeguarding Committee. In addition outcomes from these groups are shared with Leeds South and East clinical Commissioning Group (CCG) through the Children's and Adults advisory groups and with Leeds Safeguarding Children's Board (LSCB) and Leeds Safeguarding Adults Board (LSAB) through the relevant sub-groups.

Safeguarding priorities are set down in an annual work plan which is regularly reviewed and updated through the Safeguarding Committee.

Key achievements in 2016 – 17 are set out at the head of each report

The Safeguarding Team is continually learning, improving and disseminating best practice. Through our contributions to the Ofsted Special Educational Need and Disability inspection and the LCH CQC inspection as well as through collaboration with partners in Leeds Safeguarding Children Board, Leeds Safeguarding Adults Board and Safer Leeds, we have scrutinised, analysed and identified practice learning points as we strive to ensure the people of Leeds receive the possible care.

Safeguarding Adults

Key achievements 2016-17: • Wide ranging safeguarding awareness raising and training delivered through the Safeguarding Champions forum • Using the challenges presented by winter pressures to adapt and innovate • Partnership working to streamline safeguarding processes while maintaining high quality standards of risk reporting
Key ambition 2017-18: • Strengthening partnership working and staff confidence to address issues of Domestic Abuse and Honour Based Violence

Leeds Community Healthcare Safeguarding Adults team focus on producing an environment where abuse is not tolerated; we work with staff to ensure our patients can live free from abuse within their own homes. To do this we follow 6 recognised safeguarding principles set out in the Care Act (2014):

Empowerment: people being supported and encouraged to make their own decisions and give informed consent
Prevention: it is better to take action before harm occurs
Proportionality: the least intrusive response appropriate to the risk presented
Protection: support and representation for those in greatest need
Partnership: local solutions through services working with their communities – communities have a part to play in preventing, detecting and reporting neglect and abuse
Accountability: and transparency in safeguarding practice

These principles provide guidance and inform practice when making decisions within the safeguarding process as per West and North Yorkshire and York Multi-agency Policy and Procedures.

Throughout 2016-17 we have continued to embed these principles by, ensuring a robust mandatory e-Learning package is available to all members of staff which is supported by a number of accessible tools such as one minute guidelines, flow charts, SOPs, telephone assistance, 1-1 meetings and frontline clinical support accompanying staff on patient home visits, including care homes.

The Safeguarding Team encourage attendance at bi-monthly Safeguarding Champions' meetings where we are able to draw on the expertise of our partners to provide information and training on a number of key thematic subjects including:

- **Domestic Violence and Abuse** – A full afternoon of training on Domestic Abuse with colleagues from Safer Leeds;
- **Modern Slavery** – Bespoke training on Human Trafficking;
- **Think Family, Work Family** – Input from a Prison Governor on the challenges of managing the use of Spice and other psychoactive substances in the secure environment and its potential impact on family life in the community.

The Safeguarding Adults Team work in partnership frontline practitioners and service managers, offering supportive challenge to provide independent management reviews (IMRs) which feed into a multi-agency reviews surrounding Domestic Homicides, Safeguarding Adults incidents; ensuring any learning is identified and actions taken to support best practice.

A Domestic Homicide Review (DHR) is a locally conducted multi-agency review of the circumstances surrounding the death of a person over the age of 16. Two DHRs in 2016-17 have impacted across Children and Adult Safeguarding, requiring reports to be completed in partnership with our safeguarding children's colleagues.

Learning from reviews is disseminated to staff by electronic communication to be read and deliberated at team meetings, discussion at champions meetings and face to face discussion during safeguarding briefings

Winter pressures led to an extended period of operation under Silver Command status; the Adult Safeguarding Team rose to the challenges this presented not only by directly engaging in frontline practice to bolster the Neighbourhood Teams but also by innovating our to approach safeguarding support and guidance, using alternative methods of raising awareness by taking safeguarding information directly to the teams with regular attendance at team meetings, delivering bite sized pieces of information and providing clinical and safeguarding support by accompanying nurses to complex safeguarding visits and hot-desking within bases to ensure visibility and availability to teams. Our efforts were warmly received.

The Adult Safeguarding Team work closely with all partners having recently completed a piece of work with the safeguarding and risk managers at Leeds City Council where we looked at combining our own root cause analysis investigation and adult social care requests for a provider report when safeguarding is reported which has reduced duplication, increased quality and improved on the timeliness of the response in line with patient and families wishes, and the principles of 'Making Safeguarding Personal'.

Over the next year we plan to continue to raise staff knowledge and awareness of adult safeguarding and whilst focusing on all aspects we will be specifically working with Safer Leeds to introduce wide use of routine enquiry for domestic violence and abuse and Third Sector partners e.g. Karman Nirvana, to provide training for staff on honour based violence and forced marriage.

"…. the adult safeguarding team are regular visitors to my base to attend team meetings, they support patient visits where safeguarding is an issue and they also hot desk in our office. I find them approachable, helpful, knowledgeable, supportive, responsive and proactive. I value their expert knowledge and information received from them has influenced my practice ensuring safety for my patients', because safeguarding is everybody's business"
Band6 Senior Nurse Middleton Neighbourhood Team.

'I have gained much benefit over the past year as a fellow safeguarding professional in being able to link in with LCH's safeguarding team and the integrated neighbourhood teams. As a result of good working relationships and increased communication I have been able to gain assistance with safeguarding enquiries where the team have used their knowledge and skills of health and safeguarding issues leading to timely allocation of enquiries to the correct clinical lead. As partners we have made developments regarding how we make enquiries and share outcomes. The agreement to adapt and share the RCA to meet the needs of our SA3 form has been of particular value which is pragmatic and progressive for all'.
Safeguarding and Risk Manager LCC

Prevent

Key achievements 2016-17:
• Working innovatively with health partners to standardise the approach to Prevent training across the city • Demonstrating the commitment of LCH to safeguard the people of Leeds through work within the Channel Panel, Safe Leeds Silver Command and the NHS England Regional Prevent Forum
Key ambition 2017-18:
• Re-design of the Safeguarding Team web-page to ensure easy access for staff to support and guidance regarding Prevent

LCH actively supports the delivery of the CONTEST counter-terrorism strategy, which includes Prevent.

Under the Prevent Duty 2015 LCH is required to ensure we have mechanisms in place for understanding the risk of radicalisation. We must ensure staff understand the risk of radicalisation and how to seek appropriate advice and support. In keeping with NHS England guidance, the responsibility to lead on the Prevent duty and offer advice and support, falls under the remit of the Safeguarding team.

Prevent is about safeguarding people and communities from the threat of terrorism at the pre-criminal stage and sits within the Home Office counter-terrorism strategy.

Leeds is a Priority Area, which means we have an additional duty to report quarterly to NHS England our progress with raising awareness and delivering training to staff on Prevent and to give assurance that we have policies and processes in place to support staff in recognising and reporting concerns around radicalisation.

The significant contribution LCH makes to the prevent agenda in diverting both adults and children from pathways that lead towards radicalisation has been recognised in the nomination and appointment of our LCH representative on the Leeds Channel panel, to vice-chair of the group, ensuring a true multi-agency approach to reducing risk to all communities within Leeds and the wider area.

The LCH lead also attends the Safer Leeds Silver Command, and NHS England regional prevent forums.

Almost 1500 staff within the organisation have had either face-face training via Workshop to Raise Awareness of Prevent (WRAP) or basic prevent awareness training (BPAT) since data collection began 2 years ago. Efforts will continue to ensure full compliance of the duty over the next year.

WRAP is delivered via a monthly session that staff book onto via ESR.
BPAT is delivered at staff induction as well as via the online prevent course and L2 adult safeguarding training.

Bespoke training to staff groups within their own bases has also been delivered on request.

All our newly qualified starters have face to face WRAP and L2 adult safeguarding training as part of their induction, ensuring that right from the start of their career with LCH they have the knowledge and awareness of how and when to escalate concerns.

The LCH in partnership with CCG, LTHT and LYPFT colleagues is developing and planning the implementation of the new Leeds Prevent training package following a successful bid for NHS England funding, this will ensure a cross Leeds health economy approach to embedding the principles and statutory duties surrounding the prevent agenda. This will bring a Leeds specific focus to the subject and will be a modifiable resource as new information arises. Staff will be able to utilise this online to meet the requirement 3yearly update.

In 2017-18 we will developing a one-step, one-stop Prevent awareness intranet page to s ensure staff have easy access to key information, guidance and support. This will enable staff to go directly to information around how and when to escalate their concerns.

A new reporting mechanism (Unify2) is being implemented in 2017-18 which will simplify and standardise reporting requirements for Prevent priority areas.

Mental Capacity Assessment (MCA), DoLS and Dementia

Key achievements 2016-17:

- Regional and national recognition of the value of the MCA champions model
- Introduction of SystmOne consent and MCA template
- Renewed focus on Dementia

Key ambition 2017-18:

- Effective succession planning to ensure the seamless continuation of the MCA, DoLS and Dementia practice development in LCH

In my last contribution to the annual report I would like to take this opportunity to reflect on our journey over the last 5 years.

Prior to appointment of A Named Nurse for MCA and DoLS, a practitioner from social work background was commissioned and continued to work alongside the Named Nurse to deliver some basic training and "champion sessions".

Appointment of a Named Nurse led to development of a model of practice for LCH, including undertaking the Best Interests Assessor training course to bring appropriate knowledge and skills into the organisation and encouraging other to follow suit, creating a pool of practitioners to be drawn upon to meet the needs of patients.

Maintaining a viable pool of BIA practitioners is a challenge. LCH has supported 10 staff through BIA training however of those only are 2 active and 2 are currently in training; with staff moving on from their posts being the primary cause of this attrition.

A strong, values based approach around real change of culture rather than box ticking has been fundamental to developing the MCA champions' model, particularly as MCA case law has continued to develop and change through Court of Protection rulings since the introduction of the Mental Capacity Act (2005).

Since 2012 the MCA champions have met bi- monthly, for case supervision and case law updates. The model relies on enthusiastic staff, prioritising to attend at meetings then delivering MCA training sessions, bespoke to their teams; ensuring MCA is given the priority it requires in team meetings. The extended period of working under Silver Command, to address winter pressures impacted on availability of staff for MCA champions commitments.

We map the champions' bases, teams and specialisms to ensure staff have day to day support in clinical practice from podiatry, specialist dentistry to children's services, secure settings and the neighbourhoods. There has been national interest in the champions' model and the format has been adopted within other NHS Trusts.

Hundreds of face to face training sessions have been delivered over the past 5 years and this continues to be a means of not only increasing knowledge and skills across LCH, but also acts as an initial supervision sessions for practitioners in respect of their MCA practice as well as a taster of the benefits of volunteering to be an MCA champion. The feedback from those sessions and our yearly audit, form the basis for the MCA annual work plan. The LCH audit tool is now used and referenced in a London NHS Trust.

DoLS practice is now embedded in LCH adult 24 hour care units and support has been given to staff delivering care to patients in Community Intermediate Care (CIC) beds in care homes when requested or support needs are identified. Work is ongoing with DoLS in children's and young people's settings in response to Court of Protection rulings.

Working in the field of Mental Capacity highlights the importance of understanding of and ability to apply the law on consent to treatment as the starting point for ensuring staff act lawfully when providing care and treatment.

We are currently in the final stages of introducing a SystmOne consent and MCA template, which will be adapted to other IT systems in use and would like to take this opportunity to thank the Falls Team for supporting this work for the past 2 years.

LCH now has policies, SOPs and guidance on MCA, DoLS, restraint and missing persons.
The recent addition of a Specialist Nurse to support this work has been very welcome and brings with her a fresh perspective on how to continue the work plan into 2020.

The burgeoning Dementia agenda has led to this being identified as a key work strand alongside the MCA and DoLS work streams. Greater focus has been brought to bear over the past year with the development of a work plan and relaunch of the Dementia Steering Group, chaired by our Deputy Director of Nursing.

In closing I would like to see LCH continue to ensure the voice of the adult is heard particularly when they lack capacity, and people's preferences and wishes respected wherever possible. I would also like to thanks all the staff that have supported me within this role particularly the MCA champions.

Safeguarding Children

Key achievements 2016-17:

- Research into supervision standards which will support the future development of practice
- Expert support and guidance to front line services
- Maintenance of commitment to and development of practice at the Front Door Safeguarding Hub

Key ambition 2017-18:

- Introduction of tripartite meetings to ensure high quality standards of Child Safeguarding supervision
- In conjunction with Front Line Services and the Workforce Team, ensure staff are aware the level of safeguarding training and competence they are required to achieve, maintain and evidence in line with Intercollegiate Guidance (2014)

The LCH Safeguarding Children Team is a highly respected partner in practice in Leeds and committed to ensuring children, families and LCH staff receive high standards of care and support at times of significant vulnerability.

Responsiveness to and organisational leadership on emerging safeguarding issues, whether identified through Serious Case Reviews (SCRs), DHRs, case work or national guidance is at the heart Safeguarding Children team practice. Over the past year the team has been engaged in leading, developing and supporting practice across LCH and within the multi-agency partnership.

Leeds Sexual Health Service (LSHS)

Combining staff across both LTHT and LCH Trust Organisation, the Safeguarding Children team have supported the development of processes and procedures to encourage collaborative working which meets the core organisation objectives, such as training and supervision, to ensure compliance for staff as per intercollegiate document.

Multi-agency working

The Safeguarding Children Team has continued their commitment to multi agency working and supporting our partner agencies including LSCB. This has comprised of contribution to and leading multi-agency audits. Representing LCH at all safeguarding sub-group meetings; contributing to pan-Leeds and West Yorkshire Consortium Policy and Procedures, e.g. Fabricated or Induced Illness, Bruising protocol, recording of conferences. The Safeguarding Children team also chair several Task and Finish groups on behalf of LSCB and have recently contributed to the planning and implementation of the Neglect Strategy launch and planning of the LSCB annual conference.

Vulnerabilities and Risk

The Safeguarding Children Team is currently developing a mechanism within our information system for identifying children and young people with recognised risks and vulnerabilities. This is to ensure appropriate information sharing and personalised care based on individual needs. The Team is working with multi-agency partners to facilitate sharing information across all information systems e.g. Leeds Care Record, LSHS, and Care Notes.

Front Door Safeguarding Hub

Our commitment to the FDSH has ensured LCH is fully engaged in the development of safeguarding practice with our partners in West Yorkshire Police and the Children's Social Work Service, offering health support, advice and guidance to colleagues and frontline practitioners at the earliest opportunity.

2017-18 will see practice further develop, as strategy meetings in keeping with Working Together (2015) are held as part of the Front Door provision; in the past, engagement in strategy meetings has been a considerable challenge, due to the tight timeframe in which a response is needed to requests for service. Bringing those discussions to the Front Door will maximise our responsiveness at this crucial decision

"In Leeds we are proud to have a partnership that maintains a strong focus on improving the lives of children, young people and families. The LSCB established itself under Working Together to Safeguarding Children as a key strategic body to influence change as well as supporting front line practice through its Learning and Improvement Framework. To do this, the LSCB relies on each individual agency to provide resources to strengthen and support these multi-agency arrangements. Leeds Community Health Care Trust is a key agency within this safeguarding partnership and have shown consistent commitment, dedication and support within all the strands of work the LSCB have a statutory duty to undertake. This has been demonstrated through regular attendance at LSCB meetings and further support within the sub groups of the LSCB through:

- *Chairing the LSCB Performance Management Sub Group*
- *Undertaking quality assurance multi-agency audits*
- *Contributing to the training pool delivering multi-agency training*
- *Attendance and contribution to the Child Death Review Process*
- *Contributing to Serious Case reviews and Learning Lesson Reviews*
- *Developing multi-agency policy and procedures*
- *Contributing to LSCB Conferences and learning events*
- *Supporting the Risk and Vulnerability strategic group focussing on CSE, Missing, Honour Based Violence, Female Genital Mutilation and Harmful Sexual behaviour*

Leeds Community Health Care Trust also support and cascade the key learning and safeguarding messages within their own organisations to ensure that it influences front line practice"

LSCB Manager

making stage, ensuring families are offered the best response to meet their needs as soon as possible when a concern has been identified.

Care Quality Commission

The Safeguarding Children Named Nurses, along with the rest of the Safeguarding team contributed to the CQC inspection, participating in one to one interviews with members of the inspection team.

In-patient Units

We have supported our in-patient units to address identified areas of learning, practice development and escalation of safeguarding concerns with partner agencies where needed.

Training

The Safeguarding Children team, along with colleagues in the Children's Business Unit, continue to offer support to the LSCB training and development programme. LCH currently provides a number of safeguarding trainers who facilitate sessions for multi-agency professional groups. The Safeguarding Children team facilitate "Lunch and Learn" sessions on key and emerging topics to provide up to date evidenced based information to LCH practitioners across all services and job roles.

Supervision

The Safeguarding Children team recently audited supervision standards and have, as a result, updated the Trust Safeguarding Supervision Policy. In response to a significant research study conducted by a member of the team, standards for group supervision have been developed and the Safeguarding Children team plan to facilitate tripartite supervision to support consistency and quality for staff accessing supervision sessions.

Electronic Patient Record

The Safeguarding children team have developed five safeguarding e-templates which have been embedded for use throughout LCH children services SystmOne units. We are now supporting the development and implementation of these templates across the adult business unit to ensure a consistent approach to safeguarding practice across the organisation.

Serious Case Review and Domestic Homicide Review
The safeguarding Children team continue to conduct investigations ranging from scoping incidents to Agency Report writing. As part of this process we offer support to all staff affected by these cases. We identify and support the implementation of learning within our agency and within the multi-agency arena via learning events. The Safeguarding team (Adults and Children) are developing processes to support collaborative working in response to SCR/SAR and DHR's where the victims and perpetrators cross age groups.

Enquires and Support
The Safeguarding children team continue to provide guidance and support to practitioners throughout the trust from Children's and Adult's business unit in relation to Children and families where safeguarding concerns exist, we have:

- provided telephone support,
- face to face case reviews
- assistance with legal statements
- support with attendance at court; and
- escalated concerns in keeping with city-wide Concerns Resolution Process.

Audits
Audits have taken place during 2016-17 to support best practice by front line practitioners regarding management of cases and multi-agency processes. These audits relate to:

- quality and compliance with provision of multi-agency reports,
- quality of contacts with front door services; and
- attendance rates at ICPC and RCPC which continue in line with commissioning requirements.

Quality standards, policies and procedures, horizon scanning and analytical reviews of practice in response to significant incidents offer the framework in which the Safeguarding Children team ensure front line practitioners are equipped to deliver high standards of safeguarding practice and maintain the strong reputation of LCH as a credible and reliable partner in practice.

Specialist Child Protection Medical Services (SCPMS)

Key achievements 2016 – 17:

- Implemented action plan from the review of service by Royal College of Paediatrics and Child Health in August 2014, resulting in cementing of leadership roles in the service (clinical governance lead & service manager)
- Integration of the SCPMS team into wider safeguarding community via the Multiagency Safeguarding Operational Group (MASOG); resulting in
- Successful engagement to support development of the SARC Service
- Working with commissioners and MASOG to develop a feasible approach to child protection assessments
- Successful move to electronic patient records and use of diagnostic coding
- Successful move of venue from Ashley Wing, St. James' Hospital to St. George's Centre without disruption to services or adverse incident

Key ambitions 2017 – 18:

- Demonstrate better engagement in conferences and strategy discussions
- Evidence quality of child protection reports through audit and improve on timely return of child protection medical reports to Social Care i.e. within 4 working days
- Establish a robust working relationship with Sexual Assault Referral Centre (SARC) to ensure paediatric input for child sexual abuse
- Review practice when referring children for Female Genital Mutilation
- Continue to learn from our patient's experiences giving particular attention to the voice of the child by improving collection of feedback directly from children in a child friendly way

Who are we?	What are we proud of?
9 community paediatricians, 2 band 5 nurses, 1 play therapist, 4 admin staff and 1 clinical services manager Part of ICAN (integrated children with additional needs) services; commissioned by CCG	Providing a daily *consultant led* clinic to see children (0-18)referred for all forms of child abuse *Trained and skilled administrative staff* to take referrals from 0900-1700 on weekdays *Compassionate, highly skilled nursing staff* to chaperone and support families & staff in clinic Clinical work underpinned by *peer review and supervision* to challenge practice & offer support *Dedicated team*, who show great strength and resilience to rise to the many changes this year Continue to provide *medical training* in child protection *Information sharing* and working together to safeguard children *Monthly governance programme* for continued professional development

What did we do in 2016-17?

- Saw 455 children between April 2016 – March 2017
- 67% of children were seen for physical abuse, 20% of children required sexual abuse examination & 11% of children were siblings of index children
- Collect feedback from children and families on our service. We are unable to use standard Friends and Family Test and use a specially designed feedback form. 19 feedback forms were received in this period and this has been positive. 5 feedback forms were from the young person themselves. All respondents felt that children were seen in a child friendly place, and families were listened to. Respondents had received explanation of the process in clinic and felt our staff were easy to talk to. We could do better at giving written information. Comments included: "made to feel at ease after a difficult experience" and "kind staff".

- We aim to provide child protection medical reports to social care in 4 working days. We need to improve in this area as on an average only 50% of the reports are returned in a timely manner. Much of this is related to staffing issues. We have addressed some issues by switching to EPR.

- We held 44 peer review meetings in the last year with average participation of 65% of permanent staff in peer reviews, and at best 80%.
- We held 12 governance meetings to ensure continuing professional development at Level 3 Safeguarding Training and the average participation was 65%, and at best 100%.

Sudden Unexpected Death in Childhood (SUDIC)

(Abridged from the report produced for the Local Safeguarding Children Board)

Key achievements 2016-17:

- Review and update of the SUDIC Standard Operating Procedure (accessible on Leeds Health Pathways) by Leeds Teaching Hospitals Trust's (LTHT) Emergency Department Paediatric Consultant in consultation with the SSRG membership
- Review of compliance against the 2013, LSCB commissioned SUDIC Review recommendations undertaken by the LCH SUDIC Professional Lead. Areas identified for further work form the SUDIC Action Log 2017-18 which will be monitored by the SSRG.
- Identification of the need to strengthen multi-agency working, particularly with Coronial processes, and it is proposed that a West Yorkshire SUDIC event is organised in the near future.

Key ambition 2017-18:

- In conjunction with SUDIC Strategic Reference Group partners organise a West Yorkshire wide SUDIC conference

The aim of this report to is to give a detailed account of activity, in relation to the Leeds Community Healthcare NHS Trust (LCH) SUDIC Rapid Response Team for the period April 2016 – March 2017.

An unexpected death is defined in Working Together (2015) as: 'the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death'.

The Leeds SUDIC Rapid Response is facilitated by a multi-agency partnership under the aegis of Leeds Local Safeguarding Children Board (LSCB). The Leeds Community Healthcare NHS Trust (LCH) employ the team responsible for the co-ordination of the SUDIC process which is made up of; 0.5 WTE SUDIC Consultant, 1.0 WTE SUDIC Secretarial Support and 0.5 WTE SUDIC Professional Lead (Nursing). The team provide reports on the circumstances of the of the child's death to HM Coroner, Leeds LSCB Child Death Overview Panel (CDOP) and the LCH Children's Mortality Governance Group. Activity is also reported on a monthly basis to LCH Performance Monitoring who further report to the NHS Leeds Clinical Commissioner (CCG).

SUDIC Activity

All SUDIC deaths since April 2016 have been notified on the LCH Incident Management System - Datix®. These are reported into LCH Children's Mortality Governance Group and further reported to LCH Mortality Review Group where they are reviewed from an organisational perspective in order to identify opportunities for learning.

During the period April 2016 to March 2017 there were 17 childhood deaths which met the SUDIC criteria. This is 5 fewer deaths than for the same period 2015-2016.

The analysis of activity in response to the 17 SUDIC cases is set out below.

SUDIC Home Visit

Home Visits were made for 8 of the 17 cases. Visits were carried out by the LCH SUDIC Health Team to the 4 cases where unsafe sleeping was identified as a factor. Two of these cases were possible 'overlays' and the visits were carried out within 24 hours of the child's death. Of the 2 Sudden Unexpected Death in Epilepsy (SUDEP) cases, 1 visit was made within 24 hours and 1 was made outside the 48 hour timeframe, but on the next working day. Visits were carried out in close partnership with relevant multi-agency partners where appropriate.

For the remaining 4 Home Visits, 1 was carried out within 24 hours and in the remaining 3 cases at over 72 hours. The reasons for the delay were due to availability of the SUDIC Consultant in 1 case and availability of the family in the other 2 cases.

For the 9 cases where home visits were not carried out: 5 of the investigations were led by the police and either no further information could be gained from a home visit, or the home was a potential/actual crime scene. In the remaining 4 cases: 3 parents declined a visit following a telephone conversation with the SUDIC Consultant and 1 child had died of an infection in abroad and it was deemed inappropriate to carry out a home visit.

Initial Meetings
This meeting aims to 'seek to understand the reasons for the child's death, address the possible needs of other children in the household, the needs of all family members, and also consider any lessons to be learned about how best to safeguard and promote children's welfare in the future'.
Initial multi-agency meetings were held in a sit down format for 10 of the 17 cases occurring 2016-17. In the 7 cases where meetings were not held, it was considered that sufficient information had been gathered by telephone liaison to enable a 28 Day Report to be produced for HM Coroner and to assess for ongoing support to the family.

28 Day Report to HM Coroner
28 Day SUDIC Reports to HM Coroner for 15 of the SUDIC Cases have been completed. The remaining 2 are in process at the time of this report. Of the 15 completed, 4 were completed within 28 days. For the remaining 11 cases, delays were due to ongoing gathering of information in 3 cases and SUDIC Consultant availability in 7 cases. The SUDIC Consultant post has been covered by 4 individual doctors during 206-17 which may have impacted on the timeliness of the reports.

Final Case Discussion Meetings
Final Case Discussion Meetings have taken place for 11 of the 17 deaths occurring 2016-17. 5 of the 10 cases have been considered by the Leeds LSCB Child Death Overview Panel (CDOP) and recommendations were made in 1 case. The SUDIC Lead Professional (Nursing) takes responsibility for ensuring that all CDOP recommendations in respect of SUDIC cases are fed back to the LCH Children's Mortality Governance Group. The implementation of the recommendations is monitored by the CDOP.

Post Mortem Examination reports are awaited for the 7 remaining cases. Two of these cases involve ongoing criminal investigations, 1 of which is also subject to Domestic Homicide Review. Final letters have been sent to HM Coroner in respect of the cases which are ongoing criminal investigations and Final Case Discussion Meetings will not take place for these. One of the 7 cases outstanding is subject to a healthcare investigation by another NHS provider.

Final Case Discussion Meetings were held in the period April 2016 to the end of March 2017 for 8 cases occurring in the 2015-16 period. A meeting for 1 2015-16 case is in the process of being arranged in the 2017-18 period due to the Post Mortem Report being previously unavailable.

Training & Awareness Raising
The multi-agency National Training at Warwick University, Management of Unexpected Child Deaths, was undertaken by the SUDIC Consultant and the SUDIC Professional Lead in June 2016.
Five SUDIC Awareness Sessions have been facilitated with 75 clinical participants in both LCH and LTHT between April 2016 and March 2017.

Governance
The Leeds Child Death Overview Panel (CDOP) met 8 times in the year 2016-17. The SUDIC Rapid Response Team attended all the meetings, 6 were attended by both the SUDIC Consultant and SUDIC Professional Lead and 2 by the SUDIC Professional Lead. The LCH SUDIC Rapid Response Team takes responsibility for providing reports on SUDIC cases to CDOP and ensuring that the recommendations from CDOP are fed back to the LCH Children's Mortality Governance Review Group for dissemination to relevant services.

The LCH SUDIC Team takes responsibility for providing the LCH Children's Mortality Governance Review Group, which meets bi-monthly, with anonymised information regarding all Leeds deaths, deemed SUDIC. In addition, since April 2016, all SUDIC cases have been reported via the LCH Incident Management System, Datix®. Deaths not meeting the SUDIC criteria occurring in children who were actively receiving care from LCH services are also reviewed by the group. The aim of the group is to ensure that a critical appraisal of the healthcare input is carried out when a child dies and where necessary further investigations are carried out to ensure that lessons are learned. Information from the Children's Mortality Review Group is reported to the LCH Mortality Review Group which provides assurance to the LCH Trust Board.

The SUDIC Strategic Reference Group (SSRG) is made up of representatives from the SUDIC Rapid Response agencies and is a sub-group of the Leeds LSCB. The group met four times in year 2016-17. Work accomplished during 2016-17 includes:

- Review and update of the SUDIC Standard Operating Procedure (accessible on Leeds Health Pathways) by Leeds Teaching Hospitals Trust's (LTHT) Emergency Department Paediatric Consultant in consultation with the SSRG membership

- Review of compliance against the 2013, LSCB commissioned SUDIC Review recommendations undertaken by the LCH SUDIC Professional Lead. Areas identified for further work form the SUDIC Action Log 2017-18 which will be monitored by the SSRG.

- Identification of the need to strengthen multi-agency working, particularly with Coronial processes, and it is proposed that a West Yorkshire SUDIC event is organised in the near future.

Conclusion

Child Death Review processes have been under review nationally during 2016-17 (Wood Report March 2016, SUDIC Multi-agency Guidelines November 2016) and it is expected that LCH SUDIC Team will be fully involved, alongside partner agencies, in the implementation of the recommendations of the Wood Report (2016).

The SUDIC process despite following statutory guidelines as described in Chapter 5 of Working Together 2015 is organic in its day-to-day practical implementation. The SUDIC team is constantly reviewing their practice and challenging themselves as well as being challenged by partners via CDOP and the SUDIC Strategic Reference Group; this is welcomed by the team who strive to continually improve the service to families at such a sad time in their lives.

Children Looked After (CLA) and Care Leavers

Key achievements:

- Maintained high standards of performance with an increased cohort and despite a period of caseload vacancy
- Assessed and met the complex health needs of Unaccompanied Asylum Seeking Children
- Responded to a new model of working to deliver adoption services
- Contributed to the development and launch of Mindmate in partnership with CCG colleagues and Care Leavers

Key ambition 2017-18:

- Refresh the local evidence base for continuous improvement through thematic analysis of health needs arising from statutory health needs assessments

Our client group includes children placed with their parents under a Care Order; placed for adoption or fostering (voluntarily or under a Care Order); Unaccompanied Asylum Seeking Children (UASC), and those living in Residential Children's Homes in Leeds, including Adel Beck Secure Children's Home.
To meet the needs of CLA we collaborate with universal and specialist services within LCH, particularly Health Visitors, School Nurses and Community Paediatricians; with partners across the health economy; commissioners; and with the Children's Social Work Service and the Multi-Agency Looked After Partnership (MALAP).

The delivery of Children Looked After health services is crucially dependent on the commitment of practitioners across LCH children's services, all of whom recognise and respond to the specific health needs and vulnerabilities of our young people while also acknowledging and celebrating their incredible strength and resilience in coping with significantly challenging life events.

The cohort of Leeds Children Looked After has increased through 2016-17, (1245 increasing to 1278) accounted for by the arrival of Unaccompanied Asylum Seeking Children from a baseline of 30 in June 2016 to 43 in March 2017 and a slight increase in the number of Leeds children in care.

In keeping with previous years, the number entering care averaged 29.4 per month.

After initial health needs assessment (IHNA) undertaken within the Community Paediatric Service, responsibility for meeting the ongoing health needs and assessment review of these young people has largely fallen to Health Visitors, School Nurses and the CLA Specialist Nursing Team, with some reviews also being undertaken alongside PND, NAS or Adoption clinic reviews to avoid duplication of effort and ensure CLA are reviewed by the most appropriate health professional to assess and meet their needs.

The age profile, particularly of Unaccompanied Asylum Seeking Children (UASC) has led to a higher proportion of those new into care falling under the remit of the CLA Specialist team. This increase was within manageable parameters, despite having a whole time equivalent vacancy at the latter end of the year, with some adjustment to the level of commitment to non-statutory work e.g. reduced attendance at Foster Panel, Clu'd Up (care leavers group).

The caseload profile of the CLA Specialist team was also impacted by the de-commissioning of the **Family Nurse Partnership** programme, leading to the handover from FNP practitioners of 13 CLA or Care Leavers who are mothers.

The number of **UASC** likely to be placed in the city has been revised down from original estimates of up to 112, to an upper estimate of 90; this is a by-product of the dispersal of refugees from the "Jungle" camp in Calais and changes made by the Home Office to the numbers of children to be accepted into the country through the "Dubs Agreement".

Children continue to arrive either spontaneously; through the Home Office dispersal scheme (relieving pressure on arrival centres in Kent and Croydon); or in keeping with the Dublin III Treaty which allows refugee children to join family members in the UK.

Lobbying through commissioning and NHS England networks, locally, regionally and nationally has so far been unsuccessful in securing additional funds to meet the specific health needs of unaccompanied children, which has included immunisation programmes, blood borne virus screening, TB screening, tier 4 CAMHS and reconstructive surgery in addition to the increased use of translation services to ensure young people fully understand what is being asked of them and offered to them.

Reducing the number of CLA excluded from the IHNA quality indicator due to late notification from CSWS has been an area of focus throughout 2016-17. Late notifications (n=67), i.e. those received more than 10 working days after the child came into Local Authority care, continue to be the most common reason for exclusion from the quality indicator.

The only discernible pattern to late notifications is relatable to large sibling groups and the challenge this presents to Social Care in accommodating those young people; an administrative solution is being pursued to address this matter.

The Special Educational Need and Disability SEND Ofsted/CQC Inspection took place in December 2016 and included enquiry into the extent to which SEND and CLA health assessments are integrated. Discussion centred on the early identification of unmet need through the IHNA process and the assurance mechanisms in place to ensure those needs are met in a timely and effective manner. The inspection team recommended that we look at ways of ensuring children with additional or complex needs are readily identifiable within the CLA population.

This will be picked up within the thematic analysis of CLA health needs to be undertaken in 2017-18.

In addition to this we are working with colleagues in the Integrated – Children with Additional Needs (I-CAN) services to more closely align the HNA and EHC assessment tools; and offering CLA specialist nurse representation to the SEND steering group.

Our young people took over the **Corporate Parenting Board** in December and asked that each partner offer a short presentation on their service offer. We were able to highlight the work that had gone into co-producing the **Mindmate** website with CLA and Care Leavers as key participants and ongoing stakeholders.

As a result of the takeover event information was posted on the Clu'd Up platform informing Care Leavers directly of the Care Leaver health offer, where previously there has been an over-reliance on information sharing through Social Workers and Personal Advisers.

The West CCG Governing Body took an interest in Mindmate and a presentation of the site and particularly "Linda's Story" (a YouTube vignette, describing some of the stigma which may surround a Child Looked After) was warmly received in March 2017.

Nationally, 2016-17 has seen increasing **fragmentation of reciprocal arrangements** for delivery of HNAs to CLA placed out of area. This has been mitigated for Leeds CLA by our specialist nurses travelling up an 80 mile radius to see our children placed out of area. Challenge remains with regard to those outside the 80 mile radius, requiring case by case negotiation and problem solving.

2016-17 was a year of preparation for the shift of adoption services from a Local Authority to a regional footing. **"One Adoption"** came into being on 1st April 2017, though only "One Adoption – West Yorkshire" is operating as a fully constituted single entity; other agencies within Yorkshire and the

Humber continue to operate single providers within their regional footprint while working toward the West Yorkshire position.

The full impact of the move to a regional agency will unfold through 2017-18 and will be likely to bring about change to the function of Medical Advisers to Adoption Panels as the number of panels reduce, but cases heard will be from across the region, rather than from within a Local Authority area.

Work is being driven through the Coram-BAAF regional meeting of Designated Professionals and Medical Advisers to Adoption Panels to standardise pre-adoption medical processes to support the "One Adoption" model.

High standards of performance against statutory and quality indicator targets have been maintained with:

Quality Indicator	**Outcome**
Initial HNA completed within 20 working days (local target 95%)	95.4%
Review HNA completed (local target 90%)	96.6% (excluding refusals)
Review HNA completed (national target 85%)	94.2% (including refusals)

2017 – 18 will see the CLA Specialist team repeat the thematic analysis of health needs exercise last undertaken in August 2014 and align our findings against the quality indicators set out by the CQC in "Not Seen, Not Heard" in order to drive our continuous improvements ambitions in the light of a clear evidence base.

Safeguarding Annual Report Conclusion

2016-17 has been another busy and productive year for the Safeguarding Team in all areas of our practice; key themes emerging from this report point to the priorities for the Team being, the setting and maintaining quality standards; continuing professional development within the Team and across the organisation; and the essential development and maintenance of multi-agency relationships and networks

2017-18 will see us continue to respond to the training and support needs of LCH staff; embed learning from SCRs and DHRs; succession plan as several Team members approach retirement; respond to the ever changing local and national agendas; and ensure LCH safeguarding practice is responsive to the needs of the people of Leeds.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (53)

Meeting Trust Board 6 October 2017	**Category of paper**	
Report title Significant Risks and Board Assurance Framework (BAF) report	**For approval**	
Responsible director Chief Executive **Report author** Risk Manager	**For assurance**	√
Previously considered by Senior Management Team 20 September 2017	**For information**	

Purpose of the report

This report is part of the governance processes supporting risk management in that it provides information about the effectiveness of the risk management processes and the controls that are in place to manage the Trust's most significant risks.

The report provides the Board with the current risk profile. It details the Trust's risks currently scoring 15 or above, after the application of controls and mitigation measures. It provides an analysis of all risk movement, presents the risk profile, identifies themes, and links these material risks to the strategic risks on the Board Assurance Framework (BAF).

The Board Assurance Framework (BAF) summary advises the Board of the current assurance level determined for each of the Trust's strategic risks.

Main issues for consideration

There are four risks scored as 'extreme' risks.

The risks on the risk register (both clinical and non-clinical risks) have been interrogated for this report. The strongest theme is about capacity: sickness absence, vacancies, retention of staff in a competitive market, and not meeting demand for service (referral rates).

The BAF summary gives an indication of the current assurance level for each strategic risk, based on sources of assurance received and evaluated by SMT, committees, and the Board.

Recommendations

The Board is recommended to:

- Note the contents of the risk register
- Note the themes identified in this report
- Note the current assurance levels provided in the revised BAF summary
- Note the rewording and rescoring of BAF risk 1.3 (achieving 'Good' CQC rating)

RISK REGISTER AND BOARD ASSURANCE FRAMEWORK (BAF) REPORT

1.0 Introduction

1.1 This report, which is presented at Senior Management Team (SMT) monthly, and every two months to the Board provides an overview of the Trust's risks currently scoring 15 or above after the application of controls and mitigation measures. The report also provides a description of risk movement since the last register was presented to the Board in August 2017.

1.2 The paper also provides a section detailing risks scoring 12. Whilst these do not meet the definition for inclusion in the risk register extract reported to SMT and the Board, they have been detailed as they evidence those matters of high risk and are scrutinised closely by SMT and the Board. In addition, there is a short summary of those risks scoring 8 or above, which are reported to the Quality Committee or Business Committee.

1.3 The Board has previously agreed to the reduction in the number of in-depth risk register reports. Summary reports are received on a frequent basis, which alert the senior governance structure (SMT, committees, and Trust Board) to important changes in the risk register. An in-depth (full) report (such as this one) is received on a less frequent basis, and describes and analyses all risk movement, the risk profile, themes and risk activity.

1.4 The risk register has been analysed for this in-depth report and themes have been identified, which link these material risks to the strategic risks on the Board Assurance Framework (BAF).

1.5 This paper also provides a summary of the current BAF and an indication of the assurance level that has been determined for each strategic risk.

2.0 Background

2.1 Risks showing a current score of 15 or above (extreme) are reported to the Trust's Board at each meeting. Prior to Board scrutiny, the Senior Management Team (SMT) consider and moderate the risks at 15 and above (monthly). SMT also receives a summary of risks graded 12. In exceptional circumstances, a director can request inclusion of any risk onto the register extract received by the Board.

2.3 The Board Assurance Framework (BAF) is a significant tool in helping the Board hold itself to account, understand the implementation of strategy and the risks that might impede delivery of its strategy and brings together:

- The Trust's strategic goals as set out in the Trust's longer term plans, its annual operational plan and the strategic priorities of business units
- Strategic risks that might prevent the Trust from meeting its strategic goals and corporate objectives; their causes and effects
- Controls and sources of assurance in place to manage risk and so support the delivery of those goals and objectives
- Actions to remedy gaps in controls or assurances

3.0 Summary of current risks scoring 15 or above

3.1 There are four risks with a current score of 15 (extreme) or above on the Trust risk register as at 6 September 2017. These are as follows:

Table 1 Extreme risks (scoring over 15)

Risk ID	Risk description	Risk score	Risk movement
Risk 862	*Clinical capacity in adult speech and swallow team. Risk score increased from **12.***	15 (extreme)	
Risk 906	*Reduction in funding for neighbourhood teams as a result of community intermediate care beds retender. Risk score reduced from **20.***	16 (extreme)	
Risk 224	*Reduced level of care due to the prevalence of staff sickness in particular services and or across the Trust.*	16 (extreme)	
Risk 872	*Difficulties recruiting to and retaining staff within neighbourhood teams.*	16 (extreme)	

3.2 Full details of these four extreme risks are given in **appendix 1** (extreme risks).

4.0 New or escalated risks (scoring 15+)

4.1 Since the last report to the Board in August 2017, there have been no new risks scoring 15 or more.

4.2 There has been one risk escalated to 15+. This is Risk 862: *Clinical capacity in (adult) speech and swallow team.* The reason for escalation is that urgent waiting times have reduced but due to increased staff shortages and prioritising urgent referrals in August 2017, the number on the waiting list and 18-weeks breaches have increased.

5.0 Closures, consolidation and de-escalation of risks scoring 15+

5.1 Since the August 2017 Board report, there have been no closed risks previously recorded at 15 or above.

5.2 There has been one de-escalated risk. This is Risk 906 *Reduction in funding for neighbourhood teams*, which was de-escalated from a score of 20 (extreme) to 16 (extreme). This risk was deescalated after it was discussed with the commissioners in August 2017, which have indicated that funding will be maintained during the financial year 2017/18 to enable opportunity for review of the contract. The risk has been reduced, but not removed, as funding is not secure beyond March 2018.

6.0 Summary of risks scoring 12 (high)

6.1 *High clinical risks (scoring 12)*

6.1.2 To ensure continuous oversight of risks across the spectrum of severity, consideration of risk factors by the Board is not contained to extreme risks. Senior managers are sighted on services where the quality of care or service sustainability

is at risk; many of these aspects of the Trust's business being reflected in risks recorded as 'high' and particularly those scored at 12.

6.1.3 The table below details clinical risks currently scoring 12 (high risk). Risk 455 has recently been added to this list as an escalated risk from a score of 8 to a 12..

Table 2 High clinical risks (scoring 12)

ID	Title	Rating (initial)	Rating (current)	Rating (Target)
630	Increased risk of falls due to not having an effective falls reduction programme / workplan in place	**16**	12	**3**
877	Risk of reduced quality of patient care in neighbourhood teams due to need for prioritisation	12	12	**6**
455	Capacity Issue within Community Stroke Team (CST)	10	12	**3**

6.2 *High non-clinical risks (scoring 12)*

6.2.1 Continuous oversight of risks across the spectrum of severity is applied to non-clinical risk areas too. The Board considers services where service and/or financial sustainability is at risk where these aspects of the Trust's business is reflected in risks recorded as 'high' and scored at 12.

6.2.2 The table below details non-clinical risks currently scoring 12 (high risk). Risks 905, 911, and 913 have recently been added to this list as new risks. Risk 816 has been escalated from a score of 8 to a 12.

Table 3 High non-clinical risks (scoring 12)

ID	Title	Rating (initial)	Rating (current)	Rating (Target)
253	Retention of services in competitive tenders	9	12	9
259	Maintenance of childrens equipment is not commissioned.	**16**	12	**4**
353	Electronic Patient Record (EPR) non-delivery of benefits	**16**	12	**6**
675	Risk of failure of achieving national Improving Access to Psychological Therapies (IAPT) target	12	12	**3**
816	Board and management not sufficiently aware of service line performance	12	12	**4**
874	Sickness levels - Neighbourhood Teams including Neighbourhood Night Nursing Service.	12	12	**6**
875	Children's Community Dysphagia Service capacity to manage increased number and complexity of referrals	**16**	12	**3**
895	Staff capacity in Children's speech and language therapy school age learning disability (SALD) service	**16**	12	**3**
905	Risk of lack of child and adolescent mental health services (CAMHS) bed availability within shortened timescale following a detention of a patient in a 'place of safety'.	12	12	**3**
911	Insufficient registered nurses on Community Intermediate Care Unit and South Leeds Independence Centre.	**25**	12	**6**
913	Increasing numbers of referrals for complex communication assessments in ICAN service risks breaching waiting time target.	**15**	12	**3**

7.0 Summary of all risks currently scoring 8 or above

7.1 The following sections aim to apprise the Board of risks with a current score of 8 (after the application of controls and mitigations) or above.

7.2 **T**he Trust's risk register comprises 42 risks at risk score 8 or above assigned to the Trust's three business units and all directorates providing corporate and headquarters functions. This is the same number as in the previous in-depth report.

7.3 **Clinical risks scoring 8 or above**

7.3.1 The chart below shows the number of clinical risks (9) by business unit, logged on the Trust's risk management database (Datix) as at 6 September 2017.

Table 4 Clinical risks by business unit

Business area	Risks scored 8-12 High	Risks scored 15+ Extreme	Totals by Area
Adult BU	2	0	**2**
Children's BU	1	0	**1**
Specialist BU	5	0	**5**
Corporate & HQ	1	0	**1**
Totals by risk severity	**9**	**0**	**9**

7.4 **Non-clinical risks scoring 8 or above**

7.4.1 There are 33 non-clinical risks by directorates providing operational, corporate and headquarters functions as at 6 September 2017 (shown below).

Table 5 Non-clinical risks by directorate

Directorate	Risks scored 8-12 High	Risks scored 15+ Extreme	Totals by directorate
Finance and resources	5	0	**5**
Operations	21	3	**24**
Quality and professional development	2	0	**2**
Workforce	1	1	**2**
Totals by risk severity	**29**	**4**	**33**

8.0 Current risks scoring 8 or above by theme

8.1 For this report, the current material (the 'here and now') risks have been themed where possible according to the nature of the hazard and the effect of the risk and then linked to the strategic risks on the Board Assurance Framework (BAF). This themed approach gives a more holistic view of the higher level risks on the risk register and will assist the Board in understanding the risk profile and in providing assurance to the Board on the management of risk.

8.2 Themes within the current risk register are as follows:

- Eight risks concern staff absence (absence due to sickness, maternity or adoption leave)
- Nine risks concern vacancies; including difficulties recruiting staff to particular posts and problems in recruitment process
- Two risks concern high turnover of staff
- Eight risks concern demand and capacity (high numbers of referrals, complex referrals, changes in criteria for mainstream requirements, broad or undefined service specifications)

This theme links to the following BAF strategic risks:

- Risk 2.2 delivery of contracted activity requirement
- Risk 3.1 suitable and sufficient staff capacity and capability
- Risk 3.2 the scale of sickness absence

8.3 The emergence of material risks could mean that the controls in place on the BAF to manage strategic risks are not sufficiently robust. SMT will be asked to review the controls for BAF risks in October 2017, as part of its mid-year BAF review.

9.0 Risk profile - all risks

9.1 There are 22 open clinical risks on the Trust's risk register and 55 open non-clinical risks. The total number of risks on the risk register is currently 77. This is a slight decrease compared to the 80 risks reported in the previous in-depth risk register report. This table shows how all these risks are currently graded in terms of consequence and likelihood and provides an overall picture of risk.

Table 7 Risk profile across the Trust.

	1 - Rare	2 - Unlikely	3 - Possible	4 - Likely	5 - Almost Certain	Total
5 - Catastrophic	0	0	0	0	0	0
4 - Major	1	3	7	3	0	14
3 - Moderate	3	17	20	8	1	49
2 - Minor	0	6	8	0	0	14
1 - Negligible	0	0	0	0	0	0
Total	4	26	35	11	1	77

10.0 Board Assurance Framework Summary

10.1 The purpose of the BAF is to enable the Board to assure itself that risks to the success of its strategic goals and corporate objectives are being managed effectively.

10.2 Definitions:

- Strategic risks are those that might prevent the Trust from meeting its strategic goals and corporate objectives
- A control is an activity that eliminates, prevents, or reduces the risk
- Sources of assurance are reliable sources of information informing the Committee or Board that the risk is being mitigated ie success is been realised (or not)

10.3 Directors maintain oversight of the strategic risks assigned to them and review these risks regularly. They also continually evaluate the controls in place that are managing the risk and any gaps that require further action.

10.4 SMT, the Quality and Business Committees, and the Board review the sources of assurance presented to them and provide the Board (through the BAF process) with positive or negative assurance.

10.5 The BAF summary **(appendix 2)** gives an indication of the assurance level for each strategic risk, based on sources of assurance received and evaluated by committees and the Board in July and August 2017 and in line with the risk assurance levels described in **appendix 3** (BAF risk assurance levels).

10.6 Since the last BAF report in August 2017, the current level of assurance for the following BAF risks has been adjusted as follows:

Positive movement

- BAF risk 1.1 (relating to the assessment of quality) assurance level is reasonable, as there is satisfactory progress with the clinical audit plan, clinical supervision rates are compliant, and the health visiting service was rated 'outstanding' in a recent UNICEF Baby Friendly Initiative audit
- BAF risk 1.3 (achieving a ‘good’ CQC rating), the assurance level is reasonable as the Trust has now received the CQC inspection report (rating: ‘good’), and there is a robust action plan to address the outstanding issues at Hannah House
- BAF risk 2.2 (risk of not delivering contracted activity requirement) the assurance level is reasonable, moving towards substantial, given: the improvement in the Trust's variance from activity profile (as reported in July 2017), the internal audit of capacity and demand management which received a reasonable opinion and performance against national waiting time targets which is consistently good
- BAF risk 2.4 (retain existing viable business and/or win new financially beneficial business tenders), has moved further into reasonable as the business and commercial developments report received reasonable assurance
- BAF risk 3.3 (staff engagement), the assurance level is now reasonable, given the improved Friends and Family Test (staff) response and the Freedom to Speak Up Guardian reports, which were positively received
- BAF risk 4.1 (responding to the changes in commissioning, contracting and planning landscape (STP implementation) and scale and pace of change) is moving further into reasonable because of the positive evaluation of new models of care Board workshop (July 2017)

Negative movement

- BAF risk 1.4 (achievement of external and internal quality priorities and targets) the assurance level is moving from reasonable towards limited as there is a risk of not achieving some CQUINs
- BAF risk 3.4 (developing managerial and leadership capability in operational services) the assurance level is moving from reasonable towards limited as staff appraisal rates are below target and the organisational development strategy quarterly report received limited assurance

10.7 Following the receipt of the CQC inspection report and the ‘Good’ rating, BAF Risk 1.3 (If the Trust does not achieve a ‘Good’ CQC rating then there will be an impact on reputation and a greater degree of oversight and scrutiny) requires rewording.

The Executive Medical Director, as lead director, has reviewed this BAF risk and the suggestion is to amend the risk description and the risk score as follows:

10.7.1 *'If the Trust does not focus on services and areas requiring improvement, then it may not maintain a 'Good' CQC rating and will not achieve 'Outstanding'. This will have an impact on the Trust's reputation and it will receive a greater degree of oversight and scrutiny.'*

10.7.2 The risk score for BAF risk 1.3 has been reviewed and reduced from 3 x 3 (possible x moderate harm) to 2 x 3 (unlikely x moderate harm).

11.0 Risk management activity

11.1 The Risk Manager has met with NHS Digital's risk management team to compare and improve both organisations' risk register and board assurance framework processes.

11.2 Risk 902 on the risk register describes the manual handling concerns at Leeds community equipment service. The Risk Manager has been assisting the service to refresh their risk assessments and to set up their own local health and safety group.

11.3 The Risk Manager has been working with managers of neighbourhood teams to complete lone-working risk assessments. This includes providing a lone working template for managers to adapt, as there is currently a risk (Risk 867) on the risk register concerning the management of lone-working risks in a community setting.

11.4 The Risk Manager and Health and Safety Officer are compiling a library of standard risk assessment templates on the Trust's intranet for managers to take and adapt for their own team or service.

11.5 The summer edition of 'Risky Business' the Trust's risk management newsletter drew readers' attention to:

- the risks associated with hoarding unneeded equipment (and how to dispose of it)
- learning lessons from bids and tenders
- the risks associated with using the wrong preparations of sodium chloride (normal saline 0.9%) solutions used in healthcare
- lessons from a service who had to implement their business continuity plan
- the outcome of an investigation into some missing staff files
- lessons to learn from two recent arson attacks on Trust premises
- a tongue-in-cheek summer-season risk assessment about how to avoid losing holiday suitcases
- a reminder for managers to review their lone-working risk assessments before evenings begin to get dark

12.0 Impact

12.1 *Quality*

12.1.1 Risks recorded on the Trust's risk register are regularly scrutinised to ensure they remain current. Risk owners are encouraged to devise action plans to mitigate the risk and to review the actions, risk scores and provide a succinct and timely update statement. There are no known quality issues regarding this report.

12.2 Resources

12.2.1 Any financial or other resource implications are identified and managed by the risk owner/lead director responsible for individual risks.

12.3 Risk and assurance

12.3.1 This paper seeks to assure the Board that there is a robust process in place for managing risk. Evidence that risks are proactively identified and managed in the Trust can be seen in the shifting profile of the risk register, with new risks being added and subsequently updated, risk scores amended and risks being closed.

13 Next steps

13.1 The Risk Manager will continue to monitor risk review dates and remind risk owners of their responsibility to review and update risks appropriately. The Risk Manager has reviewed the risk management comments and recommendations made by the CQC in their recently received inspection report and is formulating an action plan.

14.0 Reporting schedule

14.1 Set out below is the risk register and BAF reporting schedules:

Risk register reporting schedule

		Month											
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Meeting type	RRG		FULL		FULL		FULL		FULL		FULL		FULL
	SMT	FULL	SUMMARY	SUMMARY	SUMMARY	FULL	SUMMARY	SUMMARY	SUMMARY	FULL	SUMMARY	SUMMARY	SUMMARY
	QC	FULL	SUMMARY	SUMMARY	SUMMARY	FULL	SUMMARY	SUMMARY		FULL	SUMMARY	SUMMARY	
	BC	FULL	SUMMARY	SUMMARY	SUMMARY	FULL	SUMMARY	SUMMARY		FULL	SUMMARY	SUMMARY	
	Board		FULL		SUMMARY		FULL		SUMMARY		FULL		SUMMARY

FULL	= in depth report
Summary	= snapshot report
	= information flow

BAF reporting schedule

		Month											
		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Meeting	SMT	Summary		Summary		Summary		Summary		Summary	Mid-year review	Summary	
	QC/BC										Mid-year revised		
	AC		Full		Summary			Full			Summary		
	Board		Summary		Summary		Summary		Summary		Summary		Summary

Full	= Complete BAF
Summary	= BAF overview
Mid-year review	= Mid-year review
	= Information flow

15.0 Recommendations

15.1 The Board is recommended to:

- Note the contents of the risk register
- Note the themes identified in this report
- Note the current assurance levels provided in the revised BAF summary
- Note the rewording and rescoring of BAF risk 1.3 (achieving ‘Good’ CQC rating)

Significant risks (15+)

Appendix 1

ID	Risk Owner	Director	Opened	Description	Controls in place	Adequacy of controls	Latest update	Risk level (initial)	Rating (initial)	Risk level (current)	Rating (current)	Risk level (Target)	Rating (Target)	Review date
Lead Directorate: Operations														
Portfolio: Adult Services														
872	Rowlands, Megan	Prince, Sam	23/11/2016	Title: Difficulties recruiting to and retaining staff within neighbourhood teams. There is a high turnover of staff within neighbourhood teams. There is a risk of not having enough staff capacity to meet the demands on the service, a risk of missed visits / delayed appointments impacting on patient safety, a risk of having a less experienced and reduced workforce causing additional pressures on remaining staff, which will impact on staff wellbeing, a risk of a reduced offer impacting on activity levels and finances, and on ability to release staff for skills and competency training. There is a particular risk and impact where there are issues with recruitment and retention of senior clinical staff who provide leadership as well as direct clinical care.	Management reports in each service area. Oversight at weekly Ops meeting, monthly Performance Panels and weekly at SMT Establishment Control process Service specification plans in place Weekly management consideration of workload. Support with prioritisation. Movement of staff between teams to offer more balanced capacity. Proactive recruitment plan in place Rolling recruitment and focused recruitment events Team coaching in place to support local leadership team with issues relating to staff morale Key clinical skills training matrix and enhanced training support in place Sourcing short term support via CLASS	Adequate	Sourcing short term support via CLASS continues. Small number of internal secondments from children's services continue. Subcontract in place from June 2017 to provide targeted additional capacity for Neighbourhood Team patients in residential settings in two Neighbourhood Teams. Rolling recruitment and focused recruitment events for community staff nurses - successful in recruiting additional staff. Recruitment of Senior Nurses/District Nurses remains very challenging. Recruitment of skill mixed therapy roles in progress to support retention. Leadership capacity improved in most areas but key gaps due to vacancies and sickness remain. Lack of capacity continues to impact on service delivery. Turnover remains relatively high. Ongoing action required to reduce risk rating. (Updated 23/06/2017)	Extreme	20	Extreme	16	Low	3	30/09/2017
906	Rowlands, Megan	Prince, Sam	12/06/2017	Title: Possible reduction in funding for neighbourhood teams as a result of community intermediate care (CIC) retender. There is a possible reduction in funding for neighbourhood teams associated with the community beds retender. There is a risk that resources available for neighbourhood teams will be reduced having an impact on service delivery, service quality and patient and staff experience.	Discussions underway with commissioners to seek solution.	Limited	Discussed with commissioners August 2017. Commissioners indicated that funding will be maintained during financial year 2017/18 to enable opportunity for review of contract. Risk reduced, but not removed as funding not secure beyond March 2018. (Updated 11/08/2017)	Extreme	20	Extreme	16	Medium	4	30/09/2017

Portfolio: Specialist Services														
862	Jeffries, Helen	Prince, Sam	09/09/2016	Title: Clinical capacity in (Adult) Speech and Swallow Team. Due to sickness, vacancies and difficulty in recruiting there is reduced capacity in the Adult Speech and Swallow team, which has resulted in breaching 18 week and urgent 2 week waits. This could have an impact on patient safety and care and the organisations reputation if contractual requirements are not met.	Alternative ways of working to address waiting list and activity to be introduced to team from 12/09/2016. Temporary operational manager in place 2 days per week to support setting up alternative ways of working, look at streamlining processes and increasing admin support to release clinical time. Team triage altered to focus on shared team ownership. Regular 1:1s with manager with all team members. Clinics established to improve efficiencies, new referral form introduced to reduce admin time. Team moved to 3 part model: clinic, care home clinic and home visits to increase efficiency. Contacting locum agency weekly to check for locum availability. Band 6 increased hours by 4 hours per week. Band 7 from stroke team to offer 1 day per week extra in July 2017 and 2 days per week in October and November. Team has been given permission to recruit to 0.8 WTE band 5 (where 0.72 funding is guaranteed available.	Poor	Improvement in urgent cases waiting longer than 2 weeks. Increase in number of patients waiting more than 18 weeks. The total number of patients waiting has increased from 214 in previous month to 241. Increase is due to staff shortages and prioritising urgent referrals in August 2017. Action plan: Minimal annual leave booked for September 2017 so increased staffing availability One staff member returning from maternity leave. Band 6 successfully recruited to - anticipated start date is October 2017. Staff member from another team offered extra days to address backlog. Existing staff member increasing hours from September 2017. Band 5 approved. Clinics to resume week commencing 11/09/2017 when staffing increased to allow for increase appointments for routine patients (Updated 23/08/2017)	Extreme	15	Extreme	15	Low	3	06/10/2017
Lead Directorate: Workforce														
Portfolio: Corporate & HQ functions														
224	Hobson, Ann	Ellis, Sue	01/01/2012	Title: Prevalence of staff sickness: Due to current high levels of staff sickness absence across the Trust, there is a risk of greater reliance on agency cover and a risk of remaining staff being under pressure to manage an additional workload. The impacts are the financial cost of agency cover and an effect on staff morale and wellbeing	Regular monthly reporting by individual team to managers.Monthly discussion of absence by teams at business unit performance meetings.Monthly discussion of absence by Business unit at operational performance meetings, SMT, Business Committee and Board.Health and wellbeing team in place to support managers. Greater scrutiny within business units re compliance with return to work interviews. New Managing Attendance Policy.	Limited	The Trust has seen month on month reduction in sickness absence rates during 2017. January 6.5% to June 5.2%. This is a good platform on which to launch the 'Feel good' pledge during September 2017 designed to provide signposting advice on range of services available to staff, and demonstrates commitment to working with staff to improve both their physical and emotional wellbeing. Health and wellbeing (HWB) focus will be promoted through a sustained communication plan. One comprehensive HWB plan will be produced, which will then service a variety of needs, such as CQUIN requirements. This plan will be discussed at SMT in August 2017 and shared with the Business Committee at its September 2017 meeting. (Updated 28/07/2017)	Extreme	16	Extreme	16	Medium	6	31/10/2017

Board Assurance Framework (summary) 2017-18

Appendix 2

Details of strategic risks (description, ownership, scores)								Level of Assurance					
Risk		Risk ownership		Risk score									
Corporate Objective	Risk	Responsible Director	Responsible Committee	Likelihood	Consequence	Risk Score	Risk score movement	Current Level of Assurance (denoted by ◆). No	Limited	Reasonable	Substantial	Assurance - additional Information	Assurance Movement
Ensure consistent delivery of high quality care	**RISK 1.1** If the Trust does not have effective systems and processes for assessing the quality of service delivery and compliance with regulatory standards then it may have services that are not safe or clinically effective.	MP	QC	3	4	12	⟷			◆		Clinical audit plan progress. Clinical supervision compliance. HV service rated 'outstanding' in recent BFI audit.	→
	RISK 1.2 If the Trust does not implement and embed lessons from internal and external reviews and reports, then it may compromise patient safety, and may experience intervention or damage to reputation and relationships.	MP	QC	2	4	8	⟷			◆			None
	RISK 1.3 If the Trust does not focus on services and areas requiring improvement, then it may not maintain a 'Good' CQC rating and will not achieve 'Outstanding'. This will have an impact on the Trust's reputation and it will receive a greater degree of oversight and scrutiny	AT	QC	2	3	6	↓			◆		CQC report (rating: Good) received and evaluatedin September 2017 Board workshop. Hannah House action plan.	→
	RISK 1.4 If the Trust does not achieve external and internal quality priorities and targets then this may cause damage to reputation and loss of income.	MP	QC	3	2	6	⟷			◆		Risk of not achieving some CQUINs - possible financial shortfall	←
Create sustainable services	**RISK 2.1** If the Trust does not achieve principal internal projects (integrated neighbourhood teams, EPR, E-rostering, estates rationalisation) then it will fail to effectively transform services and the positive impact on quality and financial benefits may not be realised.	SP	BC	2	4	8	⟷		◆				None
	RISK 2.2 If the Trust does not deliver contracted activity requirement, then commissioners may reduce the value of service contracts, with adverse consequences for financial sustainability.	SP	BC	2	3	6	⟷			◆		Improvement in Trust's variance from activity profile. Internal audit - capacity and demand audit received 'reasonable' opinion. Performance against national waiting time targets is consistently good.	→
	RISK 2.3 If the Trust does not improve productivity, efficiency and value for money and achieve key targets, supported by optimum use of performance information, then it may fail to retain a competitive market position.	SP	BC	3	4	12	⟷			◆			None
	RISK 2.4 If the Trust does not retain existing viable business and/or win new financially beneficial business tenders then it may not have sufficient income to remain sustainable.	BM	BC	3	4	12	⟷			◆		Business and commercial developments report received reasonable assurance.	→
	RISK 2.5 If the Trust does not deliver the income and expenditure position agreed with NHS Improvement then this will cause reputational damage and raise questions of organisational governance.	BM	BC	2	4	8	⟷			◆			None

Continue to improve staff engagement and morale	**RISK 3.1** If the Trust does not have suitable and sufficient staff capacity and capability (recruitment, retention, skill mix, development) then it may not maintain quality and transform services.	SE	BC	3	4	12							None
	RISK 3.2 If the Trust fails to address the scale of sickness absence then the impact may be a reduction in quality of care and staff morale and a net cost to the Trust through increased agency expenditure.	SE	BC	4	4	16							None
	RISK 3.3 If the Trust does not fully engage with and involve staff then the impact may be low morale and difficulties retaining staff and failure to transform services.	TS	SMT	4	3	12						Positive assurance sources: Improved Friends and family test (staff) response. Freedom to Speak Up Guardian reports. Ask Thea analysis. Board members' visits.	
	RISK 3.4 If the Trust does not invest in developing managerial and leadership capability in operational services then this may impact on effective service delivery, staff retention and staff wellbeing .	SP	BC	3	3	9						Staff appraisal rates below target. OD strategy quarterly report received limited assurance.	
Take a lead role in delivering new models of care in the city through system integration with GPs, LYPFT and tier one hospital services	**RISK 4.1** If the Trust does not respond to the changes in commissioning, contracting and planning landscape (STP implementation) and scale and pace of change then it may fail to benefit from new opportunities eg new models of care integration, pathway redesign etc.	TS	TB	3	3	9						Positive evaluation of new models of care Board workshop.	
	RISK 4.2 If the Trust does not maintain relationships with stakeholders, including commissioners and scrutiny board then it may not be successful in new business opportunities. The impact is on the Trust's reputation and on investment in the Trust .	TS	TB	3	4	12)							None
	RISK 4.3 If the Trust does not engage patients and the public effectively in Trust decisions, the impact will be difficulties in transacting change, and reputational damage.	MP	QC	2	3	6							None
	RISK 4.4 If there is insufficient capacity across the Trust to deliver all planned change programmes and strategic projects, including the Leeds Plan, then organisational priorities may not be delivered.	TS	BC	3	3	9							None

Appendix 3

Glossary- BAF risk assurance levels

Risk assurance levels	Definition
Substantial	Substantial assurance can be given that the system of internal control and governance will deliver the clinical, quality and business objectives and that controls and management actions are consistently applied in all the areas reviewed.
Reasonable	Reasonable assurance can be given that there are generally sound systems of internal control and governance to deliver the clinical, quality and business objectives, and that controls and management actions are generally being applied consistently. However, some weakness in the design and / or application of controls and management action put the achievement of particular objectives at risk.
Limited	Limited assurance can be given as weaknesses in the design, and/or application of controls and management actions put the achievement of the clinical, quality and business objectives at risk in a number of the areas reviewed.
No	No assurance can be given as weakness in control, and/or application of controls and management actions could result *(have resulted)* in failure to achieve the clinical, quality and business objectives in the areas reviewed.

Leeds Community Healthcare NHS Trust

Agenda item
2017-18
(54)

Trust Board public workplan 2017-18
Version 5 12 September 2017

Topic	Frequency	Lead officer	4 August 2017	6 October 2017	1 December 2017	2 February 2018	29 March 2018	1 June 2018
Preliminary business								
Minutes of previous meeting	every meeting	CS	X	X	X	X	X	X
Action log	every meeting	CS	X	X	X	X	X	X
Committee's assurance reports	every meeting	CELs	X	X	X	X	X	X
Patient story	every meeting	EDN	X	X	X	X	X	X
Quality and delivery								
Chief Executive's report	every meeting	CE	X	X	X	X	X	X
Performance Brief	every meeting	EDFR	X	X	X	X	X	X
Serious incident report	4 x year	EDN	X	X		X		
Operational plan including financial plan	2 x year	EDFR		X			X	
Care Quality Commission inspection reports	as required	EMD		X				
Quality account	annual	EDN				X		X
Staff survey	annual	DW					X	
Service strategy	as required							
Safe staffing report	2 x year	EDN	X			X		
Infection prevention control annual report	annual	EDN		X				
Seasonal resilience	annual	EDO		X CE's report				
Emergency preparedness and resilience report and major incident plan annual report	annual	EDO		X				
Patient experience: complaints and incidents report	2 x year	EDN			X			X
Freedom to speak up annual report	annual	CE	X					
Guardian for safe working hours annual report	annual	EMD	X					
Safeguarding annual report	annual	EDN		X				
Equality annual report	annual	EDN			X			
Strategy								
Service strategy	as required	EDFR			X			
Quality strategy	annual	EDN			X	X		
Professional strategy	annual	EDN		X	X			
OD strategy	2 x year	DW			X			X
Research and development strategy	annual	EMD	X					
Other strategic developments	as required	EDO	X Digital strategy					
Governance								
Well-led framework	2 x year	CS			X CE's report			
Medical Director's report: doctors' revalidation	annual	EMD	X					
Nurse revalidation	annual	EDN	X					
Annual report	annual	EDFR						X
Annual accounts	annual	EDFR						X
Letter of representation	annual	EDFR						X
Audit opinion	annual	EDFR						X
Audit Committee annual report	annual	CS						X
Standing orders/standing financial instructions review	annual	CS					X	
Annual governance statement	annual	CS					X	
Going concern statement	annual	EDFR					X	
Committee terms of reference	annual	CS						X
Board and sub-committee effectiveness	annual	CS						X
Register of sealings	annual	CS						X
Declarations of interest/fit and proper persons test/gifts and hospitality	annual	CS					X	
Board workplan	every meeting	CS	X	X	X	X	X	X
Significant risks and risk assurance report	every meeting	CS	X	X	X	X	X	X
Corporate governance update	As required	CS	X					
Decisions for ratification	as required	CS						
Reports								
Approved minutes of committees, Safeguarding Boards, Health and Wellbeing Board, Children's Trust Board	every meeting	CS	X	X	X	X	X	X

Key

CE	**Chief Executive**
EDFR	**Executive Director of Finance and Resources**
EDN	**Executive Director of Nursing**
EDO	**Executive Director of Operations**
EMD	**Executive Medical Director**
DW	**Director of Workforce**
CELs	**Committees' Executive Leads**
CS	**Company Secretary**

= received
= deferred to another meeting
= not required

NHS
Leeds Community Healthcare
NHS Trust

Quality Committee
Monday 24 July 2017
Boardroom, Stockdale House, Leeds
09:30 – 12:30

AGENDA ITEM 2017-18 (55a)

Present	Dr Tony Dearden	Committee Chair / Non-Executive Director
	Neil Franklin	Trust Chair
	Dr Amanda Thomas	Executive Medical Director
	Professor Ian Lewis	Non-Executive Director
In Attendance	Sam Prince	Executive Director of Operations
	Stephanie Lawrence	Deputy Director of Nursing
	Caroline McNamara	Clinical Lead for Adult Services
	Karen Worton	Clinical Lead for Children's Services
	Andrea North	General Manager Specialist Services (left meeting at 11.00)
	Carolyn Nelson	Head of Medicines Management
	Vanessa Manning	Company Secretary
	Liz Ward	Service Manager - Item 2017-18 (27)
	Pete David	Lead Nurse - Item 2017-18 (27)
Observing	Em Campbell	Business Manager – Adult Services
Minutes	Bridget Lockwood	Business Support Manager
Apologies	Thea Stein	Chief Executive
	Marcia Perry	Executive Director of Nursing
	Elaine Goodwin	Clinical Lead for Specialist Services
	Dr Florence McDonagh	Associate Medical Director – Children's Services

Item no	Discussion item	Actions
Welcome and introductions		
2017-18 (26a)	**Welcome and Apologies** The Chair opened the meeting and welcomed Professor Ian Lewis to his first Committee meeting. Apologies were noted from Thea Stein, Marcia Perry, Elaine Goodwin and Dr Florence McDonagh.	
2017-18 (26b)	**Declarations of Interest** There were no declarations of interest received.	
2017-18 (26c)	**Minutes of meeting held on 26 June 2017** The minutes were reviewed for accuracy and agreed as a true record of the meeting with amendments agreed as follows: • Head of Children and Family Services to be amended to Head of Service ICAN	

	• Item 2017-18 (19) – heading on page 3 to be amended to 'The awareness of the offer to children and families' • Item 2017-18 (21c) - amendment to wording in second sentence of final paragraph to "The Committee Chair queried if there would also be a category where guidance is not applicable to the service" • Item 2017-18 (22c) – "ADR" to be amended to "LeDeR"	**BL**
2017-18 (26d)	**Matters arising and review of action log** It was agreed that all completed actions would be removed from the action log. In addition, the following were raised for further update and discussion: • Item 2016-17(85e) – the Company Secretary highlighted the review of the effectiveness of sub groups and encouraged members to complete the effectiveness questionnaires, the result of which would be reported to the next meeting of the Quality Committee in September 2017 • Item 2017-18 (14b) – Board members' service visits – the Trust Chair informed the Committee that the Executive Director of Nursing had completed a schedule of visits for him to Children's Services. A discussion took place regarding the type of visit Non Executive Directors wished to carry out and the Executive Medical Director recognised the benefit to services such visits had made over the winter period. The Committee Chair said that the Executive Director of Nursing had drafted a flow chart which would confirm the process regarding a management response to Non Executive Director feedback following visits. The Executive Medical Director confirmed the process would be agreed by the Senior Management Team to ensure that actions were taken forward. • Item 2017-18 (20ai) – the Clinical Lead of Adult Services shared a plan to address access to training by staff in the neighbourhood teams which outlined the ongoing complex challenges identified and how these would be resolved. The position was being monitored and there would be a further audit in August 2017. It was noted that the teams were currently 89 percent compliant with statutory and mandatory training targets. The action was agreed as complete • Item 2017-18 (20aii) – Staffing issues in the Speech and Swallowing Service – the Executive Director of Operations confirmed that the position was being monitored, and that this was a risk that was being managed • Item 2017-18 (20aiii) – CAMHS Eating Disorder Service - the Clinical Lead for Children's Services had spoken with the service manager and it was felt that progress was being made to resolve the issues raised, including the use of Skype. The Trust Chair confirmed that he had received an email from the service to confirm this. Action agreed as complete.	
Service spotlight		
2017-18 (27)	Liz Ward (Service Manager) and Pete Davis (Lead Nurse) attended to provide an overview of the Leeds Integrated Sexual Health Service, a joint service provided by Leeds Community Healthcare NHS Trust, Leeds Teaching Hospitals NHS Trust (LTHT) and MESMAC. The service had been commissioned in July 2015 by Leeds City Council and was currently seeing approximately 60,000 contacts per year (around 35,000 individuals).	

	The Service operated a hub and spoke model from sites at the Merrion Centre, and in Armley, Beeston, Burmantofts and The Reginald Centre. It was a multi disciplinary team which included outreach working and a health advisory service in addition to clinics. The Service has been nationally recognised for its outreach work with sex workers, delivered in partnership with the Third Sector (Basis Yorkshire). The service monitored over 40 Key Performance Indicators (KPIs), some of which were qualitative, a number of which were reported via audits. It was noted that there had been an increase in the number of Sexually Transmitted Infections (STIs) diagnosed, particularly syphilis, partly due to an increase in screening. The Committee noted that the service consistently met its financial KPIs and had good staff morale and relationships with service users, and had good relationships with commissioners. The Service Manager highlighted some of the challenges for the service which included demand, new KPIs which present a challenge to the way staff had historically delivered the service, limited opportunity for growth and a new sub contract with General Practice. The Trust Chair asked what was not going so well in the service. The Service Manager responded that the level of demand and rota management were the areas that presented challenges. This was due to the constraints placed on the Service by the budget and the tightly prescribed service specification. The need to deliver services in the spokes when demand was increasing at the hub at Merrion Centre presented a staffing rota challenge. The Committee Chair asked about the reception area at the hub base at Merrion Centre. The Service Manager said that work had been carried out to improve the waiting area, including the installation of a television and free wifi access for clients. The Committee Chair asked what steps were being taken to widen the means by which service users could submit feedback, specifically by electronic means. The Service Manager and Lead Nurse said that they would welcome further means to obtain immediate feedback which was a challenge given the nature of the service provided. The Executive Director of Operations and General Manager for Specialist Services committed to pursue this further. A Non Executive Director (IL) asked if the KPIs referred to in the presentation were set nationally. The Service Manager responded that the commissioners had reviewed national standards and incorporated these into KPIs, and had additionally created KPIs based on challenges historically seen in the service. The General Manager for Specialist Services reflected that the service had been required to deliver against 160 KPIs as part of the previous service contract. A Non Executive Director (IL) asked how many of the KPIs were based on outcomes for patients. The Service Manager responded that in addition to data submitted against the KPIs, data was submitted nationally regarding GUM, TRAD and chlamydia screening which were benchmarked nationally. The Committee asked that information regarding where the service benchmarked be shared.	

	A Non Executive Director (IL) asked the Service Manager and Lead Nurse to describe where lessons had been learnt from an incident that had occurred in the service. A moderate harm incident had occurred the previous year regarding a PEP treatment that had been prescribed correctly to a patient with HIV but it had been found at a review meeting that this had been self-administered incorrectly. The learning applied following this incident included more explicit instruction on how the tablets were to be taken and the setting up of reminders on smartphones to ensure they were taken at the correct frequency. The Committee Chair thanked the Service Manager and Lead Nurse for an interesting and informative presentation. **Actions:** • **Consider feasibility of benchmarking data regarding outcomes.** • **IT solutions to enable further means of obtaining service user feedback to be progressed by the Executive Director of Operations and General Manager for Specialist Services**	**EG** **SP**
Quality and safety		
2017-18 (28)	**Director of Nursing: quality and safety report** The Deputy Director of Nursing presented the report which continued in the revised format introduced in May 2017. Key areas to note included falls prevention, children's services, complaints in the podiatry service and complex cases in the neighbourhood teams. The Deputy Director of Nursing also highlighted that there had been one case of clostridium difficile which had been attributable to the organisation because the patient had been on Ward J31 for more than 24 hours at the time of diagnosis. It was noted that there were no lapses in care and that the patient may have been carrying the infection for some time prior to admission to the unit. **Falls** A Falls Steering Group had been established and a first draft of an action plan had been appended to the paper. The Deputy Director of Nursing acknowledged that further work was needed regarding the actions, and progress made against the actions, and that the RAG rating needed to be updated in line with other Trust documentation. The Trust Chair asked if the same approach was being taken as had been adopted regarding pressure ulcers. The Deputy Director of Nursing confirmed that the same approach was being taken, including falls panels, the means of ensuring any learning was embedded in practice and reporting. The Trust Chair asked how staff learn from both their own and incidents that take place in other teams. The Deputy Director of Nursing responded that there was more work to be undertaken in this area but added that the panels offered the opportunity to share further learning, as did the neighbourhood team safety huddles. The Committee Chair felt that it was not clear what action needed to be taken against a suggested timeline, and that only one person should be accountable for each action. He asked how frequently the steering group met and it was clarified that the group met bi-monthly, with the next meeting taking place in August 2017.	

	A Non Executive Director (IL) asked if the standards set out in the action plan were set nationally. The Deputy Director of Nursing responded that some standards had been set internally, some were set nationally. A Non Executive Director (IL) asked that the document state if any standards had been set by NICE. The Executive Medical Director added that the NICE Report reviewed by the Committee would also include this information. In response to a query from the Trust Chair regarding the reporting of any improved performance in this area, the Clinical Lead for Adult Services assured the Committee that teams were not seeing a rise in the number of falls. The Committee noted that the Trust reported and investigate falls appropriately. The Deputy Director of Nursing added that the workstream aimed to identify recurrent themes that needed focus, and to increase knowledge around these. It was felt that it would take approximately six months to address the themes and to see a reduction in the number of falls. The Committee requested sight of a revised action plan in October 2017. **Action:** • **Revised falls action plan to be shared with the Committee in October 2017** **Children's Services** The Committee noted the programme of enhanced support in place for Hannah House, including signing off competencies and ensuring care plans were in place for each child. The Clinical Lead for Children's Services informed the Committee that a development day had been well attended the previous week. This had offered the opportunity to staff to express their passion for the service but also to identify areas of concern, including communication which was seen as a significant issue. An action plan was being created which would include identified responsibilities. The Executive Medical Director added that, following a suggestion from a staff member on the day, training had been carried out as part of the session. The Trust Chair acknowledged that it would take some time to address all the issues but that the response had been appropriate. **Complaints in the podiatry service** The Committee noted data collated regarding complaints relating to the podiatry service between July 2014 and June 2017. Following a review of themes and actions taken as a result of complaints it had been determined that the most consistent trend was regarding access to the service. The Trust Chair queried the upward trend shown in the number of complaints received relating to clinical judgement, with an increase from 9 percent in 2014-15 to 35 percent in 2015-16 and 27 percent in 2016-17. The General Manager for Specialist Services agreed to ask the Clinical Lead for Specialist Services how many of these complaints had been upheld. **Action:** • **Clinical Lead for Specialist Services to be asked to establish how many complaints relating to clinical judgement had been upheld**	**SL** **EG**

	Complex cases in neighbourhood teams The Deputy Director of Nursing highlighted that the Executive Director of Nursing had asked that two cases be shared with Quality Committee in order to show the time involved and complexity of some interventions in the neighbourhood teams. A Non Executive Director (IL) acknowledged the amount of care that needed to be delivered in such cases and asked for further clarity regarding the numbers of such cases across all teams, impact on the service in terms of staffing, and impact on the quality of service and on the organisation as a whole. The Clinical Lead for Adult Services confirmed that all neighbourhood teams had complex patients on caseloads but the cases illustrated in the paper were particularly complex. The Executive Director of Operations commented that the number of complex cases seen by teams impacted on the number of referrals that could be accepted each day which ultimately could affect the flow of patients in the city. The Trust Chair asked if commissioners were sufficiently sighted on the impact complex patients had on the resources available across the Trust and enquired as to the impact on the Trust's partnerships (for example with LTHT and Adult Social Care). The Deputy Director of Nursing informed the Committee that the Executive Director of Nursing was undertaking a piece of work regarding complexity and added that a review would be finalised in the next two to three months. The Clinical Lead for Adult Services highlighted the skills and competencies the cases demonstrated and wished to acknowledge the support offered to neighbourhood teams by leaders when dealing with complex cases. **Actions** • **Report to be submitted in October 2017 regarding quantifying identifying measures and definitions of complexity** • **Cases to be identified to share with commissioners to demonstrate the impact of complex cases on resourcing within neighbourhood teams** **Pressure Ulcer reporting process** The Committee noted the revised pressure ulcer reporting process shown as appendix two of the report which had been designed to create further capacity within the neighbourhood teams. The Clinical Lead for Adult Services thanked the Deputy Director of Nursing for her input into the revised process which set out that any incidents deemed avoidable would be reported on STEIS and be subject to a full investigation and root cause analysis process. **Clinical Governance Exception Report** The Committee noted the Clinical Governance Exception report for June 2017. An anomaly relating to Category 4 Pressure Ulcers was identified by the Deputy Director of Nursing who commented that her belief was that the pressure ulcer panel had amended the status of one potential case to avoidable, despite the recording of one incident in the performance brief. The Deputy Director of Nursing agreed to confirm at the next meeting why there had been a discrepancy and what actions were being taken to ensure a discrepancy does not occur again. **Action:** • **Explanation to be provided re discrepancy in recording of Category Four pressure ulcer case and confirmation of actions to be put in place to ensure there are no further discrepancies**	**MP** **MP** **SL**

	The Committee noted the flash report regarding serious incidents, pressure ulcers and falls. The Deputy Director of Nursing commented on the 90 falls reported in June 2017, 82 percent of which resulted in no harm or minimal harm. It was noted that a Catheter Associate Urinary Tract Infection (CAUTI) group and plan of work had been established. The Committee noted the patient experience flash report, including the Friends and Family Test response rates. The Chair queried the rise in the number of concerns and the reduction in the number of complaints recorded. This was acknowledged as a positive development as conversations were taking place early to resolve the matter and to prevent an escalation to a complaint. The Executive Medical Director informed the Committee that this brought the Trust in line with other organisations nationally. **Clinical Leads' Quality Reports** The Clinical Leads for each business unit provided a summary of the reports appended to the Director of Nursing's quality and safety report. ***Specialist Services*** The General Manager for Specialist Services highlighted the following areas to the Committee: • area of risk in the IAPT service relating to an increase in step three CBT waiting list which had increased by a third in a period of five months. A significant amount of work was underway to re-design the service and it was noted that temporary funding had been lost • the action plan was being reviewed regarding pressures in the adult speech and language service • an increase in whole prison shut downs at Wetherby Young Offenders Institute (YOI) and the resultant impact on access to health services had been escalated to the Governor and the Executive Director of Nursing and Clinical Lead for Specialist Services were scheduled to meet with him. The Executive Medical Director highlighted the significant reduction in staff sickness levels within the Business Unit, particularly within the policy custody services The General Manager for Specialist Services provided further information regarding the impact on Trust services of the recent change in process which meant that patients were now discharged from the Early Stroke Discharge Service at six weeks rather than later in their recovery. Impact assessments were being carried out in Dietetics, Community Neurology and Speech and Language Therapy services to understand referral patterns and subsequent waiting times. The Committee noted that the police custody tender had not been released and a discussion took place regarding the current financial envelope of the contracts and the opportunity to further develop the advanced nurse practitioner role, of which the Police were supportive. ***Adult Business Unit*** The Clinical Lead for Adult Services highlighted the following areas: • Four clinicians had completed the advanced clinical practice course. • A new course had been developed and would be rolled out in conjunction with the Clinical Education Team on acutely managed conditions • Internal work continued in order to clarify REAP levels, skills, resilience and rota planning in preparation for winter pressures. The Trust was working with acute trust colleagues	

	• Work was underway to enhance skill mix and competencies The Trust Chair requested an update on work relating to self care. The Clinical Lead for Adult Services confirmed that this work was proceeding well, alongside the acute trust, initially relating to the administration of Tinzaparin followed by work relating to insulin administration. The Trust Chair requested data on how many patients by clinical team were now self medicating and the Clinical Lead agreed to provide this information. The Committee Chair asked for an update on ensuring consistency of practice across neighbourhood teams. The Clinical Lead for Adult Services confirmed that an action plan was in place, essential criteria established and caseload reviews were consistently taking place. This was monitored at the monthly quality meetings and although it was difficult to provide a definitive timeline for completion, an upward trajectory was evident. **Action:** • **Data to be provided regarding number of patients now able to self care and how this is freeing up capacity in neighbourhood teams** ***Children's Services*** The Clinical Lead for Children's Services highlighted the following areas: • Nursing Strategy for ICAN – a role and competency framework for nursing staff was being developed and had been well received in the service. Gaps in training and areas for development were being identified • CAMHS – a focus was being placed on care pathways and it was noted that the service had benefited from additional organisational support in this area The Clinical Lead for Children's Services clarified that an action plan had been put in place to address any concerns that had arisen from the reduction in the number of hours the service had to assess a young person, a reduction from 72 to 24 hours when detained in a 'place of safety'. The Trust Chair asked if staffing and sickness were issues for some of the services. The Clinical Lead responded that sickness remained an issue in some services but work was underway to triangulate information, including an indication as to the proportion of long term sickness. The Executive Director of Operations added that the Business Unit was reporting an overall sickness rate of 4.8 percent which was an improved position. The Trust Chair commented on the recruitment taking place in the School Nursing service and asked if the remit of the service was to be widened. The Executive Director of Operations responded that this would be confirmed as part of the revised service specification. The Executive Director of Operations added that there was an opportunity for the Trust to approach schools regarding the procurement of additional services directly from the Trust. The Committee Chair sought to clarify the lead for the SEND reforms action plan. It was agreed that the plan needed further work and the Clinical Lead for Children's Services agreed to submit an updated version to the meeting in September 2017, including a RAG rating that was consistent with other plans within the Trust.	**CMcN**

	Action: • **Revised SEND reforms action plan to be submitted to meeting in September 2017** **Outcome:** The Committee: • Noted the contents of the performance brief and the highlighted areas • Agreed **reasonable assurance** had been provided regarding the activity relating to falls prevention • Agreed **reasonable assurance** regarding Hannah House, including crucial changes that had been made, new leadership arrangements and assurance following the away day the previous week • Agreed **reasonable assurance** had been provided regarding podiatry complaints, subject to a further piece of work which was requested regarding the number of complaints that had been upheld relating to clinical judgement and treatment • Agreed **limited assurance** regarding the impact of complex care in neighbourhood teams • Agreed **reasonable assurance** regarding the revised pressure ulcer reporting process and a discrepancy regarding the number reported in the report and in the performance brief and domain reports • Agreed **reasonable assurance** had been provided regarding the case of Clostridium Difficile on Ward J31(Community Intermediate Care Unit) • Agreed **reasonable assurance** regarding the reduction in complaints and increase in concerns recorded in June 2017	**KW**
2017-18 (28b)	**Performance brief and domain reports** The Committee reviewed the document, specifically the domains relating to safe and caring. The following areas were raised as items for discussion. The Committee Chair queried the five patients who had waited more the 18 weeks for treatment in a consultant-led service in June 2017 and the Executive Director of Operations provided assurance that this was within the agreed rate of tolerance. The Executive Director of Operations commented that the area of focus in the report, SPUR, had been included for a second time because this report would be considered by the Trust Board at its meeting on 4 August 2017. A discussion took place regarding the role of SPUR in the city and partnership working at times of increased pressure within the city. The Deputy Director of Nursing was asked to review the colour coding of the donut graphs regarding safe staffing prior to circulation of the report with Board papers. The Head of Medicines Management asked the Committee to confirm if the data presented in the report relating to compliance with NICE guidance was what was required. **Actions:** • **Safe staffing donut colour code to be checked prior to circulation of the Board papers** **Outcome:** The Committee noted the contents of the performance report for June 2017 which provided **reasonable assurance**	**SL**

2017-18 (28c)	**Risk register: operational and clinical risks** The Company Secretary introduced a summary report and confirmed that a full risk register report would be received at the next meeting of the Committee in September 2017. The Committee noted one new extreme risk (ID 906) relating to a reduction in funding for neighbourhood teams as a result of the community intermediate care (CIC) bed re-tender. The risk score was noted as 20. The Executive Director of Operations provided further information regarding the risk and the financial implications involved. The Committee was informed that following a meeting with commissioners later in the week an updated position would be provided to the Board, along with confirmation as to whether the risk score was to be reduced. The Committee also noted that risk ID 862, relating to clinical capacity in the adult speech and swallowing team had been increased from 6 (moderate) to 12 (high). **Outcome:** The Committee noted the recent revisions made to the risk register.	
Clinical Effectiveness		
2017-18 (29)	**Outcome measures** The Executive Medical Director confirmed that the Senior Management Team would be considering a paper on 2 August 2017 and apologised that an update could not be provided to the Committee until the meeting in September 2017.	
2017-18 (21b)	**Patient group directions** The Executive Medical Director confirmed that all PGDs had been through the correct processes and recommended all for ratification. **Outcome: the Committee ratified the following PGDs:** • **001-17 PGD for the administration of Seasonal Influenza Vaccine for Staff** • **017-10 PGD for the administration of Meningococcal ACWY Vaccine** • **105-03 PGD for the administration of Human Papillomavirus (HPV)** • **114-04 PGD for the administration or supply of Live Attenuated Influenza Vaccine Nasal Spray**	
Reports and minutes for approval or noting		
2017-18(30a)	**Board members' service visits** The Executive Medical Director confirmed that on a visit to Little Woodhouse Hall a Non Executive Director (Brodie Clark) had identified that a potential ligature risk relating to toiletry containers had not been resolved. The Committee Chair requested confirmation by email that this had been actioned with some urgency and had been subsequently resolved. The Trust Chair queried the issue raised in the report regarding the standard of food. The Clinical Lead for Children's Services confirmed that an audit of the food had been carried out by young people and this had been escalated to the catering service provider. The Clinical Lead provided further confirmation that the infection control issues outlined in the report had been progressed by the infection prevention and control team. In addition, the lift was being encased this week so that it could no longer be accessed.	

	The Trust Chair requested that the Committee receive a copy of the response to the Non Executive Director. The Committee Chair queried the issue regarding rostering that had been raised in the report. The Clinical Lead for Children's Services responded that clarity would need to sought from Brodie Clark regarding this. **Actions:** • **Email to be sent to committee members to confirm that the ligature risk re toiletry containers at Little Woodhouse Hall had been rectified** • **Clinical Lead for Children's Services to clarify with Non Executive Director (BC) the reference in the report to rostering** • **Committee to have sight of response to Non Executive Director (BC)** **Outcome:** the Committee received the report	**MP** **KW** **VM**
2017-18(30b)	**Commissioners' visit: SLIC 8 May 2017** The Committee noted that the issue raised in the report regarding updating the call system would not be rectified and this was recorded on the Trust's risk register. The Trust would cease to provide this service from 1 November 2017. **Outcome:** The Committee noted the commissioner's quality assurance visit report.	
2017-18 (30c)	**Mental Health Act Governance Group 16 June 2017: draft minutes** The Committee Chair highlighted that the date on the minutes was incorrect. The Clinical Lead for Children's Services confirmed that the Executive Director of Finance and Resources was pursuing the Memorandum of Understanding with Leeds and York Partnership NHS Foundation Trust regarding Mental Capacity Act Managers. **Outcome:** The Committee received the minutes and requested that the date be corrected	
2017-18 (30d)	**Clinical Effectiveness Group 22 June 2017: draft minutes** The Executive Medical Director asked the Committee to note the positive outcome of the workshop on insulin administration and that the Group had received a good report on the year end clinical audit position. **Outcome:** The draft minutes were received	
2017-18 (30e)	**Safeguarding Group 23 June 2017: draft minutes** The Committee requested that the date under Item 2 relating to the date of the last meeting be corrected. **Outcome:** The draft minutes were received	
2017-18 (31)	**Quality Committee future workplan** The Committee noted that there had been further discussion regarding the workplan and some changes had been made to the service spotlight sessions.	

2017-18 (32)	**Matters for the Board and other committees** Items to be reported to include: • Falls prevention • Hannah House • Podiatry complaints • Complex care in neighbourhood teams • Pressure ulcers • One reported case of clostridium difficile at CICU • Reduction in complaints and increase in concerns • New risk relating to the CIC bed tender • Lack of progress re outcome measures	
2017-18 (33)	**Any other business** None recorded.	
	Dates and times of next meetings (09:30 – 12:30) Monday 25 September 2017 Monday 23 October 2017 Monday 20 November 2017	

Leeds Community Healthcare NHS Trust

MINUTES

AGENDA ITEM 2017-18 (55b)

Business Committee Meeting
Boardroom, Stockdale House
Wednesday 26 July 2017 (9.00 – 12.00 noon)

Present:	Brodie Clark (Chair)	Non-Executive Director (BC)
	Tony Dearden	Non-Executive Director (TD
	Bryan Machin	Executive Director of Finance & Resources
	Sue Ellis	Director of Workforce
Attendance:	Sam Prince	Executive Director of Operations
	Vanessa Manning	Company Secretary
	Janet Addison	Head of Service (for item 33 and 35a only)
Apologies:	Richard Gladman	Non-Executive Director (RG)
	Thea Stein	Chief Executive
Note Taker:	Ranjit Lall	PA to Executive Director of Finance & Resources

Item	Discussion Points	Action
2017/18 **(32)**	The Chair welcomed the Head of Children's and Speech and Language Therapy to the meeting. **32a - Apologies**: Please see above. **32b - Declarations of Interest**: None recorded. **32c - Minutes of last meeting:** The public and private minutes of the meeting dated 28 June 2017 were approved by the Committee. **32d - Matters arising from the minutes and review of actions:** No further actions were noted; all actions on the action log due for completion by July 2017 were completed.	
2017/18 **(33)**	**Children's speech and language therapy service presentation** The presentation reflected on achievements, new skill mix, implementation of nine care pathways and the introduction of outcome measures. Whilst challenges existed in relation to the recording and reporting of contracted activity and the delivery of cost improvement plans; most concerns related to waiting times for treatment. The Head of Service said that the service was in budget in terms of staffing but further cost improvement was still to be addressed. A Non-Executive Director (TD) queried the area of responsiveness and the significant waiting times and asked whether any lessons had been learnt to minimise long waits. The Head of Service said that the service now had a clear protocol in place from access to manageable caseloads to throughput and was effectively operating within the new service model.	

	In response to a question from a Non-Executive Director (TD) relating to capacity and recruiting therapists, the Head of Service said that the service was struggling with recruitment to managerial posts. The Executive Director of Operations added that the activity figure of 15.5% was a concern, not in terms of less activity but in relation to recording of data correctly. She said she was confident that there was sufficient capacity to meet the contracted levels. The Head of Service said that in terms of service structure the Trust was below the national average. She said that if the traded capacity and NHS capacity was reviewed together, the Trust would be compared favourably. There was very little available nationally on benchmarking data. The Head of Service said that further work was being undertaken to address the recording of activity and issues around the way the service was commissioned. The Chair asked about the approach to competition in terms of gaining new business. The Head of Service responded to say that it was the responsiveness that was the key factor; schools sometimes went with the independent suppliers for an immediate response. The Committee discussed the NHS 'offer' and the opportunity for growing the 'traded offer' particularly working closely with local schools. **Other comments noted as follows:** • Consolidation had worked well; better usage of clinical space and hot desking space. The Head of Service said that there would be added value across the organisation by using a room booking system at short notice, including the availability of hot desks. • There was an online tool kit, and training for parents. The Head of Service said that asking parents to come along to sessions was a challenge. Training for parents was a new offer, and bringing parents together to share experiences was very powerful. • Regarding therapists working independently and in charge of their own caseloads, it was noted that the team managers were reviewing productivity and caseloads as part of their mentoring. The Chair thanked the Head of Service for a helpful presentation which was suitability focused on some of the issues of concerns, particularly around referrals, waiting times, the involvement of families and staff recruitment. **Outcome:** The presentation on children's service area was well received by the Committee.	
2017/18 (34)	**Project management** **34a – Projects' highlight reports** Following a recent conversation between the Chair of the Committee, the Executive Director of Finance & Resources and the Company Secretary to rationalise the projects presented to the Committee, it was agreed that the project flash reports to the Committee would be to note the progress against the project plan for e-rostering, electronic patient record and patient administration. It was noted that the electronic patient record was on track and delivering according to schedule and was effectively being managed by the project team.	

	Outcome: The Committee noted the contents of projects flash report. **34b – E-rostering project update** (Please see private minutes).	
2017/18 **(35)**	**Strategy development and implementation** **35a - Children's strategy update** The Executive Director of Operations tabled a paper to provide the Committee, with an update on the development of a children's strategy and next steps. The Committee was briefed on the initial work; the aim was to ensure that this would fit with the overarching Leeds children's and young people's plan and to develop a plan for local implementation. It was noted that consultation work had started within the business unit to agree overall aims and objectives. The objectives were child focused and social outcome focused. Following a period of consultation with young people, families and staff, a first draft of the plan would be prepared for consideration by the Business Committee in September 2017. The Executive Director of Operations said that there were a number of things to consider that were impacting on the strategy. For example: change in commissioning arrangements; commissioning of the healthy child pathway by the local authority. She said that this meant that the health visiting and school nursing may be subject to market testing in the next 18 months. The Executive Director of Operations said that currently the children's and young people's plan had three key areas of focus; safely and appropriately reducing the number of children looked after, reducing the number of young people not in education, employment and training and improving school attendance. The outcomes for the children's business unit were noted as part of the business plan for this year and future years. The Executive Director of Operations said that work over the next month would be around engagement within the Trust, young people and their families' and with the health commissioners and other stakeholders. The Director of Workforce said that the children's workforce plan that was being developed by September 2017 would also have analysis of the current infrastructure and integration with other city providers. She said that Leeds wide information about workforce was available if required. The Chair thanked the Executive Director of Operations and the Head of Service for the update. **Action:** A first draft of the children's strategy to be presented to the Business Committee in September 2017. **Outcome:** The Committee noted the report. **35b - Organisational development (OD) strategy update** Following Trust Board consideration of a revised strategy in May 2017, the Committee received an update report which also provided assurance of the alignment of the OD strategy with other key strategies.	SP

	The Director of Workforce said that the paper complimented the quarterly workforce report. She said that the OD strategy reflected future models of care and the strategic position was aligned with other strategies. The Chair said he was looking for more detail on timescales, a full set of deliverables and outcomes and a reflection on progress. The Director of Workforce responded to say that the progress made on the first two of the four objectives was reflected in the quarterly workforce report and that an action plan at the back of the strategy which specified which year objectives fell within had not been included in the update. The Director of Workforce referred to the operational plan content for 2017/18, and was happy to include that within the OD objectives in the quarterly workforce report, and assured the Committee that progress was on track. She also said that information on new models of care work was being provided in the Chief Executive's report. **Outcome:** The Committee welcomed the paper but remained keen to see more measurable actions with clear timescales for delivery; on these grounds the report provided limited assurance. **35c – Estates strategy: implementation update (presentation)** This was an update from the discussions held at the Trust Board workshop in May 2017. The presentation provided assurance on the continued delivery of the strategy and highlighted areas where focus was needed. The Committee noted successful relocation of services from James Reed House, Shaftesbury House and Ashley Wing. Consultation was currently underway in relation to the location of the child development centre. A further nine projects were in the pipeline. **Outcome:** The Committee gained reasonable assurance of continued delivery against the strategy's objectives to rationalise estate ensuring alignment with service provision.	
2017/18 **(36)**	**Business planning and commercial development** **36a – Operational plan 2017/18** The report provided an overview of progress at the end of the first quarter towards achieving the corporate objectives and priorities set out in the 2017/18 operational plan and provided a forecast for the year-end. The cover paper summarised overall assessment of progress and performance in relation to the priorities. The Chair noted that the quarter one position in terms of RAG rated for the majority of priorities was the same as the year-end. The Executive Director of Finance & Resources said that he would review the figures before the Trust Board meeting on 4 August 2017. **Action:** The progress against objectives and the RAG rating was to be examined before the paper was submitted to the Trust Board meeting. **Outcome:** The Committee noted the assessment of progress at the end of quarter one and the forecast for the year-end.	BM

	36b - Business and commercial developments report (Please see private minutes).	
2017/18 **(37)**	**Performance management** **37a – Performance brief and domain reports** The Executive Director of Finance & Resources introduced the performance brief and domain reports and said that the performance of the Trust was in a reasonable position. The Committee noted areas of satisfactory performance and some improvements across areas of previous challenges. Performance against indicators relating to the safe and caring domains was strong. The Trust continued to perform well in respect of its responsive indicators. In relation to workforce indicators performance remained below target in a number of areas. The Executive Director of Finance & Resources asked the Committee members to consider whether the contract related highlights would be better placed as part of the business development report rather than part of the performance report. The Chair said that he was only looking for any concerns or outstanding activity issues or risks. In response to the Chair asking about the 'trusted assessor' function, the Executive Director of Operations said that a multi-agency group had been established to bring more consistency to the referral pathways of the neighbourhood teams. She said a long term goal was to have a 'trusted assessor' process in place by October/November 2017. The Executive Director of Operations said that the key area of focus in the paper related to the Single Point of Urgent Referral (SPUR) which had been previously considered by the Business Committee. This was enabling better understanding of demand and referral patterns. Evidence showed that there were better outcomes in terms of bed usage than previously been the case. *Finance* It was noted that in the third month of the year the Trust met its financial targets for most of the indicators with the exception of capital expenditure in comparison to plan and cost improvement plan delivery. The Executive Director of Finance & Resources was pleased to advise that the financial position had improved in June 2017. The £7,000 of savings that was needed over and above the forecast as previously reported was now reduced to £5,000. The Executive Director of Finance & Resources said that this was a manageable risk at this stage in the year based on current forecast and the control total requirement **Outcome:** The Committee received and noted the performance report. **37b – Neighbourhoods' report, dashboard and systems resilience report** The Committee received an update on neighbourhood services. The Chair queried the substantial variances in the first three columns of the workforce indicators appendix. The Executive Director of Operations said that because of fluctuating demand and capacity, the establishments were evaluated once a year based on per team, but operationally staffing was adjusted whenever there was a need.	

	The Chair asked whether this data could be available as a balanced scorecard. The information was accessible through the internal information portal (PIP). The Executive Director of Operations offered to take a screenshot of the page by teams and would email out to the Non-Executive Directors. The Executive Director of Finance & Resources said that the neighbourhood teams' activity was low against target and that the Commissioners were aware. A winter readiness Board workshop was scheduled for September 2017 to look at winter planning. **Action:** A screenshot of the information available on PIP to be provided to the Non-Executive Directors. **Outcome:** The Committee received and noted the report on neighbourhood services. **37c – Waiting lists report** The Executive Director of Operations presented a six monthly waiting list update which noted that performances against the national waiting time targets was consistent and that the Trust had adopted the national standard in relation to non-reportable waiting lists. She said that further work was underway to reduce waiting times for follow up appointments. The performance on waiting times for autism assessments was off track and additional capacity had been sourced to support the Trust to meet the 12 week target by end of March 2018. The Executive Director of Operations said that it was a constant challenge in the service. She said that if there was a more centralised patient appointment booking system following an assessment there would be a better productivity outcome from the service. **Action:** The Chair welcomed a report back in due course following work undertaken to review assessments for autism spectrum conditions in six months' time (January 2018). **Outcome:** The Committee agreed that the waiting times were an on-going performance issue and that an update should be incorporated into the responsive section of performance brief every six months. The report provided reasonable assurance. **37d – Workforce: quarterly report** This was the first workforce quarterly report presented to the Committee. The report contained detailed information of trends and progress additional to the monthly performance data. The Director of Workforce said that the five clinical topics included within the statutory and mandatory training indicator would be provided in the next report. It was noted that 23 new starters were confirmed for preceptorship programme commencing in September 2017. The Director of Workforce said that there was also an additional post for a marketing/PR manager working with the communications team based on an 18 months contract. International nurse recruitment options from India and the Philippines were also being assessed by the Executive Director of Nursing as part of Health International cohort.	SP SP

	The Chair was pleased to note the progress and activity taking place by workforce directorate. **Outcome:** The Committee noted the quarterly workforce report. **37e – Internal audit report: statutory and mandatory training** The purpose of the report was to provide the Committee with an update following the receipt of the statutory and mandatory training audit report which resulted in limited assurance. The limited assurance was primarily in relation to access to e-learning for all of the programmes. The Director of Workforce was pleased to confirm that all learning programmes were now available to access. **Outcome:** The Committee noted the contents of the report. **37f – internal audit reports: 2017/18 plan** The report provided a summary of the outcomes from completed internal audit reports where the reports related directly to the role and functions of the Business Committee. This was the first report from the 2017/18 plan, looking at the demand and capacity planning in the neighbourhood teams and had attracted a reasonable assurance opinion. The Executive Director of Operations was pleased to acknowledge that the audit work was operationally very useful. An update on the audit would be undertaken in six months' time (January 2018). **Outcome:** The Committee noted the audits completed to date. **37g – Operational and non-clinical risks register 8+** The Company Secretary introduced the risk register report. There were two new risks added to the risk register since June 2017; impact on neighbourhood team funding of the community intermediate care bids tendering exercise and financial risk associated with CAMHS T4 new care models. It was noted that on this occasion reference to a risk around e-rostering had been included in the report but had not appeared in the risk register and had not been scored by the time of production of this report. The Executive Director of Operations explained the reason for current risk score of 20 for the neighbourhood teams. She said it was part of the re-commissioning of CIC beds and that there was a risk that resource available for neighbourhood teams would be reduced, having an impact on service delivery, quality and patient and staff experience. Further update would be provided at the Trust Board meeting on 4 August 2017 after further discussions with the Commissioners **Outcome:** The Committee noted the revisions made to the risk register.	
2017/18 **(38)**	**Minutes for noting** Contract Management Board: 28 February 2017. No comments were noted.	

2017/18 **(39)**	**Business Committee's work plan** **39b – Future work plan** - The work plan was reviewed by the Committee and no changes were requested.	
2017/18 **(40)**	**Matters for the Board and other Committees** • Children's speech and language therapy presentation • E-rostering project • OD strategy and estates strategy • Business development update • Waiting times	
2017/18 **(41)**	**Any other business** None discussed.	

Leeds Safeguarding Children Board

LSCB Board Meeting
22 March 2017

Mark Peel	LSCB Independent Chair
Superintendent Sam Millar	West Yorkshire Police, Superintendent (Vice Chair)
Steve Walker	LCC, Interim Director of Children's Services
Cllr Helen Hayden	Deputy Executive Member for Children and Families
Sal Tariq	LCC, Children's Services, Interim Deputy Director (Safeguarding, Targeted and Specialist Services)
Dave Basker	LCC, Children's Services, Head of Integrated Safeguarding Unit
Maureen Kelly	Leeds CCG, Interim Assistant Director of Nursing & Quality
Gill Marchant	Leeds South & East CCGs, Head of Safeguarding Children & Adults
Mariya Naylor	Yorkshire Place 2 Be, Third Sector Reference Group Chair
Karen Rodger	NHS England, Senior Nurse
Debbie Reilly	LCH, Head of Service for Safeguarding (for Marcia Perry)
Lindsay Britton-Robertson	LYPFT, Head of Safeguarding (for Anthony Deery)
Karen Sykes	LTHT, Head of Safeguarding
Jonathan Darling	Leeds CCG, Designated Doctor
Dee Reid	LCC, Head of Communication
Helen Christodoulides	LTHT, Director of Nursing (for Suzanne Hinchliffe)
Peter Harris	Primary Headteacher's Forum
Andy Percival	Leeds Secondary Heads Group
Rebecca Roberts	Legal Advisor to the LSCB
Robin Dow	Wetherby YOI, Head of Casework (for Andrew Dickinson)
Jon Lund	Leeds YOS, Operational Manager (for Rebecca Gilmour)
Andrew Ottey	Leeds City College, Head of Safeguarding (for Andrea Cowans)
Emma Howson	Lead Officer in Safeguarding, Public Health (for Bridget Emery)
Megan Godsell	LCC, Environment & Housing, Service Manager, Operations (for Rob McCartney)
Gill Parkinson	LCC, Children's Services, Practice Improvement Manager
Phil Coneron	LSCB Business Unit, LSCB Manager
Karen Shinn	LSCB Business Unit, LSCB Manager
Farah Husain	LCC, Children's Services, Head of Service for Children's Social Work East (observer)
Iain Hutchinson	LCC, Business Development & Practice, Work Placement (observer)
Heather Vevers	LSCB Business Unit, Senior Support Officer (minutes)

Apologies for Absence

Amanda Thomas	Leeds CCG, Designated Doctor
Rebecca Gilmour	Leeds YOS, Deputy Service Manager
Shona McFarlane	Adult Social Care, Chief Officer Access & Care Delivery
Cllr Lisa Mulherin	Executive Member for Children and Families
Marcia Perry	LCH, Executive Director of Nursing
Andrew Dickinson	Wetherby YOI, Governor
Dick Biscombe	Wetherby YOI, Head of Safeguarding
Max Lanfranchi	National Probation Service, Head of NPS (Leeds)
Debbie Addlestone	DIP Probation Manager

Sharda Parthasarathi	NSPCC, Head of Service
Amandip Johal	CAFCASS, Service Manager
Suzanne Hinchliffe	LTHT, Chief Nurse
Anthony Deery	Leeds and York Partnership NHS Foundation Trust, Director of Nursing
Sharon Yellin	Office of DPH, CDOP Chair
Andrea Richardson	LCC, Children's Services, Head of Service Learning for Life
Andrea Cowans	Leeds City College, Head of Safeguarding
Bridget Emery	Office of DPH, Chief Officer Strategy & Commissioning
Karen Townend	WYCRC, Community Director for Leeds
Rob McCartney	LCC, Environment & Housing, Head of Housing Support

Item	Description	Action
1	Introductions/apologies/new members	
1.1	1.1.1 Mark Peel welcomed everyone to the Board meeting and apologies were noted.	
2	Serious Case Reviews (Confidential Session)	
2.1	Karen Shinn provided an update of the current SCRs:	

2.2 Child A and Z

- The perpetrator was found guilty and received a life sentence of a minimum of 12 years
- The SCR Panel met on 10 March 17 and are due to reconvene in June to discuss the draft of the review. It is anticipated that the draft SCR will be presented to the Board in November 17.

2.3 Child C (Joint SCR/DHR)

- The perpetrator has pled guilty
- Richard Corkhill has been appointed as Chair and Peter Maddocks has been appointed as Lead Reviewer
- A scoping/planning meeting took place on 9 March 17. The Panel will meet to discuss the agency reports in June 17

2.4 Child B

- The Panel held a planning and scoping meeting on 20 January 17
- Agency reports and chronologies have been requested from relevant partner agencies
- The Panel are due to meet again on 28 April 17.

2.5 DHR19

- The Terms of Reference have been expanded to cover any associated learning
- The LSCB will sit on the DHR Panel as a critical friend.

2.6 BLU

- The SCR Sub Committee has sent a recommendation to Mark Peel that a LLR be initiated for this case
- Mark has not finalised his decision but noted that it would be extremely unlikely if he did not agree that a LLR should be commissioned.

2.7 JB

- This case will be a City Wide Safeguarding Review, underpinned by the principles and processes of a DHR
- A Police investigation is ongoing and advice is awaited from the CPS in relation to charges
- It is possible that the case may generate public interest.

2.7.1 Mark Peel noted that this case involved issues regarding transitional arrangements, which has also been raised at recent Scrutiny Board meetings
2.7.2 Mark stated that this is an opportunity to live up the expectations as a city for all three Boards (LSCB, LSAB and Safer Leeds).

2.8 CC – Inquest

- Mr Maguire has made an application for a judicial review
- LSCB involvement in the potential review is regarding the disclosure of the notes which Nick Page took during his interviews
- The LSCB has responded to the application and are awaiting decision as to whether the review will be held
- The Inquest has been put back to November 17.

2.8.1 Mark Peel stated that the notes do not contain anything of interest for third parties and stressed that it is the principal of disclosure and not the content. Disclosure of the notes may have a negative impact on the willingness of individuals to engage in future reviews.
2.8.2 Peter Harris queried whether the Inquest delay would impact on the action plan. Karen Shinn confirmed that it would not and that she and Mark are currently working on the action plan.

2.9 LLR 12

- The progression of LLR12 has been delayed due to emerging competing priorities, including Corpus Christi, and reduced capacity within the LSCB Business Unit.

2.9.1 Karen Shinn provided assurance that a final report will be completed by May 2017 with submission to the LSCB in July 2017. The Business Unit has identified the following steps to prevent slippage of current/future reviews:

- Robust handover where there is a change of line management arrangements including an outline and update of all ongoing pieces of work
- Supervision to ensure thorough consideration of all on-going pieces of work, including updates, identification of delay and next steps
- A Smart action plan of all ongoing reviews (SCRs, LLRs and where appropriate SARs) will be available to both the SCR Subgroup and the LSCB Board

2.9.3 Mark Peel formally apologised to the Board and stated that any future delays to cases will be fed back to the Board.

2.10 Progress SCRs & LLLRs

2.10.1 Progress of SCRs and LLRs were noted.
2.10.2 Dee Reid stated that not all of the cases discussed were included on the 'Progress SCRs & LLRs' document. Karen Shinn noted that cases being considered as SCRs/LLRs are not noted on the document until a decision has been made. The Board agreed that it would be helpful to include details of all cases on future updates.

Agreed/Actions
Actions:

- Cases being considered for SCRs/LLRs to be included on the 'Progress SCRs & LLRs' document. KS

2.8 Progress implementation SCR Action Plans

2.8.1 Progress implementation SCR action plans were noted.

3 Austerity and Safeguarding

3.1 3.1.1 Mark Peel talked to the 'Impact of Austerity on Safeguarding' report and informed the Board that he contacted eight LSCBs to ascertain the impact that austerity is having on their Board. Mark highlighted that:

- All Boards expressed varying degrees of concern about the future, post Wood Review
- A number of Boards are not filling Business Unit vacancies due to the National Insurance increase
- LSCB budgets have not increased over the years
- One Board has exhausted its budget reserves
- Independent Chair vacancies are being advertised for short term periods only
- Staff are leaving Business Units due to uncertainty of the future of LSCBs
- Boards feel like current work is on hold
    - Mark noted that it would be unwise for Leeds to take this stance

4 Wood Review Consultation

4.1 4.1.1 Phil Coneron talked to the 'Wood Review – LSCB Partner Consultation for the future arrangements of Leeds LSCB' report. Phil noted that, of the responses received, it is clear that partners would like similar multi-agency arrangements to continue.

4.1.2 Peter Harris brought the Boards' attention to the summary of the responses to Question Four of the report ("Do you have any view on how the new arrangements could be structured to ensure appropriate oversight, learning, challenge and engagement of all partners? Is there scope for a West Yorkshire/regional approach? Is a "Board" required and if not what should replace it?") and queried what the likelihood of a West Yorkshire/Regional approach to the new arrangements was and which agencies preferred this option. Mark Peel noted that he has met with the Chief Officers of the CCGs, WYP and Children's Services. Mark stated that WYP were keen that a regional approach is taken to the new arrangements.

4.1.3 Gill Marchant queried whether a good cross section of responses were received from partners; Phil confirmed that this was the case.

4.1.4 Mark stated that the three key partners noted their regard for the LSCB Business Unit and that they value the independent scrutiny of the Board, which they hope will continue. Mark will arrange to meet with remaining Board representatives prior to July's Board meeting.

4.1.5 Sal Tariq stated that the Board needs to take time to consider its purpose and function. Sal noted that discussions have taken place regarding merging the functions of the LSCB and LSAB, along with the possibility of safeguarding elements being added to the Children's Trust Board. Sal pointed out that this is an opportunity to obtain robust engagement from partners and that Children's Services Partner in Practice status could be beneficial in terms of the national conversation.

4.1.6 Dave Basker noted that present arrangements do not focus on frontline practice but that Children's Services have a knowledge and skills framework which is clear about promoting excellent child protection practice and supervision.

4.1.7 Maureen Kelly informed the Board that skills, competencies and supervision are embedded within Health.

4.1.8 Mark noted the importance of not putting practitioner led processes to one side.
4.1.9 Cllr Hayden expressed her concerns about agencies losing the forum to engage with each other and stressed the need for an organisation with the functions of the LSCB to remain.
4.1.10 Mark noted that research shows that when adult and children's service functions are merged that the voice of the child is often overshadowed by that of the adult.

Agreed/Actions

Agreed:

The Board agreed to the following proposals of the report:

- Based on the responses provided and discussions at the March LSCB Board meeting, the LSCB Business Unit, along with the Exec review to look at a proposed structure for the future
- Proposed structure to be presented to the LSCB Board for consultation summer 2017.

Action:

- Mark Peel to meet with remaining Board representatives to discuss the LSCB review.

5 Secure Settings Report

5.1 5.1.1 Paul Sharkey talked to the 'Safeguarding in Secure Settings Annual Review 2015-16' and noted the following key points:

Wetherby YOI

- Progressing two core change programmes:
  - absorbing the impact of the closures of Hassockfield Secure Training Centre and Hindley YOI
  - Implementing the Transforming Youth Custody (TYC) initiative involving young people receiving 30 hours of 'protected' education per week - This does not provide flexibility for residents to attend meetings for example medical appointments or meetings with YOS workers
- Violence between inmates and towards staff remains a challenge

Adel Beck Secure Children's Home

- Adel Beck Secure Children's Home moved into a new location in February 2015
- The move has had a positive effect and has led to a decrease in the number of restraints compared to the previous year
- Young women are being admitted to the home
- Self-harm was reported as being very low

Elland Road Police Custody Suite

- The Sub Group are now receiving more data regarding young people in Police custody in Leeds

5.1.2 Paul brought the Board's attention to the charts displayed in the report. Peter Harris queried whether it may be useful to include a comment explaining the reasons for the increase in self-harm (table 3). Robin Dow stated that the change in cohort at the YOI has had an impact on the establishment, which is seeing a great deal of copycat behaviour.
5.1.3 Dee Reid queried whether comparative data from Adult prisons was available. Paul advised that such data is not received. Karen Shinn stated that it has proved difficult in the past to obtain comparative data for young offenders and juveniles due to the differences in establishments, and therefore such comparisons with adult establishments may also prove difficult.
5.1.4 Dave Basker informed the Board that he met with the former Governor of the YOI, Marcella Goligher, and Dick Biscombe to look at working towards a Child Friendly YOI. The Social Work Team are trying to promote Think Family Work Family (TFWF) and restorative

working. Paul noted that the inclusion of a Social Work Team at the YOI has been received positively.

Agreed/Actions
Action:

- The Secure Setting Sub Group to consider additional wording to support the charts provided in the report — RG

6 Neglect Strategy

6.1 6.1.1 Karen Shinn talked to the draft Neglect Strategy. The five year strategy was sent to the Policy & Procedures Sub Group for feedback and comments, which have been included in the strategy. Leeds does not currently have a Neglect Strategy and the timing of this fits with the recent announcement that the next Joint Targeted Area Inspection will focus on neglect.
6.1.2 The strategy will be underpinned by TFWF and Early Help, both of which are both due for review, along with the Neglect Policy.
6.1.3 A proposal will be submitted to the Learning & Development Sub Group on 29 March 17 that the subject of the LSCB conference is neglect, with the strategy being launched on the same date (29 June 17).
6.1.4 The strategy will be underpinned by practitioner guidance which will be launched in the autumn.
6.1.5 Karen noted that discussions are ongoing with LSAB and Safer Leeds regarding an overarching neglect statement.
6.1.6 Karen requested that Board members return any comments/feedback to her by 3 April 17.
6.1.7 Mark Peel thanked Karen and the Policy & Procedures Sub Group for their work on the strategy.

Agreed/Actions
Agreed:

- The Board accepted the draft Neglect Strategy in principle.

Actions:

- Board members to provide comments/feedback regarding the Neglect Strategy to Karen Shinn by 3 April 17. — ALL

7 LSCB/LSAB Transitions Audit

7.1 7.1.1 Phil Coneron talked to the first joint audit between the LSCB and LSAB, 'The effectiveness of services for young people (16+) with mental health problems and/or learning disabilities when in transition from children's to adult services'.
7.1.2 Phil highlighted that:

- A total of eight cases were reviewed as part of the pilot to test the audit tool and ensure that it asked the right questions
- The audit group felt that, considering the overall findings, enough assurance has been given around the quality of transitions for children with identified needs
- The audit tool was measured against the NICE quality statements
- Five of the cases were already known to CSWS
    - Two of these cases were supported by a Child in Need plan (CiN)
    - Three of these cases were Children Looked After (CLA) and were supported

by their pathway plan

- A named worker stayed with five of the eight cases during the transition between services and acted as a voice for the young people
- An issue was identified around the pathway for young people transferring from a child inpatient ward to an adult inpatient ward; work is being undertaken to develop an agreed pathway.
- There was a good piece of work between ADHD service and CAMHS to ensure that the young person's needs were met

7.1.3 The following recommendations were made as a result of the audit:

- For Health to develop a pathway for young people transferring from child inpatient ward to adult inpatient ward September 2017
- For the Quality Assurance Task and Finish Group to consider how the views of the young people involved in these cases (where appropriate) can be gained to get a better understanding of their experience of transition September 2017

7.1.4 Lindsay Britton-Robertson noted that the Transitions Policy has been approved within LYPFT.7.1.5 Supt Millar stated that evidence shows that transitions can be problematic and queried whether the outcomes can be measured. Steve Walker queried whether it may be worthwhile revisiting the cases in a year's time.
7.1.6 Mark noted that he will invite a representative from the Norah Fry Centre for Disability Studies at Bristol University (a national center of excellence for applied social research and teaching) to discuss the findings of their research on transitions.
7.1.7 Mark thanked the Quality Assurance Task & Finish Group for the report.

Agreed/Actions
Action:
Mark Peel to invite a representative from Norah Fry Centre for Disability Studies at Bristol University to provide a presentation to the Board regarding transitions.

MP

8 PMSG Quarter 3 Performance Data Report

8.1.1 Phil Coneron talked to the 'Quarter 3 Performance Report 2016/17' and highlighted that:

- The Mosaic system will provide further data in order to gain an understanding of the number of Early Help Assessments carried out in clusters
- Positive feedback has been received from the number of audits which have taken place in clusters; a report will be brought to the July Board meeting
- Historic CiN data for 2015/16 shows that the majority of children were on plans as a result of abuse and neglect
- The number of children on Child Protection Plans have fallen to 515; the lowest recorded by the PMSG
- The number of children going back on plans has reduced to four within 2 years
- The number of CLA has stabilised to 1237
- Over 60% of CLA are aged 10+
- 95% of Health Needs Assessments were undertaken on time
- Dental checks on time have dropped to 82%.
- There has been a steady rise in the number of domestic violence incidents reported to the Police. Children were present in 32% of domestic violence incidents which the

Police attended

- The PMSG have seen an increase in the detail of partner data sets, which has highlighted a discrepancy regarding missing/absent data between Children's Services and the Police
- The PMSG are receiving comprehensive data from Children's Services and would like to obtain similar data from partners
- The PMSG have set a Task and Finish Group up to look at whether Health's DATIX system can provide useful safeguarding data

8.1.2 Karen Sykes requested that context around A&E admissions and attendance regarding self-harm be added to the report. Steve Walker noted that it would be beneficial to look whether any of the children had been re-referred.

8.1.3 Dee Reid queried whether it was possible to identify whether any Child Protection referrals had been reported as a result of the DfE 'Together we can tackle child abuse' campaign; Phil noted that it did not result in a spike of calls locally.

8.1.4 Steve noted that Children's Services are able to provide a breakdown of age categories regarding the number of Children on CPPs. Steve advised that there has been a decrease in the number of younger children on plans but an increase in teenagers on plans.

8.1.5 Mark Peel noted that it is encouraging to see the overall number of children on CPPs reducing and that this positive evidence of TFWF and Early Help. Mark asked Steve for assurance that the children who are on CPPs are receiving a level of service commensurate to their needs. Steve advised that all children on CPPs have an allocated Social Worker and noted that children are not being 'mechanically' removed from CPPs. Steve added that strong partnership working means that children are only put on, and conversely removed from CPPs, when the timing is right.

8.1.6 Peter Harris stated that where the increase in domestic violence was referred to as "steady", he felt it was more of a significant increase. Supt Millar noted her concerns that the Police data does not capture whether children are repeat victims of domestic violence

8.1.7 Peter asked for clarity in terms of the figures provided on page 44 of the report regarding 'EHA to be arranged'. Phil advised that the Mosaic system should be able to provide the outstanding information.

8.1.8 Maureen Kelly noted that the data does not give a sense of how children are aligned to CiN plans, nor how long they have been on the plans. Maureen asked for further performance data evidencing this.

8.1.9 Mark brought the Board's attention to the recommendations of the report which were accepted by the PMSG:

- Receive and consider the performance information in the report and make recommendations to the LSCB
- For the PMSG to accelerate the gathering of wider safeguarding data from the partnership.

8.1.10 Mark Peel thanked Marcia Perry and the PMSG for the report.

Agreed/Actions:

Action:

- To update the PMSG Quarter 3 Performance Data report regarding self-harm and domestic violence as a result of the discussion — PC

9 Joint Development Session – LSCB / LSAB / Safer Leeds

9.1 Mark Peel sought approval from the Board that the next meeting, on 24 May, is held as a Joint Development Session between the LSCB, LSAB and Safer Leeds; Board members agreed with

the proposal.

Agreed/Actions
Agreed:

- The Board agreed that the meeting on 24 May will be held as a Joint Development Session between the LSCB, LSAB and Safer Leeds.

10 Minutes of previous meeting 18 January 17

10.1 The minutes of the meeting on 18 January 17 were agreed.

11 Action Tracker & Forward Plan

11.1 The Action Tracker and Forward Plan were noted.

12 AOB

12.1 No further business was discussed.