Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust
Board Meeting (held in public)
Wednesday 31 May 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 (1)	Welcome, introductions and apologies	Neil Franklin	N
9.05	2017-18 (2)	Declarations of interest	Neil Franklin	N
9.10	2017-18 (3)	Questions from members of the public	Neil Franklin	N
9.15	2017-18 (4)	Patient's story: Adult services	Marcia Perry	N
9.30	2017-18 (5)	Minutes of previous meeting and matters arising: a. Minutes of the meeting held on 31 March 2017 b. Actions' log c. Committees' assurance reports: i. Quality Committee: 22 May 2017 ii. Business Committee: 24 May 2017 iii. Audit Committee: 26 May 2017	 Neil Franklin Neil Franklin Tony Dearden Brodie Clark Jane Madeley	 Y Y N N N
		Quality and delivery		
9.50	2017-18 (6)	Chief Executive's report	Thea Stein	Y
10.00	2017-18 (7)	Annual report and accounts 2016-17 a. Annual report b. Annual accounts c. Letter of representation d. ISA 260 external auditor's opinion	Bryan Machin	Y
10.15	2017-18 (8)	Quality account 2016-17	Marcia Perry	Y
10.30	2017-18 (9)	Operational plan 2016-17	Bryan Machin	Y
10.45	2017-18 (10)	Performance brief and domain reports a. Year-end performance report 2016-17 b. Performance report April 2017	Bryan Machin	Y
11.00	2017-18 (11)	Patient experience report	Marcia Perry	Y
11.15	2017-18 (12)	Organisational development strategy: update report	Sue Ellis	Y
		Governance		
11.30	2017-18 (13)	Significant risks and risk assurance report	Thea Stein	Y
11.40	2017-18 (14)	Corporate governance update a. Board and committee effectiveness review b. Audit Committee annual report 2016-17 c. Committees' terms of reference review d. NHS provider licence compliance	Thea Stein	Y
11.50	2017-18 (15)	Board workplan	Thea Stein	Y
		Minutes		
11.55	2017-18 (16)	Approved minutes for noting: a. Audit Committee: 17 February 2017 b. Quality Committee: 20 March 2017 c. Business Committee: 22 March 2017 d. Leeds Safeguarding Children Board minutes: 18 January 2017 e. Leeds Safeguarding Adult Board minutes: 8 December 2016 f. Leeds Health and Wellbeing Board minutes: 20 February 2017	Neil Franklin	 Y Y Y Y Y Y
12.00	2017-18 (17)	Close of the public section of the Board	Neil Franklin	N

Date of next meeting (held in public)
Friday 4 August 2017, 9.00am -12noon
Trust Headquarters, Stockdale House, Leeds LS6 1PF

NHS
Leeds Community Healthcare
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Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public)
Boardroom, Stockdale House, Victoria Road, Leeds LS6 1PF

AGENDA ITEM 2017-18 (5a)

Friday 31 March 2017, 9.00am–12 noon

Present:	Brodie Clark	Non-Executive Director, Trust Vice Chair (deputising for the Trust Chair)
	Bryan Machin	Executive Director of Finance and Resources (deputising for the Chief Executive)
	Jane Madeley	Non-Executive Director
	Richard Gladman	Non-Executive Director
	Elaine-Taylor-Whilde	Non-Executive Director (*from Item 90 onwards)*
	Marcia Perry	Executive Director of Nursing
	Sam Prince	Executive Director of Operations
	Dr Amanda Thomas	Executive Medical Director
	Sue Ellis	Director of Workforce
Apologies:	Neil Franklin	Trust Chair
	Thea Stein	Chief Executive
	Dr Tony Dearden	Non-Executive Director
In attendance:	Vanessa Manning	Company Secretary
	Mohammed Hussain	Insight Programme participant
	Sue Lawrenson	Senior Practitioner /Pathway Lead for Dietetics *(Item 90 only)*
	Mark Hodgson	Community Dietician *(Item 90 only)*
Minute taker:	Liz Thornton	Board Administrator
Observers:	Ruth Davies	Senior Human Resources Manager
	Steve Keyes	Head of Organisational Development
	Andrea Black	District Nursing Student (shadowing the Executive Director of Nursing)
Members of the public:	One member of the public was in attendance	

Item	Discussion points	Action
2016-17 (87)	**Welcome and introductions** The Vice Chair and Non-Executive Director (BC) welcomed Trust Board members, members of the public and observers attending the meeting. He said that he was deputising for the Trust Chair and that the Executive Director of Finance and Resources was deputising for the Chief Executive. **Opening remarks** In his opening remarks, the Vice Chair reflected on the CQC inspection which had taken place during January 2017 and noted that the formal feedback and report was expected during in the first quarter of 2017/18. He thanked the Executive Medical Director and her team for their work in delivering the information required by the CQC to support its inspection activity.	

	He said that, despite the current sustained pressures being experienced within the NHS both nationally and locally, the Trust had continued to maintain a focus on ensuring that it delivered a range of performance targets and evidencing that it provided safe, caring, effective, responsive and well led services. The Trust had satisfactorily met its financial duties for 2016/17 but in the longer term the focus would need to be on securing a viable and sustainable organisation. Working with partners to achieve change strategically and operationally in the context of the sustainability and transformation plans would be a top priority particularly in light of the recent announcements by NHS England on the NHS Five Year Forward View delivery plan. **Apologies** Apologies were noted from the Trust Chair, Chief Executive and Non-Executive Director (TD).	
2016-17 (88)	**Declarations of interest** No declarations of interest were received.	
2016-17 (89)	**Questions from the members of the public:** There was one question from the member of the public in attendance who asked "Of all the measures on Trust performance, which two are most key for you in your current role and in the current climate?" In response, the Vice Chair said that it was impossible to single out two measures that were more important than any of the others. Many of the performance measures were part of a combination of factors which contributed to the five domains that were central to the work of the Trust. All five domains were viewed as the Trust's top priorities. The Executive Director of Finance and Resources said that he would be happy to follow this up in more detail after the meeting with the member of public.	
2016-17 (90)	**Patient's story** The Executive Director of Nursing introduced the patient's story item and welcomed two members of the Nutrition and Dietetic Service. The Pathway Lead said that the Nutrition and Dietetic Service was a city wide service supporting adults and children with a wide range of nutrition and health problems. She explained that the patient concerned was unable to attend to speak to the Board in person but was content for the Community Dietician to speak about her experience. The Community Dietician presented the patient's story which related to a patient with irritable bowel syndrome (IBS) who was referred for specialist advice following a period of six months under the care of her GP. The Community Dietician explained that over the six month period the patients IBS symptoms had become so severe that they were making a significant impact on her lifestyle, mental health in terms of self-confidence and body image and beginning to affect the health and wellbeing of other members of her family. The patient had undertaken some research in advance of her consultation with the specialist dietician and was keen to follow the low FODMAP diet. The Community Dietician explained that FODMAPs were different carbohydrates found in a wide range of foods. The sugars are poorly absorbed and pass through the small intestine and enter the colon causing bloating and pain. He advised that the low FODMAP approach was a complex plan and it was important that patients received expert advice under the supervision of a registered dietitian trained in the low FODMAP approach.	

	The Community Dietician said that he was pleased to report that the patient's condition had significantly improved since adopting the low FODMAP approach combined with the advice and guidance she had received from the team. The Board was invited to view some photographs which the patient had given permission to be shared at the meeting which illustrated the effect the low FODMAP approach had made to her symptoms and impact on her physical appearance. A Non-Executive Director (JM) observed that the low FODMAP approach appeared to be a very complicated plan and wondered whether other options had been considered before embarking on this particular approach. The Senior Pathway Lead said that dieticians worked with the individual to identify the changes needed taking into account their wider healthcare needs. Clearly, this diet would not benefit everyone and was only considered after other options had proved to be unsuccessful. This particular patient had been keen to follow this approach and had undertaken a significant amount of research before she was seen in clinic. The Director of Workforce asked how long people were able to follow the diet. The Community Dietician said that improvements could usually be seen after four to six weeks and then a process of re-introducing different foods back into the diet could begin. A Non-Executive Director (ET-W) asked how long patients had to wait for an initial assessment by the service.The Senior Pathway Lead reported that the waiting list for the service was currently between 12-14 weeks but patients could be prioritised dependant on the nature of the referral from the GP. The Vice Chair thanked the team on behalf of the Board for their excellent presentation and their obvious expertise and professionalism. He asked them to pass on the Board's thanks to the patient for allowing her story to be presented at the meeting. He said that advice on diet and nutrition was an important service provided by the Trust and their expertise obviously had a very positive impact on the health and wellbeing of the patients concerned and their families.	
2016-17 (91a)	**Minutes of the previous meeting held on 3 February 2017 and matters arising.** The minutes were reviewed for accuracy and agreed as a correct record. **Matters arising**	
(91b)	**Items from the actions' log** The Vice Chair noted that there were two outstanding action (amber rated status): • *Organisational development strategy* – deferred to the 31 May 2017 Board meeting • *Safeguarding annual report 2015/16* – report to the Quality Committee in relation to the interaction between school nursing service and health visiting service deferred until April 2017 The completed actions from previous meetings were noted.	
(91c)	**Assurance reports from sub-committees** **Item 91c(i) – Audit Committee held on 17 February 2017** The report was presented by the Chair of the Committee and Non-Executive Director (JM) who drew the Board's attention to the key issues, namely:	

- The internal auditors were confident that the internal audit programme for 2016/17 could be completed in full prior to the year-end but she stressed the importance of maintaining momentum and ensuring follow up actions were implemented in a timely fashion.
- The Committee had discussed the presentation of audit reports, in particular that the timing of meetings and publication of final reports meant that some internal audit reports might be seen by the Audit Committee prior to scrutiny by the Business or Quality Committee (as appropriate) but in the normal course of business this was not the case.

Item 91c(ii) – Charitable Funds Committee held on 10 March 2017

The report was presented by the Chair of the Committee and Non-Executive Director (BC) who drew the Board's attention to the key issues, namely:

- *More than a welcome* – Work was continuing in relation to developing reception areas. This included improvements linked to customer service training and wider 'front of house' initiatives.
- *Funding recommendations* – a number of initiatives were benefitting from the charity's funds including: Giving Voice choir, Walking on Air podiatry scheme and the Winter Warmth campaign.
- *Fundraising* – new initiatives included *My Donate* giving page and street collections.

Item 91c(iii) – Nominations and Remuneration Committee held on 17 March 2017

The report was presented by the Vice Chair of the Committee and Non-Executive Director(BC) who drew the Board's attention to the key issues namely:

- *CLaSS /Bank staff working arrangements* – Assurance had been requested that a process was in place to ensure that workers did not exceed the hours set out in the working time directive. A report was expected in April 2017.
- *Tax arrangements: off payroll staff* –The risks associated with HMRC's changes to the tax arrangements under category IR 35 had been discussed and identified as a risk to the Trust. The Vice Chair invited the Director of Workforce to provide an update on further developments.

  The Director of Workforce reported that KPMG, the Trust's external auditors, had been asked to conduct a review to assess the position of two core groups of staff, namely:
  - Forensic medical examiners (FMEs) working on-call only, within the South and North Yorkshire police custody arrangements
  - Project workers providing education, training and project support to the electronic patient record project

  The Director of Workforce advised that KPMG had concluded that both groups of staff were excluded from the new requirements of IR35 and on that basis the level of assurance was now substantial.

Item 91c(iv) – Quality Committee held on 20 March 2017

The report was presented by the Non-Executive Director (E-TW) who drew the Board's attention to the key issues, namely:

- *Incidents* – The Committee had discussed the reduction in reporting of no harm and minimal harm patient safety incidents since June 2016 compared to the same period in 2015/16. Further analysis, internal and external benchmarking, survey and triangulation against other indicators were planned in a further report for June 2017.

- *Duty of Candour (DoC)* – A comparison of DoC compliance at the beginning and end of the incident management process had shown that there was greater compliance by the time the incident management had been fully investigated and it was therefore more appropriate to report on compliance with DoC by reviewing incidents closed in month. It had been agreed that in future reporting on compliance would be against closed cases. A full report would be available for the Committee in October 2017.
- *Friends and Family Test (FFT)* – Overall, the response rates to FFT had remained disappointing and current plans had not improved rates. The Committee asked that a small group be established to refresh the current approach and consider implementing a more targeted, streamlined process to increase patient participation.

Item 91c(v) – Business Committee held on 22 March 2017

The report was presented by the Vice Chair of the Committee and Non-Executive Director (RG) who drew the key points to the Board's attention, namely:

- *Neighbourhood teams* – The Committee noted increased staff turnover. The overall vacancy position standing at 56.6 (whole time equivalents) had deteriorated further in February 2017. Sickness absence levels in neighbourhood settings remained stable. In the context of continuing pressure on staff capacity and an overall gap between funded establishment and available staff, the senior management team was rigorously pursuing measures and innovations to manage demand.
- *Financial position 2016-17* – The Trust was reporting an underspend on budgets at the end of February 2017. The Trust was forecasting achievement of the control total and financial performance indicators.
- *Activity levels' monitoring* – 37 services were operating 10% above or under profile. A number of services were being examined and prioritised on the basis of: size of service, level of variance and potential for procurement. A further report had been commissioned for May 2017 which would show the current position for those services assessed at greatest risk based on the above criteria.
- *Recruitment plan 2017/18* – A range of workforce factors were impacting on the Trust's operations. Overall, there was a net reduction in the nursing workforce which was being felt most keenly in the neighbourhood teams. The Committee had scrutinised a number of recruitment actions within the plan, including: skill mix review exercises, standing interview panels and cohort recruitment of graduate nurses.
- *Organisational development* – The revised organisational development strategy and implementation plan was deferred to May 2017 to allow further development of the strategy in terms of deliverables and timescales and to include consideration of the staff survey results.

A Non-Executive Director (E-TW) referred to the overall vacancy position in February 2017 and asked what assurances could be given about the Trust's ability to attract and retain staff to safeguard essential services.

The Executive Director of Operations reported that that the Business Committee had considered the recruitment plan for 2017/18 in detail. She explained that the issue of staff capacity to deliver care remained one of the top organisational risks, and the increasing turnover the Trust had experienced in the latter half of 2016, and the agreed perception that there was insufficient staff, needed to be arrested by tackling the situation on several fronts.

She reported that a recruitment and retention summit undertaken in February 2017 had led to a significant number of work strands being progressed and as a result some initiatives had already been tested with staff in relevant groups e.g. new starters or those nearing retirement age.

	The Trust's immediate focus would be on the career opportunities it presented staff in three areas, namely: attracting the future workforce, supporting and nurturing the skills of the current workforce, and working with services to assist them develop innovative services and new roles. A Non-Executive Director (JM) asked about plans to recruit newly qualified staff for September 2017 and how confident the Trust was about attracting new recruits. The Executive Director of Nursing advised that the process to attract new recruits had already begun and representatives from the Trust had recently attended career fairs in Manchester, Birmingham and Dublin. She said that this had provided the opportunity to raise the profile of the Trust and promote the organisation as a fantastic place to work. **Outcome:** The Board noted the Committees' reports and the assurances provided on the matters highlighted.	
2016-17 (92)	**Chief Executive's report** The Executive Director of Finance and Resources presented the Chief Executive's report. He highlighted the information on new local commissioning arrangements and referred to the Leeds Health and Care Board to Board presentation which had taken place on 27 March 2017. Items covered included: • Winter pressures • Development of new models of care • Update on the West Yorkshire and Harrogate Sustainability and Transformation Plan The Vice Chair welcomed the inclusion of the information on staff awards and said the Trust was quite rightly very proud of its award winning staff. In reference to the Carter review on productivity and performance, it was noted that Lord Carter of Coles would be making a second visit to the Trust on 26 April 2017. A Non-Executive Director (JM) asked how work was progressing to develop the Leeds Academic Health Partnership (LAHP). The Director of Workforce advised that LAHP work had culminated in the exploration of the concept of a Leeds Health and Social Care Academy bringing together the in-service learning and development opportunities from across the city through a joined-up 'one workforce' approach that takes account of future workforce needs. She said that it had been agreed to advance to the next stage of business case development and the expectation was it would take between 18 months to two years for the Academy to be established. A Non-Executive Director (JM) asked about the proposed changes to the structure of the Clinical Commissioning Groups (CCGs) in Leeds. The Executive Director of Operations reported that the CCGs had recently undertaken a review called 'One Voice' which had explored a single approach for commissioning health services in Leeds. The aim was to improve services and outcomes for patients and the public. From April 2017 there would be one Chief Executive for the three CCGs who would oversee the three organisations and lead on driving forward strategic commissioning. **Outcome:** The Board noted the contents of the Chief Executive's report.	

2016-17 (93)	**Performance brief and domain reports** The report was presented by the Executive Director of Finance and Resources; he advised that the report was in two parts: • high level performance summary • more detailed domain reports 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: *Contract related highlights* York Street Health Practice – 31 March 2017 was the last day that the Trust would provide services from the practice. A demobilisation plan was in place to ensure that transfer to Bevan Healthcare was as effective, safe and robust as possible when it took over the service from 1 April 2017. *Safe and caring domain* The Vice Chair noted that the performance against the fall reductions for in-patient beds had returned to a red rating for February 2017. The Executive Director of Nursing reported that in February 2017 a higher proportion of falls in patient units caused harm than in previous months although harm sustained was minimal. Monitoring was continuing to look for any emerging trends. She advised that the work of a falls group was currently under review alongside a review of the falls pathway. The Executive Director of Nursing referred to the downward trend in the percentage of venous thromboelism (VTE) risk assessments completed, she advised that she would be investigating whether administration staff could provide support by inputting data. *Responsive domain* The Board discussed the in-month variance from profile for patient contacts of minus 10.8%. The reasons why the number of patient contacts should appear so low were noted and that the year to date variance was well within the 5% of the activity profile and provided assurance that there was no need for concern. *Finance report* The Executive Director of Finance and Resources reported that the Trust's financial position remained stable. The year to date surplus was £0.1m ahead of plan. He advised that the Trust was confident of delivering the planned surplus of £2.86 million control total. The Executive Director of Finance and Resources explained that the underspending on substantive staff in post continued however the combined level of pay expenditure did not deliver the vacancy factor for the year to date; in February 2017 the Trust underspent on pay costs by circa £200,000 after delivery of the vacancy factor. A Non-Executive Director (RG) asked whether other community trusts were achieving their financial targets. The Executive Director of Finance and Resources advised that typically most community trusts were able to achieve their financial targets those who did not were in the minority.	

	A Non-Executive Director (RG) asked about the possible risk to patient care in the context of an underspend on substantive staff in posts and the satisfactory financial position of the Trust. The Executive Director of Operations advised that ensuring that patients were seen appropriately was an essential part of service delivery and cases were prioritised accordingly. A more robust monitoring system had been introduced to assess the impact and quality of care which included a monthly audit. The Vice Chair expressed concern about the balance between finance, staffing numbers and patient care. He asked the Executive Director of Operations to clearly outline the revised measures in place to meet the staffing challenge: he also asked the Executive Director of Nursing to advise on the particular measures in place, given the extreme circumstances, to ensure that risks to patient care were identified immediately. **Action:** A report to be made to Business Committee which outlines the revised measures in place to meet the staffing challenge; to include the measures in place to ensure that risks to patient care are identified immediately. **Outcome:** The Board noted the performance brief and domain reports.	**Executive Director of Operations**
2016-17 (94)	**Annual staff survey 2016** The Director of Workforce presented the report which included the findings of the 2016 NHS national staff survey for Leeds Community Healthcare NHS Trust. The Director of Workforce reported that the response rate was comparable with last year at 51% and this was above the national average. 1425 had staff completed the survey compared with 1355 last year. The Director of Workforce explained that year-on year comparisons were difficult to analyse due to changes in questions. There had been marked improvement on some comparable measures. These included: clarity of organisational values; demonstrating and embedding values and behaviours; feedback from managers and personal development and appraisal. The Chief Executive had published an open letter to staff detailing an overview of the results and inviting comments by the end of May 2017. The material was also being discussed with the joint negotiating and consultation forum, leaders' network and the 50 voices group. A Non-Executive Director (JM) asked if non-executive directors could be invited to attend one of the open meetings for staff. **Action:** Director of Workforce to advise non-executive directors of the date and times of staff feedback events. The Vice Chair referred to the significant investment in initiatives around health and wellbeing and asked if more information could be shared around the take up of the initiatives on offer and their impact on staff. The Director of Workforce agreed to explore what data could be provided. **Action:** The Director of Workforce to share data on the outcomes and impact of the staff health and wellbeing initiatives. The Vice Chair noted the positive comments received about leadership and management and looked forward to receiving information on more specific actions.	**Director of Workforce** **Director of Workforce**

	Outcome: The Board received and noted the report, agreed the continued actions from the organisational development strategy and the new areas of focus; a more specific plan would follow after feedback had been received and further meetings with staff had taken place.	
2016-17 (95)	**Operational plan 2017/18** The Executive Director of Finance and Resources presented the operational plan 2017/18. The Board was asked to approve the Trust's operational plan including the budget proposals for 2017/18. The Executive Director of Finance and Resources reported that the operational plan had been developed in line with discussions which had taken place in the Board and sub-committee meetings held over recent months regarding the Trust's priorities and resources for 2017/18 and in line with the two year plan submitted to NHS Improvement on 23 December 2016. The Non-Executive (RG) observed that it was essential that the plan was kept under review particularly in the light of the announcements made by NHS England and the priorities set out in the NHS Five Year Froward View delivery plan. The Vice Chair agreed and advised that the Business Committee would receive quarterly reports on progress in delivering the plan and the Board would receive a mid-year and year-end progress report. The Non-Executive Director (JM) observed that the biggest risk to the financial stability of the Trust would be if the Trust lost a significant number of competitive tenders over the two years and these were not replaced by growth elsewhere. The Vice Chair observed that the need to deliver cost improvement programmes (CIP) would continue to be a challenge for the Trust with the plans for 2017-18 representing a saving of £3.4million. The Executive Director of Finance Resources said that the proposals for 2017/18 recognised the severe pressures that many of the Trust's services had faced during 2016/17. For that reason there was no general CIP applied across the Trust or across business units. Executive Directors were content that the CIPs for 2017/18 would seek to protect front line clinical delivery wherever possible and would be subject to a thorough risk assessment process. **Outcome:** The Board approved the operational plan and budget for 2017/18.	
2016-17 (96)	**Strategic risks and risk assurance: summary report** The Company Secretary presented the summary report which provided the Board with information about risks scoring 15 or above, after the application of controls and mitigation measures and the board assurance framework (BAF) summary which gave an indication of the current assurance level for each strategic risk. The Board noted there was one new risk with a current score of 15 or above relating to the financial and staff retention implications of changes to HMRC regulations in the treatment of off-payroll contractors. The Vice Chair said that the implications of these changes had been discussed earlier (under item 91c (iii)) and as a consequence the expectation was that this risk would be closed on the register. The two extreme risks remained as: sickness absence and the recruitment and retention of staff. **Outcome:** The Board noted the revisions to the risk register and the current assurance levels provided by the BAF summary.	

2016-17 (97)	**Corporate governance report** The Executive Director of Finance and Resources presented the report which included: • the draft annual governance statement • going concern statement • Board of Directors declarations of interest and compliance with fit and proper person requirements for 2016-17 • new national arrangements for the management of potential conflicts of interest • non- executive membership of the Board and committees • changes to standing orders and standing financial instructions The Director of Workforce noted the changes to the tendering thresholds and suggested that this should be communicated to all Managers through Community Talk. **Action:** An article on the changes to the tendering thresholds to be included in Community Talk. There were no additional comments or issues raised about the report or any of the components of the governance framework included within it. **Outcome:** The Board noted the report, annual governance statement 2016/17, going concern statement, approved the conclusion that the Trust is a going concern, noted the declarations of interest made by directors for 2016/17 and approved the changes to standing orders and standing financial instructions.	**Executive Director of Finance and Resources**
2016-17 (98)	**Board workplan** The Executive Director of Finance and Resources presented the Board work plan (conducted in public) which was for information. He said 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.	
2016-17 (99) **(99a)** **(99b)** **(99c)** **(99d)** **(99e)** **(99f)**	**Approved minutes** The Board noted the following final approved committee meeting minutes and formally received those minutes. Audit Committee: 9 December 2016 Quality Committee: 23 January 2017 and 20 February 2017 Business Committee: 25 January 2017 and 1 March 2017 Leeds Safeguarding Children Board minutes: 17 November 2016 Leeds Safeguarding Adults Board minutes: 13 October 2016 Leeds City Council Health and Wellbeing Board minutes:24 November 2016	
2016-17 (100)	**Close of the public section of the Board** The Trust Vice Chair thanked everyone for attending and concluded the public section of the Board meeting.	

Date and time of next meetings
Wednesday 31 May 2017, 9.00am - 12noon
Trust Headquarters
Stockdale House
Leeds LS6 1PF

Signed by the Trust Chair: Neil Franklin
Date: 31 May 2017

AGENDA ITEM 2017-18 (5b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) actions' log: 31 May 2017

Agenda Number	Action Agreed	Lead	Timescale	Status
Meeting on 7 October 2016				
2016-17 (44)	**Organisational development strategy** Further consideration to be given to the means of delivery, timescales and identification of tangible outcomes.	Director of Workforce	Workshop: January 2017 Board: ~~March 2017~~ May 2017	Completed
2016-17 (48)	**Safeguarding annual report 2015/26** Report on commissioners' review of interaction between school nursing service and health visiting service in relation to safeguarding to be reported to Quality Committee.	Executive Director of Nursing	~~January 2017~~ April 2017	Delayed to align with commissioning discussions
Meeting on 2 December 2016				
2016-17 (62)	**Patient experience: thematic report** Report to be extended to demonstrate that lessons learned are introduced into practice, embedded and changes in practice are measured to evidence improvements (Quality Committee 23 January 2017 and Board 31 May 2017).	Executive Director of Nursing	May 2017	Completed
Meeting on 31 March 2017				
2016-17 (93)	**Performance brief** A report to be made to Business Committee which outlines the revised measures in place to meet the staffing challenge. To include the measures in place to ensure that risks to patient care are identified immediately.	Executive Director of Operations	June 2017	
2016-17 (94)	**Annual staff survey 2016** Opportunities to be identified for NEDs to sit in on staff meetings when survey results are discussed.	Director of Workforce	May 2017	
2016-17 (94)	**Annual staff survey 2016** Data on the outcomes and impact of the staff health and wellbeing initiatives to be shared.	Director of Workforce	May 2017	
2016-17 (97)	**Corporate governance** Changes to the tendering thresholds to to be communicated to managers and through Community Talk	Executive Director of Finance and Resources	April 2017	Completed

Key		
Total actions on action log	**7**	
Total actions on log completed since last Board meeting: 31 March 2017	**3**	
Total actions not due for completion before 31 May 2017; progressing to timescale	**3**	
Total actions not due for completion before 31 May 2017; agreed timescales and/or requirements are at risk or have been delayed	**1**	
Total actions outstanding as at 31 May 2017; not having met agreed timescales and/or requirements	**0**	

NHS
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AGENDA ITEM 2017-18 (6)

Meeting: Trust Board 31 May 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 inspections
- Equality and diversity
- Staff news and success stories
- Well-led framework: progress with action areas
- Cyber security
- The Trust's 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

2.1 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

2.2 Following conclusion of the on-site phase of the inspection, the CQC has sought additional information from the Trust to support its inspection activity.

2.3 The formal feedback and report on the inspection is awaited; it is anticipated that the report will be made available to the Trust in the second quarter of 2016/17.

3. Equality and diversity

3.1 The Trust is working actively to embrace and raise the profile of equality and diversity within the organisation, not just to meet legislative, regulatory and contractual requirements, but to ensure that the Trust values and celebrates the individual differences of staff and patients, provide a high standard of patient-centred care across the diverse community of Leeds and reduce health and employment inequalities.

3.2 The Board, in December 2016, heard about activities in pursuit of the requirements of the Equality Act 2010 Public Sector Equality Duties (PSED) and the NHS Standard Contract and the 'next steps' the trust planned to take to support improved Workplace Race Equality Standard (WRES) compliance.

3.3 These activities included the establishment of black and minority ethnic (BME) networks and a series of workshops to identify challenges that have an adverse impact on BME staff together with potential and real solutions.

3.4 Two further workshops are now planned for June 2017 to which BME staff have been invited. A specialist facilitator has been engaged from the NHS Leadership Academy and the aim is to form the basis of an action plan for local action as well as to engage with the national agenda.

3.5 A 'lunch and learn' session also took place in May 2017. This event was led by a facilitator from Stonewall and was focused on the challenges and issues encountered by lesbian, gay, bisexual and transgender (LGBT) colleagues.

3.6 Following the staff disability network meeting in December 2016, a work plan with actions that provide support to managers and staff to better manage disability in the workplace is also in development led by staff and supported by the Patient Experience & Inclusion Manager.

3.7 To provide leadership of this important work at the highest level in the Trust, the Chair has sought 'champions' at Board level. The Chair is currently the Trust Board champion for black and minority ethnic (BME) staff and patients and is now seeking peers to mirror the champion role in the areas of disability; lesbian, gay, bisexual and transgender (LGBT); and carers.

4. Celebrating specialist services

4.1 The Trust's specialist services business unit held their annual celebration event in April 2017. Each team presented something they were proud of and spoke about how patient involvement was central to their work.

4.2 The event was extremely diverse and a sample of the information shared included:

- ***musculoskeletal services*** presented 'little things' looking at feedback and the little changes that had made big differences
- ***custody service*** explored with a great sense of reality and humour how they engage service users withdrawing from methadone
- ***neurological rehabilitation team*** was supported by a patient who talked in an extremely moving way about her journey, her illness and the care of the team.
- ***adult speech and language team*** explained work to properly engage people with learning disabilities in the friends and family test (fft).
- ***improving access to psychological therapies*** (IAPT) explained how they measure change with their clients. how they can show the change and progress in each session
- ***diabetes service*** looked at their educational sessions. they spoke of how these had been developed with patients and how they were constantly evolving using patient feedback
- ***community dental service*** showed a film (currently in development); the aim is to put children with autism at their ease when they come to the service
- ***podiatry service*** gave a fascinating talk about how they involve patients and patient feedback in every aspect of their work. they introduced 'the podia tree '…a feedback tree for people to post their comments.

5 Staff success stories

5.1 The Trust continues to be very proud of its award-winning staff. Here are some of the recent achievers.

- Congratulations to the Trust's Wound Clinical Nurse Specialist whose e-poster 'Erosive Pustular Dermatosis' was accepted as an exhibit for the European Wound Management Association conference. The conference was held 2-5 May 2017 in Amsterdam.
- News about the recently reaccredited Health Visiting service. The teams were visited by the UNICEF Baby Friendly Initiative and were given feedback that the service is 'outstanding'. Now the service is geared up to go for gold status; an award which shows that in addition to accreditation they have the leadership, culture and systems to maintain this over the long term.
- During Dementia Awareness Week (14-20 May 2017) the Giving Voice choir, a group for adults with neurological conditions and their carers, performed across Leeds. On Wednesday 17 May 2017 the group sang at the opening of the first Dementia Friendly garden in the UK at Springhead Park in Rothwell. On Saturday 20 May 2017 there was a 'pop up' choir taking shoppers by surprise.at the St Johns Centre in Leeds.

6 Foundation degree for nursing and therapy support workers

6.1 The trust is working with the Lifelong Learning Centre at the University of Leeds to provide another opportunity for development and progression for *band 3/4 staff.*

6.2 This is similar to the Nursing Associate programme and will lead to a Healthcare for Assistant Practitioners Foundation Degree and the possibility of additional training at the end of the course to become a Nursing Associate.

6.3 The initiative is open to support workers who have an interest in working in therapy as well as nursing.

6.4 The Trust would like to recruit a mixture of nursing and therapy support workers to this programme and would particularly welcome applications from existing Technical Instructors in the organisation to offer a more formal academic qualification for this group of staff.

7 Clinical professional strategy forum

7.1 The Trust approved and launched its clinical professional strategy late in 2016 and, as part of the development of an action plan and in response to what staff have said, the Trust is starting to set up a number of forums.

7.2 The first new forum is for bands 2-4, non-registered clinical staff. Up to 15 members from each business unit are invited to join the forum. Membership will be for a one-year period.

7.3 The purpose of the group will be to focus on promoting and defining the specific needs of bands 2-4 practitioners. The group will work with the Executive Director of nursing to shape the terms of reference and work programme for the group.

8 Compliance with the well-led framework

8.1 The Trust continues to demonstrate compliance with the Well-Led Framework (established by the former NHS regulator, Monitor) which is fully aligned with the CQC's key lines of enquiry for the well-led domain. The Trust believes that by robustly assessing itself and aligning improvement against the Well-Led Framework, the Trust is also aligning itself with the requirements to achieve a 'good' CQC rating for the well-led domain.

8.2 The Trust undertook a self-assessment in September 2015 and identified six priority action areas. At the meeting in October 2016, the Board was updated on progress against the action areas is reported.

Leadership and accountability

A significant focus in recent months has been work to restructure leadership within the Adults Business Unit and ensure clarity about roles and responsibilities. This work continues and will include a review of therapy structures. The refreshed LEAD programme has been launched targeted at recently appointed leaders.

Quality Boards have been embedded across adult services and are reported on a monthly basis strengthening the focus on and accountability for quality. They are also being rolled out to some services in Children's and Specialist Services Business Units. Quality forums and reporting systems continue to develop in each business unit. The sub committees below quality committee met as scheduled and continue to develop. Work is underway to implement the Clinical Professional Strategy which will strengthen clinical professional leadership and accountability. The Trust has applied positive learning from pressure ulcer review work and introduced new incident review meetings.

Work to develop a culture where candour, openness and transparency are the norm included a review of duty of candour systems and reporting, including benchmarking with comparable organisations and continuing to train and provide support to clinical teams about the process and its importance. The Trust is introducing a cultural connections process which will enable triangulation of soft intelligence gathered through the Freedom to Speak Up Guardian, staff side representatives, team coaching, the HR team and 50 voices with other soft and hard intelligence.

Learning and development

Skills and competency development has remained a priority focus for adults services although releasing staff to attend training has continued to be challenging given capacity pressures. Strengthening clinical training, preceptorship and support has also been a priority focus and key to improving recruitment and retention and equipping newly qualified staff to contribute fully to the team as quickly as possible.

Work to refresh the learning and development offers at the Trust level continues. As part of business planning, each business unit has identified a common objective of empowering clinical staff to use their clinical skills to best effect. This feeds into analysis of training needs, which is coordinated through the Learning and Development Group and has been re-launched under the chair of the Deputy Director of Nursing. The group's remit is to: provide a coordinated approach to continuously learning and improving. This will be achieved by setting clear responsibilities, accountabilities and priorities for different aspects of learning and development across the organisation linked to the learning and development requirements of the clinical professional strategy, quality strategy, OD strategy, research strategy and development of new models of care. SMT supported a proposal to develop a clinical education and training strategy which will ensure skills, competence and training matches current and future service needs across the organisation. SMT requested development, in parallel, of a non-clinical education and training strategy, and has reviewed the work for the apprenticeship strategy group. These strategies will be developed in the coming months.

Resuscitation training has been brought in-house and the statutory and mandatory training approach, including ways of reporting compliance, is to be reassessed following a recent local audit. A memorandum of understanding has been developed with other NHS providers on commonly accepting training completed by staff, if they transfer between employers. The Trust also continues to engage in a Leeds city wide option appraisal for development of a shared Academy under the auspices of the LAHP which is a longer term development.

Staff engagement

There has continued to be significant investment of time and effort in maintaining and developing staff engagement approaches: 50 Voices; the BME, disability, LGBT and carers networks; promoting team use of the engagement star and uptake of the Trust's coaching offer for teams, managers and individual staff members, including health coaching; and launching the refreshed LEAD programme. The Trust has also maintained focus on strengthening sickness absence management, having published a revised Managing Attendance Policy, incorporated difficult conversations training in sickness absence training and running further meetings with leaders of teams with the highest levels of sickness absence. The results of the national staff survey provide encouragement that the Trust is broadly heading in the right direction; working with staff to refresh 'Our Eleven' pledges as the basis of our 2017/ 18 action plan. The Board has input to the development of the refreshed OD strategy.

Performance

There has been good progress in developing performance information and reporting as a result of the additional investment in the business intelligence team in 2016/17. The target for developing outcome reporting was achieved; the development ambition for 2017/18 will be agreed by SMT this quarter.

There was significant focus on strengthening activity recording in Neighbourhood Teams which resulted in activity being above the risk threshold. This support is being extended to Children's and Specialist Services Business Units who are prioritising support requirements. Another key focus has been developing Neighbourhood Teams' capacity and demand reporting and escalation mechanisms. A city-wide tool has been developed and is being used to review capacity daily. Further work is scheduled for 2017/18 to refine the tool. The performance information portal (PIP) was launched to schedule; its development is being guided by a service user group. There has been development of heat-map reporting to services and Business Committee.

Strategy and planning

The Board is aware of progress over recent months and work planned to refresh the Trust's strategy. The Board is also sighted on the alignment of the Trust's 2017/18 Operational Plan with the West Yorkshire and Leeds Health and Care Plan, within the limitation that these plans are at an early stage of development, and that the Chief Executive and other members of SMT and senior leaders are fully involved in shaping these plans. There has been good progress in strengthening associated governance and key processes. The Chief Executive is leading work to review stakeholder engagement and develop an external communications strategy.

Governance and reporting of business developments has been strengthened with reporting to Business Committee and Board on delivery of the Trust's annual plan and quarterly SMT review of business units' progress against plan. Oversight and reporting on strategic projects and key service developments is to be strengthened. There has been good progress in developing staff understanding of quality goals and priorities in line with the quality strategy and aided by the introduction of Quality Boards and Safety Huddles introducing structured quality meetings in each business unit and embedding Quality Challenge plus across all services.

Risk management

As a result of progress made in strengthening risk management, SMT recommends de-escalating this from the Well-Led Framework development priorities. Strategic risks in the board assurance framework have been thoroughly reviewed and revised as appropriate and are fully aligned with the Trust's operational plan for 2017/18. A framework for capturing assurance has been developed and is working effectively to provide assurance to the Board that those significant risks that would otherwise impede delivery of the Trust's plans are managed. There is a risk appetite statement in place which describes the parameters within which risk will be manged. An updated risk management policy and procedure was approved April 2016. Risk reporting processes are in place and provide a reporting line from services to the Trust's committees and the Board. The effectiveness of the risk management and board assurance processes has been the subject of scrutiny of both internal and external audit. Staff awareness and understanding about effective risk identification, assessment and management is being effected through ongoing training, targeted coaching, a dedicated newsletter and content on the intranet.

8.3 The two regulators (CQC and NHS Improvement) have introduced a revised Well-Led Framework. The CQC has announced that it intends to assess 'well-led' at trust board level 'approximately annually', alongside the targeted and risk based inspection of a selection of core services. This board level well-led assessment will be based on the revised Well-Led Framework but will also take into account service level inspection findings for the well-led domain and other evidence. The scope and depth of the assessment will be tailored to each provider based on size, findings of previous inspections, information gathered from the provider, external partners and other sources on performance and risks.

8.4 The new framework is very similar to the framework currently in use: there are eight rather than 10 questions, referred to as key lines of enquiry. There is an increased focus on: culture; compassionate, inclusive and effective leadership; system leadership; and finance and resource governance with a stronger emphasis on service sustainability.

8.5 As with the current Well-Led Framework, trusts are expected to assess themselves against the framework 'to promote transparency, self-reflection and development' and carry out external reviews, which can be a peer review.

8.6 The Trust needs to effect a transition from the 'old' well-led framework to the new model. In order to do this, an approach has been developed whereby executives will review compliance with the eight key lines of enquiry and identify strengths, gaps and required actions to achieve a good standard of compliance. The combined self-assessment will then be reviewed as a whole by the senior management team and then be further reviewed by the Board in a workshop setting. Clearly, the CQC's inspection report will be an extremely important reference and influence for this assessment

9 Cyber security incident

9.1 The NHS experienced a cyber security incident on Friday 12 May 2017. The degree to which the incident impacted on NHS organisations varied across the country.

9.2 This Trust had no reported incidents of the ransom-ware virus which had affected many NHS organisations. The Trust's clinical and business systems operated as normal.

10 Performance and finance overview

10.1 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.

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

- Reducing the incidence of avoidable pressure ulcers and falls. The Trust is achieving targets for avoidable category three and four pressure ulcers; falls in inpatient units is in excess of the year to date target
- On-going work in relation to incident reporting.
- Work to ensure that the recording of duty of candour reporting matches the practice of staff is proving successful.

10.3 The Trust continues to perform well in respect of all of its responsive indicators. There is continued good performance against all statutory and non-statutory waiting times. There is a reduction in relation to the number of patient contacts; minus 10.9%.

10.4 A number of workforce related indicators remain a concern. Sickness absence (5.4% compared to 5.7% in March 2017) and staff turnover (15.6%) are subject to particular scrutiny; further detail is contained in the performance report.

10.5 The finance measures remain satisfactory. The Trust met all of its financial targets at the end of March 2017. The use of resources risk rating (1) represents the lowest risk position.

10.6 NHS England and NHS Improvement operate a single oversight framework for trusts which is designed to help trusts attain and maintain CQC ratings of 'good' or 'outstanding'. Information is collected (both directly and from third parties) on trusts' performance, against a range of metrics. Trusts are then categorised in one of four segments according to the scale of issues and challenge each trust faces. The segments range from 1 to 4 whereby 1 equates to 'no evident concerns' and 4 indicates 'critical issues'. The Trust has been categorised as category 2.

11 Recommendation

11.1 The Board is recommended to:

- Note the contents of this report

V1 18 May 2017

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (7)

Meeting Board 31 May 2017	**Category of paper**	
Report title 2016/17 Annual report, annual accounts and associate documentation	**For approval**	
Responsible director Executive Director of Finance & Resources **Report author** Executive Director of Finance & Resources	**For assurance**	√
Previously considered by Senior Management Team 12 April 2017, Audit Committee 24 May 2017	**For information**	

Purpose of the report

This paper covers a number of agenda items linked to the production of the Trust's annual report and accounts for 2016/17.

The Audit Committee has received and reviewed in detail the final accounts along with the auditors' report prior to the formal submission to the Board for adoption.

Main issues for consideration

This agenda item comprises:

- Draft annual report 2016/17 (item 7a)
- Audited annual accounts for 2016/17 (item 7b)
- Draft letter of representation which the Trust will issue to KPMG, external auditors (item 7c)
- ISA260 external audit opinion from KPMG (item 7d)

The ISA260 contains no matters that should preclude the adoption of the accounts by the Board.

The annual report is presented to the Board for approval and, in addition, will be made available more widely at the annual general meeting 14 September 2017.

Recommendations

The Board is recommended to:

- Approve the annual report 2016/17
- Approve the annual accounts 2016/17 as supported by the external auditors' opinion
- Approve the letter of representation

AGENDA
ITEM
2017-18
(7a)

Annual Report and Accounts 2016/17

Annual Report and Accounts 2016/17

Welcome from Chief Executive and Chair

Welcome to our annual report for 2016/17.

This has, as ever, been a challenging year for the NHS and we are no different. We are, however, very proud of what we have achieved. We're proud of the services we have provided, through one of the most difficult winters Leeds has faced, and the ground work we have laid for future service improvements, through new ways of working across the city of Leeds and West Yorkshire.

We are extremely proud of the part we played in the joint inspection of Children with Special Education Needs and/or Disabilities (SEND) services. This reflected positively on Children's Services. Similarly, our West Yorkshire Police Custody Services were inspected. HM Inspectorate of Prisons and HM Inspectorate of Constabulary, reported on their inspection as "the most positive inspection made of police custody for some time."

Most importantly, The Trust continues to achieve high patient satisfaction ratings (Friends and Family Test), meet national waiting time targets, and our own internal waiting times. Whilst our overall staff satisfaction score hasn't moved as fast as we would have hoped, many measures on the national staff survey show significant improvement in satisfaction with leadership, management and role. This is what we hoped to see. We continue to embed 'Our 11', our one vision, three values and seven magnificent behaviours. The scores on our staff survey show that these are becoming part of the way we do business here at Leeds Community Healthcare.

Our last CQC last inspection took place in April 2015. At this time we received an overall rating of 'Requires Improvement'. Although found to be 'Good' in the Effective, Caring, and Well-Led domains, the CQC sought some improvements from us against its 'Responsive' and 'Safe' domains.

The senior team and frontline colleagues were proud to showcase achievements made in all domains when we welcomed the CQC team back in January 2017. Inspectors visited a range of our services, including our newly established integrated Neighbourhood Teams and some of our Children's services. They also reviewed our work on quality. We await our most recent inspection results, but we are confident that our commitment to quality continues, and is strengthened, across our services. We are also confident that much is in place to address the previous report's findings.

As a partner within the West Yorkshire and Harrogate and the Leeds Plan, both of which set out a vision and direction of travel for services over the next five years. We have, in the last year, worked hard to continue to lay the ground work for the future model of care in the city. This would see services working in a more integrated way wrapped around the people on a GP list. We are fully committed to this vision, and have invested in working closely with GPs, social care, the third sector, other NHS providers across the city and the emerging federations. The aim is to co-produce with them new ways of working. This has been exciting work this year and we look forward to taking more steps forward in 2017/18.

And so, we would like to say a final thank you to all of our colleagues. As ever, you have worked with passion, demonstrating the organisation's vision, values and behaviours daily. The awards you have won are too numerous to mention, and the innovation and commitment to excellence you bring every day is a cause for our regular celebration.

Neil and Thea

Neil Franklin
Chair

Thea Stein
Chief Executive

Who we are and what we do

Leeds Community Healthcare NHS Trust (LCH) provides a range of community healthcare services to the people of Leeds. Care is always provided in, or as near to a person's home as is possible.

Our services are organised into three groups: Adult Services, Specialist Services, Children and Families.

Adult Services	Specialist Services	Children and Families
• Neighbourhood Teams • Joint Care Management Teams • Early Discharge Assessment Team • Community Intermediate Care Unit • South Leeds Independence Centre Specialist nursing: • Wound Prevention and Management • Continence, Urology and Colorectal Services	• Primary Care Mental Health/ Improving Access to Psychological Therapies (IAPT) • Podiatry (foot health) • Musculoskeletal and Rehabilitation Services • Nutrition and Dietetics • Stop Smoking Services • Specialist Dental Services • Prison Health (Young Offenders Institute, Wetherby) • York Street Health Practice • Healthcare services for police custody suite across Yorkshire and the Humber • Community Intravenous Antibiotics Service (CIVAS) • Community Tuberculosis (TB) Long term conditions which include: • Neurology • Stroke Team • Rehabilitation Unit • Speech and Language Therapy • Cardiac, Respiratory and Diabetes services • Continuing Care Neuro - Physiotherapy • Expert Patients' programme	Integrated Services for Children with Additional Needs (ICAN) including: • Child Development Centres • Paediatric Neurodisability clinics and children's outpatient clinics • Specialist child protection medical services • Community Eye service • Audiology and New Born Hearing • Physiotherapy • Occupational Therapy • Speech and Language Therapy • Nutrition and Dietetic Services Child and Adolescent Mental Health Services (CAMHS) Community Nursing Services: • Continuing Care Nursing Team • Hannah House Healthy Child Pathway Early Start Service: • Health Visiting • School Nursing • Sickle cell and Thallasaemia • Watch-It weight management

For more detailed information about any of our services, please visit our website: **leedscommunityhealthcare.nhs.uk**

When providing care, our vision is simple:

'We want to provide the best possible care to every community we serve'.

To do this, we make sure we live our values every day:

- We are open and honest and do what we say we will
- We treat everyone as an individual
- We are continuously, listening, learning and improving.

Quality priorities

To help us achieve our vision, we worked with patients, carers and public members throughout 2016/17 to develop our quality priorities.

Patients, carers and public members told us that we could improve in the following four key areas:

- Access to services
- Better communication
- Carers' needs and involvement
- Dignity, choice and respect

What next?

These four key areas are still important if we are to keep improving our services for the people of Leeds. They continue to be our 'Patient, Carer and Public' Quality Account Priorities for 2017/18.

You can found out more about our quality priorities in our Quality Account **leedscommunityhealthcare.nhs.uk**

How we're meeting our goals

Alongside our quality priorities, we've been working hard against four key goals for the people of Leeds this year.

Our Four Key Goals:

1: Provide high quality services, continuously improving patient experience and measuring our success in outcomes.
2: Work in partnership with service users, communities and stakeholders to deliver service solutions, particularly around integrated care and care closer to home.
3: Engage and empower our people, ensuring we recruit and retain the best staff.
4: Ensure we are a viable and sustainable organisation with the ability to invest in the community

Goal 1 – Improving Patient Experience:

Provide high quality services, continuously improving the patient experience and measuring our success in outcomes.

Our first priority is always high quality patient care. Our quality strategy sets out are aim to achieve 'good' and 'outstanding' across our services.

To achieve this, we assess how well we are doing by using the same questions the Care Quality Commission use in their inspections:

We ask ourselves: Are services **Safe, Caring, Responsive, Effective and Well-led**?

Our most recent CQC inspection took place In January 2017 and we are awaiting the outcome of this visit.

Safe

- ✓ We achieved 58% of patient safety incidents being reported as 'no harm'. We are working hard to meet our 70% target.
- ✓ No cases of infections such as MRSA or Clostridium Difficile acquired by patients in our care.
- ✓ No admission of patients under 16 years of age to adult services

- ✓ We achieved a **67.8**% reduction in the number of avoidable category 3 pressure ulcers. We set ourselves a target to reduce these by **15**%.
- ✓ We aimed to have no avoidable category 4 pressure ulcers in 2016/17. There have been four in the year to date. This is improving, as in the last six months of the year we have had just one.
- Below is a table showing the number of inpatient falls resulting in an injury year to date. Our target was to reduce falls to 60 (a reduction of 10%). We haven't yet made the 10% reduction, our figure is 62, but the number of harm from falls has been decreasing since Quarter 2 of the year. We continue to monitor the Trust's Sign up to Safety pledge to '*reduce falls causing avoidable harm in inpatient units by 10%'* on a quarterly basis".

Safe - people are protected from abuse and avoidable harm	2015/16 Total	2016/17 Target	YTD Target (Q1 to Q4)	YTD	Q1	Q2	Q3	Q4
10% Falls Reduction Target for Inpatient Beds	66	60	60	62	14	20	17	11

We're proud of…

The colleagues in our Community Intermediate Care Unit (CICU) who have introduced daily safety briefings and a regular education programme. They have in place a safety culture that has significantly reduced the number of falls and pressure ulcers.

To help monitor the safety of our services, our Board use key performance indicators (KPIs) and information gained from:

- Listening and talking to patients, carers and families,
- Visiting services
- Meeting with staff as they deliver care

Caring

- ✓ The Friends and Family Test shows 95.1% of our community patients would recommend our services. This is an improvement on last year.
- ✓ Working with commissioners we have put in place systems to screen patients in some services for dementia, to enable earlier treatment. We have met all our targets to improve care in this way.
- ✓ If things don't go as well as expected, we welcome complaints.
- ✓ We respond to complaints within legally set timescales most of the time, but often much quicker.

Queries, Concerns and Complaints

Patient Experience Team – Patient Advice and Liaison Service (PALS)

The needs of patients and carers should always be placed at the centre of the care we provide. In the event that we get this wrong, we need to know about it. We are a learning organisation, committed to improving as a result of individual experience.

Our aim is to fully resolve a query, concern or complaint as quickly as possible and to everyone's satisfaction. Wherever possible, we encourage a person with a query or complaint to talk to us as soon as possible. This is so that problems can be responded to quickly for the people we care for. In the case of a formal complaint, our team works closely with patients (or family members, acting on their behalf) to create a personalised and detailed complaint plan. The plan makes sure every aspect of a person's complaint is addressed. We expect all our services to identify clear learning points from a complaint to prevent, as much as is possible, the same issue from happening again.

Our Patient Experience Team receives a large variety of queries and concerns about our services, and sometimes those operated by other organisations.

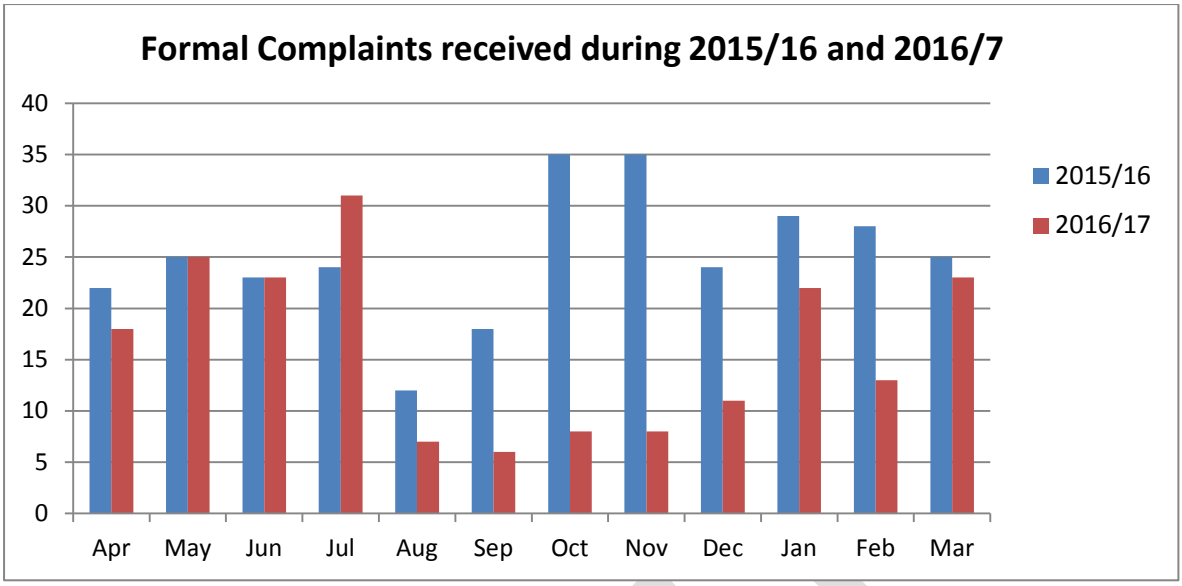
For example,

Mrs Ahmed calls looking for help to access one of our services. We provide her with the contact information she needs for the team in her area.

Mr Danby calls with a serious concern about his mother's nursing home. Although we don't run the nursing home, we are able to suggest the right agency for Mr Danby to speak to.

During 2016/17, we considered 197 formal complaints relating to services provided by Leeds Community Healthcare NHS Trust. There were also 298 concerns recorded and a total of 371 enquiries.

The table below shows the number of formal complaints received over the last two years. During 2016/7 you will see a considerable fall in the number of formal complaints. We hope this demonstrates our commitment to understanding and resolving issues before they reach a formal complaint.



The top themes for complaints during 2016/17 were:

The standard of clinical treatment	14%
Staff attitude and communication	12%
Access to services	7%
Waiting time for appointments	6%
Concerns about clinical judgement	6%
Patients unable to get an appointment	5%
Staff members failing to attend or arriving late	4%
Failure or delay in the referral process	4%

Information about our complaints is published every three months on our website.

More detailed information about the service provided by our Patient Experience Team can be found in our Quality Account available on our website: **leedscommunityhealthcare.nhs.uk**

Responsive

- ✓ We meet all nationally reportable and internal targets for waiting times.
- ✓ At year end the Trust was seeing 98.1% of patients on consultant-led pathways within 18 weeks, no patients waited more than 52 weeks.
- ✓ The Trust delivered the total number of contacts required in 2016/17
- ✓ 100% of patients were waiting less than 6 weeks for diagnostic tests at year end

- ✓ 99.6% of patients were treated within 18 weeks of referral to IAPT and 94.6% were seen within 6 weeks.

> We're proud of…
>
> Iona Taylor, and the Adult Nutrition and Dietetics team. They continue to innovate and advance their service through projects to improve the lives of patients in care homes, develop tools to help patients self-manage their conditions, and introduce new templates for improved data collection.

Effective

- ✓ We developed a new set of high level objectives to assess ourselves against this domain.
- ✓ We are compliant with all NICE Technology appraisals within 3 months.
- ✓ We have achieved the 65% target for clinical supervision through the entire year
- ✓ We have achieved our Commissioning for Quality and Innovation (CQUIN) 4 goals associated with piloting outcomes measures in Musculoskeletal Services (MSK), the neighbourhood teams and ICAN
- We are not meeting the target we set ourselves for compliance with other NICE guidance. There is no national requirement in relation to timescales but to put in place the recommendations is good practice.

What next? During 2016/17 we introduced a measure to look at how we do put in place NICE guidance. We know we could improve the rate of uptake for some guidance. Through our Quality Committee we are looking again at our 'other NICE guidance' target during 2017. We may allow ourselves more time to put in place complex care pathways with our partners.

> We're proud of…
>
> … Our Spinefit+ team. Through using service feedback, embracing transformation, and improving patient communication, they have continued to improve and adapt their offer to patients. They've never lost sight of their overall aim – to enable clients to live a better life with their pain.

Well-led

We do have some challenges and this is reflected in our own assessment of our performance.

- We know how important it is that people using health and social care services have all their needs met. We continue to work with the local authority, other NHS and voluntary organisations in Leeds to reduce health inequalities through the Equality Delivery System2 (EDS2) we currently hold an overall

EDS2 grading of 'Achieving' with an action plan in place to move us on to the next level.

- Sickness absence levels remain higher than we would like them to be.
- All staff should have an appraisal every 12 months. We have a target of 95% but we did achieve 87.1%
- We want all relevant staff to be up to date with mandatory training. The figure at the end of 2015/16 was 86.7%.
- Staff turnover remains over the target range of 9 to13% at 15.3%
- We continuously meet the requirements for safer staffing in our inpatient services.
- We adapted our use of agency staff in year and have been compliant within the overall agency cap set by NHS improvement.
- We have sustained our staff engagement and morale through the development of 'Our 11' pledges. We also introduced our 'Working Lives Star' a practical tool that supports teams to have conversations about morale and engagement.
- We have established both a BME and disability forum and identified volunteer 'champions'.

We're proud of…

…Head of Business Intelligence, Victoria Douglas. Victoria supports all of our business units to effectively use their performance information to understand operational issues and drive improvement across services.

Goal 2 –Work in partnership with service users, communities and stakeholders to deliver service solutions, particularly around integrated care and care closer to home.

Adult Services

We've continued our work this year to bring together our adult neighbourhood teams with Adult Social Care, primary care, mental health care and the third sector to improve care for frail and elderly people and those with long term conditions.

The people of Leeds, patients, carers and our staff told us what they want from a neighbourhood team:

"Support that is about me, my life, where services work closer together by sharing trusted information and focusing on prevention to speed up responses, reduce confusion and promote dignity, choice and respect."

So, we're making sure our care is wrapped around the person at its centre by establishing 13 Neighbourhood Teams:

North 1
1 **Meanwood** - Rutland Lodge ✆ 0113 843 3355
2 **Wetherby** - Wetherby Health Centre ✆ 01937 522 837

North 2
3 **Chapeltown** - Tribeca House ✆ 0113 843 4579
4 **Seacroft** - Unit 2 Killingbeck Court ✆ 0113 8432635

South 1
5 **Morley** - Morley Health Centre ✆ 0113 843 2570
6 **Beeston** - Beeston Hill Community Health Centre ✆ 0113 843 1062

South 2
7 **Kippax** - Kippax Health Centre ✆ 0113 843 1320
8 **Middleton** - Middleton Health Centre ✆ 0113 207 7023

West 1
9 **Armley** - Armley Moor Health Centre ✆ 0113 843 0394
10 **Pudsey** - Pudsey Health Centre ✆ 0113 843 8803

West 2
11 **Holt Park** - Horsforth Clinic ✆ 0113 843 3956
12 **Woodsley** - Woodsley Health Centre ✆ 0113 843 2827 / 843 2825
13 **Yeadon** - Yeadon Community Health Centre ✆ 0113 843 5578

- ✓ Alongside colleagues in social care we've established 13 Neighbourhood Teams across the city. These are based around GP registered practices
- ✓ Staff from Leeds Community Healthcare and Adult Social Care work together from the same base to provide seamless care.
- ✓ Staff who were previously district nurses, intermediate care nurses, community matrons and adult domiciliary physiotherapists now work together across the 13 neighbourhoods from 7am to 10pm.
- ✓ Within each team staff work in caseload clusters, which cover one or more practices within the team area to make sure care is consistent and that we work with other health and care professionals to deliver proactive joined up care to people and their families.
- ✓ Teams really get to know their community and are able to respond in a timely way.
- ✓ During the evening hours when demand reduces, Neighbourhood Teams come together to work out of 3 hubs, each covering 4 or 5 Neighbourhood Teams. The Neighbourhood Night Nursing Service then takes over from 9:30pm.

- ✓ Our Neighbourhood Teams provide 24 hours a day care, 365 days a year.

You can find out more about our Neighbourhood Teams here: http://www.leedscommunityhealthcare.nhs.uk/our-services-a-z/neighbourhood-teams/

We're Proud of…

…Emma Gregory, Community Matron and Clinical Lead for Electronic Patient Record and New Ways of Working. Emma has championed change across our Neighbourhoods and supported staff to embrace transformation while maintaining high clinical standards.

We're Proud Of…

… Business Change Lead, Jill Farrally. Jill has worked tirelessly, both day and night, to support our Neighbourhood Night Service. Jill supported the transition, put in place change, and improved handovers from our day to night teams.

From January – March 2017 staff in neighbourhood teams were responding to 'never seen before' pressures. Their position reflected the national picture of lack of capacity (due to vacancies and sickness) and ongoing demand for both acute and critical community health care services over the winter months. It was an extremely difficult time for NHS staff across the country, but our teams continued, often in very challenging circumstances, to support patients, families and each other.

To manage this difficult time, the Trust (alongside other local health and social care partners across Leeds) had in place 'Silver Command' arrangements. A gold, silver and bronze system is used by healthcare organisations and emergency services to categorise and then respond to high level incidents or demand.

During 'Silver Command' leadership from directors was in place and included the Executive Director of Operations and Executive Director of Nursing. Each morning the leadership team reviewed a report of the position in each neighbourhood team, and within citywide services, to determine further action needed to support service delivery across Leeds on a daily basis. This process continued into the weekends when a member of the Adult Business Unit leadership team provided citywide support on Saturday and Sunday mornings in addition to the usual 'on call' arrangements.

Joint approaches across neighbourhood teams were agreed at 'Silver Command' in order to manage the situation in the best possible way. For example, a priority order of work was agreed. This took into account clinical risk and meant that each day our available clinical workforce across the city was deployed to assist in the following order:

1. Support 'essential visits' (Clinically complex and urgent care)
2. Team capacity to attend 'call outs', (Clinically complex and urgent care not yet received into the case load).

3. Management of new referrals into the neighbourhood teams (People who no longer require a hospital bed but who have varying care needs within the community).
4. Routine visits (those visits which are important but of low risk to the patient. May even be managed through self-care, family member, or deferred visit from a member of the Neighbourhood Team until situation improves).

Other key learning as a result of 'Silver command included:

- Staff wellbeing sessions organised in response to staff suggestions (to improve morale and to keep staff well and in work).
- Processes developed to work with non-Leeds hospitals to improve joint discharge planning.
- Joint working with primary care and acute care on shared patient pathways and to explore longer term options for joint weekend clinics.
- Enhanced recruitment activity, to attract clinical workforce into Neighbourhood Teams.

Responding to Changing Demand

- We have new shift patterns in place which have standardised working patterns.
- Our 3 evening hubs each have a Clinical Coordinator in the team to manage evening workload dependent on changes to clinical need.
- A new capacity and demand tool has been launched and teams submit information on a daily basis.
- A new predictive capacity/planning monitoring tool is being trialled in West Leeds.
- Ongoing skills and competencies work to understand the full breadth and depth of the skills within each neighbourhood team. This makes sure we place the right staff, with the right skills in the right place at the right time.
- Regular caseload reviews to ensure they are up to date and that all our patients are appropriately reviewed and risk assessed.
- Development work is underway (2017/18 business plan) to produce 'clinical care' frameworks for certain treatments. This will start with wound care and should improve allocations within teams, as it will be easier to identify the likely package of care required for an individual patient. It will also define the necessary skills of the clinical professionals associated with that treatment package.

We're proud of…

… Our Palliative and End of Life Care team who have redesigned their Service Delivery Framework to make the stages of care even clearer and ensure that, wherever possible, patients' wishes at the end of their lives are met.

We're proud of…

Our Enhanced Care Home Scheme team for their work to improve the quality of life and experience for older people living in Leeds West CCG care homes.

Children's Services

As with all our services, we are committed to placing children and young people at the centre of the services we offer to them. This year we've done this by adopting a Health Coaching approach across all our services. This approach places the individual goals of children and outcomes at the centre of decision making. We've also made sure we continue our commitment to Special Educational Needs and Disabilities (SEND) as set out in the Children and Families Act 2014.

OFSTED/CQC Special Education Need and Disability Reforms Inspection

In December 2016, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection of the local area of Leeds. The aim was to understand how well organisations are working to put in place the disability and special educational needs reforms set out in the Children and Families Act 2014.

Inspectors spoke with children and young people who have special educational needs and/or disabilities, representatives of the local authority and National Health Service (NHS) officers.

Here are just some of the key findings from the inspection report:

- ✓ Children and young people who have special educational needs and/or disabilities are proud to be citizens of Leeds. They have a real voice in shaping their education, health and care plans.
- ✓ Leaders across education, health and care services demonstrate clear insight and capacity to improve services in response to unmet needs, by working together with parents and young people.
- In some health services, insufficient resources, combined with increased demand, result in children and young people experiencing unacceptable delays in having their needs assessed. This is particularly the case for those whose assessment may result in a diagnosis of autism and children waiting for speech and language therapy.

What next? We continue to work creatively and with local health partners to ensure no child is kept waiting.

Integrated Children's Additional Needs (I CAN)

This service helps children and young people with disabilities to achieve their outcomes:

- ✓ By launching our central I CAN triage function, we've improved how we organise referral into the wide range of services we offer. Having one, easy to understand access point ensures children and young people get the right care, in the right place at the right time.
- ✓ Through its 'Positive Changes Group' the Children's Continuing Care Team continues to affect positive change. The group, which includes staff and parent/carer representation, supports families to explore new approaches to care and challenge historic practice. A key example has seen one child supported at home to enable his parents/carers to take a much needed holiday.

Healthy Child Pathway

- ✓ Our School Nursing Team has brought together its patient administration function. Its new Single Point of Access can now receive and process all patient referrals.
- ✓ Our School Nursing Team has redesigned how it delivers the National Child Measurement Programme. The aim is to improve efficiency and the experience of school age children, their parents and carers. The new model is now being put in place within school settings.
- ✓ We're developing our Health Visiting Single Point of Access too. This will involve all patient administration being brought into a single team. The first stage began in December 2016.

Child and Adolescent Mental Health Services (CAMHS)

- ✓ Community CAMHS has successfully reduced Consultation Clinic waiting times to below 12 weeks
- ✓ Accepted two new commissioned contracts from NHS Leeds South and East CCG; The MindMate Single Point of Access (SPA) and the Community Eating Disorder Service.
    - ➢ The MindMate SPA is operating an effective referral management and triage function. The next step is to agree with our commissioner how we develop short term intervention for children and young people who are referred and on the waiting list.
    - ➢ We're improving the digital presence of the CAMHS Service, including an updated website, and a new service user app for CAMHS patients and staff.
    - ➢ Work is still in progress to develop our Community Eating Disorder Service.

We're proud of…

…Head of Service, Janet Addison. Janet has been a role model and leader in our Children and Adolescent Mental Health Services (CAMHS) and children's Speech and Language services. Guiding colleagues through transformation and demonstrating a clear vision for her services.

We're proud of…

…Our School Immunisations Team. They deliver their programme to 47 high schools across Leeds. The team recently contained a Hepatitis A outbreak in the city, vaccinating 97% of staff and pupils at a single school in just five days.

Specialist Services

It's been a changing landscape for our Specialist Services, with Long Term Conditions, Neurology and Community Intravenous Antibiotics (CIVAS) services joining us from Adult Services. We've also seen the loss of our York Street Health Practice, the Healthy Living Service and the Expert Patient Programme (EPP). New approaches are being explored across the city for how we work in a joined up way to keep people well and, wherever possible, out of a hospital setting. We're working with our partners in commissioning and with Leeds Teaching Hospitals NHS Trust on how we shape and expand this type of care in the future. We've already started to introduce self-management techniques, such as Health Coaching, across specialist services to assist in this aim and empower people to be active partners in the management of their healthcare conditions.

York Street Health Practice:

Our GP practice for homeless people was inspected by the Care Quality Commission (CQC) in October 2016 and rated as 'Outstanding' in December 2016. Inspectors rated the city-centre practice as 'Outstanding' for effective, responsive and well-led and 'Good' for safety and caring. Highlights from the inspection include:

- ✓ A clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- ✓ Patients' emotional and social needs were seen as equally important as their physical needs.
- ✓ Patients said they were treated with compassion, dignity and respect.
- ✓ Inspectors saw wide-ranging evidence of multi-agency working, where the practice worked closely with other organisations, such as outreach services, refugee councils and homeless shelters, in ensuring services were provided to meet patients' needs.

The York Street Health Practice transferred to a new provider on 1 April 2017.

Healthy Living Service (HLS):

Designed as a preventative service, focused on patient identified goals for issues such as weigh management and help to stop smoking, the HLS continued its work with patients on their self-identified goals. The approach which uses motivational interviewing, cognitive behavioural therapy (CBT) and solution focused therapy will continue to provide support to those on its programmes until October 2017.

Podiatry:

We received accolades for out 'Walking on Air' project - An innovative winter initiative taking care direct to the most marginalised people in the city of Leeds. This new type of outreach, not usually offered by the NHS, took place during December 2015 and again in 2016. The purpose being to educate, empower and support individuals to take ownership of their own foot health.

We're proud of…

Specialist Lead Podiatrist, Nina Davies. Nina has authored the first national mentorship framework for podiatric paediatric practitioners. Her own leadership has inspired many Podiatry staff to undertake additional training and qualifications.

Prison Health (Young Offenders Institute, Wetherby and Adel Beck Secure Children's Home):

We will continue to provide health services at Her Majesty's Young Offenders Institutes Wetherby and Adel Beck Secure Children's Home. Our new partners in this service are South West Yorkshire Foundation Partnership NHS Foundation Trust and Lifeline.

Responding to Changing Demand

- We're creating bespoke 'situation report' templates for individual services. These templates will be used to monitor capacity and demand and inform an escalation process.
- We've worked with our Business Intelligence Team to complete capacity and demand work. We have done this to understand demand and inform service delivery.
- The capacity and demand work supported by our Business Intelligence Team has been used as evidence to support additional funding requests to our commissioners. This is to make sure we can meet increasing demand.

Expanding our Horizons

We believe our recent contract losses are the result of the NHS being in a competitive market. Whilst this is disappointing, we are not complacent. We have learnt from our most recent losses and work to date has included:

- Full lessons reviews
- The use of business development experts to evaluate tender submissions
- Bid writing training for staff involved in tenders

As a leading provider of a diverse range of community health and wellbeing services there is much that the organisation can offer. As a result we're working on our business Development Strategy. Led by the Head of Business Development, we're identifying areas of potential sustainable and viable growth. This will include:

- Bidding to retain viable services that come out to tender
- Growing the services in which we excel to neighbouring areas.
- Enhancing a traded offer for our expertise in community health
- Growing strategic partnerships

Goal 3 – Engage and empower our workforce, ensuring we recruit and retain the best staff

If we are to achieve our vision to provide high quality care to every community in Leeds, our people need to feel supported to deliver high quality. The Trust has refreshed its organisational development strategy which concentrates on:

- Planning for the future –recruitment, retention workforce and talent development
- Workplace wellbeing
- Creating and developing leadership capability
- Building organisational structures that show responsibilities and accountabilities, and are fit for purpose for our services.

This year, there have been some key developments that support the aims set out in our strategy.

These are:

- A brand new programme for Leadership Development programme (LEAD) introduced during 2016. Our fist cohort of Band 7 and above leaders graduated the course in June 2017.
- An 'Engagement Star' (engagement tool) introduced to encourage staff/team engagement
- Focus on staff health and wellbeing
- Developing coaching as means to having 'better conversations' with staff and patients
- Refreshed and enhanced recruitment drive and programme is underway.

NHS National Staff Survey 2016
Every year we take part in the NHS National Staff Survey. This year 1425 staff completed the survey compared to 1355 in 2015, a good response rate of 51%. We have looked at how our key findings compare with other Community Trusts.

Some good news:

- My manager gives me clear feedback +9%
- I am satisfied with the support I get from my immediate manager +6%
- Senior managers act on staff feedback +6%
- I would feel secure raising concerns about unsafe clinical practice +6%
- The values of my organisation were discussed as part of the appraisal process +12%
- My training, learning or development has helped me to deliver a better patient service user experience +4%

Some areas of development:

- I am able to do my job to a standard I am personally pleased with -3%
- I am trusted to do my job -3%
- If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation -3%
- In the last month have you seen any errors, near misses, or incidents that could have hurt patients/service users -5%

Next Steps:

- ✓ Our survey results have been shared widely. The Chief Executive has written an open letter to all staff with an overview of the results and an invitation to comment.

- ✓ Findings are discussed with our '50 Voices group' (A cross section of 50 staff who meet regularly to discuss Trust issues), Staff side, the Leaders' Network and Board.

- ✓ The Chief Executive, Directors and senior leaders conduct Trust wide 'open sessions' and ask staff "What's important to you?" and "What can we do better?"

- ✓ Our staff pledges are co-created with staff networks and with involvement from patients. The theme for our staff pledges is 'Creating the Working Life you Want'.

- ✓ Staff health and well-being will be a key focus for 2017.

CONTINUED FOCUS FOR 2016/17

We know that changing culture is not a 'quick fix' and we continue to progress actions set out in the Trust's Organisational Development plans. Results so far demonstrate good progress.

Our top priorities remain:

- Continuing with our LEAD programme alongside specific skills based modules for leaders and managers
- Progressing an apprenticeship strategy
- Sustaining manageable workload and capacity building through our recruitment and retention plans.
- Maintaining tools of support already provided
    - manual version of workload management project is in place
    - Roll-out of Electronic Patient Record (EPR) and E-rostering continues.
- Enhancing focus on staff health and wellbeing

We will continue to consult with staff to ensure they feel better supported, involved and in control of their working lives.

Our aim is to attract the best people…we're doing this by:

- Attending careers fairs in Manchester, Birmingham, Leeds, Dublin and London to support our ability to recruit and attract high quality candidates to Leeds this year.
- Adapting our recruitment approach and introducing a number of initiatives aimed at improving our selection and assessment process. For example, introducing 'assessment centre' style selection for roles where a high number of recruits are needed or for 'hard to fill' roles.
- Further developing our preceptorship programme, to support recruitment, induction and development of newly registered and newly recruited registered nurses and therapists.

We also want to keep the best people…

We want to make sure that when we attract the best staff, we keep them happy and motivated to remain with us. Keeping good people is not about one single approach but a range of approaches that fit under the following areas:

- Recruitment: Ensuring opportunities are available for all staff to progress internally through secondments and developmental projects.
- Staff Wellbeing: Supporting staff to feel psychologically and psychically well at work providing opportunities for flexible working and time off for study and development.
- Recognition and reward: Staff feeling valued from their local management as well as the Trust forms part of this work. This can be as simple as local development opportunities for example, assignments that provide stretch and opportunities for praise. It also includes more wide ranging corporate schemes, for example, our monthly 'Thanks a Bunch' recognition scheme and the Trust's annual 'Thank You Event.'

- Staff engagement: Social media and the Leader's Networks form part of this work. This is alongside discussion at local management teams using the Trust's 'Engagement Star'.
- Career progression: Maintaining focus on professional development and new roles for example, Preceptorship and Nurse Associate Roles and making sure people are supported with development and educational opportunities.

Appraisals

With a Quality Account indicator of 91%, the compliance rate for appraisal has decreased over the last 12 months (Q1 89%, Q2 87.26%, Q3 85.73%, Q4 84%). Permission to *pause appraisals has been given to some parts of the Trust. This may contribute to the current compliance rate. On a positive note, the staff survey results indicate of those that have taken place, the quality has increased.

*At the beginning of 2016, the Trust was part of the city's 'Silver Command' response. (A gold, silver and bronze system used by healthcare organisations and emergency services to categorise and then respond to high level incidents or demand. Unprecedented winter pressures saw local health and social care providers co-ordinate a tactical response across both in-patient and community services. This focus meant some non- critical work within teams was deferred.

Health and Wellbeing

Our sickness absence rate in 2016/17 was 5.7% which is 1.1% above target.

The health and wellbeing of our staff continues to be an area of focus. During the year, we sourced a new nurse-led Occupational Health Provider, which provides timely and comprehensive support with access to a multi-disciplinary team. In March 2017, we refreshed the range of Health and Wellbeing support that staff can access which includes:

- External counselling support
- Mindfulness based stress reduction programme
- Early Intervention Services for Musculoskeletal and Improving access to psychological therapy (IAPT)
- Physical activity schemes have continued throughout the year, such as our annual pedometer challenge and promotion of the Cycle to Work Scheme.

What next?

- A work-well and work programme is currently being considered to encourage physical activity as part of daily work.

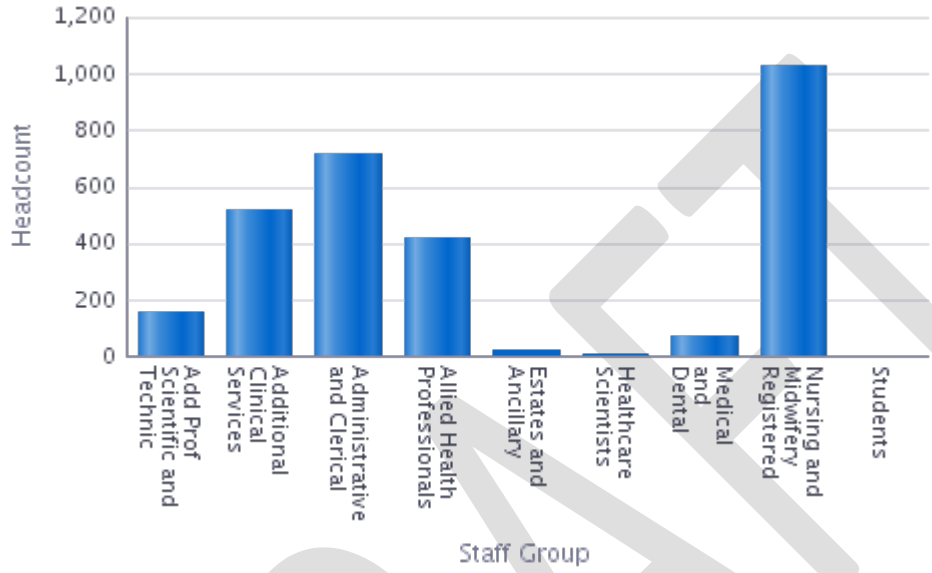
- A new Managing Attendance Policy launched on 1 April 2017, this provides earlier support for staff on long term absence and earlier management intervention for the management of short term sickness absences, when staff are unable to attend work on a regular basis.

- The Free Health and Lifestyle checks (Sheffield Hallam programme) provided for staff was re-introduced during 2017.

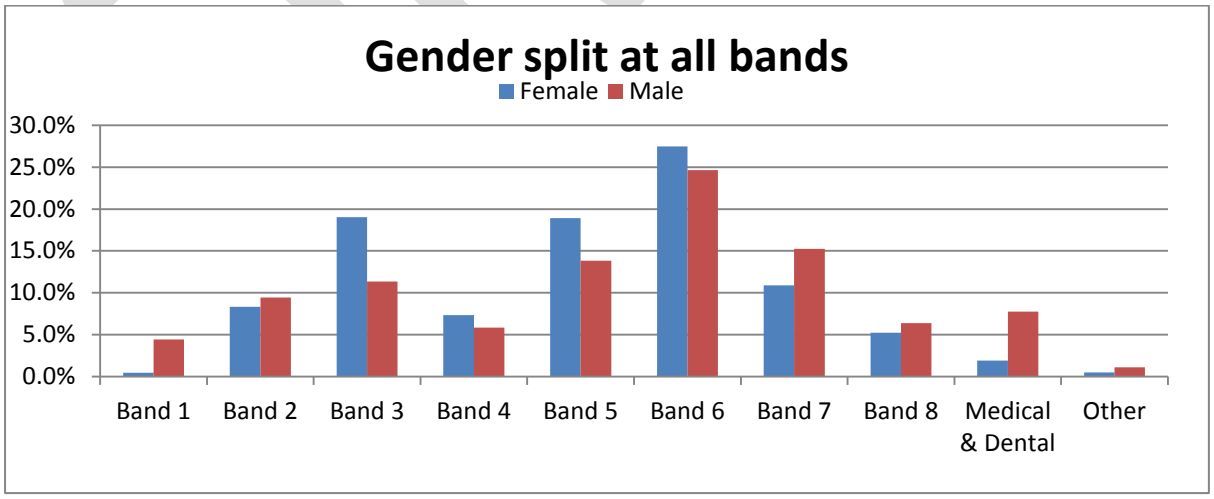
- An enhanced focus on staff health and wellbeing will be a feature of 2017, in line with feedback received through the National staff survey.

Workforce profile

We employ a workforce of 2942. Our turnover rate is above target at 15.3% for financial year 2016/17. This figure has been rising in line with the national picture for community trusts.



Our full time equivalent workforce is made up of 88.4% female and 11.6% male colleagues. The table below demonstrates how this is broken down across pay bands.



Staff flu campaign
We were delighted to receive national recognition for our campaign to fight flu this year. According to figures published by NHS Employers 76.8 per cent of the Trust's frontline staff had their flu vaccine - more than any other Community Trust in the country.

"*This is an amazing achievement given the fact our staff work in over 40 bases across the city.*

It's particularly important for staff to have the flu vaccine if they are coming into contact with patients and their families. Flu immunisation is one of the most effective ways we can reduce harm from flu and the pressures on health and social care services that it can cause." Dave Hall, Lead Infection Prevention Nurse

Goal 4: – Fit for Purpose

Become a viable and sustainable organisation with the ability to invest in the community

Membership and involvement activities

Our commitment and approach to genuine and meaningful involvement of patients, carers and the public is one way we aim to achieve this goal.

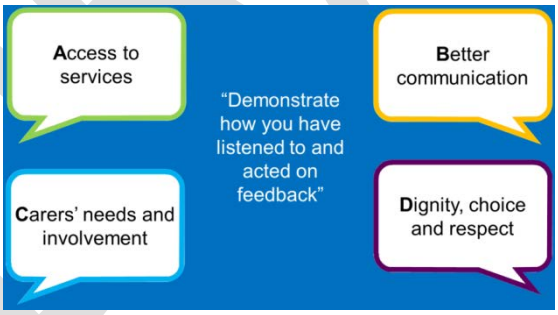
We exist to deliver the best possible care for every community we serve and to do this we want to make sure that involvement isn't just a tick box exercise. With this in mind, our focus for involvement in 2016-17 has been on how we learn from people's experience of the Trust.

Some of the ways this has happened in 2016-17 include:

- Patient Safety and Experience Governance Group (a sub-group of our Quality Committee) to develop and oversee our plans for becoming more of a learning organisation
- Opportunities for people to share their direct experience of our services at Trust Board

- Sharing learning with new staff on what good involvement is like for patients, carers and the public, through our corporate induction
- Our #littlethings campaign, which highlights the small changes that can make a big difference to people's experience of our services

- Safe Clean Care Project and PLACE (Patient Led Assessment of Care Environments) continue to make a practical differences in our health centres and inpatient units
- Involvement in judging the Trust's staff awards based on our 'How we work' behaviours. The behaviours were developed in consultation with patients, carers and the public
- Assessing applications to Leeds Community Health Charity, giving greater transparency and ensuring funding responds to patient and carer needs and experience
- Carers' experience is making improvements in our Health Centres, with all front-of-house teams becoming Dementia Friends.
- Information about carers' support is available in our health centres
- Patient and carer experience saw changes made to our incident investigation policy. Involvement is now sought when setting 'terms of reference' for our incident investigations
- 'More than a Welcome' improvement initiative, including our new '5 owl WELCOME standard' developed from feedback on people's experience of accessing our buildings and services
- We've acted on Quality Account feedback. It is now clearer how we are listening to and acting on the 4 main areas of feedback.



We judge the success of involvement not just on the range and number of opportunities available, but also by the things people tell us are important to them. These include how supported they feel in expressing their views, the response to their feedback and the confidence they have in it having an impact.

The average satisfaction rate for involvement activities in 2016-7 was 90%

Emergency preparedness and resilience

We continue to fulfil our requirements set out 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.

- Our major incident plan is regularly updated to ensure it is fit for purpose
- We have a dedicated and trained emergency management team who lead our response to a significant event. (This plan and the team are regularly tested through desk-top, situation-based training sessions and communications tests)
- Members of the emergency team, take part in regular multi-agency exercises and events to strengthen and reinforce our ability to contribute as part of a wider multi-agency response to a major incident.
- All our services have business continuity plans in place to protect against the impact a wide range of emergency situations which may affect normal service delivery.
- We have also developed a number of Resource Escalation Action Plan (REAP) plans which detail the triggers which would prompt escalation both internally and across the local health economy, and the associated actions required to mitigate and manage the incident. These REAP plans are aligned to the new Operational Pressures Escalations Levels (OPEL) system of escalation introduced by NHS England.
- We continue to participate in local, regional and national exercises and events and work closely with partners in key areas to make sure our plans work well within the wider health economy.
- As an active member of the Local Health Resilience Partnership we take part in a number of associated forums and groups along with more local planning-based task groups.

What next? In 2017/18 we will be developing a new system resilience plan, which will incorporate the Trust's Business Continuity Plan (BCP) and REAP arrangements, as well as specific plans to manage the impact of a number of incidents including Fuel Shortage, Severe Weather and Pandemic Flu. The REAP system of escalation will be rolled out across the organisation to ensure that all of our identified critical services have an individual escalation plan.

Health and safety

We are committed to maintaining a working environment where the health and safety of our staff, patients, visitors, contractors and general public is assured.

We have to have systems in place that comply with:

- The Health and Safety at Work Act (1974)
- The Management of Health and Safety at Work Regulations (1999).

The Health and Safety Group looks at progress made to oversee health and safety across the trust.

The following staff work together to ensure patient care standards are met:

- Health and Safety Officer
- Fire Advisor
- Security Officer
- Infection Prevention and Control Team
- Estates Team

This is as part of our health and safety work plan, designed to meet:

Health and Safety at Work Regulations

- Regulatory guidance from the Health and Safety Executive (HSE),
- Care Quality Commission (CQC)
- Policy guidance from the National Health Service Litigation Authority (NHSLA).

We meet the relevant legislation and continue to take positive action to prevent ill health, injury and loss and promote good health and safety practice.

Here's how we met health and safety requirements in 2016/17

Health and Safety Component	Target	Compliance Level	Comments
Policies and procedures	**100%**	**100%**	All health and safety policies are reviewed by Health and Safety Group
Slips, trips and falls e-learning	**95%**	**91.14%**	Health and Safety training is provided for all staff through induction, face to face and electronic training
Moving and handling	**95%**	**87.43**	The Trust has increased its awareness and training programme to improve compliance
First aiders at work	**100%**	**90%**	Compliance has gone down in 2016 mainly due to some health centres and clinics not having reception staff any

			more, most reception staff are first aiders. The lack of first aiders has been discussed at the Health and Safety Group. It was agreed that services in health centres and clinics would be contacted to provide first aid cover, provided they can demonstrate current knowledge and skills in first aid. The training and experience of the following qualify them to administer first aid in the workplace without the need to hold a first aid qualification: • Doctors registered and licensed with the General Medical Council • Nurses registered with the Nursing and Midwifery Council • Paramedics registered with the Health and Care Professions. Sites without clinical staff currently have first aid cover. Articles have been placed in staff facing communications to recruit more first aiders.
Managing incidents	**100%**	**100%**	All incidents including Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR) are reported through Datix, the Trust's integrated risk management system and followed up. The Health and Safety Officer works closely with managers to facilitate appropriate action to minimise incident reoccurrence.
Safety inspections of buildings	**100%**	**100%**	The Health and Safety Officer inspected all buildings and conducted a site risk assessment in accordance with the Trust's annual programme of Inspections.

Fraud
The Trust has a zero tolerance to fraud. We work hard to prevent, deter, detect and investigate fraud. Our counter fraud work is undertaken by a counter fraud specialist, overseen by the Executive Director of Finance and Resources. Our counter fraud work complies with that required of providers of NHS services.

Disclosure of personal data related incidents

- Incidents calculated to Level 2 or above ***must*** be reported to the Information Commissioner's Office (ICO), through the Health and Social Care Information Centre.
- Criteria for reporting incidents externally to the Trust (Serious Incidents Requiring Investigation – SIRI) were updated in 2015 to include cyber security.

Five incidents have been reported to the Information Commissioner's Office (ICO) under the mandatory reporting requirements. Four incidents were regarding loss of person identifiable information and one regarding inappropriate access of information.

A fact-find has been undertaken in the wake of each incident and process improvements have been actioned, where appropriate, to prevent recurrence.

We will continue to monitor and assess information governance breaches. When weaknesses in systems or processes are identified there will be interventions undertaken at source. Low level and near-miss events will be monitored and when there are common themes we will undertake Trust-wide communications to address these themes. We will continue to support Information Governance (IG) training through the national e-learning programme and ensure staff takes part in annual Information Governance training.

The Trust has a highly developed IG function and framework. It maintains effective links with the Trust's clinical teams through directorate and clinician representative delegates at the Information Governance Group meetings. The Trust's Senior Information Risk Owner (SIRO) (Executive Director of Finance and Resources) and Caldicott Guardian (Executive Medical Director) are members of this group. The group is a sub-group of the Audit Committee, thereby maintaining a reporting line to the Board of Directors as required by regulation. The group monitors IG breach incidents, maintaining oversight of breaches, as well as triggering appropriate responses to clusters of low-level incidents.

Risks to data security are managed by ensuring that all staff with access to patient-identifiable data have the requisite access permissions and have completed their compulsory information governance training. All IT equipment is fully encrypted and has effective information governance to ensure essential safeguarding of our information assets from all threats.

The Trust made a self-assessment against the Information Governance Toolkit of 'satisfactory' as at 31 March 2017, achieving Level 2 or higher for all IG requirements.

Modern Slavery Act 2015
Leeds Community Healthcare meets its responsibilities under this act, as its suppliers are subject to standard NHS terms and conditions.

Sustainability report

As an NHS organisation, and as a spender of public funds, we need to work in a way that has a positive effect on the communities we serve. Sustainability means:

- ✓ Spending public money well
- ✓ Smart and efficient use of natural resources
- ✓ Building healthy, resilient communities.

By making the most of social, environmental and economic assets we can improve health, both now and in the future, even with the rising cost of natural resources. Showing that we consider the social and environmental impact our services have means that we meet the legal requirements set out in the Public Services (Social Value) Act (2012).

We have a Sustainable Development Management Plan (SDMP), the mission statement for this plan is:

" Our Sustainable Development Plan will help us to go the extra mile and deliver quality outcomes such as:

- *Listening*
- *Taking diversity into account*
- *Service efficiencies*
- *Giving back time to staff and patients*
- *Gathering and making best use of feedback from across the board*
- *Improving conditions that surround patients and not just their healthcare need.*

We will do this by working and supporting development across the sustainability spectrum."

The board approved our SDMP in the last 12 months, so our plans for a sustainable future are well known within the organisation and clearly laid out.

Performance

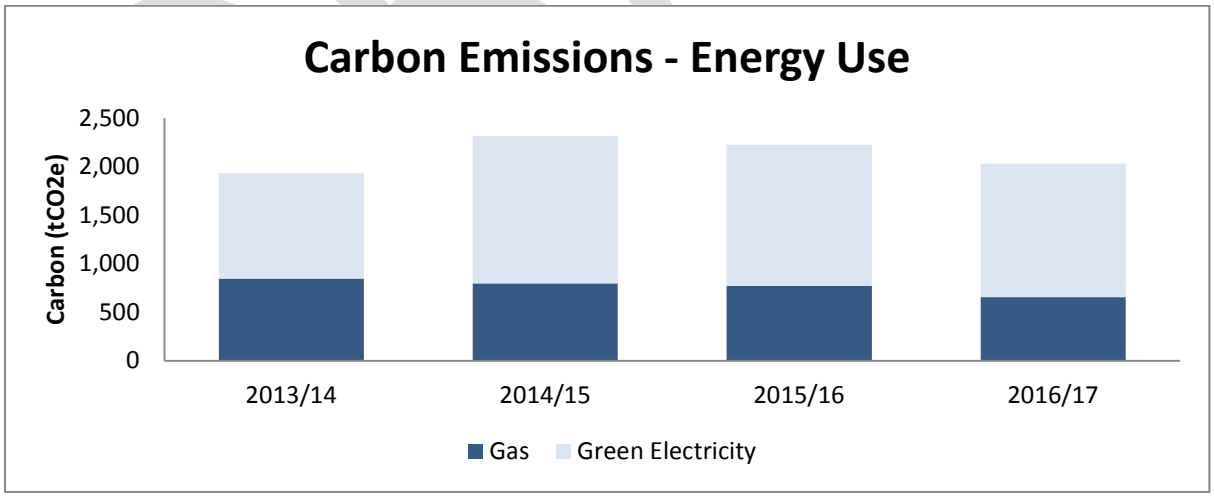
Organisation

Since the 2007 baseline year, the NHS has undergone a significant restructuring process and one which is still on-going. Here's how both the organisation and its performance on sustainability has changed over time.

Year	2013/14	2014/15	2015/16	2016/17
Floor Space (m^2)	37,796	37,508	39,504	40,558
Number of Staff	2,528	2,497	2,717	2,492

Energy

Energy use has shown a small reduction, due to less gas use. Gas use is dominated by weather conditions so a warmer winter results in less gas use. Energy control systems are in place in all buildings. Currently all our electricity comes from renewable sources, as part of the National Commitment, for all suppliers to increase their use of renewable energy.



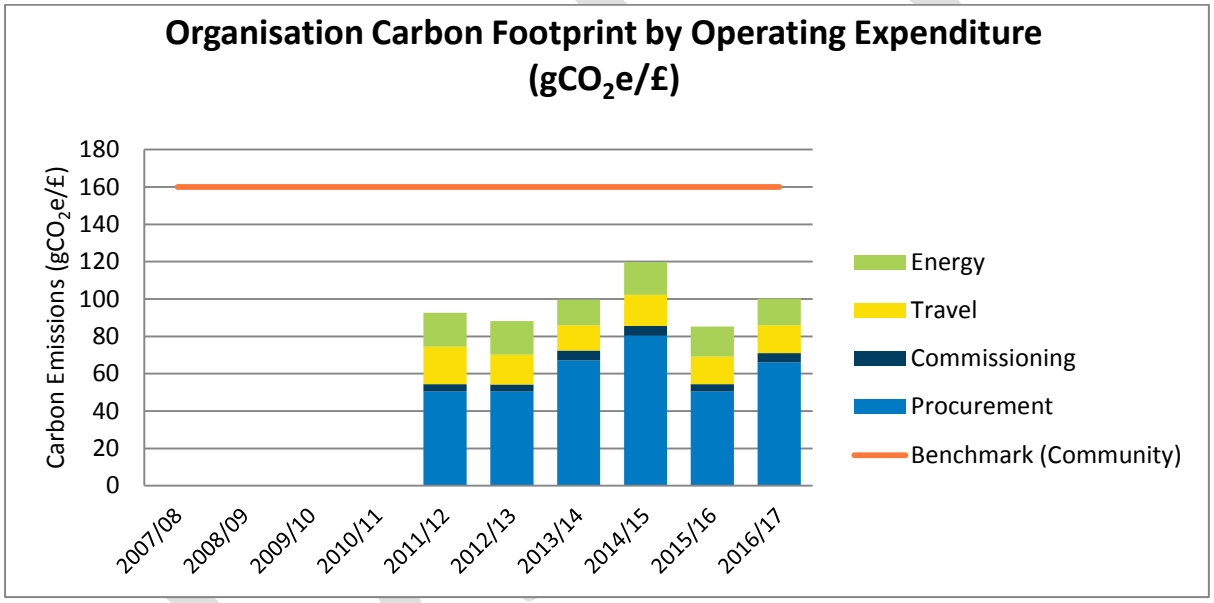
Category	Mode	2013/14	2014/15	2015/16	2016/17
Business Travel and fleet	miles	2,844,982	3,647,112	3,043,042	3,472,501
	tCO_2e	1,704.30	2,172.73	1,784.27	2,034.82
*Staff commute	miles	2,321,026	2,398,662	2,609,998	2,393,859
	tCO_2e	857.56	881.34	943.87	865.17

Travel

Every action counts. We are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO_2e) reductions. We support a culture for active travel, to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors and are caused by cars, as well as other forms of transport.

*Staff commute is a calculated result using National travel Survey data

Overall summary of carbon



Financial performance summary

Since Leeds Community Healthcare was created in 2011 we have met our key financial targets each year and did so again in 2016/17

Target	Target	Performance	Achieved
Planned surplus on income & expenditure	£3,350k	£3,350k	☑
Remain within External Finance Limit	(£1,336k)	(£30k)	☑
Remain within Capital Resource Limit	£2,581k	£1,503k	☑
Capital Cost Absorption Rate	3.5%	3.5%	☑
Agency control total	£8,150k	£6,391k	☑
Use of Resources	2	1	☑
Better Payment Practice Code:			
Non NHS invoices (number & value)	95% & 95%	95% & 97%	☑☑
NHS invoices (number & value)	95% & 95%	97% & 99%	☑☑

It could be easy to become complacent; to think that it just happens, that it's easy. Those of us working in the Trust know that is not the case. It requires hard work by managers, by all budget holders and it often requires difficult decisions to be taken. The approach we take is that wherever possible, those difficult decisions should avoid impacting on the delivery of care to our patients and not impact on our front line staff.

During 2016/17 we did have to take some difficult decisions. Early in the year it became clear that we were spending too much to achieve the £2.9m surplus of income over expenditure target we had agreed with our regulator, NHS Improvement. That target comprised:

£1.5m	Original Trust 1% surplus requirement
£0.5m	Additional surplus requirement
£0.9m	Further surplus delivered by not spending additional £0.9m Strategic Transformation Fund allocation

In June 2016 we introduced additional controls on the use of agency staff and overtime, introduced additional reviews before recruiting staff and restricted spending on goods and services that did not directly contribute to patient care. Every decision was taken with patient care at the forefront of our thoughts. 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 did improve the financial position and as the year continued we were able to relax the additional controls.

Managing our finances whilst many of our services continue to face increasing demand and some patients have increasingly complex conditions, gets more difficult every year. To help our staff to continue to deliver excellent care as efficiently as possible we have invested, and will continue to invest, significantly in an Electronic Patient Record and an e-rostering system. In time the investment in technology will free up staff time. As we roll-out these improvements our staff are to be congratulated for their hard work, their resilience and the care they give in these financially challenging times.

Sharp eyed readers of this report will note that the Trust actually exceeded its income and expenditure surplus target by £0.49m. This is entirely due to additional income received from NHS improvement and comprises the Trust's share of national Sustainability and Transformation Funds that remained unallocated at the year end. The Trust was eligible to receive a share of this resource as a result of achievement of the control total. The funds were distributed after the year end and could not have been spent during the year. The cash is available in future years to support approved capital expenditure.

The Trust continues with its strategy of investing all its internally generated capital resources on equipment, information technology and maintaining our buildings. Capital expenditure during the year comprised £1.1m on the Electronic Patient Record, £0.1m on other information technology equipment, £0.2m on speech and language therapy equipment and various other small items for clinical services and £0.1m on health centre improvements.

By the time this Annual Report is published we will be nearly half way through 2017/18. Our target surplus is £3.0m including £0.9m Strategic Transformation Fund allocation. Our careful financial management means that whilst we have to deliver efficiency savings of £3.4m during the year that is not as onerous as many other NHS organisations. We have been able to target those efficiencies where we believe they can best be achieved with minimal or no impact on front line services. It will remain a significant challenge to balance the need for providing high quality services, meeting increasing demand and delivering financial targets. As always, it is a challenge we are determined to meet.

We're Proud of…

Our Electronic Patient Record (EPR) Project team whose roll-out of EPR will revolutionise the way our Trust works by using technology to ensure that all clinical staff have access to the patient information they need, wherever they are.

Accountability report
Corporate governance

The Trust Board - What we do and how we do it

Along with all NHS trusts across the country, we have a Board of Directors to guide our work. The purpose of our Board is to govern effectively, and to build patient, public and stakeholder confidence that health and healthcare is in safe hands.

Our Board is accountable to the public and stakeholders for:

- High quality, safe health services
- Accessible and responsive health services
- Public money spent in a way that is fair, efficient, effective and economic
- Being a good employer
- Patient and the public engagement in shaping health services

The Board plays a key role in:

- Shaping the strategy, vision and purpose of the Trust.
- Holding the organisation to account for the delivery of strategy
- Ensuring value for money
- Working to shape a positive culture

Led by an independent chair and made up of both executive and independent non-executive members, the board has collective responsibility for the performance of our organisation.

The Trust's Chair and Chief Executive have led these functions throughout 2015/16.

Here are the people who sit on our Board of Directors:

Insert Board structure with photos

The Director of Workforce and the Director of Strategy and Planning (in post until 31 July 2016) are non-voting members of the Board.

Changes to the Board

The former Director of Integration retired at the end of 2015/16 and the post was dis-established. In addition, the post of Director of Strategy and Planning was also dis-established in early 2016/17.

The Trust welcomed two new non-executive directors to the Board; both of whom started on 1 April 2016.

All other executive and non-executive directors have been in post for the whole of 2016/17.

Directors' Interests

Our Director's declare interests that they have in associated businesses or areas of work. These are shown in the following table:

Leeds Community Healthcare NHS Trust
Director's declarations of interests for disclosure 2016/17

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in excess of £100 received within the past 12 months in connection with the trust
Neil Franklin	None	None	None	Board member (acting in an advisory capacity only), Donisthorpe Hall Care Home	Donisthorpe Hall, Care Home	None	None	None
Thea Stein	None	None	None	None	None	None	None	None
Jane Madeley	None	None	None	Chief Financial Officer , University of Leeds	None	None	Any contracts between the University of Leeds, Faculty of Medicine and Health, the Leeds University Business School via CIHM, Academic Health Partnership relationships and Leeds Community Healthcare NHS Trust	None

Tony Dearden	None	None	None	Fee paid Medical Member of First Tier Tribunal (Health, Education and Social Care Chamber), i.e. mental health tribunals. Fellow, Royal College of Psychiatrists.	None	None	None	None
Brodie Clark	None	None	None	Non-executive Director Compass	Compass (services for drug and alcohol misuse)	None	None	None
Richard Gladman	None Director, Deloitte MCS Ltd (to 29.08.16)	None	None	Programme director, Health & Social care Information Centre (NHS Digital) (from 30.08.16)	None	None	None	None
Elaine Taylor-Whilde	CEO,Nine Health Global &Nine Health UK Ltd	Nine Health CIC	None	CEO, Nine Health CIC	Nine Health CIC	None	None	None
Bryan Machin	None	None	None	None	None	None	None	None
Amanda Thomas	None	None	None	Signatory LTHT Postgraduate Child Protection training	None	None	None	None

				fund. CQC, National professional advisor for Integrated Children's Service and Safeguarding				
Sam Prince	None	None	None	None	None	None	None	None
Marcia Perry	None	None	None	None	None	None	None	None
Sue Ellis*	None	None	None	Governor, Greenhead College, Huddersfield (from 2 October 2015)	None	None	None	None
Emma Fraser* (until 31.07.16)	None	None	None	None	None	None	None	None

***** Non-voting Board member

Left intentionally blank

Board meetings and business in 2016/17
As with all NHS Trusts, we are required to hold formal Board meetings in public. The Board has met formally six times during the year. In addition, an annual general meeting was held in September 2016.

The Board has also met informally on a further six occasions. These events have taken the form of strategic workshops and have involved a wider group of senior leaders.

In early 2017, the Trust received a CQC inspection; the CQC inspection report is expected to be received early in 2017/18. The quality of care is at the heart of all that the Trust does; the over-arching approach to quality within the Trust is captured within the quality strategy which was approved by the Board in February 2016. All actions to fulfil the aspiration to be a high quality trust are overseen closely by the Board.

Our Board receives regular performance reports (the report brings together quality and financial information in one document). Information in the report is aligned to the CQC's five domains (safe, caring, effective, responsive and well-led).This is the main way the Board assesses that it meets all national and local standards and targets for the services provided.

The Board receives regular updates on strategic service developments. For example:

- Putting in place neighbourhood teams
- Enhancing integration across primary and secondary health and social care
- Rolling out new ways of working, for example, putting in place the Electronic Patient Record

The Board's committees (decision making groups)
The Trust has five committees that make sure it carries out its duties effectively, efficiently and economically. These are shown in the chart below.

Insert Board/Committee structure

Details of the functions of each committee can be found in our Annual Governance Statement.

Directors' statement

In line with the manual for accounts we able to make the following statement:

- Each director knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken "all the steps that he or she ought to have taken" to make himself/herself aware of any such information and to establish that the auditors are aware of it.

2016/17 Annual Accounts of Leeds Community Healthcare NHS Trust

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:

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

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

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

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

NB: sign and date in any colour ink except black

Signed.....Chief Executive

Date.....

Leeds Community Healthcare NHS Trust
Annual Governance Statement 2016/17

1. Scope of responsibility

Amongst its responsibilities, the Board is accountable for ensuring effective systems for integrated governance and internal control across the Trust's clinical and corporate activities. This is a statement to that effect made by the Trust's Chief Executive.

"As Accountable Officer and Chief Executive, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's aims and objectives, whilst safeguarding quality standards, public funds and the organisation's assets in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the Accountable Officer Memorandum. My annual governance statement is set out below."

Thea Stein

2. The governance framework of the organisation

2.1 Discharge of statutory functions

The organisation has met all of its statutory functions and remained legally compliant throughout the year.

2.2 Trust Board

The Board leads the Trust by undertaking three main roles:

- Formulating strategy
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable
- Shaping a positive culture for the Board and the wider Trust

The Board consists of six non-executive directors (including the Chair), and five executive directors. In addition, there is one non-voting member of the Board.

There is a clear division of responsibilities between the Chair and Chief Executive. The Trust's Chair and Chief Executive have discharged their leadership functions throughout the whole of 2016/17.

All non-executive directors have been in post for the whole of 2016/17.

The Director of Workforce is a non-voting member of the Board. Two further non-voting directors' posts have been dis-established; the Director of Integration at the start of 2016/17 and the Director of Strategy and Planning in the second quarter of 2016/17.

The Board has met on thirteen occasions in 2016/17; this has comprised six formal meetings held in public, six informal meetings or strategic workshops plus an annual general meeting.

Attendance at Board meetings has been good and all meetings have been quorate.

The Board has standing orders, a scheme of reservation and delegation of powers and standing financial instructions. These were reviewed during 2016/17 and a number of changes were made; these were considered by the Audit Committee and approved by the Board.

The Board has an annual work plan which demonstrates the scheduling of required and discretionary business. The five Board committees all have terms of reference and work plans all of which have been reviewed during 2016/17.

The quality of services remains the Trust's first priority and, to this end, the Board's agenda features reports reflecting key quality matters. Board meetings have received papers on the Trust's quality strategy, patient experience topics and the maintenance of safe staffing levels.

The Trust's Board receives an integrated performance report comprising a performance brief and a suite of reports aligned to the five Care Quality Commission (CQC) domains. This report is the primary mechanism for assessing compliance with national and local targets. The report brings quality and financial information together in one report.

The Trust's Board receives regular updates on strategic service developments, for example, implementing integrated neighbourhood teams, work to enhance integration across primary and secondary health care and social care and the introduction of new ways of working.

The Board receives and considers extracts from the risk register and the board assurance framework at each meeting so as to gain assurance as to the effective management of risk in the organisation. Through these arrangements, the Board receives information about existing and potential risks to the Trust.

The Board also receives minutes and assurance reports from each of its committees at Board meetings.

Information presented to the Board provides essential assurance. Formal information is enhanced by the inclusion of patients' stories at Board meetings and by regular visits to frontline services by the Board's non-executive directors (35 during 2016/17).

2.3 Assessment of Board effectiveness

The Board wishes to assure itself that it operates effectively and regularly seeks opportunities to evaluate its effectiveness and strengthen its performance, in doing so, it is mindful of the best practice contained within codes of governance.

The Board (along with senior managers) has undertaken a self-assessment against Monitor's *Well-Led Framework* and has drawn out a number of priorities to further enhance the effectiveness of elements of the Trust's governance.

In late 2015, the Board undertook an internal, theme-based assessment of its effectiveness which drew out a number of actions. The results of this effectiveness review were reported to the Board in February 2016. The review of effectiveness has been extended and the effectiveness of the Board and all sub-committees has been reviewed in 2016/17. The results being reported to the Board and are contained in committees' annual reports. The committees' chairs' also met collectively to discuss committees' effectiveness.

The Trust has a needs-based Board development programme. A feature of which is a series of Board workshops taking place every two months (six events in 2016/17); senior leaders from corporate services and business units (including clinical leads) also participate in these sessions.

The individual performance of all Board members is reviewed through a formal appraisal process and any individual development needs are identified and supported.

2.4 Committee structure

The Trust's Board has appointed five committees to carry out specific functions and provide assurance that the Trust is carrying out its duties effectively, efficiently and economically. These are detailed below.

Audit Committee

The Committee comprises three non-executive directors. The Chair of the Committee is a qualified accountant and is a Chief Financial Officer in the higher education sector. The Executive Director of Finance and Resources, the Company Secretary, the Internal Auditor and the External Auditor attend on a routine basis. The Audit Committee met formally six times during 2016/17.

The Audit Committee provides an overarching governance role and reviews the work of the other committees, whose work can provide relevant assurance to the Audit Committee's own scope of work.

During the year, the Committee has received regular reports on progress from internal audit, external audit, the local counter fraud specialist, the security management service and from information governance specialists.

The Committee has also considered a range of financial control reports and a number of governance papers, reviewed the standing orders and standing financial instructions, reviewed a revised board assurance framework and approved a revised risk management policy and procedure.

The chair of each of the Board's committees has produced an annual report which provides assurance to the Audit Committee on how each committee has met its terms of reference during the year. The committees also undertook a self-assessment exercise, which was reviewed by the Audit Committee. The committees' chairs also met to discuss the outcome.

Quality Committee

The Quality Committee's membership comprises the Trust's Chair, two non-executive directors, the Chief Executive and two executive directors; a number of other senior officers attend each meeting. The Committee met on 10 occasions in 2016/17.

The Committee provides assurance to the Board that high standards of care are provided by the Trust and that adequate and appropriate quality governance structures, processes and controls are in place to:

- Promote quality, in particular safety and excellence in patient care
- Identify, prioritise and manage clinical risk and assure the Board that risks and issues are being managed in a controlled and timely manner
- Ensure effective evidence-based clinical practice
- Produce the annual Quality Account and monitor progress

The Committee exercises these functions in the context of the Trust's quality strategy; this was Board approved in February 2016. The strategy provides an overarching framework for quality within the Trust and sets out a programme of work to achieve four key objectives and six action areas focused on patient safety, clinical effectiveness and patient experience. The Committee has received an update on a quarterly basis and has sought assurance about the implementation of specific actions.

Within that strategic framework, the Quality Committee and the Board monitors serious incidents, incidents and complaints and the associated action plans. All serious incidents are managed in accordance with the Trust's incident and serious incident management policy.

The Trust received a CQC inspection in late 2014 and the report arising from the inspection was received by the Trust in early 2015. The Trust received a rating of 'requires improvement'. Following receipt of the CQC report, a quality improvement plan was produced and is monitored by the Quality Committee at each meeting. The Trust has been re-inspected in the fourth quarter of 2016/17 and the results of the re-inspection are expected in the first quarter of 2017/18.

Business Committee

The Business Committee's membership comprises three non-executive directors, the Chief Executive and two further executives; other senior officers attend as required. The Business Committee held 10 meetings in 2016/17.

The Committee provides assurance to the Board on the financial and performance management processes within the organisation, including monitoring the delivery of the Trust's business plan and oversight of significant projects.

The Committee oversees business and commercial developments and makes investment decisions in line with the scheme of delegation and the Trust's investment policy and ensures that the Board has a sufficiently robust understanding of key performance, financial and investment issues to enable sound decision-making.

The Committee discharges a significant role in overseeing the workforce aspects of the Trust's performance. There has been consideration of recruitment and retention strategies, sickness absence management and leadership approaches.

The committee has assumed an extended role in terms of oversight of the Trust's main projects. At each meeting, the Committee receives an in depth report on one aspect of the Trust's business or one area of project work.

Nominations and Remuneration Committee

The Nominations and Remuneration Committee's membership comprises the Chair and two further non-executive directors; the Committee is supported by the Director of Workforce. The Committee has met three times in 2016/17.

The role of the Nominations and Remuneration Committee is to nominate executive directors, including the Chief Executive, for appointment and advise and make recommendations to the Board about appropriate remuneration and terms of service for the Chief Executive, executive directors, directors and any senior managers not covered by national *Agenda for Change* terms and conditions of employment.

Charitable Funds Committee

The Charitable Funds Committee's membership is comprised of the Chair and one other non-executive director; the Committee is supported by the Executive Director of Nursing. The Committee has held five meetings during 2016/17.

The purpose of the committee is to give assurance to the Board that the Trust's charitable activities are discharged within the law and regulations set by the Charity Commissioners for England and Wales. The Committee oversees charitable activities, approves charitable funds expenditure, agrees an investment policy for charitable funds and monitors investments on a regular basis.

3. Risk assessment

The Trust's risk management strategy was reviewed at the end of 2015, and to reflect lessons learnt from the application of the strategy, a new policy, procedure and risk appetite statement was developed and approved in April 2016. The board assurance framework (BAF) has been fully revised during 2016. The Audit Committee was instrumental in both of these developments.

Risks to strategic objectives contained within the Trust's clinical and service strategies and plans have been identified and are assigned to a lead executive to manage. Each of these strategic risks is also assigned to one of the Board's committees for oversight and scrutiny.

There are seventeen strategic risks aligned to the Trust's four strategic goals which are grouped into four strategic risk 'clusters':

- Failure to provide high quality, safe services, improve patient experience and measure success in terms of outcomes
- Failure to deliver integrated care and care closer to home arising from a failure to work in partnership with stakeholders to deliver service solutions
- Failure to engage and empower the Trust's workforce and the ability to recruit, retain and develop staff
- Failure to maintain a viable and sustainable organisation

These high level strategic and financial risks are recorded in the BAF and, in addition to scrutiny at committee level, are reviewed by the Trust's Board. The BAF records: risk descriptions, controls and gaps in controls, sources of assurance and gaps in sources in assurance, actions required to remedy gaps in controls or assurance.

The board assurance and risk management processes have been reviewed in 2016/17 by the Trust's internal auditors. The internal auditors have confirmed that the BAF will support the Trust's annual governance statement.

The Board receives a significant risks and risk assurance report at each meeting. The report details the Trust's risks scoring 15 or above (extreme), after the application of controls and mitigation measures. It provides an analysis of all risk movement, identifies themes and links these material risks to the strategic risks on the BAF. The report also includes the BAF summary advising the Board of the current assurance level determined for each of the Trust's strategic risks. The Senior Management Team reviews the significant risks and risk assurance report on a monthly basis. The Quality Committee reviews in more detail clinical risks and the Business Committee non-clinical risks rated as high.

Together, these mechanisms allow for the appropriate identification, monitoring, control and mitigation of risks which may impact on the Trust's objectives.

4. Risk and control framework

The Trust recognises that it is operating in a healthcare environment where patient safety, quality of care and service sustainability are paramount and are of mutual benefit to stakeholders and the organisation alike. The Trust manages clinical risks (i.e. risks to individual patients through clinical activity) and financial and business risks (i.e. risks that threaten the achievement of statutory financial duties or the safeguarding of the Trust's assets) in order to deliver its objectives in a controlled manner. Subject to controls and assurances being in place, and in line with the Trust's risk appetite statement, the Trust accepts manageable risks, but not where there is a foreseeable risk of harm or adverse outcomes to patients.

Risk management is embedded within the culture of the organisation from risk assessment in clinical practice to the consideration of risk underpinning the Board's decisions. Risks are identified and aligned to strategic objectives.

Assurance of risk mitigation is provided to the Board through the Senior Management Team, and through the Quality and Business Committees in relation to clinical and non-clinical risks respectively. The Audit Committee assures the risk management process.

Members of staff receive information and are briefed on risk management procedures as part of the induction process. Managers are trained in risk management procedures both as part of the induction process and as part of ongoing training, coaching and support.

The Trust is a high reporter of incidents when compared to similar organisations and has a good open incident reporting culture. Learning from incidents is shared with staff. When root cause analysis is undertaken, good practice in incident management is celebrated and learning shared.

Serious incidents are given very close scrutiny and are managed through a policy which is NHS Litigation Authority Level 1 compliant. The majority of managers have had serious incident investigation training and the Trust has a good record of reporting incidents in a timely way to NHS Improvement and to commissioners.

The Trust reports monthly on its performance against national key performance indicators in line with NHS Improvement's *Single Oversight Framework* and other indicators as contained within contracts with commissioners.

The Trust works to evidence good standards of data quality and accuracy in its performance reporting and is confident that key national indicators eg waiting times are accurate.

Data security risk is managed through a system of general managers and heads of service who act as information asset owners and work with the Senior Information Risk Owner to manage data security and other information related risks.

The Trust's information governance group develops relevant policies and strategies to control data security and other information related risks. As a community trust, sharing information has been identified as an area where secure email and electronic record sharing are replacing paper based forms of communication. The introduction of data security measures has reduced significantly the risk of data loss through the use of mobile devices.

Following a data breach in 2014, the Trust had been issued with a letter of undertaking by the Information Commissioner's Office, the undertaking required the Trust to have 95% of staff to be compliant with information governance training requirements on an annual basis. This requirement has been, and continues to be, met in full.

The Trust has submitted a self-assessed score of level two for the information governance toolkit submission.

5. Review of the effectiveness of risk management and internal control

The Chief Executive has responsibility for reviewing the effectiveness of the system of internal control. The review of the effectiveness of the system of internal control is informed by the work of internal auditors, the comments made by external auditors in the ISA260 report, the continuing engagement of the Audit Committee and managers and clinical leads who have responsibility for the development and maintenance of the internal control framework. The Audit Committee effects a role in terms of providing assurance to the Chief Executive.

5.1 Clinical audit

Clinical audit is vital to the quality and effectiveness of clinical services and is a fundamental part of the quality improvement process. It plays a pivotal role in providing assurances about the quality of services. Findings from clinical audit are used to ensure that action is taken to protect patients from risks associated with unsafe care, treatment and support.

Clinical audit is managed at service level with the support of the quality and professional development directorate. There has been an increase in the number of clinical audits planned for 2016-17 compared to 2015-16. The Quality Committee approves an annual programme of clinical audit and has oversight of progress during the course of the year.

5.2 Internal audit

TIAA Limited has been the provider of internal audit services since 1 April 2015. The Head of Internal Audit has provided an opinion that concludes that, based on the work undertaken in 2016/17, reasonable assurance can be given that there are adequate and effective management and internal control processes to manage the achievement of the organisation's objectives.

A number of weaknesses were identified that put the achievement of particular objectives at risk; actions to mitigate these matters have been put in place. There were two areas reviewed by internal audit where it was assessed that the effectiveness of some of the internal control arrangements provided 'limited' assurance. Recommendations were made to further strengthen the control environment; recommendations have been completed or are being progressed in a satisfactory manner.

5.3 Other review, assessment and assurance mechanisms

The Trust gains assurance from the work of the Trust's external auditor, KPMG. The external auditor will review and report on the Trust's financial statements and the annual governance statement for 2016/17. The external auditor will also review the arrangements for use of resources.

During 2016/17, the Trust ran a competitive procurement process and appointed KPMG as its external auditor from 1 April 2017 for a term of three years.

NHS Improvement has assigned the Trust a segment rating of '2'; this indicates standard oversight whereby the provider may be offered targeted support in one or more areas.

The Trust has the required standard of Level 1 compliance with the NHS Litigation Authority.

The Trust works with a range of regulators including the CQC, HM Prison Inspectorate and Ofsted. The Trust is fully compliant with the registration requirements of the CQC. During 2016/17, the Trust was involved in an inspection by the CQC which particularly focused on inpatient care, adult services, sexual health services and a Trust-wide review of the well-led domain. The outcome of the CQC inspection is expected in the first quarter of 2017/18.

6. Significant issues

During 2016/17, no significant control issues have been identified by the Trust's systems of internal control.

7. Conclusion

The Trust is a well-established health care provider that has built a system of internal control based on sound foundations. The Trust has a strong safety culture and sees quality of care as the primary objective. Ongoing scrutiny enhances learning and strengthens governance.

The annual governance statement shows that the Trust has the necessary control arrangements in place to manage risks and take action when incidents occur.

Strong financial control and the achievement of statutory financial duties support the view that, clinically and financially, the Trust has effective and improving systems in place.

Signed…….. ……. Date…….

Thea Stein
Chief Executive and Accountable Officer
DRAFT Version 5, 20 April 2017

Remuneration and staff report

Policy on senior managers' contracts

The table below provides details on the contracts for each senior manager who has been employed during the year. The contracts do not make any specific provisions for compensation for early termination in addition to the notice periods.

Name and Title	Contract date	Date of Expiry	Notice period
Susan Ellis Director of Workforce	23 January 2012	No end date	3 months
Emma Fraser Director of Strategy and Planning	12 October 2011	31/07/2016	3 months
Bryan Machin Executive Director of Finance and Resources	9 May 2011	No end date	3 months
Paul Morrin Director of Integration, Adult Health and Social Care and Acting Director of Nursing from 1-09/08/15	1 April 2011	Until 01/06/16	3 months
Marcia Perry Executive (Nurse) Director of Quality from 10/08/05	10 August 2015	No end date	3 months
Samantha Prince Executive Director of Operations	4 July 2011	No end date	3 months
Thea Stein Chief Executive	1 October 2014	No end date	6 months
Dr Amanda Thomas Executive Medical Director	5 September 2011	No end date	3 months

Payments to past senior managers (subject to audit)

We have not made any awards to past senior managers in addition to the remuneration disclosed later in this report

The Trust can confirm:

- There were no performance related payments made to senior managers in 2015/16.
- There were no senior managers service contracts awarded during 2015/16
- There were no payments to past senior managers during 2015/16
- There were no payments for loss of office during 2015/16
- There was no senior off-payroll engagement during 2015/16

Number of individuals that have been deemed 'Board members, and / or senior officers with significant financial responsibility' during the financial year. This figure includes off payroll and on-payroll engagement	14

Senior Manager Remuneration Report (subject to audit)

	2016 / 17						2015 / 16					
Name and title	Salary (bands of £5,000) £'000s	Expense payments (Rounded to the nearest hundred) £'000s	Performance pay and bonuses (bands of £5,000) £'000s	Long term performance pay and bonuses (bands of £5,000) £'000s	All pension related benefits (bands of £2,500) £'000s	TOTAL (bands of £5,000) £'000s	Salary (bands of £5,000) £'000s	Expense payments (Rounded to the nearest hundred) £'000s	Performance pay and bonuses (bands of £5,000) £'000s	Long term performance pay and bonuses (bands of £5,000) £'000s	All pension related benefits (bands of £2,500) £'000s	TOTAL (bands of £5,000) £'000s
Brodie Clark – Non-Executive Director	5 - 10	0.8				5 - 10	5 - 10	0.9				5 - 10
Dr Tony Dearden – Non-Executive Director	5 - 10	0.5				5 - 10	5 - 10	0.6				5 - 10
Ieuan Ellis – Non-executive Director (until 31/03/16)												N/A*
Susan Ellis – Director of Workforce	90 - 95				30 - 32.5	120 - 125	85 - 90	0.1			20 - 22.5	110 - 115
Neil Franklin – Chair	20 - 25	0.6				20 - 25	20 - 25	0.7				20 - 25
Emma Fraser – Director of Strategy and Planning (until 31/07/16)	15 - 20		0 - 5		0 - 2.5	20 - 25	55 - 60		0 - 5		47.5 - 50	105 - 110
Robert Lloyd – Non-Executive Director (Deputy Chair) (until 31/03/16)							5 - 10	0.6				5 - 10
Richard Gladman - Non-Executive Director (from 01/04/16)	5 - 10					5 - 10						
Elaine Taylor-Whilde - Non-Executive Director (from 01/04/16)	5 - 10	1.0				5 - 10						
Bryan Machin – Executive Director of Finance and Resources	110 - 115	0.1			52.5 - 55	165 - 170	105 - 110	0.1			0	0
Jane Madeley – Non-Executive Director	5 - 10					5 - 10	5 - 10					5 - 10
Paul Morrin – Director of Integration, Adult Health and Social Care (until 01/06/16)	10 - 15		0 - 5		0 - 2.5	15 - 20	80 - 85	0.1	0 - 5		12.5 - 15	95 - 100
Marcia Perry Executive (Nurse) Director of Quality from 10/08/15	90 - 95	0.1			42.5-45	135-140	55 - 60	0.1			132.5 - 135	190 - 195
Samantha Prince – Executive Director of Operations	95 - 100	0.1			30 - 32.5	125 - 130	90 - 95	0.1			25 - 27.5	120 - 125
Thea Stein – Chief Executive	140 - 145	0.1				140 - 145	135 - 140	0.1			50 - 52.5	190 - 195
Helen Thomson – Interim Director of Nursing from 13/10/14 to 31/07/15							45 - 50					45 - 50
Dr Amanda Thomas – Executive Medical Director	95 - 100		75 - 80			170 - 175	95 - 100	0.2	75 - 80		0	170 - 175

Pension details for senior managers (subject to audit)

	2016/17						
Board Member	Real increase in pension at pensionable age (bands of £2,500) £'000	Real increase in pension lump sum at pensionable age (bands of £2,500) £'000	Total accrued pension at pensionable age at 31 March 2017 (bands of £5,000) £'000	Lump sum at pensionable age related to accrued pension at 31 March 2017 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2016 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2017 £'000
Susan Ellis - Director of Workforce	0 - 2.5	5 - 7.5	40 - 45	125 - 130	888	55	956
Emma Fraser - Director of Strategy and Planning to 31/07/16	0 - 2.5	0 - 2.5	15 - 20	40 - 45	195	4	214
Bryan Machin - Executive Director of Finance and Resources**	0 - 2.5	5 - 7.5	40 - 45	130 - 135	800	71	873
Paul Morrin - Director of Integration, Adult Health and Social Care to 1/06/16**	0 - 2.5	0 - 2.5	35 - 40	110 - 115	736	0	0
Marcia Perry - Executive (Nurse) Director of Quality	0 - 2.5	5 - 7.5	30 - 35	100 - 105	530	45	588
Samantha Prince - Executive Director of Operations	0 - 2.5	0 - 2.5	30 - 35	90 - 95	519	26	558
Dr Amanda Thomas - Executive Medical Director*	0	0	0	0	1,090	0	0
Thea Stein - Chief Executive**	0	0	0	0	44	0	0

* Individual ceased to be a member of the scheme before the start of the financial year

** Individual ceased to be a member of the scheme during the year

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with Statutory Instrument number 1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Fair pay disclosures

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director for the Trust in the financial year 2016/17 was £173,181 (2015/16, £172,160). This was 6.1 (2015/16, 6.1) times the median remuneration of the workforce, which was £28,211 (2015/16 £28,106). The multiple is the same as last year.

In 2016/17 total remuneration ranged from £15,251 to £173,181, (2015/16, £15,100 to £172,160).

Total remuneration includes salary, non-consolidated performance related pay, clinical excellence awards and on-call payments and benefits-in-kind. It does not include severance payments, employer pension contributions or cash equivalent transfer value of pensions.

Staff Report

Staff Numbers including senior officers

Average staff numbers in post by occupation groupings.

Average Staff Numbers	2016/17 Total Number	2015/16 Total Number
Medical and dental	84	99
Administration and estates	719	735
Healthcare assistants and other support staff	540	553
Nursing, midwifery and health visiting staff	981	1,021
Nursing, midwifery and health visiting learners	9	14
Scientific, therapeutic and technical staff	469	518
Healthcare Science Staff	1	1
Other (including senior officers)	27	54
TOTAL	**2,830**	**2,995**
Staff engaged on capital projects (included above)	5	7

On average there was 165 whole time equivalent less staff in post in 2016/17; 110 of these posts relate to adult prison services the Trust ceased to provide on 1 April 2016 and a further 27 posts were funded non recurrently in 2015/16 as part of Winter resilience schemes.

Expenditure on consultancy

The Trust's expenditure on consultancy services during 2016/17 was £25k and was in respect of the business development strategy.

Off-payroll engagements

Off-payroll engagements

For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months:

Number of existing engagements as of 31 March 2017	21
Of which, the number that have existed:	
For less than one year at the time of reporting	0
For between one and two years at the time of reporting	5
For between 2 and 3 years at the time of reporting	16
For between 3 and 4 years at the time of reporting	0
For 4 or more years at the time of reporting	0

All of the existing engagements have contractual clauses to request assurance on tax status.

For all new off-payroll engagements between 1 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months:

Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	4
Number of new engagements which include contractual clauses giving the Leeds Community Healthcare NHS Trust the right to request assurance in relation to income tax and National Insurance obligations	4
Number for whom assurance has been requested	0
Of which:	
Assurance has been received	0
Assurance has not been received	0
Engagements terminated as a result of assurance not being received	0

Number of off-payroll engagements of board members, and / or senior officers with significant financial responsibility, during the year	0

Exit Packages

The figures reported here relate to exit packages agreed in year. The actual date of departure might be in a subsequent period, and the expense in relation to departure costs may have been accrued in a previous period. The data here is therefore presented on a different basis to other staff cost expenditure in the accounts.

Exit Package cost band (including any special payment element)	Total number of compulsory redundancies Number	Total cost of compulsory redundancies £s	Number of departures where special payments have been made Number	Cost of special payment element included in exit packages £s
Less than £10,000	2	8,372	0	0
£10,000 - £25,000	4	79,230	0	0
£25,001 - £50,000	24	689,419	0	0
Totals	**30**	**777,021**	**0**	**0**

Redundancy and other departure costs have been paid in accordance with the provisions of Section 16 of the Agenda for Change Handbook. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirements are met by the NHS Pensions Scheme and are not included in the table. There were no other departures during 2016/17.

Financial Statements Full accounts and notes to be appended after Audit

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AGENDA
ITEM
2017-18
(7b)

Leeds Community Healthcare NHS Trust

Annual Accounts for the period

1 April 2016 to 31 March 2017

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

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

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgments and estimates which are reasonable and prudent;

- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

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

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

By order of the Board

NB: sign and date in any colour ink except black

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

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

Statement of Comprehensive Income for year ended 31 March 2017

	Note	2016/17 £000s	2015/16 £000s
Gross employee benefits	10.1	**(106,069)**	(114,642)
Other operating costs	8	**(38,528)**	(38,395)
Revenue from patient care activities	5	**141,955**	149,460
Other operating revenue	6	**6,699**	6,907
Operating surplus/(deficit)		**4,057**	3,330
Investment revenue	12	**43**	42
Other gains/(losses)	13	**(48)**	(24)
Finance costs	14	**0**	(1)
Surplus/(deficit) for the financial year		**4,052**	3,347
Public dividend capital dividends payable		**(706)**	(681)
Transfers by absorption - gains		**0**	0
Transfers by absorption - (losses)		**0**	0
Net gain/(loss) on transfers by absorption		**0**	0
Retained surplus/(deficit) for the year		**3,346**	2,666

Other Comprehensive Income

	2016/17 £000s	2015/16 £000s
Impairments and reversals taken to the revaluation reserve	**0**	0
Net gain/(loss) on revaluation of property, plant & equipment	**0**	0
Net gain/(loss) on revaluation of intangibles	**0**	0
Net gain/(loss) on revaluation of financial assets	**0**	0
Other gain/(loss)	**0**	0
Net gain/(loss) on revaluation of available for sale financial assets	**0**	0
Net actuarial gain/(loss) on pension schemes	**0**	0
Other pension remeasurements	**0**	0
Reclassification adjustments		
On disposal of available for sale financial assets	**0**	0
Total comprehensive income for the year	**3,346**	2,666

Financial performance for the year

Retained surplus/(deficit) for the year	**3,346**	2,666
Prior period adjustment to correct errors and other performance adjustments	**0**	0
IFRIC 12 adjustment (including IFRIC 12 impairments)	**0**	0
Impairments (excluding IFRIC 12 impairments)	**0**	315
Adjustments in respect of donated gov't grant asset reserve elimination	**4**	4
Adjustment re absorption accounting	**0**	0
Adjusted retained surplus/(deficit)	**3,350**	2,985

In both financial years the £4,000 adjustment is in respect of depreciation on Hannah House, a donated asset. 2015/16 £315,000 impairment relates to the transfer of Garforth Clinic from a fixed asset used to deliver services to an asset held for sale.

The notes on pages x to xx form part of this account.

Statement of Financial Position as at 31 March 2017

	Note	31 March 2017 £000s	31 March 2016 £000s
Non-current assets			
Property, plant and equipment	16	**27,144**	27,228
Intangible assets	17	**76**	54
Investment property	19	**0**	0
Other financial assets		**0**	0
Trade and other receivables	22.1	**0**	0
Total non-current assets		**27,220**	27,282
Current assets			
Inventories	21	**0**	0
Trade and other receivables	22.1	**6,209**	6,149
Other financial assets	24	**0**	0
Other current assets	25	**0**	0
Cash and cash equivalents	26	**19,104**	19,074
Sub-total current assets		**25,313**	25,223
Non-current assets held for sale	27	**165**	165
Total current assets		**25,478**	25,388
Total assets		**52,698**	52,670
Current liabilities			
Trade and other payables	28	**(10,612)**	(13,901)
Other liabilities	29	**0**	0
Provisions	35	**(1,398)**	(1,323)
Borrowings	30	**0**	0
Other financial liabilities	31	**0**	0
DH revenue support loan	30	**0**	0
DH capital loan	30	**0**	0
Total current liabilities		**(12,010)**	(15,224)
Net current assets/(liabilities)		**13,468**	10,164
Total assets less current liablilities		**40,688**	37,446
Non-current liabilities			
Trade and other payables	28	**0**	0
Other liabilities	29	**0**	0
Provisions	35	**0**	(104)
Borrowings	30	**0**	0
Other financial liabilities	31	**0**	0
DH revenue support loan	30	**0**	0
DH capital loan	30	**0**	0
Total non-current liabilities		**0**	(104)
Total assets employed		**40,688**	37,342
Financed by:			
Public dividend capital		**256**	256
Retained earnings		**30,936**	27,561
Revaluation reserve		**9,496**	9,525
Other reserves		**0**	0
Total Taxpayers' Equity		**40,688**	37,342

The notes on pages x to xx form part of this account.

The financial statements on pages *[a to b]* were approved by the Board on *[date]* and signed on its behalf by

Chief Executive: Date:

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2017

	Public dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**256**	**27,561**	**9,525**	**0**	**37,342**
Changes in taxpayers' equity for 2016/17					
Retained surplus/(deficit) for the year		3,346			**3,346**
Net gain/(loss) on revaluation of property, plant & equipment			0		**0**
Net gain/(loss) on revaluation of intangible assets			0		**0**
Net gain/(loss) on revaluation of financial assets			0		**0**
Net gain/(loss) on revaluation of available for sale financial assets			0		**0**
Impairments and reversals			0		**0**
Other gains/(losses)				0	**0**
Transfers between reserves		29	(29)	0	**0**
Reclassification Adjustments					
Transfers between reserves in respect of assets transferred under absorption accounting	0	0	0	0	**0**
On disposal of available for sale financial assets			0		**0**
Reserves eliminated on dissolution		0	0	0	**0**
Originating capital for Trust established in year	0				**0**
Temporary and permanent PDC received - cash	0				**0**
Temporary and permanent PDC repaid in year	0				**0**
PDC written off	0	0			**0**
Transfer due to change of status from Trust to Foundation Trust	0	0	0	0	**0**
Other movements	0	0	0	0	**0**
Net actuarial gain/(loss) on pension		0		0	**0**
Other pensions remeasurement		0		0	**0**
Net recognised revenue/(expense) for the year	**0**	**3,375**	**(29)**	**0**	**3,346**
Balance at 31 March 2017	**256**	**30,936**	**9,496**	**0**	**40,688**

Balance at 1 April 2015	**1,041**	**24,827**	**9,593**	**0**	**35,461**
Changes in taxpayers' equity for the year ended 31 March 2016					
Retained surplus/(deficit) for the year		2,666			2,666
Net gain/(loss) on revaluation of property, plant & equipment			0		0
Net gain/(loss) on revaluation of intangible assets			0		0
Net gain/(loss) on revaluation of financial assets			0		0
Net gain/(loss) on revaluation of available for sale financial assets			0		0
Impairments and reversals			0		0
Other gains/(losses)				0	0
Transfers between reserves		68	(68)	0	0
Reclassification Adjustments					
Transfers between reserves in respect of assets transferred under absorption accounting		0	0		0
On disposal of available for sale financial assets			0		0
Originating capital for Trust established in year	0				0
New PDC received - cash	0				0
PDC repaid in year	(785)				(785)
Other movements	0	0	0	0	0
Net actuarial gain/(loss) on pension				0	0
Other pension remeasurement				0	0
Net recognised revenue/(expense) for the year	**(785)**	**2,734**	**(68)**	**0**	**1,881**
Balance at 31 March 2016	**256**	**27,561**	**9,525**	**0**	**37,342**

Information on reserves

1 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities. Additional PDC may also be issued to NHS trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS trust, is payable to the Department of Health as the public dividend capital dividend.

2 Retained earnings reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

3 Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

4 Other reserves
The Trust has no other reserves.

Statement of Cash Flows for the Year ended 31 March 2017

	Note	2016/17 £000s	2015/16 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		**4,057**	3,330
Depreciation and amortisation	8	**1,565**	1,774
Impairments and reversals	27	**0**	315
Other gains/(losses) on foreign exchange	13	**0**	0
Donated assets received credited to revenue but non-cash	6	**0**	0
Government granted assets received credited to revenue but non-cash		**0**	0
Release of PFI/deferred credit		**0**	0
(Increase)/decrease in inventories		**0**	63
(Increase)/decrease in trade and other receivables		**(91)**	(897)
(Increase)/decrease in other current assets		**0**	0
Increase/(decrease) in trade and other payables		**(3,492)**	489
(Increase)/decrease in other current liabilities		**0**	0
Provisions utilised		**(665)**	(392)
Increase/(decrease) in movement in non cash provisions		**636**	806
Net Cash Inflow/(Outflow) from Operating Activities		**2,010**	5,488
Cash Flows from Investing Activities			
Interest received		**43**	42
(Payments) for property, plant and equipment		**(1,338)**	(1,507)
(Payments) for intangible assets		**(46)**	0
(Payments) for investments with DH		**0**	0
(Payments) for other financial assets		**0**	0
(Payments) for financial assets (LIFT)		**0**	0
Proceeds of disposal of assets held for sale (PPE)		**36**	0
Proceeds of disposal of assets held for sale (intangible)		**0**	0
Proceeds from disposal of investment with DH		**0**	0
Proceeds from disposal of other financial assets		**0**	0
Proceeds from the disposal of financial assets (LIFT)		**0**	0
Loans made in respect of LIFT		**0**	0
Loans repaid in respect of LIFT		**0**	0
Rental revenue		**0**	0
Net Cash Inflow/(Outflow) from Investing Activities		**(1,305)**	(1,465)
Net Cash Inflow/(Outflow) before Financing		**705**	4,023
Cash Flows from Financing Activities			
Gross temporary and permanent PDC received		**0**	0
Gross temporary and permanent PDC repaid		**0**	(785)
Loans received from DH - new capital investment loans		**0**	0
Loans received from DH - new revenue support loans		**0**	0
Other loans received		**0**	0
Loans repaid to DH - capital investment loans repayment of principal		**0**	0
Loans repaid to DH - working capital loans/revenue support loans		**0**	0
Other loans repaid		**0**	0
Cash transferred to NHS Foundation Trusts or on dissolution		**0**	0
Capital element of payments in respect of finance leases & on-SoFP PFI & LIFT		**0**	0
Interest paid		**0**	(1)
PDC dividend (paid)/refunded		**(675)**	(676)
Capital grants and other capital receipts (excl. donated/gov't granted cash receipts)		**0**	0
Net Cash Inflow/(Outflow) from Financing Activities		**(675)**	(1,462)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**30**	2,561
Cash and Cash Equivalents (and Bank Overdraft) at beginning of the period		**19,074**	16,513
Effect of exchange rate changes in the balance of cash held in foreign currencies		**0**	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	26	**19,104**	19,074

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Accounting Manual 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Going Concern

These accounts have been prepared on a going concern basis.

The going concern concept was reviewed by the Trust's Audit Committee at its meeting 17 February 2017.

In considering whether the Trust is a going concern the following areas were reviewed:

● The Trust's financial monitoring throughout 2016/17 provides evidence that financial duties and targets will be met. The Trust will achieve the control total set by NHS Improvement. Historically, the Trust has achieved all its financial duties.

● The Trust's financial performance is monitored externally by NHS Improvement through monthly reporting and regular meetings. Internally, the Trust's financial performance has been monitored monthly by the Senior Management Team and the Business Committee and by the Board at each meeting.

● The Trust has reported a use of resources risk rating of 1 since it was introduced in October 2016. A rating of 1 represents the lowest risk rating for provider organisations.

● The Trust's financial plans for 2017/18 and 2018/19 demonstrate delivery of the Board approved surplus; for 2017/18 the Trust plans to achieve the NHS Improvement control total, for 2018/19 the Board currently plans to achieve a 1% surplus. Contracts with commissioners have been agreed for 2017/18 and 2018/19.

● The Trust has low levels of outstanding debt; the majority of the contract income is paid in month.

● The Trust's liquidity remains very strong with circa £19m currently in the bank. The financial plan demonstrates the Trust has sufficient cash resources to meet its operational and capital investment commitments for 2017/18 and 2018/19.

● The Board of Directors is a stable and experienced team. Two new non-executive directors were appointed on 1 April 2016 and the Chair of Audit Committee has been re-appointed for a further two years from 1 April 2017.

● The Board has considered the matter of the Trust as a going concern, through its ongoing assessment of sustainability and the resources needed to ensure it continues in operational existence for the foreseeable future.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Charitable Funds

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact. The Trust considers that the value of Charitable Funds are not material and has resolved not to consolidate the Charitable Fund's financial statements within the Trust's financial statements.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.5 Pooled Budgets

The Trust has no pooled budget arrangements.

1.6 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.6.1 Critical judgements in applying accounting policies

The Trust has provided for redundancy costs associated with the loss of service contracts, where staff will not TUPE to the new provider.

1.6.2 Key sources of estimation uncertainty

An estimate of the redundancy costs has been made and included in the Trust's expenditure for 2016/17 as required under IAS 37. The estimated value of redundancies provided for is £702k.

1.7 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

During the year the Trust has ceased to provide 2 services; Family Nurse Partnerships and York Street Excluded People service. Surplus equipment and drugs for the York Street service have been sold to the new service providers. This income, totalling £12k, has been recorded under other revenue.

1.8 Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Trust operates an alternative mandatory scheme, National Employment Savings Trust, for employees who do not qualify for or choose not to become a member of the NHS Pension Scheme.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.9 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.10 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and either
- the item cost at least £5,000; or
- Collectively, a number of items have a total cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-off and charged to operating expenses.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at cost. Software that is integral to the operation of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.12 Depreciation, amortisation and impairments

Freehold land, assets under construction or development, and assets held for sale are not depreciated/amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, on a straight line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful lives.

At each financial year-end, the Trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.13 Donated assets

Donated non-current assets are capitalised at current value in existing use if they will be held for their service potential, or otherwise at value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14 Government grants

Government grant funded assets are capitalised at current value in existing use if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.15 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.16 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The Trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.17 Private Finance Initiative (PFI) transactions

The Trust has no private finance initiative transactions.

1.18 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.19 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.20 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates. The Trust has no provisions measured in this way.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.21 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at Note 35.

1.22 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims, are charged to operating expenses as and when they become due.

1.23 Carbon Reduction Commitment Scheme (CRC)

The Trust does not contribute to the Carbon Reduction Commitment Scheme.

1.24 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.25 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the Trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and where there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

Fair value is determined by obtaining an open market valuation from the District Valuer, and takes into account an estimate of costs which will be incurred in selling the asset.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset and that have an impact on the estimated future cash flows of the asset.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.26 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value.

1.27 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.28 Foreign currencies

The Trust's functional and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.29 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them.

1.30 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.31 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.32 Subsidiaries

Material entities over which the Trust has the power to exercise control are classified as subsidiaries and are consolidated. The Trust has control when it is exposed to or has rights to variable returns through its power over another entity. The income and expenses; gains and losses; assets, liabilities and reserves; and cash flows of the subsidiary are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

The Trust has no subsidiaries.

1.33 Associates

Material entities over which the Trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the Trust's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the Trust share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the Trust from the entity.

Associates that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

The Trust has no associate arrangements.

1.34 Joint arrangements

Material entities over which the Trust has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Trust is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

The Trust provides sexual health services under a joint operation with Leeds Teaching Hospitals NHS Trust. As lead provider the contract income flows to the Trust, and Leeds Teaching Hospitals NHS Trust recharges expenditure associated with the provision of this service. The total cost of the service is recognised by Leeds Community Healthcare NHS Trust and a share of any profit or loss is transferred to Leeds Teaching Hospitals NHS Trust.

The Trust provides forensic child and adolescent mental and physical health services under a joint operation with South West Yorkshire Partnership NHS Foundation Trust. As lead provider the contract income flows to the Trust, and South West Yorkshire Partnership NHS Foundation Trust recharges expenditure associated with the provision of this service. The total cost of the service is recognised by Leeds Community Healthcare NHS Trust and a share of any profit or loss is transferred to South West Yorkshire Partnership NHS Foundation Trust.

NOTES TO THE ACCOUNTS

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method. The Trust has no joint venture arrangements.

NOTES TO THE ACCOUNTS

Notes to the Accounts - 1. Accounting Policies (Continued)

1.35 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.36 Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2016/17. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

● IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
● IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted
● IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.37 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

2. Pooled budget

The Trust has no pooled budgets.

3. Operating segments

All activity at Leeds Community Healthcare NHS Trust is healthcare related and the majority of the Trust's revenue is received from within UK government departments.

The main proportion of operating expenses are payroll related and are for the staff directly involved in the provision of healthcare and the indirect and overhead costs associated with that provision. Therefore it is deemed that the business activities which earn revenues for the Trust and in turn incur the expenses are therefore one broad provision on which it is deemed appropriate to identify as only one segment, namely healthcare.

Monthly operating results are published for assessment and review by the Trust's Chief Operating Decision Maker, which is the overall Trust Board that includes executive and non-executive directors. The financial position of the Trust to date, the Trust's statement of financial position and cash flow and projections of future performance are assessed as a whole Trust rather than individual component parts that make up the sum total. In addition all reporting of the position of the Trust is presented on a whole Trust basis that again implies a single operating segment under IFRS 8. As all decisions affecting the Trust's future direction and viability are made based on the overall total presented to Board, the Trust is satisfied that the single segment of heatlhcare is appropriate and consistent with the principles of IFRS 8.

Income from Clinical Commissioning Groups totalled £103,404k or 70% of the total income received by the Trust. £22,784k or 15% of the Trust's income was from Leeds City Council. All income is reported under the single operating segment.

4. Income generation activities

The Trust has no income generation activities.

5. Revenue from patient care activities

	2016/17 £000s	2015/16 £000s
NHS Trusts	**0**	1
NHS England	**7,997**	21,501
Clinical Commissioning Groups	**103,404**	100,487
Foundation Trusts	**2**	3
Department of Health	**0**	0
NHS Other (including Public Health England and NHS Property Services)	**0**	0
Additional income for delivery of healthcare services	**0**	785
Non-NHS:		
Local Authorities	**28,927**	24,859
Private patients	**17**	78
Overseas patients (non-reciprocal)	**0**	0
Injury costs recovery	**0**	0
Other non-NHS patient care income	**1,608**	1,746
Total Revenue from patient care activities	**141,955**	149,460

6. Other operating revenue

	2016/17 £000s	2015/16 £000s
Recoveries in respect of employee benefits	**840**	1,007
Patient transport services	**0**	0
Education, training and research	**1,885**	2,434
Charitable and other contributions to revenue expenditure - NHS	**0**	0
Charitable and other contributions to revenue expenditure - non-NHS	**0**	0
Receipt of charitable donations for capital acquisitions	**0**	0
Support from DH for mergers	**0**	**0**
Receipt of Government grants for capital acquisitions	**0**	0
Non-patient care services to other bodies	**183**	141
Sustainability & Transformation Fund income	**1,350**	0
Income generation (other fees and charges)	**0**	0
Rental revenue from finance leases	**0**	0
Rental revenue from operating leases	**434**	431
Other revenue	**2,007**	2,894
Total Other operating revenue	**6,699**	6,907
Total operating revenue	**148,654**	156,367

7. Overseas Visitors Disclosure

The Trust has no overseas visitor income.

8. Operating expenses

	2016/17 £000s	2015/16 £000s
Services from other NHS Trusts	**0**	0
Services from CCGs/NHS England	**0**	0
Services from other NHS bodies	**0**	0
Services from NHS Foundation Trusts	**0**	0
Total Services from NHS bodies *	**0**	0
Purchase of healthcare from non-NHS bodies	**627**	1,241
Purchase of social care	**0**	0
Trust Chair and Non-Executive Directors	**56**	53
Supplies and services - clinical	**11,571**	11,006
Supplies and services - general	**2,435**	2,473
Consultancy services	**25**	6
Establishment	**2,740**	3,123
Transport	**3,398**	3,548
Service charges - on-SOFP PFIs and other service concession arrangements	**0**	0
Service charges - on-SOFP LIFT contracts	**0**	0
Total charges - off-SOFP PFIs and other service concession arrangements	**0**	0
Total charges - off-SOFP LIFT contracts	**0**	0
Business rates paid to local authorities	**393**	312
Premises	**13,078**	12,048
Hospitality	**0**	4
Insurance	**133**	198
Legal fees	**248**	196
Impairments and reversals of receivables	**51**	16
Inventories write down	**0**	0
Depreciation	**1,541**	1,736
Amortisation	**24**	38
Impairments and reversals of property, plant and equipment	**0**	0
Impairments and reversals of intangible assets	**0**	0
Impairments and reversals of financial assets	**0**	0
Impairments and reversals of non current assets held for sale	**0**	315
Internal audit fees	**92**	94
Audit fees	**52**	52
Other auditor's remuneration **	**13**	0
Clinical negligence	**265**	227
Research and development (excluding staff costs)	**58**	151
Education and training	**631**	614
Change in discount rate	**0**	0
Capital grants in kind	**0**	0
Other	**1,097**	944
Total Operating expenses (excluding employee benefits)	**38,528**	38,395
Employee Benefits		
Employee benefits excluding Board members	**105,408**	113,955
Board members	**661**	687
Total Employee Benefits	**106,069**	114,642
Total Operating Expenses	**144,597**	153,037

* Services from NHS bodies does not include expenditure which falls into a category below.
** Other auditor's remuneration is in respect of taxation advice.

9. Operating Leases

The Trust has leases in respect of accommodation, vehicles and photocopiers.

The Trust has no contingent rents.

9.1. Leeds Community Healthcare NHS Trust as lessee

	Land £000s	Buildings £000s	Other £000s	2016/17 Total £000s	2015/16 £000s
Payments recognised as an expense					
Minimum lease payments				**2,414**	2,291
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**2,414**	2,291
Payable:					
No later than one year		829	1,283	**2,112**	2,139
Between one and five years	0	3,212	1,422	**4,634**	4,329
After five years	0	1,444	0	**1,444**	2,041
Total	**0**	**5,485**	**2,705**	**8,190**	8,509
Total future sublease payments expected to be received				**115**	226

9.2. Leeds Community Healthcare NHS Trust as lessor

Leasing arrangements where the Trust is a lessor relate to the sub-letting of health centres and clinics, where the lessee is generally a GP practice or other healthcare provider.

	2016/17 £000s	2015/16 £000s
Recognised as revenue		
Rental revenue	**434**	431
Contingent rents	**0**	0
Total	**434**	431
Receivable:		
No later than one year	**430**	431
Between one and five years	**1,169**	1,347
After five years	**80**	96
Total	**1,679**	1,874

10. Employee benefits

10.1. Employee benefits

	2016/17 Total £000s	2015/16 Total £000s
Employee Benefits - Gross Expenditure		
Salaries and wages	**87,855**	97,788
Social security costs	**7,586**	6,014
Employer Contributions to NHS BSA - Pensions Division	**10,186**	10,411
Other pension costs	**15**	10
Termination benefits	**702**	855
Total employee benefits	**106,344**	115,078
Employee costs capitalised	**275**	436
Gross Employee Benefits excluding capitalised costs	**106,069**	114,642

10.2. Retirements due to ill-health

	2016/17 Number	2015/16 Number
Number of persons retired early on ill health grounds	**7**	2
	£000s	£000s
Total additional pensions liabilities accrued in the year	**197**	41

10.3. Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017 is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this ‘employer cost cap’ assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Other pension costs

NEST (National Employment Savings Trust) is an alternative pension scheme set up to comply with new legislation which provides that employees fulfilling certain criteria must auto-enrol into a pension scheme. When they do not qualify for or wish to join the NHS Pension Scheme this is the Trust's mandatory alternative scheme. NEST Corporation is the Trustee body that has overall responsibility for running NEST. It is a non-departmental public body that operates at arm's length from government and is accountable to Parliament through the Department of Work and Pensions (DWP). The Trust has expensed £15k during the year in respect of contributions for employees under the NEST scheme.

11. Better Payment Practice Code

11.1. Measure of compliance

	2016/17 Number	2016/17 £000s	2015/16 Number	2015/16 £000s
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	**20,085**	**32,145**	30,917	38,106
Total non-NHS trade invoices paid within target	**19,141**	**30,870**	29,496	36,034
Percentage of NHS trade invoices paid within target	**95.30%**	**96.03%**	95.40%	94.56%
NHS Payables				
Total NHS trade invoices paid in the year	**998**	**19,647**	967	18,050
Total NHS trade invoices paid within target	**972**	**19,555**	946	17,929
Percentage of NHS trade invoices paid within target	**97.39%**	**99.53%**	97.83%	99.33%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

11.2. The Late Payment of Commercial Debts (Interest) Act 1998

	2016/17 £000s	2015/16 £000s
Amounts included in finance costs from claims made under this legislation	**0**	1
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	1

12. Investment Revenue

	2016/17 £000s	2015/16 £000s
Rental revenue		
PFI finance lease revenue (planned)	**0**	0
PFI finance lease revenue (contingent)	**0**	0
Other finance lease revenue	**0**	0
Subtotal	**0**	0
Interest revenue		
LIFT: equity dividends receivable	**0**	0
LIFT: loan interest receivable	**0**	0
Bank interest	**43**	42
Other loans and receivables	**0**	0
Impaired financial assets	**0**	0
Other financial assets	**0**	0
Subtotal	**43**	42
Total investment revenue	**43**	42

13. Other Gains and Losses

	2016/17 £000s	2015/16 £000s
Gain/(loss) on disposal of assets other than by sale (PPE)	**(28)**	(36)
Gain/(loss) on disposal of assets other than by sale (intangibles)	**0**	0
Gain/(loss) on disposal of financial assets other then held for sale	**0**	0
Gain (loss) on disposal of assets held for sale	**(20)**	12
Gain/(loss) on foreign exchange	**0**	0
Change in fair value of financial assets carried at fair value through the SoCI	**0**	0
Change in fair value of financial liabilities carried at fair value through the SoCI	**0**	0
Change in fair value of investment property	**0**	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	0
Total	**(48)**	(24)

14. Finance Costs

	2016/17 £000s	2015/16 £000s
Interest		
Interest on loans and overdrafts	**0**	0
Interest on obligations under finance leases	**0**	0
Interest on obligations under PFI contracts:		
- main finance cost	**0**	0
- contingent finance cost	**0**	0
Interest on obligations under LIFT contracts:		
- main finance cost	**0**	0
- contingent finance cost	**0**	0
Interest on late payment of commercial debt	**0**	1
Total interest expense	**0**	1
Other finance costs	**0**	0
Provisions - unwinding of discount	**0**	0
Total	**0**	1

15. Auditor

15.1. Other auditor remuneration

	2016/17 £000s	2015/16 £000s
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	**0**	0
2. Audit-related assurance services	**0**	0
3. Taxation compliance services	**0**	0
4. All taxation advisory services not falling within item 3 above	**13**	0
5. Internal audit services	**0**	0
6. All assurance services not falling within items 1 to 5	**0**	0
7. Corporate finance transaction services not falling within items 1 to 6 above	**0**	0
8. Other non-audit services not falling within items 2 to 7 above	**0**	0
Total	**13**	0

15.2. Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2016/17 or 2015/16.

16. Tangible non current assets

16.1. Property, plant and equipment

2016/17	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2016	9,550	14,605	0	33	3,664	0	2,868	596	**31,316**
Additions of assets under construction				142					**142**
Additions purchased	0	0	0		96	0	1,291	0	**1,387**
Additions - non cash donations (i.e. physical assets)	0	0	0	0	0	0	0	0	**0**
Additions - purchases from cash donations & government grants	0	0	0	0	0	0	0	0	**0**
Additions leased (including PFI/LIFT)	0	0	0		0	0	0	0	**0**
Reclassifications	0	110	0	(110)	0	0	0	0	**0**
Reclassifications as held for sale and reversals	0	0	0	0	(186)	0	0	0	**(186)**
Disposals other than for sale	0	0	0	0	(128)	0	0	(12)	**(140)**
Revaluation	0	0	0	0	0	0	0	0	**0**
Impairments/reversals charged to operating expenses	0	0	0	0	0	0	0	0	**0**
Impairments/reversals charged to reserves	0	0	0	0	0	0	0	0	**0**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from other public sector bodies under absorption accounting	0	0	0	0	0	0	0	0	**0**
At 31 March 2017	**9,550**	**14,715**	**0**	**65**	**3,446**	**0**	**4,159**	**584**	**32,519**
Depreciation									
At 1 April 2016	0	713	0		2,222	0	665	488	**4,088**
Reclassifications	0	0	0		0	0	0	0	**0**
Reclassifications as held for sale and reversals	0	0	0		(142)	0	0	0	**(142)**
Disposals other than for sale	0	0	0		(101)	0	0	(11)	**(112)**
Revaluation	0	0	0		0	0	0	0	**0**
Impairment/reversals charged to reserves	0	0	0		0	0	0	0	**0**
Impairments/reversals charged to operating expenses	0	0	0		0	0	0	0	**0**
Charged during the year	0	506	0		386	0	622	27	**1,541**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0		0	0	0	0	**0**
Transfers (to)/from other public sector bodies under absorption accounting	0	0	0		0	0	0	0	**0**
At 31 March 2017	**0**	**1,219**	**0**	**0**	**2,365**	**0**	**1,287**	**504**	**5,375**
Net Book Value at 31 March 2017	**9,550**	**13,496**	**0**	**65**	**1,081**	**0**	**2,872**	**80**	**27,144**
Asset financing:									
Owned - purchased	9,550	13,319	0	65	1,081	0	2,872	80	**26,967**
Owned - donated	0	177	0	0	0	0	0	0	**177**
Owned - government granted	0	0	0	0	0	0	0	0	**0**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	**0**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2017	**9,550**	**13,496**	**0**	**65**	**1,081**	**0**	**2,872**	**80**	**27,144**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2016	7,196	2,294	0	0	34	0	0	1	**9,525**
Movements in respect of assets disposed of in year	0	0	0	0	(29)	0	0	0	**(29)**
At 31 March 2017	**7,196**	**2,294**	**0**	**0**	**5**	**0**	**0**	**1**	**9,496**

Additions to Assets Under Construction in 2016/17	
Land	**0**
Buildings excl Dwellings	**142**
Dwellings	**0**
Plant & Machinery	**0**
Balance as at 31 March 2017	**142**

16.2. Property, plant and equipment prior year

2015/16	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2015	9,930	14,763	0	454	3,624	0	1,858	596	31,225
Additions of assets under construction				(18)					(18)
Additions purchased	0	0	0		406	0	1,222	0	1,628
Additions - non cash donations (i.e. physical assets)	0	0	0	0	0	0	0	0	0
Additions - purchases from cash donations & government grants	0	0	0	0	0	0	0	0	0
Additions leased (including PFI/LIFT)	0	0	0		0	0	0	0	0
Reclassifications	0	403	0	(403)	0	0	0	0	0
Reclassifications as held for sale and reversals	(380)	(106)	0	0	0	0	(126)	0	(612)
Disposals other than for sale	0	(455)	0	0	(366)	0	(86)	0	(907)
Revaluation	0	0	0	0	0	0	0	0	0
Impairments/reversals charged to operating expenses	0	0	0	0	0	0	0	0	0
Impairments/reversals charged to reserves	0	0	0	0	0	0	0	0	0
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	0
Transfers (to)/from other public sector bodies under absorption accounting	0	0	0	0	0	0	0	0	0
At 31 March 2016	9,550	14,605	0	33	3,664	0	2,868	596	31,316
Depreciation									
At 1 April 2015	0	359	0		2,068	0	471	457	3,355
Reclassifications	0	0	0		0	0	0	0	0
Reclassifications as held for sale and reversals	0	(6)	0		0	0	(126)	0	(132)
Disposals other than for sale	0	(455)	0		(330)	0	(86)	0	(871)
Revaluation	0	0	0		0	0	0	0	0
Impairment/reversals charged to reserves	0	0	0		0	0	0	0	0
Impairments/reversals charged to operating expenses	0	0	0		0	0	0	0	0
Charged during the year	0	815	0		484	0	406	31	1,736
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0		0	0	0	0	0
Transfers (to)/from other public sector bodies under absorption accounting	0	0	0		0	0	0	0	0
At 31 March 2016	0	713	0	0	2,222	0	665	488	4,088
Net Book Value at 31 March 2016	9,550	13,892	0	33	1,442	0	2,203	108	27,228
Asset financing:									
Owned - purchased	9,550	13,711	0	33	1,442	0	2,203	108	27,047
Owned - donated	0	181	0	0	0	0	0	0	181
Owned - government granted	0	0	0	0	0	0	0	0	0
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2016	9,550	13,892	0	33	1,442	0	2,203	108	27,228

16.3. Property, plant and equipment (Continued)

	Min Life Years	Max Life Years
Economic Lives for Non Current Assets		
Property, Plant and Equipment		
Buildings exc Dwellings	1	88
Plant & Machinery	5	10
Information Technology	5	5
Furniture and Fittings	5	10

17. Intangible non-current assets

17.1. Intangible non-current assets

2016/17	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Intangible Assets Under Construction	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2016	**0**	**212**	**0**	**0**	**0**	**0**	**212**
Additions of assets under construction						0	**0**
Additions purchased	0	46	0	0	0	0	**46**
Additions internally generated	0	0	0	0	0	0	**0**
Additions - non cash donations (i.e. physical assets)	0	0	0	0	0	0	**0**
Additions - purchases from cash donations & government grants	0	0	0	0	0	0	**0**
Additions leased (including PFI/LIFT)	0	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	0	**0**
Reclassified as held for sale and reversals	0	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	0	**0**
Upward revaluation/positive indexation	0	0	0	0	0	0	**0**
Impairments/reversals charged to operating expenses	0	0	0	0	0	0	**0**
Impairments/reversals charged to reserves	0	0	0	0	0	0	**0**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	**0**
Transfer (to)/from other public sector bodies under absorption accounting	0	0	0	0	0	0	**0**
At 31 March 2017	**0**	**258**	**0**	**0**	**0**	**0**	**258**
Amortisation							
At 1 April 2016	**0**	**158**	**0**	**0**	**0**		**158**
Reclassifications	**0**	**0**	**0**	**0**	**0**		**0**
Reclassified as held for sale and reversals	**0**	**0**	**0**	**0**	**0**		**0**
Disposals other than by sale	**0**	**0**	**0**	**0**	**0**		**0**
Upward revaluation/positive indexation	**0**	**0**	**0**	**0**	**0**		**0**
Impairment/reversals charged to reserves	**0**	**0**	**0**	**0**	**0**		**0**
Impairments/reversals charged to operating expenses	**0**	**0**	**0**	**0**	**0**		**0**
Charged during the year	**0**	**24**	**0**	**0**	**0**		**24**
Transfers to NHS Foundation Trust on authorisation as FT	**0**	**0**	**0**	**0**	**0**		**0**
Transfer (to)/from other public sector bodies under absorption accounting	**0**	**0**	**0**	**0**	**0**		**0**
At 31 March 2017	**0**	**182**	**0**	**0**	**0**	**0**	**182**
Net Book Value at 31 March 2017	**0**	**76**	**0**	**0**	**0**	**0**	**76**
Asset Financing: Net book value at 31 March 2017 comprises:							
Purchased	0	76	0	0	0	0	**76**
Donated	0	0	0	0	0	0	**0**
Government granted	0	0	0	0	0	0	**0**
Finance leased	0	0	0	0	0	0	**0**
On-balance sheet PFIs	0	0	0	0	0	0	**0**
Total at 31 March 2017	**0**	**76**	**0**	**0**	**0**	**0**	**76**

Revaluation reserve balance for intangible non-current assets							
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2016	0	0	0	0	0	0	**0**
Movements	0	0	0	0	0	0	**0**
At 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**

17.2. Intangible non-current assets prior year

2015/16	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Intangible Assets Under Construction	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:							
At 1 April 2015	0	267	0	0	0	0	267
Additions - purchased	0	0	0	0	0	0	0
Additions - internally generated	0	0	0	0	0	0	0
Additions - donated	0	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0	0
Additions Leased (including PFI/LIFT)	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Disposals other than by sale	0	(55)	0	0	0	0	(55)
Upward revaluation/positive indexation	0	0	0	0	0	0	0
Impairments/reversals charged to operating expenses	0	0	0	0	0	0	0
Impairments/reversals charged to reserves	0	0	0	0	0	0	0
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption	0	0	0	0	0	0	0
At 31 March 2016	0	212	0	0	0	0	212
Amortisation							
At 1 April 2015	0	175	0	0	0	0	175
Reclassifications	0	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0	0
Disposals other than by sale	0	(55)	0	0	0	0	(55)
Upward revaluation/positive indexation	0	0	0	0	0	0	0
Impairments/reversals charged to operating expenses	0	0	0	0	0	0	0
Impairments/reversals charged to reserves	0	0	0	0	0	0	0
Charged during the year	0	38	0	0	0	0	38
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption	0	0	0	0	0	0	0
At 31 March 2016	0	158	0	0	0	0	158
Net book value at 31 March 2016	0	54	0	0	0	0	54
Net book value at 31 March 2016 comprises:							
Purchased	0	54	0	0	0	0	54
Donated	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0
Finance Leased	0	0	0	0	0	0	0
On-balance Sheet PFIs	0	0	0	0	0	0	0
Total at 31 March 2016	**0**	**54**	**0**	**0**	**0**	**0**	**54**

17.3. Intangible non-current assets

	Min Life Years	**Max Life Years**
Economic Lives for Non Current Assets		
Intangible Assets		
Software Licences	5	5

18. Analysis of impairments and reversals recognised in 2016/17

The Trust has no impairments or reversals recognised in 2016/17.

19. Investment property

The Trust has no investment property.

20. Commitments

20.1. Capital commitments

The Trust has no capital commitments

20.2. Other financial commitments

The Trust has entered into non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements), for:

financial services;
decontamination services;
orthotic services;
network connectivity services;
software services;
dispensing services;
photocopying rental;
enteral feed supplies;
security services;
eDBS checking services;
grounds and gardens services; and
estates maintenance services.

The payments to which the Trust is committed are as follows:

	31 March 2017 £000s	31 March 2016 £000s
Not later than one year	**2,100**	948
Later than one year and not later than five year	**1,631**	1,660
Later than five years	**0**	0
Total	**3,731**	2,608

21. Inventories

The Trust has no inventories.

22.1. Trade and other receivables

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
NHS receivables - revenue	**1,156**	513	**0**	0
NHS receivables - capital	**0**	0	**0**	0
NHS prepayments and accrued income	**1,087**	217	**0**	0
Non-NHS receivables - revenue	**3,001**	3,580	**0**	0
Non-NHS receivables - capital	**0**	12	**0**	0
Non-NHS prepayments and accrued income	**821**	1,194	**0**	0
PDC Dividend prepaid to DH	**0**	19	**0**	0
Provision for the impairment of receivables	**(106)**	(70)	**0**	0
VAT	**220**	672	**0**	0
Current/non-current part of PFI & other PPP arrangements prepayments & accrued income	**0**	0	**0**	0
Interest receivables	**0**	0	**0**	0
Finance lease receivables	**0**	0	**0**	0
Operating lease receivables	**0**	0	**0**	0
Other receivables	**30**	12	**0**	0
Total	**6,209**	6,149	**0**	0
Total current and non current	**6,209**	6,149		
Included in NHS receivables are prepaid pension contributions:	**0**			

The great majority of trade is with Clinical Commissioning Groups, Local Authorities and NHS England as commissioners for NHS patient care services. As Clinical Commissioning Groups, Local Authorities and NHS England are funded by Government to buy NHS patient care no credit scoring of them is considered necessary.

22.2. Receivables past their due date but not impaired

	31 March 2017 £000s	31 March 2016 £000s
By up to three months	**2,639**	3,517
By three to six months	**2**	78
By more than six months	**299**	88
Total	**2,940**	3,683

22.3. Provision for impairment of receivables

	2016/17 £000s	2015/16 £000s
Balance at 1 April 2016	**(70)**	(54)
Amount written off during the year	**15**	0
Amount recovered during the year	**46**	32
(Increase)/decrease in receivables impaired	**(97)**	(48)
Transfers to NHS Foundation Trust on authorisation as FT	**0**	0
Transfers (to)/from other public sector bodies under absorption accounting	**0**	0
Balance at 31 March 2017	**(106)**	(70)

The Trust has made provision for impairment of non NHS receivables in excess of 90 days overdue.

23. NHS LIFT investments

The Trust has no LIFT investments.

24. Other Financial Assets

24.1. Other Financial Assets - Current

The Trust has no other financial assets - current.

24.2. Other Financial Assets - Non Current

The Trust has no other financial assets - non current.

25. Other current assets

The Trust has no other current assets.

26. Cash and Cash Equivalents

	31 March 2017 £000s	31 March 2016 £000s
Opening balance	**19,074**	16,513
Net change in year	**30**	2,561
Closing balance	**19,104**	19,074
Made up of:		
Cash with Government Banking Service	**19,100**	19,067
Commercial banks	**0**	0
Cash in hand	**4**	7
Liquid deposits with National Loans Fund	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**19,104**	19,074
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - commercial banks	**0**	0
Cash and cash equivalents as in statement of cash flows	**19,104**	19,074
Third party assets - bank balance (not included above)	**0**	0
Third party assets - monies on deposit	**0**	0

27. Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Financial Assets	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	165	0	0	0	0	0	0	0	0	0	**165**
Plus assets classified as held for sale in the year	0	0	0	0	44	0	0	0	0	0	**44**
Less assets sold in the year	0	0	0	0	(44)	0	0	0	0	0	**(44)**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	**0**
Transfers to Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from other public sector bodies under absorption accounting	0	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2017	**165**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**165**
Liabilities associated with assets held for sale at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Balance at 1 April 2015	0	0	0	0	0	0	0	0	0	0	0
Plus assets classified as held for sale in the year	380	100	0	0	0	0	0	0	0	0	480
Less assets sold in the year	0	0	0	0	0	0	0	0	0	0	0
Less impairment of assets held for sale	(215)	(100)	0	0	0	0	0	0	0	0	(315)
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	0
Transfers (to)/from other public sector bodies under absorption accounting	0	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2016	165	0	0	0	0	0	0	0	0	0	165
Liabilities associated with assets held for sale at 31 March 2016	0	0	0	0	0	0	0	0	0	0	0

Garforth Clinic was declared by the Trust Board as surplus to requirements during 2015/16 and was a non-current asset held for sale as at 31 March 2016 with a value of £165k. The clinic has not yet been sold and is still classified as held for sale as a sale is expected within the next 12 months. The District Valuer has provided an assessment of the open market value of the property as at 31 March 2017 of £175k to £200k. The Trust has used the lower valuation of £175k and estimated selling costs of £10k giving a net value, after costs to sell, of £165k.

Further non-current assets were sold during the year with a net book value of £44k. These were ultrasound equipment that was sold back to the supplier as part of a part-exchange arrangement to purchase new ultrasound equipment.

28. Trade and other payables

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
NHS payables - revenue	**274**	3,121	**0**	0
NHS payables - capital	**0**	0	**0**	0
NHS accruals and deferred income	**1,071**	911	**0**	0
Non-NHS payables - revenue	**1,492**	1,704	**0**	0
Non-NHS payables - capital	**538**	347	**0**	0
Non-NHS accruals and deferred income	**3,896**	4,518	**0**	0
Social security costs	**1,161**	1,035		
PDC dividend payable to DH	**12**	0		
Accrued interest on DH loans	**0**	0		
VAT	**0**	0	**0**	0
Tax	**739**	799		
Payments received on account	**0**	0	**0**	0
Other	**1,429**	1,466	**0**	0
Total	**10,612**	13,901	**0**	0
Total payables (current and non-current)	**10,612**	**13,901**		
Included above:				
To buy out the liability for early retirements over 5 years	**0**	0		
Number of cases involved (number)	**0**	0		
Outstanding pension contributions at the year end	**1,435**	1,446		

29. Other liabilities

The Trust has no other liabilities.

30. Borrowings

The Trust has no borrowings.

31. Other financial liabilities

The Trust has no other financial liabilities.

32. Deferred income

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Opening balance at 1 April 2016	**737**	420	**0**	0
Deferred revenue addition	**3,147**	2,958	**0**	0
Transfer of deferred revenue	**(3,029)**	(2,641)	**0**	0
Current deferred Income at 31 March 2017	**855**	737	**0**	0
Total deferred income (current and non-current)	**855**	737		

33. Finance lease obligations as lessee

The Trust has no finance lease obligations as lessee.

34. Finance lease receivables as lessor

The Trust has no finance lease receivables as lessor.

35. Provisions

		Comprising:						
	Total	**Early Departure Costs**	**Legal Claims**	**Restructuring**	**Continuing Care**	**Equal Pay (incl. Agenda for Change)**	**Other**	**Redundancy**
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Balance at 1 April 2016	**1,427**	0	164	0	0	0	577	686
Arising during the year	**957**	0	255	0	0	0	0	702
Utilised during the year	**(665)**	0	(40)	0	0	0	(369)	(256)
Reversed unused	**(321)**	0	(7)	0	0	0	0	(314)
Unwinding of discount	**0**	0	0	0	0	0	0	0
Change in discount rate	**0**	0	0	0	0	0	0	0
Transfers to NHS Foundation Trusts on being authorised as FT	**0**	0	0	0	0	0	0	0
Transfers (to)/from other public sector bodies under absorption accounting	**0**	0	0	0	0	0	0	0
Balance at 31 March 2017	**1,398**	**0**	**372**	**0**	**0**	**0**	**208**	**818**
Expected Timing of Cash Flows:								
No later than one year	**1,398**	0	372	0	0	0	208	818
Later than one year and not later than five years	**0**	0	0	0	0	0	0	0
Later than five years	**0**	0	0	0	0	0	0	0

Amount included in the provisions of the NHS Litigation Authority in respect of clinical negligence liabilities:

As at 31 March 2017	361
As at 31 March 2016	198

In respect of legal claims the uncertainty as to amounts and timings relates to the time taken to determine whether or not the Trust is liable and if so, what the value of that liability will be.

In respect of redundancy and other provisions the uncertainty as to amounts and timings relates to the time taken to complete HR processes.

36. Contingencies

The Trust has no contingencies.

37. Analysis of charitable fund reserves

The Trust has not consolidated the charitable funds and therefore has no charitable fund reserves.

38. PFI and LIFT - additional information

The Trust has no PFI and LIFT arrangements.

39. Impact of IFRS treatment - current year

There has been no impact of IFRS for the Trust in the current year.

40. Financial Instruments

40.1. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Trust Board. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust currently has no borrowings.

The Trust may borrow from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings would be for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
The majority of the Trust's revenue comes from contracts with other public sector bodies, therefore, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2017 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk
The majority of the Trust's operating costs are incurred under contracts with Clincial Commissioning Groups, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not therefore exposed to significant liquidity risks.

40.2. Financial Assets

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Embedded derivatives	0			**0**
Receivables - NHS		1,156		**1,156**
Receivables - non-NHS		3,001		**3,001**
Cash at bank and in hand		19,104		**19,104**
Other financial assets	0	0	0	**0**
Total at 31 March 2017	**0**	**23,261**	**0**	**23,261**
Embedded derivatives	0			0
Receivables - NHS		513		513
Receivables - non-NHS		3,592		3,592
Cash at bank and in hand		19,074		19,074
Other financial assets	0	0	0	0
Total at 31 March 2016	0	23,179	0	23,179

40.3. Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
Embedded derivatives	0		**0**
NHS payables		274	**274**
Non-NHS payables		2,030	**2,030**
Other borrowings		0	**0**
PFI & finance lease obligations		0	**0**
Other financial liabilities	0	0	**0**
Total at 31 March 2017	**0**	**2,304**	**2,304**
Embedded derivatives	0		0
NHS payables		3,121	3,121
Non-NHS payables		2,051	2,051
Other borrowings		0	0
PFI & finance lease obligations		0	0
Other financial liabilities	0	0	0
Total at 31 March 2016	0	5,172	5,172

The fair value of financial assets or financial liabilities for the Trust do not differ from carrying amounts.

41. Events after the end of the reporting period

During 2017/18 the Trust will cease to provide Healthy Living services following a recent tender by Leeds City Council. This will see a reduction in income for the Trust of £1.4m for the full year.

42. Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£
University of Leeds Jane Madeley (Non Executive Director) Chief Financial Officer , University of Leeds	79,693	35,301	0	21,799
CQC Dr Amanda Thomas (Medical Director) National professional advisor for Integrated Children's Service & Safeguarding	136,864	49,755	0	8,746
Royal College of Psychiatrists Dr Tony Dearden (Non Executive Director) Fellow	1,347	0	0	0
NHS Digital / Health and Social Care Information Centre Richard Gladman (Non Executive Director) Programme Director (from 30 August 2016)	4,192	0	0	0

The Department of Health is regarded as a related party. During the year 2016/17 the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent department as listed below:

Airedale, Wharfedale and Craven CCG
Barnsley CCG
Barnsley Hospital NHS Foundation Trust
Bradford City CCG
Bradford District Care NHS Foundation Trust
Bradford Districts CCG
Bradford Teaching Hospitals NHS Foundation Trust
Calderdale CCG
Care Quality Commission
Central London Community Healthcare NHS Trust
Central Manchester University Hospitals NHS Foundation Trust
Cumbria CCG
East Riding of Yorkshire CCG
Greater Huddersfield CCG
Harrogate and District NHS Foundation Trust
Harrogate and Rural District CCG
Health Education England
Hull and East Yorkshire Hospitals NHS Trust
Leeds and York Partnerships NHS Foundation Trust
Leeds North CCG
Leeds South and East CCG
Leeds Teaching Hospitals NHS Trust
Leeds West CCG
Lincolnshire East CCG
Liverpool Women's NHS Foundation Trust
Luton CCG
Mid Yorkshire Hospitals NHS Trust
NHS Business Services Authority
NHS England
NHS Litigation Authority
North Kirklees CCG
North Norfolk CCG
Northumbria Healthcare NHS Foundation Trust
Rotherham Doncaster and South Humber NHS Foundation Trust
Royal Free London NHS Foundation Trust
Sandwell and West Birmingham CCG
Scarborough and Ryedale CCG
Sheffield CCG
Sheffield Teaching Hospitals NHS Foundation Trust
South Devon and Torbay CCG
South Tyneside CCG
South West Yorkshire Partnership NHS Foundation Trust
Tavistock and Portman NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
University Hospital of South Manchester NHS Foundation Trust
University Hospitals of Leicester NHS Trust
Vale of York CCG
Wakefield CCG
Waltham Forest CCG
Yorkshire & Humber CSU
Yorkshire Ambulance Service NHS Trust

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies as listed below:

Leeds City Council
North Yorkshire County Council
Valuation Office Agency
Ministry of Justice
Community Health Partnerships
NHS Property Services
National Health Service Pension Scheme
Humberside Police and Crime Commissioner and Chief Constable
North Yorkshire Police and Crime Commissioner and Chief Constable
South Yorkshire Police and Crime Commissioner and Chief Constable
West Yorkshire Police and Crime Commissioner and Chief Constable
Network Rail
Department of Work and Pensions
HM Revenue and Customs

The Trust has received receipts from Leeds Community Healthcare Charitable Trust and Related Charities for which the Trust Board is Corporate Trustee. These are solely to reimburse the Trust for purchases made for the Charitable Trust as an agent.

43. Losses and special payments

The total number of losses cases in 2016/17 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	33,334	44
Special payments	51,250	18
Gifts	0	0
Total losses and special payments and gifts	84,584	62

The total number of losses cases in 2015/16 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	446	3
Special payments	17,028	16
Total losses and special payments	17,474	19

Details of cases individually over £300,000

There are no cases over £300,000

44. Financial performance targets

The Trust was established 1 April 2011.

44.1. Breakeven performance

	2006/07 £000s	2007/08 £000s	2008/09 £000s	2009/10 £000s	2010/11 £000s	2011/12 £000s	2012/13 £000s	2013/14 £000s	2014/15 £000s	2015/16 £000s	2016/17 £000s
Turnover	0	0	0	0	0	134,978	139,906	142,863	146,668	156,367	148,654
Retained surplus/(deficit) for the year	0	0	0	0	0	1,684	1,334	1,421	2,283	2,666	3,346
Adjustment for:											
Timing/non-cash impacting distortions:											
Pre FDL(97)24 agreements	0	0	0	0	0	0	0	0	0	0	0
Prior Period Adjustments	0	0	0	0	0	0	0	0	0	0	0
Adjustments for impairments	0	0	0	0	0	893	638	0	(279)	315	0
Adjustments for impact of policy change re donated/government grants assets						0	(163)	4	3	4	4
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*				0	0	0	0	0	0	0	0
Absorption accounting adjustment							0	0	0	0	0
Other agreed adjustments	0	0	0	0	0	0	0	0	0	0	0
Break-even in-year position	**0**	**0**	**0**	**0**	**0**	**2,577**	**1,809**	**1,425**	**2,007**	**2,985**	**3,350**
Break-even cumulative position	**0**	**0**	**0**	**0**	**0**	**2,577**	**4,386**	**5,811**	**7,818**	**10,803**	**14,153**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009/10, the Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2006/07 %	2007/08 %	2008/09 %	2009/10 %	2010/11 %	2011/12 %	2012/13 %	2013/14 %	2014/15 %	2015/16 %	2016/17 %
Materiality test (I.e. is it equal to or less than 0.5%):											
Break-even in-year position as a percentage of turnover	0.00	0.00	0.00	0.00	0.00	1.91	1.29	1.00	1.37	1.91	2.25
Break-even cumulative position as a percentage of turnover	0.00	0.00	0.00	0.00	0.00	1.91	3.13	4.07	5.33	6.91	9.52

Any figures in the above tables for periods prior to 2009/10 have **not** been restated to IFRS and remain on a UK GAAP basis as that was the basis on which the targets were set for those years.

44.2. Capital cost absorption rate

The dividend payable on Public Dividend Capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

44.3. External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2016/17 £000s	2015/16 £000s
External financing limit (EFL)	1,336	377
Cash flow financing	(30)	(3,346)
Finance leases taken out in the year	0	0
Other capital receipts	0	0
External financing requirement	**(30)**	(3,346)
Under/(over) spend against EFL	**1,366**	3,723

44.4. Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2016/17 £000s	2015/16 £000s
Gross capital expenditure	1,575	1,610
Less: book value of assets disposed of	(72)	(36)
Less: capital grants	0	0
Less: donations towards the acquisition of non-current assets	0	0
Charge against the capital resource limit	**1,503**	1,574
Capital resource limit (CRL)	2,581	1,615
Under/(over) spend against the capital resource limit	**1,078**	41

45. Third party assets

The Trust has no third party assets.

Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2017-18 (7c)

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Clare Partridge
Partner
KPMG LLP
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31 May 2017

Dear Clare

This representation letter is provided in connection with your audit of the Trust financial statements of Leeds Community Healthcare NHS Trust ("the Trust"), for the year ended 31 March 2017, for the purpose of expressing an opinion:

- as to whether these financial statements give a true and fair view of the state of the financial position of the Trust as at 31 March 2017 and of the Trust's income and expenditure for the financial year then ended; and
- whether the Trust's financial statements have been prepared in accordance with the Department of Health Group Accounting Manual (GAM).

These financial statements comprise the Trust Statement of Financial Position, the Statement of Comprehensive Income, the Statement of Cash Flows, the Statement of Changes in Taxpayers Equity and notes, comprising a summary of significant accounting policies and other explanatory notes.

The Board confirms that the representations it makes in this letter are in accordance with the definitions set out in the Appendix to this letter.

The Board confirms that, to the best of its knowledge and belief, having made such inquiries as it considered necessary for the purpose of appropriately informing itself:

Financial statements

1. The Board has fulfilled its responsibilities for the preparation of financial statements that:

   i. give a true and fair view of the financial position of the Trust as at 31 March 2017 and of the Trust's income and expenditure for that financial year; and

   ii. have been prepared in accordance with the GAM 2016/17.

   The financial statements have been prepared on a going concern basis.

2. Measurement methods and significant assumptions used by the Board in making accounting estimates, including those measured at fair value, are reasonable.

3. All events subsequent to the date of the financial statements and for which IAS 10 Events after the reporting period requires adjustment or disclosure have been adjusted or disclosed.

4. The effects of uncorrected misstatements are immaterial, both individually and in aggregate, to the financial statements as a whole. There are no uncorrected adjustments above £110k following audit of the 2016/17 financial statements.

Information provided

5, The Board has provided you with:

- access to all information of which it is aware, that is relevant to the preparation of the financial statements, such as records, documentation and other matters;
- additional information that you have requested from the Board for the purpose of the audit; and
- unrestricted access to persons within the Trust from whom you determined it necessary to obtain audit evidence.

6. All transactions have been recorded in the accounting records and are reflected in the financial statements.

7. The Board confirms the following:

   i. The Board has disclosed to you the results of its assessment of the risk that the financial statements may be materially misstated as a result of fraud.

      Included in the Appendix to this letter are the definitions of fraud, including misstatement arising from fraudulent financial reporting and from misappropriation of assets.

   ii. The Board has disclosed to you all information in relation to:

      a) Fraud or suspected fraud that it is aware of and that affects the Trust and involves:

         - management;
         - employees who have significant roles in internal control; or
         - others where the fraud could have a material effect on the financial statements; and

      b) allegations of fraud, or suspected fraud, affecting the Trust's financial statements communicated by employees, former employees, analysts, regulators or others.

      In respect of the above, the Board acknowledges its responsibility for such internal control as it determines necessary for the preparation of financial statements that are free from material misstatement, whether due to fraud or error. In particular, the Board acknowledges its responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

8. The Board has disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.

9. The Board has disclosed to you and has appropriately accounted for and/or disclosed in the financial statements, in accordance with IAS 37 Provisions, Contingent Liabilities and Contingent Assets, all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

10. The Board has disclosed to you the identity of the Trust's related parties and all the related party relationships and transactions of which it is aware. All related party relationships and transactions have been appropriately accounted for and disclosed in accordance with IAS 24 Related Party Disclosures. Included in the Appendix to this letter are the definitions of both a related party and a related party transaction as we understand them and as defined in IAS 24.

11. The Board confirms that all intra-NHS balances included in the Statement of Financial Position (SOFP) at 31 March 2017 in excess of £100,000 have been disclosed to you and that the Trust has complied with the requirements of the Intra NHS Agreement of Balances Exercise. The Board confirms that Intra-NHS balances includes all balances with NHS counterparties, regardless of whether these balances are reported within those SOFP classifications formally deemed to be included within the Agreement of Balances exercise.

12. The Board confirms that:

    a) The financial statements disclose all of the key risk factors, assumptions made and uncertainties surrounding the Trust's ability to continue as a going concern as required to provide a true and fair view.

    b) Any uncertainties disclosed are not considered to be material and therefore do not cast significant doubt on the ability of the Trust to continue as a going concern.

This letter was tabled and agreed at the meeting of the Board of Directors on 31 May 2017.

Yours sincerely

Thea Stein

Chief Executive, for and on behalf of the Board of Leeds Community Healthcare NHS Trust

Neil Franklin OBE

Chair

Appendix to the Board Representation Letter: Definitions

Financial Statements

IAS 1.10 states that a complete set of financial statements comprises:

- a statement of financial position as at the end of the period;
- a statement of comprehensive income for the period;
- a statement of changes in equity for the period;
- a statement of cash flows for the period;
- notes, comprising a summary of significant accounting policies and other explanatory information;
- comparative information in respect of the previous period; and
- a statement of financial position as at the beginning of the earliest comparative period when an entity applies an accounting policy retrospectively or makes a retrospective restatement of items in its financial statements, or when it reclassifies items in its financial statements.

Material Matters

Certain representations in this letter are described as being limited to matters that are material.

IAS 1.7 and IAS 8.5 state that:

"Material omissions or misstatements of items are material if they could, individually or collectively, influence the economic decisions that users make on the basis of the financial statements. Materiality depends on the size and nature of the omission or misstatement judged in the surrounding circumstances. The size or nature of the item, or a combination of both, could be the determining factor."

Fraud

Fraudulent financial reporting involves intentional misstatements including omissions of amounts or disclosures in financial statements to deceive financial statement users.

Misappropriation of assets involves the theft of an entity's assets. It is often accompanied by false or misleading records or documents in order to conceal the fact that the assets are missing or have been pledged without proper authorisation.

Error

An error is an unintentional misstatement in financial statements, including the omission of an amount or a disclosure.

Prior period errors are omissions from, and misstatements in, the entity's financial statements for one or more prior periods arising from a failure to use, or misuse of, reliable information that:

a) was available when financial statements for those periods were authorised for issue; and

b) could reasonably be expected to have been obtained and taken into account in the preparation and presentation of those financial statements.

Such errors include the effects of mathematical mistakes, mistakes in applying accounting policies, oversights or misinterpretations of facts, and fraud.

Management

For the purposes of this letter, references to "management" should be read as "management and, where appropriate, those charged with governance".

Related parties

A related party is a person or entity that is related to the entity that is preparing its financial statements (referred to in IAS 24 *Related Party Disclosures* as the “reporting entity”).

a) A person or a close member of that person’s family is related to a reporting entity if that person:

   i. has control or joint control over the reporting entity;

   ii. has significant influence over the reporting entity; or

   iii. is a member of the key management personnel of the reporting entity or of a parent of the reporting entity.

b) An entity is related to a reporting entity if any of the following conditions applies:

   i. The entity and the reporting entity are members of the same group (which means that each parent, subsidiary and fellow subsidiary is related to the others).

   ii. One entity is an associate or joint venture of the other entity (or an associate or joint venture of a member of a group of which the other entity is a member).

   iii. Both entities are joint ventures of the same third party.

   iv. One entity is a joint venture of a third entity and the other entity is an associate of the third entity.

   v. The entity is a post-employment benefit plan for the benefit of employees of either the reporting entity or an entity related to the reporting entity. If the reporting entity is itself such a plan, the sponsoring employers are also related to the reporting entity.

   vi. The entity is controlled, or jointly controlled by a person identified in (a).

   vii. A person identified in (a) (i) has significant influence over the entity or is a member of the key management personnel of the entity (or of a parent of the entity).

Related party transaction

This is a transfer of resources, services or obligations between a reporting entity and a related party, regardless of whether a price is charged.

KPMG

External Audit Report DRAFT

Leeds Community Healthcare NHS Trust

—

26 May 2017

I confirm that this is the final version of our ISA 260 Audit Memorandum relating to our audit of the 2016/17 financial statements for Leeds Community Healthcare NHS Trust. This document was discussed and approved by the Trust's Audit Committee on 26 May 2017.

.....
Clare Partridge

Partner for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
Leeds

31 May 2017

Our audit opinions and conclusions:	
Financial Statements: unqualified	Use of resource: clean

Content

The contacts at KPMG in connection with this report are:

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We are committed to providing you with a high quality service. If you have any concerns or are dissatisfied with any part of KPMG's work, in the first instance you should contact Clare Partridge the engagement lead to the CCG, who will try to resolve your complaint. If you are dissatisfied with your response please contact the national lead partner for all of KPMG's work under our contract with Public Sector Audit Appointments Limited, Andrew Sayers (on 0207 6948981, or by email to andrew.sayers@kpmg.co.uk). After this, if you are still dissatisfied with how your complaint has been handled you can access PSAA's complaints procedure by emailing generalenquiries@psaa.co.uk, by telephoning 020 7072 7445 or by writing to Public Sector Audit Appointments Limited, 3rd Floor, Local Government House, Smith Square, London, SW1P 3HZ.

Important Notice

This report is presented under the terms of our PSAA engagement. This report is addressed to Leeds Community Healthcare NHS Trust (the Trust) and has been prepared for your use only. Circulation of this report is restricted. The content of this report is based solely on the procedures necessary for our audit. We accept no responsibility towards any member of staff acting on their own, or to any third parties. The National Audit Office (NAO) has issued a document entitled Code of Audit Practice (the Code). This summarises where the responsibilities of auditors begin and end and what is expected from the Trust. External auditors do not act as a substitute for the Trust's own responsibility for putting in place proper arrangements to ensure that public business is conducted in accordance with the law and proper standards, and that public money is safeguarded and properly accounted for, and used economically, efficiently and effectively.

Basis of preparation: We have prepared this External Audit Report (Report) in accordance with our appointment by Public Sector Audit Appointments Ltd.

Purpose of this report: This Report is made to the Trust's Audit Committee in order to communicate matters as required by International Audit Standards (ISAs) (UK and Ireland), and other matters coming to our attention during our audit work that we consider might be of interest, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone (beyond that which we may have as auditors) for this Report, or for the opinions we have formed in respect of this Report. This Report is subject to disclosure restrictions.

Limitations on work performed: This Report is separate from our audit opinion included in the Trust's Annual Reports and Accounts and does not provide an additional opinion on the Trust's financial statements, nor does it add to or extend or alter our duties and responsibilities as auditors reporting. We have not designed or performed procedures outside those required of us as auditors for the purpose of identifying or communicating any of the matters covered by this Report. The matters reported are based on the knowledge gained as a result of being your auditors. We have not verified the accuracy or completeness of any such information other than in connection with and to the extent required for the purposes of our audit.

Status of our audit: Our audit is not yet complete and matters communicated in this Report may change pending signature of our audit report. We will provide an oral update on the status of our audit at the Audit Committee meeting but would highlight the following work is still outstanding:

- *Checking the final version of the accounts and consistency with the consolidation schedules*
- *Completion of final audit review and closure procedures*
- *Receipt of a signed letter of representation*

KPMG

Summary

Section One

Summary

Value for money	Quality Accounts
We are required to report to you if we are not satisfied that that the Trust has made proper arrangements to secure economy, efficiency and effectiveness in its use of resources. Based on the findings of our work, we have nothing to report.	The Trust's Quality Accounts do not require an external audit review.

Financial Statements Audit	Other Matters
We intend to issue an unqualified audit opinion on the accounts following the Board adopting them and receipt of the management representations letter. We have completed our audit of the financial statements. We have also read the content of the Annual Report (including the Remuneration Report) and reviewed the Annual Governance Statement (AGS). Our key findings are: • There are no unadjusted audit differences, explained in section 2 and appendix 2. • We have agreed presentational changes to the accounts with Finance, mainly related to compliance with the Department of Health Group Manual for Accounts (GAM) 2016/17. • In additional to our routine requests we are not asking for any specific management representations. • We have reviewed the annual report and have no matter to raise with you.	We intend to issue an unqualified Group Audit Assurance Certificate to the NAO regarding the Whole of Government Accounts submission, made through the submission of the summarisation schedules to Department of Health. We are satisfied that the Trust has addressed the recommendation raised in our 2015/16 report. We have made two recommendations as a result of our 2016/17 work. The recommendations are shown in appendix 1. In auditing the accounts of an NHS body auditors must consider whether, in the public interest, they should make a report on any matters coming to their notice in the course of the audit, in order for it to be considered by Trust members or bought to the attention of the public; and whether the public interest requires any such matter to be made the subject of an immediate report rather than at completion of the audit. There are no matters that we wish to report. We are required to certify that we have completed the audit of the Trust financial statements in accordance with the requirements of the Code. If there are any circumstances under which we cannot issue a certificate, then we must report this to those charged with governance. There are no issues that would cause us to delay the issue of our certificate of completion of the audit.

KPMG

Financial Statements Audit

Section Two

Financial Statements Audit

We audit your financial statements by undertaking the following tasks:

Work Performed	Accounts production stage		
	Before	During	After
1. Business Understanding: review your operations	✓	✓	–
2. Controls: assess the control framework	✓	–	–
3. Prepared by Client Request (PBC): issue our prepared by client request	✓	–	–
4. Accounting standards: agree the impact of any new accounting standards	✓	✓	–
5. Accounts Production: review the accounts production process	✓	✓	✓
6. Testing: test and confirm material or significant balances and disclosures	–	✓	✓
7. Representations and opinions: seek and provide representations before issuing our opinions	✓	✓	✓

We have completed the first six stages shown above and report our key findings below:

1. Business Understanding	In our 2016/17 audit plan we assessed your operations to identify significant issues that might have a financial statements consequence. We confirmed this risk assessment as part of our audit work. We have provided an update on each of the risks identified later in this section.
2. Assessment of the control environment	We have assessed the effectiveness of your key financial system controls that prevent and detect material fraud and error. We found that the financial controls on which we seek to place reliance are operating effectively. We have made no recommendations. We have reviewed the work undertaken by TIAA, your internal auditors, in accordance with ISA610 and used the findings to inform and planning and audit approach. We have chosen not to place reliance on their work due to the approach we adopted for the financial statements audit.
3. Prepared by client request	We produced this document to summarise the working papers and evidence we ask you to collate as part of the preparation of the financial statements. We discussed and tailored our request with Senior Financial Accountant and this was issued as a final document to the finance team. The team produce good quality working papers. For the first time we set up a sharepoint site to store documents this was very effective.
4. Accounting standards	We work with you to understand the changes to accounting standard and other technical issues. For 2016/17 these changes have related to updates to the content of the annual report and removing the separation of some Directors benefits disclosures . These changes had limited impact on the Trust.

Section Two

Financial Statements Audit

5. Accounts Production	We received complete draft accounts by 26 April 2017 in accordance with the Department of Health's deadline. The accounting policies, accounting estimates and financial statement disclosures are in line with the requirements of the Department of Health. As in previous years, we will debrief with the Finance team to share views on the final accounts audit. Hopefully this will lead to further efficiencies in the 2016/17 audit process. In particular we would like to commend Trust finance staff who were available throughout the audit visit to answer our queries. We thank the finance team for their co-operation throughout the visit which allowed the audit to progress and complete within the allocated timeframe.
6. Testing	We have summarised the findings from our testing of significant risks and areas of judgement within the financial statements on the following pages. During the audit we identified only presentational issues which have been adjusted as they have no material effect on the financial statements. We have identified presentation changes to the accounts along with audit adjustments to PPE and Creditors which we have presented in appendix 2.
7. Represent-ations	You are required to provide us with representations on specific matters such as your going concern assertion and whether the transactions in the accounts are legal and unaffected by fraud. We provided a draft of this representation letter to the Executive Director of Finance and Resources on 19 May 2017. We draw your attention to the requirement in our representation letter for you to confirm to us that you have disclosed all relevant related parties to us. We are not asking management to provide any specific representations.

We are required under ISA 260 to communicate to you any matters specifically required by other auditing standards to be communicated to those charged with governance; and any other audit matters of governance interest. We have not identified any other matters to specifically report.

Financial Statements Audit

Results of our testing on areas of high audit risk

In our External Audit Plan 2016/17, presented to you in February 2017, we identified the areas assessed as significant risks in terms of their impact on our financial statements audit opinion. We have now completed our testing of these areas and over the next pages set out:

- The results of the procedures we performed over valuation of property, plant and equipment which were identified as significant risks within our audit plan;
- The results of our procedures to review the required risks of the fraudulent risk of revenue recognition and management override of control; and
- Our view of the level of prudence you have applied to key balances within your financial statements.

SIGNIFICANT audit risk	Account balances effected	Summary of findings
Property, plant and equipment	Property Plant and Equipment. £27.1m, PY £27.3M	The Trust had a full revaluation of its land and buildings in 2014/15. The Trust, in discussion with the District Valuer, has decided not to revalue in 2016/17. A paper was presented to the Audit Committee explaining this in February 2017. Based on the information supplied by the District Valuer if a revaluation had been undertaken in year this would have resulted in a £718k potential adjustment (increase) to the value of the Trust's buildings. The outcome of this high level review is not material and supports the Trust's decision not to revalue. It has not been identified as an audit difference. In response, our audit procedures in this area included: • **External Valuer:** We critically assessed the competence, capability, objectivity and independence of the Trust's external valuer and considering the terms of engagement of, and the instructions issued to, the valuer for consistency with the requirements of the Department of Health's Group Accounting Manual 2016/17; • **Valuation basis:** Reviewed the Trust's assumptions on the current valuation of property plant and equipment and figures used for inclusion in the financial statements. Assessed the impact of the Trust not performing a revaluation basing on the BCIS provided by the District Valuer. • Assessed the value of depreciation charged to the 2016/17 accounts. • **Additions testing:** We sample tested in-year capital expenditure to confirm that additions were appropriately recognised and classified within the financial statements. This included agreement to purchase records. Other than recommending that the Trust carry out a desktop review of assets values in 2017/18, there are no matters arising from this work that we need to bring to your attention.

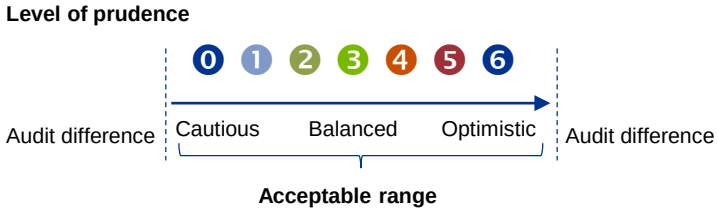
Financial Statements Audit

Risks that ISAs require us to assess in all cases	Why	Our findings from the audit
Fraud risk from revenue recognition	Professional standards require us to make a rebuttable presumption that the fraud risk from revenue recognition is a significant risk. We recognise that the incentives in the NHS differ significantly to those in the private sector which have driven the requirement to make a rebuttable presumption that this is a significant risk. These incentives in the NHS include the regulatory pressure to meet agreed control totals as well as the incentive to report the delivery of specific targets..	For NHS Trusts, we do not consider the fraud risk from revenue recognition to be a significant audit opinion risk. The Trust receives all income from other NHS bodies and non NHS bodies through contracts which are tested during our audit. We have undertaken a range of routine audit procedures to enable us to identify if there are any potential issues around income recognition. This work has included inspecting confirmations of balances provided by the Department of Health as part of the Agreement of Balances exercise. There were no issues that came to our attention during our work that would suggest fraudulent recognition of revenue. There are no matters arising from this work that we need to bring to your attention.
Fraud risk from management override of controls	Professional standards require us to communicate the fraud risk from management override of controls as significant because management is typically in a unique position to perpetrate fraud because of its ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively. We have not identified any specific additional risks of management override relating to this audit.	Our procedures, including testing of journal entries, accounting estimates and significant transaction outside the normal course of business, did not identify any instances of fraud. There are no matters arising from this work that we need to bring to your attention. We performed a specific procedures to review the year end cut off processes to ensure that revenue and expenditure items have been reflected within the correct period.

Financial Statements Audit

Judgements in your financial statements

We always consider the level of prudence within key judgements in your financial statements. We have summarised our view below using the following range of judgement:



Assessment of subjective areas				
Asset/liability class	Current year	Prior year	Balance (£m)	KPMG comment
Provisions	3	3	£1.4m(PY: £1.4m)	We have reviewed the basis on which the Trust has made this provision which is primarily associated with staff redundancies and consider the disclosures to be proportionate.
Accruals	3	3	£4.6m(PY: £4.5m)	We have reviewed this balance through our audit testing and conclude it is accurately stated based on appropriate supporting documentation.
Deferred income	3	3	£855k(PY: £737k)	The balance is related to a number of contracts with the local authority and non NHS bodies. We have seen support for these items and consider the disclosure to be proportionate.

Section Two

Financial Statements Audit

Annual report

We have read the contents of the Annual Report (including the Accountability Report, Performance Report and AGS) and audited the relevant parts of the Remuneration Report. Based on the work performed:

- We have not identified any inconsistencies between the contents of the Accountability, Performance and Director's Reports and the financial statements.
- We have not identified any material inconsistencies between the knowledge acquired during our audit and the director's statements. As Directors you confirm that you consider the that the annual report and accounts taken as a whole are fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.
- The part of the Remuneration Report that is required to be audited were all found to be materially accurate;
- The AGS is consistent with the financial statements and complies with relevant guidance subject to updates as outlined within section three; and

Independence and Objectivity

ISA 260 also requires us to make an annual declaration that we are in a position of sufficient independence and objectivity to act as your auditors, which we completed at planning and no further work or matters have arisen since then.

Audit Fees

Our fee for the audit was £43,425 plus VAT (£43,425 in 2015/16). This fee was in line with that highlighted within our audit plan agreed by the Audit Committee in February 2017. We have also completed non audit work at the Trust during the year on tax implications on off payroll payments and have included in appendix 3 confirmation of safeguards that have been put in place to preserve our independence. This additional work was within additional fee envelope permissible under the PSAA engagement.

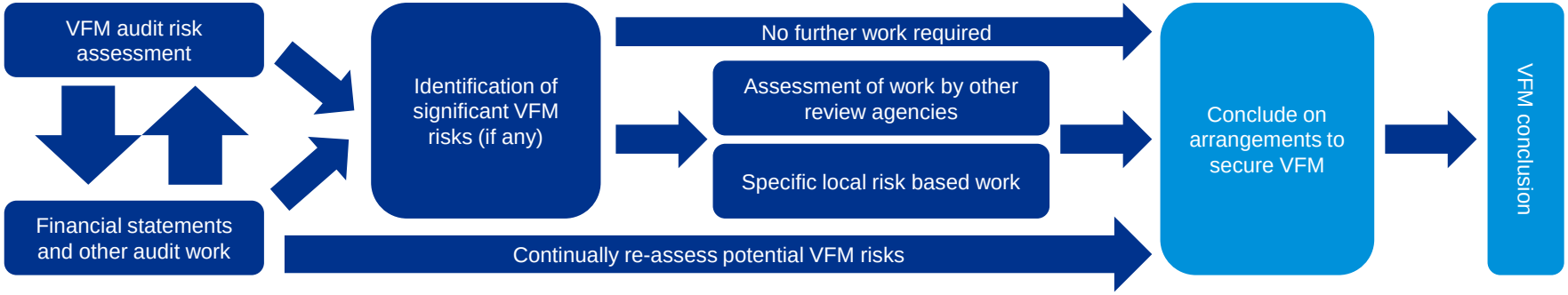
KPMG

Value for Money

Section Three

Value for Money

For 2016/17 our value for money (VFM) work follows the NAO's guidance. It is risk based and targets audit effort on the areas of greatest audit risk. Our methodology is summarised below. We identified one significant VFM risk which is reported overleaf and provide a summary below of the routine work required to issue our VFM conclusion, which is that we are satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2017, based upon the criteria of informed decision making, sustainable resource deployment and working with partners and third parties.



AGS review	Regulatory review	Other matters considered in risk assessment
We reviewed the 2016/17 AGS and took into consideration the work of internal audit. We confirm that the AGS reflects our understanding of the Trust's operations and risk management arrangements.	We considered the outcomes of relevant regulatory reviews (NHS Improvement, CQC, etc.) in reaching our conclusion. The Trust is waiting for the results of a recent CQC inspection which is expected in June 2017. The Trust's current CQC rating is 'requires improvement'. NHS Improvement have improved the Trust rating from 3 to 2 with 1 meaning no concerns.	As part of our risk assessment we reviewed various matters, including: • forecast run rate position. • core assumptions in the 2016/17 Annual Plan. • recurrent cost improvement schemes are identified and delivered • current operational performance and commissioner relationships / contractual risks. • planned VS actual outturn. • Management's assessment of the Trust's ability to continue as a going concern. • partnership arrangements / relationships with key third parties.

Section Three

Value for Money

Significant risk based VFM audit work

The table below sets out the detailed findings of our significant risk based VFM work. This work was completed to address the residual risks remaining after our assessment of the higher level controls in place to address the VFM risks identified in our planning and financial statements audit work.

Value for money risk	Why this risk is significant	Our audit response and findings
Financial standing, including CIPs and contractual performance	NHS Trusts and Foundation Trusts submitted financial plans for 2016/17 that in aggregate totalled a £580 million deficit. The achievement of financial balance, whilst maintaining the quality of healthcare provision, is therefore a key objective for all organisations. ■ The Trust set an initial annual forecast for 2016/17 of a £1.5m surplus, which has been increased to £2.8m during the year to date. The Trust is forecasting that this level of surplus will be achieved. ■ At the beginning of 2016/17 the Trust was overspending against the budget for the year but has developed a recovery plan to bring spending back in line by careful management. The focus was on the main area of spend – staffing, and more specifically agency staffing costs ■ The Trust's ability to reach this target was dependent upon its ability to achieve the Cost Improvement Programme (CIP) savings plans and identify further in year savings. CIP totals £3.9m for the year with only £0.4m being achieved by December 2016. ■ As such, the Trust faced a challenge to meet its forecast position. Key to this was the ability to make substantial savings whilst maintaining high standards of quality and performance delivery.	The Trust achieved financial duties in 2016/17 delivering a surplus of £3.35m which included £490k of additional STF income at the year end. The Trust identified financial challenges at the start of the year but put in place strong controls to reduce spending and declare a surplus at the end of the financial year Cost savings were achieved by additional control on use of agency staff and control on overtime and staff recruitment. There were also controls on other goods and services. The Trust also delivered savings target for the year although £1.5m were non recurrent which will increase the savings target for 2017/18. We have confirmed with Management that contracts with commissioners have been agreed for 2017/18 and we have considered Management's assessment of the Trust's ability to continue as a going concern and we are content that it is appropriate. We considered whether any significant one-off items were included within the reported headline result for 2016/17 (including STF funding) and we have no matters of concerns to bring to your attention. Based on the findings of our work, whilst we recognise the significant challenges going forward, we have concluded that the Trust has adequate arrangements to secure economy, efficiency and effectiveness in its use of resources.

KPMG

Appendices

Appendix 1

Recommendations raised and followed up

The recommendations raised as a result of our work in the current year are as follows:

Priority rating for recommendations					
1	Priority one: issues that are fundamental and material to your system of internal control. We believe that these issues might mean that you do not meet a system objective or reduce (mitigate) a risk.	2	Priority two: issues that have an important effect on internal controls but do not need immediate action. You may still meet a system objective in full or in part or reduce (mitigate) a risk adequately but the weakness remains in the system.	3	Priority three: issues that would, if corrected, improve the internal control in general but are not vital to the overall system. These are generally issues of best practice that we feel would benefit you if you introduced them.

#	Risk	Issue, Impact and Recommendation	Management Response / Officer / Due Date
Financial Statements			
1	3	**Timely review of bank reconciliations** During our interim audit at the end of 24 February 2017, there was no evidence of review of the January 2017 bank reconciliation. Bank reconciliations should be reviewed by the fifth working day of the month end. **Recommendation** Bank reconciliations should be reviewed promptly.	Agreed. The Assistant Financial Accountant will review the bank reconciliation completed by SBS by working day 5 of the following month. The Senior Financial Accountant will review the work during the month along with other control account reconciliations. Officer: Deputy Director of Finance; Date: 31 May 2017
Financial Statements			
2	3	**Fixed asset revaluation** It was noted that the Trust's calculation of changes in asset values for 2016/17 based on guidance obtained from the District Valuer was 9.7% which was below the threshold of 10% set by the Trust to trigger a full review. **Recommendation** The Trust should be mindful of the results of this calculation in future years and be prepared for a full desk top revaluation exercise if there is a significant change in property values	Agreed. As part of the Trust's usual annual accounts preparation, the statement of financial position carrying value of the non-current assets is considered and advice is sought from the District Valuer as to whether these values remain consistent with current market values. To prevent year on year variation when markets are volatile the Trust has set a 10% threshold on movement to trigger a revaluation exercise. Given the movement for 2016/17 was estimated at 9.7% it is likely a revaluation will be required for the 2017/18 accounts. This work will be undertaken in Q3 2017/18 and the results/action will be reported to Audit Committee in line with current procedures. Officer: Deputy Director of Finance; Date 31 Dec 2017

Appendix 1

Recommendations raised and followed up

We have also follow up the recommendations from the previous years audit, in summary:

Total number of recommendations	Number of recommendations implemented	Number outstanding (repeated below):
1	1	0

#	Risk	Issue, Impact and Recommendation	Management Response / Officer / Due Date	Current Status (May 2017)
Financial Statements				
1	2	**Authorisation of Journals** In our testing of journals we found 4 journals which had been authorised by the person who prepared the journal. This is not in accordance with the Trust's procedures. From our testing we found no other examples. Staff should be reminded of the Trust's procedure to ensure this check on processing is maintained.	This has been raised with staff verbally already and the finance team will also be emailed to remind them of the correct procedure in respect of journal authorisation. Access rights will be reviewed in an attempt to restrict the possibility of this happening in future. Interim Deputy Director of Finance, 30/06/16	The Trust has actioned this recommendation, No issues were identified in our testing in 2016/17.

Appendix 2

Audit Differences

Unadjusted audit differences

We are required by ISA (UK and Ireland) 260 to communicate to the Audit Committee all unadjusted audit differences (including disclosure misstatements) identified during the course of our audit, other than those that we believe are clearly trivial. As part of our planning process we agreed a definition of trivial with you which reflected balances below £110k. In line with ISA (UK&I) 450 we request that you correct uncorrected misstatements. We are also required to report all adjusted audit differences that management has corrected but that we believe should be communicated to the Audit Committee assist it in fulfilling its governance responsibilities.

There are no unadjusted audit differences following the completion of our audit of the Trust for the year ended 31 March 2017.

Adjusted audit differences

Under UK auditing standards (ISA UK&I 260) we are required to provide the Audit Committee with a summary of adjusted audit differences (including disclosures) identified during the course of our audit. The adjustments below have been included in the revised financial statements. The Deputy Director of Finance and Resources has prepared a detailed paper for the Audit Committee meeting. The adjustments are:

Errors in the Remuneration Report

There are three minor errors in the Remuneration Report; correction to bandings and roundings

Receivables and accruals

Both receivable and accruals balances are overstated by £519k due to error in the treatment of a disputed invoice with Leeds City Council. We have confirmed that the Trust's income is correct.

Other matters

- Additional values added to the Related Part Disclosure Note (Note 42) in respect of NHS Digital and Royal College of Psychiatrists
- Minor amendments in disclosures

Appendix 2

Audit Differences

We are required to report any inconsistencies greater than £250,000 between the signed audited accounts and the consolidation data and details of any unadjusted errors or uncertainties in the data provided for intra-group and intra-government balances and transactions regardless of whether a Trust is a sampled or non-sampled component. We have provided details of the inconsistencies that we are reporting to the NAO as follows:

There are no inconsistencies greater than £250,000 that need to be reported

Appendix 3

Audit Independence

The purpose of this Appendix is to communicate all significant facts and matters that bear on KPMG LLP's independence and objectivity and to inform you of the requirements of *ISA 260 (UK and Ireland) Communication of Audit Matters to Those Charged with Governance.*

Integrity, objectivity and independence

We are required to communicate to you in writing at least annually all significant facts and matters, including those related to the provision of non-audit services and the safeguards put in place that, in our professional judgement, may reasonably be thought to bear on KPMG LLP's independence and the objectivity of the Engagement Lead and the audit team.

We have considered the fees paid to us by the Trust for professional services provided by us during the reporting period. We are satisfied that our general procedures support our independence and objectivity.

General procedures to safeguard independence and objectivity

KPMG LLP is committed to being and being seen to be independent. As part of our ethics and independence policies, all KPMG LLP Audit Partners and staff annually confirm their compliance with our Ethics and Independence Manual including in particular that they have no prohibited shareholdings.

Our Ethics and Independence Manual is fully consistent with the requirements of the Ethical Standards issued by the UK Auditing Practices Board. As a result we have underlying safeguards in place to maintain independence through: Instilling professional values, Communications, Internal accountability, Risk management and Independent reviews.

We would be happy to discuss any of these aspects of our procedures in more detail. There are no other matters that, in our professional judgement, bear on our independence which need to be disclosed to the Board of Governors.

Audit matters

We are required to comply with *ISA (UK and Ireland) 260 Communication of Audit Matters to Those Charged with Governance* when carrying out the audit of the accounts.

ISA 260 requires that we consider the following audit matters and formally communicate them to those charged with governance:

- Relationships that may bear on the firm's independence and the integrity and objectivity of the audit engagement lead and audit staff.
- The general approach and overall scope of the audit, including any expected limitations thereon, or any additional requirements.
- The selection of, or changes in, significant accounting policies and practices that have, or could have, a material effect on the Trust's financial statements.
- The potential effect on the financial statements of any material risks and exposures, such as pending litigation, that are required to be disclosed in the financial statements.
- Audit adjustments, whether or not recorded by the entity that have, or could have, a material effect on the Trust's financial statements.

Appendix 3

Audit Independence

- Material uncertainties related to event and conditions that may cast significant doubt on the Trust's ability to continue as a going concern.
- Disagreements with management about matters that, individually or in aggregate, could be significant to the Trust's financial statements or the auditor's report. These communications include consideration of whether the matter has, or has not, been resolved and the significance of the matter.
- Expected modifications to the auditor's report.
- Other matters warranting attention by those charged with governance, such as material weaknesses in internal control, questions regarding management integrity, and fraud involving management.
- Any other matters agreed upon in the terms of the audit engagement.

We continue to discharge these responsibilities through our attendance at Audit Committees, commentary and reporting and, in the case of uncorrected misstatements, through our request for management representations.

Auditor Declaration

In relation to the audit of the financial statements of the Trust for the financial year ending 31 March 2017, we confirm that there were no relationships between KPMG LLP and the Trust, its directors and senior management and its affiliates that we consider may reasonably be thought to bear on the objectivity and independence of the audit engagement lead and audit staff. We also confirm that we have complied with Ethical Standards in relation to independence and objectivity.

Appendix 3

Auditor independence

We have summarised below the non-audit services that we have been engaged to provide, the estimated fee, the potential threats to auditor independence and the associated safeguards we have put in place to manage these.

Description of non audit services	Estimated Fee 2016-17	Potential threat to auditor independence	Associated safeguards in place
Tax implications of off payroll payments	£13,250, excluding VAT	Our work involved reviewing the Trust's arrangements for dealing with IR35 changes from April 2017. We do not perceive any potential threats to auditor independence from this engagement neither advocacy, self-review, self-interest, intimidation, familiarity or management. As the impact of IR35 is not material to the 2016/17 financial statements there is no self review threat.	This piece of work was carried out by a Tax Director from our Newcastle Office, who has no connection with the external audit team. We were approached by the Trust to carry out this work. Negotiation of the fee, scoping the work and completing the work was the responsibility of the Tax Director. The fee agreed is within the additional fee allowed for a PSAA engagement.
Total fees	£13,250, excluding VAT		
Total fees as a percentage of the external audit fees	31%		

We have considered the ratio of audit to non-audit fees as required by the APB Ethical Standards. The principal threat which arises from fees from non-audit services which are large in absolute terms of relative to the audit fee is the perception of self-interest and advocacy. In this regard, we do not consider that the above ratio creates such a self-interest or advocacy threat since the absolute level of non-audit fees is not significant to our firm as a whole and neither the audit partner nor members of the audit team are incentivised on, or rewarded in respect of, the provision of non-audit services to you. We believe that the question of perception is best addressed through appropriate disclosure as to use of the auditor for the provision of non-audit services in the Trust's annual report.

Appendix 4

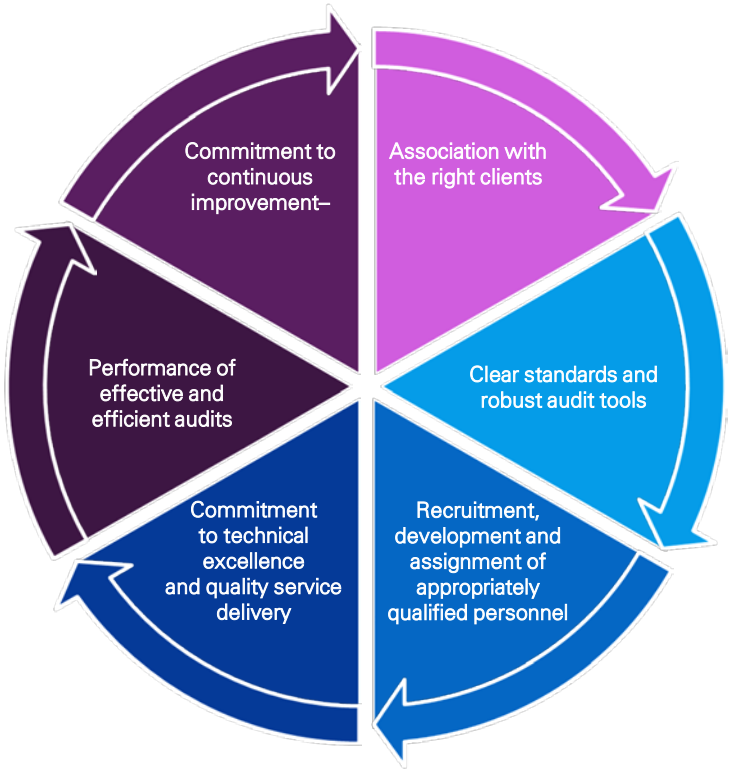
KPMG's Audit quality framework

Audit quality is at the core of everything we do at KPMG and we believe that it is not just about reaching the right opinion, but how we reach that opinion. To ensure that every partner and employee concentrates on the fundamental skills and behaviours required to deliver an appropriate and independent opinion, we have developed our global Audit Quality Framework

- Comprehensive effective monitoring processes
- Proactive identification of emerging risks and opportunities to improve quality and provide insights
- Obtain feedback from key stakeholders
- Evaluate and appropriately respond to feedback and findings

- Professional judgement and scepticism
- Direction, supervision and review
- Ongoing mentoring and on the job coaching
- Critical assessment of audit evidence
- Appropriately supported and documented conclusions
- Relationships built on mutual respect
- Insightful, open and honest two way communications

- Technical training and support
- Accreditation and licensing
- Access to specialist networks
- Consultation processes
- Business understanding and industry knowledge
- Capacity to deliver valued insights



- Select clients within risk tolerance
- Manage audit responses to risk
- Robust client and engagement acceptance and continuance processes
- Client portfolio management

- KPMG Audit and Risk Management Manuals
- Audit technology tools, templates and guidance
- Independence policies

- Recruitment, promotion, retention
- Development of core competencies, skills and personal qualities
- Recognition and reward for quality work
- Capacity and resource management
- Assignment of team members and specialists

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NHS
Leeds Community Healthcare
NHS Trust

Quality account

2016 : 2017

Contents

Introduction

We are pleased to introduce our 2016/17 Quality Account for Leeds Community Healthcare NHS Trust (LCH). This account describes the quality improvements and developments we have achieved within our services over the last year, as well as describing any challenges in relation to quality. The account also sets out the quality priorities we have identified for the forthcoming year and how we will measure and report on these.

Our Vision at LCH is *'To provide the best possible care to every community in Leeds'*. We remain committed to working with patients, carers and the public and to engage with them as part of improving the quality of services. This approach has been key to identifying our priorities for 2017/18.

Engagement with our staff is equally important. We know that they deserve the best possible working environment. In last year's Quality Account we described the introduction of the 'How We Work' (HWW) framework and its seven magnificent behaviours. This year we further supported achieving our vision and values with the 'Our Working Lives Star' and staff 'Pledges' in response to our staff survey results. This looks at what we feel are the most important elements to make our working life the best it possibly can be. We also commenced the LEAD Programme as part of developing our staff to become exemplary leaders within their teams.

This year we have experienced the challenge to maintain our workforce numbers, particularly in the fields of nursing and allied health professions. Recruiting and retaining staff remains a high priority for us. In 2016 we hosted two conferences dedicated to nursing and allied health professions, working in partnership with two local universities. These were an opportunity for our staff to present and celebrate their innovative work and promote LCH as an employer. We are proud to have been successful our partnership bid to become a national pilot site for the nursing associate role this year.

Like many NHS organisations we continue to meet the challenge of improving the quality of care in a time of constrained resources and increased demand for our services. Positive work continues to transform and develop these services to make them as effective and responsive as possible. This is reflected in our contribution to the West Yorkshire and Harrogate Sustainability and Transformation Plans (STPs), which combine NHS and local council proposals to improve health and care. This is further enhanced through upholding stability within our Senior Management Team and Trust Board; and links to our aim to provide strong, consistent and clear leadership.

Patient safety and quality of clinical care is at the heart of everything we do. Reducing avoidable harm remains a high priority for LCH. We have made progress by reducing the incidence of the most harmful pressure ulcers and have improved the quality of serious incident investigations through our pressure ulcer steering group, review meetings and a new training programme. We have identified that there is a need to refocus our work to reduce avoidable falls in our inpatient units and our action plan for this is included within this account. Reducing avoidable harm will continue to be a quality improvement priority for 2017/18 in conjunction with our Sign up to Safety pledge.

Going forward into 2017/18 we are placing further focus on improving the management and investigation of incidents. We also want to ensure we always appropriately notify patients and carers when things go wrong (Duty of Candour); and learn from their experiences through all sources of feedback. We will be looking at how we can increase feedback in order to provide a full picture of satisfaction that encompasses all of the communities we serve.

This account details all of our quality improvement priorities for 2017/18. For consistency and in line with many organisations, reporting on the priorities will continue to be against the CQC domains of Safe, Effective, Caring, Responsive and Well led.

*awaited

Statement of directors' responsibilities in respect of the Quality Account

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

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

- The Quality Account presents a balanced picture of the organisation's performance over the reporting period.
- The Quality Account provides a summary of the organisation's values, achievements and goals, which are explored in the body of the account.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice.
- The performance information reported in the Quality Account is reliable and accurate.
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.
- The Quality Account has been prepared in accordance with Department of Health guidance.

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

By order of the Board

Signed ..... Date 02 June 2017

Neil Franklin, Chair

Signed ..... Date 02 June 2017

Thea Stein, Chief Executive

Section 1
A review of quality in LCH

Improving quality through the engagement and involvement of patients, carers and the public

Our commitment and approach to genuine and meaningful involvement of patients, carers and the public is one way we ensure we work to our values:

"we are open and honest and do what we say we will"

"we treat everyone as an individual; and are continuously listening learning and improving"

Included within this Quality Account are 'what matters' and 'what makes a difference' highlights, which demonstrate how last year's quality priorities led to improvements for patients, carers and the public. These are shared with our stakeholders as part of the process of producing the Quality Account.

We also respond to feedback about involvement by showing how we have listened to and acted upon feedback. Developing this year's Quality Account has been part of this commitment, meaning that:

- We have simplified our Quality Account to be more transparent about priorities
- We have focussed our Quality Account priorities on areas where other methods have so far not achieved the desired results
- We will continue to promote all the ways we engage in quality improvement in addition to the Quality Account

- We haven't picked targets that are easy to achieve
- We haven't duplicated quality improvement goals that are reported elsewhere
- Where quality improvement targets continue from last year, we won't just do the same things and expect a different result; we have formed new action plans to achieve these

By reviewing ongoing feedback, satisfaction surveys, complaints and incidents we know that four things continue to make a difference to patients' experience of our services. Our quality priorities for next year (2017/18) respond to these common themes:

By focussing on and including these four areas as quality priorities we can make significant and sustained improvements across the trust.

Additional areas of quality improvements happen within individual services and these are managed through services' own quality improvement plans.

We will continue to provide feedback throughout the year, as well as through next year's Quality Account.

This will include:

- progress made using *"you said…we did"*
- continuing to involve patients, carers and the public in finding solutions or improvements using *"you said…we didn't, why, and what we're doing instead"*

This is part of our approach to using quality outcomes and learning that looks beyond reporting numerical progress to also report the impact on the quality of our care and service.

The patient's voice at Board meetings

The Trust has always been keen to ensure that discussions at the Board and at Board sub-committees are informed by the views of patients and members of staff.

This is achieved through a number of means.

- All Board members participate in service visits to gain first hand insights into services; often including opportunities to meet patients and a wide range of staff. There have been 35 visits to frontline services undertaken during 2016/17. Reports from service visits are reviewed by the Trust's Quality Committee so that 'lessons learnt' can be collected and shared amongst services.
- At each meeting of the Trust's Quality Committee, a presentation is received from one service. This service 'spotlight' enables clinical leaders to look at quality processes through the eyes of the service, focusing on: achievements, challenges and opportunities for development.
- At each Board meeting, Board members hear directly from patients, carers or families through a 'patient story'. This well-regarded agenda item has included reflection on the experience of patients using our palliative care, health visiting and specialist diabetes care.

Information presented to the Board in this way provides essential assurance that those at Board level, who are charged with oversight of quality and safety, do so in a way that is informed by patient experience.

Our Diabetes Service – A Story for the Trust Board

The Community Diabetes Service provides an assessment, education and treatment service for patients with Type 2 diabetes; a type of diabetes controlled by diet or medication. The service is provided by a team of specialist nurses, dieticians, podiatrists and GPs, who all have a special interest in diabetes.

On 7 October 2016 we supported two of our patients to attend the monthly Trust Board meeting and share their experiences of using the Diabetes Service. Both patients talked positively about the care they received at our Armley Clinic; they described feeling looked after by the team as well as how beneficial it had been to talk to someone who had the time to help them manage their own condition. They particularly felt it had been helpful to see both a nurse and dietician in the same clinic.

During their presentation the patients prompted a discussion regarding communication between us and our partner Trusts. They highlighted how the transfer of information was sometimes difficult and how they thought it would be helpful if staff had access to both GP and secondary care information. An issue regarding medications being changed or stopped at the time of discharge from a service was also raised. The patients felt that this was not always managed in a timely way by primary care or pharmacy services. We took the opportunity to discuss these themes, which are common to healthcare services, and gave assurance that this would be looked into.

It was important for the Diabetes team to listen to and use patients' views as a means of working towards a gold standard approach of using patient and carer involvement to make improvements within the service they provide.

Review of 2015/16 quality priorities

At Leeds Community Healthcare NHS Trust (LCH) we use the Care Quality Commission (CQC) framework and domains of Safe, Effective, Caring, Responsive and Well Led to review the quality of our services. This section of the quality account reviews the priorities we set ourselves for 2016/17 and describes our achievements, and challenges, over that last year.

Safe

The table below shows the priorities we set for 2016/17 relating to LCH being **safe**, the progress we have made against each priority goal and what we will do in 2017/18 in relation to that priority:

Quality area for action	Achievements to date	Comments
Protecting patients from harm that happens in our care Sign up to SAFETY LISTEN LEARN ACT	**a) 15% reduction in avoidable category 3 pressure ulcers*** Achieved **b) No avoidable category 4 pressure ulcers*** Not achieved **c) 10% reduction in falls resulting in avoidable harm in our community inpatient units*** Progress made towards target	Preventing and reducing avoidable pressure ulcers will continue to be a priority for 2017/18; and will be aligned to our Sign up to Safety pledge. Details are included in Section 3 of this document. *During 2016/17, a revision of how this information took place in order to better understand and better reflect the reduction based on numbers. The quality improvement ratings have been adjusted accordingly for the year.

Quality area for action	Achievements to date	Comments
Safeguarding	**Provide accessible information to the Safeguarding team on Pressure Ulcer incidents.** **Develop and improve the identifying and sharing learning from any Safeguarding aspects of pressure ulcer development, management and treatment.** **We should expect to see a rise in awareness and the reporting of pressure ulcers related safeguarding incidents.** Safeguarding representation at Pressure Ulcer Panels has resulted in the identification of safeguarding concerns at an earlier stage in the progress of pressure ulcer development, leading to earlier remedial action. Practitioners are supported by the Safeguarding team in identifying and addressing Safeguarding aspects of pressure ulcer development and management.	The incidence of pressure ulcers continues to be a significant focus for the Trust as it strives to maintain the highest levels of patient safety and ensure ongoing attention is given to improving patient care in this area. Monitoring will take place via representation of the Safeguarding team at pressure ulcer panels.
Serious Incident investigations (SIs)	**Hold an accessible register of trained SI investigators.** **Increase the number of staff trained in SI investigation.** A register of trained investigators is now held by the Clinical Governance Team. At year end 2016/17,138 staff had undertaken training and 38 managers were registered to attend future sessions in 2017. 105 further places are currently available.	The management and quality of SI investigations is monitored at SI panels and issues are reported via the Quality Committee to ensure good governance is in place.

The quote opposite applies equally to services for children, families, and adults. Over the last year a number of key publications have recommended that we maintain a strong focus on the importance of *'doing with'* rather than *'doing to'*. The first of these documents *'Not Seen, Not Heard'* (July 2016), was published by the Care Quality Commission (CQC). It drew together the CQC's findings from 50 inspection visits into child safeguarding and health care for Looked After Children and resulted in a suite of 38 recommendations.

Through the recommendations, the CQC are challenging health providers, commissioners and partner agencies to address the variation they found in care outcomes for children and young people being looked after or safeguarded. Healthcare organisations are required to clearly demonstrate that the voice of the child is heard and responded to within care plans and re-designing of services. We are responding to the challenge of these recommendations by working with our partners the Leeds Safeguarding Children Board (LSCB) and the Multi-Agency Looked After Partnership (MALAP).

At LCH we ensure that we listen to children and young people, for example via the 'Have A Voice and Care Leavers Councils'; and through robust quality assurance and audit processes. By doing so we are better able to demonstrate that children and young people are both heard and influential in the way we deliver our services.

Another important area is the Mental Capacity and Deprivation of Liberty Safeguards (DoLS). DoLS are put in place when people who lack the capacity to decide for themselves are accommodated in a hospital or care home for the purposes of receiving care or treatment. Whenever this happens, we need to ensure that the measures we put in place are the least restrictive they can be and last for the shortest possible length of time. Our Multi-disciplinary Teams (MDTs) and ward managers carefully monitor and review all DOLS applications. How we practice in healthcare against this is set to undergo significant change. Since 2014 the Law Commission has been consulting with a wide range of stakeholders to develop a new approach to the law on DoLs. In May 2016, the Law Commission published a *'Mental Capacity and Deprivation of Liberty Interim Statement'*, which acknowledged the need to move away from case law to a different legislative approach. This set out some of the ideas emerging from the consultation.

We look forward to seeing the final report/recommendations and any resulting legislation being taken through Parliament. We know that whatever the outcome, we need to ensure we fully focus on respecting the human rights and dignity of all the vulnerable adults in our care.

Serious Incidents - Making improvements through education and training

A particular focus of our Quality Account quality improvement priorities last year was our aim to reduce the incidence of pressure ulcer and falls incidents. This remains a high priority for LCH and forms part of our 'Sign up to Safety' pledge.

The effective management of incidents is an essential part of enabling us to identify learning when things go wrong. This leads to developments and improvements being made in order to reduce re-occurrence of these incidents.

Unfortunately, sometimes incidents do cause harm. All incidents are investigated by a responsible manager and the level of harm is assessed. When the level of harm is determined to be moderate or severe; or when a death occurs, an in-depth detailed investigation is undertaken. This investigation is called a Root Cause Analysis (RCA).

Certain categories of incidents are reported externally to the Clinical Commissioning Group (CCG) as 'Serious Incidents' (SI's). All managers who conduct RCA's or SI investigations are provided with training to ensure they are armed with the skills and practical techniques to undertake an appropriate and robust investigation.

To date this year, 138 managers have participated in our SI investigation training and a further 38 managers are registered to attend over the next 12 months with and we will continue to promote the training. Improving the quality of these investigations will enable us to identify the true cause of incidents, develop improvements to address the cause, and reduce the likelihood of similar incidents happening again.

In 2017/18 we will continue to support investigation managers to ensure they are fully equipped to undertake and further improve the quality of their investigations. This will include:

- Supporting managers to conduct investigations in specialist areas outside of their own field of expertise in order to improve independence of investigations
- A review of investigation outcomes and action plans to identify where improvements in quality can be made
- Providing opportunities for investigators to work with other lead investigators to share learning and best practice

We are committed to learning from incidents. Over the next year we will be engaged in looking at how learning from investigations is not only identified but embedded within clinical practice and patient safety across our services.

Infection control - Raising the profile of Infection Prevention through innovation and engagement

In the context of a global increase in antibiotic resistant bacteria and the enhanced vulnerabilities of some of the patients we care for, we continue to place infection prevention and basic hygiene at the heart of safe care and clinical practice. We are committed to a "zero tolerance" approach to preventable healthcare associated infection.

Development of the Infection Prevention Champions programme has been at the centre of this, both within LCH and the care home setting.

During the last year the Infection Prevention Team has explored new and exciting ways to promote a clear message to improve infection prevention within the Trust. Development of the Infection Prevention Champions programme has been at the centre of this both within LCH and the care home setting.

Enhanced engagement through this work has significantly raised the profile of infection prevention. This has been instrumental in promoting the ethos that infection prevention is everyone's responsibility and should be an integral part of a patient's care. To date LCH has achieved the local and national targets for reportable infections: Clostridium difficile (CDI) and MRSA bacteraemia.

- No cases of MRSA bacteraemia have been assigned to LCH within 2016/17
- One case of CDI was reported in our South Leeds Independence Centre during November 2016. A full Post Infection Review (PIR) was completed and this concluded that there were no lapses in care or evidence of transmission within the unit

During November 2016 the Infection Prevention team coordinated an Infection Prevention Awareness Week. This week long programme was delivered in a variety of venues and engaged with LCH staff groups and the wider community. The identified objectives for the initiative were to:

- Raise the profile of Infection Prevention Control
- Address seasonally important issues such as influenza, Norovirus, hand hygiene
- Enhance engagement with our Neighbourhood Teams and specialist departments
- Highlight sharps safety compliance, both organisationally and with the general public
- Reinforce that IPC is everyone's responsibility
- Launch an Adult Pathway Sepsis flow chart

Promotional screensavers and bottom right, staff at the Community Rehabilitation Unit discussing outbreak management during IPC Week.

Marcia Perry, Executive Director of Nursing, meets Frankie and Flo

A significant highlight of 2016/17 is our success in vaccinating LCH staff through the Flu Vaccination Campaign. The Infection Prevention team were challenged with a requirement to vaccinate 75% of our frontline staff before the end of December 2016.

A comprehensive action plan was developed which included an innovative social media campaign, the novel use of storytelling; and the creation of our flu bug characters, Frankie and Flo.

We linked with local media, Leeds Rhinos' Rugby Team, Leeds United Football Club and engaged with the NHS Employers organisation to enhance the profile of the campaign. This enabled promotional messages to be developed wide groups of staff. As a result, we not only achieved our target, we surpassed it 3 weeks ahead of schedule!

Throughout the year LCH has seen the prevention of Healthcare Acquired Infection as a quality priority. We will continue to hold this at the forefront our commitment to deliver safe, clean care within the Leeds community.

Nurses Alison Tetley and Laura Johnson give Head Coach Garry Monk his flu jab at Leeds United

Effective

LCH conferences 2016 - Nursing and Allied Health Professionals

During the summer of 2016 we hosted two conferences for nurses and allied health professionals in partnership with Leeds University and Leeds Beckett University. Over 300 delegates attended these conferences from LCH, other trusts in Yorkshire and further afield.

We were fortunate to have nationally recognised key note speakers at the conferences, which provided a fabulous opportunity for our own staff to showcase some excellent and innovative ways they have enhanced the delivery of patient care through partnership working.

We were equally fortunate to hear the positive impact of this high quality care from patients sharing their stories.

The two days was well supported with a wide range of workshop presentations led by nurses and therapists; and leads in areas that support care delivery from library services, research and business planning. Delegates were able to view a poster display competition with posters presented from a range of professions. We also hosted stands on the day alongside colleagues from other professional organisations and the university.

Examples of presentations from key note speakers:

'Achieving #SoMe Clout: Raising the visibility, profile and strategic influence of AHP professions' (Dean and Pro Vice-Chancellor for Health and Social Sciences Leeds Beckett University)

'Our Journey for recognition as an integral part of the public health workforce' (Lead Allied Health Professional and National Engagement Lead for Police and Fire Services – Public Health England)

'How AHPs will transform care: An emerging mandate for change' (Chief AHP Officer NHS England)

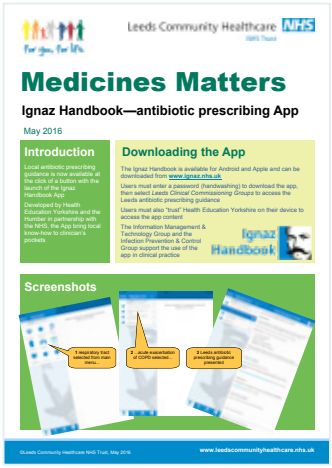
The table below shows the priorities relating to **effectiveness** set for 2016/17, the progress we have made against each priority goal and actions for 2017/18 in relation to that priority:

Quality area for action	Achievements to date	Comments
Outcome Measures	**A pilot study will be undertaken to develop outcome measures involving 3 services in each of our Business Units.** **Dashboards reporting outcomes will be developed for each of these services and the analysis of the pilot studies will be used to establish what further resources are needed to roll this work out across all services.** The collection of relevant Outcome Measures within service teams is being progressed as part of the Outcome Measure CQUIN. Work continues on the 2016/17 CQUINs relating to outcomes. The Musculoskeletal service, Neighbourhood Teams and the Integrated Children with Additional Needs (ICAN) service are developing outcome measures as part of this process. Due to system pressures the approach for the Neighbourhood Teams has been scaled back; however the pilot is still expected to deliver the information required to support wider roll out of outcome measures.	Outcome measures have been highlighted by the Business Units in their Business Plans for 2017/18. In parallel this will continue to be a quality improvement priority in 2017/18 with an updated approach, as detailed in Section 3.
All patients have an accurate and complete record of their care provided by the Trust	**Increase in the percentage of patients with fully completed and comprehensive care records as measured by the annual documentation audit.** **Overall compliance at year end was 91%** (number of records 1274). Robust processes are in place to increase submissions from all services in a timely manner.	The standards and training will be included within the preceptorship programme. This audit will be reported on and monitored through the Clinical Effectiveness Group.

Medicines Management

Ignaz Handbook

Introducing the Ignaz Handbook App was one of our pledges for 2016 as introduced in last year's Quality Account. This was part of our commitment to the national campaign to ensure that antibiotics are used appropriately.


Leeds Community Healthcare NHS

Medicines Matters

Ignaz Handbook—antibiotic prescribing App

May 2016

Introduction

Local antibiotic prescribing guidance is now available at the click of a button with the launch of the Ignaz Handbook App

Developed by Health Education Yorkshire and the Humber in partnership with the NHS, the App bring local know-how to clinician's pockets

Downloading the App

The Ignaz Handbook is available for Android and Apple and can be downloaded from www.ignaz.nhs.uk

Users must enter a password (handwashing) to download the app, then select *Leeds Clinical Commissioning Groups* to access the Leeds antibiotic prescribing guidance

Users must also "trust" Health Education Yorkshire on their device to access the app content

The Information Management & Technology Group and the Infection Prevention & Control Group support the use of the app in clinical practice

Ignaz Handbook

Screenshots

1 respiratory tract selected from main menu...

2 acute exacerbation of COPD selected...

3 Leeds antibiotic prescribing guidance presented

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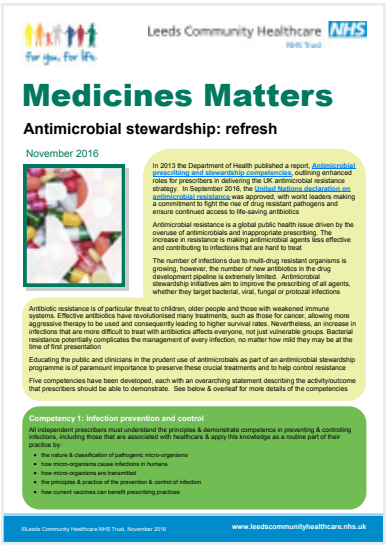
The Ignaz Handbook App was launched Trust-wide in May 2016 supported by the Infection Prevention and Control Group and the Information Management and Technology Group. The App, available for both android and Apple devices, provides easy access to the Leeds antibiotic prescribing guidance (available on the Leeds Health Pathways website) bringing local evidence-based practice to clinicians' pockets.


Leeds Community Healthcare NHS

Medicines Matters

Antimicrobial stewardship: refresh

November 2016

In 2013 the Department of Health published a report, Antimicrobial prescribing and stewardship competencies, outlining enhanced roles for prescribers in delivering the UK antimicrobial resistance strategy. In September 2016, the United Nations declaration on antimicrobial resistance was approved, with world leaders making a commitment to fight the rise of drug resistant pathogens and ensure continued access to life-saving antibiotics

Antimicrobial resistance is a global public health issue driven by the overuse of antimicrobials and inappropriate prescribing. The increase in resistance is making antimicrobial agents less effective and contributing to infections that are hard to treat

The number of infections due to multi-drug resistant organisms is growing, however, the number of new antibiotics in the drug development pipeline is extremely limited. Antimicrobial stewardship initiatives aim to improve the prescribing of all agents, whether they target bacterial, viral, fungal or protozoal infections

Antibiotic resistance is of particular threat to children, older people and those with weakened immune systems. Effective antibiotics have revolutionised many treatments, such as those for cancer, allowing more aggressive therapy to be used and consequently leading to higher survival rates. Nevertheless, an increase in infections that are more difficult to treat with antibiotics affects everyone, not just vulnerable groups. Bacterial resistance potentially complicates the management of every infection, no matter how mild they may be at the time of first presentation

Educating the public and clinicians in the prudent use of antimicrobials as part of an antimicrobial stewardship programme is of paramount importance to preserve these crucial treatments and to help control resistance

Five competencies have been developed, each with an overarching statement describing the activity/outcome that prescribers should be able to demonstrate. See below & overleaf for more details of the competencies

Competency 1: Infection prevention and control

All independent prescribers must understand the principles & demonstrate competence in preventing & controlling infections, including those that are associated with healthcare & apply this knowledge as a routine part of their practice by:

- the nature & classification of pathogenic micro-organisms
- how micro-organisms cause infections in humans
- how micro-organisms are transmitted
- the principles & practice of the prevention & control of infection
- how current vaccines can benefit prescribing practices

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Our implementation of NICE guidance on antimicrobial stewardship *(NG15, published in August 2015)* continues through partnership working with primary and secondary healthcare and the Local Authority. This work aims to change prescribing practice to help slow down the emergence of antimicrobial resistance and ensure that antimicrobials remain an effective treatment for infection.

In November 2016 a refreshed version of the principles of good antimicrobial stewardship was circulated to our clinicians who prescribe these treatments, as part of the Trust's Infection Prevention and Control week. In December 2016 our Trust Board approved our first Medicines Optimisation Strategy. This strategy sits alongside the Quality Strategy; and work streams to deliver safe, efficient and effective medicines optimisation for patients and staff across the organisation.

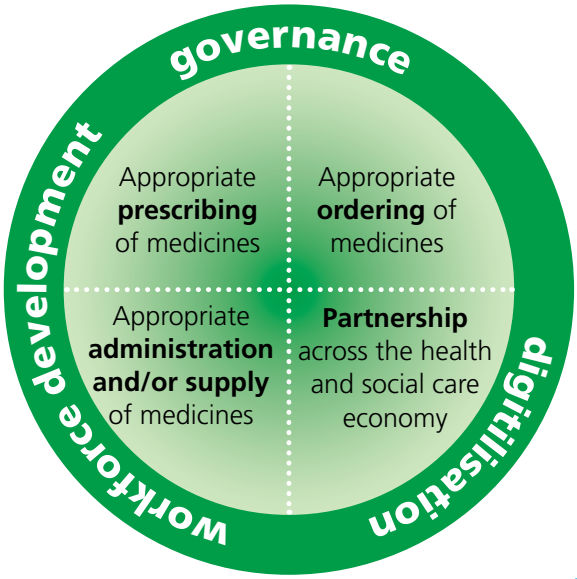
The vision of the strategy is to ensure that the right patient receives the right medicine and the right dose, at the right time, via the right route – every time.

We will achieve this through four objectives:

- Appropriate **prescribing** of medicines
- Appropriate **administration and/or supply** of medicines
- Appropriate **ordering** of medicines
- **Partnership working** across the health and social care economy

Three specific complimentary work streams will support this work:

- **Governance** of medicines to ensure that all legislation is complied with at all times by all staff
- **Workforce development** to support a range of professionals to make the best use of medicines as part of their clinical role
- **Digitalisation** of systems and processes to ensure we are as efficient as possible and reduce the risk of errors occurring



Caring

The table below shows the priorities relating to **caring** and **experience** set for 2016/17, the progress against each priority goal and actions for 2017/18 in relation to that priority:

Quality area for action	Achievements to date	Comments
Staff health and well being	**Reduce the percentage of staff that report sickness absence due to work related stress using the appropriate question from the Friends and Family Test.** The staff FFT question used to measure this indicator has been removed from the survey. Going forward the survey will better reflect the National Staff Survey questions.	Staff absence will continue to be part of our CQUINs for 2017/18.
Friends and Family Test (FFT)	**A) Increase survey response rates, to bring about an improved level of understanding of patient experience and satisfaction.** **B) Demonstrate three services in each business unit using patient feedback or co-production to change the shape of services to improve patient care.** Organisational FFT response rate **8.0%** (baseline for improvement at 1 April 2016 was **1.9%**). Our Specialist Business Unit now operates an alternative practice to replace the FFT paper based process in Police Custody Suites. We have developed and shared a Standard Operating Procedure (SOP) for staff to use to enable patients to complete the FFT survey on laptop devices. Examples of how FFT feedback has been acted upon and changed practice (from all Business Units) include: We changed the text message that is sent to patients regarding an appointment. It now includes the Health Centre that the patient should attend along with the appointment date and time The Musculo-skeletal service has implemented extended hours in one clinic, now open until 1930hrs Water dispensers have been placed in clinical waiting areas in LCH premises The Health Visiting service has created a public Facebook page to provide service information via a platform that people wanted	A new focus will take the aim of increasing responses to FFT into 2017/18 and this will feature in our quality priorities for the next year.

Josh's Story

Josh was diagnosed with Hypoplastic Left Heart Syndrome, a life limiting condition, before he was born. This meant that he only had half a heart. Josh spent the early part of his life undergoing complex surgical procedures and medical interventions, including heart surgery; and the first 5 months of his life in hospital. His parents made the most of their time with him and his sister Amy whenever this was possible and he spent time with his mum or dad in his sling, where they laughed, hoped, smiled and had fun.

Josh was referred to the Children's Nursing and Butterfly Team in March 2016 for support with any nursing care that he may require in the Community, and ultimately palliative care. He was also referred to the Children's Continuing Care Team for any respite support the family might require.

Eventually Josh was discharged from hospital. However, several challenging and difficult weeks at home resulted in another brief stay in intensive care where the family were told that nothing further could be done and Josh might have only a short time to live.

The family initially attended Martin House and made a conscious effort, when circumstance allowed, enjoying that precious time as a family at home where they belonged. The family wanted to be at home as much as they could be and if at all possible, when Josh died.

The team at Martin House, Children's Continuing Care and the Children's Nursing and Butterfly Team all worked in partnership to support the family in their wish for Josh to die at home. The Continuing Care Team and Children's Nursing Team drew up a rota to ensure the family had 24 hour cover, with staff working beyond their usual working patterns to ensure evening and night shift cover. In addition medical cover was provided 24 hours per day to care for Josh's daily needs.

In that last week of Josh's life he and his family managed trips to parks, the woods, the pub, and a trip to the ward to see the doctors and nurses at hospital after his feeding tube came out. With his feeding bag, oxygen cylinder, bag of controlled drugs and syringe driver ever present, the family continued to make the most of their time together, supported by the partnership working of the care teams.

It was a Saturday night when sadly Josh's condition deteriorated to end stage heart failure. The Children's Nursing and Butterfly Team and the Children's Continuing Care Team with Martin House, worked together for 2 days and nights to ensure Josh received the appropriate medication, care and attention he needed. This high standard of care and support meant that the family had an exceptionally peaceful last day with Josh. Josh died in bed with his parents, smiling.

Freedom to Speak Up Guardian (appointment of and look forward)

The role of our Freedom to Speak Up Guardian is a statutory requirement. It follows national reports on whistleblowing. Our guardian was appointed in September 2016 and works across our organisation; and creates spaces for staff to share concerns about patient care and safety. The role is independent and reports directly to the Chief Executive and the Trust Board with the aim of ensuring that staff concerns can be heard within a supportive environment that encourages people to speak out.

The work of the Freedom to Speak Up Guardian also contributes to the creation of a regional network across NHS services through which we can learn and support the emergence of best practice. The role is essentially connected to culture sensing and shaping.

The Freedom to Speak Up Guardian also supports and complements the work of our staff side representatives, human resources team, our 50 Voices group, team coaching and more. It is important that the guardian engages internally within the Trust to triangulate themes, patterns and issues that are brought to them by staff.

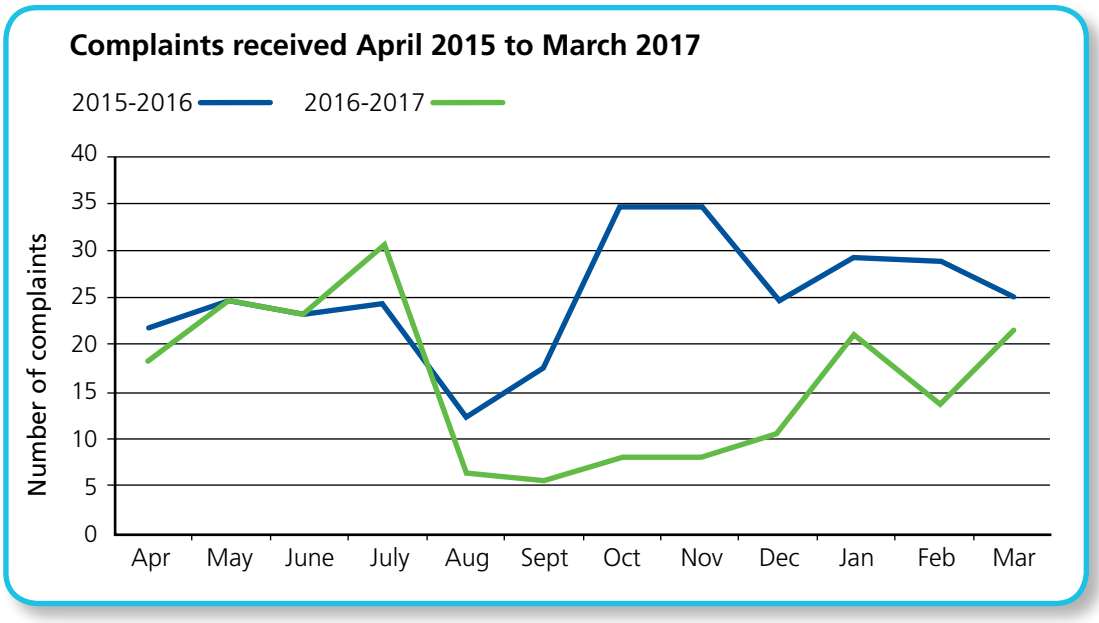
We hope the introduction of this role will add to the quality and effectiveness of our service through supporting staff to share their concerns confidentially. Wider communication regarding issues of patient safety will helps us identify where we need to make changes to improve the quality of working lives and ultimately patient care across Leeds and the wider community.

Responsive

Patient Experience – PALS, concerns, complaints

During 2016/17 an increased emphasis was placed on resolving concerns quickly and efficiently. We recognise that the formal complaints process is not always the most suitable pathway for patients and families to receive a speedy resolution to a problem. We have therefore encouraged early resolution to concern raised by our service users. This has proven to be successful, as evidenced by a significant reduction (33%) in formal complaints for 2016/17 compared to the previous year.

At the time of reporting, in 2016/17 the Patient Experience Team had dealt with 290 concerns and 194 formal complaints. The chart below shows the comparison of complaints received over the last two years:



Learning from a person's experience of our service is one of the most important aspects of any complaints process. This year we have developed central monitoring of action plans generated in response to a complaint.

Weekly summaries of action plan statuses are sent to all Business Units as part of monitoring the timeliness of producing action plans. This will be further strengthened from April 2017 as the Patient Experience Team begins to track the progress of individual action points via their database system.

Key themes for complaints during 2016/17 were:

- Staff attitude and communication (12%)
- Poor treatment (11%)
- Staff member(s) failing to arrive or being late (7%)
- Issues relating to home visits (6%)
- Waiting time for appointments (5%)
- Dignity concerns (4%)

Dignity, choice and respect

☑Respecting and valuing people's views by acting on feedback (reported on our Members' Zone)

☑ Improving information to support choice in location of service

Quality Account focus on areas of particular need:

☆Action plans for complaints about attitude

☆Confidence in the range of views (return rate and equality data)

Themes of concerns tend to vary from formal complaints. Concerns are often problems that require immediate action such as a missed visit from a community nurse. The overriding area of concern for patients and relatives during 2016/17 was issues relating to appointments; accounting for just over a quarter of all concerns received. Other themes included issues relating to communication and staff attitude.

The overriding area of concern for patients and relatives during 2016/17 was issues relating to appointments

We continue to promote a welcoming and positive culture for everyone making contact with the Patient Experience Team. For example, rather than diverting patients or relatives to "write in" or contact the team via other methods, we consider the initial contact to be very important in capturing our service users' comments effectively and compassionately. All complainants receive a written complaint plan to ensure our investigation targets all areas of concern or dissatisfaction.

Statutory regulations require us to acknowledge complaints within 3 working days. This was achieved in 95% of cases in 2016/17. Of the complaints closed to date, none exceeded the statutory maximum response time of 180 working days.

In all cases complainants receive a clear apology for any instances of poor service/patient care together with details of corrective action taken.

my LCH experience

Carers' needs and involvement

☑Carers' survey continuing and reported on our Members' Zone

☑ Every health centre has information for carers

☑Receptionists now 'Dementia Friends'

Quality Account focus on areas of particular need:

☆Access to Continence, Urology and Colorectal Services

☆Carers' involvement in Terms of Reference for serious incident investigations

The table below shows the priorities relating to **responsiveness** that we set last year, the progress we have made against each priority goal and what we will do in 2017/18 in relation to that priority:

Quality area for action	Achievements to date	Comments
Learning from incidents and complaints	**All Serious Incidents (SIs) and all complaints will have a completed learning and action plan.** **100%** of all closed (to LCH) SIs continue to have an action plan in place. Complaint action plans are now tracked for compliance on a weekly basis and reviewed monthly at a collective review within the BU. In addition there has been a greater focus on ensuring complaint outcomes are assessed and entered appropriately by the Patient Experience Team in order to appropriately trigger the need for action plans (i.e. all partially and fully upheld complaints). **49 of 156** closed complaints (from 2016/17) were awaiting an action plan (31%) at year end.	Work is still needed to ensure all relevant complaints have an action plan as part of the response– this priority will be carried forward into 2017/18. Continued monitoring will take place and be reported to the Quality Committee.

Quality area for action	Achievements to date	Comments
Duty of Candour	**All patients /persons affected by an incident that has resulted in a moderate increase in treatment with significant harm will receive an appropriate apology. Target 100% of persons affected as per the definition will receive an appropriate apology (by 31 March 2017).** Meeting the Duty of Candour (DoC) target has been a challenge over the year. Considerable work has been undertaken with services to embed the DoC process, raise staff awareness and reinforce incident handler responsibilities for accurately recording the DoC process. Over the past year an apology was provided as appropriate in **58.25%** of applicable cases. In March 2017 the DoC process was followed in 100% of applicable cases. This improvement in compliance was partially due to a change in the reporting process. This change will provide us with assurance that the DoC process has been followed. There have also been a number of updates to the incident database to support services to appropriately record DoC. Benchmarking the Trust's performance on DoC compliance with two similar Community organisations to ensure good practice showed there are inconsistent approaches to managing and monitoring the process nationally; thus making comparison difficult.	This will continue to be a quality priority for us in 2017/18. Details are included in section 3 of this account.
Access to Services	**Patients are seen at the right time, in the right place within a reasonable time.** **Achievement of the 18 week referral to treatment time (RTT). Target of 95% RTT for every service.** Business Units have processes in place to review access times and address any non-compliance with waiting time targets. Data quality processes are much improved. Business Committee no longer wishes to review monthly reporting on waiting times as they are assured that the validation and escalation processes are robust.	Cases of long waits will continue to be highlighted via the business unit performance meetings and Senior Operations Team Performance meeting. Further reducing waiting times to our access services will have a focussed approach for 2017/18 as detailed within section 3.

Equality and Diversity

If we are to realise the vision of delivering the best possible care to all communities, it is essential that our workforce is as diverse as the community we provide services to. To this end, during the last year we have continued work to build knowledge, skills and behaviours within the healthcare community. In common with other public service organisations we have policies to guide us to achieving this aim; however, it is the way we enact our policies that makes a difference.

At LCH we continue to raise awareness of equality and diversity issues, in particular we have established networks of Black Minority Ethnic (BME) staff and those with a disability. The latter group is also generating champions for disability.

To help understand why staff experience inequality of opportunity or treatment, we have provided opportunities for all staff to access face to face Unconscious Bias education sessions.

The course delegates are encouraged to reflect on the learning from the Unconscious Bias session and link this to their clinical and personal practice to positively influence how they interact with colleagues and patients.

As part of our continuing Workplace Race Equality Standard (WRES), Staff Disability and Stonewall Diversity Champions work, Unconscious Bias has been included within our Recruitment and Selection training for recruiting managers. This is one area where we can make a difference to help change the representation of all communities within our workforce.

Unconscious bias happens by our brains making incredibly quick judgements and assessments of people and situations without us realising. Our biases are influenced by our background, environment and personal experiences.

Well-led

Developing leadership - Introduction of the Our Working Lives Star

Our Working Lives, also known as our engagement star, was designed by our Organisational Development team following conversations about engagement and morale across LCH. Using the most up-to-date engagement research and our knowledge of the Trust and our staff, the star came to life.

Essentially, the star highlights the five key areas that we feel are the most important to get right in our working lives:

- Feedback
- Control
- Recognition
- Support
- Involvement

It asks staff to think about where they would rate themselves or their team on a scale from 1 to 5. The numbers themselves do not mean anything, they are a tool to provoke a conversation about that point of the star and how people feel about it at that point in time. The overarching aim of the star is to act as a conversation starter about meaningful issues between individuals and their manager, colleagues, and teams.

Feedback to date on the star has been positive, and people have commented that it has helped them have more meaningful conversations and discuss important issues. Our Healthy Living Service commented that:

> "The team really liked the star and how it represented and conveyed the feelings of the team."

> "(we) are really excited about being able to use it to help in the growth and development of our service."

The team use the star as a basis for more specific questions to further explore engagement in the team.

The table below shows the priorities relating to **well led** as set last year, the progress against each priority goal and actions for 2017/18 in relation to that priority:

Quality area for action	Achievements to date	Comments
Appraisal	**Increase the percentage of staff that have received an appraisal in the previous 12 months. Baseline for improvement based on year-end percentage of 91%.** At year end, compliance was reported as **87%**. It is notable that during Q3 2016/17 the Trust was operating at Silver Command status. During this time permission was given to pause appraisals in some parts of the Trust. This may have been a contributor to us not achieving the target. Significant progress has been made to improve the number of staff receiving an appraisal and incorporate our 'How We Work' framework within those. Further work continues to introduce the 'Our working life' model to support clinicians and managers in undertaking the appraisal process.	This remains a priority for the trust and is reported regularly via established monitoring within the Trust. Areas of non-compliance are identified and highlighted via the business intelligence reports via Manager Self Service. Compliance will be discussed at the performance panels for each Business Unit/service.

Appraisal cont'd	Based on feedback received from appraisers, support was needed on having difficult conversations. A programme of sessions on this ran from June to September 2016 to support the development of these skills.	
Leadership	**Behaviours expected of leaders are identified and shared with all staff. Increase year on year the score for staff reporting (through National NHS Staff Survey) that they have received support from immediate managers. Year-end 2015/16 figure of 3.60 out of 5 forms baseline for improvement.** The National Staff Survey results (at month 11) regarding 'Support from Immediate Managers' shows a score of **3.77** out of a possible 5 (an **increase of 0.17** from last year's survey). Support to managers in the last 12 months that contributed to this includes: • Refresh of appraisal documentation to include values and behaviours • 'Our Eleven' vision and values • LEAD programme • Our Engagement Star • Manager as Coach sessions	Monitoring of this will continue via established monitoring within the Trust using national data reports.
Staff Engagement	**Increase year on year the score for staff who feel engaged in the organisation and its work as reported in the NHS National Staff Survey. Year-end 2015/16 figure of 3.71 out of 5 forms baseline for improvement.** The actions from last year's survey have been developed and are now presented as our Pledges. These are our promises that we have listened and that we will act on what we have heard. The National Staff Survey results for 2016/17, for Staff Engagement, is **3.70** compared to **3.71** in 2015/16.	Monitoring of this will continue via established monitoring within the Trust using national data reports and we will refresh our Pledges. Staff well-being and engagement will be a focus at our Leaders network, 50 voices group and other forums within the Trust in 2017/18.

Health Coaching and how it made a difference

Since 2014 approximately 170 LCH staff from various professions and teams have undertaken a two-day health coaching training programme, including our neighbourhood nursing teams, Healthy Living Services and ICAN. The purpose of the programme is to equip healthcare professionals with coaching skills. This enables better conversations with patients to increase their awareness of their own health condition and take responsibility for their health care.

Our clinicians have reported that using a health coaching approach has given them more energy and motivation and patients have felt empowered and motivated to actively participate in their health care. The Healthy Living Service has been working on a patient centred approach for a number of years through delivering training to staff regarding motivational interviewing, Cognitive Behaviour Techniques (CBT) and solution focused therapy. The introduction of Health Coaching was an excellent opportunity to revitalise the work undertaken to enable behaviour change.

Mary, one of our Neighbourhood Clinical Practitioners based at Middleton Health Centre, took part in the health coaching training programme in May 2015 and would recommend it for all staff:

"Everyone will get something out of it, as it's something we should all be doing- active listening and better conversations with patients about their individual health needs."

"It's powerful with a real impact- triggering self-belief in patients and changing their pathways in life."

From a system perspective, health coaching has enabled LCH to work alongside other provider organisations, the city's Clinical Commissioning Groups (CCGs) and influence the STP and Wellbeing strategy.

A further 60 staff will have been trained in health coaching within 2016/17 and more staff will undertake the programme in 2017/18. Awareness sessions are also being provided to teams and we are working on means through which a health coaching approach can be embedded and synergised with our other coaching programmes.

Our contribution to health coaching reflects the national work which began in 2010, driven by Dr Penny Newman - GP and National Innovation Fellow in health coaching. Leeds is a pioneer for health coaching, which was recognised through a finalist position in the 2016 Yorkshire and Humber Leadership Academy recognition awards.

York Street 'Outstanding' Care Quality Commission Inspection

The Specialist Business Unit was proud to celebrate an 'Outstanding' outcome rating following the CQC inspection of our York Street Practice in October 2016.

Inspectors rated the practice as 'Outstanding' for Effectiveness, Well-led and Responsiveness, as well as 'Good' for Safety and Caring. Some of the highlights from the inspection included:

- A clear vision, which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- Patients' emotional and social needs were seen as equally important as their physical needs.
- Patients said they were treated with compassion, dignity and respect.
- Inspectors saw that there was wide-ranging evidence of multi-agency working, where the practice worked closely with other organisations, such as outreach services, refugee councils and homeless shelters, in ensuring services were provided to meet patients' needs.

"From all that I have seen and read about this practice I can say it was one of the best the CQC has visited. It demonstrates what can be achieved with excellent leadership and cooperation with local agencies. They are all to be congratulated - it is an exemplary practice delivering top class, patient-centred care and thoroughly deserves its rating of Outstanding."

Professor Steve Field (CQC Chief Inspector of General Practice 2017)

A full report of the inspection has been published at: **www.cqc.org.uk/location/RY663**

Section 2

Statements on quality as mandated in the regulations

This section of the Quality Account contains all the statements that we are required to make. These statements enable our services to be compared directly with other organisations and services submitting a quality account.

Review of services

During 2016/17 LCH provided and/or sub-contracted 64 NHS services. LCH has reviewed all the data available to it on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2016/17 represents 100% of the total income generated from the provision of NHS services by the LCH for 2016/17.

Transformation

Having been through a significant transformation of our clinical and corporate services in recent years, we continue to look for opportunities to make quality, outcome and efficiency improvements.

Work to integrate our Neighbourhood Teams continues. This has brought together nurses, therapists and adult social care workers to create integrated multidisciplinary teams within all neighbourhoods, aligned to GP clusters. We have established new shift patterns and introduced New Ways of Working (NWoW). The Neighbourhood Teams provide the foundation for achieving the city's ambition to improve quality of care and health outcomes by integrating and increasing the provision of health care in the community.

The development of Neighbourhood Teams is being supported by a number of IT, system and process transformations to support integration and the NWoW. The roll out of the Electronic Patient Record (EPR) and mobile working for Neighbourhood Teams was an essential piece of work for us in 2016/17. This progressed slower than was originally planned as we began to recognise the impact of the scale of change being implemented. EPR and mobile working was rolled out to 6 of the 13 Neighbourhood Teams with pre roll out staff engagement sessions currently taking place within three further teams. Nine Children's services went live with EPR Lite. We are on track to roll out EPR to all Neighbourhood Teams by 2018/19.

The implementation of e-Rostering was a further piece of work involving procurement and a pilot study within in 4 services. When fully implemented, the system will enable more effective and efficient allocation of staff in services. Further information regarding e-Rostering can be found in section 3.

Examples of how we have improved quality within our services over the last year

Adult Business Unit (ABU)

This year the established Neighbourhood Teams have made substantial progress across Leeds. Key achievements include:

- The introduction of Quality Boards. These display information relating to quality metrics such as clinical staffing levels, clinical incidents, supervision and appraisals and are now in place in all Neighbourhood Teams.
- 'Safety huddles' are held in each Neighbourhood Team. These meetings are used to discuss items and issues of patient safety with a view to improving patient safety and learning from incidents. Many teams hold safety huddles alongside their Quality Boards.
- Daily clinical handovers support effective patient care and ensure that skills and competencies developed through training are reinforced and consolidated through daily practice. For example, identification and management of the deteriorating patient is discussed as part of daily handovers.
- Quality Metrics folders have been introduced and are monitored within each Neighbourhood Team; and at a weekly Quality Meeting chaired by the Executive Director of Nursing and the ABU Clinical Lead.
- We are targeting areas for improvement in clinical care such as reducing the incidence of Pressure Ulcers, Falls and medication errors.
- We have made significant progress in developing the skills and competencies of all clinical staff working in the Neighbourhood Teams. This includes delivering Holistic Assessment training for 400 staff.
- We continue to develop and redesign new clinical roles to give us greater flexibility within limited resources. This has included the establishment of Pharmacy Technicians aligned to each Neighbourhood Team.
- We continue to increase the number of our nurses and physiotherapists who are qualified to prescribe medication. This group of staff meet regularly as part of an established forum for ongoing education and peer support.
- We have become part of a national pilot site to be part of introducing the new apprentice Nursing Associate role.
- Community Matrons continue to provide a vital leadership role in supporting effectiveness of the New Ways of Working (NWoW).
- Standard Operating Procedures for NWoW have been developed and are now in use across all Neighbourhood Teams.

Children's Business Unit

The Children's Business Unit works in partnership with Leeds City Council, education and local agencies. We aspire to the Leeds ambition of being the best city in the UK for children and young people to grow up in and work together to provide holistic child centred care. This includes working closely with children, young people and their families, actively listening and being responsive to their concerns, needs, and goals.

The children's service promotes choice. We collaborate with children to support them in achieving their aims with flexibility and responsiveness to change in need and preference. Areas of particular focus are social, emotional and mental health and special education need and disability.

Transformation plans and national reforms are being dynamically embedded across services with shared pathways and increased collaboration enabling seamless transition. Services are keen to encourage and respond to feedback from young people and families and strive to co-produce and explore service development opportunities.

An initiative to introduce the concept of "better conversations" within the Health Coaching model allows children, young people and their family greater empowerment and influence in their care. This is being launched within a quality outcomes framework which will allow services to understand what works well and inform future developments.

Specific examples of achievements made within Children's Services this year include:

- The Health Visiting service received an award in the 'Innovation' category of the Journal of Health Visiting Awards in Birmingham for the development, implementation and evaluation of 'Leeds Assessments Frameworks' as part of delivering the Healthy Child Programme.
- CAMHS is working in partnership with NHS England to develop digital technology to increase CAMHS interaction with young people and increase user involvement in their care.
- The School Nursing service achieved all allocated NHS England immunisation targets for the last academic year and was identified as our Team of the Year.
- ICAN held a series of training events to support the delivery of new pathways for children with complex and additional needs, with the emphasis on delivering personalised goals and outcomes.
- The Infant Mental Health Team were shortlisted for the Analeaf Award at the Infant Mental Health Awards 2016.

Specialist Business Unit

Examples of achievements made by the Specialist Services Business Unit to improve the quality of its services in 2016/17:

- Implementing initiatives to retain staff within specialist staff groups such as Nutrition and Dietetics, Musculoskeletal services, Improving Access to Psychologies Therapies (IAPT) and HMP healthcare services for example.
- Worked jointly with colleagues in the Adult Business Unit services to share staff and to maintain services when the healthcare system was under pressure.
- A task and finish group for recruitment and retention in the Dietetics service was established to explore sustainable solutions going forward.
- The introduction of an Apprentice Dental Nurse in the Dental Service created a career pathway for Community Dental Nurses. This was an innovative approach as most apprentice positions have been recruited to administrative posts. The team welcomed the apprentice and provided mentorship and support during their training. The apprentice qualified as a dental nurse ahead of schedule and following success of this initiative funding has been secured for a second apprentice.
- The Healthy Living Service is trialling a new smoking cessation pathway. Early indicators show an increase of outcome measures with an increase in the rate of smoking cessation from 65% to 87%.
- Patient centred coordinated care led to patients being discharged to be cared for successfully at home rather than experiencing a lengthy hospital stay. This work involved the Tuberculosis and Community Intravenous Antibiotic Services (CIVAS) working together with patients with multiple complex needs.
- The Community Stroke team implemented an early stroke discharge pathway.
- The Dietetics team introduced a 'passport' to support patients to self-manage their care.
- Police Custody remodelled their service to introduce a Health Care Practitioner led model to reduce reliance on Forensic Medical Examiners.
- The Diabetes service is part of a joint pilot project with primary care services in the north area. This aims to increase the skills of primary care staff and ensure patients receive the right level of intervention early in their care.

These are just a few examples of services and staff going that extra mile to ensure that patients receive high quality care. Such innovation has been recognised through awards such as the Musculoskeletal team being nominated for the LCH Team of the Year; and the Podiatry 'Walking on Air' project, nominated for Yorkshire Evening post Best of Health award.

Involvement in city-wide service improvement

As part of our ongoing commitment to quality improvement, we have continued to maintain a partnership with the Leeds Institute for Quality Health Care (LIQH) for a third year. The start of this year of partnership working saw a new Faculty Team having responsibility for ongoing delivery of the programme. Following the Year Two Programme Evaluation, over the summer of 2016 a range of engagement events were initiated by the Faculty Team to review the ongoing programme and ensure that this was responsive to the local context and requirements.

The aim of working with the LIQH Fellowship and the programme they offer is to develop individuals across the organisation that can lead and support change and improvement projects. Over the year our staff have participated in the LIQH programmes with colleagues from other organisations across the local system. The aim is to equip attendees with:

- An in-depth understanding of improvement concepts
- An ability to apply improvement methodology
- An increased understanding of health and care to form a 'whole system' perspective
- Increased skills in leading and supporting change and improvement

New skills gained through the programme have been used by staff within our neighbourhoods to work as 'change champions' to enhance our ongoing model of service integration and support clinically-led, place-based new care models. This includes developments in Armley, Crossgates and Beeston.

Work has commenced to scope the focus for a Year Four programme of learning. As part of this, the faculty team are working with members of the executive team to explore how a future programme might support the delivery of ongoing changes as identified through the Sustainable Transformation Plan (STP) for West Yorkshire and the local Leeds Plan.

Clinical Audit

All clinical audits that are planned to be undertaken within LCH should be registered on the clinical audit and effectiveness registration database. The monitoring of each audit includes results, summary report and action plans.

National clinical audits

During 2016/17 two national clinical audits and two national confidential inquiries covered the NHS services that LCH provides.

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

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

Eligible National Clinical Audits
Chronic Obstructive Pulmonary Disease
Sentinel Stroke National Audit Programme
Eligible National Confidential Enquiries
National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)
Chronic Neurodisability

The national clinical audits and national confidential enquiries that LCH participated in during 2016/17 are as follows:

There were no national audits applicable to our organisation that we did not participate in.

Eligible National Clinical Audits
Chronic Obstructive Pulmonary Disease
Sentinel Stroke National Audit Programme
Eligible National Confidential Enquiries
National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)
Chronic Neurodisability

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

National Audit	Number of cases submitted	Percentage
National Chronic Obstructive Pulmonary Disease (Clinical Audit of Pulmonary Rehabilitation services)	**Organisational audit:** still ongoing no data present. Closes 28 April 2017 **Clinical audit:** data collection ongoing. Closes 31 July 2017	Currently unavailable
Sentinel Stroke National Audit programme	April 2016 - Data has been submitted monthly into the National database. This is analysed nationally	100% of all cases identified

National Confidential Enquiries	Number of cases submitted	Percentage
National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)	National Report will be published which confirms LCH participation. No individual report available at this time	Currently unavailable
Chronic Neurodisability	Organisational Questionnaires completed. 1 case identified	100%

The report of 3 national clinical audit(s) was reviewed by the provider in 2016/17 and LCH intends to take the following actions to improve the quality of healthcare provided:

National Audit	LCH action 2015/16
National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)	The report recommendations do not identify individual Trusts. Any action plans and learning will be based on the overall submissions nationally.
Sentinel Stroke National Audit programme	This audit requires information to be inputted into a national database. The results are published online and currently unavailable for review.
Chronic Obstructive Pulmonary Disease (clinical audit of pulmonary rehabilitation services)	National report published which identifies recommendations to improve the care for patients undergoing pulmonary rehabilitation due to chronic obstructive disease (lung disease). Currently unavailable.

Local clinical audit

The reports of 75 local clinical audits were reviewed by the provider in 2016/17 and LCH intends to take the following actions to improve the quality of healthcare provided:

- Audits were carried out to look at the recorded reasons why a patient's medicines were not given and if a recognised code had been documented in the correct place on the medication/prescription chart. The results confirmed that staff recognise and understand why completion of these details is important. This evidences good clinical practice in this area, and reflects the quality of care given.
- The Diabetes Service completed an audit which looked at the compliance for providing an insulin passport following commencement of insulin treatment. The findings from the audit have ensured further discussions with other services to monitor elements of the Insulin Passport Scheme within the electronic patient record system. This includes education of staff and implementation of the Standard Operating Procedure (SOP) for use of the passport.
- An audit by the South Leeds Independent Centre (SLIC) showed a considerable improvement in the number of falls reported during this period (45). This reduction is a great achievement, reflective of the changes staff have made to improve patient safety. This has been achieved through implementing the following interventions: through completion of the Tier 2 assessments and falls care plan within 24 hours of admission; implementation of a falls log; daily 'Focus 5 for falls/safety briefing'; use of the falling star symbol; hourly rounding; use of sensors on admission; and using extra low beds and fall mattresses.
- Leeds NHS Stop Smoking Service completed an audit on the number of booked appointments that convert to face to face contact and how many lead to a positive outcome. As a result of the findings and feedback from service users, changes were made to the way appointments are booked.
- An audit by the Integrated Children's Additional Needs (ICAN) services looked at the inappropriately triaged referrals. Several changes where introduced to ensure that the process for triaging referrals was improved. Improvements included: increased communication with the referrers at other organisations such as General Practitioners (GP) and Health Visitors; revised clinic rotas to ensure a child receives the best care pathway when being referred to the rapid access clinic; or a joint clinic with a doctor and dietician working together. A Standard Operating Procedure for children requiring referral to other services was developed.
- The 'Watch It Children's service' undertook an audit looking at feedback received from service users that did not engage in the programme, to identify areas for service improvement. Families were contacted by telephone to ask for their views and to complete a survey. Feedback enabled the service to develop and deliver training for staff in school nursing, which will improve telephone conversations with parents. It also identified that sometimes parents/carers could not get in touch via telephone hence a process has been introduced to divert calls to the school nursing team. Finally information sent to parents/carers about how they could contact their service led to further improvements being made.
- The Leeds Child and Adolescent Mental Health Service (CAMHS) collected feedback from young people, their parents and carers regarding the service and convenience of appointment times offered. Some service users felt that appointment times were inconvenient. As a result, more appointment times have been offered at 3pm or later.

- Patients with a condition called osteoarthritis are often referred by a doctor to the musculoskeletal (MSK) service for treatment. An audit and service evaluation has been undertaken by the MSK service; looking at the standard of care offered for this condition when affecting the knee. Changes introduced included training for all clinical staff on the NICE guidance for osteoarthritis and more information being discussed with the patient on the treatment options, risks and benefits of different treatments.

During 2016/17 all services were required to participate in the annual documentation audit and produce an improvement plan to identify required improvements. Our Neighbourhood Teams within the Adult Business Unit included collection of data relating to end of life care, pressure ulcer management and falls in keeping with some of the priorities for improving patient care in the organisation.

Additionally, the Infection Prevention and Control Team undertake a range of local audits. These include; Environmental audits, PLACE audits and Essential Steps to Safe, Clean Care audits. These audits aim to reduce the risk of microbial contamination in everyday practice and to ensure our environment is managed in a way that minimises the risk of infections to patients, staff and visitors.

This table does not include audits that will be continued into 2017/18:

Local clinical audits completed during 2016/17 - by business unit

Adult Services		
• Documentation Audit • Clinical Supervision • Environment Audit • PLACE Audit	• Missed and Delayed Dose Audit (CICU) • Audit to Evaluate the Number of Falls Over a 6 Months Period	• Controlled Drug Audit • Prescribing Standards (SLIC) • Prescribing Standards CICU • Missed and Delayed Dose Audit (SLIC)

Children's Services

- Clinical Supervision Audit
- Documentation Audit
- Audit on Idopathic Constipation Management Pathway
- An Audit of the Prescribing Practice with Young People who have a Learning Disability
- An Exploration of Service User Views on Convenience of Appointment Times within Leeds Child and Adolescent Mental Health Service
- Environment Audit
- PLACE Audit
- Service Attrition Audit
- Speech and Language Service Evaluation benchmarking
- Assessment of Compliance to Monitoring Standards for Patients in the Emotional Disorder pathway
- Exploration of Service User Views on Convenience of Appointment Times
- Service Evaluation for Measurement of Staff Experience including sickness rate, leavers staff, morale measure and availability to recruit
- Prescribing Practice with Young People who have learning Disability
- Inpatient Controlled Drug Audit
- CAMHS Section 136 Assessment
- Audit in Medication Review Appointments in Patients on Methylphenidate
- Audit of Aetiological Investigations in Deaf Children
- Mattress Audit
- Integrated Children's Additional Needs (ICAN) services Inappropriate Triaged Monitoring
- Audit of Completing Part C Health Plans
- Spasticity Management Using Botulinum Toxin Audit
- Mini Documentation Audit
- Audit of Constipation Management on New Constipation Pathway
- Audit of Reports by CAMHS and Socrates as part of ESREP
- Audit of Current View Completion
- Breastfeeding Initiative Audit
- Percentage of Service Users on Caseload with No Recorded Contact
- Cow's Milk Protein Tolerance in Children with Downs Syndrome

Specialist Services and Health and Justice Services

- Synergy/CSSD Clinic Protocol Dental Nurse Compliance
- Documentation Audit
- Environment Audit
- PLACE Audit
- Clinical Supervision Audit
- IV Diuretic Guidelines
- Methadone and Citalopram audit
- Audit of Compliance for Providing an Insulin Passport following Insulin Initiation
- Using DNA rates to Indicate How People Are Voting with their Feet
- Audit of Treatment Plan
- Audit of Lichen and Sclerosis
- Booked Appointments that Convert to Actual Face to Face Contact
- Clinical Supervision
- Sharps Instruments in Healthcare PIR Survey
- Audit of Management of Paediatric Dental 'Did Not Attend' Appointments
- Amber Drug Audit
- Antibiotic Prescribing Audit
- Pregabalin and Gabapentin Prescribing Audit
- Audit on Completion of Generic Wound Assessment Template
- Patient Safety Audit Humberside Yorkshire Police Custody Suite
- Patient Safety Audit North Yorkshire Police Custody
- Patient Safety Audit South Yorkshire Police Custody
- Patient Safety Audit West Yorkshire Police Custody
- Re-Audit PGIC Compliance
- Supervision Audit
- Controlled Drug Audit
- Antimicrobial Stewardship at Wetherby Young Offenders

Clinical research

The number of patients receiving NHS services provided or sub contracted by LCH in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 300.

The LCH Research Department facilitates and manages our participation in projects that range from nationally funded multicentre research, to student research and local service evaluations. The Trust continues to host strong research collaborations in a number of services, in particular the musculoskeletal and wound care services; as well as palliative care through strong links with St Gemma's Hospice. The transfer of prison health care to another service provider on 1 April 2016 led to the closure and transfer of LCH hosted prison research studies.

Over the last year, development of national policy has led to our Research Department assessing the research capability and capacity of clinical services within the organisation to participate in, and host, research. The adoption of the "EDGE" research management system has facilitated a better degree of overall intelligence regarding study progress and accruals. Closer links with the National Institute for Health Research (NIHR), Clinical Research Network (CRN) and Study Support Service have enabled an increased degree of horizon scanning to identify up and coming studies that might fit with our services and be of benefit to our patients.

LCH has been proactive in recruiting participants from across the Trust to the Yorkshire Health Study. This is a large questionnaire cohort study recruiting from the whole population of Yorkshire. The cohort research will facilitate multiple randomised controlled trials to be conducted in the same population and will allow for greater comparability between studies. This will offer opportunities for future research on obesity and weight management, including how these issues contribute to long-term health conditions. In addition to recruiting patients, the recruitment of our own staff into the study has been particularly successful with over 500 members of staff participating to date. The participation of staff as study participants has given research staff an opportunity to raise the profile of research and discuss research opportunities with individuals on a more personal level.

This year a publication of a 5 year research programme regarding wound care was made, in which the Trust played a significant role. The programme identified that approximately 1.5 people per 1000 have a complex wound. Affected patients were greatly troubled by the social consequences of such wounds. Most patients and health professionals wanted healing of the wound to be the primary treatment goal.

If routine clinical data was collected, registers of prospective complex wounds might be implemented. This could inform wound care services and help to answer important research questions. Research on the effectiveness of treatments for complex wound healing was found to be inadequate and a top 12 list of research priorities in prevention and treatment of pressure ulcers were identified. Strategies for improving research in the field were also highlighted. The publication summary can be found at:

www.journalslibrary.nihr.ac.uk/pgfar/volume-4/issue-13#plain-english-summary

Commissioning for quality and innovation (CQUIN)

A proportion of LCH income in 2016/17 in based on achieving quality improvement and innovation goals agreed between LCH and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2016/17 and for the following 12 month period are available on request from **victoria.douglas@nhs.net**

Commissioner	CQUIN goal	Reporting process/achievement	Actual (YTD)
LSE CCG	Introduction of health and wellbeing initiatives	This CQUIN requires the organisation to develop and implement a programme of work aimed at improving staff health and wellbeing.	Achieved
LSE CCG	Healthy food for NHS staff, visitors and patients	This CQUIN challenges organisations to review and revise food and drinks served within their premises to staff with the aim of improving staff health and wellbeing. The expectation is that organisations change their providers were necessary to increase the options of healthy food and drink. The nature of community provider services means that we have no premises that have a canteen or vending machines and therefore we are submitting a nil return on UNIFY.	Achieved
LSE CCG	Improving the uptake of flu vaccinations for front line staff within Providers	This CQUIN requires services to achieve an uptake of flu vaccinations by frontline clinical staff of 75% by the end of quarter 3.	Achieved
LSE CCG	Improved Care Pathways: Respiratory	This is a new CQUIN for 2016/17 which requires Leeds Community Healthcare to work jointly with Leeds Teaching Hospitals to conduct a collaborative, comprehensive review of current major respiratory pathways to optimise best care.	Achieved
LSE CCG	Improved Care Pathways: Cardiology	This is a new CQUIN for 2016/17 which requires Leeds Community Healthcare to work jointly with Leeds Teaching Hospitals to conduct a collaborative, comprehensive review of current Cardiology pathways. The review will focus on scoping, identifying gaps and optimising the pathway for: • Acute Coronary Syndromes including post treatment rehabilitation and medication titration • Heart Failure	Achieved
LSE CCG	Embedding Integrated Neighbourhood Teams	This is Year 3 of this developmental CQUIN promoting joint working between Neighbourhood Teams and Primary Care.	Achieved

LSE CCG	Development of Quality indicators - Adult Services	Piloting use of outcome measures in Neighbourhood Teams	Achieved
LSE CCG	Development of Quality indicators - Specialist Services	Piloting use of outcome measures in MSK	Achieved
LSE CCG	Development of Quality indicators - Children's Services	Piloting use of outcome measures in ICAN	Achieved
NHS E CAMHS	Family and carer involvement in patient pathway	Implementation of good practice regarding the involvement of family and carers through a CAMHS journey, to improve longer term outcomes.	Achieved
NHS E H&J	Health and wellbeing for people with learning disabilities	This is a new CQUIN for 2016/17 which requires LCH to contribute to the development of evidence based health and wellbeing service for patients with Learning Disabilities cared for in prisons within the Yorkshire and Humber region.	Achieved
NHS E H&J	CHAT for Children and young people	This CQUIN will ensure that actions meet the health and wellbeing needs of children and young people identified via CHAT are incorporated in to auditable care pathways that are based upon evidence based practice and, where appropriate upon recent and relevant NICE Guidance.	Achieved
NHS E HV	Improve uptake Screening and Immunisation Programmes for people with learning difficulties or mental health conditions in the eligible population	This CQUIN requires school immunisation service to identify how they will increase access to their services for children diagnosed with a learning disability or mental health condition. The service is currently a high performing team when compared nationally. The action plan will look at baselining what they currently deliver, develop a process to identify children who may be missing and develop systems and resources to ensure they are included in the future.	Achieved

Care Quality Committee (CQC) registration, ratings and improvement plans

LCH is required to register with the Care Quality Commission (CQC) and its current registration status is full registration without condition. The current overall rating LCH achieved (22 April 2015) is 'requires improvement', as reported in our 2015/16 Quality Account.

At the time of reporting we await the outcome of our most recent CQC inspection, which took place at the end of January 2017. The inspection did not include Child and Adolescent Mental Health Service (CAMHS) Out-Patients service as the CQC re-inspected both the specialist CAMHS services and CAMHS Out-Patients services in June 2015. The Out-Patients service was rated 'good' whilst maintaining the 'requires improvement' rating for the specialist CAMHS service.

The Trust was delighted that the CQC rated the York Street Health Practice 'outstanding' in its inspection report published in December 2016 which identified excellent, safe compassionate care, robust and effective systems and strong leadership and management.

We have also been completing outstanding actions from the CQC's Trust-wide inspection in November 2014. Implementing the overall improvement plan has been a significant focus for LCH during 2016/17 resulting in improved practices, processes, governance and organisational culture:

Safe

- Addressing the outstanding compliance notice on registration for our specialist Child and Adolescent Mental Health Service (CAMHS) relating to safety risks associated with the inpatient premises. Extensive work has been undertaken to ensure effective identification and mitigation of ligature risks, including an independent review. The Trust is no longer progressing the move to suitable new premises as the commissioner has notified us that suitable premises will be commissioned as part of the service tender. We expect this to be published by quarter 3 of 2017/18.
- Adult services – ensuring safe staffing and safe practice in our Neighbourhood Teams. Staffing levels and skill mix have been reviewed as part of a wider programme of work to create integrated, sustainable neighbourhood teams and embed the New Ways of Working that support safe, efficient and effective utilisation of resources. Key focuses have included introducing an electronic patient record, new shift patterns, demand and capacity monitoring and flexible arrangements between teams, a new leadership structure, case management and consistent rotas.

Responsive

- Ensuring children and young people are able to access CAMHS out-patients services within a reasonable time frame; the focus in 2016/17 having been on reducing waiting times for Autistic Spectrum Disorder Assessments to below 12 weeks. This target was not met due to a 35% increase in referrals during the course of the year.
- Ensuring compliance with national guidance in relation to transcribing medicines safely by deploying our pharmacy technicians to undertake the majority of transcribing.

Effective

- Reviewing assessment and discharge planning and infection prevention and control at the Community Intermediate Care Unit following its transfer back to LCH control from Leeds Teaching Hospitals Trust.
- Developing reporting on outcomes.
- Improving rates and recording of supervision.
- Ensuring incident investigations are completed on a timely basis.

Well-Led

The Trust Board receives quarterly reports on progress in addressing the actions and monthly reports are provided through Quality Committee and Senior Management Team meetings.

Ofsted and CQC undertook a joint SEND inspection of services provided by the Local Authority, NHS providers including LCH and schools for children with Special Educational Needs.

- We continually meet our requirements for safer staffing in inpatient areas.
- We have adjusted to expectations on the use of agency staff and have been compliant with our overall agency cap set by NHS Improvement.

LCH has not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC has not taken enforcement action against LCH during 2016/17.

Secondary uses and hospital episode data

LCH submitted records during 2016/17 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- that included the patients valid NHS Number was 100% for admitted care and was 99.97% for outpatient care
- that included the patient's valid General Medical Practice Code was 99.84% for admitted care and 99.87% for outpatient care

*The above confirms data available for 1 April 2016 to 31 January 2017; the submission timetable for data does not require data for 2016/17 (to 31 March2017) to be submitted until May 2017.

Information governance

LCH is expected to achieve overall Level 2 compliance in 2016/17 and be graded green (Satisfactory) as part of the Information Governance Toolkit assessment conducted annually. This ensures that LCH has the relevant policies, procedures and working practices in place to comply with the requirements of the Data Protection Act and mitigate risk across the organisation.

LCH also deals with large volumes of requests for personal data and consistently meets statutory deadlines in compliance with the Data Protection Act 1998 and Access to Health Records Act 1990 legislation. Deadlines are consistently met in compliance with the Freedom of Information Act 2000.

Some directed actions we have already taken or commenced to improve our compliance score are:

- Ensuring all staff complete the Information Governance Training on commencement of employment within LCH whether this be on a temporary or permanent basis.
- Introduce a more robust process to ensure our staff have access to Information Governance Training before being provided access to clinical information systems. This includes removing access to the systems should the validity of their training expire.
- Introduce a mandatory annual cycle of refreshing Information Governance training, which is administered and monitored through our Electronic Staff Record System (ESR).
- Staff who support responses to Subject Access Requests have been provided with bespoke training, which will be refreshed on an annual basis.

Payment by results

LCH was not subject to the Payments by Results clinical coding audit during 2016/17 by the audit commission.

Staff satisfaction

The table below shows the percentage of staff employed by the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends*, as reported on the NHS National Staff Survey**. This includes comparison with the previous three years.

Year	Number of staff employed	% of those staff employed who recommend the trust to family or friends	National average	Highest/ lowest
2013/14	2970	60%	67%	76%/60%
2014/15	2960	64%	70%	83%/62%
2015/16	2672	69%	73%	82%/67%
2016/17	2790	65%	73%	86%/65%

LCH considers that this percentage is as described for the following reasons:

As with previous years, the Trust has seen a degree of change across all services that may have impacted on our percentage. We see 65% as a positive outcome given the ongoing challenges our staff face on a daily basis. 86% of our staff feel their role makes a difference to patients/service users.

The LCH intends to take/has taken the following actions to improve this percentage, and so the quality of its services, by:

- Our focus this year is on recruitment, retention and wellbeing of our staff. We know having a healthy workforce has a positive outcome on patient care.

  Engagement of our staff is very important to us and we do this through:

  - The executive team spending more time with our clinical members of staff and teams to better understand their roles and challenges
  - An 'Ask Thea' facility for staff to ask the Chief Executive about matters important to them
  - 50 Voices – a voluntary group of 50 staff who come together to form a focus group on a rotating basis
  - Themed reports to the Trust Board
  - Our Organisational Development
  - Clinical and Professional strategy
- Continuing our focus on the health and wellbeing of our staff through a variety of supportive interventions such as counselling, coaching, mindfulness, mediation.
- Celebrating the contribution of our staff through appraisals, Thank You Awards and Thanks a Bunch.

For the last 2 years we were asked to include the most recent LCH NHS Staff Survey results for indicators:

- 'KF19' reported in the LCH 2015 results as **KF26** (Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months)

In 2016/17 we achieved 16% for this indicator, which is a 7% decrease compared to 2015/16 and 4% lower than the national average for other community Trusts.

And:

- 'KF27' reported in the LCH 2015 results as **KF21** (Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion) for the Workforce Race Equality Standard

In 2016/17 we achieved 92% for this indicator (an increase of 3% compared to 2015/16), showing us to be above the national average of 90%.

What else are we doing?

- We are reviewing our Organisational Development (OD) Strategy to ensure we are focusing on the recruitment, retention and wellbeing of our staff
- We are promoting our coaching offers (health and manager as coach) to support our staff in taking the initiative to improve patient care
- We have developed and will continue to deliver our leadership programme (L.E.A.D.) to build our leadership capability
- We are re-establishing a recruitment and retention task group to ensure we meet the challenge of recruiting and retaining the appropriate level of staff

Patient experience of community mental health services

The table below summarises patient experience of LCH **Specialist Child and Adolescent Mental Health Service** (CAMHS) interventions during this reporting period and the previous three years:

Reporting year	Community CAMHS		Inpatient CAMHS	
	Young persons' satisfaction	Parents and carers' satisfaction	Young persons' satisfaction	Parents and carers' satisfaction
2013/14	80.81%	88.98%	49.51%	73.21%
2014/15	78.24%	88.50%	38.54%	40%
2015/16	78.26%	88.15%	71.43%	86.46%
2016/17	82.18%	88.16%	79.17%	88.89%

Source: CHI-ESQ, a CAMHS-specific satisfaction questionnaire used nationwide

LCH considers that this indicator score is as described for the following reasons:

We have proactively implemented a number of actions to encourage feedback on experience from children, young people and their families using the CAMHS services.

LCH intends to take/has taken the following actions to improve this indicator score, and so the quality of its services, by:

- Young people and carers being involved in recruitment of new CAMHS staff. Participants have received training in selection processes, formulating and asking questions at interviews. Feedback from both service users and interviewees has been very positive.
- The recruitment and employment of a CAMHS Participation Worker who is leading the Involvement Champions in CAMHS to make a difference to the patient experience.
- By actively involving young people and their families in the design of the new CAMHS Eating Disorder Service.

- Young people and clinicians working together to develop an emotional health App which is now being piloted in the Leeds CAMHS.
- Significantly improving our waiting times to less than 12 weeks for access to CAMHS.
- Working with Leeds City Libraries to establish 'Bibliotherapy' in libraries with books recommended by parents/carers and clinicians.
- Young people working on our website design and content including recommended reading and other resources.
- Increasing the use of outcome measures to improve collaboration in children and young people's care.

More information regarding these developments is available upon request by emailing: **hannah.beal@nhs.net**

Increasing Access to Psychological Services (IAPT)

Satisfaction within the Increasing Access to Psychological Services (IAPT) is collected and recorded as part of a national data set.

The LCH patient experience of community mental health services indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period is given in the table below:

Reporting year	Percentage satisfaction all of the time
2013/14	77%
2014/15	83.5%
2015/16	84.2%
2016/17	83.5%

LCH considers that this data is as described for the following reasons:

- Patient Experience data collection is a national requirement of all IAPT Services, with satisfaction measured post screening and at the end of treatment.
- Audits are carried out quarterly by the service

The IAPT Partnership at LCH intend to take the following actions to improve this indicator score, and so the quality of its services by:

- Reviewing all patient feedback on a regular basis and sharing learning across the service.
- Collaboratively working with GP practices and the new Primary Care mental Health Liaison Practitioner roles to help patients be better informed about the services available.
- Using our patient leaflets, developed with patients, which describe the range of services offered.
- Continuing to host, attend and learn from events with patients regarding our service, for example consultations, times and venues.
- Continuing to improve access to the service by reducing waiting times.

This work will continue next year alongside the following actions:

- Redesigning the mental health pathway with Community Mental Health Teams and other key partners in line with the Leeds Mental Health Framework in order to streamline access for service users and improve experience.
- The redesign will be informed by the "I Statements" which were co-created by service users in Leeds. The basis of the change is to embrace the key messages that service users have been feeding back, through various opportunities, about what they want and need from mental health services.
- A fundamental principle of the redesign will be to focus on the recognition of the potential that many people have for managing their own health and well-being, particularly when supported with high quality information and resources.

More information regarding these developments is available upon request by contacting Steve Callaghan, IAPT Service Manager: **steve.callaghan1@nh.net**

Patient safety incidents

The table below shows the number and percentage of patient safety incidents (PSIs) reported within the LCH during the reporting period and previous years, and the number and percentage of such patient safety incidents that resulted in severe harm or death:

The way these incidents are categorised and reported has changed through developments over time hence 2016/17 figures are comparable to 2015/16 figures only. LCH reports all incidents that affect our patients; however some occur in other organisations, for example care homes or other hospitals. The breakdown below of incidents occurring within our care at LCH and those occurring in other organisations is included to reflect the balance of incidents that are directly linked to our organisation. The greyed sections represent all PSI incidents for that year whereas the latter two years compare LCH PSIs only.

Reporting year	Number of all patient safety incidents	Number (and %) of patient safety incidents that occurred within LCH care	Number of patient safety incidents that resulted in severe harm or death (caused directly by the PSI)	Number as a percentage of all patient safety incidents
2012/13	2371	Unavailable for these years	20	0.84%
2013/14	3199		35 (30 severe harm + 5 deaths)	1.09%
2014/15	3927		27 (25 severe harm + 2 deaths)	0.69%
2015/16	4207	3215 (76.4%)	49 (47 severe harm + 2 deaths)	1.2% (LCH PSI incidents)
2016/17	4189	3156 (75.3%)	61 (60 severe harm + 1 death)	1.93% (LCH PSI incidents)

LCH considers that this number and/or rate are as described for the following reasons:

- Staff are encouraged to be open when something untoward has occurred through the reporting of incidents and learning from these
- We are continually developing the incident reporting processes to improve the quality of the data we can produce

LCH has taken the following actions to improve this number and/or rate, and so the quality of its services, by:

- Promoting the reporting of all incidents that occur within our services
- Providing training on incident reporting and investigation for all staff
- Providing training on investigating serious incidents for managers and holding a register of trained investigators
- Improving the systems in place for reporting incidents in order to ensure we are capturing all the important information that we can learn from, to prevent a recurrence of when things go wrong
- Increasing the involvement of all levels of staff and members of the public in discussions about how the organisation can improve learning from incidents and other sources of information
- Benchmarking our organisation against other community Trusts to assess our performance against other organisations that are performing well

According to the NHS National Reporting & Learning System (NRLS) (2015) organisations that report more incidents generally have a better, more effective safety culture. The number of incidents we report in LCH is currently above the national average* when comparing our organisation to other community Trusts. Nevertheless, we want to continue to improve the reporting of incidents so that we can learn as much as possible. Alongside this we strive to achieve a higher rate of 'no harm' incidents and develop of culture of staff who feel supported to report incidents when they occur.

*at the time of reporting

Inquests

During and to date 2016/17 we have registered by the Coroner to be involved in 28 inquests, 23 of which have been concluded. LCH has not received any Prevention of Future Death (PFD) reports served by the Coroner under the Coroner's (investigations) Regulation 28.

Mortality Surveillance Group

In 2017/18, providers will be expected to report on their progress in using learning from deaths to inform their quality improvement plans. This builds on the work of the Royal College of Physicians in developing a methodology to support this process. We are therefore beginning to plan how we can best report on and monitor this to demonstrate learning from deaths.

The LCH Mortality Surveillance Group (MSG) was established in April 2014 and is part of our governance structure reporting into the Quality Committee. LCH is a learning organisation with a focus on quality improvement and mortality surveillance is an important element. The overall aim of the MSG is to:

- review all data on patient deaths that occur within our inpatient units and the community
- promote quality care and identify sub-optimal care
- identify learning
- consider strategies to reduce avoidable mortality
- have a particular focus on Learning Disability and Mental Health

The monthly group has multi-professional membership demonstrating a breath of clinical knowledge. It is underpinned by three Business Unit mortality governance meetings, which also have multi-professional membership.

This year we have continued to refine our processes and improve our data collection and reporting. As a Community Trust we have a number of data sources and we are not always notified when a patient dies in the community. To help overcome this we have identified 'core reporting services' and redesigned roles to ensure that there are lead reviewers within the clinical Business Units and corporate support team. Further support is received from the Business Intelligence Team.

The Trust's Performance Brief (our monthly summary of performance within LCH) now includes data on the number of unexpected deaths in our inpatient units and the number of Sudden Unexpected deaths in Childhood (SUDIC) on our caseload. We have extended our reporting process to incorporate all our community services and inpatient units, to enable us to identify trends and themes and promote the provision of quality care. We have also strengthened our internal links with Serious Incident reporting and the SUDIC service.

The MSG also reviews national documents, reports and notifications from regulatory bodies. Following the Mazars report (t*he independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust from April 2011 to March 2015*) the Trust held a number of presentations to raise awareness. We amended our reporting process to include the ability to record if a patient who has died had a known mental health issue or learning disability.

There is currently no national guidance on appropriate recording of mortality information for Community Trusts so we have made links with leads in other Community organisations in Kent & West Sussex to share best practice. We were pleased to be selected as one of a number of Trusts to be visited as part of a Care Quality Commission (CQC) review on investigating deaths across NHS mental health, acute and community settings. The CQC published their report *'Learning, Candour and Accountability: A Review of the way NHS Trusts Review and Investigate the Deaths of Patients in England'* in December 2016. Although there were no specific recommendations for LCH, the visit allowed us to reflect on our processes, identify our strengths and weaknesses and enabled us to consider how we can develop these further.

Continual learning and improvement

Our approach to Continuous Quality Improvement (CQI) is a key component of our Quality Strategy and Organisational Development Strategy. A CQI model has been developed with engagement from staff, leaders and the Senior Management Team to triangulate:

- development of effective teams (e.g. leadership, engagement, behaviours, systems/processes)
- improvement knowledge (e.g. tools, measurement, analysis, co-production)
- the necessary strategies to ensure teams are able to focus on improvement.

Other ways we participate in CQI include:

- Pressure ulcer and falls review meetings
- Conferences
- Innovation and Research Council meetings
- Presentations
- Masterclasses
- Quality Improvement Community of Practice sessions

An Improvement, Innovation and Research hub page is currently being developed for staff to access and this is expected to go live in 2017/18.

Section 3

Quality improvements for the coming year

Quality Strategy

In February 2016, the board approved the quality strategy for 2016-2018. The quality strategy describes the quality improvement ambitions of the trust aligned to the organisational strategic objectives.

Twenty one separate actions were identified as necessary to achieve the quality improvement ambitions. Half of these actions have so far been completed or are well on their way to completion. These include:

- refreshing the process for services to self-assessment and visitors to assess the quality of their services
- setting up quality dashboards in all inpatient and neighbourhood teams
- refreshing the organisational development strategy
- launching 'Our Eleven' set of vision, values and behaviours
- continuing with the staff engagement group, 50 voices
- developing and implementing the professional strategy for clinical staff
- developing and delivering a management training programme
- work to reduce pressure ulcers and work to demonstrate learning from incidents and complaints

There are eleven actions that will need attention in the coming year to ensure we realise our ambitions. There are four themes that link these actions and these are included in our quality account improvement priorities for the coming year. Two of the actions will need processes and practices embedding across services to be successful. For example, we have identified through our monthly Director of Nursing report and by tracking our quality account priorities from last year that we need to be better at recording we have said sorry (Duty of Candour) after a harmful incident hence the need to embed Duty of Candour will continue to be a quality improvement priority for 2017/18.

Several of the identified actions relate to change in the neighbourhood teams. We need to do more work on EPR, the roll out of holistic training and the development of outcome measures. We have set priorities for achieving this in the effectiveness part of the quality account for this year.

Data is another theme that connects the actions requiring further work this year. We need to ensure that the organisation has access to data that reflects the quality of services offered, which supports quality discussions and review at a service level. We also need to look at how we use data to develop continuous quality improvement within the organisation.

A final area for attention that will help us achieve our quality ambitions is staffing. We have already completed a number of actions in this area, such as the development of the professional strategy and engagement in the development of new roles. More work is underway to ensure we have enough staff including the roll out of e-Rostering and ensuring staff have the right competencies. We have reflected this in the leadership priorities for this year.

Professional Strategy for Clinical Staff – developing and engaging staff

LCH has a vision to provide the best possible care in every community. To achieve this vision it has 4 objectives of which one is to recruit and retain the best workforce. The majority of clinical staff within the organisation are registered professionals (Allied Health Professionals (AHPs), Nursing and pharmacy staff and their support staff. The aim of this strategy is to set out our aspirations for these groups of clinical staff and how we can work together with patients and partners to ensure the professional competency and skill of our clinical workforce.

The strategy has been developed with involvement of front line staff through focus groups and professional forums.

There are four aspirations we have for AHP, nursing and pharmacy staff in LCH:

- That they promote the health and well-being of the people of Leeds through effective AHP, Nursing and Pharmacy interventions delivered by well trained professional staff, using the best available evidence; and demonstrate the difference this makes to people's lives.
- That patients and carers are active partners in their care and staff work in a truly integrated way with each other and other organisations; to deliver care in the most appropriate place and in the most appropriate way to meet the patient's needs.
- That we are the employer of choice for AHP, Nursing and Pharmacy careers. Staff are supported from recruitment to achieve their full potential through robust professional support and development.
- That we are a centre of excellence for innovative community health care and education. AHPs, nurses and pharmacists in LCH are creative and solution focused in their response to the needs of patients, carers, commissioners and educators. We use business intelligence and benchmarking to demonstrate what we do, sharing with commissioners and education providers to shape future provision and the workforce.

Within the strategy each aspiration is broken down into a number of objectives with measures of success. These will be developed into action plans with staff. The delivery of the plans will be monitored by the Executive Director of Nursing through our Senior Management Team meetings and relevant sub committees.

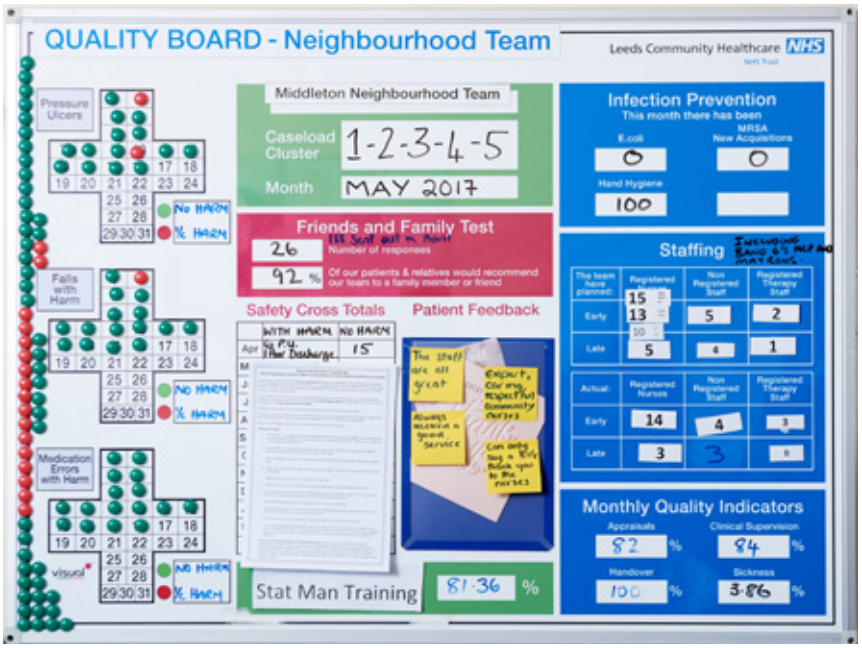
Safe

Introduction of Quality Boards - supporting staff to understand how their team is doing

Quality Boards were introduced in the Adult business Unit in June 2016 within the 13 Neighbourhood Teams, the Night service and our three inpatient units, to promote safer care and improve clinical outcomes for patients.

The boards display information regarding patient feedback, incidents, clinical supervision and, staffing levels. These help staff to focus on successes, where improvements are required and provide an opportunity to reflect on quality work being delivered in their team. Handovers of patient care are held around the boards, where conversations include updates on patients and their condition, identification of any changes in care required and acting on any concerns.

'Safety huddles' are held weekly. These focus on reducing the number of falls, pressure ulcers and are used to prioritise key messages for staff. The process for monitoring the completion, benefits and impact of the boards is discussed in the weekly Neighbourhood Team Quality Meeting, chaired jointly by the Executive Director of Nursing and Clinical Lead for Adult Services.

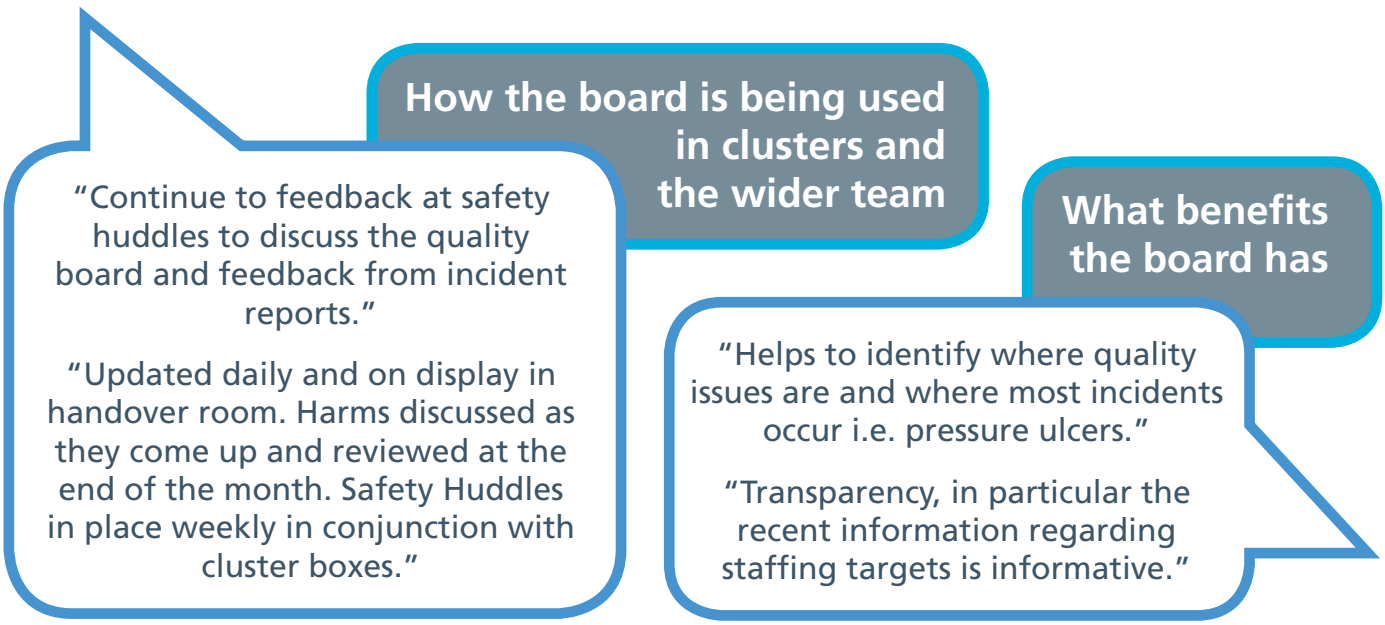


Extracts from teams using the quality boards:

What has worked well that month, celebrating the good practice

"Implemented cluster boxes into the team, which are being taken into each handover session. Started to attend regular handovers to audit the effectiveness of the process, and to share specific leadership information. Worked well with operational staff to improve the staffing section of the board. Massive reduction in sickness within the Middleton team to 7.58% but due to staffing vacancies this has not had as good an impact on services as we hoped. No falls with harm this month."

"29 Harm free days. Supervision rates increased to 81%, FFT increased to 30 responses."



This year our priorities for improving **safety** are:

Quality area for action	Projected outcome 2017/17	Indicators
Protecting Patients from harm that happens in our care (Sign up to Safety)	Reduce the number of patients who develop an avoidable pressure ulcer. Reduce the number of patients who have a fall whilst in our care.	a) 10% reduction in avoidable 3 pressure ulcers (category 2 pressure ulcers will also be monitored via our Director of Nursing Report) b) No avoidable category 4 pressure ulcers c) 5% reduction in falls resulting in avoidable harm in our community inpatient units
Incident Management	Strengthen incident management and ensure investigations are completed on time.	All incidents and Serious Incidents (SIs) should be investigated and closed in accordance with the Incident Management Policy: including SI management. Improvement will be measured from a baseline taken at end Q4.

Falls Group and Pressure Ulcer management

This year we established a new Falls Steering Group, which is chaired by the Deputy Director of Nursing. The aim of the group is to raise the profile of falls within the organisation and ensure learning is shared from falls incidents.

The group has met twice to date and has already reviewed and updated the falls leaflet as well as developing a set of useful literature for staff. This includes a handy reference guide to when and what falls risk assessments are required. In addition panels are now held for all cases of major harm caused by a fall, to establish if the harm was avoidable from the organisation's perspective to ensure that learning from them is shared.

Our Pressure Ulcer Steering Group and Root Cause Analysis (RCA) process, that reviews the development of a pressure ulcer, is now well established. Work continues to ensure that action plans are effective and learning is shared across the organisation.

Our aim is to continue to reduce harms from falls and pressure ulcers and to ensure that LCH staff provide high quality, effective care at all times through learning from previous incidents.

Effective

This year our priorities for improving **effectiveness** are:

Quality area for action	Projected outcome 2016/17	Indicators
Outcome measures	Build on the progress made in 2016/17 and increase the number of services centrally reporting clinical outcome measures (2017/18)	**Q1** The appropriateness of using TOMs and EQ5D in additional services will be assessed and will inform an action plan to roll this out. Commissioners have requested that defined services develop action plans for the implementation of commissioning for outcomes; and build on the pilots of outcome measures carried out in 2016/17. Action plans will be developed accordingly during this quarter. **Q2 forward** Progress will be measured by the number of services that recording outcome measures and are having these reported via the Business Intelligence Team.
Continue to progress the roll out of the E-rostering system	Have clear rotas in place in a range of services including Neighbourhood Teams	**Q1 – finalise current pilot** From Q2 – roll out within a minimum of 4 areas per quarter with a view to increasing the number further each quarter. This will ensure all NHTs are covered. This programme of work will continue to 2019/20.

E-rostering

Look back

- Procurement for an e-Rostering system to fit our community needs began in January 2016 with suppliers responding to our specification for what we needed.
- Following reviews of potential suppliers, the Trust Board approved full procurement and contract negotiations began in March, leading to contract agreement in April.
- Preparation for implementation began with initial developments to commence use of the e-Rostering system.
- From June to September the system was further developed in with line with our requirements.
- Four services were identified to pilot e-Rostering and the pilot was progressed as the implementation team was established.
- Between October and the end of the year the pilot services gained access to the system and we have since been developing detailed knowledge and briefings; and specific system processes.

Look forward

- Once initial pilot services have been fully implemented and the system developed to standard, there will be a wider roll out across the organisation with an initial focus within the Adult Business Unit.
- The key benefits of e-Rostering will be realised and functionality of the system will continue to expand.
- The roll out process will be complete in 2019/20.
- The project implementation will be monitored via Senior Management Team meetings and Business Committee meetings.

Quality Challenge+

In 2016 we launched our new quality assessment framework for services called **Quality Challenge+**. This framework provides services with a tool to assess themselves against our policies, our behaviours, national indicators and guidance, alongside the Care Quality Commission's five domains of quality. It was developed with staff, with users and by looking at ideas from other health organisations.

All services completed a self-assessment by the end of July 2016 last year. The self-assessment included asking services to rate themselves as *good, requires improvement* or *inadequate* across a total of 10 standards. All services reported themselves as good or *requiring improvement*, with examples of innovative and caring practice.

We are now following up the self-assessments with **Quality Visits** to services. The visits are undertaken by staff who have volunteered their time to support the process. They involve talking to staff and patients about their experiences. The visitors also observe the day to day work of the service, which could be in the patient's home, a health clinic, an inpatient unit or other setting.

These visits take place every 3- 9 months and provide a way for services to celebrate their achievements as well as continually identify where improvements need to be made.

The quality visits have identified areas of outstanding practice with staff showing compassionate care. Service users report that they felt safe and listened to. After each visit services have described how they could do things better. Examples include:

- keeping the area clean and tidy
- better and different types of information for services users
- increasing support available to staff

Quality Visits will continue in 2017/18, with the inclusion of service users as part of our visiting teams. Services will have the opportunity to reassess themselves against the standards in the Quality Challenge+ tool next year again too.

Caring

Neighbourhood Palliative Care Lead role

The Neighbourhood Palliative Care Lead (NPCL) service was developed in 2015. The service consists of seven senior nurses whose role it is to support staff within neighbourhood teams to deliver high quality palliative and end of life care. These staff provide seven-day clinical leadership, advice and support; and deliver education and training programmes.

Working with our Acting Palliative Care Lead and staff in the Neighbourhood Teams enables the NPCLs to lead service improvements locally. These include supporting patients being cared for to die in the place of their choice, often their home or care home, to improve patient and carer experience and prevent unnecessary hospital admission at the end of life. The NPCL team has demonstrated a significant impact in these areas, reflected in a wide range of positive feedback and improved reporting of care outcomes. This culminated in them winning LCH's 2016 Patient Care Award in December 2016.

The NPCLs have supported neighbourhood teams to improve reporting of, and increase the percentage of, patients achieving their preferred place of death. Data quality has improved from around 70% to over 90% enabling us to report with confidence that more than 86% of patients known to our Neighbourhood Teams in 2016/17 have died in their preferred place of death, compared to 82% last year. More staff have attended palliative care training and are now supported in practice to develop their skills and confidence.

The role continues to evolve and we will be implementing a full programme of continuous service improvement throughout 2017.

Below and opposite are some examples of feedback about the NPCL role from carers and staff:

Carers

[NPCL and nurse] were "top notch and we would not have coped without you, thank you."

"Thank you so much for all you did for all three of us. You have a very special job..... and obviously the respect of your colleagues, patients and relatives."

Staff

"Thank you for today! You were a huge support and I feel we got some great learning and I learnt lots from you! I feel very privileged we have you around to bounce ideas off and offer support."

"Thank you for summarising [progress to date], it… shows what a valuable asset you are to the team and also how much progress you have made in a short period of time."

"The adults Performance Team would like to thank you all for the work completed in supporting the neighbourhood staff in improving the quality of care to patients and formally recording the patients preferred place of death."

"The [NPCLs] have been extremely supportive and (in some cases) integral to the safe discharge/transfer of care… from hospital for patients at the end of life."

[NPCL role] is "fantastic and visibly having an impact on patient care."

This year our priorities for improving **experiences** for patients and staff are outlined as follows:

Quality area for action	Projected outcome 2016/17	Indicators
Friends and Family Test (FFT)	a) Increase survey response rates, to bring about an improved level of understanding of patient experience and satisfaction. b) Demonstrate three services in each business unit using patient feedback or co-production to change the shape of services to improve patient care.	Quality Leads/FFT Lead are working to agree new plan for 2017/18. This will include: An overall quarterly increase using previous year as a baseline. b) Baseline of FFT equality data to be produced at end Q4.
Duty of Candour	All relevant persons will receive an appropriate apology in the event of a notifiable safety incident, as per the definition and regulatory requirement.	100% of relevant persons should be notified of a safety incident (as per the definition) in person, given reasonable support in relation to the incident; and a written notification (unless declined). In all applicable cases, this must be recorded in writing (via our Datix database system). This will be monitored by the Clinical Governance Team and reported monthly.

Better communication

☑Engagement to improve communication about pressure ulcers and 'Duty of Candour'

☑ Documentation audit reported to Quality Committee

Quality Account focus on areas of particular need:

☆Duty of Candour

☆ Incident investigations

Feedback in 2015/6

"around 20% of the Leeds population includes Black and Minority Ethnic (BME) communities …understand and tailor services to meet the needs of all communities"

You said… for 2016/7, we will:

Focus on equality data as well as response rate for satisfaction surveys to develop culturally-sensitive quality improvement plans in services

HMYOI Wetherby and Adel Beck

We were delighted to be successful in continuing with the contract to provide health services at HMYOI Wetherby and Adel Beck in 2016/17. Mobilisation of the contract will continue into 2017/18 focusing on the transformation of the medical element of the service to improve quality and cost effectiveness of services provided to the young people at both secure units.

'Secure Stairs' is a therapeutic care model being piloted nationally in secure children's homes with the intention of rolling it out across the Young Peoples' Secure Estate. Adel Beck has been awarded funding to support the introduction of Secure Stairs which will create a Psychologically Informed Environment (PIE) thus supporting staff to apply a therapeutic approach to the care of young people to improve their experience.

Police Custody Suites

A recent inspection of police custody services in West Yorkshire was carried out by HM Inspectorate of Prisons and HM Inspectorate of Constabulary. This was described as "the most positive inspection made of police custody for some time".

Also noted was the increase in performance response rates. Consistently, over 95% of detainees are seen by a health care practitioner within 60 minutes, partly improved through the introduction of a clinical triage tool and training for practitioners.

Feedback for the healthcare team included:

"we observed excellent interactions between Health Care Professionals and detainees and care provided was good"

"a pharmacy technician made regular visits to the custody suites which supported the effective governance of medicines management"

"clinical record keeping was good… and regular documentation audits completed"

Responsive

Specialist Community CAMHS: improving access to the service

In 2015/16 the Specialist Community CAMHS service was challenged with improving access to first appointments and successfully achieved a maximum 12 week waiting time by the end of March 2016. The service is proud to have maintained this target with all children and young people being seen within 8-12 weeks of referral.

The new challenge for 2016/17 has been for the service to address its waiting times for Autistic Spectrum Condition (ASC). Nationally, waits for this type of assessment are high and our waiting times for this service reflected this national trend with a waiting time of 52 weeks and over at the start of this initiative.

The service has worked creatively and differently to begin improvement of the waiting times for ASC assessment.

It has been an opportunity for the staff to try new ways of working such as:

- running Saturday assessment clinics
- trialling twilight/evening assessment clinics
- considering "fast track" approaches for less complex cases
- increasing skills of our partners in schools to provide more detailed referral information to facilitate a quicker diagnosis
- standardising how we do things across the service to improve outcome and efficiency

Unfortunately, we did not achieve the target waiting time of 12 weeks by the end of March 2017. This is mainly due an increase in referrals to the service (double) during the year, which was not anticipated. However, the service is on track to deliver the target within 2017/18.

The hard work and innovative approach to solving the issue demonstrate the ambition and commitment of our staff to improve access times for children and young people.

This year our priorities for improving **responsiveness** are:

Quality area for action	Projected outcome 2016/17	Indicators
Access to Services	Reduce internal waiting times: understand waits and agree priority areas for intervention. Increase timely access to Child and Adolescent Mental Health Service (CAMHS), Integrated Services for Children with Additional Needs (ICAN) and Continence Urology and Colorectal Service (CUCS), particularly in relation to accessing clinical interventions	a) **CAMHS:** access to clinical intervention (i.e. following assessment) to be no longer than 12 weeks. Target to be measured from the date of being placed on the internal waiting list for intervention. b) **ICAN:** • parent group intervention for Children with ASD diagnosis within 12 weeks of diagnosis • follow up medical appointments within 4 weeks of planned date • see 80% of initial appointments for OT and PT within 12 weeks c) **CUCS** Associate Practitioner initial assess 18 weeks Specialist Nursing Review: **Q1** <=30 wks / **Q2** <=25 wks / **Q3** <=20 wks / **Q4** <=18 wks Will reflect on priorities agreed for 17/18 following analysis of current internal waits and assessment of resource implications to progress the work. To include CAMHS Eating Disorder service 4 week wait.

Priorities for improving **responsiveness** cont'd:

Quality area for action	Projected outcome 2016/17	Indicators
Learning from patient experience	a) All partially and fully upheld complaints should have a SMART action plan as part of the complaint response. b) The Patient Experience Policy will be reviewed and revised	a) 100% of partially and fully upheld complaints will have SMART action plans. To be achieved by end Q4 with demonstrable improvement over the year. This will be reported via the Executive Director of Nursing report and a baseline taken at end Q4 2016. b) The policy will be revised as part of wider service changes underway. This will encompass reflecting how we demonstrate and evaluate service improvements resulting from complaints. By end Q1.

Access to services

☑18-week targets met and monitored through Business Committee

☑ 'Quality Challenge' includes action plans to reduce waiting times

Quality Account focus on areas of particular need:

☆Child & Adolescent Mental Health Services

☆Integrated services for Children with Additional Needs

☆Continence, Urology and Colorectal Services

Dignity, choice and respect

☑Respecting and valuing people's views by acting on feedback (reported on our Members' Zone)

☑ Improving information to support choice in location of service

Quality Account focus on areas of particular need:

☆Action plans for complaints about attitude

☆Confidence in the range of views (return rate and equality data)

Enhancing the role of the pharmacy technician and its contribution to improving quality, reducing nurse transcribing and incidents

An expansion of the neighbourhood pharmacy technician team (from four to seven) was undertaken in April 2016 in response to a requirement to reduce the reliance on nurses transcribing Medication Administration Record (MAR) charts in the community. Up until this time pharmacy technicians only undertook routine transcribing of MAR charts except in exceptional cases where a delay may have been detrimental to patient care.

The transcribing role of the pharmacy technicians is now fully embedded within the community Neighbourhood Teams. The technicians have taken over all routine re-transcribing tasks in relation to the MAR charts, which enables us to respond to requests to transcribe charts at short notice. Each technician covers two neighbourhoods and evaluation of their role shows that other staff within the team understand their function and how to refer to them.

Analysis of feedback from teams has provided evidence that the input from the technicians is valued for its contribution to improved quality, safety and reduced demand on nurses for transcribing.

Some good examples of improved outcomes include:

- Enhanced patient safety by following up on discrepancies with patient's prescribed medicines
- A reduction in the number of visits to prompt and administer medicines by neighbourhood teams
- Interventions involving family members and carers to help support medicines administration
- Development of solutions to problems of adherence; and educating patients to independently self-administer their medicines safely

Well-led

The Lead Programme

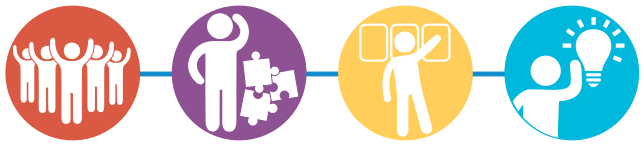
Our leadership development is an integrated and sustained process, not a one off event, or series of disconnected events. The leadership concepts and understandings embedded in our LEAD programme are designed to be relevant, connected, and applicable to the real world and work environments. The programme, introduced this year, is designed to explore the essential habits and mind-sets required of us as a leader. The corresponding competencies are embedded in the course curriculum.

Themes emerging from a wide range of conversations and surveys over the last 12 months showed a need for more clinical and managerial support. At LCH we are also aware of the need for leadership development, particularly for leaders who may be new to the organisation or have commenced a new leader role in the last 2 years. We want to ensure that these staff feel supported by being equipped for their role in managing and leading within the organisation.

The programme focusses on the coaching aspect of leadership. The principal aim is to assist us improve; this in turn helps colleagues and our organisation to flourish and grow.

The LEAD programme offers a variety of experiential courses:

- Core to the programme is **Manager as Coach (MAC)** which is made up of five modules. There are opportunities to attend the relevant manager/lead courses that have been designed to equip new leaders in skills development in the fundamental areas of management.
- Participants will attend the **Mindfulness for Leaders** day.
- Throughout their leadership journey, small groups of approximately 6 LEAD participants have come together through a **Learning Exchange**. These sessions are facilitated in the early stages of group formation to combine learning and encourage collective support, before becoming self-facilitated.



- As part of the programme, participants undertake a **360 Degree Feedback** process based on our seven magnificent behaviours (How We Work). The report generated is shared with participants using a coaching approach. They also complete a **WAVE Professional Styles** assessment which highlights personal motives, talent, potential and the culture they thrive in.

  Evidence suggests that when personal analysis includes looking at performance and potential together, this can help in development gaps and aid career movement.

- There is opportunity to attend all of our courses on the **Manager/Lead Development Programme** to further develop their skills in the fundamental areas of management as well as leadership.
- Participants can access **One-to-one Coaching** too.

health coaching
better conversations
better health

This year our priorities for improving **leadership** are:

Quality area for action	Projected outcome 2016/17	Indicators
Leadership	Develop leadership and management throughout the organisation through implementation of the leader development LEAD programme.	Reporting will be timed with cohorts to the programme. We will measure the quality impact to through surveys which will assess: a) achievement of Personal learning objectives b) impact on the team c) feedback from line managers To be conducted 6 months following completion of the cohort to allow for change to take place (June completion will be surveyed in September).
Staff engagement	Increase year on year the score for staff who feel engaged in the organisation and its work as reported in the NHS National Staff Survey.	Year end 2016/17 results will inform baseline and provide for discussion regarding quality improvement target.

Nursing Associate role

We are pleased to have been successful in a partnership bid to become a national pilot site for the new Nursing Associate role.

Working with our partners in Leeds, Bradford and Airedale, including three universities, we will support ten employees to undertake this training in January 2017. The course runs for two years and is designed to develop experienced support workers to become competent Nursing Associates.

This role has been developed by Health Education England:

"The new role is expected to work alongside care assistants and registered nurses to deliver hands-on care, focusing on ensuring patients continue to get the compassionate care they deserve. Its introduction has the potential to transform the nursing and care workforce."

In addition Jane Cummings, Chief Nursing Officer for England said:

"It is important that we build a workforce to meet the changing needs of the people we care for. The new Nursing Associate role will be a part of a team built around those needs and will provide an exciting opportunity for those who want to progress their careers in the field of health and care.

The new role also has clear benefits for registered nurses, providing additional support and releasing time to provide the assessment and care they are trained to do, as well as undertake more advanced tasks. This will ensure we use the right skills in the right place and at the right time.

The introduction of Nursing Associates is a positive and welcome step forward and I look forward to following progress made as training begins."

We see participation in the pilot of this role as highly positive for LCH. We look to see its introduction develop and improve the skill mix of our nursing teams moving forwards. It will also provide a new career structure for the support worker workforce, which is warmly welcomed.

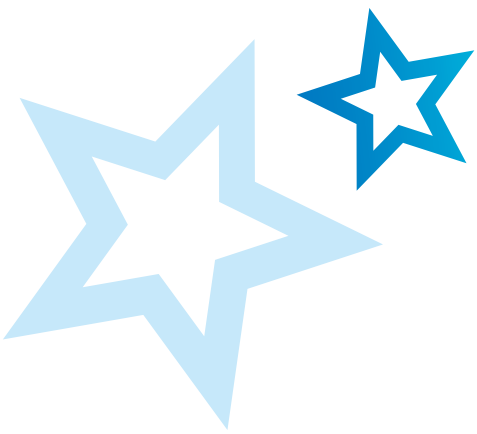
How our quality and quality priorities will be monitored throughout the year

The indicators from the quality account priorities are monitored on a quarterly basis through the Senior Management Team. These indicators also feature within our monthly reports which are reviewed by Business Committee and Quality Committee before being presented to our Trust Board.

Reporting and monitoring in this way ensures that senior managers and the Trust Board are aware of how we are performing against our quality improvement priorities. It is also an opportunity for them to scrutinise and seek further assurance on any actions underway to make those improvements, in order to better ensure they are achieved.

At Business Unit level a detailed review of the indicators is included in the information shared with services, as part of their regular performance reviews and on quality impact assessment dashboards made available to them. This enables services to know how they are doing in relation to quality improvement. Work is ongoing to ensure that following an incident, learning from it is consistent, effective and shared.

Last year we talked about how we had revised our governance meetings from which a sub-committee called the Patient Safety, Experience and Governance Group (PSEGG) was formed. Over the year a number of workshops have been held, chaired by the Executive Director of Nursing. These bring together staff, managers and the public to look at themes and learning from incidents and experience. From those workshops actions are identified with a view to progress against these and the impact of them being monitored by the Group. We recognise that there is still work to do to embed and develop this function in order to ensure it fulfils its purpose to improve the quality of care through learning from experience; and assure the Quality Committee on the safety and quality of our services. This will be an area of focus for 2017/18.



Section 4

Statements from others on the quality of LCH services

Healthwatch Leeds, Overview and Scrutiny Committee for Health and Public Health and Social Care for Leeds

"The Trust gave a concise summary of their QA draft and was open about the challenges in some of the priorities as well as the progress made. There is a commitment to have patient and carer feedback influence service improvement in a measurable way and a structure to monitor and report feedback and engagement. The improvement plans are based on patient and carer feedback.

The actual QA format is as clear and accessible as possible and includes pictures. There is a plan to share key parts of the QAs through newsletters and the website to make the information for wider dissemination.

Given that around 20% of Leeds's population includes Black and Minority Ethnic (BME) communities, it is hoped that more can be done to understand and tailor services to meet the needs of all communities."

NHS Leeds Clinical Commissioning Groups

Thank you for providing us with the opportunity to comment on your quality account. As the three Clinical Commissioning Groups (CCGs) in Leeds continue to work towards a single commissioning voice, this response is provided on behalf of the three CCGs.

The Trust has faced some considerable challenges over the past year, particularly in relation to recruiting and retaining staff, a challenge currently faced by many providers of healthcare in the NHS. This has at times had significant impact on the Trust's ability to fully meet the demands of the local healthcare system, particularly over the winter period. We note the work described within the account to support teams, including executive team spending more time with staff, listening events, the development of a leadership programme, partnership working with universities to deliver two conferences for nurses and allied health professionals and the success in being chosen as a national pilot site for the nursing associate role. We hope these initiatives will help the Trust to develop a responsive and resilient workforce.

The Trust has made some notable achievements, such as the aforementioned nursing associate role pilot, the introduction of the apprentice dental nurse and has delivered training in serious incident investigation and holistic assessment to large numbers of staff. The Trust is also to be commended on achieving the requirement for 75% of staff to take up the offer of flu vaccination. We congratulate the Trust on receiving an award in the 'Innovation' category of the Journal of Health Visiting Awards for the development implementation and evaluation of Leeds Assessments Frameworks as part of the Healthy Child programme.

The Trust is also to be commended for the positive impact on patient's end of life care that the Neighbourhood Palliative Care Leads have had, and on their success in winning a Trust award in December 2016.

We note the continued work in reducing pressure ulcers and the arrangements put in place to support this. However, we also acknowledge that this has been a priority for some years and that some of the aims of this work have not been fully achieved.

We hope that the Trust will make a concerted effort over the forthcoming year to achieve its aims of significantly reducing or eliminating the incidence of the most severe pressure ulcers. Similarly we note the work that has been undertaken in support of reducing the number of falls by patients under the care of the Trust and the intention to continue this work.

We are pleased to note the progress made in improving the number of staff attending serious incident investigation training and note the continued work in improving the processes under the Duty of Candour requirements. We hope that the Trust maintains the performance reported for March 2017. We welcome the inclusion of patient stories within the Account; it would have been even more helpful if some narrative had been included on what changes have been made as a result.

The Trust has faced significant challenges in recent months due to high levels of sickness absence in some neighbourhood teams. The narrative relating to this with regard to reducing number of staff reporting feeling unwell due to work related stress is vague, and does not indicate whether the Trust's ambitions were achieved or why the question was removed from the survey. The Trust is also one of the lowest scoring community Trusts for staff recommendation in the National Staff Survey but there is no specific reference to improve this score in the quality improvement proposals for 2017-18.

We do however welcome the Trust's continued work to support staff through listening events, executive team visits and interventions such as coaching, mindfulness and leadership development. The work undertaken in relation to developing the skills and competencies of clinical staff and the redesign of clinical roles to improve flexibility is also welcomed. This will support the Trust in a rapidly changing healthcare environment and improve responsiveness.

We support and approve of the changes made within neighbourhood teams to further improve the service, particularly where it provides improved oversight at a clinical leader level and supports integration with primary care. We are also pleased to note the work undertaken in teams to improve quality, such as the introduction of safety boards, safety huddles and quality metrics folders. This will support the Trust's ambitions to protect patients from harm.

We are broadly supportive of the Trust's proposals for improving quality for 2017-18. We believe the Account could be strengthened by including more focus on recruitment and retention of staff, and initiatives to ensure that service standards and quality are maintained under pressure. Given the challenges outlined in recruiting, developing and retaining a skilled workforce, we hope that the initiatives proposed within the account will have a positive impact and that the Trust will maintain a strong focus on this work, recognizing that system integration and in particular integration of nursing practice and clinical pathways will be a key factor in Quality Improvement. We see the Trust's leadership team shaping this over the coming months, with support from Commissioners.

We look forward to continuing to work with the Trust in the development and monitoring of the proposals contained within the account, and associated progress as part of our ongoing assurance arrangements in the coming year."

Leeds Community Healthcare NHS Trust's response to comments received

Thank you to Healthwatch Leeds, Overview and Scrutiny Committee, Public Health and Social care for Leeds and our Clinical Commissioning Groups for taking the time to comment on our 2016/17 Quality Account.

We welcome the recognition of our commitment to ensure patient, carer and public involvement continues to be an integral part of shaping and delivering our services. This enables us to make them the best they can be and identify where we need to make quality improvements.

It was our aim to further simplify the Quality Account document this year so we are pleased to read that the format was found to be clear and accessible.

We continue to work in partnership with our commissioners and other healthcare providers to reduce existing health inequalities in Leeds and develop our services accordingly. We currently to provide a

number of specific services to meet the needs of BME communities and reduce health inequalities, which include our Community Sickle Cell and Thalassemia service, TB Screening service and a specialist nurse lead for the Gypsy and Traveller community. Within our Diabetes and Cardiovascular service we have specialist nurse leads for BME patients and our Health Visiting service has a lead Health Visitor for the Gypsy and Traveller community. Additionally the IAPT service delivers a specific service to BME communities through our partners at Touchstone.

Our Quality Account quality improvement priorities for 2017/18 support our enthusiasm to improve equality data to further enable the identification of areas of focus.

The CCGs acknowledgement of the challenges the Trust has faced over the past year, particularly in relation to the nationally recognised issue of recruitment and retention of staff as well as staff sickness absence, is welcomed. We would like to assure stakeholders that recruitment and retention of staff and staff well-being is a priority for the Trust and robust plans are in place to drive this forward. As part of this work we have set up the Recruitment and Retention Steering Group that will specifically focus on all aspects of recruitment and selection.

With regards to the staff FFT survey question that was removed during 2016/17, the original question within the survey asked if staff had 'not attended work due to work-related stress'. This question was removed from the local survey as we felt the information collected could be enhanced to be more useful in identifying and addressing any issues. The question was therefore developed to make it more holistic, looking at the physical and psychological factors that improve staff well-being, such as asking staff if their manager provides them with support, guidance and feedback on their work and if they feel valued at work; all of which can contribute to an improved working environment.

We are already beginning to see significant positive changes to sickness levels within the Neighbourhood Nursing Teams (NHTs) with levels in some teams falling below the Trust average. Initiatives within the NHTs include a new task and finish group to support staff well-being and reduce occupational injury such as musculoskeletal problems. We are also reviewing case distribution in order to prevent staff undertaking repetitive tasks within their daily work load.

Our dedication to improve our position for 'staff recommendation' in the National Staff Survey is demonstrated throughout the Quality Account document with reference to the wider organisational development and cultural change programmes underway. We hope as these become embedded, we will begin to see anticipated positive change. We are pleased to read that the CCGs are supportive of the contributions to this through staff listening events, executive team visits, coaching, mindfulness and leadership development, as well as the development of skills and competencies of clinical staff; and redesign of clinical roles. We welcome continued feedback from our commissioners to assist in our achievement of this work.

It continues to be a challenge to prioritise non-essential training during times of pressure on the healthcare system. However, are fully committed to a programme of holistic assessment training for clinical staff which will provide key clinical skills training over the summer months in preparation and readiness for winter pressures and to ensure resilience within our services.

With regards to patient safety, we acknowledge the CCGs comments regarding the work to address the incidence of pressure ulcers. This work forms part of the Trust's Sign Up to Safety Pledge, which spans a 3-year period. Whilst significant progress has been made in reducing category 3 pressure ulcers, we would like to provide assurance that pressure ulcer occurrence continues to receive our utmost attention as we work to eradicate completely the most severe pressure ulcers. There is a renewed focus at our Pressure Ulcer Steering Group and a strong work plan to support our concerted efforts to achieve this aim.

We are monitoring each element of pressure ulcer work and learning arising from this and have extended screening for pressure ulcers to include Enhanced Care home Scheme Therapists.

Further, we will continue with the safety huddles and use of the Quality Boards, which look at the fundamental parameters of patient safety ensure early address of issues and sharing of learning across clinical teams.

Acknowledgements

We would like to sincerely thank everyone who made a contribution to the content and publication of our 2016/17 Quality Account. This includes, but is not limited to, patients, carers and representative groups, many of our staff, the Senior Management Team and the Board of Directors.

This Quality Account provides an insight into how we are working to realise our vision, values and strategic objectives, and our Quality Strategy. Quality is at the heart of everything we do; we hope we have demonstrated within this document how quality is created, embedded, developed and improved within LCH through sharing examples of initiatives underway to help us achieve these aims.

In line with other NHS organisations, we produce an Annual Reports and Accounts to outline our financial and other key performance measures. These can be found on our website at **www.leedscommunityhealthcare.nhs.uk**

How to comment on the Quality Account

If you would like to comment on this document you may do so:

- By email to **rle-hair@nhs.net**

  Please ensure you include **'Quality Account 2015/16 feedback'** as the subject of your email.

- In writing to:

  The Clinical Governance Manager
  Quality Account 2016/17 Feedback
  Clinical Governance Team
  Leeds Community Healthcare NHS Trust
  1st Floor, Stockdale House
  Headingley Office Park
  Victoria Road
  Headingley
  Leeds LS6 1PF

Services provided by Leeds Community Healthcare NHS Trust

For a full list of our services, please visit our website:
www.leedscommunityhealthcare.nhs.uk/our_services_az/

Glossary

Appraisal – a method of reviewing the performance of an employee against nationally agreed standards within the NHS.

Antibiotic – A drug used to treat bacterial infections.

Antimicrobial resistance – The ability of bacteria and other microorganisms to resist the effects of an antibiotic to which they were once sensitive. Antibiotic resistance is a major concern of overuse of antibiotics. Also known as drug resistance.

Audit – a review or examination and verification of accounts and records (including clinical records).

Clinical supervision – a reflection process that allows clinical staff to develop their skills and solve problems or professional issues. This can take place on an individual basis or in a group.

Care Quality Commission (CQC) – Health and Social Care regulator for England.

Clinical coding – an electronic coded format that describes the condition and treatment given to a patient.

Commissioners – organisations that agree how money should be spent on health within a community. This could be for example Clinical Commissioning Groups (CCGs – Groups of GPs) or NHS England (the central government organisation).

Clostridium difficile (Cdiff) – an infection caused by bacteria that affects the digestive system. It most commonly affects people who have been treated with antibiotics.

Commissioners – organisations that agree how money should be spent on health within a community. This could be for example Clinical Commissioning Groups (CCGs – Groups of GPs) or NHS England (the central government organisation).

Continuous Quality Improvement (CQI) – a management approach that organisations use to reduce waste, increase efficiency, and increase internal (employee) and external (customer/patient) satisfaction. It is an ongoing process that evaluates how an organisation works and ways to improve its processes.

CQUIN (Commissioning for Quality and Innovation) – a financial incentive encouraging Trusts to improve the quality of care provided.

CIVAS (Community Intravenous Antibiotic Service) – a service that facilitate an early hospital discharge for patients, allowing them to return to their homes and receive antibiotics there as soon as they are medically stable.

Datix – an electronic risk management system (database) used to record incidents, complaints and risks for example.

DOLS (Deprivation of Liberty) – DoLS protect people who lack capacity to consent to being deprived of their liberty. This means that because an illness, an injury or a disability has affected the way their mind works they are not able to agree that they will not be allowed to do certain things.

Duty of Candour (DoC) – a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to harm.

EDGE research management system – a computer software system that allows organisations and staff to better manage and make the most of their research programmes.

E-Rostering – an electronic staff management tool used to plan staff requirements and reported on staff hours worked, annual leave, sickness etc.

Equality Delivery System (EDS2) – part of the NHS Equality and Diversity Council's pledge to commit to implement two measures to improve equality across the NHS. This system helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination.

Forensic Medical Examiner (FME) – a doctor used by the police in the United Kingdom.

Friends and Family Test (FFT) – a measure of satisfaction usually via a survey or text message, which asks if staff/ patients would recommend the service they received to their friends or family.

Information governance – the rules and guidance that organisations follow to ensure accurate record keeping and secure information storage.

Inquest – a judicial inquiry to ascertain the facts relating to an incident.

Leeds Institute for Quality (LIQH) – an organisation that enables clinicians to develop shared expertise in innovation and improvement.

Leeds Plan (Leeds Health and Care Plan) – a strategic plan that aims to achieve a whole city approach to healthcare in Leeds and make Leeds the best city for health and wellbeing.

Leeds Safeguarding Children's Board (LSCB) – a statutory body which is independently chaired and consists of senior representatives of all the principal agencies and organisations working together to safeguard and promote the welfare of children and young people in the City.

Medicines management – processes and guidelines which ensure that medicines are managed and used appropriately and safely.

Meticillin resistant Staphylococcus aureus (MRSA) – blood stream infection caused by bacteria that is resistant to some treatments.

Methodology – a system of methods used in a particular area of study or activity.

Multi-Agency Looked After Partnership (MALAP) – a network that brings together partners from across services and sectors with a shared aim of improving outcomes for looked after children and young people in Leeds.

NHS England (NHSE) – the central organisation that leads the NHS in England and sets the priorities and direction of the NHS.

NHS Improvement (NHSI) – an NHS organisation that supports us to provide consistently safe, high quality, compassionate care.

National Institute for Health and Care Excellence (NICE) – an organisation that provides national guidance and advice to improve health and social care with the aim of improving outcomes for people using the NHS and other public health and social care services.

National NHS staff survey – a survey that gathers the views of staff working in the NHS to give an overall indication of their experience of working for the NHS.

National Reporting and Learning System (NRLS) – a central database of patient safety incident reports.

Neighbourhood Multi-disciplinary Teams (MDTs) – integrated teams of health and therapy staff working as a team within a location (neighbourhood) in the community.

Outcome Measures – a measure (using various tools) of the impact of the intervention from a clinician's perspective or a measure of progress related to a specific condition or issue.

Patient Advice and Liaison Service (PALS) – a service that provides a listening, enquiry and signposting service to ensure that patients, carers and public have their questions and concerns resolved as quickly as possible.

Patient experience – feedback from patients on 'what happened and how they felt' in the course of receiving their care or treatment.

Patient satisfaction – a measurement of how satisfied a person felt about their care or treatment.

Payment by results – the system applied to some services whereby NHS providers are paid in accordance with the work they complete.

Psychologically Informed Environment (PIE) – a place or a service in which the overall approach and the day-to-day running have been consciously designed to take into account the psychological and emotional needs of the service users.

Preceptee – a person undergoing preceptorship (see below).

Preceptor – an experienced member of staff who provides role support and learning experiences to the preceptee to assist them acquire new competencies.

Preceptorship – a structured period of transition for a newly qualified member of clinical or therapy staff when then begin their employment in the NHS.

Pressure ulcer – damage caused to the skin and the tissue below when it is placed under enough pressure to stop the blood flowing.

Preventing Future Deaths report – because the power comes from regulation 28 of the Coroners (Inquests) Regulations 2013. The report is sent to the people or organisations who are in a position to take action to reduce this risk.

Public Health England – an organisation that works to protect and improve national health and wellbeing, and reduce health inequalities.

Risk Assessment – a process to identify risks and analyse what could happen as a result of them.

Root cause analysis (RCA) – a method of investigating and analysing a problem that has occurred to establish the root cause.

Scrutiny Board (Health and Well-being and Adult Social Care) – a function of the local authority with responsibility to hold decision makers to account for the services they provide.

Sign up to Safety Pledge – a national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible.

Silver Command – part of a nationally recognized three tiered command and control structure (gold, silver, bronze) used during major incidents or disasters.

Strategy – the overall plan an organisation has to achieve its goals over a period of time.

Stonewall – a lesbian, gay, bisexual and transgender (LGBT) rights charity in the United Kingdom.

Subject Access Requests (SAR) – requests made for personal information under the Data Protection Act 1998.

Standard Operating Procedure (SOP) – a set of step-by-step instructions compiled by an organisation to help workers carry out routine task.

Sustainability and Transformation Plans (STPs) – the NHS and local councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and care. These proposals, called sustainability and transformation plans (STPs), are place-based and built around the needs of the local population.

Trust Board – the team of executives and non-executives that are responsible for the day to day running of an organisation.

Unconscious bias – unconscious bias happens by our brains making incredibly quick judgments and assessments of people and situations without us realising.

Quality account

2016 : 2017

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Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (8)

Meeting Trust Board 31 May 2017	**Category of paper**	
Report title Quality Account	**For approval**	√
Responsible director Executive Director of Nursing **Report author** Clinical Governance Manager	**For assurance**	√
Previously considered by Quality Committee 22 May 2017	**For information**	

PURPOSE OF THE REPORT

This report provides the Trust Board with the finalised 2016/17 Quality Account for approval.

MAIN ISSUES FOR CONSIDERATION

The Quality Committee has recommended the Quality Account to the Board for approval. The account has been developed in line with national guidance given in the Department of Health Quality Account Tool Kit and the Quality Account Regulations.

The year-end position for the 13 current quality improvement priorities (15 outcomes in total) and progress against them has been monitored through Quality Committee over the year. How these areas will be reported on and monitored in 2017/18 is included in Section 1 of the Quality Account document.

Section 2 contains statutory information as required by the Quality Account Toolkit (2011) and any subsequent directives from the Department of Health and NHS England.

The priorities for quality improvement (2017/18) have been identified through patient, public and carer engagement, discussions with stakeholders and through a review of: performance data; feedback from the CQC and commissioners; and learning from incidents, experience and complaints. Projected outcomes and indicators have been agreed with relevant operational and corporate leads.

A combination of 10, new and refreshed priorities have been identified for 2017/18, as previously agreed by SMT and Quality Committee. These can be found in Section 3 of the Quality Account document. The priorities and progress against them will be monitored quarterly by the SMT during 2017/18 and overseen by Quality Committee.

The draft Quality Account was shared widely with all stakeholders for comment and these were received during May. The Trust's response to all feedback is included in Section 4.

The glossy version of the Quality Account is currently being finalised and can be viewed via the Communications Team. This will be submitted to Department of Health via NHS Choices by 30 June 2017.

RECOMMENDATION

- The Trust Board is recommended to receive and approve the 2016/17 Quality Account

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (9)

Meeting Board 31 May 2017	**Category of paper**	
Report title Operational plan 2016/17: end of year report	**For approval**	
Responsible director Executive Director of Finance & Resources **Report author** Business Planning Manager	**For assurance**	✓
Previously considered by Business Committee 26 April 2017	**For information**	

Purpose of the report

This report provides an overview of delivery at the year-end of the 5 corporate objectives, key actions and success measures. The Board received a mid-year progress report on 7 October 2016. On 25 January 2017 the Business Committee received a report on progress at quarter 3. This year end report reflects points made by the Business Committee following its consideration of the assessment received at its meeting on 26 April.

Main issues for consideration

The 2016/17 operational plan, signed off by Board on 31 March 2016, set out five corporate objectives, key actions to drive success in achieving the corporate objectives and success measures.

Year-end performance

Of the 27 success measures:

- 13 (50%) green: achieved. All success measures achieved for corporate objective 5 relating to engagement in development of the West Yorkshire STP and Leeds Plan and new models of care. Financial requirement to deliver the income and expenditure surplus control total also achieved (final page of report)
- 4 (15%) amber: narrowly missed
- 7 (27%) red: not achieved, 4 of relate to the staff engagement and morale corporate objective
- 2 (8%) neutral: action progressed but not yet measured

Assessment of reasons for not achieving targets

Reasons for objectives / targets not being achieved were:

Several targets were over ambitious:

Corporate objective 1: foundations in place to deliver high quality care

- 0 Category 4 Pressure Ulcers (amber): given incidence of category 4 pressure ulcers in 2015/16, a target of zero category 4 pressure ulcers was very unlikely to be achieved.

Corporate objective 2: Neighbourhood Teams

- establish effective case management (amber)
- roll out EPR across all teams (red)

The scope and complexity of the Neighbourhood Team integration and change programme and its impact on staff and operational delivery were under-estimated when setting 2016/17 targets

Corporate objective 4: staff engagement and morale

- staff reporting feeling engaged (red) - although the targets were not achieved, the results of both the annual national staff survey and quarter 4 staff FFT were encouraging and are set against a context of a significant change programme within Neighbourhood teams, uncertainty for staff in services being tendered, organisational vacancy control throughout most of 2016/17 and financial challenges within Childrens services.

Impact of factors outside the Trust's control:

Corporate objective 1: foundations in place to deliver high quality care

- reducing waiting times for CAMHS ASD assessment (red) – target not achieved principally due to 33% increase in referrals.
- rolling 12 month turnover target (red) – the increased level of turnover is consistent with other community Trusts nationally which suggests that national system pressures and workforce supply issues are contributing factors

Impact of both internal and external factors:

Corporate objective 3: Prepare services expected to be tendered in 16/17

- success in retaining business (red) - tender decision are outside of our control. Lessons learnt review undertaken, progressing work to review and strengthen bid management and the quality of service offers

Corporate objective 4: staff engagement and morale

- turnover target (red) - turnover is in line with the average for community Trusts. Heightened turnover in neighbourhood teams in the second half of the year reflects both external system pressures over winter and internal factors.
- focused recruitment (red) - reflects the increase in Adult Business Unit nursing vacancies. Recruitment and retention plans refreshed following internal recruitment summit; being implemented as a top organisational priority. Key actions include re-establishing standing interview panels and attending recruitment fairs over a wider geography
- staff sickness absence (red) - continued relatively high levels of staff sickness reflect factors including winter pressure capacity demands on neighbourhood teams and some specialist services and the impact of recruitment lagging turnover combined with the impact of implementing the neighbourhood team integration and new ways of working programme

Competing priorities / insufficient focus:

Corporate objective 1: foundations in place to deliver high quality care

- Excellent improvement by Neighbourhood Teams but insufficient focus elsewhere in the trust leads to an overall amber rating

Reporting on the 2016/17 Operational Plan has highlighted the need for greater focus in ensuring SMART success measures for corporate priorities are defined and there is a clear rationale and agreement about thresholds for RAG ratings. This has been embedded in the approach to agreeing the 2017/18 plan.

Recommendations

Board is recommended to:

- note progress at year-end in delivering the 2016/17 priorities and success measures.
- consider the assessment of the reasons for not achieving targets

Key	On track	Slight under performance & / or risk of not achieving success measure	Not achieved / not expected to achieve success measure

Corporate objective 1: Ensure the foundations are in place to consistently deliver and improve high quality care

Priorities	Key actions	Success Measure	Year end status
Protect patients from harm Continue our focus on safety	• Ten Priorities pressure ulcer (PU) prevention campaign and staff training programme • Introduction of Safety Huddles and quality dashboards • Strengthened RCA process • Management focus on timely incident investigation completion	15% reduction in avoidable Cat 3 PUs against Q1 baseline	Target exceeded. Q1: 12 avoidable Cat 3 PUs, Q2: 4, Q3: 6, Q4: 2. Pressure Ulcer Steering Group and panel now well established. Maintaining focus on ensuring action plans are robust and learning is shared across the organisation
		Original target: 0 at 4 PUs. Q3-4 improvement trajectory agreed: maximum 3	Original target not achieved: 4. Q3-4 improvement trajectory achieved: 1 avoidable Category 4 pressure ulcer in Q3.
		10% reduction in avoidable falls causing harm in in-patient units	Target narrowly missed: 7% reduction. Falls Steering Group refocussed, Major Falls Panel established and new RCA documentation for falls introduced drawing on learning from successful Pressure Ulcer reduction approach
		Incident investigations completed within timescales. From Jan '17 report on compliance with policy:15 days low/no harm, 30 days moderate	Outstanding incidents reduced from 128 in April '16 to 86 in Dec'16. Reporting on compliance with policy introduced Jan '17: good compliance for moderate and above incidents. Bus Units focussed on low / no harm incident 15 day requirement. NTs fully compliant March '17
Further develop outcome reporting	Agree metrics and reporting mechanisms. Establish reporting	Establish central reporting for selected services in each Business Unit	Central reporting established for the selected services
Reduce waiting times	Develop capacity and demand model to inform resourcing	Autism spectrum disorder (ASD) assessments <12 weeks by year end.	Target not achieved due to 35% increase in-year in referrals:at year-end 136 waiters >12 weeks. Revised time-scale agreed with commissioners: December '17. Running additional clinics since January '17 using additional non-recurrent commissioner funding, constrained by difficulty recruiting temporary specialist resource.

Corporate objective 1 (continued): Ensure the foundations are in place to consistently deliver and improve high quality care

Priorities	Key actions	Success Measure	Year end status
Ensure patients & carers are at the heart of what we do	Renew focus on the quality impact assessment (QIA) process for service change	* Conduct QIA review of priority Service Reviews * Review QIA process	QIA reviews of priority Service Reviews completed in Q3. QIA process reviewed; revised process being operationalised in quarter 1 17/18.
	* All services complete self-assessment; start peer visits and re-visits * Initiate peer visits & service re-assessment	Roll-out refreshed Quality Challenge process: all services complete initial self-assessment by April 2016, complete initial and follow-up visits by March 2018.	On track. All services completed self-assessments by April 2017. By year-end 18 out of 42 Quality Visits taken place. Plan being implemented to increase the number of peer visitors to ensure time-frame for visits met:. Feedback from services and visitors positive: 90% of services end of year summaries indicate how the Quality Challenge Plus has supported delivery of safe quality care
	Ensure robust approach to addressing CQC concerns and recommendations from the CQC's inspection reports	Achieve CQC 'good' rating.	Rated neutral as still await outcome of the January / February 2017 CQC inspection: confident but not complacent about outcome. Robust preparation programme built on learning from previous inspections. Implementing action plan to address issues arising from CQC inspection of Han-
	Ensure staff participate in clinical supervision	Year-end targets: LCH 75%, Bus Units: Adults: 75%, Childrens 90%, Specialist incl Specialist Adults 90%, Health & Justice (excl Police Custody) 75%, Police Custody 60%, Corporate 90%	LCH target (75%)exceeded: 80%. Adults, despite significant pressures in Q3-4, and Specialist Bus Unit Justice (excl Police Custody) exceeded Business Unit targets. Childrens and Specialists other services below target, amber, Corporate red

Corporate objective 2: Consolidate and develop the integrated neighbourhood teams

Priorities	Key actions	Success Measure	Year end status
Establish integrated pathways, systems and ways of working	* Establish integrated pathways, systems and ways of working supported by team coaching * Establish the new shift pattern * Start the roll-out of e-rostering	Effective case management. Consistent cluster level handover.	Range of development work in place to improve and standardise case management across teams including regular caseload reviews under Community Matron leadership (some variability), E-rostering roll out plan agreed, skills and competencies work ongoing — at 31 December nearly 400 staff trained in holistic assessment. The pace of training delivery has slowed due to severe service pressures in Q4 limiting staff availability to attend training as direct patient care needed to be prioritised. Daily cluster level handovers in place.
		Improved staff morale.	Q4 FFT results show improvements against a range of indicators e.g. 79.85% staff likely or extremely likely to recommend the organisation as a place to receive care, up from 66.07% in Q2 53.48% staff likely to recommend the organisation as a place to work, up from 33.04% in Q2. 62.02% staff satisfied with the support from their immediate manager, up from 45.53% in Q2. These are slightly higher than the Q4 organisational averages.

Corporate objective 2 (continued): Consolidate and develop the integrated neighbourhood teams

Priorities	Key actions	Success Measure	Year end status
Further develop skill mix to reflect local needs and support career progression and recruitment	Initial review of Neighbourhood team staffing and skill mix	30% reduction in use of agency staff. Q2 agreed reduction in agency, bank and overtime a better measure	30% decrease in use of agency and bank from 2015/16 to 2016/17 reflecting management action from June 2016 to contain use of bank, agency and overtime. 50% reduction in use of agency staff, 31% increase in use of bank. The cost of overtime was not available.
Fully implement Electronic Patient Record	Roll-out EPR to all teams	EPR being used in all teams.	EPR now in place in 6 Neighbourhood Teams, roll out currently in West 2 with pre engagement work currently underway in North 1 and 2 teams. Original roll out plan was altered based on learning of need to allow time for consolidation and embedding of new practices and processes within teams. Ongoing roll out to other Neighbourhood Teams throughout 17/18. EPR will be rolled out all Neighbourhood Teams by October 2017, with further work to embed New Ways of Working complete by the end of 17/18.
Work closely with primary care, social care and 3rd sector	Initiate Neighbourhood Leadership Development forums Establish monthly MDT case management meetings.	Improved GP satisfaction with the service	Rated neutral as GP satisfaction has not yet been measured as too early to assess. Will assess GP satisfaction once New Ways of Working embedded; scoping to start quarter 1 2017/18. Continuation of MDT case management meetings. Planning some further focused engagement with primary care to raise awareness of the Neighbourhood Team model.

Corporate objective 3: Prepare services expected to be tendered in 16/17

Priorities	Key actions	Success Measure	Year end status
Provide support to be 'tender ready' and ensure you are fully involved	Agree and implement a tender management resourcing model	Tender management resourcing model agreed and operationalised in Q1 16/17	Achieved. Interim Business Development Lead established in post June '16. Head of Business Development appointed and now in post. Business Development Strategy being drafted which will include further developing the Business Development Team, ensuring we have the right resource to win business.
	Support services with a programme of work to ensure they are tender ready	Complete assessment of all services expected to be tendered in Q1.	Achieved. self-assessment completed by all services being tendered to inform service tender-preparedness planning. Business Development Board reviewed the current tender-readiness and bid management process. A Business Development User Guide is being developed which brings together in one central place all LCH's tools, resources, systems and processes: to be finalised by end of May '17 and will include tender-ready activities which are monitored by the Business Development Board.
	Success in retaining business that is appropriate to retain	Success in retaining business.	Actual: Healthy Living Service and York Street tenders unsuccessful. Activities being undertaken to address this: * work to review and improve relationships with commissioners * external evaluation of York Street bid * bid-writing training offered across the organisation * Business Development Strategy being drafted * full lessons learnt review * strengthen independent review of future bids before submission

Corporate objective 4: continue to listen to and work with colleagues

Priorities	Key actions	Success Measure	Year end status
Inspire staff in areas with low morale Implement a staff led plan to address areas for improvement highlighted by the 15/16 national staff survey	Dedicated OD and change support to NTs Development and communication of Our Working Lives: Our 11 Pledges — staff led plan to address national staff survey areas for improvement	National staff survey: increase in staff feeling engaged in the Trust & its work. 2015 score: 3.71 FFT: staff recommending LCH as a place to work. year-end target: 57%	Rated red reflecting targets not met.: National staff survey: 2016 engagement score: 3.70, very slight decrease. FFT: staff recommending LCH as a place to work. Actual: 52%: 3% improvement on 15/16 However, of the 32 Key Findings only 1 deteriorated, 16 improved, 15 no change. March '17 Board received report about initial findings
		Rolling 12 month turnover target: 9-13%.	Actual: Q4: 15.3%- in line with 16/17 community Trust average. Improved Q1, 14.6, to Q2, 13.9, peaked Q3, 15.7% principally reflecting NT increase. Retention is a key focus of the refreshed OD Plan.
Focused recruitment	NTs: planned recruitment of smaller cohort of newly qualified nurses, resume fortnightly standing interview panels—paused July 16. Focus on Dietetic Service	NTs: recruit smaller cohort of newly qualified nurses and recruit band 5/6 nurses. Stabilise Dietetics staffing	Large number of qaulifed nursing vacancies in the Adult Bus Unit. Since December 16 attending Nursing Career Fairs over a wider geography, relocation package for Band 5 and above clinical staff introduced . Standing interview panels for adult community nurses re-established. Newly qualified cohort recuited as planned. Recruitment campaigns created to attract nurses, further investment in the preceptorship programme. Dental Service stabilised as a result of a number of initiatives .
Embed How We Work behaviours within appraisal and recruitment process	Embed How We Work behaviours within the appraisal and recruitment process. Difficult conversations training,	How We Work behaviours embedded in appraisal and recruitment .Difficult Conversations' training evaluated positively	How We Work behaviours embedded within appraisals and being embedded in recruitment. National staff survey reflected positively on value of appraisals. 'Difficult Conversations' training evaluated positively, being incorporated in LEAD programme.
Reduce levels of staff sickness absence	Refresh Managing Attendance Policy Pilot Health Check	Staff sickness absence target 4.6%.	Actual at year end: 5.7%. Similar trend as turnover - improvement Q1 to Q2, peak Q3. Managing Attendance Policy revised, Difficult Conversations training incorporated in sickness absence training. Quarterly review meetings continue between Director of Operations with leaders of teams with highest sickness absence.

Corporate objective 5: Provide the best possible joined up care

Priorities	Key actions	Success Measure	Year end status
* Support the development of the Leeds 5-year plan (STP) and the wider plan for West Yorkshire * Work with partners across Leeds and West Yorkshire * Be a key partner in the city * Work with the 3 CCGs to deliver new models of care	Engage actively in development of the West Yorkshire and Leeds STP	Active engagement in development of the West Yorkshire STP and Leeds Plan	Directors and senior managers continue to lead / be actively engaged in development and implementation of relevant West Yorkshire STP and Leeds Plan workstreams. The Chief Executive leads the WY Community and Primary Care workstream. We have consistently flagged capacity and financial constraints in relation to developing and implementing initiatives and concern at lack of pump-priming funding to realise the Plans' ambition. The Leeds Plan is mainstreamed within LCH's 2017-19 Plan and SDIPs are focussed on Leeds Plan implementation.
	Support the development of new model of care prototypes in each	Good engagement from LCH with other partners in the new models of care initiatives across each of the CCGs.	Good engagement by LCH with other partners for all new care model initiatives in the 3 CCG areas. The degree of development of initiatives is variable based primarily on the length of time the local leadership team has been in place. In the West each of the 7 localities leadership teams agreeing its focus. South and East scheme being trialled in 2 localities, employing additional LCH staff. The North has a range of schemes which are at different stages of planning / implementation
Ensure we can effectively monitor and evidence the impact and outcomes of new services and new models of care	Ensure the Trust can effectively monitor and evidence the impact and outcomes of new services	Each initiative should have a clear plan for learning and sharing from experience, demonstrate positive feedback from patients and stakeholders and be able to evidence outcomes.	Achieved: clear intent for all New Models of Care schemes. Each scheme is at a different stage of evolution but all are committed to developing both qualitative and quantitative outcome measures that will be used to demonstrate impact over the life of the agreed new model of care initiatives.

Financial performance was not explicitly a specific corporate objective in the Operational Plan but is included here as a crucial component of Trust delivery .

Priorities	Key actions	Success Measure	Year end status
Achieve the income and expenditure surplus control total	Implement controls on expenditure to recover the over-spend recorded in first half of year	Achieve the income and expenditure surplus control total	Subject to external audit of the Trust's Accounts the target income and expenditure control total has been achieved

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (10a)

Meeting: Trust Board 31 May 2017	**Category of paper**	
Report title Performance Brief and Domain Reports: Year End 2016/17	**For approval**	
Responsible director: Executive Director of Finance and Resources **Report author:** Head of Business Intelligence	**For assurance**	✓
Previously considered by: Senior Management Team, 17 May 2017 Business Committee, 24 May 2017	**For information**	

Purpose of the report

This report provides a high level summary of performance within the Trust during March 2017 and as such provides a year end position for 2016/17.

Main issues for consideration

Safe

The Trust ends the year with three green rated measures:

- As predicted harm free care (Safety Thermometer) achieved the target in the final month of the year.
- The Trust achieved its target to reduce avoidable category 3 pressure ulcers by 15% actually achieving a reduction of 69%
- The adjusted target for avoidable category 4 pressure ulcers was also met with only one reported category 4 pressure ulcer in the second half of 2016/17.

Two measures are rated amber, namely:

- Percentage VTE risk assessment completed, this is thought to be a recording error rather than a failure to complete the assessment. Recent initiatives have increased the number of assessments completed by around 20%, but this has not been enough to achieve the target
- The 10% falls reduction target was not met, but a reduction of 4.8% was achieved.
- The Trust has not met the targets for Patient Safety Incidents reported as “No Harm”, the 15% reduction in Serious Incidents or Duty of Candour. However, following a review of the cases to which Duty of Candour should apply our percentage improved greatly in March from 62% to 100%.

Caring

The Trust has met all of its targets for 2016/17 in the caring domain.

Effective

Each of the Business Units has reported a green RAG rating for their outcome CQUINS for quarter 4 2016/17.

There are two green rated measures in the effective domain; compliance with technology appraisals within 3 months and clinical supervision. Compliance with other NICE guidance within 1 year is rated red. The Trust will review the target for 2017/18 as full compliance with this KPI is unliklely to be possible or necessary

Responsive
The Trust continues to perform very well in respect of all of its responsive indicators of which there are eight. Seven of these relate to waiting times.

Activity is within 5% of our profile at year end.

Well Led
The measures in the well-led domain remain broadly at the same rating as reported in February. Turnover, sickness, appraisals and staff recommending the Trust as a place of work remain rated red.

Compliance with statutory and mandatory training has improved this month to 89.4%; an amber rating.

The response rate for the staff friends and family test has improved and is now rated green at 24.5%.

The other measures rated green are safer staffing and the total agency staff expenditure cap.

Finance
The end of year financial position was as per plan. All measures achieve a green rating with the exception of recurrent CIP delivery which was mitigated by non-recurrent savings.

Recommendations
The Board is recommended to:

- Note levels of performance as at year end 2016/17
- Determine levels of assurance on any specific points

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust

Performance Brief
2016/17 Year End

Senior Management Team – 17th May 2017
Business Committee – 24th May 2017
Trust Board – Wednesday 31st May 2017

AGENDA ITEM 2017-18 (10a)

Executive Summary

This report provides a high level summary of performance of Leeds Community Healthcare (LCH) in 2017/18.

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 performance.

More detailed narrative on each of the individual indicators is available in the Domain Reports. These papers follow this report.

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 reflect the Trust's high level indicators which are aligned to the CQC domains.

1.1.1 Safe

The Trust ended the year with 3 green rated measures:

- As predicted Harm free care (Safety Thermometer) achieved the target in the final month of the year.
- The trust achieved its target to reduce avoidable category 3 pressure ulcers by 15% actually achieving a reduction of 69%
- The adjusted target for avoidable category 4 pressure ulcers was also met with only 1 reported category 4 pressure ulcer in the second half of 2016/17.

Two measures are rated amber, namely:

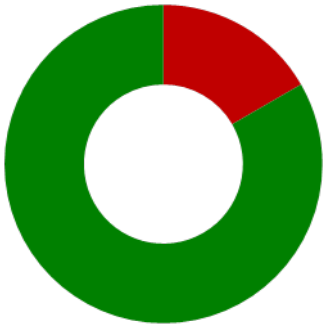
- Percentage VTE risk assessment completed, this is thought to be a recording error rather than a failure to complete the assessment. Recent initiatives have increased the number of assessments completed by around 20%, but this has not been enough to achieve the target
- The 10% falls reduction target was not met, but a reduction of 4.8% was achieved.

The Trust has not met the targets for Patient Safety Incidents reported as "No Harm", the 15% reduction in Serious Incidents or Duty of Candour. However, following a review of the cases to which Duty of Candour should apply our percentage improved greatly in March from 62% to 100%.

1.1.2 Caring

The Trust has met all of its targets for 2016/17 in the caring domain.

1.1.3 Effective



Each of the Business Units have reported a green RAG rating for their outcome CQUINS for Q4 2016/17.

There are two green rated measures in the effective domain; compliance with technology appraisals within 3 months and clinical supervision. Compliance with other NICE guidance within 1 year is rated red. The Trust will review the target for 2017/18 as full compliance with this KPI is unliklely to be possible or necessary.

1.1.4 Responsive

The Trust performed very well in respect of all of its responsive indicators of which there are eight. Seven of these relate to waiting times.

Activity is within 5% of our profile at year end.

1.1.5 Well Led

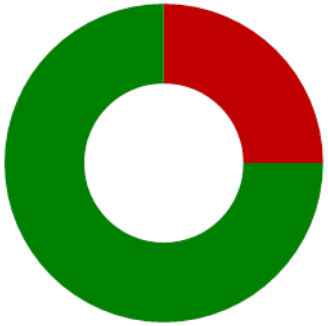
The measures in the well-led domain have remained broadly consistent all year. Turnover, sickness, appraisals (AfC and Medical) and staff recommending LCH as a place of work remain rated red against our high expectations.

Compliance with statutory and mandatory training reached 89.4%; an amber rating.

The response rate for the Staff FFT has been improving and is rated green at 24.5%.

The other measures rated green are safer staffing and the total agency cap.

1.1.6 Finance



The end of year financial position was as per plan. All measures achieve a green rating with the exception of recurrent CIP delivery which was mitigated by non-recurrent savings.

1.2 Statutory Breaches

Leeds Community Trust achieved all nationally set targets.

Further observations on waiting time performance in March are in the Responsive domain section on page 15.

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	Q2	Q3	Q4	Year End Pos
Patient Safety Incidents Reported in Month Reported as "No Harm"	2016/17	70%	56.0%	56.7%	56.8%	54.3%	55.7%	●
	2015/16		64.2%	64.5%	67.3%	65.1%	60.1%	
Potential Under Reporting of Patient Safety Incidents	2016/17	-	2.47	2.64	2.66	2.09	2.51	
	2015/16		-	-	-	-	-	
15% SI Reduction Target	2016/17	88	96	30	16	19	31	●
	2015/16		118	22	27	36	33	
Harm Free Care (Safety Thermometer)	2016/17	95%	-	94.2%	96.1%	94.3%	94.0%	●
	2015/16		-	93.9%	94.2%	93.4%	94.3%	
Percentage New Harms (Safety Thermometer)	2016/17	TBC	-	3.3%	2.7%	1.1%	0.6%	
	2015/16		-	3.3%	2.6%	3.4%	2.9%	
Percentage VTE Risk Assessment Completed	2016/17	95%	-	81.0%	88.8%	83.9%	77.5%	●
	2015/16		-	89.3%	90.2%	89.0%	94.6%	
10% Falls Reduction Target for Inpatient Beds	2016/17	60	62	14	20	17	11	●
	2015/16		66	20	19	16	10	
15% Category 3 Pressure Ulcer Reduction Target	2016/17	78	24	12	4	6	2	●
	2015/16		-	-	-	-	-	
0 Avoidable Category 4 Pressure Ulcers	2016/17	<=3*	1	1	2	1	0	●
	2015/16		-	-	-	-	-	
Percentage of Incidents Applicable for DoC Dealt with Appropriately	2016/17	85%	58%	79%	75%	55%	61.5%	●
	2015/16		-	-	-	-	-	

*** Target shown is for the period from October 2016 to March 2017**

Caring - staff involve and treat people with compassion, kindness, dignity and respect		YTD Target	YTD	Q1	Q2	Q3	Q4	Year End Pos
Percentage of Staff Recommending Care (Staff FFT)	2016/17	73%	-	77.5%	73.7%		77.7%	●
	2015/16		-	76.8%	78.0%			
Percentage of Inpatients Recommending Care (FFT)	2016/17	95%	-	100.0%	93.9%	97.0%	100.0%	●
	2015/16		-	97.0%	96.0%	97.0%	94.3%	
Percentage of Community Patients Recommending Care (FFT)	2016/17	95%	-	96.3%	95.2%	94.0%	96.4%	●
	2015/16		-	94.2%	93.8%	94.5%	87.5%	
Written Complaints - Rate	2016/17	TBC	154	77	48	29	63	
	2015/16			61	50	100	90	

1. Introduction and Main Issues for Consideration

1.1 Low/No Harm Incidents

National benchmarking data from the National Learning and Reporting System (NRLS) was published on 22 March 2017 for the reporting period 01 April 2016 – 30 September 2016. Although historical data, this provides some further opportunity for comparison of LCH reporting patterns against those of other community Trusts.

During the reporting period Apr-Sep 2016 LCH was in the top 25% of reporting community organisations for no harm patient safety incidents with 77.8% of all incidents resulting in no harm. The average reported no harm incidents for all community trusts was 56.7% which places LCH well above the national average for that reporting period.

When looking at community organisations of a similar size and demographic, LCH had the highest rate of no harm incidents. However, when this is combined to look at No/Low harm together LCH is in the middle of the group.

2. Duty of Candour

March is the first month where the reporting on Duty of Candour compliance is taken from incidents that have been investigated and closed. This change will provide assurance that the DoC process has been followed in a timely manner.

In March there were 19 confirmed incidents where Duty of Candour was triggered (i.e. where there was a moderate harm or higher LCH patient safety incident) and in every case an appropriate apology was given.

3. Pressure Ulcers

The total number of pressure ulcers reported in March was 74 which is an increase and the highest number reported per month in 2016/17. The increase is attributable across category 2 and 3 and unstageable ulcers reported. The YTD average is 57.5.

During February no pressure ulcers occurred in inpatient units or services based in a hospital setting (CICU).

A review of unstageable ulcers (UU) for 2016/17 shows the following breakdown:

Total Number of UU reported	Remained UU at close of investigation	Debrided to a Category 3 PU	Debrided to a Category 4 PU	Debrided to a category 2 / healing PU	Patient died (end of life PU)	Investigation process ongoing
135	72	6	2	6	Data not available	49

Of the 72 that remain unstageable, if these debride to a category 3 or four following closure of the investigation a new incident report will be completed.

In 2017/18 the data on closed investigations for unstageable pressure ulcer incidents at end of life will be collected to identify those patients that died whilst the pressure ulcer was unstageable or during the investigation process. This will assist identification of any pressure ulcers that had developed due to the patient being at end of life.

4. Falls

There were 81 falls overall in March which is stable for this quarter and consistent with the YTD average of 80). Of these 81 falls 52% resulted in No Harm or Minimal/Low Harm. This is the highest level of no harm this quarter and reflects a positive picture with regards to falls resulting harm (overall) this month.

In March 4 falls (5% of all falls) caused major harm (YTD average 5.8%):

Location of Major Harm Falls	
Patients Home	3
Nursing/Residential Home	1

From August to December inclusive the number of falls in inpatient units increased month on month. However in January this changed and falls reduced to 18. This was stable in February and has seen a further decrease in March, combined with a decrease in the proportion (27%) which caused harm. All harm sustained was minimal.

There were 2.03 injurious falls per 1000 occupied bed days (inpatient units) reported in March. This is not significant as it is below the mean and within the expected variation parameters. Monitoring continues for the emergence of any trends.

Injurious Falls per 1000 OBDs in Inpatient Units (all Adult Business Unit)

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Injurious Falls	8	5	6	10	5	4	6	4	6	4	4	2	3	4	7	4	10	6	5	6	6	0	7	4
Occupied Bed Days	2160	2232	2270	2347	2053	1970	1650	954	903	1121	1160	1024	1038	847	1554	1636	1628	1536	1700	1701	1949	2098	1900	1971
Falls per 1000 OBDs	3.70	2.24	2.64	4.26	2.44	2.03	3.64	4.19	6.64	3.57	3.45	1.95	2.89	4.72	4.50	2.44	6.14	3.91	2.94	3.53	3.08	0.00	3.68	2.03

A new process will be introduced from 1 April 2017 which requests a checklist review of all reported falls resulting in moderate or above harm within 48 hours. This will determine if the incident is attributable to LCH and whether there are any obvious gaps in care provision.

The Deputy Director of Nursing will review all checklists submitted and identify those which require further full RCA investigation and panel validation or an SI process top trigger. This new process will ensure that full RCA investigation is triggered appropriately and resources are not targeted in areas where it is not indicated.

Monitoring on the Trust's Sign up to Safety pledge to 'reduce falls causing avoidable harm in inpatient units by 10%' continues through the Quality Account priority (2016/17) report on a quarterly basis.

5. Infection Prevention and Control

5.1 MRSA Bacteraemia and Clostridium Difficile

In 2016/17 there have been no cases of MRSA Bacteraemia assigned to LCH. During the reporting period there have been 2 MRSA bacteraemia cases identified within the wider community economy, which have been subject to a full multi agency Post Infection Review (PIR). Although involvement from LCH care teams was identified in each case, no lapses in care leading to the infection were identified. In one of the two cases, the Holt Park Neighbourhood Team was commended on the effective way in which they managed and facilitated wound healing in one case.

Although not a lapse in care for LCH, the case highlighted ongoing issues with the resource availability within the LTHT Urology Team. Delays in undertaking a Trial without Catheter (TWOC) within hospital and deficits in communication between hospital and community resulted in an extended duration of catheterisation. The Commissioners are reviewing this deficit and safety netting measures are being explored within the Holt Park Neighbourhood Team.

No new cases of C difficile infection have been assigned to LCH resulting in the year ending with one case.

5.2 Outbreak Situations

An increased incidence of gastric illness was been reported at SLIC on the 30th March 2017. Restrictions in patient and staff movement have been instigated on the ground floor area of the unit. The facility as a whole remains operational, with outbreak control measures being reviewed on a daily basis.

5.3 Legionella Update Morley Health Centre

Improvement work has been undertaken at Morley to improve the safety compliance. Post improvement sample results indicate that the initial Legionella contamination has been eradicated and the system is now compliant with current legal requirements.

5.4 Infection Prevention and Control Mandatory Training Update

IPC mandatory training compliance rate has improved with a current uptake figure of 85%. A comprehensive programme of bespoke training in bases continues to be delivered.

5.5 Sharps Safety Issues

All incidents relating to needle stick injuries continue to be monitored and a 6 month follow up programme with injured staff is provided by the IPC team. For the first time in 18 months there were no needle stick reported injuries, subsequently a safety strategy, used in industry to publicise the number of incident free days with graphics, is being promoted on ELSIE.

5.6 Patient Led Assessments of Care Environment (PLACE) Inspections

During March PLACE inspections were carried out at Little Woodhouse Hall, CRU and CICU J31. Initial indications suggest that the standards of cleanliness and privacy and dignity have improved in comparison to the previous year. Issues relating to the condition and maintenance of the facilities in which LCH activity is housed, continues to generate some concerns. Full action plans are being developed and will shortly be circulated. The inspection at SLIC was planned to be undertaken during April.

5.7 Staff Influenza Vaccine Campaign Update

Following organisational success with the 2016-17 staff flu campaign, the IPC team presented the LCH experience at both NICE and NHS Employers forums and received three “Highly Commended” awards at the recent Flu Fighter event.

5.8 Hand Hygiene Observational Audit Compliance Assurance

The IPC Team have created and launched a modified version of the Essential Steps programme to provide more of a robust organisational assurance of compliance with hand decontamination requirements. This has initially been circulated to all Adult Neighbourhood Teams and will subsequently been implemented within the Children’s Business Unit.

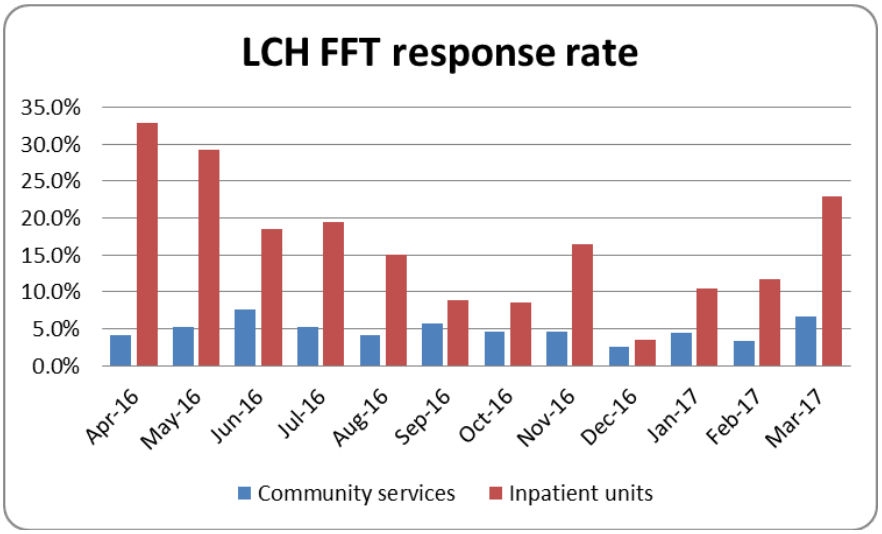
6. Friends and Family Test (FFT)

6.1 FFT Performance Dashboards – response rates (community and inpatient)

The number of completed FFT surveys fluctuates on a monthly basis due to variation in when surveys are received in month by the Clinical Governance Team.

Overall performance against the quality indicator is reported on a quarterly basis via the Quality Account reporting plan, along with progress against developed action plans.

At the time of reporting Q4 and year end data was still in the process of being collected and collated. This month's report therefore indicates the position at the time of reporting. A complete year end position, and overall percentage of response rates will be available in May.

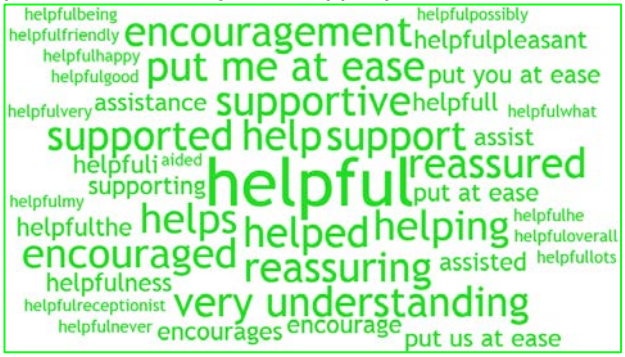


6.2 Performance by Business Unit

Mar-17		% Recommended	Response Rate	Comments
ABU	Services	90.9%	3.4%	79
	Inpatients	100%	23.8%	9
CBU	Services	97.6%	5.0%	160
	Inpatients	No data	No data	No data
SBU	Services	97.7%	8.8%	603
	Inpatients	No data	No data	No data

The FFT recommended % has increased for all three business units to date.
The MES FFT database contains an analytical tool that can produce data in different formats. The following presentation of themes has been produced from the 7352 comments received in the previous 12 months:

Clinical Service Quality
(Emotional and Physical Support)



Staff
(Professional and Competent)

Communication
(Information)

7. Coroners' Inquests

One inquest was held in March 2017:

Synopsis	Outcome
Death in Custody 2013: A prisoner at HMP Leeds was found in his cell in the segregation unit hanging from a ligature made of a tear-resistant blanket. Despite prompt emergency assistance, resuscitation was unsuccessful.	Update to be provided at Board meeting

Of the 28 Inquests year to date, 6 remain open. One is currently ongoing (see above) and four are listed to commence between March 2017 and October 2017. All the cases currently listed require legal input and support as identified below which is in place and ongoing. A further inquest is awaiting listing:

Synopsis	Inquest Date
Death in Custody; HMP Leeds November 2015	02/05/17
Death in Custody; HMP Leeds January 2016	03/07/17
Death in Custody; HMP Leeds May 2015	04/09/17
Death in Custody; HMP Leeds February 2016	09/10/17
Patient with multiple areas of pressure damage and deterioration under Nursing Homs and LCH care died shortly after admission to hospital.	Not yet listed

Leeds Community Healthcare NHS Trust

Effective Domain Report

Effective - people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence		YTD Target	YTD	Q1	Q2	Q3	Q4	Year End Pos
Compliance with Technology Appraisals Within 3 Months	2016/17	100%	-	100%	100.0%	-	100.0%	●
	2015/16		-	-	-	-		
Compliance with Other NICE Guidance Within 1 Year	2016/17	67%	-	29%	17.0%	20.0%	14.0%	●
	2015/16		-	-	-	-		
Total Number of Audits	2016/17	-	-	24	141	256	1339	
	2015/16		-	-	-	-		
Compliance with Clinical Supervision	2016/17	65%	-	65%	72.5%	68.1%	80.0%	●
	2015/16		-	-	-	-		
Development of Service Outcome Measures for Adult Community Services (CQUIN 4a)	2016/17		-					●
	2015/16		-	-	-	-		
Development of Service Outcome Measures for Specialist Services (CQUIN 4b)	2016/17		-					●
	2015/16		-	-	-	-		
Development of Service Outcome Measures for Children's Services (CQUIN 4c)	2016/17		-					●
	2015/16		-	-	-	-		
Number of Unexpected Deaths in Bed Bases	2016/17	-	5	4	0	1	0	
	2015/16		-	-	-	-		
Number of Sudden Unexpected Deaths in Infants and Children on the LCH Caseload	2016/17	-	8	3	1	5	3	
	2015/16		-	-	-	-		

1. Compliance with NICE guidance

1.1. Technology appraisals

There was one NICE Technology Appraisal published in Q3 2016/17 that was relevant to the Trust:

- TA 418 Dapagliflozin in triple therapy for treating type 2 diabetes. Compliance has been achieved by the Community Diabetes Team and York Street Health practice within the three month timeframe.

1.2. Other NICE guidance

Seven other pieces of NICE guidance were published in Q4 2015/16 that are relevant to the Trust. Full compliance has been achieved with one (CG 62 (updated) antenatal care for uncomplicated pregnancies) within the last twelve months.

Work is ongoing to ensure compliance with the six other relevant pieces of guidance:

- NG 33 Tuberculosis:
  - TB Service working with city-wide partners to implement the 300 recommendations in the guidance and to agree the required changes to the Leeds TB pathway;
  - Infection Prevention & Control Team & Prison Healthcare: HMYOI Wetherby reviewing specific recommendations for their services;
  - Full compliance for York Street Health Practice.
- NG 43 Transition from children's to adults' services for young people using health or social care services:

    - All Children's Services reviewing implications across wider pathway
- CG 72 UPDATED: Attention deficit hyperactivity disorder: diagnosis and management:
    - CAMHS Service have developed action plan;
    - Community Paediatrics, Prison Healthcare: HMYOI Wetherby & York Street Health Practice reviewing implications for their services.
- CG 137 UPDATED: Epilepsies: diagnosis and management:
    - Community Paediatrics Service are reviewing implications for their service;
    - Full compliance with relevant recommendations for York Street Health Practice.
- CG 185 UPDATED: Bipolar disorder: assessment and management:
    - York Street Health Practice are reviewing implications for their service;
    - Full compliance with relevant recommendations for CAMHS Service.
- NG 13 Workplace health – management practices:
    - The Workforce Team are reviewing the implications for the Trust.

Oversight of compliance at a service level is reported to the Quality Committee on a quarterly basis.

2. Audit

The documentation audit results are as follows:

Business Unit	Overall Compliance	Number of Records Audited	Number of Services
Adults	86%	192	10
Children and Families	92%	398	11
Specialist	91%	754	17
Trust Total	**90%**	**1339**	**38**

All registered Clinical staff in the Neighbourhood Teams have attended Holistic Assessment training in October 2016 to establish the standard of comprehensive clinical assessment in the NTs and improve the quality of clinical assessment and documentation in both paper and EPR care records. Neighbourhood Teams undertook the documentation audit during February and March 2017 and will submit their results by the end of April 2017.

The Children's Business Unit are submitting documentation audits and identifying additional information that will inform any reconfiguration of the documentation audits going forward into next year. 1 service results are still outstanding. This is not overdue.

Documentation audit data has been submitted from all services apart from one . No audits are overdue. Submissions have not been received from service that have been decommissioned during this reporting period.

The Trust number of records audited has improved compared to 2016-17 figures. It is expected that the compliance rate will be 100% at the end of April 2017.

Compliance against the Trustwide clinical audit database is the following:

Q4 Audit Status – All Business Units	
Ongoing	18%
Completed	55%
Not started	5%

The above completed figure does not reflect the individual business units documentation compliance as this audit is recorded as one audit only.

3. Clinical Supervision

77% of LCH staff are receiving regular clinical supervision. This is up from 68% in quarter 3 2016/17 and means that the Trust is meeting its target in this area overall. However some individual services areas did not meet their target for the year as detailed in the table below:

Service Area	% Clinical Supervision	Service Area Target
Adult	**80.00%**	75%
Children	**83.60%**	90%
SBU: including specialist adult services	**74.48%**	90%
SBU: Health and Justice excluding Police Custody	**100%**	75%
SBU: Police Custody	**55%**	60%
Corporate	**55%**	90%
Trust Wide	**77%**	**75%**

4. CQUINs

Each of the Business Units have reported a green RAG rating for their outcome CQUINS for Q4 2016/17.

5. Mortality Surveillance

5.1. Update on National Guidance

In March 2017 national guidance on Learning from Deaths was published which will require additional processes to be put in place within Trusts. There are requirements to:

- Have an Executive Director to take responsibility for the learning from deaths agenda
- Have a Non-Executive Director to take responsibility of oversight of progress
- Review and enhance skills and training
- Have a clear policy for engagement with bereaved families and carers
- Have a clear policy on responding to deaths which shows how it will respond to and learn from deaths of patients who die under its care

From April 2017 trusts are required to collect and publish specified information on deaths on a quarterly basis which should be through a paper and an agenda item to a public board meeting each quarter. Changes to Quality Accounts regulation will required that the data providers publish to be summarised in Quality Accounts from June 2018.

In Leeds Community Healthcare Dr Mandy Thomas is the Executive Director with responsibility for the learning from the deaths agenda and Tony Dearden is the Non-Executive Director with oversight. A policy for engagement is being developed. A quarterly report is also being developed and will be published for quarter on 2017/18 in July 2017. The Quality Account will include the appropriate information from June 2018.

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	Q2	Q3	Q4	Year End Pos
Patient Contacts - Variance from Profile	2016/17	0 to ± 5%	0.0%	1.2%	1.3%	0.5%	-3.0%	●
	2015/16		-4.4%	-8.0%	-5.5%	-3.0%	-1.0%	
Percentage of patients treated within 18 weeks (Consultant-Led)	2016/17	95%	99.5%	99.8%	99.8%	99.8%	98.3%	●
	2015/16		-	99.9%	99.9%	99.9%	99.2%	
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	2016/17	92%	-	100.0%	100.0%	99.9%	99.9%	●
	2015/16		-	99.9%	99.9%	99.9%	99.8%	
Number of patients waiting more than 52 Weeks (Consultant-Led)	2016/17	0	0	0	0	0	0	●
	2015/16		0	0	0	0	0	
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	2016/17	99%	-	100.0%	99.7%	100.0%	99.9%	●
	2015/16		-	99.2%	100.0%	100.0%	100.0%	
% Patients waiting under 18 weeks (non reportable)	2016/17	95%	-	98.9%	98.4%	97.6%	98.7%	●
	2015/16		-	98.0%	-	-	98.8%	
Cancellation Rate	2016/17	TBC	8.2%	7.5%	8.0%	9.2%	9.4%	
	2015/16		6.3%	6.1%	6.4%	6.5%	7.2%	
IAPT - Percentage of people treated within 18 weeks of referral	2016/17	95%	-	99.9%	98.9%	98.8%	99.5%	●
	2015/16		-	100.0%	100.0%	100.0%	100.0%	
IAPT - Percentage of people treated within 6 weeks of referral	2016/17	75%	-	98.3%	98.3%	98.7%	96.2%	●
	2015/16		-	99.5%	98.7%	98.5%	98.7%	

It is pleasing that all targets for the year were met. A small number of patients do wait longer than we would like. In March, 10 patients waited more than 18 weeks for treatment. 9 of these patients were waiting to be seen at the Paediatric Neuro Disability Service. All had first appointments booked in March. The remaining patient was waiting to be seen in the Community Dental Service. This patient required a supported bed in LTHT. The delays were due to this bed not being available, rather than a delay in obtaining an appointment from the service.

Although the service is under pressure currently there have been no breaches in the 6 week waiting time for diagnostic tests in Children's Audiology. Staff have been reallocated to offer audiology assessments in order to keep these waiting times down.

In IAPT the service is meeting its targets for wait times in March. 94.6% of patients were seen within the 6 week waiting target for IAPT and 99.6% of patients were seen within 18 weeks. These are comfortably above the national targets.

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	Q2	Q3	Jan	Feb	March	Year End Pos
Overall Safe Staffing Fill Rate - Inpatients	2016/17	97%	-	100.9%	100.6%	99.4%	103.9%	104.5%	104.3%	●
	2015/16		-	101.2%	100.9%	101.0%	100.6%	101.2%	102.3%	
Staff Turnover Rolling Year	2016/17	9% to 13%	-	14.6%	13.9%	15.7%	16.4%	15.9%	15.3%	●
	2015/16		-	-	-	-	-	-	-	
Executive Team Turnover	2016/17	-	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
	2015/16		-	-	-	-	-	-	-	
Short term sickness absence rate (%)	2016/17			1.3%	1.6%	2.3%	2.5%	2.5%	2.2%	
	2015/16		-	-	-	-	-	-	-	
Long term sickness absence rate (%)	2016/17			4.4%	4.0%	3.8%	4.0%	3.9%	3.5%	
	2015/16		-	-	-	-	-	-	-	
Total sickness absence rate (%)	2016/17	4.6%	-	5.6%	5.1%	6.3%	6.5%	6.4%	5.7%	●
	2015/16		-	5.0%	5.2%	5.8%	6.1%	5.7%	5.5%	
AfC Staff Appraisal Rate (12 Month Rolling - %)	2016/17	95.0%	-	88.8%	87.2%	85.7%	87.8%	84.5%	87.1%	●
	2015/16		-	-	-	-	-	-	-	
Medical staff appraisal rate (%)	2016/17	100%		86.4%	93.3%	98.0%	78.1%			●
	2015/16		-	-	-	-	-			
6 universal Statutory and Mandatory training requirements	2016/17	91.5%	-	88.6%	86.5%	89.9%	90.3%	86.7%	89.4%	●
	2015/16		-	87.6%	88.9%	86.1%	88.4%	89.5%	90.0%	
Total agency cap	2016/17	8,064k	6,366k	1,926k	3,576k	4,796k	388k	507k	675k	●
	2015/16		-	-	-	-	-	-	-	
Percentage Spend on Temporary Staff	2016/17	-	7.8%	9.6%	8.5%	8.3%	6.0%	8.0%	9.8%	
	2015/16		-	-	-	-	-	-	-	
Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	2016/17	57%	-	49.0%	42.8%		52.0%			●
	2015/16		-	43.0%	44.0%		49%			
Response Rate for Staff FFT	2016/17	23%	-	22.2%	21.0%		24.5%			●
	2015/16			19.8%	23.0%		20.6%			
Response Rate for Inpatient FFT	2016/17	TBC	-		9.7%	7.9%	10.5%	11.7%	23.1%	
	2015/16		-	2.7%	2.1%	2.3%	3.3%	1.4%	1.1%	
Response Rate for Community FFT	2016/17	TBC	-		5.1%	2.9%	4.4%	3.3%	6.8%	
	2015/16		-	25.1%	18.2%	12.8%	0.9%	1.1%	1.5%	

1. Appraisals

As at the end of March 2017 87.1% of available staff were registered as having had an appraisal within the last 12 months. This has seen a slight increase on last month's figure of 84.5%.

There continues to be a targeted discussion at the Performance panels and information made available via Business Intelligence. There is an Appraisal policy, toolkit and streamlined appraisal paperwork in place to support managers in completing appraisals and guidance available from the OD team.

A refresh of the Organisational Development Strategy will be ratified at Trust Board in May 2017.

In the strategy we set out 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.

From the recent NHS National Staff Survey results, there has been a significant increase in the question responses that can be attributed to these key priorities.

- The values of my organisation were discussed as part of the appraisal process up 12%
- Appraisal helped me to improve how I do my job up 3%
- My manager gives me clear feedback up 9%
- My manager can be counted on to help me with a difficult task at work up 8%
- I am satisfied with the support I get from my immediate manager up 6%
- Senior managers act on staff feedback up 6%
- I am satisfied with the recognition I get for good work up 5%
- My manager encourages those who work for her/him to work as a team up 5%
- My manager asks for my opinion before making decisions that affect my work up 5%
- My training, learning or development has helped me to deliver a better patient / service user experience up 4%

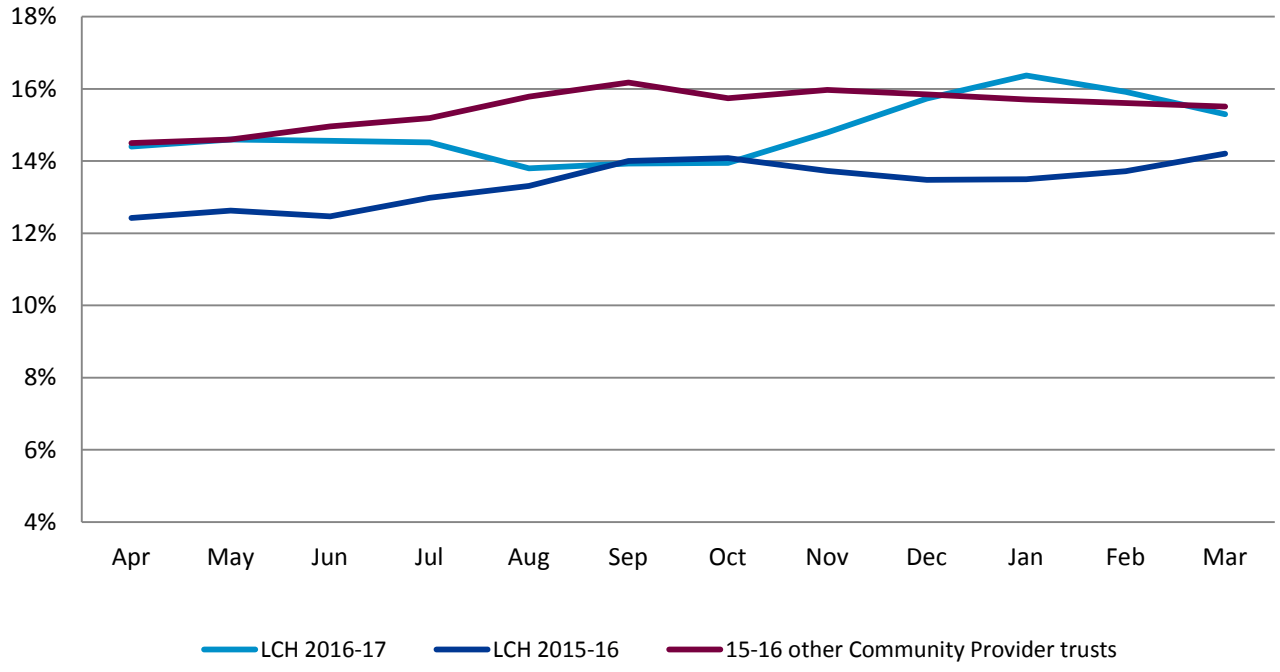
2. Statutory & Mandatory Training

The level of staff compliance with universal statutory & mandatory training has decreased from 88.9% last month to 89.4%
The individual topics report as follows:

- Information Governance training is at 91.9%
- Equality and Diversity training is above target with a compliance rate of 95.2%
- Health and Safety (Slips, Trips and Falls) training is 92.3%
- Fire Training, Infection Prevention and Control and Moving and Handling are all below target compliance rate at 83.16%, 85.6% and 88.3%.

3. Turnover

The figure for the rolling year has decreased from 15.9% in February to 15.3 % and remains above target. Although excluded from our turnover figures , it is of note that as at 31st March the staff of new-born hearing (14 WTE) transferred under TUPE to LTHT and staff of York Street (9 posts) transferred to Bevan. Also the services of FNP and EPP have been decommissioned resulting in 16.67 WTE being removed from establishment. For all FNP staff in service we have achieved redeployment – for remaining EPP staff there are 2 post holders under notice of redundancy



In March 2017 there were 36 leavers across the Trust.

Business Unit	March 2017 Leavers
833 Adult Business unit	16
833 Children's Business Unit	8
833 Corporate Directorate	1
833 Operations	2
833 Specialist Business Unit	9

Staff Group	March 2017 Leavers
Nursing	12
Administrative and Clerical	11
Allied Health Professionals	6
Add Prof Scientific and Technical	1
Support Services	5
Medical and Dental	1

The top 3 reasons for leaving were:

- Voluntary Resignation – Work life balance (7)
- Voluntary Resignation – Promotion (6)
- Retirement Age (6)

Workforce Information has put in place additional checks from February 2017 to improve the data quality to reduce the number of 'other/not known' reasons for leaving through ESR.
Work is underway to contact staff who left the trust within the first 12 months of employment as the full reasons are not fully known or understood. This will be reported on in April/May 2017.

Work continues to progress on a number of retention initiatives and leads have been established to develop these further. A monthly Recruitment Steering Group has been re-established to support this work.

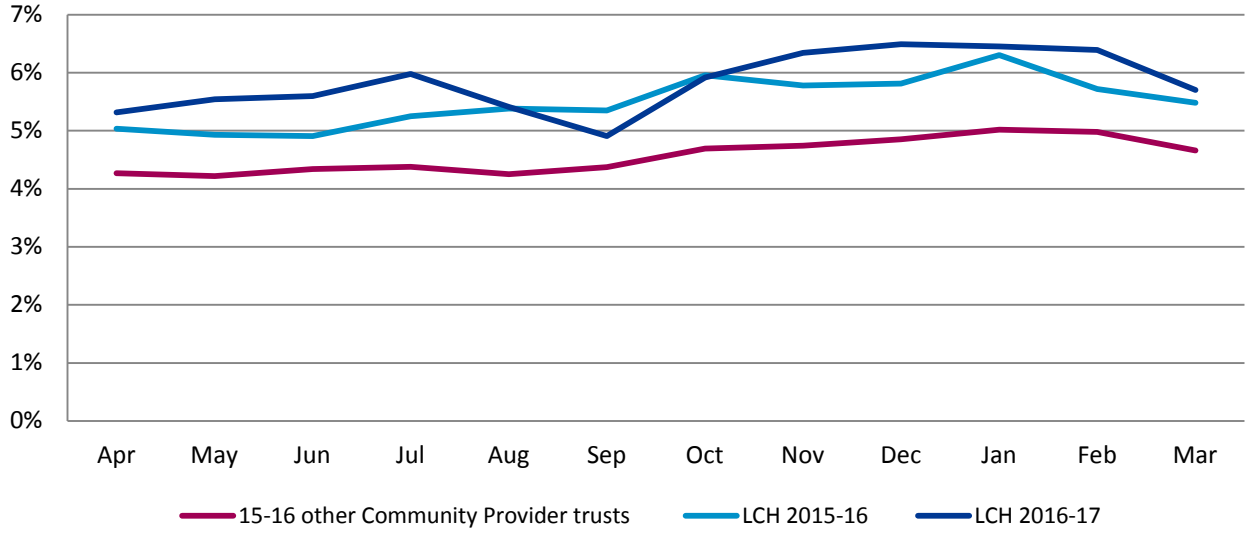
3. Workforce Race Equality Standard (WRES)

The trust target is based on the 2011 census which reports a Black and Ethnic Minority (BME) working age population at 19.2%, or 18.9% of the overall population. As at 2015/16 the trust reported a 12.02% BME workforce which is not reflective of the population it serves. The trust is required to report annually in August.

Work continues to develop the BME networks and train managers in Unconscious Bias.

4. Sickness Absence

Sickness absence rate for March was 5.7%, against a target of 4.6%. The absence for this same period last year is similar; however of note, is that this year has seen a bigger decrease in absence from February to March.



The 5.7% absence is broken down into Long-term 3.5% absence at and Short-term absence at 2.2%.

The encouraging news is that this month all areas level of absence has decreased.

Business Unit	March 2017 absence rate
Adult	6.35%↓
Children	5.50%↓
Specialist	5.53%↓
Corporate and Executive Directorate	5.22%↓
Estates & Ancillary Staff (Operations)	5.08%↓

The range of specific HWB work-streams/key areas of focus during April and May are:-
Communication will be sent to individuals and teams with 100% attendance during the period 16/17.

To build on the HWB results from the staff survey, there will be a campaign of staff involvement in a variety of ways to generate ideas that would improve their health and wellbeing.

The Executive Director of Operations and Assistant Director of Workforce met with Leaders of the Top areas with the highest sickness absence to test their “grip” on sickness absence and can report that managers were pro-actively managing this, with additional support identified for the more complex health cases.

The Pedometer Challenge generated healthy competition within teams.

The New Managing Attendance Policy launched. Evaluation of compliance of Policy will take place September/October 2017.

Leeds Community Healthcare NHS Trust

Finance Report

Finance		YTD Target	YTD	Q1	Q2	Q3	Jan	Feb	March	Year End Pos
Net surplus (-)/Deficit (+) (£m) - YTD	2016/17	-£2.9m	-£2.9m	-£0.1m	-£1.8m	-£0.2m	-£0.3m	-£0.4m	-£0.2m	●
	2015/16		-£0.3m	-£0.3m	-£0.1m	-£2.0m	-£0.7m	-£0.4m	£0.1m	
Net surplus (-)/Deficit (+) (£m) - Forecast	2016/17	-£2.9m	-£2.9m	-£2.9m	-£2.9m	-£2.9m	-£2.9m	-£2.9m	-£2.9m	
	2015/16		-	-£1.5m	-£2.2m	-£2.7m	-£3.0m	-£3.0m	-£3.0m	
Forecast underlying surplus	2016/17	-£1.5m	-£1.5m	-£1.5m	-£1.5m	-£1.5m	-£1.5m	-£1.5m	-£1.5m	
	2015/16		-	-£1.5m	-£1.5m	-£0.8m	-£0.8m	-£0.8m	-£0.8m	
Capital expenditure in comparison to plan (£k) - YTD	2016/17	£2,581k	£1,574k	£354k	£510k	£740k	£800k	£909k	£1,574k	●
	2015/16		-	-	-	-	-	-	-	
Capital expenditure in comparison to plan (£m) - Forecast	2016/17	£2.6m	£1.6m	£3.2m	£3.2m	£2.1m	£1.8m	£1.6m	£1.6m	
	2015/16		-	-	-	-	-	-	-	
CIP delivery (£m) - YTD	2016/17	£3.9m	£2.4m	£0.2m	£0.4m	£1.1m	£1.6m	£2.1m	£2.4m	●
	2015/16		-	-	-	-	-	-	-	
CIP delivery (£m) - Forecast	2016/17	£3.9m	£2.4m	£0.7m	£0.7m	£1.8m	£2.1m	£2.4m	£2.4m	
	2015/16		-	-	-	-	-	-	-	
Use of Resources Risk Rating (from Oct 2016)	2016/17	-	1	-	-	1	1	1	1	●
	2015/16		-	-	-	-	-	-	-	

NB the net surplus of £2.9m in the above table was as required in the financial plan. After the year end an additional £490k was received from NHS Improvement being a share of national STF resources that had not been distributed. The total surplus is therefore £3,350,000

1. Summary & KPIs

The Trust's financial performance for 2016/17 has once again been strong. During the first half of the year the Trust was significantly overspent each month; mitigating actions to curb expenditure were introduced and these were effective in turning the position around and the Trust has closed the year delivering the control total in full and achieving a use of resources rating of 1.

The Trust's turnover for 2016/17 was £148.7m from which a surplus of £3.35m or 2.25% was achieved. This includes the original £2.0m Trust surplus plus £0.86m core Sustainability & Transformation Funding (STF) plus a further £0.49m incentive STF transferred at the end of the year from DH. The cash earned from the surplus will be retained by the Trust for future capital investment.

The Trust has delivered its control total of £2.86m set by NHS Improvement; being £2.0m initial target surplus plus £0.86m additional surplus funded by core STF. On 24 April 2017 the Trust was allocated a further £0.49m incentive STF bringing the total surplus for the year to £3.35m overall. The Trust has met NHSI's surplus expectations in full. The Trust was set an agency control total of £8.2m, outturn expenditure on agency staff was £6.4m which means the agency cap was not breached.

The Trust has maintained a very strong cash position through the year and has £19.1m in the bank at the end of March; this is £1.9m more than planned. The Trust has achieved the Better Payments Practice Code target of 95% for all four measures. The Trust remained within its external financing limit.

The Trust's 2016/17 financial plan required the delivery of £3.9m of recurrent efficiency savings to meet the national inflationary pressures and internal objectives. The Trust delivered £2.4m of recurrent savings in year; a further £1.5m of non-recurrent savings were achieved. The shortfall

relates to non-delivery of the vacancy factor in year. This was mitigated by the release of un-utilised reserves and curtailing discretionary expenditure.

The Trust originally planned to spend £3.2m on capital assets. Given the financial position for the whole of the NHS; DH did not issue permission to incur capital expenditure until the autumn when the Trust's Capital Resource Limit was set at £2.5m. This represented the planned depreciation for the year plus £0.8m, the amount the Trust agreed to defer last financial year. The Trust spent £1.1m on the electronic patient record project, £0.3m on IT and other equipment and £0.1m on estates. Overall the Trust's reported capital expenditure was £1.575m this has been adjusted for disposals made in year of £72k giving a net charge against the £2.581m CRL of £1.503m; this is an under-shoot of £1.078m which is allowed.

The Trust has achieved all the statutory financial duties set by NHS Improvement for 2016/17 and closed the year with a Use of Resources score of 1.

Performance against National and Local Targets

Table 1

Target	Performance	Achieved
Planned surplus on income & expenditure - £2,000k	£2,000k surplus	☑
Additional stretch target surplus from core STF - £860k	£860k surplus	☑
End of year incentive STF - £490k	£490k surplus	☑
Remain within External Finance Limit £(1,336)k	£(30)k	☑
Remain within Capital Resource Limit £2,581k	£1,503k	☑
Capital Cost Absorption Rate 3.5%	3.50%	☑
CIP savings in year – recurrent £3,915k	£2,412k	☒
CIP savings – non recurrent	£1,503k	☑
Better Payment Practice Code:		
Non NHS invoices - 95% number & value	95% & 97%	☑☑
NHS invoices - 95% number & value	97% & 99%	☑☑
Agency control total - £8,150k	£6,391k	☑
Use of Resources (no target, introduced mid year)	1	☑

2. Income & Expenditure

The Trust has achieved slightly less income than planned for the year. Expenditure is marginally underspent at the end of the year. The Trust has 118 wte or 4.4% less staff in post than funded in March; this is after the planned vacancy factor reduction. Pay costs are in line with the February forecast; temporary staffing costs have increased by £168k in month. Non pay expenditure is £1.1m underspent at the end of March and £0.5m of reserves have remained utilised. There is a small underspending on budgeted depreciation costs following the delay in permission to spend capital this year.

Table 2 Income & Expenditure Summary	March Plan WTE	March Actual Contract WTE	Annual Plan £m	Actual Outturn £m	Outturn Variance £m	Forecast Variance last month £m
Income						
Contract Income			(138.5)	(138.3)	0.2	0.2
Other Income			(9.9)	(9.9)	0.0	0.1
Total Income			***(148.4)***	***(148.2)***	***0.2***	***0.3***
Expenditure						
Pay	2,671.6	2,553.7	105.0	106.5	1.5	1.5
Non pay			37.6	36.6	(1.1)	(1.3)
Reserves & Non Recurrent			0.5	0.0	(0.5)	(0.3)
Total Expenditure	***2,671.6***	***2,553.7***	***143.1***	***143.0***	***(0.1)***	***(0.1)***
EBITDA	**2,671.6**	**2,553.7**	**(5.3)**	**(5.1)**	**0.1**	**0.1**
Depreciation			1.7	1.6	(0.1)	(0.1)
Public Dividend Capital			0.7	0.7	(0.0)	(0.0)
Profit/Loss on Asset Disp			0.0	0.0	0.0	0.0
Interest Received			(0.0)	(0.0)	0.0	0.0
Retained Net Surplus	**2,671.6**	**2,553.7**	**(2.9)**	**(2.9)**	**0.0**	**(0.0)**
	Variance =	**(117.9)**				

The Trust has met the targets set by NHS Improvement in respect of access to the Sustainability and Transformation Funding (STF) and the position reported here includes £860k STF monies but not the £490k received on 24 April.

2.1 Income

Contract income for the year to date is running marginally behind plan as a result of penalties on the police custody contracts. The shortfall of other income relates to CICU, for April and May £0.1m. The Trust has agreed the year end CQUIN position with the CCGs and NHS England.

2.2 Pay

Table 3 below illustrates the total pay costs by category. The underspending on substantive staff in post continued in March however the combined level of pay expenditure does not deliver the vacancy factor for the year.

Table 3 Annual Pay Costs by Category	Annual Plan £k	Actual Outturn £k	Outturn Variance £k	Last Month YTD Variance £k	Last Month Forecast Outturn Variance £k
Cost of staff directly employed	102,602	97,471	**(5,131)**	**(4,418)**	
Seconded staff costs	707	785	**78**	**94**	
Vacancy Factor	(6,586)		**6,586**	**6,037**	
Sub-total Direct Pay	**96,723**	**98,257**	**1,533**	**1,713**	
Bank Staff	170	1,839	**1,669**	**1,488**	
Agency Staff	8,064	6,365	**(1,699)**	**(1,702)**	
Total Pay Costs	**104,958**	**106,461**	**1,503**	**1,499**	**1,545**

All business units continue to be overspent on pay at the end of March.

Specialist services: £997k (Feb £961k, Jan £985k) overspending mostly police custody and non-delivery of the vacancy factor for health and justice offset by an underspending in other specialist services.

Children's services: £671k (Feb £722k, Jan £856k) overspending being mostly the non-delivery of the vacancy factor (2016/17 new target plus the historic target not being achieved) speech and language therapies and consultant paediatricians.

Adult services: £583k (Feb £517k, Jan £493k) overspending was on neighbourhood teams now EDAT and personal health budgets.

QPD Clinical: £360k, (Feb £308k, Jan £293k) overspending.

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. During the year the Business Units have looked to reduce all variable staffing costs including agency bank and overtime usage.

Table 4 Month on Month Pay Costs by Category	April £k	May £k	June £k	July £k	August £k	Sept £k	Oct £k	Nov £k	Dec £k	Jan £k	Feb £k	Mar £k	Outturn Actuals £k
Directly employed staff	8,260	8,445	8,298	8,258	8,132	7,964	8,252	8,031	7,994	8,098	7,745	7,994	97,471
Seconded staff costs	248	-99	38	57	57	79	77	76	78	74	60	41	785
Bank staff	170	136	192	146	141	149	112	126	170	136	167	194	1,839
Agency staff	732	577	618	553	532	565	382	419	419	388	507	675	6,365
Total Pay Costs	**9,409**	**9,058**	**9,146**	**9,015**	**8,861**	**8,757**	**8,823**	**8,652**	**8,661**	**8,696**	**8,480**	**8,903**	**106,461**

Agency costs overall are £675k this month which is £168k more than last month.
The main areas of agency expenditure and associated staffing positions are:

- Specialist BU £1,919k (Feb £1,775k, Jan £1,651k)
  13.99 wte less than planned
- Children's BU £887k (Feb £790k, Jan £754k)
  4.62 wte more than planned
- Adult's BU £1,837k (Feb £1,601k, Jan £1,436k)
  36.43 wte less than planned
- QPD Clinical £801k (Feb £555k, Jan £492k)
  10.37 wte less than planned
- Corporate £686k (Feb £631k, Jan £554k)
  19.37 wte less than planned

The Trust planned for agency expenditure of up to £8,064k to the end of March which the agency cap was based on. The Trust has spent £1,699k less than this. Agency staff are recruited to replace essential substantive staff vacancies they are funded from underspendings on substantive staff as they provide the alternative capacity to enable services to continue care provision; an additional £0.5m was included in planned pay costs in respect of an agency cost premium. The Trust has remained within the agency cap set by NHSI.

2.3 Non Pay

There has been a small increase in non-pay expenditure in the final month of the year. The main changes are in premises where NHS providers of estates have brought their accounts up to date for minor works including costs for Littlewood House Hall. Clinical supplies and services relates to increased charges for the continence service. Other non pay includes the transfer of the profit share to Leeds Teaching Hospitals for the sexual health service; this had been accounted for as a commitment in reserves previously. Overall non pay is £1.1m underspent at the end of the year as a result of the actions taken to curb discretionary expenditure to address the overspending on pay in the first half of the year.

Table 5 Year to Date Non Pay Costs by Category	Annual Plan £k	Actual Outturn £k	Outturn Variance £k	Last Month YTD Variance £k	Last Month Forecast Outturn Variance £k
Drugs	1,301	1,294	(7)	(21)	
Clinical Supplies & Services	9,242	9,058	(184)	(259)	
General Supplies & Services	2,540	2,449	(90)	(98)	
Establishment Expenses	6,795	6,416	(378)	(346)	
Premises	13,991	13,529	(462)	(602)	
Other non pay	3,775	3,830	54	(101)	
Total Non Pay Costs	**37,644**	**36,577**	**(1,068)**	**(1,426)**	**(1,316)**

3. Reserves & Non Recurrent

The Trust retained £0.5m in reserves at the end of March this to enable the financial target to be achieved.

4. Service Line & Contract Performance

Table 6 Service Line	Budget WTE	Actual Contract WTE	Variance WTE	Annual Budget £m	Actual Outturn £m	Outturn Variance £m	Annual Plan Activity	Actual Outturn Activity	Outturn Variance Activity	Corr-elation
Specialist Services	627.7	613.7	(14.0)	36.4	36.2	(0.2)	509,367	468,816	(40,551)	•••
Childrens Services	707.9	712.5	4.6	29.7	30.3	0.6	365,688	371,648	5,959	•••
Adults Services	833.4	797.0	(36.4)	33.6	34.1	0.5	844,510	883,389	38,879	•••
QPD Clinical	91.2	80.9	(10.4)	6.1	6.7	0.7	28,285	23,547	(4,738)	•••
Ops Management & Equipment	50.5	42.3	(8.3)	1.2	1.4	0.2				••
Service Line Totals	**2,310.8**	**2,246.4**	**(64.4)**	**107.0**	**108.7**	**1.7**	**1,747,850**	**1,747,399**	**(450)**	•••
Corporate Support & Estates	360.8	307.4	(53.5)	27.1	25.8	(1.3)				••
Total All Services	**2,671.6**	**2,553.7**	**(117.9)**	**134.1**	**134.6**	**0.5**	**1,747,850**	**1,747,399**	**(450)**	•••

In March operational services have 64.4 wte less in post than planned (62.9 wte less in February, 35.9 wte less in January). The services are a net £1.7m overspent year to date which is £0.1m more than the position reported last month. All operational budgets but specialist services have ended the year overspent.

For the year the overall activity is marginally 0.03% less than planned; this will move as records are brought up to date in the next few weeks before the freeze position. Children's and Adult services continue to be ahead of plan and Specialist and QPD Adult services have delivered less than expected. The Trust had a risk reserve in respect of underperformance of Adult NT activity from August; given the level of activity in year there has been no financial impact.

- Specialist services activities are 8.0% less than planned, (Feb -8.6%)
- Children's services activities are 1.6% more than planned, (Feb +2.1%)
- Adult NT services activities are 4.6% more than planned, (Feb +4.4%) and
- QPD Clinical services activities are 16.8% less than planned, (Feb -17.5%).

5. Cost Improvement Plans

The majority of the cost savings for 2016/17 were planned to come from underspendings on pay as a result of the level of staff turnover and the reduction in agency costs as a consequence of more substantive staff being in post following successful recruitment campaigns.

The overspending on pay means the additional vacancy factor for 2016/17 hasn't been delivered in full; however the reduction in pay expenditure in the second half of the year means that £1.7m of the vacancy factor has been achieved. All other efficiency savings have been delivered as planned.

Table 7 Savings Scheme	2016/17 Annual Plan £k	2016/17 Actual Outturn £k	2016/17 Outturn Variance £k	2016/17 Outturn Variance %
Vacancy factor	3,195	1,692	(1,503)	-47%
Drugs	100	100	0	0%
Non Pay	311	311	0	0%
Estate maintenance	158	158	0	0%
Travel	151	151	0	0%
Total Efficiency Savings Delivery	**3,915**	**2,412**	**(1,503)**	**-38%**

6. Capital Expenditure

NHS Improvement has confirmed the Trust is permitted to spend £2.581m in 2016/17; the Trust had originally requested permission to spend £3.15m but curtailed expenditure at NHS Improvement's request. The outturn capital expenditure is £1.574m; there have also been capital disposals of £0.071m for assets that have ceased to be used in service delivery eg York Street, New-born Hearing; those which weren't located during the physical verification exercise and those no longer operational in the MSK service; giving a total charge against the Capital Resource Limit (CRL) of £1.503m. This represents an under-shoot of £1.078m which is permitted. In March the Trust agreed with NHSI that the total CDEL charge would be £1.513m; the Trust has finished the year £10k under this estimate.

Capital expenditure during the year was £0.3m pay and £0.8m on pay mostly IT kit for the EPR project. Estates expenditure of £0.1m included health centre refurbishments and new boilers and spend on IT/Equipment consisted of £0.13m for servers, speech and language therapy equipment costing £0.09m and various other small items for clinical services.

Table 8 Scheme	Annual Plan £m	Actual Outturn £m	Outturn Variance £m
Estate maintenance	0.7	0.1	(0.6)
Equipment/IT	0.5	0.3	(0.2)
Electronic Patient Records	1.2	1.1	(0.1)
CAMHS Inpatients Estate	0.8	0.0	(0.8)
NHSI adjustment - approved limit	(0.6)		0.6
Totals	**2.6**	**1.6**	**(1.0)**

7. Statement of Financial Position

The statement of Financial Position for the year is included in the Accounts elsewhere on the Boards's agenda. The usual table 9 is therefore not included in this report.

8. Working Capital

The Trust's cash position is strong at £19.1m which is £1.9m more than planned due to slippage on the capital programme and the increase in provisions.

As table 10 demonstrates the Trust's performance against the **Better Payment Practice Code** target of 95% has been met for the year.

Table 10 Measure	Cumulative Performance Year End	Cumulative Performance Last Month	Target	RAG
NHS Invoices				
By Number	97%	97%	95%	G
By Value	99%	99%	95%	G
Non NHS Invoices				
By Number	95%	95%	95%	G
By Value	97%	97%	95%	G

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. This replaces the old sustainability and financial risk rating (SFRR).

The Trust continues to score 1 at the end of the year which is the lowest risk.

Table 11 Criteria	Metric	Performance	Rating	Weighting	Score
Liquidity	Liquidity ratio (days without WCF)	33	1	20%	0.2
Balance Sheet sustainability	Capital servicing capacity (times)	7.3	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	-21%	1	20%	0.2
Overall Use of Resources Risk Rating					**1**

10. Conclusion on Financial Performance

In a difficult financial climate the Trust has managed to deliver all of the financial targets for 2016/17; this is despite early overspendings on pay costs and a short fall in achieving the vacancy factor savings.

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2017-18 (10b)

Meeting: Trust Board 31 May 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, 17 May 2017 Business Committee, 24 May 2017	**For information**	

Purpose of the report

This report provides a high level summary of performance within the Trust during April 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 of its targets within the safe domain with the exception of two. Duty of candour is currently rated amber, however, it is expected that the one delayed apology will be provided to the patient and that this will change the rating to green.

There have been two avoidable, injurious falls in April 2017; this is above the monthly target limit of one therefore the measure is rated red.

Green is forecast for all other indicators.

Caring
The Trust is currently meeting all of its targets in the caring domain and the Trust expects this picture to be the same at year end.

Responsive
The Trust continues to perform well in respect of most of its responsive indicators of which there are seven. Six of these relate to waiting times and all but the six weeks diagnostic waits indicator is rated green. Information on this is provided in section 1.2 of the performance brief.

The Trust's variance from activity profile is currently rated as red as activity is -10.9% below profile. As the Trust has only one month's data it is not possible to tell whether this is a developing trend. Activity levels will continue to be monitored and are expected to meet the target at year end.

Well Led
The Trust is currently rated green for:

- Executive team turnover
- Short term sickness absence
- Total sickness absence
- Universal statutory and mandatory training
- Time between placing advertisements and filling vacancies (all three measures)
- The number of staff leaving the organisation within 12 months
- Reduce “other” category for “reason for leaving” to 10%

It is rated amber for:

- Staff turnover
- Stability index
- Long term sickness absence
- Appraisals

The friends and family test response rates for both inpatient and community patients are rated red.

Finance
In the first month of the year, the Trust is meeting its targets for the use of resources risk rating and net surplus/deficit. Capital expenditure in comparison to plan and cost improvement programme delivery are currently rated red, but the Trust is forecast to achieve these targets by year end.

Recommendations
The Board is recommended to:

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

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (10b)

Leeds Community Healthcare NHS Trust

Performance Brief, April 2017

Quality Committee - 22nd May 2017
Business Committee – 24th May 2017
Trust Board – 31st May 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.

More detailed narrative on each of the individual indicators are available in the Domain Reports.

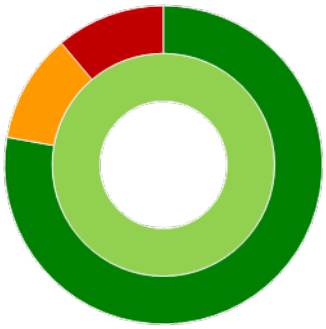
1. High Level Performance Summary

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.

Please note the new format of the donut charts below. They now show both the current performance and forecasted performance. The outer, darker ring shows the current performance of the indicators in the domain. The inner, lighter ring shows what performance is forecast to be at year end.

1.1.1 Safe



The Trust is currently achieving all of its targets within the safe domain with the exception of two. Duty of Candour is currently rated amber, however, it is expected that the 1 delayed apology will be provided to the patient and that this will change the rating to green.

There have been two avoidable, injurious falls in April, this is above the monthly target limit of one therefore the measure is rated red.

Green is forecast for all indicators.

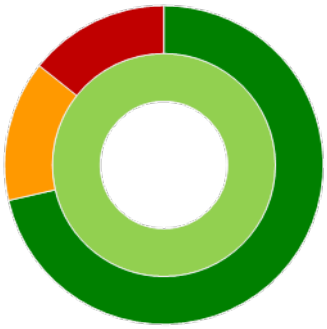
1.1.2 Caring

The Trust is currently meeting all of its targets in the caring domain and we expect this picture to be the same at year end.

1.1.3 Effective

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

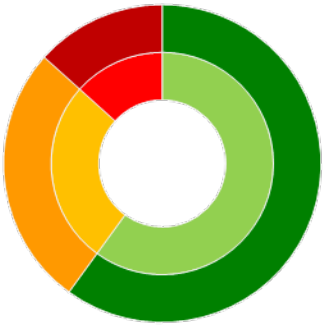
1.1.4 Responsive



The Trust continues to performs well in respect of most of its responsive indicators of which there are seven. Six of these relate to waiting times and all but our 6 week diagnostic waits indicator is rated green. Further information on this is provided in section 1.2.

The Trust's variance from our activity profile is currently rated as red as activity is -10.9% below profile. As we only have one month's data it is not possible to tell whether this is a developing trend. Activity levels will continue to be monitored and are expected to meet the target at year end.

1.1.5 Well Led



The Trust is currently rated green for:

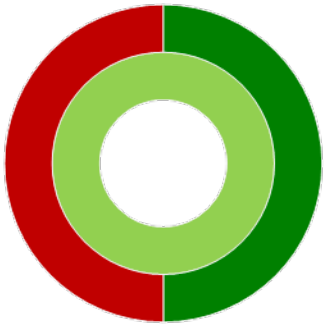
- Executive Team Turnover
- Short Term Sickness Absence
- Total Sickness Absence
- Universal Statutory and Mandatory Training
- Sustain the Time between Placing Adverts and Filling Vacancies (all 3 measures)
- The number of staff leaving the organisation within 12 month
- Reduce “other” category on ESR for “reason for leaving” to 10%

It is rated amber for:

- Staff turnover
- Stability Index
- Long Term sickness absence
- Appraisals

The FFT response rates for both inpatient and community patients are rated red.

1.1.6 Finance



In the first month of the year the trust is meeting its targets for the Use of Resources Risk Rating and Net Surplus/Deficit. Capital Expenditure in comparison to plan and CIP delivery are currently rated red, but the Trust is forecast to achieve these targets by year end.

1.2 Statutory Breaches

Leeds Community Trust is currently performing within all nationally set targets with the exception of diagnostic waits. In April 10 patients waited longer than the 6 week target. Staff are being reallocated to offer audiology assessments with the aim of bringing down waiting times and the service is looking at changing its opt in procedure from a process that takes 3 weeks to one that takes 48 hours.

In April one patient was waiting more than 18 weeks for treatment. This breach is in the Paediatric Neuro Disability Service; a patient cancelled an appointment and a subsequent appointment was not available within the 18 week timeline.

The service is meeting its targets for wait times in IAPT. 96.5% of patients were seen within the 6 week waiting target for IAPT and 99.6% of patients were seen within 18 weeks. These are comfortably above the national targets.

2. Contract Related Highlights

2.1 Contracting Round for 2017/18 and 2018/19

We have received an acceptable offer for the 2017/18 contract year for Community Dental Service.

2.2 Leeds City Council

Leeds City Council have confirmed their intention to extend Watch It to end of March 2019. This would bring it in line with the re-procurement of Health Visiting and School Nursing as such we assume they intend to amalgamate these three services into a single tender.

Meetings have started with Reed, the new provider of the Healthy Living Service to ensure a smooth transfer in October 2017.

2.3 CIC Beds - CCG

Exploratory discussions between Leeds Community Healthcare, Leeds City Council and Leeds Teaching Hospital Trust continue with the aim of pulling together a city wide consortium. We anticipate the tender will have been issued by the time of the Board meeting.

2.4 Childhood BCG – NHS England

The first meeting with Leeds Teaching Hospitals Trust to start the process of transferring the baby element of the childhood BCG service to their maternity team took place on 16th May 2017.

NHS England have indicated that the school age element of the service will transfer to local GP providers who would also be expected to vaccinate any new movers into the area from within the UK. We will be working with them to ensure a consistent message to GP practices around this change in the pathway.

2.5 Health and Justice – Wetherby YOI

In relation to the ongoing discussion around constant watch we have a difference of opinion as to whether responsibility for funding this activity is still within our contract. We will be meeting with NHS England at the earliest opportunity to try and resolve the issue without further dispute.

2.6 IAPT Recovery Rates

IAPT have achieved a 50.5% recovery rate in Q4 2016/17, this is the first time that the service has exceeded the recovery target over a full quarter. Amongst other things, one key initiative that has helped to achieve this is additional support to clients in step 2 groups and SilverCloud programmes, including offering additional interventions aimed at achieving recovery prior to discharge.

2.7 CCG Contract Report – HNA LAC

Whilst the Trust did meet the target to deliver 95% of Health Needs Assessments for Looked After Children within 20 days in 2016/17, there was a dip in performance in March. Only 76.5% of Looked After Children were seen within 20 days. These breaches were due to a Doctor having to take leave at short notice and having to cancel clinics as a result.

3. Key Areas of Focus

3.1 End of Life Care

Information recorded on EPaCCS in 2016-17 shows a number of improvements compared to previous years and as a result of improved use of EPaCCS by LCH Neighbourhood Teams we can demonstrate that:

- More patients have been included on EPaCCS, suggesting increased recognition of patients palliative care needs and improved coordination of care
- A higher proportion and number of patients died in their preferred place of death in 2016-17 (85% target achieved), which is likely to reflect the improvements in care supported by the Neighbourhood Palliative Care Leads since October 2015 and new ways of working within Neighbourhood Teams
- Recording of preferred place of death (PPD) and actual of place of death (APoD) has significantly increased, suggesting more advanced care planning discussions are taking place and being recorded
- Verification of death by registered nurses has almost doubled, suggesting an improvement in the experience of families and carers who may previously have waited many hours, especially out of hours, for a doctor to attend
- More patients died at home or in their care home supported by Neighbourhood Teams

	2014-15	2015-16	2016-17
New patients registered on EPaCCS	-	2166	**2426**
Patient deaths recorded on EPaCCS	1887	1806	**2038**
PPD achieved	82.3% (950)	81.8% (**1139**)	**85.5% (1345)**
Complete recording (PPD and APoD recorded)	70.4%	**88.1%**	**91.2%**
Deaths verified by LCH nurses	36%	**57%**	**65%**
Deaths at home/Care home	61% (1026)	62% (882)	60% **(1200)**

These improvements may reflect an improvement in reporting rather than an actual increase in the number of palliative patients cared for by Neighbourhood Teams, however we are now in a position to identify trends more accurately going forward. In 2017-18 the focus will be on maintaining these improvements and identifying possible further improvements to both reporting and patient experience. Providing local Palliative Care Reports now enables teams to reflect locally on what is working well and where further improvements could be made.

3.2 2017/18 CQUINs

3.2.1 Background

CQUINs are agreed with each commissioner as part of the annual contract. All CQUINs for 2017/18 and 2018/19 are national CQUINs and will cover a 2 year time span. This year we have 10 CQUINs in total although some have several parts as shown in the table below.

Commissioner	CQUIN No	CQUIN Title	Value 17/18	Value 18/19
Leeds South and East CCG	1a	Improvement of health and wellbeing of NHS staff	£75,328	£75,409
	1b	Healthy food for NHS staff, visitors and patients	£75,328	£75,409
	1c	Improving the uptake of flu vaccinations for front line staff within Providers		
	2	Supporting Proactive and Safe Discharge – Community Providers	£75,328	£75,409
	3a	Tobacco screening	£451,970	£452,456
	3b	Tobacco brief advice	£11,299	£11,311
	3c	Tobacco referral and medication offer	£45,197	£45,246
	3d	Alcohol screening	£56,496	£56,557
	3e	Alcohol brief advice or referral	£56,496	£56,557
	4	Improving the Assessment of Wounds	£56,496	£56,557
	5	Personalised Care & Support Planning	£225,985	£226,228
	6	Supporting Local Areas: Engagement with STP	£225,985	£226,228
	7	Supporting Local Areas: Control Total Risk Reserve	£451,970	£452,456
Health and Justice	8a	CHAT		
	8b	Escort and bed watch		
NHS England Public Health	9	Health inequalities school imms	£10,405	£9,733
NHS England CAMHS	10	CAMHS discharge	£37,589	£37,626

Payment rules apply to most CQUINs allowing partial payment for partial achievement. A detailed summary of each CQUIN is available from the contracting or quality and professional development teams if required.

3.2.2 Current Position

All services are aware of CQUINs that apply within their contracts and leads have been identified for all CQUINs with the exception of CQUINs 6 and 7. The exact detail of how the success of these two CQUINs will be measured is still to be finalised with commissioners.

CQUIN 1b, Healthy food for staff, visitors and patients, does not apply to our organisation. The value of this CQUIN will be transferred to another in agreement with them.

There are 3 CQUINs (CQUINs 2, 4 and 5) that require input from the neighbourhood teams to achieve. All are achievable and relate to work underway or previously undertaken. Consideration has been given to implications this has on resources and the services have agreed that the CQUIN is achievable.

All CQUINs have been reviewed by SMT. There is a risk that CQUIN 1a will not be achieved. This CQUIN will be awarded on achievement of a 5 percentage point improvement in two of the three NHS

annual staff survey questions on health and wellbeing, MSK and stress (questions 9a,b and c) using the 2015 staff survey as a baseline. The 2016 staff survey showed a 2% increase in one of these 3 questions and a 2% decrease in the other two. A 5% improvement is statistically significant and will be hard to achieve. SMT agreed that there needs to be ongoing focus and work around this CQUIN which will be aligned to the work of the OD strategy and the response to this year's staff survey.

3.2.3 Next steps

Quarterly reports are required to be sent to the relevant commissioners at agreed times. All CQUIN leads have been provided with a report template and timeline. SMT will be reviewing progress against each CQUIN quarterly prior to the reports going to commissioners.

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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	Apr	May	Jun	Forecast
Overall Safe Staffing Fill Rate - Inpatients	2017/18	>=97%	-	97.0%			●
	2016/17		-	101.6%	100.0%	101.1%	
Patient Safety Incidents Reported in Month Reported as Harmful	2017/18	0.58 to 0.96	0.78	0.78			●
	2016/17		0.77	0.88	0.77	0.80	
Potential Under Reporting of Patient Safety Incidents	2017/18	1.23 to 2.53	2.00	2.00			●
	2016/17		2.47	2.92	2.46	2.55	
Serious Incident Rate	2017/18	0 to 0.13	0.04	0.04			●
	2016/17		0.05	0.06	0.05	0.09	
Percentage VTE Risk Assessment Completed	2017/18	>=95%	96.6%	96.6%			●
	2016/17		83.4%	67.4%	92.7%	83.0%	
5% Reduction in Falls Resulting in Avoidable Harm in our Community Inpatient Units	2017/18	1	2	2			●
	2016/17		13	-	-	-	
10% Category 3 Avoidable Pressure Ulcer Reduction Target	2017/18	<=22	1	1			●
	2016/17		24	5	6	1	
0 Avoidable Category 4 Pressure Ulcers	2017/18	0	0	0			●
	2016/17		0	0	0	1	
Percentage of Incidents Applicable for DoC Dealt with Appropriately	2017/18	100%	95.7%	95.7%			●
	2016/17		57.8%	55%	48%	50%	

Caring - staff involve and treat people with compassion, kindness, dignity and respect		YTD Target	YTD	April	May	June	Forecast
Percentage of Staff Recommending Care (Staff FFT)	2017/18	>=73%	-				
	2016/17		-	77.5%			
Percentage of Inpatients Recommending Care (FFT)	2017/18	>=95%	-	100.0%			●
	2016/17		-	100.0%	100.0%	100.0%	
Percentage of Community Patients Recommending Care (FFT)	2017/18	>=95%	-	95.9%			●
	2016/17		-	96.2%	97.3%	95.5%	
Written Complaints - Rate	2017/18	No Target	18	18			
	2016/17		217	19	28	29	

Technical note – Statistical process control

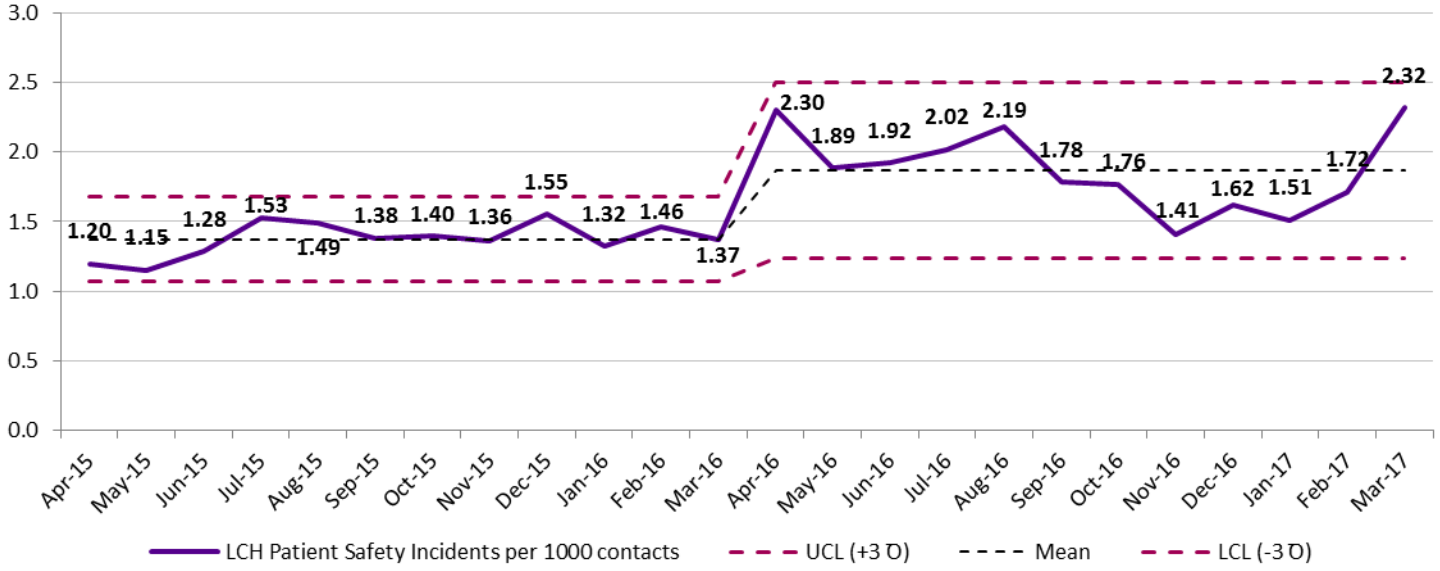
In the context of an NHS setting statistical process control (SPC) is a means of quality control in which statistical methods are used. SPC is applied in order to monitor and control a process or service and maintain the quality of them. Monitoring and controlling the process ensures that it operates at its full potential. Key tools used in SPC include control charts, and a focus on continuous improvement.

Within this report Statistical Process Charts (SPC) are used to interpret the data. These charts have an upper control limit (UCL) and lower control limit (LCL) value that is determined by historical data. If data points are within these limits the process is stable i.e. the variation is within the expected normal variation.

There are 3 main rules to help interpret the charts. These rules indicate that the data is outside the expectation for random variation and that there is a specific cause for this e.g. a spike in the number of incidents, perhaps a business unit has tightened up on their reporting procedures and more are getting reported or a decrease in the number of contacts, where maybe sickness or vacancies mean there are fewer contacts.

1. Patient Safety Incidents (LCH only)

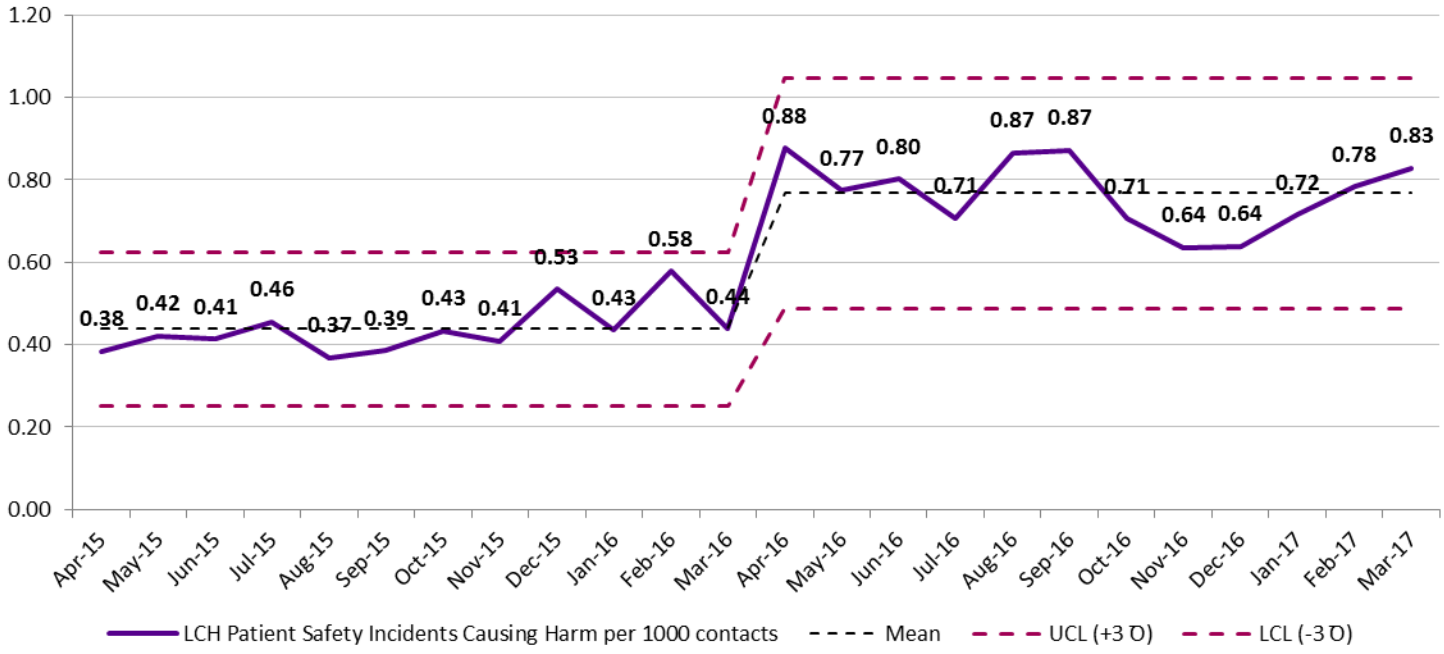
LCH PSIs per 1000 contacts *(March 2017 data)* remains within the variation limits at this time.



data available to March 2017 only

2. Incidents causing harm (LCH only)

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



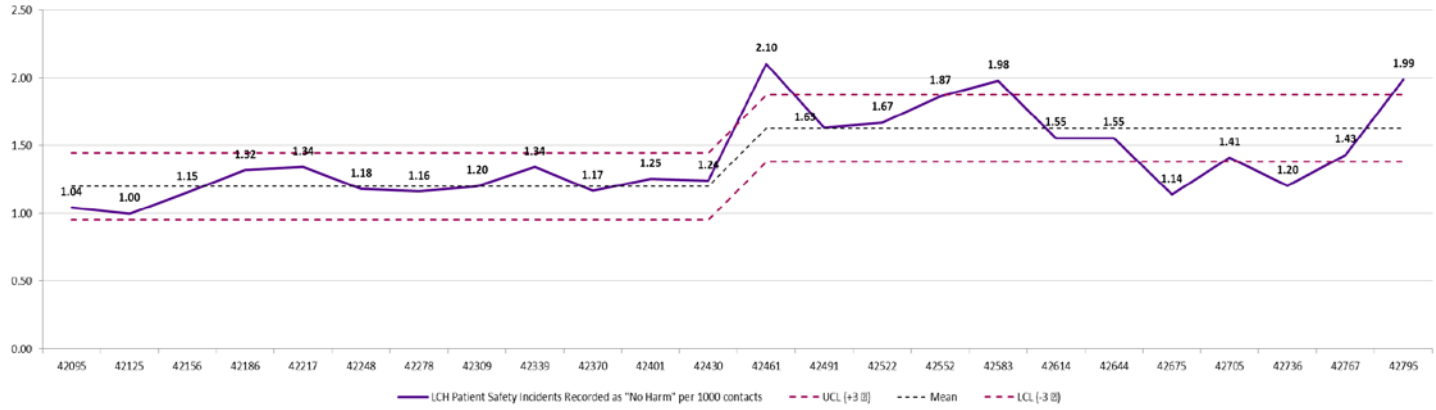
data available to March 2017 only

Analysis of this information and associated data shows that whilst there was no significant change in the number of contacts in March, the number of LCH PSIs in the Children's Business Unit more than doubled during the month (71 LCH PSIs in March compared to 31 in February). This will have had an impact on the above data.

Thirty six of the 40 incidents, by which there was an increase, were attributable to 4 patients in Littlewood House Hall relating to self-harm attempts, violence or attempts to abscond. These children have since left the unit and the number of incidents decreased in April accordingly.

3. No Harm Incidents

The number of LCH ***incidents causing no harm per 1000 contacts*** also rose above the upper control variation limit and reflects the position reported in 1.0.



Analysis of previous work undertaken over the past year to identify reasons for patterns and trends in No/Low Harm incidents concluded last month.

A survey looking at staff perception of reporting has concluded there to be no particular concerns regarding under reporting. The survey provided an opportunity to update staff knowledge on reporting discrepancies (coding and categorisation). There is no evidence to suggest there would be further value in repeating the survey hence the focus will continue to ensure staff awareness and capability with reporting.

Benchmarking included in the last Director of Nursing Report identified LCH to be in the top 25% of reporting community organisations for No Harm patient safety incidents.

Furthermore, we know that monitoring the percentage of No/Low Harm incidents does not provide a true indication of the quality of our services (good/not good, safe/unsafe). Going forward, a statistically accurate and reliable method of measuring harms and no harms will be used and the level of No/Low Harms will be analysed via SPC (per 1000 contacts), as above. This will allow us to identify statistically significant changes in reporting and undertake further analysis in the right areas when indicated.

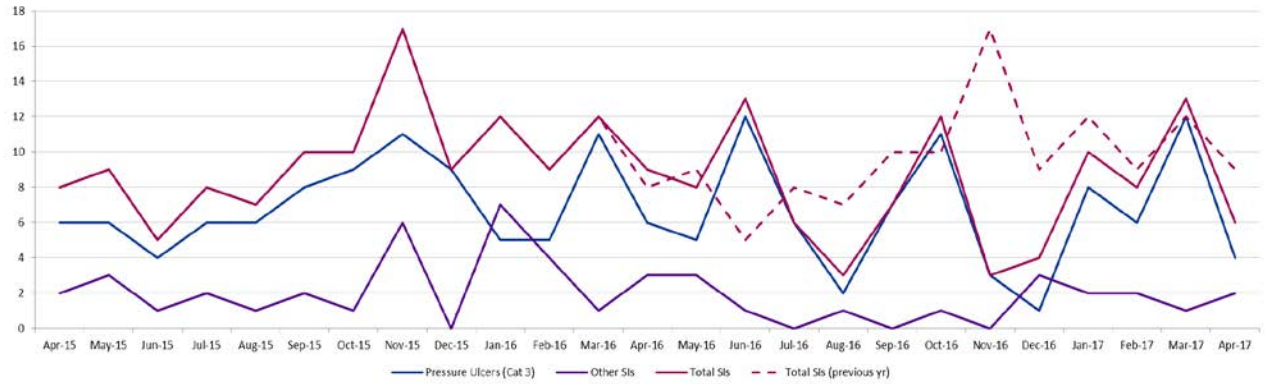
A plan for improving staff training in incident reporting has since been developed. This includes a review of the training programme content, access to training and taking a 'train the trainer' type approach in order to ensure a high standard of knowledge in each business unit and service. This will commence in June 2017.

The Quality Leads and Clinical Governance team are leading the implementation of the plan, which will be reviewed in January 2018 after the new approach to training has been in embedded. This will be reported quarterly as one of our Quality Account priorities for 2017/18.

Reporting and monitoring of No Harm LCH PSIs will continue monthly using SPC to identify concerns and exceptions requiring additional analysis.

4. Serious Incidents

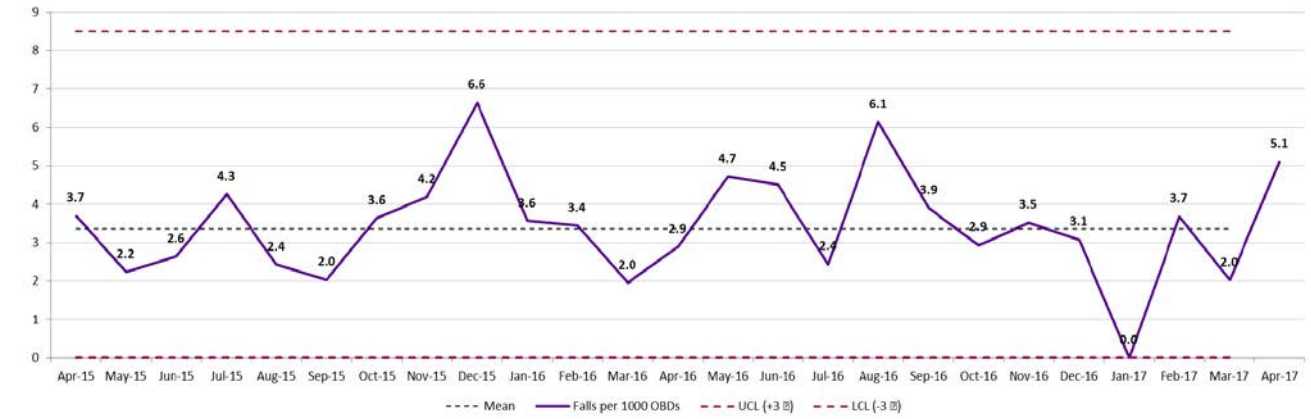
The pattern of reported SIs continues to parallel the pattern for category 3 pressure ulcers since March 2016 demonstrating the known relationship between the two; and the relatively low numbers of other SIs.



5. Quality Account Priorities

5.1 Avoidable harm caused by falls in inpatient units

There were 5.10 injurious falls per 1000 occupied bed days (inpatient units) reported in April. Whilst this is an increase from previous months it remains within the upper and lower variation limits. Monitoring continues for indications for further investigation.



5.2 Reduction (10%) in avoidable Category 3 Pressure Ulcers

In April 3 pressure ulcers incidents were closed, of which 1 was avoidable (33%).

5.3 Zero tolerance of avoidable Category 4 Pressure Ulcers

There have been no avoidable category 4 pressure ulcers since October 2016

6. Duty of Candour

During April, at the time of incident closure, DoC was applicable (ie. verified as actual moderate + harm and attributable to an LCH PSI) to 24 (57%) incidents. Initial data showed:

- 21 apologies were recorded as given (87.5%)
- 2 verbal apologies were not given (8.3%)
- 1 record was incomplete (4.2%)

Of the two records identified as verbal apology not given:

- 1 had provided a final written apology letter to the patient
- 1 has not been given due to the patient being admitted to hospital at the time of the incident. The patient has dementia and is currently out of area with no carer contact details available. The neighbourhood team will progress their enquiries and attempt to complete DoC when the patient returns to area

The specialist reviewer for the incident associated with the incomplete record has advised that this incident was inappropriately identified as applicable for DoC and the record updated accordingly.

Therefore DoC was applicable in 23 incidents and 22 **(95.6%)** received an appropriate apology.

*

7. Never Events

There have been no Never Events reported.

8. Safety Alerts (CAS)

There have been no Safety Alert response breaches.

9. Infection Prevention Control (IPC)

9.1 MRSA bacteraemia and C difficile Infection

During April 17 there were no MRSA bacteraemia cases identified within the wider community economy. This maintains total number of cases identified in the wider community to 13 for the year ending March 17. None of these cases have been assigned to LCH during this period.

No cases of C difficile infection have been assigned to LCH during April 17. The total number of cases assigned to LCH during year 2016-17 remains at 1, as previously reported.

9.2 Sharps Safety Issues

The IPC Team continue to monitor all incidents relating to needle stick injuries within LCH and have a programme where all injured staff are followed up for a period of 6 months after injury. Four sharps injuries were reported in April, these caused minimal harm. This is an increase compared to March 2017 albeit a reduced number compared to the 10 cases reported during the same period in April 2016.

9.3 Outbreak Situations

An outbreak of confirmed Norovirus was reported on SLIC during April. A potential primary source of the virus was thought to be a patient with behavioural issues who tended to wander within the unit. The outbreak duration was 13 days with 20 patients and 7 staff being symptomatic. This particularly virulent strain of Norovirus also caused significant disruption within the wider community, with outbreaks noted in a number of care homes and communal settings during the same period.

Leeds Community Healthcare NHS Trust

Effective Domain Report

The indicators in the effective domain are assessed quarterly. As such there 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	April	May	June	Forecast
Patient Contacts - Variance from Profile	2017/18	0 to ± 5%	-10.9%	-10.9%			●
	2016/17		0.0%	-0.8%	3.8%	0.5%	
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	2017/18	>=92%	-	99.9%			●
	2016/17		-	100.0%	100.0%	100.0%	
Number of patients waiting more than 52 Weeks (Consultant-Led)	2017/18	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%	-	91.6%			●
	2016/17		-	100.0%	100.0%	100.0%	
% Patients waiting under 18 weeks (non reportable)	2017/18	>=95%	-	98.7%			●
	2016/17		-	99.0%	98.6%	98.9%	
IAPT - Percentage of people treated within 18 weeks of referral	2017/18	>=95%	-	99.6%			●
	2016/17		-	100.0%	99.7%	100.0%	
IAPT - Percentage of people treated within 6 weeks of referral	2017/18	>=75%	-	96.5%			●
	2016/17		-	98.6%	98.1%	98.3%	

Each of the measures for discussion in the Responsive Domain Report are addressed in the Performance Brief this month. Please see the following:

- section 1.1 for information on patient contacts – variance from profile
- section 1.2 for information on waiting times

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	April	May	June	Forecast
Workforce Race Equality Standard	2017/18	>=14.7%	-				
	2016/17		-		-		
Staff Turnover	2017/18	<=15%	-	15.6%			
	2016/17		-	14.4%	14.6%	14.6%	
Executive Team Turnover	2017/18	<=15%	-	0.0%			
	2016/17		-	0.0%	0.0%	0.0%	
Stability Index	2017/18	>=85%	-	83.1%			
	2016/17		-	-	-	-	
Short term sickness absence rate (%)	2017/18	<=1.6%	-	1.6%			
	2016/17		-	1.6%	1.2%	1.1%	
Long term sickness absence rate (%)	2017/18	<=3.6%	-	3.8%			
	2016/17		-	3.9%	4.7%	4.5%	
Total sickness absence rate (%)	2017/18	<=5.67%	-	5.4%			
	2016/17		-	5.7%	5.9%	5.6%	
AfC Staff Appraisal Rate (12 Month Rolling - %)	2017/18	>=87.8%	-	87.3%			
	2016/17		-	89.3%	89.3%	88.8%	
Medical staff appraisal rate (%)	2017/18	100%	-				
	2016/17		-		86.4%		
6 universal Statutory and Mandatory training requirements	2017/18	>=89.9%	-	90.5%			
	2016/17		-	89.7%	88.3%	88.6%	
Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	2017/18	>52.0%	-				
	2016/17		-		49.0%		
Percentage of staff who are satisfied with the support they received from their immediate line manager	2017/18	>61%	-				
	2016/17		-		-		
Response Rate for Staff FFT	2017/18	>24.5%	-				
	2016/17		-		22.2%		
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	<=20%	-	19.4%			
	2016/17		-	-	-	-	
Responses in exit questionnaire with Category of Reason of Leaving "other/unknown"	2017/18	<=10%		8.3%			
	2016/17		-	-	-	-	
Response Rate for Inpatient FFT	2017/18	>=23.1%	-	11.0%			
	2016/17		-	-	-	-	
Response Rate for Community FFT	2017/18	>=6.8%	-	4.6%			
	2016/17		-	-	-	-	
Total agency cap	2017/18	£583k	£563k	£563k			
	2016/17		£6,366k	732k	577k	617k	
Percentage Spend on Temporary Staff	2017/18	TBC	8.6%	8.6%			
	2016/17		7.5%	10.6%	8.5%	9.7%	

1. Appraisals

As at the end of April 2017 87.3% of available staff were registered as having had an appraisal within the last 12 months. This has seen a slight increase on last month's figure of 87.1%.

There continues to be a targeted discussion at the Performance panels and information made available via Business Intelligence. There is an Appraisal policy, toolkit, and streamlined appraisal paperwork in place to support managers in completing appraisals and guidance available from the OD team.

A refresh of the Organisational Development Strategy will be ratified at Trust Board in May 2017. In the strategy we set out 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.

From the recent NHS National Staff Survey results, we have previously highlighted there has been a significant increase in the question responses that can be attributed to our key priorities (ranges of increase on detailed questions of 4-12%).

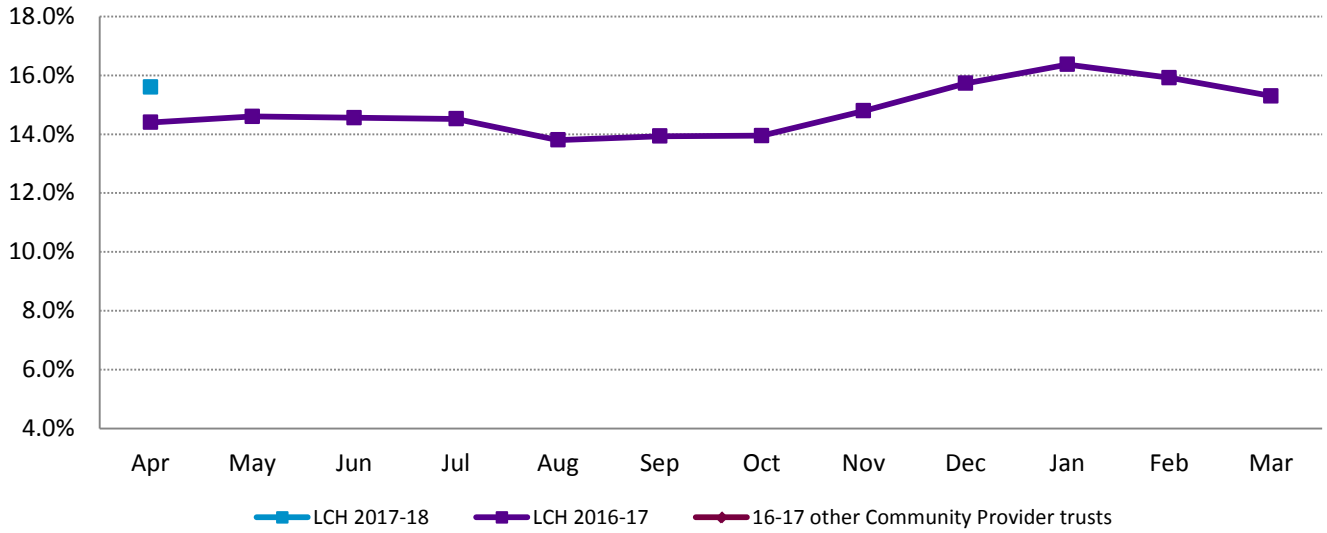
2. Statutory & Mandatory Training

The level of staff compliance with universal statutory & mandatory training has decreased from 90.5% last month to 88.9%
The individual topics report as follows:

- Information Governance training is at 94.5%
- Equality and Diversity training is above target with a compliance rate of 95.7%
- Health and Safety (Slips, Trips and Falls) training is 92.8%
- Fire Training, Infection Prevention and Control and Moving and Handling are all below target compliance rate at 84.1%, 87.3% and 88.6%.

3. Turnover

The figure for the rolling year has increased from 15.3% in March to 15.6 % and starts the year above the target of 15%.



In April 2017 there were 36 leavers across the Trust.

Business Unit	April 2017 Leavers
833 Adult Business unit	11
833 Children's Business Unit	13
833 Corporate Directorate	4
833 Operations	3
833 Specialist Business Unit	5

Staff Group	April 2017 Leavers
Nursing	15
Administrative and Clerical	10
Allied Health Professionals	4
Add Prof Scientific and Technic	3
Support Services	3
Medical and Dental	1

The top 3 reasons for leaving were:

- Retirement Age (7)
- Voluntary Resignation - Work Life Balance (7)
- Voluntary Resignation – Relocation (4)

Workforce Information has put in place additional checks from February 2017 to improve the data quality to reduce the number of 'other/not known' reasons for leaving through ESR.

Work is underway to contact staff who left the trust within the first 12 months of employment as the full reasons are not fully known or understood. Due to the small numbers of returns so far it has not been possible to produce a meaningful report. This will be reviewed at the end of May 2017.

Work continues to progress on a number of retention initiatives and leads have been established to develop these further. .A monthly Recruitment and Retention Steering Group has been re-established to support this work.

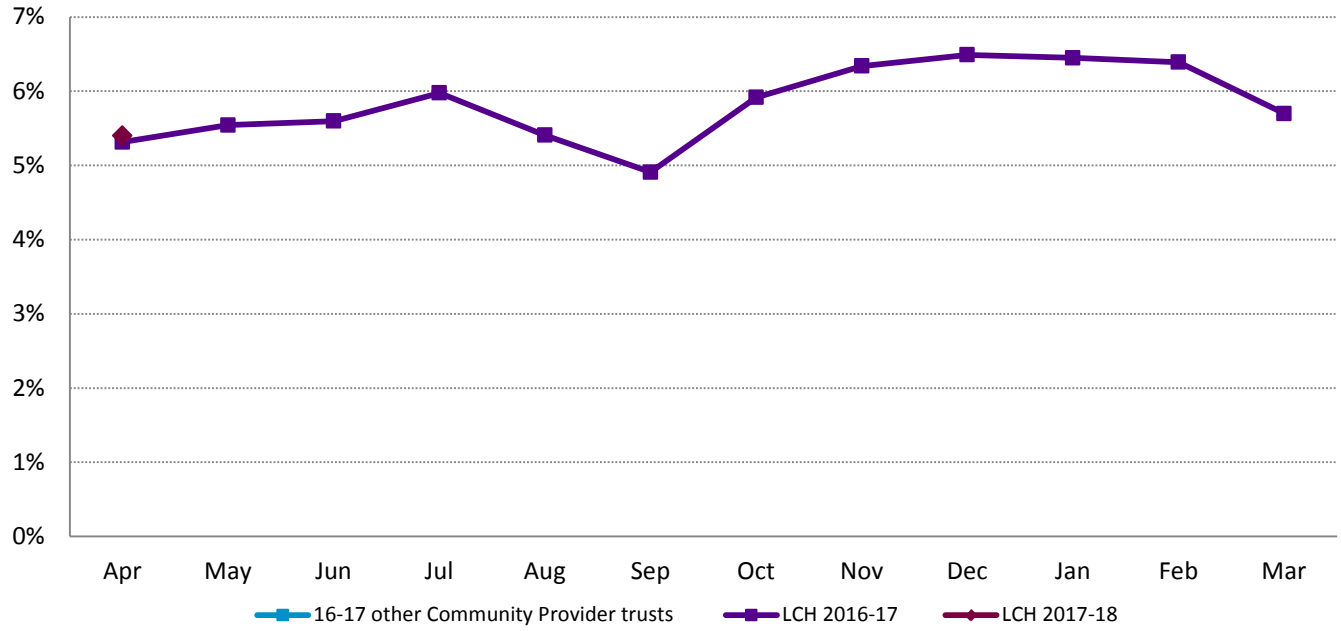
4. Workforce Race Equality Standard (WRES)

The trust target is based on the 2011 census which reports a Black and Ethnic Minority (BME) working age population at 19.2%, or 18.9% of the overall population. As at 2015/16 the trust reported a 12.02% BME workforce which is not reflective of the population it serves. The trust is required to report annually in August.

Work continues to develop the BME networks and train managers in Unconscious Bias.

5. Sickness Absence

The Sickness absence rate for April is 5.4%, against a target of 5.67% for April. This trend is encouraging, with month on month reduction since January, the most notable being a 1% decrease in absence rates comparing February to April 2017.



The 5.4% absence is broken down into long-term absence at 3.8% and short-term absence at 1.6%.

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

The range of specific Health and Well Being work-streams/key areas of focus during May :-

Last year, 738 staff achieved the feat of being fit and healthy enough to come to work every single working day. To acknowledge staffs dedication, commitment and hard work, a personal email of thanks was sent to each of them, from the Chief Executive.

On looking closely at the feedback from the staff survey and friends and family test, SMT were keen to look at different ways to improve staffs health and wellbeing. Staff have been informed that there is some non-recurrent monies available, to introduce small changes which could make a big difference to their overall working environment.

The 2017 Pedometer Challenge, “On Yer bike”, has now finished, with 89 teams (353 staff) taking part. The winning teams will be announced shortly.

Work will be commencing shortly on scoping out the Health and Well Being Action plan required to deliver the CQUIN for 2017/18 onwards

Leeds Community Healthcare NHS Trust

Finance Report

Finance		YTD Target	YTD	April	May	June	Forecast
Net surplus (-)/Deficit (+) (£m) - YTD	2017/18	-£0.2m	-£0.2m	-£0.2m			
	2016/17			£0.5m	-£0.2m	-£0.2m	
Net surplus (-)/Deficit (+) (£m) - Forecast	2017/18	-£3.0m	-£3.0m	-£3.0m			●
	2016/17		-	-£2.0m	-£2.0m	-£2.9m	
Forecast underlying surplus	2017/18	-£1.4m	-£1.4m	-£1.4m			●
	2016/17		-	-£1.5m	-£1.5m	-£1.5m	
Capital expenditure in comparison to plan (£k) - YTD	2017/18	£0.0m	£0.1m	£0.1m			
	2016/17		-	£12k	£16k	£354k	
Capital expenditure in comparison to plan (£m) - Forecast	2017/18	£1.8m	£0.0m	£0.0m			●
	2016/17		-	£3.2m	£3.2m	£3.2m	
CIP delivery (£m) - YTD	2017/18	£0.3m	£0.2m	£0.2m			
	2016/17		-	£0.1m	£0.1m	£0.2m	
CIP delivery (£m) - Forecast	2017/18	£3.4m	£3.4m	£3.4m			●
	2016/17			£0.7m	£0.7m	£0.7m	
Use of Resources Risk Rating (from Oct 2016)	2017/18	2	1	1			●
	2016/17		-	-	-	-	

1. Summary & KPIs

The Trust has commenced 2017/18 with an overall position in line with the planned control total. There is early overspending on pay budgets across all but the Specialist business units which are being mitigated by underspending on non-pay. The Trust has not breach the agency cap in April. Cost savings plans are 25% below expected levels. The Trust has spent £0.1m on capital assets this month. Cash is running £0.5m ahead of plan and the use of resources risk rating is 1.

Table 1 Key Financial Data Statutory Duties	Year to Date	Variance from plan	Forecast Outturn	Performance
Income & Expenditure retained surplus	(£0.4m)	(£0m)	(£3.043m)	G
Remain with EFL of £2.717m			£2.717m	G
Remain within CRL of £1.816m	0	0	£1.816m	G
Capital Cost Absorption Duty 3.5%			3.5%	G
BPPC NHS Invoices Number 95%	99%	4%	95%	G
BPPC NHS Invoices Value 95%	97%	2%	95%	G
BPPC Non NHS Invoices Number 95%	98%	3%	95%	G
BPPC Non NHS Invoices Value 95%	100%	5%	95%	G
Trust Specific Financial Objectives				
Use of Resources Risk Rating	1	-	1	G
CIP Savings £3.0m recurrent in year	£0.2m	-25%	£3.4m	R
CIP Savings £0.5m non recurrent in year	£0.5m	100%	£0	G

2. Income & Expenditure

The Trust's income is on plan for April. Overall operating expenditure is as expected however an overspending on pay costs is being offset but underspending on non-pay and reserves. The Trust has 100 wte or 3.8% less staff in post than funded in April; this is after the planned vacancy factor reduction. Temporary staffing costs are £745k for the month. Non pay expenditure is £0.1m underspent at the end of April and £0.1m of reserves have remained utilised.

Table 2 Income & Expenditure Summary	April Plan WTE	April Actual Contract WTE	YTD Plan £m	YTD Actual £m	Variance £m	Annual Plan £m	Forecast Outturn £m	This Month Variance £m
Income								
Contract Income			(11.4)	(11.4)	0.0	(135.6)	(135.6)	0.1
Other Income			(0.6)	(0.6)	(0.0)	(6.4)	(6.2)	0.2
Total Income			***(11.9)***	***(11.9)***	***0.0***	***(142.0)***	***(141.8)***	***0.2***
Expenditure								
Pay	2,631.5	2,531.2	8.4	8.6	0.2	100.4	103.4	3.0
Non pay			2.8	2.7	(0.1)	33.8	32.8	(1.0)
Reserves & Non Recurrent			0.2	0.1	(0.1)	2.1	0.8	(1.3)
Savings Requirement							(0.7)	(0.7)
Total Expenditure	***2,631.5***	***2,531.2***	***11.4***	***11.4***	***0.0***	***136.3***	***136.3***	***(0.0)***
EBITDA	2,631.5	2,531.2	(0.6)	(0.6)	0.0	(5.7)	(5.5)	0.2
Depreciation			0.2	0.1	(0.0)	1.8	1.7	(0.1)
Public Dividend Capital			0.1	0.1	(0.0)	0.9	0.8	(0.1)
Profit/Loss on Asset Disp			0.0	0.0	0.0	0.0	0.0	0.0
Interest Received			(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	0.0
Retained Net Surplus	2,631.5	2,531.2	(0.4)	(0.4)	(0.0)	(3.0)	(3.0)	(0.0)
	Variance =	(100.3)						

2.1 Income

Both contract and non-contract income is running in line with plan. This includes accruals for CQUIN income paid in arrears. The income assumption includes the STF monies for 2017/18.

2.2 Pay

Table 3 below illustrates the total pay costs by category. The underspending on substantive staff in post continues in April however the combined level of pay expenditure does not deliver the vacancy factor for the year.

Table 3 Annual Pay Costs by Category	YTD Plan £k	YTD Actual £k	YTD Variance £k	Forecast Outturn Variance £k
Cost of staff directly employed	8,302	7,816	**(485)**	
Seconded staff costs	59	72	**13**	
Vacancy Factor	(559)		**559**	
Sub-total Direct Pay	**7,802**	**7,889**	**87**	
Bank Staff	7	182	**174**	
Agency Staff	582	563	**(19)**	
Total Pay Costs	**8,392**	**8,633**	**242**	**2,999**

Only the Specialist business unit has not overspent on pay at the end of April.

Specialist services:	£12k underspent, this is after delivery of the vacancy factor savings.
Children's services:	£135k overspending being mostly the non-delivery of the vacancy factor.
Adult services:	£74k overspending non delivery of vacancy factor, agency costs more than underspending on substantive posts, overspending on admin and clerical posts.
QPD Clinical:	£73k, 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.

Agency costs overall are £563k this month.

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

- Specialist BU £136k 10.86 wte less than planned
- Children's BU £32k 19.56 wte more than planned
- Adult's BU £170k 48.90 wte less than planned
- QPD Clinical £44k 7.37 wte less than planned
- Corporate £15k 27.61wte less than planned

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.

2.3 Non Pay

Non pay expenditure is running slightly behind plan for the first month of the year.

Table 4 Year to Date Non Pay Costs by Category	YTD Plan £k	YTD Actual £k	YTD Variance £k	Forecast Outturn Variance £k
Drugs	88	98	10	
Clinical Supplies & Services	755	733	(22)	
General Supplies & Services	209	195	(14)	
Establishment Expenses	566	529	(38)	
Premises	1,130	1,035	(95)	
Other non pay	74	100	26	
Total Non Pay Costs	**2,823**	**2,690**	**(133)**	**(1,038)**

3. Reserves & Non Recurrent

The Trust has £2.1m in reserve at the end of April; all un-committed reserves have been released into the forecast outturn position. Based on the forecast at this early point in the year the Trust will require an additional £0.7m of savings to achieve the control total agreed with NHSI for the year.

4. Service Line & Contract Performance

Table 5 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	34.7	613.7	602.8	(10.9)	2.9	2.8	(0.1)	40,783	33,959	(6,824)	•••
Childrens Services	27.8	673.9	693.5	19.6	2.3	2.4	0.1	29,660	24,293	(5,367)	•••
Adults Services	32.6	841.5	792.6	(48.9)	2.7	2.8	0.1	69,412	66,452	(2,960)	•••
QPD Clinical	6.2	90.6	83.2	(7.4)	0.5	0.6	0.1	2,325	1,955	(370)	•••
Ops Management & Equipment	1.2	50.5	44.7	(5.8)	0.1	0.2	0.1				••
Service Line Totals	**102.6**	**2,270.2**	**2,216.8**	**(53.4)**	**8.5**	**8.8**	**0.2**	**142,179**	**126,659**	**(15,520)**	•••
Corporate Support & Estates	26.1	361.3	314.4	(46.9)	2.2	2.1	(0.1)				••
Total All Services	**128.7**	**2,631.5**	**2,531.2**	**(100.3)**	**10.7**	**10.8**	**0.1**	**142,179**	**126,659**	**(15,520)**	•••

This month operational services have 53.4 wte less in post than planned. The services are a net £0.2m overspent for April. All operational budgets but specialist services have overspent in the first month of the year.

The overall activity is 10.92% behind plan, as all business units have not reached the planned levels of activity for April; however there will be some lag in recording; this will improve as records are brought up to date in the next few weeks before the freeze position

- Specialist services activities are 16.73% less than planned,
- Children's services activities are 18.09% less than planned,
- Adult NT services activities are 4.26% less than planned, and
- QPD Clinical services activities are 15.91% less than planned.

5. Cost Improvement Plans

Table 6 has the Trust's performance against the cost savings plan for 2017/18. Overall the plan is £67k or 25% behind at this early point in the year. Actions will be taken to recover the shortfall and this is reflected in the forecast outturn.

Table 6 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	2	2	0	20	20	0	0%
Night Nursing	4	0	(4)	50	50	0	0%
JCMT	17	0	(17)	200	200	0	0%
Admin Review	0	0	0	250	250	0	0%
CAMHS	21	12	(9)	250	250	0	0%
Corporate Support	13	13	0	150	150	0	0%
LSH	13	13	0	150	150	0	0%
Orthotics	2	2	0	20	20	0	0%
Child Health Continence Products	2	2	0	25	25	0	0%
Geriatricians Overhead Charge	4	0	(4)	50	50	0	0%
Training	17	0	(17)	200	200	0	0%
Procurement	15	0	(15)	180	180	0	0%
Travel	13	13	0	150	150	0	0%
Drugs	4	2	(2)	50	43	(7)	-15%
Non pay inflation	30	30	0	360	360	0	0%
Mobile/data line charges	8	8	0	100	100	0	0%
Rents	12	12	0	140	140	0	0%
Estates other	8	8	0	100	100	0	0%
Contribution to overheads/fixed costs	27	27	0	325	325	0	0%
IT kit	21	21	0	250	250	0	0%
Release of reserves	33	33	0	400	400	0	0%
Total Efficiency Savings Delivery	**264**	**197**	**(67)**	**3,420**	**3,413**	**(7)**	**0%**

6. Capital Expenditure

NHS Improvement has yet to confirm the Trust's capital resource limit for 2017/18. The Trust has planned for capital expenditure of £1.816m; this should not be committed until the CRL has been approved.

Expenditure has been incurred in respect of the EPR project £18k and estates maintenance of £33k for Morley HC essential toilet and water system works.

Table 7 Scheme	YTD Plan £m	YTD Actual £m	YTD Variance £m	Annual Plan £m	Forecast Outturn £m	Forecast Variance £m
Estate maintenance	0.0	0.0	0.0	0.5	0.5	0.0
Equipment/IT	0.0	0.0	0.0	0.8	0.8	0.0
Electronic Patient Records	0.0	0.0	(0.0)	0.5	0.5	0.0
Totals	**0.0**	**0.1**	**0.0**	**1.8**	**1.8**	**0.0**

7. Statement of Financial Position

Table 8 has the statement of financial position as at the end of April; this is in line with the planned position overall.

Trade receivables total £5.7m at the end of April. The largest debtor is Leeds City Council which owes £1.8m. Accrued income totals £2.2m, £0.8m of this is SFT monies due for last year and April 2017/18; £0.6m is contract income due from police commissioners, £0.4m for CQUIN income yet to be paid and £0.4m for NHS England contract income.

Trade payables total £10.5m at the end of April. Accrued expenditure totals £4.5m, made up of £1.6m for property charges and various other smaller accruals. Provisions total £1.4m for clinical and employment claims, outstanding holiday pay and redundancies these have yet to be discharged.

As a result of the above the cash position is £0.5m higher than planned, with cash and cash equivalents totalling £19.8m.

Table 8 Statement of Financial Position	Plan 30/04/17 £m	Actual 30/04/17 £m	Variance 30/04/17 £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	27.3	27.1	(0.2)	*27.1*	27.5	27.5	0.0
Intangible Assets	0.0	0.1	0.0	*0.1*	0.0	0.0	0.0
Total Non Current Assets	**27.3**	**27.1**	**(0.2)**	*27.2*	**27.5**	**27.5**	**0.0**
Current Assets							
Inventories	0.0	0.0	0.0	*0.0*	0.0	0.0	0.0
Trade and Other Receivables	6.3	5.7	(0.6)	*6.7*	6.6	6.6	0.0
Cash and Cash Equivalents	19.4	19.8	0.5	*19.1*	20.7	20.7	0.0
Sub-Total Current Assets	**25.7**	**25.5**	**(0.2)**	*25.8*	**27.3**	**27.3**	**0.0**
Non-Current Assets held for sale	0.2	0.2	0.0	*0.2*	0.0	0.0	0.0
Total Current Assets	**25.8**	**25.7**	**(0.2)**	*26.0*	**27.3**	**27.3**	**0.0**
TOTAL ASSETS	**53.2**	**52.8**	**(0.4)**	*53.2*	**54.8**	**54.8**	**0.0**
Current Liabilities							
Trade and Other Payables	(11.5)	(10.5)	1.0	*(11.1)*	(11.1)	(11.1)	0.0
Provisions	(0.8)	(1.4)	(0.6)	*(1.4)*	(0.4)	(0.4)	0.0
Total Current Liabilities	**(12.3)**	**(11.9)**	**0.4**	*(12.5)*	**(11.5)**	**(11.5)**	**0.0**
Net Current Assets/(Liabilities)	**13.6**	**13.6**	**0.2**	*13.5*	**15.8**	**15.8**	**0.0**
TOTAL ASSETS LESS CURRENT LIABILITIES	**40.9**	**40.9**	**(0.0)**	*40.7*	**43.2**	**43.2**	**0.0**
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	**40.9**	**40.9**	**(0.0)**	*40.7*	**43.2**	**43.2**	**0.0**
TAXPAYERS EQUITY							
Public Dividend Capital	0.3	0.3	0.0	*0.3*	0.3	0.3	0.0
Retained Earnings Reserve	13.3	13.0	(0.3)	*12.8*	15.6	15.6	0.0
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	9.2	0.0
TOTAL EQUITY	**40.9**	**40.9**	**(0.0)**	*40.7*	**43.2**	**43.2**	**0.0**

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 £19.8m which is £0.5m more than planned.

Chart 1

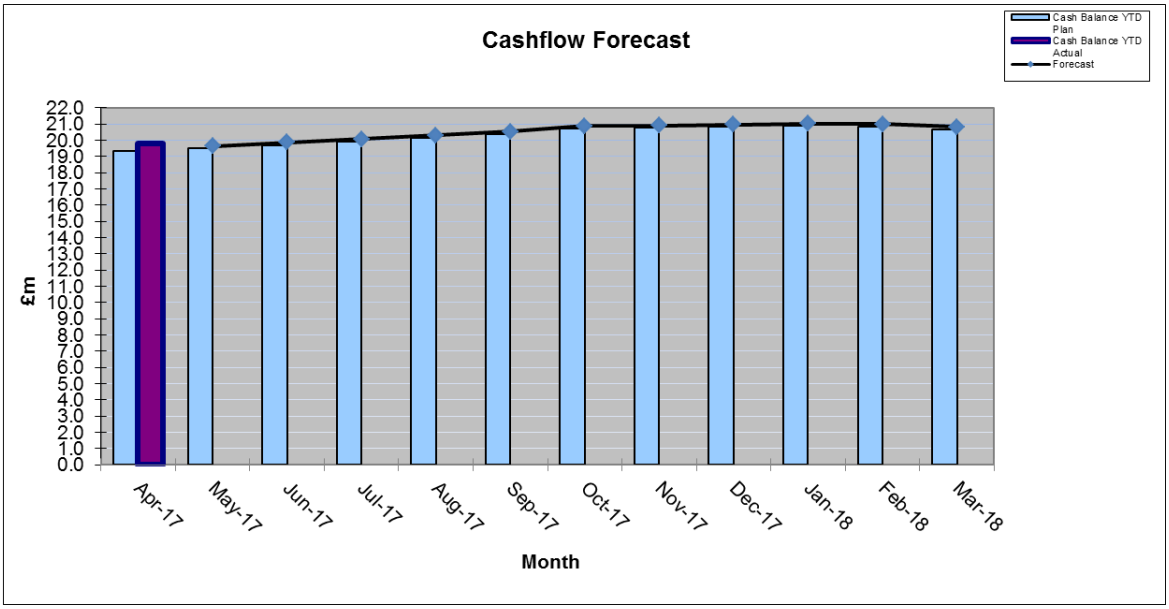


Table 9 Measure	Performance This Month	Target	RAG
NHS Invoices			
By Number	99%	95%	G
By Value	97%	95%	G
Non NHS Invoices			
By Number	98%	95%	G
By Value	100%	95%	G

Table 9 demonstrates the Trust's performance in respect of the Better Payment Practice Code.

9. Use of Resources Risk Rating

Table 10 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 April the Trust overall result is 1, which is the lowest risk.

Table 10 Criteria	Metric	Performance	Rating	Weighting	Score
Liquidity	Liquidity ratio (days without WCF)	35	1	20%	0.2
Balance Sheet sustainability	Capital servicing capacity (times)	6.6	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	-7%	1	20%	0.2
Overall Use of Resources Risk Rating					**1**

10. Conclusion on Financial Performance

At this early point in the year the Trust is overall in line with the planned financial performance. CIP delivery has been poor for April and pay overspending has been mitigated by underspending on non-pay and release of reserves. Staffing levels are below funded wtes for all business units except Children's, temporary staffing is in place to mitigate service risks. Activity levels are less than planned for the month however these should improve as records are updated in early May.

The forecast outturn demonstrates there are some financial risks in achieving the control total set by NHSI of £3.034m for the year.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (11)

Meeting Trust Board 31 May 2017	**Category of paper**	
Report title Patient Experience and Incidents Thematic Report	**For approval**	
Responsible director Executive Director of Nursing **Report author** Clinical Governance Manager	**For assurance**	√
Previously considered by Not applicable	**For information**	

PURPOSE OF THE REPORT

This report provides the Trust Board with a six month update on the themes of patient experience and incidents within Leeds Community Healthcare NHS Trust between 1 October 2016 and 31 March 2017 and overall during 2016/17. It identifies themes arising from complaints, concerns, incidents and feedback; and offers assurance that actions are in place to address areas for improvement.

MAIN ISSUES FOR CONSIDERATION

The report provides a thematic review of complaints, concerns, incidents and feedback via the Friends and Family Test for the final 6 months of 2016/17 and looks at overarching themes over the year as a whole. It compares the data with previous years, national data and benchmarks against other comparable community Trusts. It later analyses identified themes in greater detail and triangulates information where possible to identify commonalities across all sources of intelligence.

Clinical Judgement/Treatment, Attitude, Appointments, Communication and Access/Availability have continued to feature within the top 5 themes of complaint and concern from October 2016 to March 2017 and this is reflected when looking at themes for the whole year 2016/17. This is generally in keeping with the national picture with the exception of one subject: admission, discharge and transfer arrangements, which is commonly a national theme (as this data includes intelligence from acute Trusts as well as community).

There is variation between Trusts in the interpretation and categorisation of subject headings hence results are not wholly reliable for true benchmarking; however benchmarking of the annual data shows our themes to be in common with other comparable community Trusts.

When triangulating data between incidents, concerns and complaints: Access, Appointment and Clinical Care are a theme. These two subjects were also top themes identified in the previous thematic report. Again national data is comparable with regards to top themes albeit a higher number of medication incidents are reported within the Trust in comparison to the benchmarking organisations. A detailed medicines management section is provided in the quarterly Director of Nursing report, which also looks to identify themes, actions and learning.

Friends and Family Test (FFT) intelligence is generally unreflective of the themes identified. FFT feedback is mostly positive with few true negative comments being received through this source (4). The number of overall responses to FFT is low hence the use and significance of FFT intelligence is limited for this type of analysis.

A deeper analysis of the top thematic findings is contained within section 3.6 of the report.

A summary of themes by Business Unit, taken from all sources of intelligence, is included in section 4. This forms a useful visual guide to identify commonalities and areas of focus for learning from experience across the Business Units.

Examples of Actions and Learning for all themes, sourced from Business Unit Clinical Leads and the Director of Nursing Report, are detailed in Appendix 1.

RECOMMENDATIONS

Trust Board is requested to:

- Note the themes identified and comparisons provided
- Receive assurance that actions and learning is in progress to address the themes identified

1. PURPOSE OF THIS REPORT

The purpose of this report is to provide a six month update of the themes of patient experience and incidents within Leeds Community Healthcare NHS Trust (LCH) between 1 October 2016 and 30 March 2017. This information has been taken from reported complaints, concerns and incident data; and the Friends and Family Test.

2. BACKGROUND

2.1 The Trust Board has corporate responsibility for the monitoring and management of quality of care. Within LCH, the Chief Executive delegates responsibility for the management of patient experience and incident management to the Executive Director of Nursing.

2.2 The Clinical Governance Team is an arm of the Quality Professional & Development Department within the profile of responsibility of the Executive Director of Nursing and Quality. The CGT is responsible for providing overarching services for the organisation and includes:

- Quality and safety of patient care
- Meeting statutory/regulatory requirements
- Supporting services in all fields of governance
- The organisations reputation with external and internal stakeholders

Concerns and Complaints, Incidents/Serious Incidents and the Friends and Family Test (FFT) are managed alongside other governance priorities within this structure.

2.3 Annual complaints and incident reports are prepared in accordance with the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. This report contributes to those requirements and draws on additional available sources of feedback to gain a more complete picture of the quality of our services.

2.4 A performance summary of patient experience is provided on a monthly basis via the performance brief report and a fuller analysis via the quarterly Director of Nursing Quality Report.

3. OVERARCHING THEMES

3.1 LCH Complaints and Concerns

3.1.1 This section provides an overview of themes year on year and during 6 month periods (2016/17) alongside a national comparison from 2015/16, for the **top five subjects of complaint**. Subjects of the same theme are colour coded. The themes are taken from the primary subject of complaint recorded on the Datix system.

	2014/15	2015/16	Apr – Sep 16	Oct 16 - Mar 17	Nationally 2015/16[*1]
1	Clinical judgement / Poor treatment	Appointments	Appointments	Clinical judgement / Poor treatment	All aspects of clinical treatment
2	Appointments	Clinical judgement / Poor treatment	Clinical judgement / Poor treatment	Attitude, conduct, cultural and dignity issues including Staff attitude and communication	Attitude of staff
3	Medication issues	Access and availability	Attitude, conduct, cultural and dignity issues including Staff attitude and communication	Appointments	Communication/ information to patients (written and oral)
4	Attitude, conduct, cultural and dignity issues including Staff attitude and communication	Attitude, conduct, cultural and dignity issues including Staff attitude and communication	Access and availability	Communication issues with the patient (verbal and written	Appointments, delay / cancellation (outpatient)
5	Communication issues with the patient (verbal and written)	Medication issues	Communication issues with the patient (verbal and written)	Access and availability	Admissions, discharge and transfer arrangements

[*1] **2016/17 annual formal complaints data will be published in September 2017 by NHS Digital**

3.1.2 **"Clinical judgement / Poor treatment"** was the main theme for 26% of complaints during October to March 2016/17. Sub-categorisation of these complaints shows that 50% have an overall theme relating to Clinical/Professional Judgement/Opinion and 31% suggest poor treatment received.

3.1.3 **"Attitude, conduct, cultural and dignity issues including Staff attitude and communication"** was the second most important theme (25% of complaints) during October to March 2016/17 with Staff Attitude and communication accounting for 80% of the complaints within this subject category.

3.1.4 **"Appointments"** was the 3rd highest subject group with 19% of all complaints received followed by "Communication issues with the patient" (12%) and "Access and Availability" (3%).

3.1.5 The differences between the Trust's findings and the national picture can be seen above. This is to be expected given the national statistics include data submitted by acute Trusts thus the fifth biggest issue nationally focuses on admissions, discharges and transfers.

3.1.6 **Medication issues** are no longer a top 5 theme of **complaint** since April 2016 having featured as a theme in the previous 2 years. This change is confirmed as attributable to reduced numbers of offender healthcare complaints following changes to the provision of offender healthcare.

3.2 Benchmarking with national comparison

3.2.1 The themes from **complaints** received during the whole year 2016/17 are shown in the table in 3.2.2 below against the data from comparable community Trusts for the same period. The overall themes for 2016/17 are generally in keeping with comparable organisations.

Nb. there is variation between Trusts in the interpretation and categorisation of subject headings hence results are not wholly reliable for true benchmarking.

3.2.2

	LCH	Birmingham	Bridgewater *(NB: data for Apr-Sep only - no update available)*	Derbyshire
1	Clinical judgement / Poor treatment	Coordination of care	Aspects of clinical treatment	All aspects of clinical care
2	Attitude, conduct, cultural and dignity issues	Lack of Communication	Attitude of staff	Communication
3	Appointments	Devices / Equipment	Aids & appliances, equipment, premises	Staff attitude/ behaviours
4	Communication issues with the patient (verbal and written	Access (including premises)	Appointment delay or cancellation (outpatient)	Appointments
5	Access and availability	Medication problem	Failure to follow agreed procedures	Premises

3.2.3 The **top five subjects relating to concerns** received in the October to March 2017 period generally reflect the themes of complaint.

- Appointments
- Communication issues with the patient
- Clinical judgement/Treatment
- Attitude, conduct, cultural and dignity issues
- Medical Devices & Equipment

3.2.4 **Appointments** remain a top concern/complaint for our patients and carers. This is addressed in more detail in 3.6.1.

3.2.5 Of the concerns received within the reporting period, 22% had no subject recorded. This is likely to have been affected by staffing issues within the Clinical Governance Team during the October to December 2016 period; and has since been addressed. From January to March 2017 no concerns were recorded without both a subject and sub-subject.

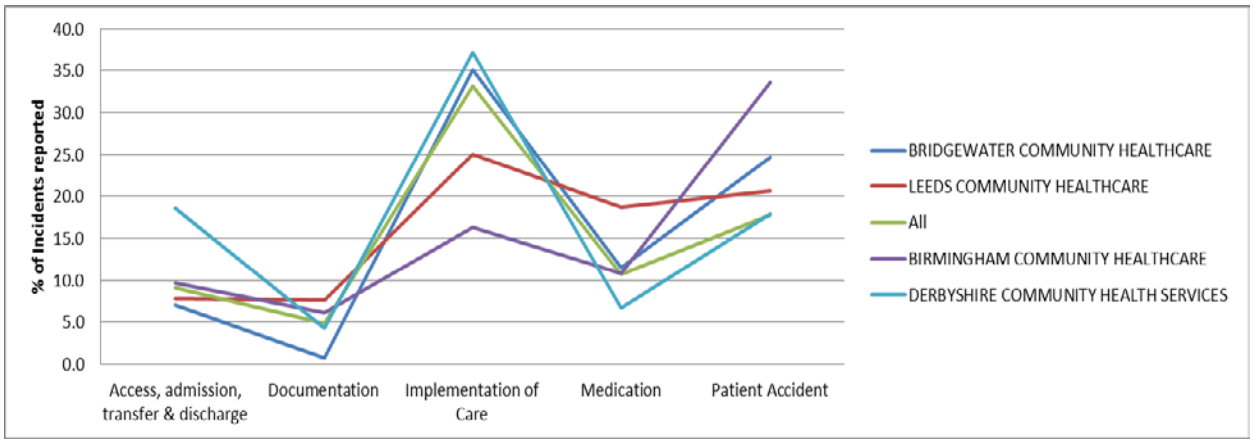
3.3 Incident themes

3.3.1 Incident themes are consistent with the national picture as shown in the table below:

	Incident Themes (LCH Patient Safety Incidents (PSI's) only)				
	2013/14	**2014/15**	**2015/16**	**2016/17**	**NRLS National Data Apr-Sep 2016**
1	Accidents that may result in personal injury	Accidents that may result in personal injury	Accidents that may result in personal injury	Implementation of care or ongoing monitoring /review	Implementation of care or ongoing monitoring /review
2	Medication	Medication	Implementation of care or ongoing monitoring /review	Accidents that may result in personal injury	Accidents that may result in personal injury
3	Implementation of care or ongoing monitoring /review	Implementation of care or ongoing monitoring /review	Medication	Medication	Medication
4	Abusive, violent, disruptive or self-harming behaviour	Access, Appointment, Admission, Transfer, Discharge	Access, Appointment, Admission, Transfer, Discharge	Access, Appointment, Admission, Transfer, Discharge	Access, Appointment, Admission, Transfer, Discharge
5	Access, Appointment, Admission, Transfer, Discharge	Infrastructure or resources (staffing, facilities, environment)	Abusive, violent, disruptive or self-harming behaviour	Abusive, violent, disruptive or self-harming behaviour	Other

3.3.2 Overarching themes exist across complaints and incidents as seen in the tables provided, particularly **access/appointments and clinical care**. Further analysis identifies any commonalities arising from these themes in section 3.6.

3.3.3 Themes from **incidents** are again benchmarked against the comparable community Trusts below using the latest published data from the National Reporting and Learning System (**April 2016 – September 2016)**. This shows the Trust themes to be comparable to the national data:



3.3.4 A higher number of medication incidents are reported within the Trust in comparison to the benchmarking organisations. Our Adult Nursing services report 75% of all medication incidents. A detailed medicines management section is provided in the quarterly Director of Nursing report, which also looks to identify themes, actions and learning.

3.4 Serious Incident Themes (SIs)

3.4.1 As reported to Board on a monthly basis, there are recurring themes within reported LCH SIs, which are consistent with other community Trusts and national trends.

3.4.2 Forty seven SI's were reported in the second 6 months of 2016/17 with the primary theme being category 3 and 4 pressure ulcers. The themes for October 2016 – March 2017 are reflective of the previous year's with the exception of a reduced number of Deaths in Custody (DiC) following changes to HMP service provision.

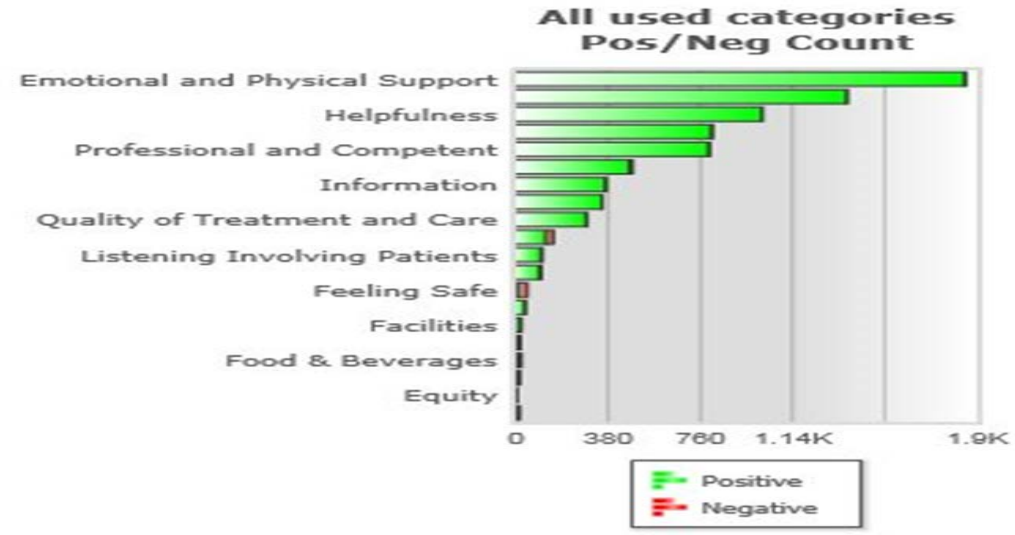
3.4.3 Themes from SI investigations are detailed in the bi-monthly SI learning board report and any exceptions are highlighted monthly in the performance brief report. In brief the themes arising from investigations are consistent and relate to:

- Documentation
- Communication
- Care Delivery/Processes
- Equipment, education and training
- Patient factors including non-concordance

3.4.4 Extensive work is ongoing within the Trust to reduce the incidence of avoidable pressure ulcers. This is driven by the work of the pressure ulcer steering group.

3.5 Friends and Family Test

3.5.1 The FFT results between October and March 2017 demonstrate an overall positive response to the FFT question as highlighted in the comments detailed in the graph below. This shows a positive response to **'communication to patients'** and **'quality of treatment and care'** for example, which appears contrary to the complaint and incident data in those areas (as seen in previous reports):



3.5.2 These comments are provided from 6667 FFT surveys, which represents an 8% response rate for the year. A negative response was identified within the area of safety, however a deep dive into this identifies that just 3 of the 28 negative triggers were made in a true negative context. 76% of negative words were used within a positive piece of feedback hence the feedback was not truly negative.

3.5.3 Comparison with the same Trusts used for benchmarking in section 3.2 is limited by the availability of published comparable data. Areas for improvement from other Trusts are indicated as parking, staff communication and waiting times. Parking continues to a commonality with LCH feedback.

3.6 Deeper analysis of thematic findings

This section looks at some of the findings in more detail to assist in identifying any required courses of action to reduce negative feedback and improve the quality of care.

3.6.1 **Appointments remain a key issue within both concerns and complaints.**

3.6.1.1

As noted earlier within the report, appointments were the dominant theme within concerns and consistently represent a top theme within complaints. Examples of <u>complaints</u> within this category are:

- Long waiting times for podiatry
- Appointments cancelled within dental service
- District nursing visits being cancelled at short notice
- District nurses do not attend twice daily as needed

Examples of <u>concerns</u> within this category are:

- Waiting times for a patient to be seen by CAMHS
- District nurses not attending as planned
- Patient not able to be seen at the Merrion Centre for the walk-in Sexual Health service

3.6.1.2

Whilst appointments were a key theme within the organisation, when combining complaints and concerns (C&Cs) together there are very few “hot spot” areas with most teams receiving only a small number of issues. However, a review of the annual data shows Podiatry (13% of all C&Cs) and Middleton Neighbourhood Team (11%) receive almost a quarter of appointment issues between the two service areas.

There is frequent mention within Podiatry C&Cs of waiting times. For Middleton NHT C&Cs, non-attendance is an issue with district nurses not arriving as planned. This is explored further across the twelve month period in the Experience Wall below.

3.6.2 Experience Wall – Appointment Issues Middleton Neighbourhood Team

3.6.2.1

Each block below represents a C&C contact from a patient or family member about their negative experiences with Middleton NT appointments (domiciliary visits). This relates to experiences from 1 April 2016 to 31 March 2017.

inconsistency of times	do not visit twice daily as needed	not visited for two weeks	not attended for 9 days	care not as regular as expected
nurses do not attend every other day	uncoordinated service	late visit	visits not started as expected	failed visits
nurses not turning up	no visits on two occasions this week	no attendance for leg ulcer dresing	not arriving on time	concerned about routine of visits

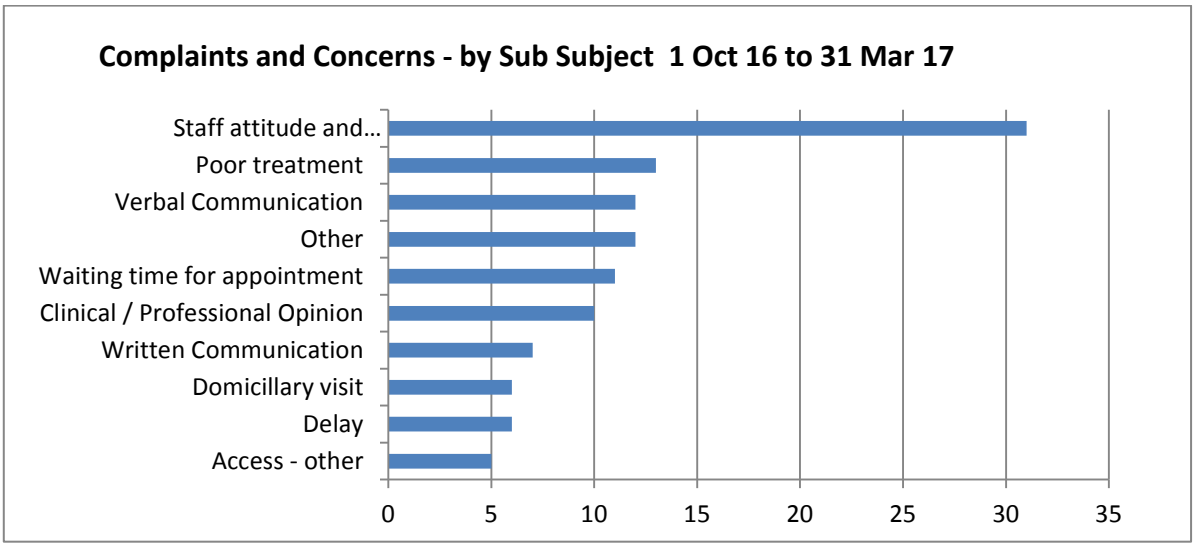
3.6.2.2

It is notable that, by volume of contacts, Middleton is a significantly larger neighbourhood team. The level of appointment C&Cs per face-to-face contact for Middleton for 2016/17 was minimal at 0.015%. Middleton also had a relatively low level of C&Cs for the reporting period overall. Nonetheless it is important to address every experience a patient or family member has and for each complaint an action plan is requested; and teams are asked to use feedback from concerns to revised and improve local processes where necessary.

3.7 Complaint & Concern Sub-Subjects

3.7.1 Sub-subjects lie below the main subject of complaint within the Trust's Complaint & Concern database (C&C). They offer the opportunity for the user to select a more specific representation of the patient or carer's main issue.

3.7.2 The chart below represents the top ten C&C subcategories:

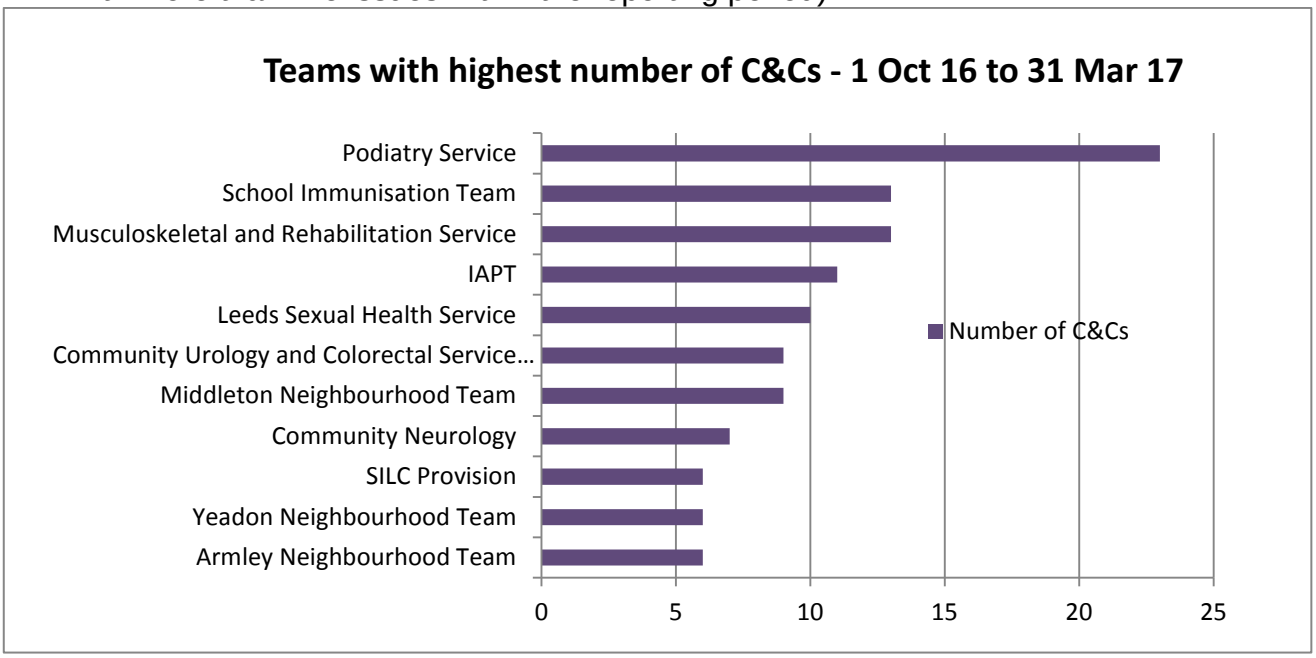


3.7.3 This level of categorisation can deepen understanding of the core issues of C&C. The options presently available do not provide significant additional insight beyond the higher level category selected. For example, within "staff attitude and communication" it is unclear whether these are mainly specific problems with rudeness or with a communication breakdown. The "Other" definition also represents the fourth highest C&C subcategory.

3.7.4 In view of the age of the Datix system and the developments that have occurred within services over its history, it is timely to note the need for a full review of the Datix system and categorisation used. This has been identified as a piece of work to be completed by year-end 2017/18.

3.8 Teams with highest number of C&Cs

3.8.1 The chart below demonstrates the teams with the highest number of C&Cs (i.e. all teams with more than five issues within the reporting period):



3.8.2 The teams with the most C&Cs are areas with high numbers of patient contacts. They also represent either services where patients receive care for a chronic condition that may be difficult to manage (e.g. MSK services) or those where there is a high level of demand for the service.

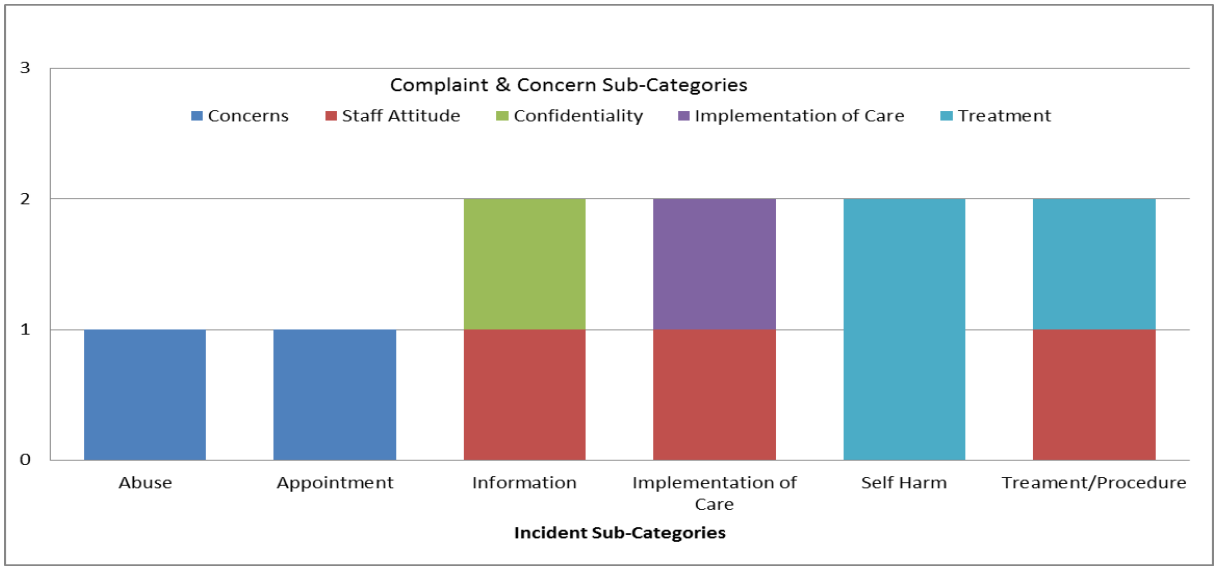
3.8.3 There are no unexpected complaint clusters identified within the reporting period.

3.9 Incident and C&C data analysis

3.9.1 Under the incident sub-category of **Treatment, procedure – other** there appears to be a correlation between this and the C&C category of **Poor Treatment**. However further investigation of the incident reports evidences that only one record is linked.

Ten incident records have link to a Concern or Complaint. This is currently a manual process undertaken by the Clinical Governance or Patient Experience Team and data is limited to a minimum number of records. Analysis of this limited information shows only 3

complaint reports to match the initial incident report sub-category. This information is not considered to be a source of thematic data.

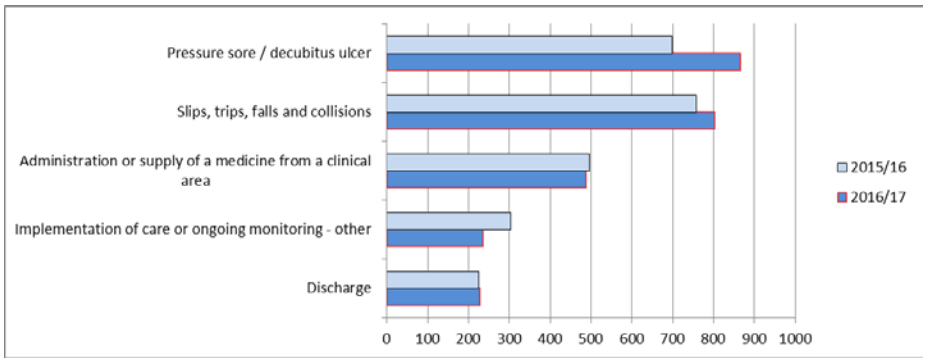


3.9.2 There are minimal incidents to compare with regards to **staff attitude, conduct, cultural or dignity issues** as these issues are not captured specifically within the incident reporting system. However, 3 of the linked Incident/C&C records do highlight staff attitude as the reason for complaint (although not mentioned in the incident) which is reflected in the previously described thematic findings.

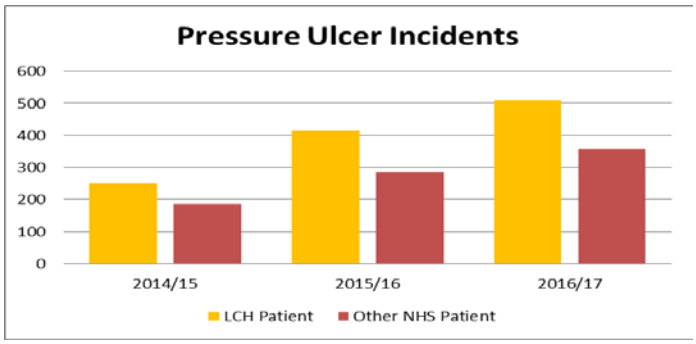
FFT analysis provides a different picture and positive response in the domains of communication with patients and information given.

3.9.3 **Implementation of Care (PSI's)** is the highest reported incident category within LCH over the reporting period 01/10/16 to 31/03/17 and the full financial year. This is a change to previous years where **Accident that may result in personal injury** (reporting category for Slips, trips and falls) has consistently been the highest reported category.

Further analysis of the data shows that there has been a year on year increase in the reporting of pressure ulcers which has resulted in the Implementation of Care category becoming a top theme within 2016/17:



3.9.4 The highest reported **sub-category is Pressure ulcers**, with a reporting increase on 2015/16 of 24%. This is a change from previous years where Slips, trips and falls have been the highest reported sub-category (there has also been an increase in this sub-category):



These figures include incidents not occurring in LCH care, as all patient safety incidents are reported regardless of where the incident originated; further analysis of this shows a year on year rise of both LCH and other NHS pressure ulcer incidents.

3.9.5 Whilst **Medication** complaints have continued to decrease in 2016/17, Medication remains the third top category for incident reporting. The change to HMP healthcare provision has contributed to the decrease in medication related complaints and incidents. However, the overall number of reported medication incidents remains constant with increases seen in the majority of Adult Neighbourhood Teams. Further examination of the type of patient (LCH or Other NHS) shows an increase in the LCH medication incidents rather than those occurring with other NHS providers.

The top five subcategories of these were;

- Medication not administered
- Dose or strength was wrong or unclear
- Frequency for taking medication was wrong
- 'Other' medication incident
- Wrong drug or medicine

These are consistent both in theme and figures with the previous report; the only exception being the fifth listed subject which has changed from 'medication not available'.

This data and actions and learning from it monitored via the Director of Nursing quarterly report.

4. SUMMARY OF THEMES BY BUSINESS UNIT

4.1 The table below provides a visual guide to the commonalities across Business Units. Themes from this information can be used by the Patient Safety, Experience and Governance Group (PSEGG) for future workshop focus and sharing of learning across the Trust.

Business Unit	Complaints	Concerns	Incidents
Adults	Appointment	Appointment	Implementation of care or ongoing monitoring/review
	Attitude, conduct, cultural and dignity issues	Attitude, conduct, cultural and dignity issues	Medication
	Clinical judgement / Treatment	Clinical judgement / Treatment	Accident that may result in personal injury
Children's	Appointment	Appointment	Abusive, violent, disruptive or self-harming behaviour
	Clinical judgement / Treatment	Communication issues with the patient	Infrastructure or resources (staffing, facilities, environment)
	Attitude, conduct, cultural and dignity issues	Clinical judgement / Treatment	IG, Confidentiality, Consent or Communication
Specialist	Clinical judgement / Treatment	Appointment	Medication
	Appointment	Communication issues with the patient	Accident that may result in personal injury
	Attitude, conduct, cultural and dignity issues	Attitude, conduct, cultural and dignity issues	Access, Appointment, Admission, Transfer, Discharge
		Clinical judgement / Treatment	

5. ACTIONS AND LEARNING TO IMPROVE SERVICES

5.1 An update was requested from Business Unit Clinical Leads to evidence action and learning relating the themes identified throughout this report and in the table above.

5.2 Appendix 1 offers assurance that all Business Units are aware of these areas for improvement; and provides live examples of actions in progress to address the themes identified.

5.3 Themes by Business Unit and organisation, and actions to bring about improvement are also monitored via the monthly performance brief and the quarterly Director of Nursing Report.

6. RECOMMENDATIONS

6.1 Trust Board is requested to:

- Note the themes identified
- Receive assurance that actions and learning is in progress to address the themes identified

APPENDIX 1: ACTIONS AND LEARNING TO IMPROVE SERVICES

1. Appointments and Access to services

1.1 Adult Business Unit:

- The ABU completes a monthly "deep dive" audit of all planned visits to identify how many were cancelled, deferred or delayed. The results of the audit are reviewed in the monthly Quality Meeting. While work is ongoing to embed processes, over the past 9 months the Neighbourhood Team shave sustained the two thirds reduction in the number of appointments cancelled, deferred or delayed. The leadership team acknowledge further work is required and to ensure this progress is maintained two new processes are being rolled out across all the Neighbourhood Teams: firstly the new Capacity and Demand tool which supports the teams to plan and manage their visits more effectively, the second initiative is the e-rostering tool and we are optimistic that these new processes when embedded will lead to further improvement in access to services.
- The work to phase out paper records is ongoing across the city with eight neighbourhood teams currently using the patient electronic record and roll out planned to continue across all teams.

  Reducing waiting times for CUCS is a priority and has been identified within the 2017/18 Quality Account.
- Waiting list analysis has been undertaken and changes made to how appointments are allocated to create more flexibility in the service.
- Additional clinics have temporarily been provided at a weekend to reduce waiting times.
- Skills within the team have been reviewed and roles developed.
- This has resulted in maximum waiting time reducing from 41.6 weeks (at its highest in January with, with 138 people waiting over 18 weeks) to 22.7 weeks (w/c 8/5/17) with 9 people waiting over 18 weeks. This is expected to continue to improve.

1.2 Children's Business Unit:

- A Children's Business Unit priority for the year is to reduce internal waiting times and agree priority areas for intervention. CAMHS continues to develop the single point of access (SPA) and pathway model, offering referrers direct referral access, coupled with increased information and signposting for families. The SPA is currently developing a facility of offering short term intervention for young people at the point of SPA contact where clinically indicated. The SPA model has also been successfully rolled out within the School Nursing service and is now extended to Health Visiting. Services are offering increased service information online, across health and local authority platforms, coupled with increased availability of self - help material and resources. CAMHS has developed a forum encouraging parent / carer involvement to inform the further development and responsiveness of the service.
- Reducing waiting times in AMHS and ICAN has been identified as a Quality Account priority for 2017/18.

1.3 Specialist Business Unit:

- Services working on capacity and demand with service development colleagues.
- Clinician's to review diaries for availability for discussion in service wedge meetings.
- Service is using patient feedback to identify relevant training for staff.
- The senior leadership team on a regular basis discusses complaints with staff. This has led to a change in Rota's allowing staff more time for key administration duties.
- Service to review patient information on display in waiting area.

2. Clinical Judgement

2.1 The Adult Business Unit

- Daily handover meetings have been established at caseload cluster level led by a senior clinician to support clinicians in their clinical decision making.
- There are monthly case load reviews that are peer reviewed to support reflection upon evidence based practice and clinical service delivery.
- Clinical Supervision rates have increased to over 80% and the business unit exceeded its Q4 target, the work is now continuing to improve the quality and impact of regular clinical supervision.
- The Learning form clinical incidents is now routinely shared across the Neighbourhood Teams and this supports the development of clinical judgement.
- Clinical education is being actively supported across all professional groups in the NTs as advanced clinical practice and as routine In-service Training.
- Community Matrons and Advanced Clinical practitioners, specialist nursing colleagues from the WPaMS and EoL Palliative Care Lead nurses all support the quality and effectiveness of the NT Caseload Clusters and undertake direct supervision and peer support.

2.2 Children's Business Unit:

- Across the Business Unit, importance is placed on high quality and high standard of clinical judgement in care delivery. This is being underpinned by the roll out of Health Coaching as an approach which enables personalised care to be offered within a focused model driven by the service user. High quality intervention is further supported by services developing bespoke clinical supervision models compatible with service delivery and approach. As a result, increasing numbers of staff are regularly accessing supervision and models are extending to include group reflection and shared learning.

2.3 Specialist Business Unit:

- Referral pathways and waiting times for senior clinical assessment to be discussed with patient before referral.
- Service to develop written information for patients where there is a risk of footwear damage due to orthosis.
- Issues relating to clinical judgement are discussed with staff and anonymised learning share with the team.

2.4 All:

- Feedback and learning from complaint investigation findings/outcomes is shared within teams and clinical forums.

3. Attitude of staff & Communication

3.1 Adult Business Unit

- Staff are supported by their NT Leadership Team to understand and embed into their practice the LCH 7 Magnificent Behaviours along with the Trust's Vision and Values.
- To support "better conversations" staff are encouraged to attend training on health coaching and motivational interviewing which supports proactive and beneficial communication with patients.
- Staff are encouraged to attend conflict resolution training.

3.2 Children's' Business Unit:

- Emphasis is being placed on staff communication, attitude and wellbeing. Staff are being encouraged to offer peer support, managers to prioritise appraisal, sickness management and team time to ensure that clinicians feel heard, valued and part of the team. The positive effect of this initiative is evidenced through staff survey feedback. Business unit leads and managers are supporting team managers to maintain and embed staff values ensuring that the Clinical Forum and Performance meetings reflect this priority and offer support to managers in undertaking the role.
- Improvements to infrastructure and resources have been made in recent months following changes in the interpreting service. Information regarding the new provision has been sent to all staff to establish and maintain effective communication with children, families and service users.

3.3 Specialist Business Unit:

- Clinicians to ensure that they involve patients in decisions affecting their care during the consultation.
- Service reviewed use of coloured forms to non that are gender specific.
- Service are looking at health Coaching and this is being offered to staff. By promoting a positive patient experience with staff who feel more involved and empowered it is hoped that there will be fewer complaints about staff attitude.
- Where concerns are raised relating to access of confidential information the IG team undertake audits of HCP access to records.
- Issues relating to staff communications with patients are all discussed with the individual member of staff to identify any learning.

4. Implementation of care or ongoing monitoring/review

4.1 Adult Business Unit:

- Provision of the New Ways of Working and Holistic Assessment Training for all clinical staff within the Neighbourhood Teams.
- The Pressure Ulcer and Falls Steering Group and the Incident Panel process ensure that the importance of risk assessment and regular reviews are embedded as routine practice. Case Load reviews are continuing to be established as an essential aspect of Neighbourhood Team clinical practice where monitoring of clinical care supports effective care.
- Two new service improvement work streams have been initiated to support high quality care within the NTs:
  1) Patient dependency scoring,
  2) Clinical care frameworks to reduce the variation in practice across the NTs
- Team Coaches are continuing work with aligned Neighbourhood Teams supporting specific work streams within the development plans, such as supporting the Caseload Cluster development and working with the specific groups such as the Band 6 nurses and the therapists to work through the stages of New Ways of Working (NWoW).
- Embedded senior clinical and operational leadership within the Neighbourhood Teams unit has been provided to support areas with embedding NWoW in all teams.
- Learning from Neighbourhood Team incidents and complaints is routinely shared at the individual monthly NT meetings and consolidated by the Quality Board and Patient Safety Briefings.
- Thematic learning from incidents shared in the Holistic Assessment training sessions.

4.2 Children's Business Unit:

- The organisation is addressing IG and issues of confidentiality of incidents by developing a recording of Datix criteria to enable better information collection and analysis. There is increased awareness across the business unit re information sharing particularly with the introduction and roll out of the electronic patient record (EPR). Staff increasingly access the IG service to seek advice and guidance where appropriate.

5. Medication

5.1 Adult Business Unit

- Additional clinical support provided to Neighbourhood Teams (with high reported levels of medication related incidents) via the Adult Services Quality Lead.
- The SOPs for Neighbourhood Team Missed Visits and Administration of Insulin have been reviewed.

5.2 Specialist Business Unit

- An action plan is in place in the Specialist Services Business Unit for reconciliation of medicines within the Police Custody suites. This includes: medication checks to be changed to each shift rather than weekly; commencement of management checks; and action taken if staff are not reconciling medication.
- WYOI reinforcing with staff CD receiving (2 persons to check on receipt) and disposal process in line with policy and rising staff awareness of SOP on a regular basis.
- Checking patient ID as per policy.
- Action for Pharmacy techs to ensure clear labelling of bottles to reduce risk of misidentification.
- Staff to complete a WASP for medicines administration following meds error.
- Proposal at WYOI to move to using stock medications instead of patient labelled.
- Reinforcement of importance of doing a thorough medication assessment at each contact. To be discussed at team meetings.

6. Accident that may result in personal injury (specifically falls)

6.1 Adult Business Unit

- Revised format of Trust Clinical Steering Group with agreed actions focus on improved information, education and training on falls prevention.
- Revised documentation for investigation of falls incidents.
- The Neighbourhood Team's Holistic Assessment standard has Falls Risk Assessment (Tier1 and 2 FRAT) as a first contact must do screening process.
- Revised format for major falls panels to ensure robust scrutiny of investigation and consistency with Serious Incident processes.
- Head of Service for inpatient areas working with the service managers to perform spot checks looking at falls prevention measures.
- Daily safety huddles implemented with a specific focus on falls and high risk patients
- Consultant input into safety huddles on weekly basis.
- Continued monitoring of compliance with staff competency in falls prevention, equipment use and updates in falls Tier2 training.
- Feedback from senior team throughout shifts.
- Targeted focus on falls prevention during intentional rounds.

Specialist Business Unit

- Themes of incidents discussed at specialist services clinical forum meetings with monthly report presented by Quality lead.
- There is multidisciplinary team working, joint risk assessments with third parties and discussions at team meetings relating to patient smoking whilst on O_2.

7. Abusive, violent, disruptive or self-harming behaviour

7.1 Children's Business Unit

- Within the Children's Business Unit specialist services offer assessment and intervention for children and young people with emotional and mental health difficulties. Within the acute CAMHS setting there have been some instances of violent and aggression associated with mental illness or acute emotional distress. The service actively reviews all such incidents in order to continually tailor individualised packages of care to meet the needs of the young person. In addition, the service has completed two RCA's to ensure that service wide improvements support and compliment individual care provision. This has included additional specialist training for staff, the development of guidelines and SOPS to ensure safe and effective practice. Environmental risk is considered within all risk for young people and corporate support is in place to ensure responsive support if required.

8. Access, Appointment, Admission, Transfer and Discharge

Specialist Business Unit

- Consideration to be given if faxed referrals are necessary given that patients can self-refer on a secure online system.
- Issues being raised with the prison service relating to officer availability to take detained person for hospital appointment. Plan in place to record when Appointments are being prevented due to Prison staffing and regime and continue reporting via DATIX as evidence.
- Clerical Support Assistant to spend some time with service so that they can get a full insight of how the service works.
- Share with peers at team meeting to prevent further incidents occurring where care was not provided due to staff absence or not responding to tasks on S. Incident learning to be shared across all teams by the team mangers and in weekly news bulletin.
- Issues related to discharge information being provided to community healthcare from Hospitals being addressed.

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9. Actions related to Serious Incident Management

- Monitoring of SI action plan compliance via Datix.
- Focus on Pressure Ulcer action plans via monitoring at the Pressure Ulcer Steering Group commencing Q2 2017.
- Lead investigator training continuing on rolling programme.
- Development of Patient Safety, Experience and Governance Group (PSEGG) to identify forum for learning from SI's.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (12)

Meeting Trust Board 31 May 2017	**Category of paper**	
Report title: Organisational Development strategy and action plan 2017-19	**For approval**	x
Responsible director: Director of Workforce **Report author:** Head of Organisational Development /Director of Workforce	**For assurance**	
Previously considered by: SMT & Business Committee 24 May 2017	**For information**	

Purpose of the report

The purpose of this paper is to present a refreshed organisational development (OD) strategy, which describes the actions which Leeds Community Healthcare NHS Trust will take to promote and develop our organisation and the people who work for us over the next two years; so that the Trust will deliver its vison of 'best possible care to every community we serve'.

This is accompanied by a revised action plan based on updated four key objectives of :

- Planning for the future including recruitment, retention, aligned workforce plans and talent development
- Improving staff engagement and morale as part of workplace wellbeing
- Creating and developing leadership capability
- Building a foundation of organisational structure/infrastructure that shows responsibilities and accountabilities, and is fit for purpose for our services

Main issues for consideration

The OD plan has been revised following progress in delivery of the original strategy and action plans which covered the period 2014-17. The progress made is described and illustrated by some key metrics from the recent staff survey.

The Trust has also recently revised its strategic objectives and undergone a CQC inspection with enhanced focus on the people aspects of care delivery.

This revised strategy and action plan for delivery :

- Consolidates the work of the original plan,
- Links our various staff engagement initiatives under 'Building the Working Life we want' which has been reported regularly to the Board by the Chief executive
- Addresses the key risk of staff capacity (recruitment and retention) and also staff health and wellbeing
- Advances how we need to develop leadership for a more fluid future
- Matches up the people and organisational design aspects of the LCH strategy and

links to core business plans from the 3 Business units.

- Gives updated staff pledges following the 2016 NHS staff survey results reported to the Board in March 2017

The attachments to this cover paper are :

- OD strategy – with appendices
    - How we build working lives diagram
    - OD strategy action plan April 2017 /19
    - Draft text for revised Staff pledges

Recommendations

The Board is recommended to:

- Note the outcome of the Business committee discussion on 24 May 2017 (to be reported verbally)
- Approve the refreshed OD strategy and action plan as the focus of the work from 17/18 onwards
- Determine how the Board wishes to receive feedback on progress of OD strategy and action plan delivery

Organisational Development Strategy 2017-19
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Executive Summary

Executive Summary

This Organisational Development (OD) strategy describes the actions which Leeds Community Healthcare will take to promote and develop our organisation and the people who work for us over the next 2 years; so that we deliver our vison of best possible care to every community we serve.

The local implementation of the national Five Year Forward View (5YFV) and our strategy and core capabilities, all underpin our revised OD strategy and action plan whilst holding true to our existing vision and values. The progress made since our 2014 original strategy is described and illustrated by some key metrics from the recent staff survey.

Our focus of the refreshed organisational development (OD) strategy is now centred on 4 objectives:

- Planning for the future including recruitment, retention, aligned workforce plans and talent development
- Improving staff engagement and morale as part of workplace wellbeing
- Creating and developing leadership capability
- Building a foundation of organisational structure/infrastructure that shows responsibilities and accountabilities, and is fit for purpose for our services

Each objective has a statement of where we believe we are now, and what further steps are necessary for success.

We have captured this in an overarching diagram on 'How we build the working lives we want' which frames our ongoing development, reflecting that we not only need to work at several levels, but also with people as individuals, teams and leaders. (Appendix 1).

The delivery will be supported by an action plan on which there has been wide consultation and which is also attached. (Appendix 2), and revised staff survey pledges (Appendix 3).

1. Introduction

This Organisational Development (OD) strategy describes the actions which Leeds Community Healthcare will take to promote and develop our organisation and the people who work for us over the next 2 years; so that we deliver our vison of best possible care to every community we serve.

The local implementation of the national Five Year Forward View (5YFV) and our strategy and core capabilities underpin our revised OD strategy and action plan whilst holding true to our existing vision and values. The purpose of this strategy is to build on work to date and outline an approach that takes account of:

- Current local/national drivers and economic conditions
- Best practice interventions in the public and private sectors
- Evidenced based diagnostics, interventions and evaluation of outcomes and other key measures
-

The progress made since our 2014 original strategy is described and illustrated by some key metrics from the recent staff survey.

Our focus of the refreshed organisational development (OD) strategy is now centred on 4 objectives:

- Planning for the future including recruitment, retention, aligned workforce plans and talent development
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We have captured this in an overarching diagram on 'How we build the working lives we want' which frames our ongoing development, reflecting that we not only need to work at several levels, but also with people as individuals, teams and leaders. (Appendix 1).

The delivery will be supported by an action plan on which there has been wide consultation and which is also attached. (Appendix 2), and revised staff survey pledges (Appendix 3).

2. Context

2.1 Five Year Forward View

In March 2017 the next steps on the NHS Five-year Forward View were published. This includes a section on 'Strengthening our workforce' and a recognition nationally that NHS staff are under real pressure.

2.1.1 The previous national achievements identified include additional staff overall in England, creation of new roles including nurse associates,

and developing new routes into the NHS such as on the job apprentices.

2.1.2 The annual NHS staff survey is referenced as the basis for the general report on working conditions, including actions taken on workplace culture and employee support. At Leeds Community Healthcare feedback from the local 2016 staff survey was given to the Board in March 2017 and we continue to use this as our key staff engagement benchmark.

2.1.3 Like other NHS organisations, our staff continue to show concerns in respect of staff health and well-being, although we recognise our performance is less good than benchmark community trusts .The FYFV requires that action on NHS staff health and well-being is to be extended so that we need to have a plan in place to improve our health and well-being of workforce and a CQUINN incentive payment is now linked to this.

2.1.4 The national focus for registered nursing includes an expectation of work required on education and training, retention, return to practice, new fast track notes first programme, supporting new advanced clinical practice nurse roles, and use of E rostering and effective job planning.

2.1.5 The national leadership bodies have drafted a document entitled Developing people improving care' and this framework for leadership and improvement capabilities has also been embraced within this OD strategy. Improving care depends in a large part on the quality of leadership throughout LCH and the ability of leaders to engage and support staff.

2.2 Local strategy and capability

The Trust has recently revised its strategic objectives and undergone a CQC inspection with enhanced focus on the people aspects of care delivery. The Trust strategy is underpinned by four objectives for 17/18 which set out how we will achieve our vision over the longer term:

- Ensure consistent delivery of high quality care
- Create sustainable services
- Continue to improve staff engagement and morale
- Influencing system transformation and new models of care

We have also defined core capabilities (see box below) which differentiate the uniqueness of the Trust and can be used to guide where we position ourselves and shape future direction within the context of the Leeds Plan and the West Yorkshire Sustainable Transformation Plan (STP).

- **Scale of our operation** – We have the ability to mobilise services at scale and pace across the city. We are the only organisation that provides community care 24/7 in Leeds.
- **Diverse and highly capable workforce** – Our workforce is multi-skilled which allows us to evolve our service portfolio quickly to meet the constantly changing needs in our communities.
- **Community insight** – working closely with people in the community on a day-to-day basis provides us with deep insight into the population's health needs, trends, complexities and potential solutions.
- **Long term relationships with people** – The close relationships that we have with people are special. They put us in a strong position to empower patients to take control of their own health and provide us with insight into the best way to manage their care.
- **Flexible, innovative and value driven culture** – We care for and actively reach out to the most vulnerable groups in our communities. We can evolve and change quickly to provide services that best meet their needs.
- **We are innovative -** We provide different services to different communities and work at both a citywide and very local level

2.3 CQC rating

Our current rating at LCH remains 'Requires improvement' dating from an inspection in November 2015. In January 2017 we underwent a further CQC inspection. Although the outcome is not yet known to us, this gave an opportunity to take stock of both our services and governance, and how we felt that we meet the 'well-led section' of the CQC framework. Actions arising from the forthcoming CQC rating and changes to the well-led element of the framework will also need to be considered and factored into our OD strategy going forward.

2.4 Our role as part of a system

The success of STPs and the new care models hinges on experienced organisational leaders developing into system leaders who are able to work across boundaries to negotiate and implement improvements in care. This requires leaders who are 'comfortable with ambiguity' because they are able to work within fluid and often rapidly changing organisational arrangements.

2.4.1 Leeds plan
Whilst the West Yorkshire STP is important, at a local level the Leeds plan is central to achieving the ambitions of the city:

- A progression from our citywide Health and Wellbeing Strategy that serves the twin aims of: feeding into the West Yorkshire STP; and providing a delivery plan for our citywide health and care ambitions in Leeds.
- A 'roadmap' for how we will improve health and wellbeing, improve care and quality and work towards more financial sustainability, providing a focus for services to work together.

Our OD work is therefore also important in the local system and we must continue to be a local influencer as systems begin to change. LCH has already established a lead role in system integration, and connecting our services with primary care and new models of care/systems.

2.5 Getting best value

As an organisation with an annual budget of around £138m LCH has scope to be more productive. Increasing productivity has become more urgent as funding increases have fallen and deficits among NHS providers have risen. The Carter review identified many ways of improving productivity, including through changes in clinical practice. Supporting clinical teams to reduce unwarranted variations in care and to improve care should be the priority. The use of tried and tested quality improvement methods has been shown to deliver results; staff need training in these methods and time to realise the benefits.

3. Vision and Values

3.1 Vision

LCH has a simple vision which places quality at the heart:

To provide the best possible care to every community we serve

3.2 Values

This is complemented by our values

- We are open and honest and do what we say we will
- We treat everyone as an individual
- We are continuously listening, learning and improving

3.3 Behavioural Framework that sets out 7 behaviours

We have also in 2015/16 developed our 7 'magnificent behaviours' –through a process of involving staff, staffside and managers using appreciative enquiry techniques to identify examples of great leadership. This has been distilled into:

- Caring for patients
- Making the best decisions
- Leading by example
- Caring for one another

- Adapting to change and delivering improvements
- Working together
- Finding solutions

3.4 Our 11

This (Vison, Values and Behaviours) is set out as '**our 11**' and captured in the revised appraisal approach introduced from April 2016 (see sample header of form below).

4. LCH OD Strategy progress to date

Version 2.0 of our OD strategy first adopted in June 2014 focussed on five key themes which were:

- Developing a shared vision and enabling
- Bringing LCH values to life
- Aligning structures, systems and processes to the vision
- Developing a high performance culture
- Building capability for innovation and learning

Outlined below are key interventions grouped against the themes that have been actioned since the development of the original strategy.

4.1 Developing a shared vision & bringing values to life

- Behavioural framework
- Redesign/streamlined appraisal system
- Created values based recruitment and attraction media
- Cultural branding “Creating the Working Life we want” (Our eleven)
- Creating and developing pledges on back of staff survey results as organisational commitment
- Created the LCH Team Effectiveness model
- Thea’s Road shows
- Engagement star
- Leaders network redesigned
- Sustained relations with Staffside
- 50 voices
- Creation of disability and BME networks and champion volunteers
- Business unit led showcase events

4.2 Aligning structures, systems and processes to the vision

There continues to be some organisational restructuring with a key focus in 16/17 on supporting the Adult business unit. This meant realignment of some services to Specialist and QPD enabled concentration on developing neighbourhood teams. The action plan led by the Director of Operations and Director of nursing had six overarching work streams

- Quality
- Staff morale
- New ways working/EPR
- Demand and capacity
- Delivering the contract

Teams in ‘special measures’

Other changes have been introduced due to loss of the prison contract at March 2016, expansion of Police custody services and changes in response to the competitive environment in contracting for some of our services.

4.3 Developing a high performance culture and Building Capability for Innovation and learning

- Developed and running Manager/ Lead programme with different knowledge based learning workshops
- “Managing difficult Conversations” workshops attended by 329 managers to support revised Appraisal process
- LEAD development programme designed for new to role managers – including Mindfulness, Learning exchange, 360 performance data feedback and personality assessment and feedback

- Designed/Expanded and aligned our four coaching interventions:
    - 1:1 Coaching
    - Team Coaching
    - Manager as Coach
    - Health Coaching

- Open offers of Mindfulness 8 Week Mindfulness Based Reduction programme
- Redesign of attraction, selection and assessment methods and aligning systems and process around our core “11” brand

4.4 Impact of these initiatives – Measurable Outcomes

The national staff survey gives us rich data that the OD strategy directly impacts upon. The response from this year’s survey was 51%, the same percentage uptake from last year however the sample response rate has increased from 1355 (2015) to 1425 (2016).

Survey responses for individual items that could be attributed to a range of OD inventions which are listed below (In brief). One important point to note is that there will also be other factors that influence opinions with services.

Embedding values, feedback and involvement:

- Are you aware of Leeds Community Healthcare's values? 95% up +1%
- Do managers demonstrate the values at work 59% up +7%
- Do other colleagues demonstrate the values at work 67% up +5%
- My immediate manager gives me clear feedback on my work 61% up +9%
- My immediate manager asks for my opinion before making decisions that affect my work 54% up +5%
- My immediate manager values my work 72% +4%
- The support I get from my immediate manager 68% up + 6%
- My immediate manager encourages those who work for her/him to work as a team 76% up +5%
- The extent to which my organisation values my work 39% up +3%

Training and development:

- My training, learning or development has helped me to do my job more effectively 89% up +3%
- My training, learning or development has helped me to stay up-to-date with professional requirements 88% up +1%
- My training, learning or development has helped me to deliver a better patient / service user experience 85% up +4%
- Have you had any mandatory training in the last 12 months? 98% up +2%

Appraisal:

- In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review? 88% up+1%
- It helped me to improve how I do my job 71% up +3%
- It helped me agree clear objectives for my work 85%
- It left me feeling that my work is valued by my organisation 74% up +3%
- The values of my organisation were discussed as part of the appraisal process 77% up +12%
- My manager supported me to receive this training, learning or development 90% up +2%

5. The updated strategy looking forward 2017 – 2019

5.1 OD Strategic Objectives

We have seen much change since 2014 and our organisational strategy is taking shape to become more aligned to developing new models of care .We have however a core purpose **now** to deliver our vison of best possible care to every community we serve and that means we must continue to develop our organisation and the people who work for us over the next 2 years as a realistic planning timeframe.

The objectives of this updated OD Strategy to achieve progress are:

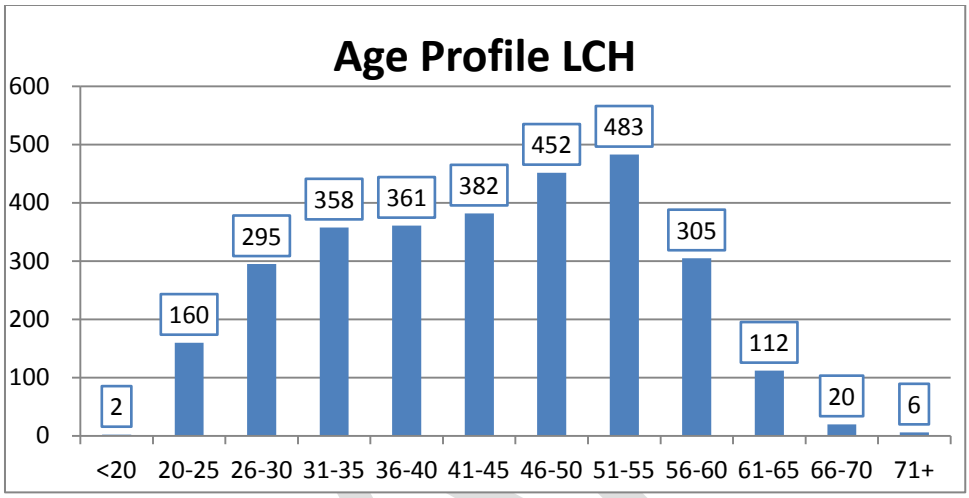
- Planning for the future including recruitment, retention, aligned workforce plans and talent development (section 6)
- Improving staff engagement and morale as part of workplace wellbeing (Section 7)
- Creating and developing leadership capability(section 8)
- Building a foundation of organisational structure/infrastructure that shows responsibilities and accountabilities, and is fit for purpose for our services (Section 9).

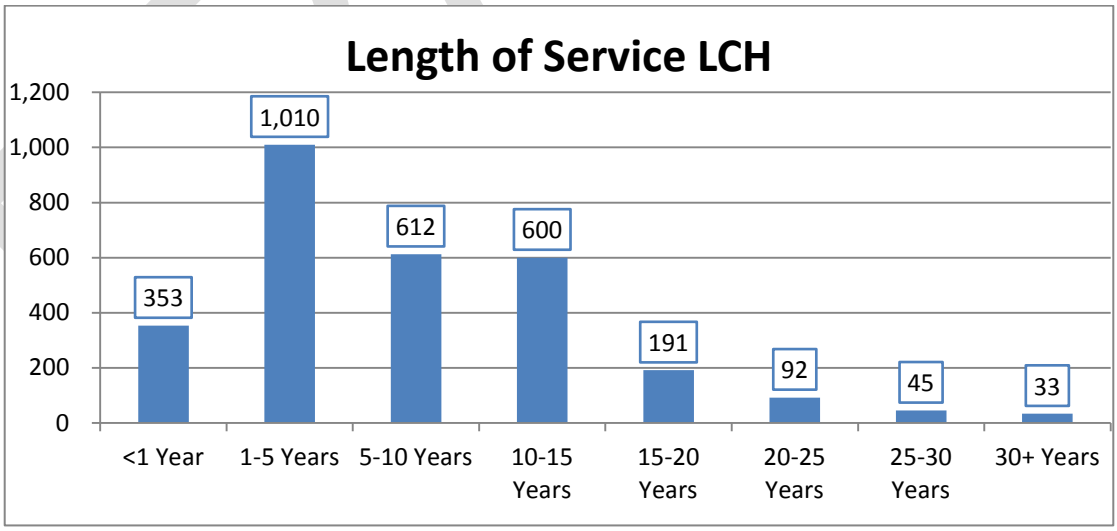
6. Planning for the future recruitment, retention aligned workforce plans and talent development

When planning for the future of care we should think “key people.” This can be categorised as ‘talent’. There is a set of critical skills and roles in most organisations that drive 50 % to 80 % of business value, and for us this means critical employees in roles such as Nurses, Health Care Support Staff etc.

6.1 Where are we now?

We already provide regular updates relating to turnover and workforce supply, and have seen increasing turnover in 16/17 and further identified concerns at the relatively high (25%) number of staff leaving within 12 months of joining LCH. The age profile of LCH has some worrying indicators and this is replicated across the NHS. Therefore through the development of our recruitment and retention talent management processes we can help attract, select and retain staff.





Work continues with particular focus on attraction and selection and this also focuses on:

- Workforce planning – ability to identify talent supply against business demands particularly relevant to nursing posts and therapists.

- Resourcing and recruiting – internal (linked to potential and performance data including development) and external resourcing capability including considering selective international recruitment
- Employer branding capability – induction and on boarding
- Retention – maturity level of career management/career paths, ensuring retention of high performing/high potential staff
- Succession planning – readily available talent profile data through assessment centre approach,
- Development – development planning implementation and management of plans

6.2 **Success & how will we know?**

In order to deliver success we will focus on these outcomes:

- We align workforce planning activities with the overall business strategy
- We consistently analyse current headcount vs. forecasted headcount needs and in keeping with individual Business unit plans
- We attain our agreed targets for turnover and stability
- Our talent plans are easy to understand and staff can relate to them and the impact they have on their services
- We restructure and know who to move into new positions of leadership and key roles
- We locate the right talent and on-board them rapidly to meet new needs.
- We identify the criticality of job roles in the business strategy
- We align workforce planning with succession management and internal mobility
- We use apprenticeship levy money to attract into new and current roles
- We have all leaders across corporate and operational services role modelling positive behaviours
- Each business unit has a learning and development feedback culture
- We have strengthened clinical training, preceptorship and support which equips newly qualified staff to contribute fully to the team as quickly as possible
- Culture of quality and safety is maintained through learning and clinical professional strategy, quality strategy, research strategy and OD strategy actions are linked and complementary
- Our approach to training (for clinical and nonclinical staff) and professional development ensures skills, competence and training matches current and future service needs across the organisation.

7. Improving staff engagement and morale as part of workplace wellbeing

7.1 Where are we now?

Our overall sickness level in March 201was 5.6%, above the Community trust benchmark and composed of absence of long term at 3.5 % and short term 2.2%. The impact of sickness absence across LCH has been significant on our staffing capacity, particularly in neighbourhood teams. Although we have numerous and evidence based health and wellbeing initiatives in place for staff, this issue has proved intractable for us over the last 3 years, but there is no complacency.

It is proven that individual wellbeing, employee engagement and a culture of wellbeing link to important organisational outcomes, such as productivity and employee retention.

Questions posed in the 2016 staff survey include- does your organisation take positive action on health and well-being? 88% of staff responded positively with a 2% increase from the previous year. We have progressed work that supports staff to be healthier in the workplace together with polices on flexible working. Yet there is still much to do to improve our attendance figures and staff support.

South West Yorkshire Partnership Foundation Trust (SWYPFT) is now our Occupational Health Provider. The service is provided by a multi-disciplinary team consisting of Occupational Health Advisers and Occupational Health Practitioners, Registered Mental Nurse (RMN) and Occupational Therapy, who provide the following range of services to LCH staff:

- Work Health Assessments (Pre-employment)
- Workplace immunisations: For TB, Hepatitis B, Varicella and MMR where clinically indicated
- Counselling
- In-service management referrals for absence
- Self-referrals
- Support for staff who sustain a Sharps or Splash injury

We also provide bullying and harassment training, one to one coaching and Manager as Coach training.

Additionally we have delivered Mindfulness Based Stress Relief programmes which is an eight week programme with sessions lasting for 2/2.5 hours. Since 2016/16 we have had 180 participants attend and evaluation of the programme is based on

- Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)
- Perceived Stress Scale (PSS)
- Five Facet Mindfulness Questionnaire (FFMQ)

This shows overall improvement in well-being of 12.3% (as measured by the WEMWBS) and reduction in stress of 21.2% (as measured by the PSS).

There is a plan being developed to deliver improved health and wellbeing of our workforce and to achieve the CQUINN incentive for 17/18. This requires that we measure staff responses on issues in next year's staff survey (5% improvement on staff survey questions on health and wellbeing, stress and MSK).

7.2 Staff engagement

Evidence shows key correlations between engagement and aspects of working life can be made with quality of patient care. From the 2016 staff survey as outlined previously, we have made good progress in the development of leaders and developing our people to be better informed and engaged. The development of the "Creating the working life you want" and the 12 pledges in the last staff survey created a platform to design, progress, engage and communicate with staff.

We have seen significant shifts in the way managers engage with their staff and this has been in part the work over the last two years architecture built around "Our Eleven", appraisal redesign, Staff Engagement Star (Our Working Lives), creating open space for leaders, Thank You flash mob celebrations, Theas road shows and continual engagement as well as director and non-exec visits. All of this helps to create the "Working Life you want" and this work will continue.

Again focussed work needs to take place with the reinforcement of the core brand (Our 11).Last year we created 14 staff survey pledges and progress has been assessed and these have been revised in the light of the latest staff survey feedback .This means we have retired/replaced 3 and substituted 2 new ones – one on sharing the direction of travel and how this fits for staff roles, and secondly one on whether LCH cares for staff health and wellbeing.

7.3 Success and how will we know

In order to deliver success we will continue to monitor results through staff survey and staff friends and family responses and focus on these outcomes:

Revised targets set and monitored through the Business Committee for sickness and recruitment/ retention performance data,

Revised absence management policy implementation is monitored

We attain our CQUINN metrics required through the action plan on health and wellbeing,

Disability and BME networks continue to be supported

On staff engagement this means:

- Staff feel proud to work for LCH and would recommend its services and as a place to work to family and friends
- Staff have the skill to be able to apply improvement methodologies that involve their team/s
    - Our people understand our vision, purpose and core objectives and how this fits with their contribution linked to their appraisal

- Having a system that recognises career ambitions aligned to development and succession plans
- Sustained low levels of discrimination and bullying

8.0 Create and develop leadership capability

8.1 Where are we now?

Compassionate and inclusive leadership creates an environment where our '7 magnificent behaviours' are the norm.

We will also maintain our investment in developing leaders through internal programmes and our overall coaching strategy.

The Leadership programme concept we have designed is showing good progress to date. We aim to expand and the LEAD programme to deliver for 3 further cohorts in 2017/18. This means we need sufficient capacity not only to deliver, but also for staff to be released from the workplace to attend.

The Leadership, Exploration, Ability, Development (L.E.A.D) programme includes.

- 360 degree feedback process based on "How We Work" - the recipient will have a coach to discuss the report clearly lined to your performance at work
- WAVE psychometric personality instrument and facilitated feedback linked to your potential
- Mindfulness for Leaders (one day event) dates to be confirmed
- Facilitated learning exchange groups
- Manager As Coach (MAC) programme – this is core

We will continue to expand our coaching offers with particular emphasis on Team Coaching as we see this as core to the enablement of team transition and transformation. Linking this to service improvement methods and skills will enable teams to not only to be able to more cohesively but deliver on performance (See LCH Team Effectiveness Model).The Leeds plan and city wide initiatives also require a health coaching approach, and for which we have already trained over 300 staff and LCH will become the host organisation for the city lead from May 2017.

A further development programme is in design on having better conversations so that managers feel supported and have personal insight.

Management skills and knowledge development is typically different from that described above which equips managers with key skills in a range of core curriculum ranging from communication, change, recruitment and selection to risk management. These offers will also be maintained.

Evidence shows that organisations with a clear focus on improvement & innovation employ staff who feel connected and engaged with their work and workplace. In turn, indicators of care quality are high. Improvement & innovation is a core component of patient centredness, which is the value that brought most of our staff to work in a care setting in the first place.

We are committed to enabling staff to undertake improvement and innovation work as a core part of their roles. The service improvement team share their knowledge and capability in this field and provide opportunities to learn by doing. We will encourage further development and knowledge sharing in this field and we will promote share and spread through the improvement & innovation hub page on Elsie.

We also aspire to better information and data at team level to drive quality improvement and enable measurement for improvement: we will support teams to use the Performance Information Portal (PIP) and other information sources to support the Quality Improvement work. There will also be support to extend the use of Quality Boards as a key vehicle for displaying and using information and data to drive improvements.

Core quality improvement concepts will be included within our leadership development programmes during the forthcoming year, particularly looking at the role of the leader in creating the conditions for quality improvement to flourish within teams. This will be enhanced by access to the Leeds Institute for Quality Healthcare Improvement fellowship programmes for a number of leaders, together with participation in Core Improvement Concepts classes. On-line quality improvement learning by the Improvement Academy supported by face to face events will be promoted to all staff.

8.2 Success and how will we know?

In order to deliver success we will focus on these outcomes

- Leaders role model the seven core behaviours (competencies) that are underpinned by “Our 11” Vison and Values
- Our vision and objectives are easy to understand and leaders and staff can see how their contribution effects “Our 11”
- Leaders can see beyond their own work and across organisational boundaries shaping the vision and have potential experience to work across new models of care
- Staff feel empowered to implement day to day improvement to augment quality and efficiency of care
- Improvement methodologies are part of any system change work

- Staff want to stay working for LCH for the long term and can see a future for their careers
- Leaders display capabilities required to engage people effectively in participative change processes across the organisation
- Leaders coach their staff and ask what could be better?
- A bigger pool of aspiring senior leaders including clinical leaders, a higher number of qualified candidates per leadership vacancy, and fewer such vacancies.

9.0 Building a foundation of organisational structure/infrastructure that shows responsibilities and accountabilities, and is fit for purpose for our services

9.1 Where are we now?

Our defined leadership and management structures support the cultural changes necessary to thrive in the current political and commercial environment. We must adapt appropriate organisational structures and where necessary reconfigure in the light of commissioning changes.

The three business units were originally configured in 2013, with a triumvirate of a General Manager, Clinical Lead and Medical Lead. Specialist services no longer have a Medical Lead and each Clinical Lead reports into the Director of Nursing. Each General Manager reports into the Director the Operations. This has changed over time due to director portfolios and difficulty in recruiting medics into a role.

Each business unit has changed structures and accountabilities in 2016/7 as contracting arrangements have shifted and expectations/pressures have changed. In particular the Adult Business unit has been reshaped to focus on developing neighbourhood teams. Staff do feedback however that each individual is not clear about their accountability.

Our thinking must expand into areas such as estate/ environment factors – 'Building the Workplace we want'. Workspace design is an important element within job design as we move into enabling our estates strategy. Agile working and social space for team meetings and relationship should be at the core of our design work.

Implementation of the EPR rollout and overarching digital strategy is fully aligned to and supported by a service transformation programme. In the future provision of digital services, it is essential that the resources through Organisational Development (OD) and Service Improvement teams is fully embedded within the scope of the work and the change aspects (working practices, and procedures) are fully supported

9.2 Success and how will we know

In order to deliver success we will focus on these outcomes:

- All staff have a clear understanding of their purpose, role fit, role accountabilities and responsibilities
- Identifying the optimum structures (fitness of purpose)
- Systems and processes support achievement of LCH's corporate objective and local business objectives
- Corporate work structures and director portfolios are aligned with LCH Business plan
- Smooth delivery of change in estate/ workspace
- EPR and implementation is achieved and lessons learned are transferred to subsequent programmes such as e-rostering roll out

10. Impact

10.1 Supporting capacity and resource

The Chief Executive is accountable to the Board for the development and delivery of the OD Strategy. This is supported by the Workforce OD team, and Service improvement and professional development staff in Quality and Professional Directorate corporately and within operations directorate there are Business unit innovation leads.

There are some principles through which the workforce directorate and service improvement /innovation teams work.

- Based in corporate teams there are 'process' experts to improve any substantive organisation processes (e.g. planning, group meetings and relationships, communication, HR change advice)
- The primary leaders of OD are the Trust leaders and managers not HR/OD/SI professionals
- Focus is on the 'total system' even if asked to look at a specific organisational issue/s
- OD practitioners are 'helpers and catalysts' to leaders of the organisation.
- Technology of applied behavioural science and improvement sciences is used to support the organisation towards healthy development
- Activities are evidence based, process focussed, value driven

10.2 Risks

The Trust's two top risks on the current risk register relate to staff capacity and sickness absence:

o Staff turnover and wastage is a risk due to the need for an experienced stable workforce, increased recruitment costs and potential impact on morale

- o High levels of staff absence impact on workloads and care delivery, and the wellbeing of other staff.

The actions within the OD strategy which will shift these significant concerns will only be delivered if resources and capacity to support are sustained.

11. Next Steps

11.1 This Strategy has been subject at a high level to consultation with Staffside representatives, and management and staff, and so now detail of the action plan needs to be disseminated

11.2 Action plan identifies leads actions required and SMT oversight Workforce directorate support delivery against these objectives

11.3 The Business Committee and Board role on how progress is monitored needs to be considered. There is an option now that there is planned to be a quarterly workforce report to Business committee to use this as the vehicle for tracking progress.

Appendices

How we build working lives diagram – Appendix 1

OD Strategy Action plan April 2017 /19– Appendix 2

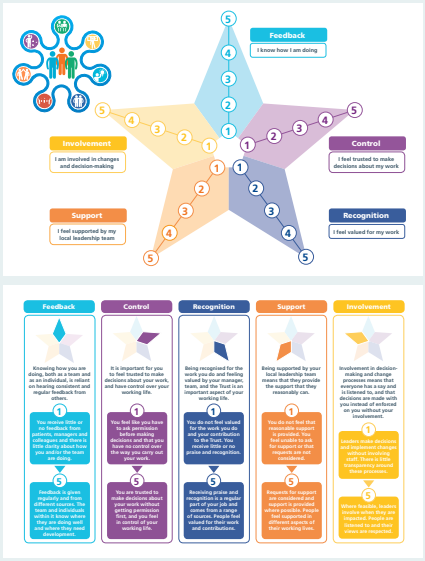
Revised Staff pledges – Appendix 3

How we build the **working lives we want**

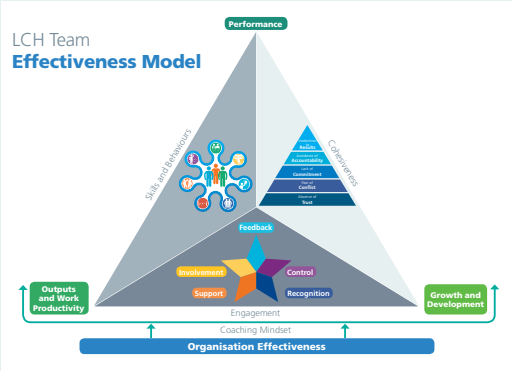
NHS
Leeds Community Healthcare
NHS Trust

Our Eleven: Shared Vision, Values and Behaviours

Individuals

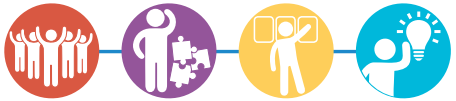


Teams



Leaders

Building leadership skills



Resilience

Wellbeing

Improved wellbeing for self and others

Individual | Team | **Coaching mindset** | Managers as Coach | Health

How do we build who we are?

Priorities › Recruitment › Potential + performance › Talent + careers

Organisational structure / infrastructure

Who is in charge, what are my responsibilities, what am I accountable for?

Where do I sit? | **What is my kit?** | **Where do I talk to people?**

OD Strategy Action Plan from May 2017/19

Objective	Action Required	Outcomes	Corporate objective No.	Time Frame	Lead
1. Planning for the future –recruitment, retention workforce and talent development	**a. Workforce Planning –** ability to identify talent supply against business demands • Gather data for the "big picture: strategic plans, current and projected budget information, and external market data/trends. Create a set of assumptions to set the scope of the planning effort. • After workforce segmentation assess supply side through recruitment and retention so that the current and future workforce that will deliver on LCH organisational objectives • Gather data through the roll out of E-rostering to provide a better understanding of demand and capacity across the city • Gap Analysis will identify how well the workforce is positioned for the future; shortfalls require action; excesses require realignment • Review findings with senior leaders to validate projections and secure support; confirm, gaps and excesses and define associated actions; model alternate projection scenarios • Refine needs in terms total numbers and competency requirements • Outline how the skills can be developed; recruited, developed through training, re-training, relocation, on-the-job etc. and the lead times involved to be fully competent • Identify and provide for clinical skills training that reflects what is required to fill critical roles • Determine whether internal roles/candidates can be reshaped to meet need and how internal sourcing will be handled • Identify alternative sourcing strategies – schools/colleges/universities, flexible arrangements, relocation, secondments, etc. • Apprenticeships are used to retain through development and where possible recruit to specific posts	1. Analytics that reflects LCH's key priorities and indicates how workforce planning will tackle strategic workforce challenges 2. A workforce planning framework for Neighbourhood teams 3. Assessed potential impact of Brexit on workforce supply 4. Shared understanding of the required workforce profile for pivotal roles and job categories (e.g. positions, classifications, skills and professions) 5. Targeted recruitment and retention plans reviewed on quarterly basis 6. Clear picture of the current state of the workforce and use of bank and agency, and associated costs 7. Comprehensive training plans tailored to specific areas of LCH (e.g. BU, departments) 8. On-going dialogue with line managers on emerging business and workforce issues 9. Apprenticeships are used provided frameworks are available to meet any talent gaps	2 (1) & 3 (4)	2017/18	HWI& HRS
	b. Succession Planning – readily available talent profile data through assessment centre approach 1. Identify Key and Critical Positions – Focus on both professional and management roles 2. Assess 'High Potentials' – A high potential employee has the potential, ability and aspiration for successive management / leadership positions within LCH in part talent data collected through new leadership capability model (internal mobility)	1. Understand the nature of high potentials for succession planning 2. Executive and senior leadership have talent data to understand the nature and gaps of potential successors 3. Positive action demonstrates that minority communities are moving into	3 (4) (5)	2019	HOD

Objective	Action Required	Outcomes	Corporate objective No.	Time Frame	Lead
	3. Understand and link to BME data and minority communities representation 4. Implement Talent Reviews – Will form part of Talent discussions at SMT as part of an overall succession management process. Also local management plans. 5. Develop action plans and talent dashboard 6. Establish numbers of apprentices across the Trust linked to talent pools and succession planning	more senior roles 4. Talent data is available as part of LCH performance dashboard 5. LCH Apprenticeship strategy			
	b. Resourcing and Recruiting – including internal sourcing capability) linked to leader development 1. Review of recruitment and selection process, systems and methodologies including: • Developing stronger links to partner organisations and higher education, colleges and schools • Evaluate process and selection methods to ensure measures of engagement, sickness/absence, retention • Develop detailed metrics for selection for HR analytics: Average time to hire, average time to hire for critical roles (need to define critical roles), total new hire costs (hiring, on boarding, training etc.) • Quality of hire – Links to behavioural competency measures and performance measures (may include clinical proficiency, CPD etc.), meeting objectives set and the degree to which the incumbent has met these. • Ensuring where possible skills gaps are progressed through apprenticeships	1. First year new hire (can be internal or external) voluntary turnover 2. Number of applicants per hire 3. Offer acceptance rate 4. Percentage of positions filled by internal candidates 5. Manager satisfaction on hiring of new recruit 6. Time to productivity for new hires/placement (develop metrics) 7. Various Apprenticeship provision for recruiting apprentices at different ages groups for career development	1(4) 3 (4)	2017/18	HOD RM
	c. Induction and on boarding Ensure induction enables core brand to be promoted and links to: 1. Pre-joining information ensure relevant documentation is tailored to specific job role where necessary 2. Review induction processes and implications for Statutory/Mandatory training etc. 3. On boarding portal is developed and implemented for new staff and tailored to BU's 4. Recruitment system linked to onboarding website 5. Digital resourcing that includes mobile friendly 6. Publishing job ads to multiple platforms **d. Branding**	1. All staff are clear about their roles responsibilities/accountabilities and are able to be effective from week one of employment 2. All staff are clear about core brand and what Our 11 is about 3. Faster induction and onboarding system 4. Training of statutory/mandatory training is accepted from other relevant employment and where possible done before entry into the workplace	3 (5)	2017	HOD RM HWI& HRS

Objective	Action Required	Outcomes	Corporate objective No.	Time Frame	Lead
	1. Develop and design a consistent approach that attracts suitable applicants for jobs and that relates to Our 11	5. Making the candidate experience better and more timely 6. Use of digital media to enable quick turnaround internally for processing i.e. QCF and tracking 7. On boarding is tailored to individual business units and departments and roles 8. Monitor turnover of staff in post less than 12 months 9. Identify which recruitment sources are most effective 10. Report on the key performance of all recruitment activity 11. Detailed analysis of time to hire and activity durations 12. Recruitment source and cost analytic 13. View application trends over time			
2. Workplace Wellbeing	1. Developing and implementing a work and wellbeing framework, based on good practice and key recommendations 2. Monitor delivery and impact of revised attendance policy and toolkit 3. Difficult conversation training and support for managers 4. Developing and promoting key initiatives on wellbeing and healthy working e.g. Mindful employer, Mindfulness, physical exercise, A.C.T (Acceptance and Commitment Training) 5. Developing the use of an evidence base to address key general (physical) and mental health (stress and anxiety) awareness and interventions	1. Reduction in sickness absence levels and turnover rates- tighter performance management 2. Additional difficult conversation training course offered 3. Delivery of CQINN metrics on health and wellbeing 4. Impact of Mindfulness provision on 3 scales: • Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) 20% improvement • Perceived Stress Scale (PSS) 30% reduction • Five Facet Mindfulness Questionnaire (FFMQ) post course 15% increase Impact of A.C.T: Additional measures: • General Health Questionnaire 12	3 (2) (3) (5)	2017-2019	HOD ADW

OD Strategy Action Plan from May 2017/19

Objective	Action Required	Outcomes	Corporate objective No.	Time Frame	Lead
		• Acceptance and Action Questionnaire			
3. Create and develop leadership capability	**a. Implementation of LCH leader development approach based on**: 1. Work on next cohorts for band 7/8a's and above who have started in LCH in last 2 years 2. Manager as coach programme 3. Mindful leadership 4. Learning exchange 5. Manager Lead modules 6. Reviewing existing leadership development offers to include leadership for improvement	1. Individual l Identify how, when and where coaching can help raise awareness and goal achievement 2. Access peer support to develop your coaching skills. 3. Learning outcomes 4. Team outcomes 5. Staff outcomes i.e. better conversations 6. Leeds & wider Systems input and roles exercised 7. Widespread evidence of improvement & innovation activities	1 (2b) 3 (1,2,5)	2017/18	HOD
	b. Coaching Interventions that underpin development and capability: 1. Individual coaching 2. Team coaching 3. Health coaching 4. Manager as coach 5. Underpinned by governance and supervision 6. Move to an a more centred coaching culture, empowering and collective problem solving	1. Behaviour change at individual and team level 2. System changes at team and BU level 3. Better outcomes for patients through patient activation 4. Links to outputs from STP and Leeds Plan 5. Patient Activation through PAMs 6. CQUIN 5 7. Staff survey results see staff survey pledges and actions	1 (2b) 3 (1,2,5)	2017 ⇨	HOD
	c. Ensuring staff are engaged on our 11: 1. Staff survey pledges and actions	Staff Survey Metrics – aim to improve the following 1. Overall staff engagement score increase from 3.70 2. Increase in recognition and value of staff by managers and the organisation from 3.86 3. Increase in staff satisfaction with level of responsibility and involvement from 3.80	3 (1,2,3,4,5)	2017/18	CE DW HOD

Objective	Action Required	Outcomes	Corporate objective No.	Time Frame	Lead
		4. Able to contribute to improvements at work from 73% 5. Support from immediate line managers from 3.59 6. Staff motivation at work increase from 3.86 7. Percentage of staff able to contribute towards improvements at work from 67% 8. Staff satisfied with opportunities for flexible working from 51%			
	d. In-house senior leaders programme in response to talent assessment 1. 8b's and above programme that underpin Our 11 linked to: • Psychological flexibility • Coaching mind-set • Succession planning and career pathways • Learning exchange/project work	1. Co-production of work and outputs on CQC domains 2. Understanding of differing perspectives and organisational objectives 3. Clear personal development plans that link to LCH objectives 4. Healthier senior leaders 5. Engaged senior leaders	1 (2a,b,c,3,4,5) 2 (1,2,3,4,5) 3 (4,5) 4 (1,2,3)	2017/18	EDO HOD
	e. Build improvement capability 1. Developing capability for quality improvement 2. Standardised use of quality boards 3. Use of PIP and other data streams to enable focus on improvement 4. Training in improvement methods for all staff 5. Team coaching and the use of improvement methods where necessary 6.	1. Increase in staff satisfaction with level of responsibility and involvement 2. Percentage of staff able to contribute towards improvements at work from up from 67% 3. More evidence-based improvements underpinned by measurement of outcomes 4. Linked to outcomes of quality strategy	1 (3) 2 (1)	2017/18	EDO QIL
4. Build organisational structures and where necessary configure those to meet	**Align corporate structures to enhance business unit capability by:** 1. Review and implement corporate structure alignment with Executive Directors portfolios 2. Review corporate projects that overlap different directorates **Align business structures to achievement of commissioning of services by:** 1. Ensuring clarity of roles and responsibilities of both senior leaders and	Securing sustainability of LCH and having credible plans that that link to the following areas: 1. Quality strategy 2. Nursing strategy 3. Digital strategy 4. Financial and business strategy	All	2017/18 /19	CE

OD Strategy Action Plan from May 2017/19

Objective	Action Required	Outcomes	Corporate objective No.	Time Frame	Lead
the needs of the services we are commissioned for	departments impacted by tenders **Support business delivery and capability** 2. Clarity on structure and line accountability for every staff member 3. Deliver work streams on improving productivity 4. Agile working policy related to Estates changes 5. Rollout service improvement e-learning package 6. Identify and deliver other improvement methodology support	5. Future commissioning and service strategy 6. Securing a sustainable organisational form 7. Leadership capability and capacity 8. Quality improvement			

Key

CE	Chief Executive
EDO	Executive Director of Operations
DW	Director of Workforce
ADW	Assistant Director of Workforce
HOD	Head of Organisational Development
HWI &HRS	Head of Workforce Information and Human Resource Systems
RM	Recruitment Manager
QIL	Quality Improvement Lead

Leeds Community Healthcare NHS Trust
Summary of 2017/18 pledges based on Staff survey result . Most retained from last year - 3 retired and 2 new in red

Pledge	Our action	Staff action	What have we done	What more to do
You say you listen but nothing happens. I don't expect all my ideas to be acted upon but I expect feedback.	• Consult you where we can • Listen to your views and always tell you clearly what we are doing as a result • Be honest about the things we cannot change	• Talking to us (emailing us in confidence on address below); • Escalating issues appropriately	• Elsie polls • Staffside feedback • 50 Voices group feedback • Leaders Network feedback	• My manager listens • Create space for Innovation and good ideas • Be open and honest about changes and why
IT hardware isn't good and often lets me down, particularly at weekends. The support team is good but his isn't enough.	• To do the best with the resources we've got • Organise our IT support more effectively • Ensure that password reset software is implemented so people are not "locked out" without access at nights and at weekends	• Becoming confident in the use of your IT • Being open to learn from others and share skills • Using the facilities we have (password reset software)	• IT help/support now available at weekends? • Password reset arrangements in place • IT skills training offers promoted on Elsie • EPR roll-out adapted to give staff more time • wifi nearly all Health Centres	• Still on a journey • Sustain EPR rollout with training and local buddy system .
I'm not always clear who to report unsafe clinical practice to.	• Continue to foster an open, honest, no blame culture • Listen to you if you have any concerns about safe practice • Provide opportunities for you to speak out • Until such time, please alert the Clinical Lead, Medical Director of Chief Executive to highlight concerns	• Always speaking out if you are worried about clinical practice • Talking openly and honestly to managers • Ensuring you understand and use processes for escalation	• Clinical forums within services • Showcase events on best practice • Follow up of learning on incidents within teams • Freedom to Speak Up Guardian appointed	• Continue to promote quality board safety huddles • Clinical and feedback forums sustained and introduced for different staff groups (bands 2 to 4) • Use cultural connections activity
Workloads are often too high. I can't do my best work because of that.	• Continue our work to recruit and retain high quality staff • Look after you to prevent absence and help you back to work in a supportive way • Ensure the right staff, in the right place at the right time using a new e-rostering system • Be open and honest and make sure we talk it through together • Be clear with commissioners • Continue to train people in health coaching methods (you told us this helps)	• Evaluating and reviewing working patterns in your team • Discussing within your team if workload is unequal • Maximising clinical time (patient facing) • Being open to innovation and challenge • Self-responsibility for health and wellbeing • Saying no appropriately if workload not manageable	• Recruitment process sustained and reviewed vacancy control • Health & Wellbeing initiatives and revision of policy (launch March 2017) • E-rostering project roll-out to plan • Regular discussions with commissioner and staff, and Staffside engagement re tendering processes • Health coaching training • Silver command process lead to more explicit prioritisation	• Recruitment • Retention • Workload management in adults and shared awareness • CAMHS workload SALT workload } Service specific • Continue to use learning from silver command • Review skill mix and competencies • Support for writing business cases to commissioners for extra resource • Use library for best evidence • Understand roles and accountabilities
New leaders (clinical and managerial) don't always have enough support. This impacts on them and on me as a member of the team.	• Roll out a new leadership programme from September 2016 onwards • Increase general support to all leaders	• Being open with your managers • Trusting that ours is a supportive culture • Escalating issues appropriately	• LEAD programme offering 24 places Oct – June17 • Leadership network reframed to 'Open space' • Manager as Coach courses available	• Getting better feedback and keep doing Breakfast meetings • Continue to provide support and clarity on expectations • Better induction / better preceptorship /training bespoke

Leeds Community Healthcare NHS Trust
Summary of 2017/18 pledges based on Staff survey result . Most retained from last year - 3 retired and 2 new in red

NEW I am more aware of future direction of the Trust but where does my job fit in the future – bit scared following losing tenders.	• Continue our communication and be open and honest • Stop, discuss, explain, reflect and move on together • Describe and share the exciting new model of care future • Using Engagement star regularly • Demystify the future picture • Deliberate communication plan at both formal and in formal basis • Promote message that clinical skills will always be required • Wraparound structures may change • New recruits to be inspired on the integrated vision • Sell patient benefits	• Placing our 11 essentials at the heart of your practice (1 vision, 3 values, 7 behaviours) • Engaging in the resilience and thankyou activities • Roll out engagement star • Emphasise value of clinical skill set • Sustain integrated model with GPs		
Some of our buildings are not fit for purpose, for me of the people I serve.	• Listen if you have an improvement idea that is legal and affordable • Make your ideas work or tell you why we cannot • Alongside other partner organisations, look across Leeds at how we make the best use of all our buildings and find the best solutions • Involve you and take into account the needs of staff with a disability • Be honest and tell you that we will never have enough parking everywhere	• Being open to change and making better use of space in the future • Working with us to better match the space we need with how we work now and in the future	• Innovation and Research champions and council • Estates Steering Group and estate Stockdale undertaken • Offered open disability meeting and identified 4 disability champions	• Review mileage and how e-expenses working, considered parking issues as they arise and create review group with Staffside • Deliver on what can we do to improve estate based on staff ideas • Connect our health and well-being linkage such as showers
It's hard to make improvements in my working life. The culture is too concerned with saving money and hitting targets (such as waiting lists / appraisals	• Be honest with you and say that many of these targets are ones that we are required to meet • Support innovation and creativity • Work with you create the working environment you want, so that change can happen more flexibly and easily	• Helping us meeting important targets such as shorter waiting lists, staff appraisal • Looking at where you can deliver improvements within your team • Working together to find solutions • Staying focused on 'Our Eleven' so that we hit the target but don't miss the point!	• Business units clear on targets and leadership involved in agreeing improvement plans e.g. appraisal , hidden waits • Innovation and research champions and council • Quality board huddles • Ask Thea and Elsie anonymous suggestions	• E-learning package offered on improvement technologies • Expand use of performance information portal (PIP) and data confidence • What's app groups discuss innovation ideas
I'm from a Black Minority Ethnic (BME) background. I would like more support.	• Continue and expand our BME forum which will hold the organisation to account • Continue the work plan developed by the forum, to ensure BME staff have a good experience of working here •	• Treating everyone as an individual – it's one of our 3 value • Take part in the forums • Caring for one another	• BME forum has met 3 times • Mutual support network created • WRES plan updates • Articles on Elsie about equality topics	• Wider sharing of stories and experience • Sustain emphasis on unconscious bias and access to training • Offer all staff workshops on diversity • make plan to address equality of opportunity in recruitment • Develop LGBTQ work • Reenergise Stonewall activity

The working life you want - pledges

Leeds Community Healthcare NHS Trust
Summary of 2017/18 pledges based on Staff survey result . Most

I have a disability and you don't always support me well enough.	• Continue and expand a disability forum which will hold the organisation to account • Set up a network of disability champions to ensure our estate policy reflects disability issues • Continue to review our return to work policies and ensure more information / support is available to managers	• Treating everyone as an individual – it's one of our 3 values • Take part in the forums • Caring for one another	• Open meetings of Disability Forum • Four Disability champions identified • Attendance policy review and toolkit for managers on return to work	
NEW I don't believe the organisation really cares about my health and wellbeing.	• Describe and promote Staff Support • Review Revised absence management policy • Say thank you - recognise effort • Consider disability leave policy as part of attendance management • Create a culture that expects a lunch break • Sustain clinical supervision • revise carer policy and support offer • Enable protected time for professional development • Publicise impact of new ways of working/agile working and greater flexibility for staff • Create staff events for well-being team lead • Sustain delivery of mindfulness and resilience support • Discuss work life balance overworking and out of hours culture • Assess WHO framework (International Classification of Functioning disability and health) for potential leading to cultural change	• Emphasise caring for one another • Prioritise time for clinical supervision • Consider benefits of menopause support group • Care for each other in supporting development and mentoring • Get explicit agreement on team core hours		

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (13)

Meeting: Trust Board 31 May 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: SMT	**For information**	

Purpose of the report:

This report is part of the governance processes supporting risk management in that it provides a source of assurance about the effectiveness of the risk management processes and that adequate controls 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 risk movement, presents the risk profile and details any risk management activity.

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 three risks scored as extreme risks. One of these risks is a recent escalation. This is Risk 868 (Six-week waiting times breach risk in children's audiology due to reduced clinical staff capacity).

The BAF summary gives an indication of the current assurance level for each strategic risk, based on sources of assurance received and evaluated by committees and the Board.

Recommendations

The Board is recommended to:

- Note the contents of the risk register
- Note the current assurance levels provided in the revised BAF summary

RISK REGISTER AND BOARD ASSURANCE FRAMEWORK (BAF) REPORT

1.0 Purpose of this report

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 March 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 the Board, they have been detailed as they evidence those matters of high risk and are scrutinised closely by the Board. In addition, there is a short summary of those risks scoring 8 or above whether clinical or non-clinical and which are reported at the Quality Committee or Business Committee at each meeting.

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, and risk activity.

1.4 The BAF has been recently revised and this paper 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). Senior Management Team also receives a summary of risks graded 12. In exceptional circumstances, a director can request inclusion of any risk onto the register received by the Board.

2.2 Risks recording a current high or extreme score (8 or above) and designated as clinical risks are reported to the Quality Committee for scrutiny. The Business Committee discharges a similar role in respect of non-clinical risks scoring 8 or above.

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

2.4 As part of the planning cycle, the full content of the BAF has been reviewed alongside the 2017/18 operational plan, by individual directors and then collectively by SMT. SMT has agreed the strategic risks, the controls, and the sources of assurance. The revised BAF template and reporting schedule has been endorsed by the Audit Committee at its meeting on 28 April 2017.

3.0 Summary of current risks scoring 15 or above

3.1 There are three risks with a current score of 15 (extreme) or above on the Trust risk register as at 8 May 2017. These are as follows:

Table 1 Extreme risks (scoring over 15)

Risk ID	Risk description	Risk score	Risk movement
Risk 868 Non-clinical risk	*Six-week waiting list breach risk in children's audiology due to reduced clinical staff capacity.*	15 (extreme)	
Risk 224 Non-clinical risk	*Reduced level of care due to the prevalence of staff sickness in particular services and or across the Trust.*	16 (extreme)	
Risk 872 Non-clinical risk	*Difficulties recruiting to and retaining staff within neighbourhood teams.*	16 (extreme)	

3.2 Full details of these three extreme risks are given in **appendix 1** (risk register extreme risks).

4.0 New or escalated risks (scoring 15+)

4.1 Since the last report to the Board in March 2017, there have been no new risks scoring 15 or more.

4.2 There has been one risk escalated to 15+ since the March 2017 Board report:

Risk ID	Risk description
Risk 868	***Six-week waiting times breach risk in children's audiology due to reduced clinical staff capacity.*** The replacement of a 1.0 WTE B6 clinical audiologist vacant post is currently on hold, with a loss of clinical contact time. The 1.0 wte vacancy represents 25% of the clinical workforce (4.0 wte) at this Band so the impact is very significant. This has been further compounded by a 0.8 WTE B7 retirement on 31December 2016. There is a risk of not having enough staff capacity to meet demand on the service. The impact will be an increase in waiting list length. There is a risk of a breach of 6-week waiting targets and 18-week targets with an impact of

	financial penalties for LCH. There is a risk of a delay in appointment times and identification of hearing loss. The impact will be a delay in intervention for hearing loss. There is a risk of expressions of service dissatisfaction from families and service users and increased complaints received from families with regard to long wait times. The impact will be on the Trust's reputation. There is a risk of not retaining staff due to pressures of work, which will exacerbate the situation. **Recent actions:** Applicants for Band 6 post to be interviewed on 21/04/2017. The likely appointment date to be around 2-3 months. Further mitigations have been put in place to increase capacity: One applicant for the above post has registered with CLaSS and will be interviewed (for CLaSS) on 07/04/2017 with the aim of using in service in an assistant role to help manage the waiting list. A request was sent out by CLaSS manager to all existing registered CLaSS workers for expressions of interest for Band 2 support workers to support audiologists in clinic (will increase capacity). Some interest has been shown already by potential applicants but training would need to be given. Consultant Community Paediatricians also offered some limited dates and may be used as support workers if required. Breach of waiting times has now occurring and a risk of continued breaching remains very high as a time delay will be incurred before CLaSS workers and/or paediatricians can be effectively used.

4.3 No risk descriptions have been refined.

5.0 Closures, consolidation and de-escalation of risks scoring 15+

5.1 There is one deescalated risk, which previously scored 16 (extreme) and is now scored at 9 (high):

Risk ID	Risk description
Risk 893 Non-clinical risk	***Financial and retention implications of amended tax rules for off-payroll contractors.*** The reason for de-escalation is that KPMG conducted some review work to assess the position of two core groups, which were cause for concern. Their conclusion is that the scope of this tax rule means the impact for the Trust is not as great as first thought. Agencies have been advised that the Trust will only accept IR35 compliant agency workers or agency employees. The Trust has notified agencies that there may be delay in payment of invoices. A backlog of invoices may cause financial cash flow issues for small agencies, which may have an impact on the reputation of the Trust and the willingness of agencies to work with the Trust.

5.2 Since the March 2017 Board report there have been no closed risks previously recorded at 15 or above.

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).

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	6
800	Diabetes service backlog waiting list for podiatry - risks exceeding 18 week target.	9	12	3
876	Insufficient nursing resource within the Inclusion Nursing Service	12	12	3
877	Risk of reduced quality of patient care in neighbourhood teams due to need for prioritisation	12	12	6

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). Risk 865 has recently been added to this list as an escalated risk.

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
844	Risk of breach of agency expenditure cap	12	12	4
865	Escalated: Lack of service specification in the Community Sickle Cell & Thalassaemia Service	12	12	3
869	Actual and predicted further overspend on drugs budget in young offender healthcare	**15**	12	3
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

7.0 Summary of all risks currently scoring 8 or above

7.1 The following sections aim to appraise the Board of risks with a current score of 8 (after the application of controls and mitigations) or above.

7.2 Presently the 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 a decrease compared to the 54 risks on the risk register 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 (14) by business unit, logged on the Trust's risk management database (Datix) as at 8 May 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	3	0	**3**
Specialist BU	8	0	**8**
Corporate & HQ	1	0	**1**
Totals by risk severity	**14**	**0**	**14**

7.4 Non-clinical risks scoring 8 or above

7.4.1 There are 28 non-clinical risks by directorates providing operational, corporate and headquarters functions as at 8 May 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	3	0	**3**
Operations	18	1	**19**
Quality and professional development	2	0	**2**
Workforce	2	2	**4**
Totals by risk severity	**25**	**3**	**28**

8.0 Risk profile - all risks

8.1 There are 31 open clinical risks on the Trust's risk register and 49 open non-clinical risks. The total number of risks on the risk register is currently 80. This is a slight decrease compared to the 83 clinical risks reported in the previous in-depth risk register report. The 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	2	5	7	2	0	16
3 - Moderate	3	17	18	7	1	46
2 - Minor	0	8	7	1	1	17
1 - Negligible	0	0	1	0	0	1
Total	5	30	33	10	2	80

9.0 Board Assurance Framework Summary

9.1 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.

9.2 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).

9.3 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.

9.4 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.

9.5 The BAF summary **(appendix 2)** gives an indication of the current assurance level for each strategic risk, based on sources of assurance received and evaluated by committees and the Board, in line with the risk assurance levels described in **appendix 3** (BAF risk assurance levels).

9.6 Since the last BAF report in March 2017, the current level of assurance for the following BAF risks has been adjusted as follows:

- BAF risk 1.1 (relating to the assessment of quality) assurance level is still 'reasonable', however it has moved towards 'limited' as there is a concern about quality assessment processes given that medication issues at Hannah House had not been highlighted prior to the CQC visit.
- BAF risk 2.5 (income and expenditure position) assurance level is now moving towards 'substantial' as the overall financial position is satisfactory.

- BAF risk 3.3 (staff engagement), the assurance level is now cautiously 'reasonable', given the recently published staff survey response rate. Exit interview information is still limited hence, the cautious score.
- BAF risk 4.4 (capacity to deliver planned change programmes) is now cautiously 'reasonable' as there is evidence of a more collaborative approach to projects, better staff engagement and progress against overall project plans.

9.7 Strategic risks 4.1 (responding to changes in commissioning, contracting and planning landscape) and 4.2 (maintaining relationships with stakeholders) have limited information available to indicate the assurance level.

10.0 Risk management activity

10.1 A number of services have been supported to complete risk assessments. Managers new to post who have the responsibility for updating risks on the risk register are being offered individual support and tuition by the Risk Manager.

10.2 In January 2017, an additional requirement was added to the Datix risk register form, for new risks to have a completed risk assessment attached to any newly reported risk. This will ensure that risks are described in their entirety, risk scores are properly considered, and controls and actions are separated appropriately. Ideally, these risk assessments will also draw out the root causes of the hazard, i.e. how the hazard has come about, which will better inform the committees. The Risk Manager will monitor the quality of completed risk assessments and provide guidance and support.

10.3 The spring edition of 'Risky Business' the Trust's risk management newsletter was published and distributed in March 2017. This latest edition draws readers' attention to the risks of not supervising young people in work placements, the risks of not conducting a visual inspection on electrical equipment, the risks of not checking medication before administering it, and a link to an inter-active BBC iWonder session about hot-desking. There are examples of NHS Trusts who have been the victims of IT 'Ransomware' and how our Trust can avoid this. The newsletter also gives a roundup of recent activity within services to reduce risks, including the Specialist Business Unit's method of capturing learning and sharing.

11.0 Impact

11.1 Quality

11.1.1 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.

11.2 Resources

11.2.1 Any financial or other resource implications are identified and managed by the risk owner/lead director responsible for individual risks.

11.3 Risk and assurance

11.3.1 This paper seeks to reassure the Board that there is a robust process in place in the Trust 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.

12 Next steps

12.1 The Risk Manager will continue to monitor risk review dates and remind risk owners of their responsibility to review and update risks appropriately.

12.2 Traditionally, the Quality Committee has been apprised of risks categorised as 'clinical' and the Business Committee apprised of risks deemed 'non-clinical'. It is difficult to categorise many risks as exclusively clinical or non-clinical. An operational risk will often have a clinical impact. The solution to the operational risk will most likely be of interest to the Business Committee, but the management of the potential clinical impact would be better scrutinised by the Quality Committee. In future, risk register reports will inform both committees of risks categorised as 'operational', so that the full extent of the risk can be appreciated. This will take effect from June 2017.

13.0 Reporting schedule

13.1 Set out below is the risk register and BAF reporting schedules to which this report conforms:

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

14.0 Recommendations

14.1 The Board is recommended to:

- Note the contents of the risk register
- Note the current assurance levels provided in the revised BAF summary

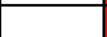
Significant risks (15+)

ID	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	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. 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 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	Adequate	Sourcing short term support via CLASS continues. Small number of internal secondments from children's services continue. Exploring subcontract arrangement to provide dedicated capacity for patients in residential settings. 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. (Updated 07/05/2017)	Extreme	20	Extreme	16	Low	3	30/06/2017
Portfolio: Children's Services													
868	Prince, Sam	09/11/2016	Title: Six-week waiting times breach risk in children's audiology due to reduced clinical staff capacity. There is a risk of not having enough staff capacity, due to vacancies, to meet demand on the service. The impact will be an increase in waiting list length. There is a risk of a breach of 6-week waiting targets and 18-week targets with an impact of financial penalties for LCH. There is a risk of a delay in appointment times and identification of hearing loss. The impact will be a delay in intervention for hearing loss. There is a risk of expressions of service dissatisfaction from families and service users and increased complaints received from families with regard to long wait times. The impact will be on the Trust's reputation. There is a risk of not retaining staff due to pressures of work, which will exacerbate the situation.	Where possible, increase clinical capacity within existing staff resource. However, this capacity is not enough to sustain medium-long term service delivery within 6-week targets.	Poor	Applicant for B6 post has fully registered with CLaSS. No other B2/3 suitable CLaSS support workers that expressed an interest (following CLaSS managers email to all potential CLaSS staff) are able/available to work. Waiting response from Consultant Community Paediatrician for availability on limited dates. Drive to re-configure and skill mix current vacant post (school screener) to allow for better mid-long-term flexibility. (updated 18/04/2017)	High	12	Extreme	15	Medium	4	30/06/2017

Portfolio: Corporate & HQ functions													
224	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.	Limited	New Managing Attendance Policy launch 01/04/2017, with earlier intervention for the management of short term sickness absences. HR run twice weekly drop in-sessions for managers to access for support and guidance. In December 2016, the Executive Director of Operations and Senior HR Manager met with 8 x managers of areas of highest sickness absence to be assured that managers were managing sickness absence appropriately. A similar exercise planned for March 2017. The new nurse-led Occupational Health Provider is in place, which provides more timely and comprehensive support with access to a multi-disciplinary team and includes access to a counselling service. Internal auditors continue to monitor/audit various aspects of attendance management. (updated 20/03/2017)	Extreme	16	Extreme	16	Medium	6	25/05/2017

Board Assurance Framework (summary) 2017-18

Risk		Risk ownership		Risk score				Level of Assurance					
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	⟷			◆		DON report - Meds errors and VTE assessments = Limited. Hannah House issues bring reliability of assessment of quality into question	←
	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	⟷			◆		Remains towards limited as learning from incidents is not currently measurable	
	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.	AT	QC	3	3	9	⟷			◆		CQC visit Hannah House brought out issues around medicines management = Limited. CQC inspection report (Special Educational Needs and Disabilities) = Reasonable	
	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 (was 9)	↓				◆		
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	⟷			◆			
	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	⟷			◆			
	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	⟷			◆			
	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	⟷			◆		No change in available information therefore assurance level remains the same.	
	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 (was 12)	↓				◆	Agency spend = Reasonable. Financial position = Substantial	→

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						Neighbourhood Teams - modest improvement in vacancy position = Reasonable. Retention initiatives outlined in recruitment plan =Limited. Safe staffing levels = Reasonable	
	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						Neighbourhood Teams - modest improvement in sickness levels = Reasonable. Performance brief sickness absence levels +Limited	
	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						Board members visits = Reasonable. Ask Thea = Reasonable. Staff survey response rate = Reasonable. Exit interviews = Limited	
	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							
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 (was 6)						Collaborative approach with commissioners and partnership working described in business reports. Limited information available for assurance level indication.	
	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 (was 8)						There is limited information available for assurance level indication.	
	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						Friends and Family Test (patients) low numbers of patients completing survey =Limited. Non-Executive Directors service visits = Reasonable	
	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						EPR/ new ways of working collaborative approach to aspects of project and staff engagement = Reasonable.	

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 (14)

Meeting: Trust Board 31 May 2017	**Category of paper**	
Report title: Corporate Governance Report	**For approval**	√
Responsible director: Chief Executive **Report author:** Company Secretary	**For assurance**	√
Previously considered by Not applicable	**For information**	

Purpose of the report

This paper covers a number of corporate governance requirements for consideration.

Main issues for consideration

The Trust operates, at all times, within a range of statutory and mandatory regulations and national guidance that together provide a framework for the appropriate governance of the Trust. In the main, these are enacted through the Trust's standing orders, standing financial instructions and scheme of reservation and delegation of powers.

Adherence to this governance framework enables the organisation to demonstrate it is well governed and meets the requirements of corporate governance codes.

In order to ensure that the Board is discharging its role effectively, it should regularly review the components of the governance framework and receive assurances that requirements are being met.

This paper covers a number of annual requirements, including:

- Board and committee effectiveness review
- Audit Committee annual report 2016-17
- Committees' terms of reference review
- Statement of NHS provider licence compliance

Recommendations

The Board is recommended to:

- Note the outcome of the annual review of Board and committees' effectiveness
- Receive the Audit Committee's annual report 2016/17
- Approve changes to the terms of reference of Board sub-committees
- Receive and note the self-certification against required NHS provider licence conditions

Corporate Governance Report: 31 May 2017

1 Purpose of the report

1.1 The purpose of the report is to provide a number of requirements for consideration on an annual or infrequent basis in relation to the effective corporate governance of the Trust.

2 Background

2.1 The Trust operates, at all times, within a range of statutory and mandatory regulations and national guidance that together provide a framework for the appropriate governance of the Trust.

2.2 In the main, these statutes, regulations and guidance are enacted through the Trust's standing orders, standing financial instructions and scheme of reservation and delegation of powers.

2.3 Adherence to this governance framework enables the organisation to demonstrate that it is well governed and meets the requirements of corporate governance codes.

2.4 In order to ensure that the Board is discharging its role effectively, it should regularly review the components of the governance framework and receive assurances that requirements are being met. This paper deals with a range of related assurances.

3 Annual review of Board and committees' effectiveness

3.1 At all levels in the NHS, boards are encouraged to periodically review their own performance in order to build on strengths and to identify areas where there is room for further development in order to draw out the full benefits of the NHS unitary Board model.

3.2 The report at **appendix A** provides a summary of the outcomes from an exercise to review the effectiveness of the non-executive and executive contribution to the Board, Board sub-committees and the wider Trust.

3.3 The report provides information gathered from a Board and committees' effectiveness diagnostic exercise and the results from a Board effectiveness workshop held in March 2017. The outcomes of the review have focused on a number of themes as areas in which the Board should aspire to optimum effectiveness:

- Strong and effective leadership between at Board and amongst committees
- Effective decision-making and accountability for delivery
- Demonstrating values and behaviours
- Strategy development and alignment
- Operational delivery
- Relationships between the Board and committees

3.4 In addition to the themed comments, the report on effectiveness also includes a range of comments attributable to the individual sub-committees.

3.5 The report also sets out a number of areas for development linked to the themes above.

4 Committees' annual reports 2016/17

4.1 The terms of reference of the Trust's Audit Committee require that the committee has oversight of Board sub-committees annual effectiveness process and reviews the adequacy of the governance of the sub-committees. This assurance is given through the provision of an annual report from Board sub-committees to the Audit Committee.

4.2 In turn, the terms of reference for each committee require that the committee's chair submits an annual report to the Audit Committee which demonstrates how the committee has fulfilled its duties as delegated to it by the Trust's Board and as set out in the terms of reference and committee's work plan. The reports provide an overview of the workings of the committees and demonstrate that the committees have complied with the respective terms of reference.

4.3 At the Audit Committee on 28 April 2017, the annual reports for 2016/17 for the following committees were received:

- Quality Committee
- Business Committee
- Charitable Funds Committee
- Nominations and Remuneration Committee

4.4 Each report had been reviewed by the committee's chair and executive lead and by the relevant committee. The reports provided an overview of the workings of the committees and demonstrate that the committees have complied with the respective terms of reference. Sections within each annual report described:

- Duties of the committee
- Membership and attendance
- Review of committee's activities
- Review of effectiveness
- Areas for future development

4.5 In order to complete this cycle of review, the Audit Committee's annual report for 2016/17 is attached **(at appendix B)** for receipt by the Board and demonstrates that the committee has operated in line with its terms of reference and has undertaken a review of its effectiveness. The Trust's external auditors (KPMG) have confirmed the annual report contains all relevant information.

5 Committees' terms of reference

5.1 The Trust's Board has appointed five sub-committees to carry out specific functions and provide assurance that the Trust is carrying out its duties effectively, efficiently and economically (as recorded in standing orders). In March and April 2017, the Trust's sub-committees reviewed their terms of reference as part of their annual review of committee functioning and effectiveness.

5.2 The tables in **appendix C** summarise the changes made in order to amend and update content (the changed text being shown in red). Once approved, an electronic version of the full amended document will be made available to Board members, managers and staff. Use will be made of the Trust's intranet and website to publish the documents.

5.3 In order to reflect the best distribution of Board membership across the committees so that they are able to fully discharge their respective responsibilities, committee membership for 2017/18 is shown in the table below.

	Non-executive directors	Executive directors
Audit Committee	Jane Madeley (chair) Richard Gladman Elaine Taylor-Whilde	
Quality Committee	Dr Tony Dearden (chair) Neil Franklin Elaine Taylor-Whilde	Chief Executive Executive Medical Director Executive Director of Nursing
Business Committee	Brodie Clark (chair) Dr Tony Dearden Richard Gladman	Chief Executive Executive Director of Finance & Resources Director of Workforce
Charitable Funds Committee	Brodie Clark (chair) Neil Franklin	Executive Director of Finance & Resources Executive Director of Nursing
Nominations and Remuneration Committee	Neil Franklin (chair) Brodie Clark Jane Madeley	

5.4 In addition, the Quality Committee has a number of sub-committees, one of which, the Mental Health Act Governance Group, is chaired by a non-executive director; this function rests with Elaine Taylor-Whilde.

6 Compliance with NHS provider licence: self-certification

6.1 The Health and Social Care Act 2012 introduced the requirement for organisations which provide an NHS service to hold a provider licence. Although NHS trusts (which are not NHS foundation trusts) are exempt from holding the NHS provider licence (as required for foundation trusts), from May 2013 to March 2016 NHS trusts were required to report on compliance with the 28 conditions equivalent to the licence on a monthly basis.

6.2 Revised directions from the Secretary of State (effective from 2016/17) now require NHS Improvement to ensure that NHS trusts comply with the licence conditions as it deems appropriate. NHS Improvement's single oversight framework bases its oversight on the NHS provider licence. NHS trusts are therefore legally subject to the equivalent of certain provider licence conditions (including condition G6 and condition FT4) and must self-certify under these licence provisions.

6.3 In particular, providers need to self-certify against the following two conditions after the financial year-end:

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (condition G6) (self-certification required by 31 May 2017)
- The provider has complied with required governance arrangements (condition FT4) (self-certification required by 30 June 2017

6.4 The document attached at **appendix D** is a tabulation showing an assessment of compliance with the provider licence's conditions; including the two conditions (G6 and FT4) against which the Trust is required to self-certify. It should be noted that a limited number of conditions are not applicable as they apply to foundation trusts only. 'NHS Improvement' has been substituted for 'Monitor' in all instances; Monitor, as the former regulator of foundation trusts, was the originator of the provider licence methodology.

6.5 When reviewing the document, the Board will note that the Trust is recording compliance against all applicable conditions. Board members will recall that, when reporting against the conditions in 2015/16, the Trust had previously reported non-compliance against condition G8 in relation to publishing service eligibility and selection criteria. It has now been concluded that the Trust takes all reasonable steps in this regard; the service information available and published is consistent with that made available by other trusts and extending this significantly would require the deployment of significant resource.

7 Recommendations

7.1 The Board is recommended to:

- Note the outcome of the annual review of Board and committees' effectiveness
- Receive the Audit Committee's annual report 2016/17
- Approve changes to the terms of reference of Board sub-committees
- Receive and note the self-certification against required NHS provider licence conditions

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Agenda item 2017-18 (14) Appendix A

Leeds Community Healthcare NHS Trust
Reviewing Board and committees' effectiveness

1.0 Purpose of the report

1.1 The purpose of the report is to provide a summary of the comments received from the review, by Board members, of the effectiveness of the non-executive and executive contribution to the Board, the Board's sub-committees and the wider Trust.

1.2 The sections below provide anonymised information gathered from a Board effectiveness diagnostic exercise and the conclusions from a Board effectiveness workshop

2.0 Background

2.1 By way of context, the purpose of NHS Boards is to govern effectively and in doing so to build patient, public and stakeholder confidence that health and healthcare is in safe hands *(The Healthy NHS Board 2013).* In meeting this purpose the Board has three key roles, to:

- Formulate strategy
- Ensure accountability by holding the organisation to account for the delivery of strategy and through seeking assurance that systems of controls are robust and reliable
- Shape a strong culture for the Board and the organisation

2.2 Building on the exercise undertaken towards the end of 2015/16, the Chair determined that there would be value in reflecting on the effectiveness of the non-executive contribution to the Board, committees and the wider Trust and to consider how non-executive and executive colleagues could further develop as a team to:

- Ensure strong and effective leadership at Board level and throughout the Board sub-committees
- Develop a culture of full and proper personal accountability
- Maintain a strategic perspective
- Ensure the Trust identifies the necessary operational changes to meet the quality and financial sustainability challenge
- Balance risk and opportunity
- Work in a partnership environment

2.3 Two questionnaires were developed to elicit views; one related to Board effectiveness and the second was applicable to committees' effectiveness. The questionnaires comprised 20 statements grouped under the headings of *leadership and accountability* and *strategy development and operational delivery* (Board questionnaire) and *capacity, capability and ways of working* and *conduct of business and effectiveness of decision-making* (committees' questionnaire).

2.4 The questionnaires asked for ratings on a scale of 1 (strongly disagree) to 5 (strongly agree); plus narrative comment on opportunities for change. Responses in the questionnaires remain anonymous and have only been used to distil themes to facilitate discussion.

2.5 The sections below contain high level summary statements from the questionnaire responses. Section 3 has comments related to the Board effectiveness questionnaires and sections 4 to 8 describe the responses relating to the effectiveness of committees. Section 9 draws out areas for development.

3.0 Board questionnaire: themed summary of responses

3.1 Strong and effective leadership at Board and amongst committees

3.1.2 The Board was seen as 'well-led' with strong, visible leadership. Committees were seen to have developed well although the Quality Committee and Charitable Funds Committee were seen as warranting further development. .

3.1.2 All Board members recognised that there was a good level of appropriate skills and expertise around the Board table. However, there was some reflection on whether the alignment of skills and expertise was appropriately matched to the priorities of the Trust and whether the expertise of non-executives was always capitalised on to the best effect.

3.1.3 Respondents felt there was generally good, transparent, open and engaging debate and that this was a strong feature of the Board. There were some observations related to whether discussion was sufficiently focused on the most strategic as opposed to operational issues and whether conclusions from debate translated into actions.

3.1.4 Wider participation in Board meetings was seen as a desirable feature if the potential benefits of contributions from the whole Board membership were to be realised. Individual Board members commenting outside of their own area of expertise was seen as positive and to be encouraged further; this was seen as strong evidence of a unitary board in practice.

3.2 Effective decision-making and accountability for delivery

3.2.1 Respondents commented on the robustness of information to inform decision-making. There was acknowledgement of improvement in this area over the past year; but Board members (particularly non-executive colleagues) also indicated that there was often a considerable volume of data, without enough focused analysis and realistic and achievable actions.

3.2.2 Clarity as to the outcomes from discussions, the identification of actions and the indication of the accountable lead director was seen as an area for continuing development. Both non-executives and executives sought constructive approaches to 'holding the executive to account' whilst recognising the unitary nature of the Board.

3.3 Values and behaviours

3.3.1 Statements relating to the demonstration of the Trust's values and behaviours were scored consistently highly by respondents. The Board demonstrated appropriate challenge, constructive debate and collective responsibility. There was also a strong belief that there needed to be a focus on 'championing' the work of the Trust both externally and internally. The non-executive cohort felt that there was more that they could do in this area.

3.4 Strategy development and alignment

3.4.1 All Board members indicated that the Trust had undertaken further work in reviewing the Trust's overall strategy. Most respondents felt that the vision and strategy would benefit from greater clarity and sharper articulation to enable wider communication and understanding both within the organisation and across the wider health and social care economy.

3.4.2 There was some consideration amongst Board members about the alignment of strategies and whether enabling strategies were fully aligned to service strategy and whether the capacity and capability to deliver strategic aspirations was in place.

3.4.3 Board members indicated that individuals brought appropriate expertise, perspective and challenge to strategy development; the wide range of skills and expertise brought to the Trust by non-executives was seen as an asset. The introduction of workshops as an opportunity for greater engagement in strategy development was welcomed.

3.4.4 The balance between strategic development and operational delivery was seen as improved and this was enabled by the effectiveness of committees which were seen as a balancing mechanism to Board discussions. Board discussions were still seen to reflect operational rather than strategic considerations; often as a result of operational imperatives.

3.5 Operational delivery

3.5.1 There was seen to be ample opportunity for discussion of risks to objectives and the scrutiny of risks and assurances had been significantly improved. A greater focus on risk as part of strategic discussions was welcomed.

3.5.2 Respondents felt that they were generally aware how operational plans and activities linked to the Trust's overall strategy, but an emphasis on rigorous and realistic plans and outcomes should be the aim; with more overt monitoring of progress against objectives.

3.5.3 The meeting of in-year quality and financial challenges was generally seen as a strength; quality and financial challenges were known and addressed. Some respondents identified the need to maintain a focus on evidence-based assurances matched to operational delivery with a focus on greater clarity of actions when assurance was limited.

3.5.4 There was a range of views related to communication. Some respondents felt this was good 'with intelligence delivered early' but some respondents felt there was insufficient 'early warning' on issues.

4.0 Audit Committee questionnaire: summary of responses

4.1 The core purpose and main objectives of the Committee were felt to be clear and described satisfactorily in the Committee's terms of reference. Work planning is appropriate and the standard of papers was seen as good

4.2 The Committee's membership and attendees were seen as demonstrating a good balance of skills and knowledge.

4.3 An outstanding challenge for the Committee was identified as the progressing of audit matters and the need to seek assurance that actions were being undertaken. Slippage on follow-up actions was challenged appropriately.

4.4 The 'flow' of audit reports between Audit Committee and other committees had improved but was not handled in a uniform fashion

5.0 Quality Committee questionnaire: summary of responses

5.1 The Committee had revised its terms of reference and revised the Committee's sub-structure; sub-groups were seen to be developing and there would be some benefit from balanced workplans and agendas.

5.2 The effectiveness of the meeting had continued to improve. Respondents gave some contrasting views about the number, nature and contributions of members and attendees.

5.3 An area for further development for the Committee is to ensure that it 'operates to purpose', focuses on key issues (rather than processes), and strikes the best balance of items requiring detailed scrutiny and more strategic consideration.

5.4 Respondents identified the opportunity to further streamline agendas and supporting documentation to reflect key issues and to avoid duplication of information.

5.5 Recording of actions was noted to have improved. The Committee was keen to see robust improvement actions particularly when assurance was 'limited'.

6.0 Business Committee questionnaire: summary of responses

6.1 The understanding of the Committee's main purpose was felt to be clear.

6.2 The Committee's membership provided a good combination of skills and knowledge and the attendance of non-committee members on specific topics had been a welcome development.

6.3 Reports to the Committee had improved but would further benefit from tighter analysis of facts and data leading to conclusions, solutions and actions. It was felt that discussion generally led to consensus and clear outcomes.

6.4 There was generally robust follow up on actions and reasons for delayed actions or deferred items were made clear. Robust actions were sought on those items seen as providing limited assurance.

7.0 Charitable Funds Committee questionnaire: summary of responses

7.1 The Committee had significantly reviewed its role and function during 2016/17. Revised terms of reference had been developed with the aim of focusing the Committee's work and ensuring 'constancy of message'.

7.2 The executive lead for the Committee had changed during 2016. Members were seen to be continuing to gain skills and knowledge which was constructive in making good known gaps in capacity and capability. The pace of progress continues to be limited by capacity.

7.3 The main performance report was seen to have improved; it facilitated discussion and led to clear decisions and accountability for actions.

8.0 Nominations and Remuneration Committee questionnaire: summary of responses

8.1 The core purpose and main objectives of the Committee were felt to be clear (and with no specific gaps) since revision to the terms of reference; responsibilities had changed during 2016 to reflect the change in the Trust's approach to the approval of policies.

8.2 Members felt that they had the requisite skills and knowledge and, given the specific role of the Committee, the membership was wholly appropriate.

8.3 There were felt to be effective systems and processes within the Committee in relation to agenda setting, production of papers etc; continued emphasis was being applied to the supply of full and appropriate information to inform discussions and decision-making. Committee members felt that scrutiny and challenge was offered appropriately.

9.0 Areas for development

9.1 This section draws some conclusions from the questionnaire responses about areas for continuing development. The main themes emerge as follows:

Leadership, decision-making and accountability for delivery

- Skills and experience utilisation: further use of skills aligned to priorities, particularly in relation to use of non-executive directors' expertise so as to be of greatest benefit to the Trust
- An understanding of the healthy balance of non-executive and executive contributions and roles, particularly in relation to the matter of accountability
- Greater participation and wider contribution by all Board and committees' members and attendees in meetings

- Continued emphasis on the level of analysis contained in Board and committees' papers to inform decision-making (moving from data to informed analysis to conclusions, solutions and actions); improving consistency within and between papers and over time and avoidance of duplication
- Refinement of workplans and agendas to ensure alignment with the Trust's, Board's and committees' objectives and to ensure appropriate assurance can be gained from papers and reports

Values and behaviours

- Full use of opportunities for greater visibility of all directors throughout the organisation; from 'Board to floor'
- Further proactive opportunities to be sought for Board members to advocate the Trust's work, particularly externally
- Further development of public and stakeholder engagement

Strategy development and operational delivery

- Continuing refinement of a clear and well-articulated vision and strategy that can be easily and comprehensively communicated and understood (within the organisation and across the wider health and social care economy)
- Alignment of strategies to ensure coherence between enabling strategies and service strategies and the capacity and capability (resources) to deliver
- Focus on the achievement of strategic objectives; ensuring that Board and committees' reports are aligned to and evidence progress towards objectives
- Planning to be informed by the strategic direction but also by horizon scanning around risks and opportunities
- Maintaining the balance of operational and strategic considerations at Board and committees
- Maintenance of due rigour in relation to decision-making and the implementation of actions; greater clarity and next steps being imperative when assurance is limited

Relationships between the Board and committees

- Greater use of expertise available amongst committees' and Board members
- Continued reinforcement of the distinct functions delegated by the Board to committees to discharge
- Reinforcing the Board's role in examining performance being to reflect on strategic implications to quality, delivery and sustainability

Agenda item 2017-18 (14) Appendix B

Leeds Community Healthcare NHS Trust
Audit Committee: Annual Report 2016/17

1.0 Purpose of the report

1.1 The purpose of the report is to provide a summary of the Audit Committee's activities during 2016/17.

1.2 The terms of reference for the Committee require that the Committee's Chair submits an annual report which demonstrates how the Committee has fulfilled its duties as delegated to it by the Trust's Board and as set out in the terms of reference and the Committee's work plan.

1.3 The sections below describe:

- Duties of the Committee
- Membership and attendance
- Review of Committee's activities
- Review of effectiveness
- Areas for future development

2.0 Background: duties of the Committee

2.1 The Audit Committee is one of five committees established as sub-committees of the Trust's Board and operates under Board approved terms of reference (version 6.1 dated 21 October 2016).

2.2 The Committee is well-established and has been conducting a portfolio of business on behalf of the Board since the establishment of the Trust.

2.3 The Committee provides an overarching governance role and ensures that the work of other committees provides effective and relevant assurance to the Board and the Audit Committee's own scope of work.

2.4 The duties of the committee can be categorised as follows:

- **Governance, risk management and internal control:** reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.
- **Internal audit:** ensuring that there is an effective internal audit function established that meets mandatory NHS internal audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.
- **Counter fraud and security management:** ensuring satisfactory arrangements in place for countering fraud managing security and shall review the annual plan and outcomes of work.
- **External audit:** reviewing the work and findings of the appointed external auditor and considering the implications of and management's responses to their work.

- **Financial reporting and annual accounts review:** including: monitoring the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance; ensuring that systems for financial reporting to the Board are subject to review as to completeness and accuracy of the information provided to the Board; reviewing the annual statutory accounts before they are presented to the board of directors to determine their completeness, objectivity, integrity and accuracy and reviewing all accounting and reporting systems for reporting to the Board.
- **Standing orders, standing financial instructions and standards of business conduct**: reviewing the operation of and proposed changes to the standing orders, standing financial instructions and standards of business conduct, the constitution, codes of conduct and scheme of delegation.

2.5 In February 2017, the Committee approved the establishment of a sub-group to be known as the *Information Governance Group*. The Group will meet every two months and will discharge a range of duties as delegated by the Audit Committee and recorded in a Committee approved set of terms of reference.

3.0 Membership and attendance

3.1 The terms of reference for the Audit Committee set out the Committee's membership which is as follows:

- Three non-executive directors, including one non-executive director with significant, recent and relevant financial experience (one of which serves as the chair of the committee and one as the deputy chair)
    - Jane Madeley (Chair and providing financial experience)
    - Richard Gladman (Deputy Chair)
    - Elaine Taylor-Whilde

3.2 In addition to the membership, the following participants are required to attend meetings:

- Executive Director of Finance and Resources
- Company Secretary
- Internal audit representative (including counter fraud specialist)
- External audit representative

3.3 The Chief Executive attends to discuss: the process for assurance that supports the annual governance statement, the annual report and accounts and the draft internal audit plan.

3.4 In addition, the Chief Executive, other executive directors and senior managers may attend for discussions when the Committee is discussing areas of risk or operational management that are their responsibility.

3.5 The Committee has met formally six times in the last 12 months and has been quorate on all occasions. A table recording attendance is shown below.

Attendee	22 April 2016	13 May 2016	27 May 2016	22 July 2016	21 Oct 2016	7 Dec 2016	17 Feb 2017	Meetings attended
Jane Madeley	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7
Richard Gladman	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7
Elaine Taylor – Whilde	Yes	Yes	No	Yes	Yes	Yes	Yes	6/7
Bryan Machin*	Yes	Yes	Yes	Yes	Yes	Yes	Yes	7/7
Thea Stein*	NA	NA	Yes	NA	NA	NA	NA	1/1

*Director in attendance

3.6 In line with its terms of reference, the Committee has had regular private meetings with auditors prior to each formal meeting. In addition, there was one informal meeting.

4.0 Review of Committee's activities

4.1 The Audit Committee has an approved annual work plan. Topics scheduled for consideration at each meeting reflect a mix of scheduled items drawn from the work plan and occasional further items that have arisen as a result of specific issues brought to the Committee's attention from internal or external sources.

4.2 Governance, risk management and internal control

4.2.1 The Committee reviewed the annual governance statement for 2016/17 prior to its approval by the Board. In considering the statement, the Committee reviewed assurances from a range of sources including: the Head of Internal Audit opinion

4.2.2 Annual reports were received from internal audit, counter fraud, security management and Board sub-committees.

4.2.3 The risk management strategy, policy and procedure was reviewed in December 2015 and approved in April 2016. The revised document separated out procedure from policy and presented a more streamlined description of the process for identifying, assessing and managing risk. Risk management updates are scheduled six monthly and took place in July and December 2016.

4.2.4 The Committee considered the process for and the nature of reporting risks contained within the board assurance framework in July 2016 and in October 2016 approved a new format and reporting structure.

4.2.5 Updates in relation to information governance and performance against the information governance toolkit were considered by the Committee in July and December 2016. The reports describe any matters related to non-compliance with information governance policy. The Trust has received a positive audit opinion and has submitted a self-assessed level 2 compliance score for the end of March 2017.

4.2.6 The Committee has been cognisant of increasing cyber-security risk and has monitored the Trust's arrangements for managing that risk. The Trust asked NHS Digital, through its CareCERT Assure service, to help assess its cyber security measures against industry standards, and provide recommendations to improve data security measures and reduce vulnerabilities. The Committee will continue its focus in this area in 2017/18 and will monitor action in response CareCERT Assure's recommendations.

4.3 Internal audit

4.3.1 The Trust's internal audit service was provided by TIAA Ltd. The Committee reviewed and agreed an annual audit plan for 2016/17. The plan contained 21 areas of audit activity.

4.3.2 In completing the audit plan, the Committee has reviewed a wide-ranging portfolio of reports, considered recommendations, adopted action plans and overseen progress. Topics have included a broad mix of financial, corporate governance and quality topics; some of which are shown below with summary, main recommendations:

- Sickness absence management: instances of non-compliance with notifying and recording of absences
- Staff leavers: reporting of leavers was not always undertaken promptly
- Off payroll contractors: lack of robust policy and procedure
- Hand hygiene: good levels of compliance and excellent practice
- Incidents management: monitoring and implementing of actions and particularly recording and sharing of lessons learnt
- Data quality – end of life: shortfalls in recording indicated training requirements
- Data quality – patient experience: under-reporting of friends and family test results to NHS England website
- Risk management: evidence of adherence to policy and review of risk registers; actions to be more consistently monitored
- Contract bid process: absence of policy and standard operating procedure and business intelligence not fully aligned
- Procurement: significant expenditure outside of 'purchase order' process; thresholds for approval to be reviewed
- Key financial systems: notable improvements in control in year
- SystmOne resilience: limited assurance only as a result of lack of availability and testing of business continuity plans within the Trust and with third party provider

4.3.3 The Audit Committee has ensured that the relevant Board committee is aware of the outcome of all relevant audits and has the opportunity to consider internal audit reports, including the robustness of actions to address recommendations and the associated timescales.

4.4 Counter fraud and security management

4.4.1 The Committee received the local counter fraud annual report and the security management annual report in July 2016. There have been regular updates on progress against the counter fraud plan for 2016/17 which have, in addition to noting local counter fraud activity, introduced lessons learnt from fraud incidents from elsewhere.

4.5 External audit

4.5.1 The ISA 260 external audit opinion was presented in May 2016, detailing the external auditors' work in relation to use of resources and the annual accounts.

4.5.2 The Committee received the annual audit letter in July 2016. This reported an unqualified opinion on the Trust's 2015/16 financial statements, along with a statement confirming that there were no matters arising and that an unqualified group audit assurance certificate had been issued.

4.5.3 Regular technical updates have been provided to the Committee to highlight those issues that impact on the NHS and to which the Trust should be aware.

4.5.4 New national arrangements related to the appointment of external auditors came into force during 2016 and required NHS trusts to appoint external auditors from 2017/18. The Trust established an 'auditor panel' to advise on the appointment of its external auditors. The Trust carried out a competitive procurement process and appointed KPMG as the Trust's external auditors with effect from 1 April 2017.

4.6 Financial reporting and annual accounts review

4.6.1 In line with its work plan, the Committee reviewed the annual report and accounts in detail in May 2016 prior to recommending the annual report and accounts to the Board for approval.

4.6.2 The Committee reviewed the charitable funds annual report and accounts in July 2016 prior to approval by the Charitable Funds Committee.

4.6.3 The Committee also discharged a number of further aspects of financial reporting, including: schedules of debtors and creditors, losses and special payments and overpayments and underpayments.

4.7 Standing orders, standing financial instructions and standards of business conduct

4.7.1 The Committee has approved a full set of amendments to standing orders, reservation and delegation of powers and standing financial instructions in July 2016. Changes reflected: national good governance guidance, new regulations, changes in NHS structure and local changes such as amendments to procurement processes.

4.7.2 The Committee noted a number of waivers to tendering procedures and reviewed the register of gifts and hospitality.

5.0 Assessment of Committee's effectiveness

5.1 All members of the Committee were invited to complete a self-assessment questionnaire including rating elements of performance. The main points raised were as follows:

5.2 Capacity, capability and ways of working

- The core purpose and main objectives of the Committee were felt to be clear and described satisfactorily in the Committee's terms of reference
- The addition of the information governance sub-group was welcomed
- The membership and attendees were appropriate with a good balance of skills and knowledge being displayed
- On occasions, there was a delay in progressing matters due to the appropriate executive not being in attendance; such situations should be assessed in advance and assurance sought that actions were being undertaken
- The 'flow' of audit reports between Audit committee and other committees had improved but was not handled in a uniform fashion
- The wide range of views and contributions were valued and welcomed and behaviours were felt to be appropriate
- There was an appropriate level of support and challenge provided by members

5.3 Conduct of business and effectiveness of decision-making

- Agenda setting flowed satisfactorily from work plan and minutes were well-recorded
- The quality of reports presented to the Committee was seen to be good
- Follow-up on actions was seen as variable but delays and slippage were always challenged
- Greater ownership and engagement by executives in following up audit outcomes was a welcomed development in 2016/17; greater input or attendance from executives in priority areas was to be further considered
- There was an improving level of understanding between committees; the blend of membership providing clear linkage between sub-committees and the Board.

6.0 Future developments

6.1 Whilst acknowledging that there is an existing work plan for 2016/17, the following changes are to be implemented.

Action
Seek opportunities for triangulation of information with committees, through: o Cross-representation o Key issues reports to Board o Committees' chairs meetings
Review work plan ensuring sufficient time is given to key issues at an appropriate frequency
Ensure that draft internal audit reports are received reviewed and amended in a timely manner
Sustain robust follow up of actions ensuring greater input or attendance from executives in priority areas particularly when assurance is limited
Ensure that all completed audit reports are noted by the relevant committee
Induct new committee member

7.0 Recommendation

7.1 The Committee is asked to receive the report and approve its content.

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Leeds Community Healthcare NHS Trust
Changes to committees' terms of reference

The tables below summarise the changes made in order to amend and update content (the changed text being shown in red).

Quality Committee	
Section	**Change**

7.4	The Committee is authorised by the Board to establish such sub-groups (duly constituted and operating within approved terms of reference) as it deems necessary to discharge responsibilities of the Committee. Those sub-groups currently constituted are:
	• Mental Health Act Governance Group
	• Clinical Effectiveness Group
	  o Learning and Development Group
	• Patient Safety and Experience Group
	  o Infection, Prevention and Control Group
	• Mortality Surveillance Group
	• Safeguarding Children and Adults Group

8.1.2	To approve and oversee an annual programme of clinical audit
8.1.6	To receive reports (in full or summary) from internal audits which relate to the responsibilities of the Committee.
10.2	The Audit Committee will monitor the effectiveness of the Committee through receipt of an annual report in accordance with best practice. The Quality Committee will review the effectiveness of such sub-groups as established by the Committee.

Business Committee	
Section	**Change**
8.2.1	• Provide assurance that the finance and performance reporting systems of the organisation are robust through detailed review of the ~~integrated performance report~~ performance brief and domain reports at each meeting. • Keep the content of the ~~integrated performance report~~ performance brief and domain reports under review ensuring that it provides appropriate performance metrics to provide assurance to the Board on all aspects of organisational performance in line with strategic goals and corporate objectives. • Receive highlight reports from each of the designated significant projects and provide oversight of project performance undertaking in depth scrutiny as appropriate • Receive reports (in full or summary) from internal audits which relate to the responsibilities of the Committee.

Charitable Funds Committee	
Section	**Change**
3.1	The Charitable Funds Committee's membership will be: • Two non-executive directors (one of whom will Chair the Committee; the second will cover as Deputy Chair)) • Executive Director of Finance and Resources • Executive Director of Nursing
4.1	The ~~Executive Director of Nursing and the~~ Membership and Involvement Manager will attend the meeting.

Nominations and Remuneration Committee	
Section	**Change**
3.3	Other directors or senior managers may be invited to attend (at the discretion of the Chair) as appropriate.
	A number of references to NHS Trust Development Authority were changed to NHS Improvement.

Audit Committee	
Section	**Change**
7.4	The Committee is authorised by the Board to establish such sub-groups (duly constituted and operating within approved terms of reference) as it deems necessary to discharge responsibilities of the Committee. The Committee will receive minutes from the sub-group, receive papers on any matters escalated to the Committee and periodically review the effectiveness of the sub-group in discharging its delegated responsibilities. The sub-group currently constituted is: • Information Governance Group

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Appendix C

Leeds Community Healthcare NHS Trust
NHS Provider Licence: compliance assessment

Section 1: general conditions

Condition	**Compliance**
G1: Provision of information *The Licensee shall furnish such information and documents, and shall prepare or procure and furnish to NHS Improvement such reports as NHS Improvement may require.*	The Trust has systems and processes in place to ensure compliance with all information requests whether routine, regular or ad-hoc in such form as requested and in a timely manner.
G2: Publication of information *The Licensee shall comply with any direction from NHS Improvement to publish information about health care services, in a manner that is accessible to the public.*	The Trust determines that it is compliant with this condition. Wide variety of routine information published on website and in hard copy documents, including: Board and associated papers; annual reports and information and advice to the public and referrers about services. The Trust is committed to openness and making information available in accessible formats.
G3: Payment of fees to NHS Improvement *The Act gives NHS Improvement the ability to charge fees, the Licensee shall pay all fees to NHS Improvement in each financial year of such an amount as NHS Improvement may determine.*	Not applicable. Fee requirement did not transfer from Monitor to NHS Improvement The Trust pays all other fees as due (eg to the Care Quality Commission and to NHS Resolution).
G4: Fit and proper persons *The Licensee shall ensure that no person who is unfit may become or continue as a governor (FTs only) or as a director. The Licensee shall not appoint as a director any person who is an unfit person.*	Full compliance with requirements reported to Board 31 March 2017. On appointment and annually thereafter, all directors are subject to a fit and proper persons' declaration process. Information is validated externally where possible. All directors complete an annual declaration of interests' statement.
G5: NHS Improvement guidance *The Licensee shall at all times have regard to guidance issued by NHS Improvement.*	The Trust complies with this requirement and has full regard to guidance as promulgated. Guidance notified to the Trust is reviewed on receipt by the relevant director and a lead is assigned in accordance with subject matter to enact the guidance as appropriate.

Section 1: general conditions contd.

Condition	Compliance
G6: Systems for compliance with licence conditions and related obligations *The Licensee shall take all reasonable precautions against the risk of failure to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have regard to the NHS Constitution, including: processes and systems to identify risk and guard against occurrence and regular review of the effectiveness of these processes and systems* *The Licensee must self-certify that:* *'Following a review, the directors of the Licensee are satisfied that, in the financial year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have regard to the NHS Constitution.'*	The Trust is compliant with requirements to take all necessary steps to manage the risk of failure to comply with conditions; there are robust processes are in place to identify risks to compliance. Strategic and operational risks of failure to comply with aspects of the licence are scrutinised at Board, Board sub-committee and executive director levels. In 2016/17, the Trust re-structured and revised the board assurance framework including: identification of strategic risks that would otherwise impede delivery of Trust's objectives. The Board and sub-committees receive reports in order to gain assurance that strategic risks are being managed. In 2016/17, the Trust revised its risk management policy and procedure; oversight of effectiveness of risk management processes occurs through receipt of reports to Board and sub-committees. The Trust's risk appetite statement describes parameters within which risk is managed. The effectiveness of risk management and assurance processes has been audited and gained an opinion of reasonable assurance.
G7: Registration with the Care Quality Commission *The Licensee shall at all times be registered with the Care Quality Commission.*	The Trust is fully compliant. The Trust is registered without conditions. Current rating is 'requires improvement'. The outcome from a re-inspection January 2017 is awaited. The Trust has a quality governance approach including quality assessment visits which is fully aligned to the Care Quality Commission's domains.
G8:Patient eligibility and selection criteria *Licence holders are required to set transparent eligibility and selection criteria for patients and apply these in a transparent manner.*	Having previously reported as not being fully compliant, the Trust now concludes that it is compliant with this licence condition. Service information is published on the Trust's website and in patient information. Service eligibility and selection information is detailed in service specifications and is available readily to 'Choose and Book' referrers. The Trust has investigated the potential for extending service information published on NHS Choices and this is not to be pursued. Having reviewed service information published by a sample of other trusts, the Trust's published material is entirely comparable to that available from other trusts.
G9: Application of Section 5 (continuity of services) *The condition applies where the Licensee is subject to a contractual obligation to provide a commissioner requested service and relates to maintenance of continuity of services.*	The Trust is aware of services which the commissioners deem to be commissioner requested services; also known as essential services. Trust achieves good level of compliance with commissioned contractual requirements. Contract management arrangements between the Trust and its commissioners provide oversight of service delivery in line with contractual requirements.

Section 2: Pricing

Condition	**Compliance**
P1: Recording of information *The Licensee shall obtain, record and maintain sufficient information about costs of providing services.*	The Trust meets this condition. Finance systems and processes are set up to meet all internal and external reporting requirements. Board approved annual budgets and financial plan in place. Reference costs are reported annually.
P2: Provision of information *The Licensee shall furnish to NHS Improvement such information and documents, and shall prepare or procure and furnish to NHS Improvement such reports, as NHS Improvement may require.*	Trust complies with all requests to supply information as requested. The information collected and recorded in relation to condition P1 is made available as requested.
P3: Assurance report on submissions to NHS Improvement *If required by NHS Improvement, the Licensee shall, as soon as reasonably practicable, obtain and submit to NHS Improvement an assurance report in relation to the accuracy of costing and pricing.*	Trust will fully comply with any such request as and when the requirement arose. Third party assurance provided periodically for example by internal audit on reference costs in 2017/18.
P4: Compliance with national tariff *The Licensee shall only provide health care services for the NHS at prices which comply with, or are determined in accordance with, the national tariff.*	This condition is not generally applicable to community trusts. The Trust only provides one service which is part of the national tariff with which it is fully compliant.
P5: Constructive engagement concerning local tariff modifications *The Act allows for local modifications to prices. The Licensee shall engage constructively with commissioners to reach agreement locally.*	Not applicable. The Trust operates under a block contract. Only one service is subject to national tariff and is supplied at national tariff.

Section 3: Choice and competition

Condition	**Compliance**
C1: The right of patients to make choices *The Licensee shall ensure that at every point where a person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by commissioners, he or she is notified of that choice and told where information can be found.*	The Trust is compliant and offers choice where applicable. Choice and 'choose and book' approaches in place in relation to applicable services, namely those described as 18 week reportable services.
C2: Competition oversight *The Licensee shall not enter into or maintain any agreement or other arrangement which has the object or which has (or would be likely to have) the effect of preventing, restricting or distorting completion in the provision of health care.*	The Trust would pursue service opportunities within statutory and accepted procurement, bidding and contracting practices; this ensures that competition is not prevented, restricted or distorted by the Trust. Procurement and contract bid processes have been the subject of internal audits. No compliance issues identified.

Section 4: Integrated care

Condition	**Compliance**
IC1: Provision of integrated care *The Licensee shall not do anything that would reasonably be regarded as against the interests of people who use health care services for the purposes of the NHS to be integrated with the provision of such services.*	Fully compliant. The Trust is a significant leader in the development of integrated care approaches as reflected by the role played in the STP, Leeds Plan, the development of new models of care and initiatives to effect closer integration. Actions falling to the Trust are captured in the Trust's operational plan 2017/18. Stakeholder engagement underpins the development of integrated approaches.

Section 5: Continuity of services

Condition	**Compliance**
COS1: Continuing provision of commissioner requested services *The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any commissioner requested service except where permitted to do so in the contract.*	Fully compliant Contract management arrangements in place between the Trust and its commissioners; any material changes agreed through contract management board. Trust achieves good level of compliance with commissioned contractual requirements including those services deemed to be commissioner requested services. Contracts and service specifications are in place and as agreed with commissioners.
COS2: Restriction on the disposal of assets *The Licensee shall establish, maintain and keep up to date, an asset register of assets relevant to commissioner requested services and have due regard to consent before disposal.*	No compliance issues identified in the disposal of assets related to commissioner requested services without consent of NHS Improvement. Asset register processes have been the subject of scrutiny by internal and external audit.
COS3: Standards of corporate governance and financial management *The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as:* *(a) suitable for a provider of the commissioner requested service provided by the Licensee, and* *(b) providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern.*	The Trust has robust systems for corporate and financial management including standing orders, standing financial instructions, and schemes of reservation and delegation of powers (revised and re-approved in 2016). Compliance is monitored through Audit Committee, recorded in the annual governance statement and 'going concern statement' and has been subject to internal and external audit.
COS4: Undertaking from the ultimate controller *The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee.*	Not applicable.
COS5: Risk pool levy *The Licensee shall pay any sums required to be paid in consequence of any requirement imposed on providers by way of a levy.*	Not applicable. No NHS Improvement risk pool levy system in place. The Trust would comply with this condition when any requirement arose. The Trust participates in NHS Resolution's clinical negligence scheme for trusts.

COS6: Co-operation in the event of financial stress *The Licensee shall provide such information as NHS Improvement may direct and co-operate with such persons as NHS Improvement may appoint to assist in the management of the Licensee's affairs, business and property.*	The Trust would comply with this condition as and when any requirement arose.
COS7: Availability of resources *The Licensee shall at all times act in a manner calculated to secure that it has, or has access to the required resources.*	Fully compliant. Compliance is evidenced through: annual contract negotiations, approval of operational plan for 2017/18 and associated financial plan and annual budgets, approval of going concern statement and regular monthly monitoring of performance against plan.

Section 6: NHS foundation trust conditions

Condition	**Compliance**
FT1: Information to update the register of NHS foundation trusts *The Licensee shall ensure that NHS Improvement has available to it written and electronic copies of the following documents:* *(a) the current version of the Licensee's constitution;* *(b) the Licensee's most recently published annual accounts and any report of the auditor on them, and* *(c) the Licensee's most recently published annual report*	Compliant where applicable. All information as required to be supplied to NHS Improvement from NHS trusts supplied in accordance with requirements. Constitution applies to foundation trusts only.
FT2: Payment to NHS Improvement in respect of registration and related costs *The Licensee must pay NHS Improvement a fee in respect of NHS Improvement's exercise of its functions.*	Applicable to foundation trusts only.
FT3: Provision of information to advisory panel *The Licensee shall comply with any request for information or advice made of it.*	Not applicable. Advisory panel provisions apply to governors of foundation trusts only.

Section 6: NHS foundation trust conditions continued

Condition	**Compliance**
FT4: NHS foundation trust governance arrangements 1. *The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health services to the NHS.*	The Trust is fully compliant. The Trust develops an annual governance statement which is scrutinised by Board sub-committees prior to Board approval (31 March 2017). The annual governance statement is reviewed by internal and external auditors as part of the process for finalising the Trust's report and accounts. The Trust has satisfactory opinion reports from the Head of Internal Audit (TIAA Limited) and from the Trust's external auditors (KPMG) The Trust operates at all times within a framework of standing orders, standing financial instructions, and schemes of reservation and delegation of powers (revised and re-approved in 2016) and approved policies and procedures.
2. The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.	The Trust's governance arrangements are developed with due regard of all guidance as issued from time to time.
3. The Board is satisfied that the Licensee has established and implements: *(a) Effective Board and Committee structures* *(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees* *(c) Clear reporting lines and accountabilities throughout its organisation.*	The Trust has a fully constituted Board and five sub-committees. The terms of reference for all committees have been reviewed in early 2017; ensuring appropriate membership, lines of accountability and clear areas of delegated responsibility. The Board and committees operate to annual cycles of business. Board and committee effectiveness is reviewed annually (and reported to Board). Each committee produces an annual report. There is a robust process for recording assurances provided by committees to the Board against matters contained in the board assurance framework.

4.The Board is satisfied that the Licensee has established and effectively implemented systems and/or processes: *(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively* *(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations* *(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions* *(d) For effective financial decision-making, management and control including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern* *(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making* *(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence* *(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery* *(h) To ensure compliance with all applicable legal requirements.*	Review and approval of operational plan 2017/18 involved consideration of key areas of risk in respect of quality of services and financial performance (as recorded in board assurance framework). Areas of risk have been reported to Board through risk assurance reports and monitoring of operational plan; the latter having been considered in detail by the Trust's Quality and Business Committees. Assurances are provided by committees to the Board against matters contained in the board assurance framework. Performance management framework allows the timely monitoring of main operational clinical and financial indicators. Performance reporting is fully aligned to Care Quality Commission's five domains. Monthly performance data (quality, activity and financial) is reported to the sub-committees and Board for scrutiny. There are also regular reports on key issues (eg patient safety, clinical effectiveness, patient experience, demand and capacity, recruitment and retention etc). Monthly finance reports track actual performance against plan. An annual 'going concern' review is undertaken by Audit Committee and approved by Board (31 March 2017). Quality priorities are recorded in Trust's Quality Strategy. Actions to enhance quality are contained in improvement plans; performance against which is monitored by Quality Committee and Board. Care Quality Commission inspection in 2014 indicated 'requires improvement'; results are awaited from further inspection in January 2017. Standing orders, standing financial instructions, and schemes of reservation and delegation of powers in place, revisions approved in 2016. Monthly performance and finance reports to Business Committee and Board. Audit Committee provide oversight of systems of internal control including efficacy of financial reporting. Risk management policy and procedure, risk appetite statement and board assurance framework all revised in 2016. Board assurance framework updated in 2017 to align with operational plan 2017/18. Timely and robust risk reporting processes in place with scheduled reports to committees and Board.

	A programme of internal and external audit is in place aligned to principal risks. Annual business planning cycle produces operational plans aligned with external strategy (STP and Leeds Plan) and commissioner plans. Business Committee and Board receive progress reports on delivery of plan.
5. The Board is satisfied that that the systems and/ or processes referred to in paragraph 4 (above) should include the but not be restricted to systems and /or processes to ensure: *(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided* *(b) That the Board's planning and decision making processes take timely and appropriate account of care considerations* *(c) The collection of accurate , comprehensive, timely and up to date information on quality of care* *(d) That the Board receives and takes into account accurate , comprehensive, timely and up to date information of the quality of care* *(e) That the Licensee , including its Board, actively engages on quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.*	All Board posts filled. Strong complementary skill sets amongst non-executive and executive Board members. Clear distinction of 'portfolios' whilst remaining fully operational as a unitary board. Essential leadership of quality agenda by medical and nursing directors. Board approved quality strategy sets out strategic action areas enacted through action plans and monitored through quality and safety reports to Quality Committee and Board. Quality account, quality challenge and clinical audit programme all require measurement, evaluation and reporting of essential quality data. Internal audit investigations on data quality have indicated reasonable assurance in all instances. Board has self-assessed against the (former) quality governance assurance framework and well-led framework and completed aligned action plans. Active programme of Board members engagement with services through visits and leadership of initiatives. There are multiple means to raise concerns related to quality of care including stakeholder meetings, staff forums and 'freedom to speak up' activities

6. *The Board is satisfied that there are systems in place to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of the NHS provider licence.*	Fully constituted Board and committees each with full and active membership. Ongoing Board development including range and balance of skills. Full line management structure linked to each executive director's portfolio. Board fully appraised of workforce indicators, including: compliance with safe staffing ratios, vacancy rates, staff turnover, retention, agency staff deployment, sickness absence, appraisal rates, professional revalidation and training compliance. Business Committee has oversight of workforce issues; extensive consideration of areas of challenge (eg recruitment and retention in clinical services).

Leeds Community Healthcare NHS Trust

Trust Board public workplan 2016 -17
Version 8 27 April 2017

Agenda item 2017-18 (15)

Topic	Frequency	Lead officer	2 December 2016	3 February 2017	31 March 2017	31 May 2017	4 August 2017	6 October 2017	1 December 2017
Preliminary business									
Minutes of previous meeting	every meeting	CS	X	X	X	X	X	X	X
Action log	every meeting	CS	X	X	X	X	X	X	X
Committee's assurance reports	every meeting	CELs	X	X	X	X	X	X	X
Patient story	every meeting	EDN	X	X	X	X	X	X	X
Quality and delivery									
Chief Executive's report	every meeting	CE	X	X	X	X	X	X	X
Performance Brief	every meeting	EDFR	X	X	X	X	X	X	X
Operational plan including financial plan	2 x year	EDFR	Draft considered in private		X	X		X	
Care Quality Commission inspection reports	as required	EMD		X					
Quality account	annual	EDN				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	
Emergency preparedness and resilence report and major incident plan	annual	EDO						X	
Patient experience: complaints and incidents report	2 x year	EDN	X			X			X
Freedom to speak up annual report	annual	CE					X		
Guardian for safe working hours report	4 x year	EMD					X		X
Safeguarding annual report	annual	EDN						X	
Equality annual report	annual	EDN	X						X
Strategy									
Service strategy	as required	EDFR	X						
Quality strategy	annual	EDN		X					
OD strategy	2 x year	DW			X	X		X	
Research and development strategy	annual	EMD					X		
Other strategic developments	as required	EDO							
Governance									
Well-led framework	2 x year	CS				X CE 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		X		
Annual governance statement	annual	CS			X	X			
Going concern statement	annual	EDFR			X				
Committee terms of reference	annual	CS				X	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	X
Significant risks and risk assurance report	every meeting	CS	X	X	X	X	X	X	X
Corporate governance update	As required	CS	X		X	X			
Decisions for ratification	as required	CS	X						
Reports									
Approved minutes of committees, Safeguarding Boards, Health and Wellbeing Board, Children's Trust Board	every meeting	CS	X	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

Leeds Community Healthcare NHS Trust

Audit Committee

Boardroom, Stockdale House, Headingley Office Park, Victoria Road, Leeds, LS6 1PF
Friday 17 February 2017
9.00 am – 12.00noon

Agenda item 2017-18 (16a)

Present:	Jane Madeley (JM)	Chair
	Richard Gladman (RG)	Non-Executive Director
	Elaine Taylor-Whilde (ET-W)	Non-Executive Director
In Attendance:	Bryan Machin	Executive Director of Finance and Resources
	Vanessa Manning	Company Secretary
	Jackie Rae	External Audit Manager (KPMG)
	Peter Harrison	Head of Internal Audit (TIAA Limited)
	Tim Norris	Internal Audit Manager (TIAA Limited)
	Beric Dawson	Counter Fraud Specialist (TIAA Limited)
Observer:	Mohammed Hussain	Insight Programme participant
Minutes:	Liz Thornton	Board Administrator

Item	Discussion Points	Action
2016-17 (50)	**Welcome, introductions and preliminary business** The Chair welcomed members and others in attendance.	
2016-17 (50a)	**Apologies** Apologies were received from Clare Partridge, External Audit Partner (KPMG).	
2016-17 (50b)	**Declarations of interest** There were no declarations of interest.	
2016-17 (50c)	**Minutes of the previous meeting 9 December 2016** The minutes of the meeting held on 9 December 2016 were reviewed and agreed as an accurate record. **Outcome:** The Committee approved the minutes of the previous meeting held on 9 December 2016.	
2016-17 (50d)	**Matters arising and actions' log** The following outstanding action were discussed and an update provided: **2016-17(41a): Progress against annual plan 2016/17** The Executive Director of Finance and Resources confirmed that a further audit to replace the audit on CQC compliance was scheduled for quarter 4. **2016-17(41b): Internal audit recommendations update- audit on data quality** The Executive Director of Finance and Resources advised that he was seeking clarity on the current practice in terms of recording activity and would report back to members of the Committee by e-mail following the meeting.	

	Action: The Executive Director of Finance and Resources to provide clarity on the current practice on recording activity. **2016-17(41b): External Audit technical update–development of Vanguards** The External Audit Manager advised that she was still exploring what information could be shared in relation to the progress and development of 'vanguards' a further update would be provided at the next meeting. **Action:** The External Audit Manager to identify any information that could be shared with the Committee in relation to the progress and development of 'vanguards'. **2016-17(42a): Information governance report – serious incidents** The Executive Director of Finance and Resources said that he was confident that role based data protection training was being progressed throughout the Trust but undertook to confirm this to Committee members by e-mail following the meeting. **Action:** The Executive Director of Finance and Resources clarify the position on role based data protection training.	**Executive Director of Finance and Resources** **External Audit Manager** **Executive Director of Finance and Resources**
2016-17 (51a)	**Internal Audit** **Summary of internal controls assurance report** The Internal Audit Manager introduced the report and advised that eight reviews had been completed since the Committee's last meeting on 9 December 2016. There were six audits with a reasonable assurance opinion, one had a limited assurance opinion and one was a status update report. These reports were received by the Committee. **Progress against the annual plan for 2016/17** The Internal Audit Manager introduced the report; particularly noting that good progress had been made on the remaining reports due for quarter three and that he was confident that the remaining audits for quarter four were on target for completion by the end of the year The Chair observed that there remained a significant amount of work to progress during March 2017 to ensure that the outstanding reports were completed on time. The Internal Audit Manager said that good co-operation and partnership working was in place with the executive leads and service managers and he was confident that processes were in place to ensure timely completion of the remaining internal audit reports for 2016-17. The Chair referred to the table of completed audits and asked whether the appropriate sub committees of the Trust Board had been sighted on those recently completed audits. The Company Secretary advised that processes were in place to ensure that the committees were sighted on the appropriate internal audit reports. The timing of meetings and publication of final reports meant that (by exception) some internal audit reports might be seen seen by the Audit Committee prior to scrutiny by the Business or Quality Committees but in the normal course of business this was not the case. The Committee discussed the executive summary and management action plans for the audits finalised since the last meeting.	

	Key financial systems A Non-Executive Director (ET-W) asked about progress on the review of procedures relating to the removal of access rights to Oracle for staff leavers. The Executive Director of Finance and Resources said that procedures had been reviewed and a robust system was now in place to ensure that checks were made by a senior officer when staff left the Trust. *Pressure ulcers* The Chair of the Committee questioned the justification for the reasonable level of assurance for this audit given the number of key findings. In particular she highlighted the 50/50 split between investigations carried out in line with the policy and procedures and those investigations that were not of the required standard and the inconsistency in pressure ulcer reporting across the Trust. In response to the Chair, the Internal Audit Manager said that the overall assurance assessment had taken account of the strategies in place to manage and reduce the number of avoidable pressure ulcers, including: improved training, the establishment of pressure ulcer panels and a review of the pressure ulcer prevention and management policy. He said that a more detailed narrative could be included in future reports to justify the level of assurance given. **Action:** The Internal Audit Manager to include more detailed narrative relating to the level of assurance in future reports. A Non-Executive Director ET-W advised that the Quality Committee received regular reports on serious incidents including pressure ulcers and there had been progress in relation to the incidence of pressure ulcers with harm. She said that an action plan had been developed which was regularly reviewed for effectiveness and impact. Discussions in the Quality Committee would continue to focus on reducing the incidence of avoidable pressure ulcers. *SystmOne service resilience* The Chair of the Committee noted the limited level of assurance given, the key findings and the number of urgent and important actions. She observed that given the complexity surrounding the recommendations and the associated management comments, it would be helpful for the Assistant Director of Business Intelligence, Systems and IT to attend the next Committee meeting on 28 April 2017 to present a more detailed progress update. **Action:** The Executive Director of Finance and Resources to invite Assistant Director of Business Intelligence, Systems and IT to attend Committee meeting on 28 April 2017 to present a more detailed progress update on SystmOne resilience. *Sickness and absence* The Chair of the Committee noted the reasonable level of assurance given for the audit and probed around the rationale behind it given that sickness absence levels continue to be identified as an extreme risk for the Trust. The Internal Audit Manager advised that a reasonable level of assurance had been given based on evidence as to how the current sickness absence policy was applied and the processes undertaken by line managers rather than an assessment based purely on the levels of sickness absence across the Trust. The Executive Director of Finance and Resources advised that the Business Committee would continue to focus on the level of sickness absence and would	**Internal Audit Manager** **Executive Director of Finance and Resources**

	receive reports on the implementation and effectiveness of the new sickness absence policy which was due to be introduced in April 2017.	
2016-17 (51b)	**Internal audit recommendations update** The Executive Director of Finance and Resources presented the report. He referred to the summary report for all internal audit recommendations that had an agreed implementation date by 20 January 2017 and the more detailed report on the outstanding actions. He noted that there were eight recommendations to report this month that had not been completed by the due date. The overdue recommendations were reported in detail with an update on progress from the responsible manager; the current position had been RAG rated which indicated whether the action was considered completed or that the required action had not progressed sufficiently. He added that overdue recommendations had been reviewed by SMT. The Committee discussed the overdue recommendations. Referring to the audit of cyber security the Chair of the Committee proposed that the Assistant Director of Business Intelligence, Systems and IT should provide a further update on the outcome of the planned penetration testing at the next Committee meeting on 28 April 2017. **Action:** The Executive Director of Finance and Resources to invite Assistant Director of Business Intelligence, Systems and IT to attend the next Committee meeting on 28 April 2017 to present an update on the outcome of the planned penetration testing. **Outcome:** The internal audit update report was received and the contents noted. Including progress against the internal audit recommendations.	**Executive Director of Finance and Resources**
2016-17 (51c)	**Internal audit follow-up: procurement** The Executive Director of Finance and Resources introduced the report which provided information on a range of procurement matters requested by the Audit Committee at the meeting on 9 December 2016. He advised that following a recent internal audit report, he had reviewed the tender and quotation delegated limits. The report included the rationale for proposing the following changes to the current system and authorisation limits: • a purchase order will be required for any expenditure up to £5,000 • a quotation and purchase order will be required for expenditure between £5,000 and £30,000 • a tender will be required for expenditure over £30,000 **Outcome:** The Committee noted and approved the new authorisation limits.	
2016-17 (51d)	**Interim Head of Internal Audit opinion** The Internal Audit Manager introduced the draft year-end report and stated that the draft opinion was that reasonable assurance could be given that there were adequate and effective management and internal control processes to manage the achievement of the Trust's objectives. This conclusion was based on the current audit findings; maintaining the level of assurance contained in the draft opinion was dependant on the outcome of outstanding audits and evidenced progress with high priority recommendations. **Outcome:** The Head of Internal Audit opinion was noted.	

2016-17 (51e)	**Draft internal audit annual plan 2017/18** The draft internal audit annual plan for 2017/18 was presented by the Internal Audit. Manager. He advised that during March meetings had been fixed with all the executive directors to discuss and review the plan and a final version would be presented for approval at the Audit Committee meeting on 28 April 2017. The Chair of the Committee said that it was important that the Chairs of the Quality and Business Committees also had the opportunity to review and shape the plan for the coming year and that the final version of the internal audit plan should be made available to them for comment before the end of March 2017. The Chair also requested that the plan be presented in April within a document that provides clear linkage to the BAF, risk register and the NHS landscape. **Action:** The Executive Director of Finance and Resources to ensure that the internal audit plan is made available to the Chairs of the Business and Quality Committees for review and comment.	**Executive Director of Finance and Resources**
2016-17 (52a) **2016-17 (52b)**	**External Audit** **External audit technical update** The External Audit Manager presented the technical update for February 2017. She drew the Committee's attention to the item on the draft Finance Bill for 2017 which included changes to IR 35 in relation to off-payroll working in the public sector effective from 6 April 2017. The Executive Director of Finance and Resources said he was aware of the proposed changes and work was in progress to assess the impact of these changes on the Trust. It was explained that the implications of IR 35 changes in relation to off-payroll working in the public sector from 6 April 2017 were to be considered by the Nominations and Remunerations Committee. **Action:** The Executive Director of Finance and Resources to confirm that the changes to the treatment of off-payroll working in the public sector and their impact on the Trust were considered at the next meeting of the Nominations and Remuneration Committee. **Outcome:** The Committee received and noted the update **External audit annual plan 2016/17** The External Audit Manager presented the plan for 2016/17. A copy of the draft plan was made available to Committee members at the meeting. The External Audit Manager indicated that elements of the work within the plan had already commenced. She set out the timescale whereby the external audit opinion would be available by the end of May 2017, noting that the deadline for submission of the final accounts by the Trust was 1 June 2017. The External Audit Manager drew the Committee's attention to a number of specific items, namely: • materiality: the level of materiality had been set taking account of the current level of financial pressure in the NHS • mandated risks: to be considered as part of the audit: fraud arising from revenue recognition and management override of controls • local risks to be considered as part of the audit: risk arising from the	**Executive Director of Finance and Resources**

	valuation of lands and buildings • value for money audit approach: economy, efficiency and effectiveness in the deployment of resources and financial resilience **Outcome:** The draft external audit plan for 2016/17 was noted.	
2016-17 (53a)	**Counter Fraud and security management** **Counter fraud: annual work plan 2017/18** The Local Counter Fraud Specialist presented the fraud risk assessment and strategic workplan for the Trust for 2017/18. The fraud risk assessment was split into several key areas where fraud could occur and included an analysis of the Trust specific fraud risks (RAG rated) alongside the TIAA portfolio and national policy issues. The strategic workplan is a three year rolling plan, cross referenced to the fraud risk assessment as well as to the NHS Protect Standards for providers **Outcome:** The Committee received and approved the fraud risk assessment and counter fraud annual work plan.	
2016-17 (54a) **2016-17 (54b)** **2016-17 (54c)** **2016-17 (54d)**	**Annual report and accounts** **Annual reports and accounts timetable and progress report** The timetable for the production of the Trust's annual report and accounts was received. The Executive Director of Finance and Resources said that all aspects were being completed to timescale. **Outcome:** The detailed annual report and accounts timetable was noted. **Going concern consideration** The Executive Director of Finance and Resources presented the going concern paper for consideration to the Committee. **Outcome:** Based on the paper the Committee recommended to the Board that when approving the annual accounts it does so in agreement that the Trust is a going concern. **Fixed assets revaluation** The Executive Director of Finance and Resources presented the report which set out the consideration undertaken in reaching a recommendation as to whether the Trust should undertake a full revaluation exercise of the Trust's fixed assets at this year-end. The Executive Director of Finance and Resources advised that based on the points set out in the report a revaluation exercise was not deemed necessary at this year-end as there was no reason to expect the carrying values of the fixed assets to be reported in the Statement of Financial Position to be materially different to the market value. **Outcome:** The Committee supported the recommendation not to revalue the fixed assets. **Annual governance statement** The Company Secretary introduced the draft annual governance statement for 2016/17 which would form part of the annual report and accounts and would be available to external auditors to review as part of the process to finalise the annual accounts.	

	The Committee members reviewed the statement and made a number of changes:
	• the section on the Trust Board: that the Board receives and considers the summary risk register and the board assurance framework at every meeting
	• the section on the Audit Committee
	  ➢ the job role of the Chair to be updated to: Chief Financial Officer in the higher education sector
	  ➢ include a reference to the Audit Committee receiving regular reports on information governance and an annual security management report
	• the section on review of the effectiveness of risk management and internal control: restatement of the role of the Audit Committee in providing assurance to the Chief Executive
	• the section on clinical audit: reference to be made to the Quality Committee in approving the annual clinical audit plan
	
	A Non-Executive Director (RG) suggested that members of the Business and Quality Committees should have the opportunity to review the relevant sections of the annual governance statement.
	
	Action: The Company Secretary to ensure that the Business and Quality Committee are given the opportunity to review the relevant sections of the annual governance statement.
	
	Outcome: The Committee reviewed and commented on the annual governance statement prior to consideration by the Board.
		Company Secretary

2016-17 (55a) **2016-17 (55b)**	**Governance** **Risk Management update** The Company Secretary presented the report which provided the Committee with an update on the ongoing development of the Trust's risk management processes, particularly focussing on actions completed since the last report in July 2016. She explained that the paper described further actions taken in order to strengthen risk management processes and planned developments to enhance the future reporting and management of risk. The Chair said that she was surprised to see that the number of managers accessing risk management training through the formal manager/leader development programme was low. In response the Company Secretary said there were a number of alternative learning opportunities available for managers and staff and she was confident that sufficient numbers of staff were receiving training on an individual or team basis tailored to their needs. **Outcome:** The Committee noted the report. **Board assurance framework** The Company Secretary introduced the report. She highlighted the work undertaken to update and improve the Board Assurance Framework (BAF) since it was reviewed by the Committee in October 2016 and the responsibilities and 'flow' of Business through SMT, sub-committees and the Board. It had been reviewed by individual directors and then collectively by SMT who had examined the strategic risks, controls and the sources of assurance. The Committee reviewed the BAF in detail and commented on each of the strategic risks in terms of key controls, gaps in controls, sources of assurance and gaps in	

	sources of assurance. The Committee's suggestions included in some instances the addition of more controls, recommendations that some of the completed gaps in control could now be moved into the control section, and that some of the risk scores need to be increased or decreased in line with the current level of risk posed to the Trust's objectives. The Company Secretary thanked members for their detailed comments and agreed to ensure that the BAF was updated to reflect the most up to date position and that risk owners would reflect on the comments made by the Committee. **Action:** The Company Secretary to ensure that the BAF is updated in response to the Committee's comments.	**Company Secretary**
2016-17 (55c)	**Outcome:** The latest draft of the BAF was reviewed and noted. **Information governance group: terms of reference** The Executive Director of Finance and Resources presented the paper which contained a proposal that the Trust's Information Governance Group (IG Group) should operate as a sub-group of the Audit Committee and that the terms of reference be approved in accordance with the proposal. He said that if the proposal was approved the IG Group would provide assurance to the Audit Committee and in turn to the Trust Board. The IG Group was responsible for ensuring that the Trust had effective policies and management arrangements covering all aspects of information governance in line with the Trust's Information Governance Management Framework Policy. The Committee reviewed the terms of reference for the group and requested the following changes: • a quorum to be five rather than four members • review the wording relating to members attendance at meetings. The committee felt that the allowance of 60% attendance should be removed • Under duties and responsibilities ➢ more information should be included relating to the duties and responsibilities of the Caldicott steering group ➢ reference should be made to cyber security Referring to the membership of the IG Group the Chair of the Committee asked whether it was appropriate for a non-executive director to be a member of the group. The Company Secretary advised that it was normal practice for executive directors and senior managers as appropriate to sit on sub committees of the Business, Quality or Audit Committees. A Non-Executive Director (RG) asked how the group would report to the Audit Committee. The Executive Director of Finance and Resources advised that the Information Governance Group would continue to report to the Committee twice a year (December and July) and in addition would receive minutes from meetings of the group **Outcome:** The Committee approved the alignment of the IG Group as a sub-group	

	of the Audit Committee and subject to the changes set out above agreed the terms of reference.	
2016-17 (55d)	**Non–compliance with standing orders and standing financial instructions** There were no matters of non-compliance to report.	
2016-17 (56a)	**Financial controls** **Tender and quotations waiver report** The Executive Director of Finance and Resources introduced the report. He advised that the report represented an extract from the 2016/17 register of waivers completed during the financial year. He noted there had been one waiver since the last report in December 2016; the report contained details of the supplier, the rationale for the waiver and the authorisation process within the Trust. **Outcome:** The Committee received the report and the content was noted.	
2016-17 (56b)	**Losses, claims and special payments report** The Executive Director of Finance and Resources presented the report which covered any such transactions made between November 2016 and January 2017. The Chair of the Committee noted that the total value for the reporting period was £13,000, the net cost of two claims after NHS Litigation Authority reimbursement. **Outcome:** The losses, claims and special payments report was received by the Committee.	
2016-17 (56c)	**Over and under payments and off payroll payments** The Executive Director of Finance and Resources presented the report which provided details of under and over payments of salary for the period to 31 January 2017. **Outcome:** The Committee received and noted the report and the current position.	
2016-17 (56d)	**Schedule of debtors and creditors** The Executive Director of Finance and Resources presented the report which provided details of aged trade receivables (debtors) and payable (creditors) individually over £5,000 in value as at 31 January 2017, subsequent transactions and actions to clear the balances. **Outcome:** The Committee received and noted the report and the current position.	
2016-17 (56e)	**Changes to investment policy** The Executive Director of Finance and Resources presented the report which introduced a revised investment decision making policy for the Trust. He explained that the policy proposed a set of principles in relation to making decisions about investments and the associated governance framework. The Committee reviewed the policy and asked the Executive Director of Finance and Resources to consider the following comments: • Section 4: Roles and Responsibilities - paragraph 4.1.2: the Chair of the Committee questioned whether the Trust's approach to the risk adjusted rate of return needed to be escalated for Board approval in every case. • Section 4: Business Committee – paragraph 4.3.10: the Chair of the Committee asked that the wording be reviewed in relation to the Business Committee 'reviewing and monitoring compliance with the investment policy'.	

	• Section 5: The Business Case Process – paragraph 5.1: the Chair of the Committee proposed that value for money and benefits realisation should be added to the considerations set out in the final sentence. **Outcome:** Subject to the consideration of the comments set out above the Committee approved the adoption of the Investment Decision Making Policy.	
2016-17 (57)	**Audit Committee work plan** There were no matters removed from or changes made to the work plan.	
2016-17 (58)	**Matters for the Board and other committees** The Chair of the Committee noted the following items to be referred to Board colleagues: • the importance of maintaining momentum on internal audit recommendations and ensuring follow up actions were implemented in a timely fashion • the draft internal audit plan to be reviewed by sub-committees before finalisation • feedback from the review of the BAF • the establishment of the Information Governance Group as a sub-group of the Audit Committee • the implications of IR 35 changes in relation to off-payroll working in the public sector from 6 April 2017 to be considered by the Nominations and Remunerations Committee.	
2016-17 (59)	**Any other business** There were no matters for discussion.	
	Date and time of next meeting Friday 28 April 2017 9.00am- 11.30am, Boardroom, Stockdale House Leeds Community Healthcare LS61PF	

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2017-18 (16b)

Quality Committee
Monday 20 March 2017
Boardroom, Stockdale House, Leeds
09:30 – 12:30

Present	Dr Tony Dearden	Committee Chair / Non-Executive Director
	Neil Franklin	Trust Chair
	Elaine Taylor-Whilde	Non-Executive Director
	Dr Amanda Thomas	Executive Medical Director
In Attendance	Sam Prince	Executive Director of Operations
	Stephanie Lawrence	Deputy Director of Nursing
	Mo Drake	Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience
	Vanessa Manning	Company Secretary
	Karen Worton	Clinical Lead for Children's Services
	Elaine Goodwin	Clinical Lead for Specialist Services
	Caroline Schonrock	Business Planning Manager (items 83b and 83e)
Observer	Helen Blenkinsopp	Clinical Audit and Effectiveness Manager
Minutes	Sonia Phull	Interim PA to Executive Director of Nursing
Apologies	Thea Stein	Chief Executive
	Marcia Perry	Executive Director of Nursing
	Caroline McNamara	Clinical Lead for Adult Services
	Carolyn Nelson	Head of Medicines Management

Item no	Discussion item	Actions
Welcome and introductions		
2016-17 (81a)	**Welcome and Apologies** The Chair opened the meeting and welcomed everyone. He indicated that a significant focus for the meeting would be the key issues in the Director of Nursing's report, namely: low and no harm incidents' recording, duty of candour requirements and response rates to the friends and family test. He added that there were a number of further items presented for assurance. Apologies were received from Marcia Perry, Thea Stein, Caroline McNamara and Carolyn Nelson.	
2016-17 (81b)	**Declarations of Interest** There were no declarations of interest received.	
2016-17 (81c)	**Minutes of meeting held on 20 February 2017** The minutes were reviewed for accuracy and agreed as a true record of the meeting with the following amendment: **Item 73c – Minutes of the previous meeting** It was noted that the date should read 23 January 2017 and not 21 November 2016.	

2016-17 (81d)	**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 noted: <u>2016-17 (66) Service spotlight: health visiting</u> It was noted that a risk related to the implementation of a single point of access for the health visiting administration team had been entered onto the risk register; other estates related matters would be addressed as part of the wider estates strategy. The action was closed. <u>2016-17 (75a) (i) Director of Nursing: quality and safety report</u> It was agreed that there needed to be a further discussion at the next meeting on unstageable pressure ulcers and the associated conversion rates <u>2016-17 (75ai) Performance brief and domain reports</u> Continuing poor performance against the recording of VTE risk assessments to be investigated and reported to next meeting including the option for administrative staff to input data	
Service spotlight		
2016-17 (82)	The Deputy Director of Nursing stated that there was no service presentation for this month; however she explained to the Committee her proposed plan for future presentations. The Trust Chair pointed out that he would like to see presentations which have a more balanced approach with an element of accountability, challenges, issues and proposals to improve services. The Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience said that some guidelines as to what might be required in the presentations would be useful and that she would be happy to discuss this with the QPD team. The Executive Medical Director was concerned that attending the Committee to present should not give the impression of a 'performance panel'. The Trust Chair suggested that it would be a good idea to draft a letter from him and the Committee Chair highlighting the presentation requirements. The Clinical Lead for Children's Services added that post-presentation feedback would also be useful. **Action: The Trust Chair asked the Deputy Director of Nursing to draft a letter.** **Outcome:** The Committee agreed the schedule for forthcoming service spotlights.	**SL**
Quality governance and safety		
2016-17 (83)	**Director of Nursing: quality and safety report** The Deputy Director of Nursing presented the report on behalf of The Executive Director of Nursing. The Deputy Director of Nursing highlighted the main areas of focus: • Incident reporting • Duty of candour (DoC) • Friends and family test ***Incident reporting*** The Chair referred to the all incidents and patient safety incidents' graph and pointed out that whilst there was an overall reduction in patient safety incidents compared to this time last year there is a progressive decrease in the number of	

	no harm incidents recorded and he queried whether this meant a proportionate increase of incidents resulting in harm. The Executive Medical Director explained that the number of incidents causing harm per 1,000 contacts remained within the variation limits. The Trust Chair asked where incidents were most prevalent. The Deputy Director of Nursing replied that the largest number of major and moderate harm incidents were in the adults' business unit (neighbourhood teams). The Executive Medical Director added that there was no direct correlation with capacity issues but noted the increased demand, complexity of patients and early discharge by hospitals. The Committee discussed the general decline in the reporting of low and no harm incidents. The Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience outlined current investigative work and identified three main potential reasons: categorisation, lack of time to record and staff not recognising the value of such reporting. She added that there was some work to be done on benchmarking and correlation with other factors. The Chair pointed out that a further discussion is needed particularly on internal benchmarking (by three business units and thirteen neighbourhood teams) and asked for updates in the Director of Nursing's report in April and May 2017 with a full, standalone report for June 2017. There was no agreement to alter the current target. The Committee only gained **limited assurance** in relation to this item. **Action: The Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience to provide an update on benchmarking in April and May with a full (standalone) report for the June 2017 meeting.** ***Duty of candour (DoC)*** The Trust Chair opened the discussion and asked about the timing of letters of apology and the appropriateness of sending letters before an investigation had taken place and the facts had been established. The Professional Lead for Allied Health Professional (AHP) and Head of Patient Experience replied that when incidents had caused moderate or major harm a letter of apology was sent in all cases. The Trust Chair also asked how the DoC process is initiated. The Executive Medical Director replied that incidents are recorded on Datix and that this triggers the process. She added that not all incidents required investigation and therefore it was proposed that monitoring takes place against closed cases when it would be clear that DoC applied. Improvement would be incremental with the aim of achieving 90% compliance by the end of quarter one 2017/18. **Action: The Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience to provide a full (standalone) report on DoC for the October 2017 meeting.** In reply to the Trust Chair, it was confirmed that the Executive Medical Director or the Executive Director of Nursing signed apology letters for serious incidents and for less serious incidents it was the Lead Manager. The Deputy Director of Nursing suggested that she would ask the Pressure Ulcer Panel and the Falls Panel to review a sample of letters to ensure they were compliant. The Committee concluded **reasonable assurance** had been provided by the report and discussion.	**MD** **MD**

	Action: The Deputy Director of Nursing to ask Pressure Ulcer Panel and Falls Panel to review sample apology letters.	**SL**
	Friends & Family Test The Deputy Director of Nursing referred the Committee to the action plan and noted that the response rate remained low; the most significant issue being lack of patient participation. A Non-Executive Director (ETW) noted that there would not be a single course of action suitable for all services and approaches needed to be flexible; the important element being to gain information to inform quality improvements. The Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience suggested a group be convened to examine how response rates can be increased and to report back to the May 2017 meeting. Bearing in mind the low response rate and the limited benefit from initiatives to date the Committee considered there was only **limited assurance.**	
	Action: The Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience to organise a group to work on increasing response rates.	**MD**
	Adult services business unit The Executive Director of Operations said that there were currently 60 vacancies in this area and it was unlikely that there would be an improvement until September 2017 when new graduates would become available; she noted her concern about the extra burden on current staff members but added that all flexible staffing options were being deployed. The Executive Director of Operations assured the Committee that all essential services were being maintained through a clear process of prioritisation and allocation. The Chair stated that one way to alleviate pressure was to scrutinise demand on services. The Executive Director of Operations outlined discussions amongst senior managers about referral management (including hospital discharges), holistic assessment, care planning and case review processes. ***Children services' business unit*** The Executive Director of Operations pointed out that staff sickness levels remained high and that she was looking at ways, with human resources advisers, to address reasons and help staff to return to work. Workshops had been organised for managers to deal with such situations and the sickness absence management policy had been revised. The Executive Medical Director referred to the wider consideration of a children's services strategy. ***Specialist services' business unit*** The Clinical Lead for Specialist Services noted that the psychological therapies (IAPT) target for February 2017 had been met but that this was under pressure due to increased referrals. The Clinical Lead for Specialist Services highlighted an issue related to the electronic reporting of pathology test results (gynaecology); no incorrect results had gone out but the situation is being closely monitored.	

	The Executive Medical Director referred to recent incidents whereby deaths had been recorded for a small number of patients who had been waiting for routine speech and language therapy. She pointed out that all deaths should be recorded on Datix. The Deputy Director of Nursing undertook to take this matter back to the Mortality Surveillance Group; the outcome from which would then be reported to the April 2017 meeting. **Action: Deputy Director of Nursing to discuss with Mortality Surveillance Group the recording all deaths on Datix.** **Outcome:** The quality and safety contents were noted and actions endorsed.	**SL**
2016-17 (83i)	**Performance brief and domain reports** The Committee reviewed the document. In relation to the safe and caring domains, the Chair expressed his concern that the year-end forecasts might be ambitious based on the performance as at February 2017. The Trust Chair referred to the venous thromboembolisms (VTE) risk assessment and the current delay between assessments and reporting. It was noted that the Executive Director of Nursing had been asked to investigate whether administration staff could provide support by inputting the data. **Outcome:** The Committee noted the contents of the performance report for February 2017.	
2016-17 (83ii)	**Risk register: clinical risks** The Company Secretary presented the report which was written in a summary style and recorded the changes since the last report (February 2017). She noted that there were no new or escalated clinical risks scored as extreme (15+) or high (8+). A number of risks had been de-escalated whereby capacity and caseload situations had improved and had been determined to be of a lesser risk. The Company Secretary drew the Committee's attention to one new non-clinical risk related to changed arrangements for off-payroll contractors which had been rated as extreme. **Outcome:** The Committee noted changes in clinical risks	
2016-17 (83b)	**Quality improvement plan (QIP)** The Business Planning Manager presented her report and asked the Committee to approve closure of three actions for which there had been significant improvement and for which there would be continued oversight by SMT, Quality Committee, Business Committee and Board through routine reporting. It was proposed that this report was the last of the phase one QIP reports to Quality Committee and the remaining four open actions would be incorporated into the second phase QIP. The scope of the second phase QIP was to be finalised but would include, in due course, actions in response to the February 2017 CQC inspection and other external reviews and inspections. **Outcome:** The actions proposed for closure were approved and phase one QIP reporting was closed.	

2016-17 (83c)	**Quality Account** The Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience introduced her paper which summarised performance as at the end of February 2017. Of the 15 outcomes, five were reported as 'off track' and of concern; these related to falls, pressure ulcers, duty of candour, friends and family test and appraisal rates. The Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience also presented a draft of the Quality Account for 2016/17. She indicated that there would be little change in the priorities for the coming year but some measures would be strengthened. The Chair asked that the reference to the increase in patient safety incidents resulting in severe harm should be accompanied by some narrative explanation. It was noted that comments from stakeholders would be sought in April 2017 in accordance with national requirement. The final Quality Account 2016/17 would be presented to Quality Committee in May 2017 for to the Board on 31 May 2017. **Outcome:** The Committee noted progress with current priorities and the progress of Quality Account in its current state of production; the report on the current year's progress provided **reasonable assurance.**	
2016-17 (83d)	**Key performance indicators (KPIs) for 2017/18** A draft list of indicators for the coming year was received and reviewed by the Committee. The Chair identified the following areas which he was keen to see resolved: • A move to zero avoidable category 4 pressure ulcers • An increase in the number of services reporting outcome measures (subject to the availability and/or deployment of resources) • Time taken to recruit (advertisement to vacancy filled); sustain 2016/17 rate **Outcome:** The list of (quality-related) KPIs, subject to finalisation, was approved.	
2016-17 (83e)	**Operational plan 2017/18** The Business Planning Manager introduced the final version of the operational plan 2016/17 which the Committee was asked to consider prior to approval by the Board on 31 March 2017. The Committee particularly focused on the first corporate objective related to ensuring consistent delivery of high quality care. The Chair suggested a number of amendments: • Improving access: to include a reference to IAPT services • Safe staffing: insert extra measure of success in relation to compliance with guidance about safe staffing levels in community teams • Friends and family test and duty of candour to be split into two priorities each with measures of success (increased response rates and 100% compliance respectively) **Action: The Business Planning Manager to make amendments and take the report to the Business Committee prior to Board approval.** **Outcome:** The Committee noted the operational plan 2017/18	**CS**

Clinical Effectiveness		
2016-17 (84)	**Patient group directions** The Committee received two patient group directions in relation to the administration of hepatitis A and hepatitis B vaccines for adults **Outcome:** The Committee ratified all the patient group directions.	
Reports and minutes for approval or noting		
2016-17(85a)	**Special educational needs and disabilities (SEND) Inspection: final report** The Clinical Lead for Children's Services went through the report. She explained that Ofsted and the Care Quality Commission had an inspection framework to cover children's services and health arrangements for children and young people with SEND, in accordance with the Children and Families Act (2014). Leeds was the fifteenth local authority to be inspected under the framework, with a one-week inspection having taken place in December 2016. The Clinical Lead for Children's Services highlighted key strengths and areas for development and focused on the recommendations; particularly those relating to recruitment and retention. After discussion, it was agreed that she would develop an action plan and take it forward to the Safeguarding Group. Actions specifically falling to the Trust would be incorporated into the phase two QIP. **Action: The Clinical Lead to develop a SEND inspection action plan.** **Outcome:** The special educational needs and disabilities (SEND) Inspection final report was noted. It was considered to provide **reasonable assurance.**	**KW**
2016-17 (85b)	**Board members' service visits** The paper was received for assurance. A Non-Executive Director (ETW) referred to her visit to South Leeds Independence Centre. She noted that there had been difficulties with the falls sensor system but that overall she had judged the unit to be well-led with valued staff. The Deputy Director of Nursing confirmed that a solution had been implemented in relation to the falls sensors. **Outcome:** The report of recent service visits and schedule of future visits was noted and provided **reasonable assurance.**	
2016-17 (85c)	**Clinical Effectiveness Group: minutes 10 January 2017** **Outcome:** The draft minutes were received.	
2016-17 (85d)	**Safeguarding Children and Adults group: minutes 15 December 2016** **Outcome:** The draft minutes were received.	
2016-17 (85e)	**Quality Committee annual report 2016/17 and terms of reference** The Company Secretary presented the Committee's annual report which was accepted. The Committee also undertook an annual review of terms of reference. The Chair noted the responsibility for the Committee to review the effectiveness of the Committee's sub-groups. The Company Secretary said that she would carry out an effectiveness review in May 2017 and report the results to the Committee in July 2017.	

	Action: The Company Secretary to instigate an effectiveness review of sub-groups and report back in July 2017. **Outcome:** The Committee approved its annual report 2016/17 and terms of reference as amended.	**VM**
2016-17 (85f)	**Annual governance statement** The Company Secretary presented the Trust's draft annual governance statement for 2016/17. The Committee was asked to review the document in that it made reference to the functions of the Quality Committee. **Outcome:** The Committee noted the draft annual governance statement 2016/17.	
2016-17 (85g)	**Internal audit plan 2017/18** The Company Secretary asked the Committee for feedback on the draft plan. A number of comments were made: • Effectiveness of the Quality Committee (five days); the time has now been reduced and the focus would be a broader consideration of the links between all committees and the Board. • CQC compliance audit would be scheduled for quarter three of 2016/17 • Clinical governance (10 days) clarity as to scope needed to be ensured to avoid overlapping audits • Youth offenders' institution (7 days) to be focused around the partnership agreement **Action: The Company Secretary to advise the auditors of the amendments required to the plan.** **Outcome:** The contents of the draft plan, subject to amendment, were noted.	**VM**
2016-17 (86)	**Quality Committee work plan** Future work plan was received for information The Executive Medical Director pointed out that she would like the clinical audit plan to be discussed in March each year (currently planned for July). For this year, the clinical audit plan is to be received at the April 2017 meeting **Action: The Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience to prepare the clinical audit plan 2017/18 for the Committee in April 2017.** **Action: Work plan to be adjusted accordingly**	**MD** **LR**
2016-17 (87)	**Matters for the Board and other committees** It was agreed that the Committee Chair and Executive Medical Director would produce the assurance report for the Board	
2016-17 (88)	**Any other business** None recorded.	
	Dates and times of next meetings (09:30 – 12:30) Monday 24 April 2017 Monday 22 May 2017 Monday 26 June 2017 Monday 24 July 2017 Monday 25 September 2017 Monday 23 October 2017 Monday 20 November 2017	