Leeds Community Healthcare NHS Trust

Board Meeting (held in public)
Friday 1 December 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 (57)	Welcome, introductions and apologies	Neil Franklin	N
9.05	2017-18 (58)	Declarations of interest	Neil Franklin	N
9.10	2017-18 (59)	Questions from members of the public	Neil Franklin	N
9.15	2017-18 (60)	Patient's story: child and adolescent mental health services	Marcia Perry	N
9.30	2017-18 (61)	Minutes of previous meeting and matters arising: a. Minutes of the meeting held on 6 October 2017 b. Actions' log c. Committees' assurance reports: i. Quality Committee: 20 November 2017 ii. Business Committee: 27 November 2017	 Neil Franklin Neil Franklin Tony Dearden Brodie Clark	 Y Y Y N
		Quality and delivery		
9.50	2017-18 (62)	Chief Executive's report	Thea Stein	Y
10.10	2017-18 (63)	Performance brief and domain reports	Bryan Machin	Y
10.30	2017-18 (64)	Patient experience and incidents: thematic report	Marcia Perry	Y
10.40	2017-18 (65)	Guardian for safe working hours report	Thea Stein	Y
		Strategy and planning		
10.50	2017-18 (66)	Child and adolescent mental health services	Bryan Machin	Y
11.00	2017-18 (67)	Professional strategy: annual update	Marcia Perry	Y
11.10	2017-18 (68)	Organisational development strategy: six monthly report	Ann Hobson	Y
11.20	2017-18 (69)	Equality and diversity report	Marcia Perry	Y
11.30	2017-18 (70)	Major incident plan	Sam Prince	Y
		Governance		
11.40	2017-18 (71)	Significant risks and board assurance framework report	Thea Stein	Y
11.50	2017-18 (72)	Board workplan	Thea Stein	Y
		Minutes		
11.55	2017-18 (73)	Approved minutes (for noting): a. Audit Committee: 21 July 2017 b. Quality Committee: 25 September 2017 and 23 October 2017 c. Business Committee: 27 September 2017 d. Leeds Health and Wellbeing Board: 20 June 2017	Neil Franklin	 Y Y Y Y
12.00	2017-18 (74)	Close of the public section of the Board	Neil Franklin	N

Date of next meeting (held in public)
Friday 2 February 2018, 9.00am -12noon
Trust Headquarters, Stockdale House, Leeds LS6 1PF

NHS
Leeds Community Healthcare
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AGENDA ITEM 2017-18 (61a)

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

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

Friday 6 October 2017, 9.00am – 12.00noon

Present:	Neil Franklin	Trust Chair
	Thea Stein	Chief Executive
	Brodie Clark	Non-Executive Director
	Dr Tony Dearden	Non-Executive Director
	Jane Madeley	Non-Executive Director
	Richard Gladman	Non-Executive Director
	Professor Ian Lewis	Non-Executive Director
	Bryan Machin	Executive Director of Finance and Resources
	Marcia Perry	Executive Director of Nursing
	Sam Prince	Executive Director of Operations
	Dr Amanda Thomas	Executive Medical Director
Apologies:	Ann Hobson	Interim Director of Workforce
In attendance:	Vanessa Manning	Company Secretary
	Benita Powrie	Head of Service, Integrated Children's Additional Needs Service, ICAN (for item 42)
Minute taker:	Liz Thornton	Board Administrator
Observers:	Rachel Howitt	Incident and Assurance Manager
	Sue Wilson	HR Advisor
	Vanessa Hunt	Professional Lead for Allied Health Professionals
Members of the public:	Two members of the public	

Item	Discussion points	Action
2017-18 (39)	**Welcome and introductions** The Trust Chair welcomed Trust Board members and extended a welcome to members of staff from the Trust attending as observers and members of the public. **Apologies** Apologies were noted from the Interim Director of Workforce. **Chair's opening remarks** The Trust Chair said he wished to make some opening remarks in order to provide a strategic context for the Board's deliberations during the course of the meeting, he set out a number of key strategic issues for the Trust, these being: • ***Meeting the requirements of the Trust's regulators, particularly the Care Quality Commission (CQC):*** ensuring and evidencing that the Trust's services are safe, caring, effective, responsive and well-led for patients, for staff and for the organisation as a whole. The Trust had secured a 'good'	

	rating from the CQC's inspection in January 2017 but work to improve where the Trust needed to do so, and to maintain the excellent care in many areas, must be a continuing focus for the Board and particularly for the Quality Committee. • ***Financial performance***: meeting the challenges in the short term. The Trust had satisfactorily met its financial duties in 2016/17 and financial performance remained satisfactory in the early months of 2017/18 but the Chair said that there would be additional pressures moving into the winter period and, in the longer term, the focus needed to be on maintaining a viable and sustainable organisation. • ***Leadership:*** meeting the need to grow and retain good leaders to build on achievements in 2016/17 and to continue to address the quality, financial and workforce challenges in 2017/18. Although recruitment and sickness absence rates were improving, alongside retention they remained the Trust's most significant risks. • ***Working within the wider Leeds health and social care economy***: working co-operatively with partners in the best interests of patients and their families to achieve change strategically and operationally in the context of the Leeds Health and Care Plan would be a top priority. The Chair spoke in particular about a recent meeting with the Chair of Leeds Teaching Hospitals NHS Trust (LTHT) at which they had discussed the excellent examples of partnership working which had been demonstrated as part of the LTHTs 'perfect week' initiative.	
2017-18 (40)	**Declarations of interest** A Non-Executive Director (JM) declared an interest in item 44 on the agenda in relation to the associated teaching trust agreement signed between the Trust and the University of Leeds' School of Medicine.	
2017-18 (41)	**Questions from members of the public** There were no questions from any of the members of public in attendance.	
2017-18 (42)	**Patient's story: Integrated Children's Additional Needs (ICAN) Service** The Executive Director of Nursing introduced the patient's story item. She welcomed the Service Manager, ICAN and the parent and carer of a young person with complex medical conditions who had received care and support from the ICAN services provided by the Trust. The carer presented the young person's story on behalf of his mother. She explained that, at the age of three, he had been diagnosed with epilepsy and subsequently with autism and cerebral palsy. She said that, despite his multiple disabilities, the young person had a positive outlook on life and with the support of his family and a multi-disciplinary team of health and care professionals, his quality of life was extremely good. Six months ago he had suffered a series of tonic cluster seizures which resulted in two periods as a hospital in-patient; initially under the care of the Hospital for Sick Children at Great Ormond Street and subsequently LTHT. The carer spoke positively about the input from Leeds Community Healthcare NHS Trust's ICAN services and the healthcare professionals who had stepped in to work with and support the family immediately after the young person's discharge from hospital. This included assessments by an occupational therapist and a physiotherapist which had resulted in the timely provision of specialist equipment. She also explained the difficulties the family had experienced in managing a nasogastric feeding tube and, because the young person removed the tube on a regular basis, frequent trips to A&E had been necessary.	

	The young person's attendance at school had also been disrupted. A combination of these factors had had a significant impact on the quality of his day to day life and as a result he had been unable to participate in a number of activities such as residential and school reward trips. The involvement of a specialist nurse from the Trust in providing training for his carer to replace the feeding tube had been a welcome development for the young person, his family and carers. The carer drew the Board's attention to a series of photographs the family had agreed to share which illustrated the progress made by the young person over recent weeks and demonstrated how the partnership between the Trust, the family and carers had achieved a positive outcome. The Chair thanked the carer for delivering a compelling story and speaking about the young person's experience and invited questions from members of the Board. The Executive Director of Finance and Resources asked about the young person's experience when he had been discharged from LTHT. The carer highlighted some concerns and hoped that, in future, the transition from hospital to community care could be as seamless as possible. The Executive Director of Operations said that she would discuss the discharge arrangements with LTHT and provide feedback to the family through the ICAN Head of Service. A Non-Executive Director (BC) observed that the carers' organisation obviously worked closely with the Trust but he asked about the nature of relationships with other organisations in the city. The carer agreed that the working relationship with the Trust was very positive and the dialogue between the two organisations was open and honest. She said that the organisation also worked closely with Leeds and York Partnership NHS Foundation Trust and Leeds City Council. The Chief Executive said she was particularly concerned to hear about the disruption to the young person's education and asked the Executive Director of Nursing to investigate the training provided for nurses based in the special inclusive learning centres. A Non-Executive Director (IL) asked the young person's mother about the practical things that the Trust could put in place to help her son in the future. The young person's mother said that her son's condition was unpredictable and it was extremely difficult to plan for what might occur in the future. She felt that one of the most important things was for the family to be able to access help and support quickly when necessary and that they had the benefit of a key worker as an initial point of contact. The Trust Chair thanked the young person's mother and the carer on behalf of the Board for taking the time to attend the meeting. Reflecting on the presentation, he said that clearly there were many positives which the Trust could take from this young man's story but it had also highlighted areas of concern which the Executive Director of Nursing and Executive Director of Operations had agreed to investigate and provide feedback to the family. He also asked that the positive comments made about the ICAN services were passed on to members of the team.	

2017-18 (43)	**Minutes of the previous meeting held on Friday 4 August 2017 and matters arising**	
(43a)	**Minutes of the previous meeting held on Friday 4 August 2017** The minutes were reviewed for accuracy and agreed to be a correct record.	
(43b)	**Items from the actions' log** ***Item 2017-18 (26):*** This action referred to data related to responses to the Friend and Family and Family Test (FFT). The Executive Director of Nursing advised that a report would be made to the Quality Committee on 23 October 2017. ***Item 2017-18 (27):*** This action referred to the interaction and links between the role of the Freedom to Speak Up Guardian and the Trust's whistleblowing policy. The Chief Executive advised that a draft of the revised whistleblowing policy was still under consideration. The completed actions from previous meetings were noted.	
(43c)	**Assurance reports from sub-committees** **Item 43c(i) – Quality Committee 25 September 2017** The report was presented by the Chair of the Committee and Non-Executive Director (TD) who highlighted the key issue for the Board's attention, namely: • **Pressure ulcers –** Work to deliver the pressure ulcer improvement plan continued. The Committee had been concerned that the performance brief for August 2017 showed a re-emergence of past themes in the management of avoidable pressure ulcers; there had been four avoidable category 3 pressure ulcers and one avoidable category 4 pressure ulcer. The total number of all pressure ulcers reported was 61. This was the highest total reported by month since the end of 2016. Category 2 ulcers accounted for 51% of the overall total. The Trust Chair asked about the steps taken to identify the underlying reasons why former patterns were re-emerging. The Executive Director of Nursing advised that a matter relating to poor practice had been identified in relation to the category 4 pressure ulcer and this had been addressed promptly. She assured the Board that this had not been due to staffing issues during August 2017. Steps had been taken to remind staff about the systems and processes in place in relation to the avoidance and management of pressure ulcers and weekly e-mails were being sent to staff to reinforce the importance of good practice. A Non-Executive Director (IL) asked if there was any evidence on emerging themes and whether common errors were occurring in relation to pressure ulcer management. The Executive Director of Nursing agreed to undertake further analysis to identify whether there were any systemic issues underlying the management of pressure ulcers. **Action: The Executive Director of Nursing to undertake further analysis to identify themes and common errors in the management of pressure ulcers and provide a report to the Quality Committee on 23 October 2017.** In summary, the Trust Chair said that the need to sustain significant systemic effort on pressure ulcer avoidance and management was a key issue for the Quality Committee. The greater incidence of pressure ulcers in August 2017 needed to be addressed as a matter of urgency to avoid the emergence of a continuing trend.	**Executive Director of Nursing**

	Item 43c(ii) – Business Committee 27 September 2017 The report was presented by the Chair of the Committee and Non-Executive Director (BC) who drew the main items to the Board's attention, namely: • **Children's strategy –** The Committee had welcomed the first draft of a strategy for children's services. Further developments would be incorporated in subsequent drafts prior to receipt by the Board; the core of the document would be shared at a children's service celebratory event in December 2017. • **E-Rostering –** The Committee received an update on the implementation of e-rostering and had noted concerns about the continuing delays in meeting the project milestones. • **Activity levels –** The Committee discussed the variance from activity profile (-10.9% in August 2017) and had agreed that further work was needed to understand the underlying reasons for the variance from profile. **Outcome:** The Board noted the update reports form the committee chairs and the matters highlighted.	
2017-18 (43d)	**Minutes of the annual general meeting held on 14 September 2017** The Board received the minutes of the annual general meeting held on 14 September 2017. . **Outcome:** The Board approved the minutes of the annual general meeting held on 14 September 2017.	
2017-18 (44)	**Chief Executive's report** The Chief Executive presented her report, the items highlighted included: • formal feedback from the CQC inspection resulting in an overall rating of the Trust as 'good' • launch of the 'Feel Good' pledge – to ensure that the working environment for staff supported their physical and mental health and wellbeing • sponsorship of three conferences for staff before the end of 2017 • success in being shortlisted for a number of national Health Service Journal awards. A Non-Executive Director (RG) asked how the Trust had supported LTHT's 'perfect week' initiative. The Chief Executive said that the aim had been to try and run the hospital as 'perfect' as possible for a full seven days. All issues or delays encountered were escalated locally in their units to a 'bronze command' and if they could not be resolved within two hours they were escalated again to a 'silver command'. The Executive Director of Operation reported that the staff from the Trust had been asked to participate in 'silver command' between 8am to 6pm every day and the feedback to the Trust from LTHT had been excellent. Staff in the neighbourhood teams had responded quickly to the needs of people as they were discharged and had balanced this alongside work which was aimed at avoiding unnecessary admissions to the acute hospital. In response to a question from Non-Executive Director (IL) about staffing resources to support the 'perfect week', the Executive Director of Operations reported that many staff had had some level of involvement; the majority of the time had been taken in logging issues and dealing with 'hot spots' arising from the discharge of patients from particular wards within the hospital. She said that the learning from the exercise would be evaluated and considered carefully in the	

	planning for managing hospital admissions and discharges over the winter period. A Non-Executive Director (RG) asked if a report would be made available to the Board. The Executive Director of Operations advised that LTHT would be collating conclusions from the exercise and material from which would be made available to a subsequent Business Committee. **Action: The Executive Director of Operations to provide further feedback on the 'perfect week' initiative to a subsequent Business Committee.** **Outcome**: The Board noted the Chief Executive's report and the matters highlighted.	**Executive Director of Operations**
2017-18 (45)	**Care Quality Commission (CQC) inspection report** The Executive Medical Director presented the report which set out the findings from the final CQC reports published on 29 August 2017. The Executive Medical Director advised that the report provided an overview of the CQC inspection findings following the announced inspection of some of the Trust's services between 31 January 2017 and 2 February 2017, and a progress report to the Board on the development and delivery of a robust organisational response to the CQC's inspection findings and reporting requirements. The Trust was required to submit a written response to the actions in the requirement notices to CQC by the 30 October 2017.The Quality Committee had considered the report on 25 September 2017. The Executive Medical Director drew the Board's attention to the new assessment framework published by CQC in June 2017 which included revisions and additions to key lines of inquiry. In response to a question from Non-Executive Director (TD), the Executive Medical Director confirmed that the meeting proposed by CQC with members of the Trust to discuss the inspection reports findings would take place on 12 October 2017 and would include representatives from all commissioners. Referring to the ratings for Hannah House, a Non-Executive Director (JM) asked how the specific findings for that service had been communicated to the parents and carers of the children and young people. The Executive Director of Nursing reported that all parents and carers had been sent a letter on the date that the CQC reports had been published, to inform them about the inspection outcomes and provide a point of contact if they had further questions. She advised that the family of one young person had responded by letter and further feedback had been received verbally from a number of other parents and carers. The Chief Executive said that the letter was an appropriate response following the publication of the CQC report and provided a level of assurance to parents and carers about the Trust's intentions to address the issues which were rated as inadequate or required improvement. The Trust Chair welcomed the report but emphasised that the Trust required a plan to achieve a rating of 'good' in all areas whilst remaining vigilant to maintain overall standards across the Trust.	

	Outcome: The Board: • received the information with regard to the CQC inspection and ratings published on 29 August 2017 • approved the proposed monitoring and reporting arrangements through the Senior Management Team (SMT) and Quality Committee to the Board • agreed the proposal for consideration of the CQC's new key lines of enquiry.	
2017-18 (46)	**Third sector in health and social care in Leeds** The Executive Director of Operations presented the paper which provided an overview of the breadth and diversity of the third sector in Leeds, the partnership and joint working already in place and the potential for further developments that would support the Trust and the third sector to develop the future health and care landscape. The Trust Chair welcomed the comprehensive briefing paper which set out clearly the current position on the Trust's partnership and joint working with the third sector; he highlighted the Trust's aim to continue to add value through existing partnerships and to seek new opportunities for partnerships with the third sector in future. He said the Board looked forward to receiving further updates on the development of a vision and strategy for engagement with the third sector. **Outcome:** The Board received and noted the briefing paper.	
2017-18 (47)	**Performance brief and domain reports** The Executive Director of Finance and Resources presented the report, which comprised: • high level performance summary • more detailed reports on the five domains: safe, caring, effective, responsive, well-led and finance. The Executive Director of Finance and Resources said that the report provided a focus on key performance areas that were of current concern to the Trust and a summary of performance against targets and indicators in these areas. He highlighted the following: ***Safe*** The Trust was achieving all but one of its targets within the safe domain. The exception was avoidable category 4 pressure ulcers of which there had been one during August 2017. This had been discussed in detail under Item 43c(i). All other measures were rated as green. ***Caring*** The Trust was meeting all of its targets in the caring domain and expected this to be the position at the end of the 2017/18. ***Effective*** The Board noted that reporting under this domain was made on a quarterly basis and therefore a report was not included in the report for this meeting. ***Responsive*** The Trust continued to perform well in respect of a number of responsive indicators for example waiting times; six were rated as green for August 2017.	

	The volume of clinical activity for August 2017 was 10% below profile and was rated as red. The Executive Director of Finance and Resources advised that a working group had been set up to examine the reasons for the reported decrease in activity in the neighbourhood teams and further analysis would be carried out to determine why reported activity levels were lower. Activity levels were expected to meet the target at the end of 2017/18.Board members agreed that a further report and details of the analysis should be considered by the Business Committee in November 2017. **Action: A report and analysis on activity levels to be considered by the Business Committee on 27 November 2017.** ***Well-led*** The Board were pleased to note that sickness absence rates had fallen to 5.5% and that the rating had returned to green. The Trust Chair noted that staff turnover remained above target at 15.1% and asked whether this figure would rise as a result of the transfer of staff in some services under the Transfer of Undertakings (Protection of Employment) Regulations (TUPE). The Executive Director of Operations said she understood that the national reporting requirements meant that the numbers of staff transferred under the TUPE arrangements had to be included in the figures but figures could be presented to the Board which excluded those staff for information. A Non-Executive Director (BC) noted that the figure for staff turnover was above target and that staff appraisal rates and compliance with statutory and mandatory training remained below target. He observed that a range of initiatives had been put in place with the aim of improving retention figures and proposed that more information about their effectiveness should be included in the quarterly workforce report to the Business Committee in October 2017. **Action: Information on a retention plan to be included in quarterly workforce reports to Business Committee.** The Trust Chair observed that the response rates for the inpatient and community Friends and Family Test remained disappointing. The Executive Director of Nursing said that this was an area of concern and work continued to try to improve response rates. The intention was to address this by the introduction of an action plan in each of the business units. ***Financial position*** The Executive Director of Finance and Resources reported that, in the fifth month of the year, the Trust was meeting its financial targets for most of the indicators with the exception of capital expenditure in comparison to plan and cost improvement plan delivery and he was confident in achieving the control total for 2017/18. The Executive Director of Finance and Resources said that the Trust's financial performance at the end of August 2017 continued to run slightly ahead of the planned control total surplus. He advised that the contract settlement for the community and adolescent mental health services included a reserve to mitigate the cost improvement plan. The report showed that child and adolescent mental health services were not delivering the cost improvement plan.	**Executive Director of Finance and Resources** **Interim Director of Workforce**

	Referring to the information on pay costs contained in the report, a Non-Executive Director (JM) asked if future reports could include more information on agency staff costs along with vacancy factor and cost improvement plan considerations. **Action: Future reports to ensure consideration of the triangulation of data about agency staff costs, vacancy factor and cost improvement plans** **Outcome:** The Board noted the Trust's performance for August 2017.	**Executive Director of Finance and Resources**
2017-2018 (48)	**Serious incidents report** The Executive Director of Nursing introduced the report which provided an update on the outcomes, themes and learning from serious incident investigations closed during July and August 2017. The Executive Director of Nursing reported that there had been a total of 11 serious incidents reported in July and August 2017 taking the total for 2017/18 the year to date to 34. This was a 10.5% reduction overall in serious incidents compared to the same time last year. Ten of the serious incidents related to pressure ulcers; with one other related to complex catheter management. A Non-Executive Director (TD) asked for more information about the re-classification of the incident referred to in the report which related to a fall resulting in a fracture. **Action: The Executive Director of Nursing to provide information on the re-classification of the incident referred to in paragraph 2.9 of the report as a serious incident for all Non-Executive Directors.** A Non-Executive Director (TD) referred to the partnership work with the Clinical Commissioning Group (CCG) to cross reference all serious incidents and asked that a sample of the root cause analysis action plans be made available for the Quality Committee to review in November 2017. **Action: The Executive Director of Nursing to discuss the approach to root cause analysis with the Chair of the Quality Committee.** **Outcome**: The Board: • received and noted the contents of the report • received assurance regarding the management of serious incidents and handling of inquests.	**Executive Director of Nursing** **Executive Director of Nursing**
2017-18 (49)	**Review of operational plan including financial plan 2017/18** The Executive Director of Finance and Resources presented the report which provided an overview of progress towards achieving the corporate objectives and priorities set out in the 2017/18 operational plan at the end of month five and a forecast for the year-end. A Non-Executive Director (BC) advised that the report had been considered by the Business Committee and he felt the report presented to the Board provided reasonable assurance about the achievement of priorities. Referring to the delivery of the corporate objective related to the delivery of high quality care, a Non-Executive Director (JM) asked about the delays in the implementation of safety huddles and quality board in some services.	

	The Executive Director of Nursing advised that safety huddles and quality boards had been implemented across all adult services but were still under development in the children's and specialist services' business units. She said that she was confident that they were on target to be implemented before the year-end. **Outcome:** The Board: • noted the assessment of progress at the end of month five and the forecast for the year-end • approved SMT's proposal to revise the success measure: *all services to complete a service self-assessment by 31 March 2018 in order to reflect the organisational priority to ensure processes support services preparing for tenders are robust* • received a reasonable level of assurance in relation to the achievement of priorities for 2017/18.	
2017-18 (50)	**Emergency preparedness and resilience report and major incident plan report 2016/17** The Executive Director of Operations presented the paper which provided the Board with an overview of emergency preparedness, resilience and response (EPRR) activity over the last year and identified priorities for 2017/18. The Executive Director of Operations advised that, in addition, the Trust had been required to undertake a self-assessment against the national 2017/18 EPRR core standards and to complete a statement of compliance identifying the organisation's overall level of compliance. The Board noted the self-assessment of the Trust's position against the EPRR standards: • the Trust was fully compliant (green) with 51 of 54 core standards and five of the six governance standards • the Trust was not fully compliant with three of the core standards - an improvement plan which set out how the Trust would become fully compliant within the next 12 months had been developed • the Trust had identified a non-executive director (BC) to oversee the portfolio but as this information had not yet been publicised appropriately this governance standard had been rated as not fully compliant • there were no standards where the Trust was not compliant. **Action: The Trust's major incident plan to be received at the next Board meeting on 1 December 2017** **Outcome:** The Board: • noted the EPRR activity over 2016/17 and the priorities for 2017/18 • noted the self-assessment against the EPRR core standards • noted that there were three core standards and one governance standard considered to be 'not fully compliant' • approved the recommendation to submit an overall assessment of 'substantially compliant' against the standards (in line with the national guidance) • reviewed and approved the Trust's associated improvement plan.	**Executive Director of Operations**
2017-18 (51)	**Infection prevention and control annual report 2016/17** The Executive Director of Nursing presented the report which provided information and assurance to the Board in relation to infection prevention and control activities within the Trust and assurance that the organisation was compliant with current legislation, best practice and evidence based care.	

	The Trust Chair commended the work of the team particularly in achieving 76.9% uptake in the staff flu campaign; the top community trust in England in 2016/17. **Outcome:** The Board approved the infection and prevention control annual report 2016/17 and noted the work programme for 2017/18.	
2017-18 (52)	**Safeguarding annual report 2016/17** The Executive Director of Nursing presented the report which reflected the close partnership working between the Trust's frontline services, the multi-agency partnership particularly commissioners, Leeds Safeguarding Children Board, Leeds Safeguarding Adults Board and Safer Leeds. In response to an observation made by Non-Executive Director (IL) about the timeliness of reports to HM coroner in cases of sudden unexpected death in childhood, the Executive Director of Nursing advised that, in cases where reports had not been completed within 28 days, the reasons for the delays had been outside the Trust's direct sphere of responsibility. **Outcome:** The Board approved the safeguarding annual report 2016/17.	
2017-18 (53)	**Significant risks and risk assurance report** The Chief Executive presented the report which comprised: • the summary report which provided the Board with information about risks scoring 15 or above, after the application of controls and mitigation measures. It also provided an analysis of all risk movement, presented the risk profile, identified themes and linked risks to the strategic risks on the board assurance framework. • the board assurance framework (BAF) summary report which gave an indication of the current assurance level determined for each of the Trust's strategic risks. The Board discussed two risks with a current score of 15 (extreme) or above: • the new extreme risk related to *clinical capacity in the adult speech and swallowing team* where a combination of staff shortages and the prioritisation of urgent more complex referrals had impacted on the number of patients on the waiting list and an increase in the number of 18–week breaches. • the de-escalated risk related to a *reduction in funding for neighbourhood teams as a result of the community intermediate care beds re-tender*. The Executive Director of Operations advised that, following confirmation from commissioners that funding would be maintained during the financial year 2017/18, this risk had been de-escalated. The Board discussed two strategic risks contained with the BAF: • the proposed re-wording of the risk relating to *if the Trust does not receive a 'good' CQC rating.* In response to a suggestion from Non-Executive Director (TD) it was agreed that the wording be revised to reflect the need for maintaining 'good' for all services as well as where improvement was required. • the risk related to *the Trust's response to changes in commissioning, contracting and planning landscape*. It was agreed that a risk related to new partnership arrangements should be considered.	

	Outcome: The Board noted: • the content and revisions to the risk register • the current assurance levels provided by the BAF summary • the suggestions made about the rewording of an existing risk and development of a new risk in the BAF.	
2017-18 (54)	**Board work plan** The Chief Executive presented the Board work plan (public business) for information and noted that the work plan would be revised, as and when required, in line with outcomes from the Board meetings. **Outcome**: The Board noted the work plan.	
2017-18 (55)	**Approved minutes of Board committees** The Board noted the following final approved committee meeting minutes and reports presented for information. a. Quality Committee: 24 July 2017 b. Business Committee: 26 July 2017 c. Leeds Safeguarding Children Board minutes: 21 March 2017	
2017-18 (56)	**Close of the public section of the Board** The Trust Chair thanked everyone for attending and concluded the public section of the Board meeting.	
Date and time of next meeting **Friday 1 December 2017, 9.00am – 12 noon.** **Boardroom, Trust Headquarter, Stockdale House, Victoria Road, Leeds LS6 1PF**		

Signed by the Trust Chair: Neil Franklin
Date: 1 December 2017

AGENDA ITEM 2017-18 (61b)

Leeds Community Healthcare NHS Trust
Trust Board meeting (held in public) actions' log: 1 December 2017

Agenda Number	Action Agreed	Lead	Timescale	Status
6 October 2017				
2017-18 (43c)	**Quality Committee Assurance Report: p**ressure ulcers - analysis to identify themes and common errors in the management of pressure ulcers to Quality Committee 23 October 2017.	Executive Director of Nursing	October 2017	Completed
2017-18 (44)	**Chief Executive's report:** feedback from LTHT'S 'perfect week' to Business Committee on 27 November 2017.	Executive Director of Operations	November 2017	Completed
2017-18 (47)	**Performance brief and domain reports:** responsive domain – report and analysis on activity levels to be considered by Business Committee on 27 November 2017.	Executive Director of Finance and Resources	November 2017	Completed
2017-18 (47)	**Performance brief and domain reports:** retention information to be included in the quarterly workforce reports to Business Committee	Interim Director of Workforce	October 2017	Completed
2017-18 (47)	**Performance brief and domain reports: f**uture reports to ensure consideration is given to triangulation of data about agency staff costs, vacancy factor and cost improvement plan	Executive Director of Finance and Resources	November 2017	Completed
2017-18 (48)	**Serious incidents report:** information on the re-classification of the incident relating to a fall resulting in a fracture to be circulated to non-executive directors	Executive Director of Nursing	November 2017	Completed
2017-18 (48)	**Serious incidents report:** approach to root cause analysis action planning to be discussed with the Chair of Quality Committee	Executive Director of Nursing	November 2017	
2017-18 (50)	**Emergency planning:** major incident plan to be received by Board on 1 December 2017	Executive Director of Operations	December 2017	Completed

Key		
Total actions on action log	**8**	
Total actions on log completed since last Board meeting: 6 October 2017	**7**	
Total actions not due for completion before 1 December 2017; progressing to timescale	**1**	
Total actions not due for completion before 1 December 2017; agreed timescales and/or requirements are at risk or have been delayed	**0**	
Total actions outstanding as at 1 December 2017; not having met agreed timescales and/or requirements	**0**	

NHS
Leeds Community Healthcare
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AGENDA ITEM 2017-18 (61ci)

Report to: Trust Board 1 December 2017
Report title: Quality Committee 20 November 2017: Committee's Chair assurance report
Responsible Director: Chair of Quality Committee **Report author:** Executive Director of Nursing
Previously considered by: Not applicable

Purpose of the report
This paper identifies the key issues for the Board from the Quality Committee held on 20 November 2017 and indicates the level of assurance based on the evidence received by the Committee where applicable.

Service spotlight: Infection prevention and control service
The Committee received a presentation from the infection prevention and control (IPC) service. The highly skilled and dedicated specialist team had had a number of achievements, including: high uptake in the flu campaign; no cases of MRSA bacteraemia had been assigned to the Trust; one case of C difficile infection had been reported during October 2016 but there had been no 'lapses in care' related to case acquisition; implementation of a sepsis management algorithm; development of a group of IPC champions; engagement opportunities with the public to enable environmental inspections. The service was not without challenge and the Committee noted issues related to needlestick injuries, the increase in antibiotic resistant organisms and achieving mandatory training target of 90%.

Director of Nursing (DoN) and quality governance report
Serious incidents: pressure ulcers
During October 2017 there had been one avoidable category 3 pressure ulcer and one avoidable category 4 pressure ulcer. The total number of all pressure ulcers reported in October 2017 was consistent at 60. The need to sustain significant systematic effort on pressure ulcer avoidance and management was reinforced as the Committee felt that the greater incidence of pressure ulcers needed to be addressed to avoid emergence of a continuing trend. The Committee noted that November 2017 will be a month focused on pressure ulcers; this will reiterate learning, good practice and key messages; a workshop in December 2017 will focus on reducing the incidence of avoidable pressure ulcers

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

Caseload complexity and dependence
The Committee heard about patient caseload complexity and dependency levels in neighbourhood teams. A spot check audit, using an initial set of six criteria, had been undertaken to provide evidence of caseload complexity; It was noted that this was early work and there was not an evidence based tool. Work continues to develop an appropriate complexity monitoring tool. As at 1 November 2017, the neighbourhood teams' caseload size across all teams was 7290, with 207 highly complex and dependant patients. At the point of this audit the percentage of complex and high dependency level patients is 2.9%; the patient complexity profile is not evenly distributed across the city.

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

Patient self-care
The Committee noted the ongoing development of effective self-care strategies and approaches including those supported by health coaching. Opportunities for self-care were explored during holistic assessments and caseload handovers. The Committee heard about initiatives including: administration of Tinzaparin and other low molecular Heparins and Insulin.

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

Performance brief and domain reports

Safe staffing levels

The Committee noted that the safe staffing 'fill' rate in inpatient facilities had fallen below the 95% target in October 2017. The Committee was keen to acknowledge that the inpatient units worked hard and had maintained high standards of care amidst underpinning staffing pressures and shortages. This was also in the final month of the closing of a unit and transition to a new model.

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

Venous thromboembolism (VTE) assessments

The percentage of completed VTE assessments had increased in October 2017 (94.9%) compared to September 2017 (77.8%) against a target of 95%. Whilst the year to date position remains rated as 'red', the Committee noted further work to improve recording and verify data was required; the Committee would be updated further.

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

Clinical audit

The number of clinical audits completed stands at 10 (against a target of 117 for 2017/18). Whilst it was noted that 19.6% of audits had been started and a significant volume of reporting was scheduled for completion towards the end of the year, the Committee was concerned about the apparent shortfall in completed audits.

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

Clinical supervision

The Committee noted that 61% of practitioners had received clinical supervision in quarter two. This is down from 80% in quarter one of 2017/18. Services continued to be supported to achieve the 80% target including ensuring there is accurate recording of supervision. The Committee noted that work was required around recording and ease of system use.

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

Hannah House

The Committee received an update on the progress at the quality improvement measures being introduced at Hannah House. Staffing is currently below establishment due to a combination of factors including maternity leave, staff sickness (23%), vacancies and waiting for staff to take up post. In order to provide safe care, capacity has been reduced by two beds for a three month period. A programme of estates work has been carried out, recruitment activity and staff engagement work has continued, The unit continues to receive enhanced support.

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

'Speaking out' reports

The Committee received scheduled reports from the Guardian of Safe Working Hours and the Freedom to Speak Up Guardian. Both of which provided reasonable assurance that the Trust had effective processes in place to allow staff to raise concerns about working conditions and/or the quality of patient care and that, when matters were raised that concerns could be addressed and 'lessons learnt'.

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

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2017-18 (62)

Meeting: Trust Board 1 December 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 some aspects of the context in which the Trust works and helps to frame the Board's consideration of the Board meeting's papers.

Main issues for consideration

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

- Care Quality Commission inspection outcome: implementing actions
- New service models
  - Community care beds
  - Child and adolescent mental health services
- Seasonal resilience: planning for winter
- Celebrations: awards and staff conferences
- Well-led framework
- The Trust's overall performance
- National developments

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

2 Care Quality Commission: inspections of services

2.1 Earlier in 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 The formal report on the inspections indicated an overall rating of the Trust as 'good'. This outcome (as reported to the Board on 6 October 2017) was excellent news and reflects the commitment and hard work of all staff to provide the highest standards of care to the people of Leeds.

2.3 On 12 October 2017, senior staff from the CQC met with the Trust and the Trust's commissioners. The inspectors shared their perspectives on both good practice and areas where the Trust has some important work to undertake in order to ensure that the quality and safety of care is of a comparable high standard across all areas.

2.4 The commissioners were positive about the Trust and viewed the Trust's ratings as celebratory, viewing the Trust as 'forward thinking and well structured'. The commissioners provided assurance to the CQC in relation to positive engagement and were open, honest and transparent about the inspection findings and the Trust's actions following the inspection.

2.5 The CQC action plan (quality improvement plan) was scrutinised at Quality Committee on 23 October 2017 and submitted to the CQC on 30 October 2017.

2.6 In order to record action to sustain and improve quality, performance against the quality improvement plan will be monitored closely both by officers of the Trust and by the Board's Quality Committee.

2.7 As part of this monitoring, the Quality Committee will be particularly keen to see improvements in relation to the Trust's inpatient units for adults and for children. The Quality Committee received a dedicated paper on quality improvements at Hannah House at its meeting on 20 November 2017.

3 Developing new service models

3.1 The Trust remains committed to maintaining services that deliver superlative care and meet the health care needs of local people. In addition, the Trust also seeks out opportunities for business growth particularly where this complements and enhances the Trust's current 'portfolio' of services.

3.2 In recent months, there have been a number of opportunities whereby local commissioners have invited competitive bids from service providers to run new or revised service models.

3.3 The Trust has had some notable successes in this respect. For example:

- Community care beds (see section 4 below)
- Child and adolescent mental health inpatient services (see section 5 below)

4 Community care beds

4.1 On 1 November 2017, a new community intermediate care inpatient services model 'went live' in Leeds.

4.2 The Leeds Community Bed Alliance with Leeds City Council and Leeds Teaching Hospitals NHS Trust includes 40 community care beds at South Leeds Independence Centre (renamed Recovery Hub @ South Leeds) and 32 beds at Suffolk Court (renamed Recovery Hub @ North West Leeds). A further 12 beds have been awarded at Pennington Court and these will be subcontracted initially on a temporary six months basis.

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

4.4 The Board would want to pay tribute and say 'thank you' to staff from the Community Intermediate Care Unit (CICU) and South Leeds Independence Centre (SLIC) who have provided an excellent standard care for many years and who have worked tirelessly through the period of transition to the new service model.

5 Child and adolescent mental health inpatient services

5.1 The Trust has been identified as the lead trust in a new arrangement to provide a coordinated response to the provision of child and adolescent mental health inpatient services (tier 4) across West Yorkshire.

5.2 The commissioner for the service (NHS England) invited proposals and the Trust, working with its partners (Leeds and York Partnership NHS Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust and Bradford District Care NHS Foundation Trust) was identified to introduce a new model of care for this highly specialist area of work (also see later item on the Board's agenda).

6 Seasonal resilience: planning for winter

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

6.2 The importance of good local planning has been emphasised by national communications placing a focus on patient flow to benefit clinical outcomes and free up capacity.

6.3 Jim Mackey, Chief Executive of NHS Improvement wrote to trusts on 1 November 2017 and acknowledged continued local leadership in preparation for winter. He wrote that:

'We need to significantly reduce the number of patients experiencing delays to discharge to improve their care and free up much-needed capacity in the acute and non-acute sector over winter.

Over the last two years, non-acute delays have risen by 24%. The interface between acute, social care and community services contributed significantly to this increase, with a 49% rise in patients awaiting care packages at home (with around two-fifths wholly or partly attributable to the NHS). It is vital for the patients under our care and for the efficient running of our services that you, together with your boards, prioritise reducing delays in discharge over the coming months. This will require both action within your organisation and working across your local system to improve flow throughout the entire patient journey.'

6.4 Chief executives who provide community services have been invited to a national meeting on 27 November 2017 to discuss managing patient flow over winter. The meeting, organised by NHS Improvement, will be led by both Jim Mackey, Chief Executive of NHS Improvement and Simon Stevens, Chief Executive of NHS England.

6.5 In Leeds, as reported previously, a local delivery plan has already been drawn up. The plan comprises some nationally mandated components and local priorities and covers approaches to:

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

6.6 Internal work includes:

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

6.7 The internal winter plan is overseen by a fortnightly steering group and progress discussed with SMT no less frequently than on a monthly basis.

6.8 A number of aspects of effective and productive systems and processes were tested recently. The Trust fully participated in an initiative led by Leeds Teaching Hospitals NHS Trust called 'perfect week', whereby problem-solving resources were targeted at rapid escalation and resolution of issues and incidents that would otherwise impede the smooth running of hospital services.

6.9 The Trust has launched its seasonal flu campaign as part of the Trust's approach to planning for additional service pressures this winter. Year on year, the Trust wishes to see more frontline staff vaccinated to help protect staff, families, communities and vulnerable patients. Last year, the Trust achieved 76.6% uptake. This year's campaign is well underway and, as at 20 November 2017, 57% of frontline staff have taken up the offer of vaccination. This represents a huge effort by the Trust's infection prevention and control team to keep everyone safe and well this winter.

6.10 However, in addition, this year Leeds is facing an additional challenge in that there has been an increase in the number of reported cases of measles amongst school age children in the city. The Trust has responded promptly and has offered a programme on measles, mumps and rubella (MMR) immunisations to school pupils. The Board will wish to thank all those staff who responded to an appeal for suitably-skilled staff to help with this urgent programme of work.

7 Staff success: national awards

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

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

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

7.3 The teams at Wetherby Young Offenders Institute and Adel Beck Secure Children's Home have won an award at the Nursing Times Awards 2017. 'Locked up and still hard to reach: integrated healthcare for children and young people in custody' was a joint submission by the Trust, South West Yorkshire Partnership NHS Foundation Trust and NHS England and recognised the outstanding work of the teams in some of the most difficult environments working with the most vulnerable patients.

7.4 The Trust has also been recognised for the excellent work undertaken by the Trust's freedom to speak up guardian. The Trust received a runner up award in the category for 'learning from speaking up' in the national freedom to speak up awards 2017.

7.5 One of the Trust's consultant clinical psychologists has been awarded the Association for Infant Mental Health UK Louise Emanuel award. The award was presented at a national conference in London. It was given to 'a person who has demonstrated a significant contribution to infant mental health in terms of practice or through their work in research and policy'.

8 Conferences for staff

8.1 The Trust proudly hosted a conference for all non-registered staff on 2 November 2017. The aim of the event was to recognise the contribution made by this group of staff; on the day there was the opportunity to:

- Hear inspirational stories from individuals who began their careers in non-registered roles and have gone on to more senior positions both inside and outside of the Trust
- Hear from service users about the difference the non-registered workforce make to their lives on a daily basis
- Discuss ideas with like-minded people and inspire each other

8.2 The event, which was a 'first' for the Trust, has been very well-evaluated and the Trust is already working to implement a number of actions.

8.3 The Trust also held a medical and dental conference on 6 November 2017; the conference was jointly chaired by the Trust's Chair, Neil Franklin and the Trust's newest non-executive director, Professor Ian Lewis. This annual conference covered:

- New models of care
- Medical and dental leadership
- PReP for dental appraisals
- European Data Protection Directive
- Personal resilience

9 Compliance with the well-led framework

9.1 The Trust continues to demonstrate compliance with the national well-led framework which is fully aligned with the CQC's key lines of enquiry for the well-led domain. By robustly assessing itself and aligning improvement against the well-led framework, the Trust is therefore also aligning itself with the requirements to achieve a 'good' CQC rating for the well-led domain.

9.2 The Trust undertook a self-assessment in September 2015 and identified six priority action areas. At the meeting in June 2017 the Board was updated on progress against the six priority action areas.

9.3 Over the past six months examples of significant achievements and challenges across the six priority action areas have included:

- Receiving a 'good' overall CQC rating and for 'effective', 'caring', 'responsive' and 'well-led' domains. For the well-led domain, the CQC report highlighted
  - stable, cohesive and visible leadership
  - most staff positive about the open culture
  - staff aware of the Trusts' vision and values
  - governance processes stronger since the 2014 inspection and the majority of QIP actions addressed

  however:
  - governance and assurance processes in Hannah House and Little Woodhouse Hall require strengthening
  - staff engagement lower in Hannah House and Little Woodhouse Hall
  - public engagement excellent in some services but could be stronger in others
- The Chief Executive, other members of SMT and senior leaders are fully involved in shaping key strands of the Leeds Health and Care Plan.
- The focus on quality in services has been strengthened through the rolling out quality boards and safety huddles. In Children's Services quality boards and safety huddles have been established in Hannah House, Little Woodhouse Hall and ICAN. The Specialist Business Unit is implementing quality boards and safety huddles in services where appropriate in quarter three of 2017/18.

- Work commenced to further strengthen identification and escalating of risks to quality in services, particularly small services and services where practitioners are isolated, so that appropriate support can be provided on a timely basis.
- Cultural mapping established: triangulation of soft intelligence to enable identification of teams and services requiring additional support or intervention
- Strengthening learning from incidents: positive learning from development of the pressure ulcer review processes has been applied to the falls review
- Skills and competency development remained a priority focus for adults services although releasing staff to attend training has continued to be challenging given capacity pressures.
- Staff engagement to understand how best to address staff health and well-being issues identified through the 2016 staff survey: led to development of the 'Feel Good' pledge
- Agreement of a plan for developing outcome reporting based on outcome measures identified as being relevant and meaningful for the greatest number of services
- Continued review of Trust-wide activity. Activity profiles have been revised or are in the process of being revised for multiple services which will allow a more accurate assessment of performance. Focused analysis of neighbourhood teams' activity has shown an increase in contact duration. A decrease in the number of contacts was expected due to the implementation of initiatives such as New Ways of Working.
- A challenge for the Trust is evidencing increased complexity of patient caseloads that many services are experiencing. Neighbourhood teams are trialling an approach for reporting complexity.

9.4 As previously reported, the CQC and NHS Improvement have revised the well-led framework. Under the CQC's new inspection regime, the CQC 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.

9.5 The new framework is very similar to the framework currently in use. There is an increased focus on culture, finance and resource governance with a stronger emphasis on service sustainability.

9.6 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. Compliance with the eight well-led key lines of enquiry will need to be reviewed in order to identify strengths, gaps and required actions to achieve a good standard of compliance.

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:

- Safe staffing 'fill rate' in inpatient units: 94.4% against a target of 95%
- Reducing the incidence of avoidable pressure ulcers: regrettably, after good performance in the first quarter of the year, the Trust recorded both avoidable category three and category four pressure ulcers in quarter three and a further category four pressure ulcer was recorded in October 2017; this matter is the subject of focused work with regular reports to the Quality Committee
- The target reduction in falls in inpatient units has been achieved in the year to October 2017
- On-going work in relation to incident reporting continues and particularly the 'closing' actions arising from incidents
- Work to ensure that the recording of duty of candour reporting matches the practice of staff is proving successful; 100% of applicable incidents received an appropriate apology
- Percentage of patients recommending care: is 100% for inpatient settings and 96.2% for community patients against target of 95%
- Progress against the clinical audit programme for 2017/18 is behind the planned position for the year to date
- The reported figure for the level of clinical supervision stands at 61% against a 80% target

10.3 The Trust continues to perform well in respect of the responsive indicators with continuing good performance against all statutory and non-statutory waiting times. There continues to be a negative variance from profile in relation to the number of patient contacts in October 2017 (minus 5.4%); the year to date figure is minus 6.2% against a target of up to 5%.

10.4 A number of workforce related indicators remain a concern, for example staff turnover has improved by a small margin (14.1%) but remains a concern. Staff appraisal rates have reduced and are below target at 81.3% (target 90%) and compliance with statutory and mandatory training requirements stands at 91.5%; further detail is contained in the performance report. The overall sickness absence rate has worsened in October 2017 to 5.8%.

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

11 NHS Improvement: use of resources rating

11.1 On 8 November 2017, NHS Improvement and the Care Quality Commission (CQC) published a joint consultation inviting all interested stakeholders to comment on a proposed approach to reporting and rating how efficiently and effectively NHS trusts and foundation trusts are using their resources to provide high quality, sustainable care. The consultation follows previous work by NHS Improvement and CQC seeking stakeholders' views on a proposed methodology and framework for assessing how trusts are using their resources. We published our response to this consultation and the final Use of Resources framework and methodology in August 2017.

11.2 This new consultation covers the final steps in the process. Specifically, seeking sector-wide feedback on our approach to how CQC's trust-level quality ratings (ie safe, caring, effective, responsive and well-led) will be combined with NHS Improvement's use of resources rating to produce an overall trust-level rating.

12 NHS Improvement: consultation on single oversight framework

12.1 On 13 November 2017, NHS Improvement published a refreshed document which sets out a single oversight framework covering all NHS providers.The framework sets out how information will be collected on trusts' performance, how concerns will be identified and a model by which trusts will categorised in one of four segments according to the level of challenge each trust faces.

12.2 The segments range from 1 to 4 whereby 1 equates to 'no evident concerns' and 4 indicates 'critical issues'. The level of monitoring of a trust by NHS Improvement will be determined linked to the segment ie from lower frequency monitoring for segment 1 to mandated support with directed improvement actions and recovery trajectories at segment 4. To determine the segmentation, NHS Improvement will scrutinise a range of performance measures and indicators across five areas, namely the assessment of:

- Quality of care: using ratings from four of the CQC domains (safe, caring, effective and responsive) plus progress against standards for implementing seven day services
- Finance and use of resources: including progress against financial control totals and financial efficiencies as captured in the use of resources rating
- Operational performance: reflecting existing national targets and standards including waiting times, referral to treatment times, response times and access to services
- Strategic change: focusing on progress in implementing strategic changes with a particular focus on sustainability and transformation plans
- Leadership and improvement capability: building on the CQC's and NHSI's joint well-led framework to capture good governance and leadership and to introduce a focus on capacity for improvement

13 Recommendation

13.1 The Board is recommended to note the contents of this report

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM
2017-18
(63)

Meeting Trust Board 1 December 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, 15 November 2017 Quality Committee, 20 November 2017 Business Committee, 27 November 2017	**For information**	

Purpose of the report

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

The report highlights any current concerns relating to contracts that the Trust holds with its commissioners. It also 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 is available in the domain reports.

Main issues for consideration

Safe
The Trust is currently achieving most of its targets within the safe domain for the year to date. The exceptions are avoidable category 4 pressure ulcers of which there has been one this month and the percentage of venous thromboembolism risk assessments completed. The latter measure has increased to 94.4% in October (amber) after a reduction in September to 77.8%, but the year to date rating remains red.

The overall safe staffing fill rate is rated amber.

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

Caring
100% of respondees would recommend inpatient care in October and this measure returns to pre-September levels.

All indicators are expected to be rated green at year end.

Effective
61% of practitioners have received clinical supervision in the last quarter, in accordance with the Trust's policy. This is down from 80% in quarter one 2017/18 and means the Trust is moving away from its end of year target after strong quarter one performance. Services continue to be supported to achieve the 80% target.

Responsive
The Trust continues to perform well in its indicators relating to waiting lists. All remain rated as green for October.

The Trust is 5.4% below its activity profile in October resulting in amber rating again this month and an amber rating year to date. A recovery was seen in September but this has decreased by 0.5% in October. The Trust is in a better position than reported in August which was 9.7% below profile. This challenge is the subject of the key areas of focus section in this report.

Well Led
The total sickness absence has risen to 5.8% this month. This is predominantly due to an increase in short term sickness which has risen from 1.9% in September to 2.3% this month. Both of these indicators are currently rated red. The short term sickness absence rate is now forecast as amber. Long term and overall sickness absence are forecast green.

The staff appraisal rate remains rated red in October. Also rated red are the response rates for the inpatient and community friends and family test measures, both of which are also forecast to be red.

The number of days between placing advertisements and filling vacancies has increased to 131 days for qualified nurses and to 96 for administrative staff and are rated red but police custody suite services are rated green at 106 days and well within target.

Finance
The Trust's financial performance is marginally ahead of plan. Cost improvement plans delivery continues to be a concern and pay overspending has been mitigated by the release of reserves. Staffing levels are below funded whole time equivalents for all business units; temporary staffing is in place to mitigate service risks.

The forecast outturn position demonstrates the Trust should be able to achieve the control total surplus of £3.034m. However, there are further financial risks such as the non-delivery of CQUINs, winter pressures, contract changes and redundancy costs that may have a negative impact as the year continues and the Trust has limited resources available to mitigate these should they arise.

Recommendations

The Board is recommended to:

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

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare NHS Trust

Performance Brief, October 2017

Senior Management Team – 15 November 2017
Quality Committee – 20 November 2017
Business Committee – 27 November 2017
Trust Board – 1 December 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.

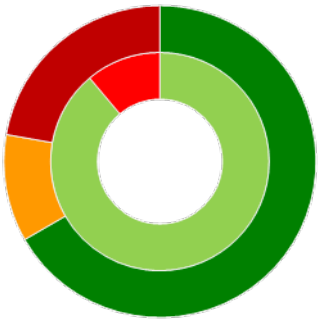
It provides a focus on key performance areas that are of current concern to the Trust. It provides a summary of performance against targets and indicators in these areas, highlighting areas of note and adding additional information where this would help to explain current or forecast performance.

1. High Level Performance Summary

1.1 Summary of Performance Against High Level Indicators

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

1.1.1 Safe



The Trust is currently achieving most of its targets within the safe domain for the year to date. The exceptions are avoidable category 4 pressure ulcers of which there has been 1 this month and the percentage of VTE Risk Assessments Completed. The latter measure has increased to 94.4% in October (amber) after a dip in September to 77.8%, but the year to date rating remains red.

Overall Safe Staffing Fill Rate is rated amber.

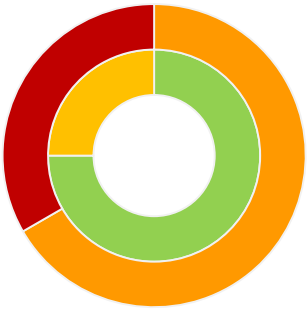
Green is forecast for all indicators with the exception of the number of avoidable category 4 pressure ulcers.

1.1.2 Caring

100% of Inpatients would Recommend Care in October and return to pre-September levels.

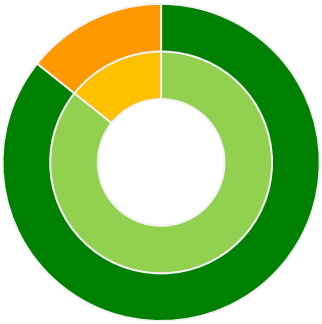
All indicators are expected to be rated green at year end.

1.1.3 Effective



61% of LCH practitioners have received clinical supervision in the last quarter, in accordance with LCH policy. This is down from 80% in Q1 2017/18 and means the Trust is moving away from its end of year target after strong Q1 performance. Services are expected to achieve the 80% target.

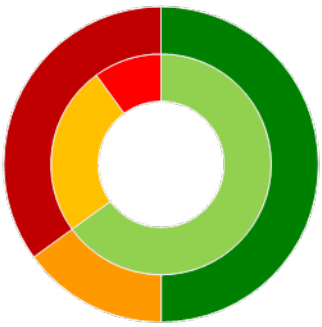
1.1.4 Responsive



The Trust continues to perform well in its indicators relating to waiting lists. All remain rated as green for October.

The Trust is 5.4% below its activity profile in October resulting in amber rating again this month and an amber rating year to date. A recovery was seen in September but this has decreased by 0.5% in October. We are in a better position than we reported in August which was 9.7% below. This challenge is the subject of the Key Areas of Focus section in this report.

1.1.5 Well Led

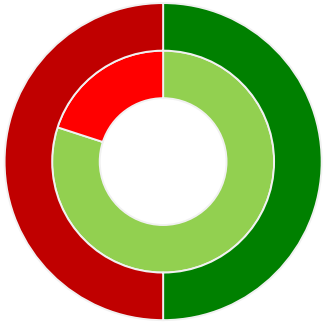


The total sickness absence has risen to 5.8% this month. This is predominantly due to an increase in short term sickness which has risen from 1.9% in September to 2.3% this month. Both of these indicators are currently rated red. The short term sickness absence rate is now forecast as amber. Long term and overall sickness are forecast green.

The AfC staff appraisal rate remains rated red in October. Also rated red are the response rates for the inpatient and community FFT measures, both of which are also forecast to be red.

The number of days between placing adverts and filling vacancies has increased to 124 days for qualified nurses and is rated red. It is 85 days for administration staff which is amber but police custody is rated green at 106 days and well within target.

1.1.6 Finance



The Trust financial performance is marginally ahead of plan. CIP delivery continues to be a concern and pay overspending has been mitigated by the release of reserves. Staffing levels are below funded wtes for all business units; temporary staffing is in place to mitigate service risks.

The forecast outturn position demonstrates the Trust should be able to achieve the control total surplus of £3.034m. However there are further financial risks such as the non delivery of CQUINs, winter pressures, contract changes and redundancy costs that may have a negative impact as the year continues and the Trust has limited resources available to mitigate these should they arise.

1.2 Statutory Breaches

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

2. Contract Related Performance Highlights

2.1 Health Needs Assessments for Looked After Children

Under the contract with the CCG the Trust is expected to deliver Health Needs Assessments for Looked After Children within 20 days in 95% of cases. In September only 86.4% of children were seen within this time frame. There was a high demand for these assessments in September. There were 22 eligible children in comparison to an average of 14 per month this year. This high demand meant that there were not enough appointment slots available. Patients were offered the first available appointment.

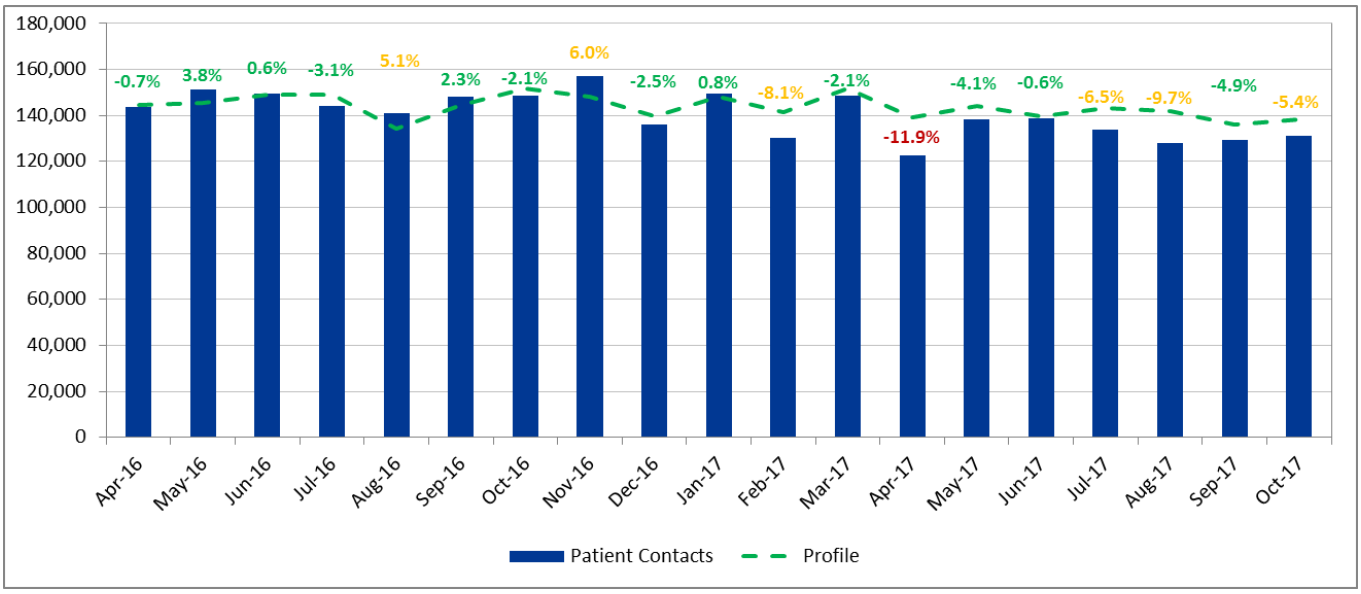
2.2 IAPT – Proportion of Patients Moving to Recovery

The proportion of patients moving to recovery in our IAPT service dropped below the 50% target for the first time in September. This is an exception. A pilot project to improve recovery transitioned from Northpoint's direct control to the consortia overall over the summer. It is thought that it is this transition that caused the low figure in September. The service are confident that the transition period has now finished. The total quarter 2 figure is expected to exceed the target and an improved recovery rate is expected in quarter 3.

3. Key Areas Of Focus

3.1 Patient Contacts – Variance from Profile

The Trust continues to miss its target for patient contacts. Activity has recovered since August when activity was 9.7% below profile, but October's activity is still 5.4% below profile. The graph below shows trust-wide, monthly patient contacts in comparison to profile.



Since we last commented in August's report a number of services have had new profiles signed off by the CCG. These services are now assessed against profiles that reflect the work that is being undertaken in those services.

Continence, Urology and Colorectal Services, Adult Nutrition and Dietetics and the Leeds Wound Prevention Service all have new profiles that consider not only face to face contacts, but also non-face to face and non direct patient activity. These profiles were developed as the services had changed their service provision. They had increased the non-face to face contacts with patient, for example conducting simple reviews on progress over the telephone, and also increased the amount

of professional support they deliver to other LCH staff; providing specialist input to cases without directly seeing the patient themselves.

Increases in profile have been signed off for CIVAS, and the diabetes and respiratory services. These reflect additional investment.

The activity delivered by these services makes up a small proportion of the trust-wide total and therefore does not affect the overall variance from profile.

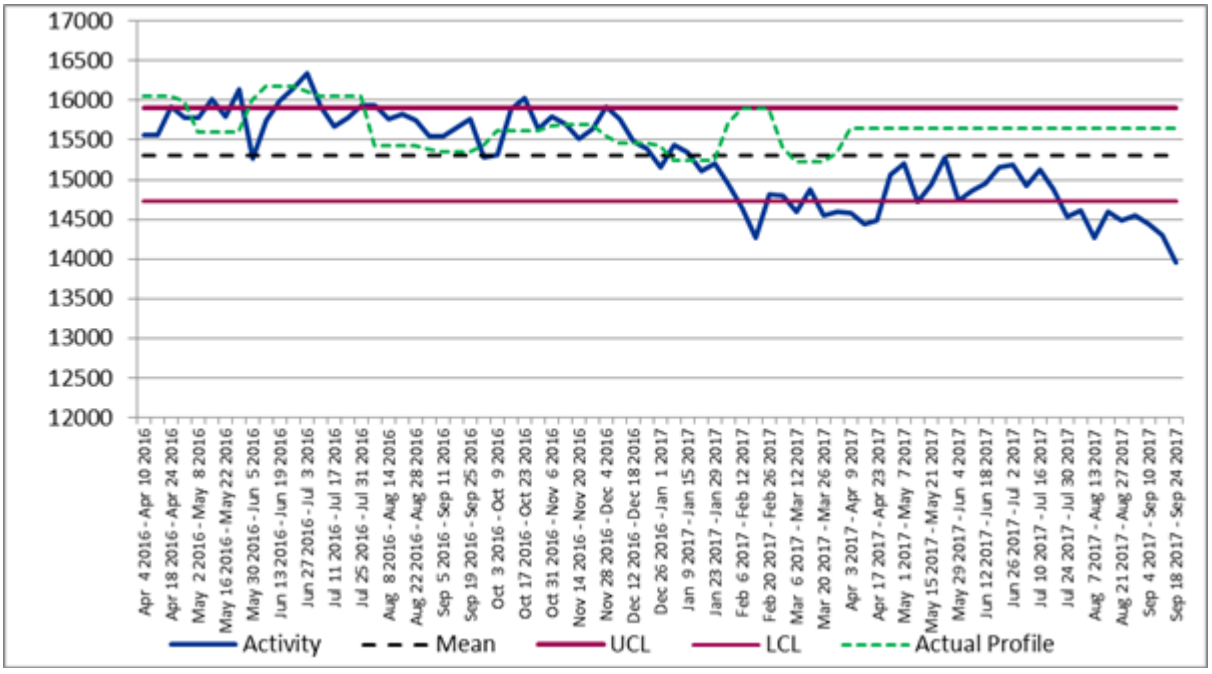
Work on revising profiles for an additional set of services continues. Each of these profile reviews are at various stages. Regular updates will be provided in this report on the progress of these. These services include:

- IAPT
- Leeds Sexual Health Service
- MSK
- School Nursing
- Early Start Service (Health Visiting)
- Children's Occupational Therapy
- Child Protection Medical Service
- Children's Physiotherapy
- Paediatric Neuro Disability
- Community Paediatrics

IAPT, Leeds Sexual Health Service, MSK, School Nursing and the Early Start Service make up significant proportions of the activity delivered by the Trust. Adjusting profiles so they are more reflective of actual service delivery is likely to bring these services closer to profile and therefore improve trust-wide variance from profile.

The most significant contributor to trust-wide patient contacts are the Neighbourhood Teams. They are currently delivering on average around 63,000 contacts per month. This makes up around 45% to 50% of the Trust's total activity.

The number of patient contacts in the neighbourhood teams has been below profile since February 2017 as shown in the statistical process control (SPC) chart below.



The graph shows that there was a significant reduction in recorded patient contacts at this point, although the downward trend had been evident since summer 2017. It is thought that the decrease in contacts is due to a positive change in care delivery. In order to confirm that the reduction is in line with expectations the Neighbourhood Team Activity Review Group has been meeting regularly both as a group and with Senior Management.

A decrease in the number of patient contacts delivered was expected as a result of the implementation of New Ways of Working (NWOW) and the electronic patient record (EPR). This decrease represents an increase in the efficiency of the services provides by the Neighbourhood Teams. Patient contacts increased significantly in duration between July and December 2016 from around 30 to 37 minutes. Seemingly small, this 7 minute increase is material in a service delivering over 60,000 contacts per month. Higher numbers of interventions are now being delivered in fewer contacts as the service is delivered more efficiently to patients; this increase in the patient contact time per visit but reduced number of visits is not only more efficient but provides a higher quality and more convenient service to patients. In addition to EPR and NWOW, other programmes and initiatives have been implemented over this time period, including:

- Implementation of holistic assessment
- EPR implementation
- Data quality
- Improved outcoming
- Staff available
- Improved case management
- Increase in complexity
- First to follow up ratio
- Stricter triage
- Number of referrals
- Implementation of re-ablement
- Triage role
- Reduction in inappropriate referrals
- Case management approach

Each has had an impact on contact duration. To date a causal link between the change in contact duration and each individual initiative has not been made. Each of these have affected Neighbourhood Teams processes in part and in different ways as they were each delivering the service locally in varying ways. Whilst it is not possible to isolate the impact of each individual initiative, together they have had a significant impact on how the service is delivered

This increase in contact duration means that Neighbourhood Team clinicians are spending more time with patients each week. Estimates show that staff are currently delivering around 16 hours of patient facing contacts per WTE. This is in comparison to 14 hours between April and July 2016.

This provides an explanation of why the Neighbourhood Teams remain under pressure despite a drop in the number of patient contacts. Other reporting mechanisms have shown that this is the case. An audit of rescheduled visits shows that these have been increasing and individual Neighbourhood Teams are regularly reporting their daily Reap level at level 5 indicating that they are struggling to cover essential visits.

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	Oct	Nov	Dec	Forecast
Overall Safe Staffing Fill Rate - Inpatients	2017/18	>=95%	-	97.7%	98.7%	94.4%			●
	2016/17		-	100.9%	100.6%	100.0%	98.2%	100.1%	
Patient Safety Incidents Reported in Month Reported as Harmful	2017/18	0.63 to 1.01	0.91	0.94	0.89	0.90			●
	2016/17		0.77	-	-	0.71	0.64	0.64	
Potential Under Reporting of Patient Safety Incidents	2017/18	1.39 to 2.66	2.27	2.28	2.26	2.39			●
	2016/17		2.47	-	-	2.32	1.94	2.01	
Serious Incident Rate	2017/18	0 to 0.13	0.06	0.06	0.06	0.08			●
	2016/17		0.05	-	-	0.08	0.02	0.03	
Percentage VTE Risk Assessment Completed	2017/18	>=95%	93.9%	96.3%	89.9%	94.9%			●
	2016/17		83.4%	81.0%	88.8%	82.8%	94.4%	74.6%	
5% Reduction in Falls Resulting in Avoidable Harm in our Community Inpatient Units	2017/18	7	4	3	0	1			●
	2016/17		13	-	-	-	-	-	
10% Category 3 Avoidable Pressure Ulcer Reduction Target	2017/18	13	9	2	6	1			●
	2016/17		24	12	4	3	1	2	
0 Avoidable Category 4 Pressure Ulcers	2017/18	0	2	0	1	1			●
	2016/17		0	1	2	1	0	0	
Percentage of Incidents Applicable for DoC Dealt with Appropriately	2017/18	100%	100.0%	100%	100%	100%			●
	2016/17		57.8%	79%	75%	45%	61%	57%	

Caring - staff involve and treat people with compassion, kindness, dignity and respect		YTD Target	YTD	Q1	Q2	Oct	Nov	Dec	Forecast
Percentage of Staff Recommending Care (Staff FFT)	2017/18	>=73%	-	81.0%	75.0%				●
	2016/17		-	77.5%	73.7%				
Percentage of Inpatients Recommending Care (FFT)	2017/18	>=95%	-	100.0%	96.7%	100.0%			●
	2016/17		-	100.0%	93.9%	100.0%	96.0%	100.0%	
Percentage of Community Patients Recommending Care (FFT)	2017/18	>=95%	-	95.3%	95.5%	96.2%			●
	2016/17		-	96.3%	95.2%	91.4%	95.6%	95.0%	
Written Complaints - Rate	2017/18	No Target	50	50	57	21			
	2016/17		217	77	48	8	9	12	

1.0 Patient Safety Incidents (LCH only)

1.1 **LCH PSIs per 1000 contacts** remain within the control limits. However, between March 2017 and our latest reporting month, there are now 7 data points above the mean which is statistically significant and indicates that there is something, other than normal process variation, affecting this system. The reporting of low and no harm incidents has also risen during this same time period. The reporting of low and no harm incidents is positive and may explain this increase in patient safety incidents

**data available to Sep 2017 only*

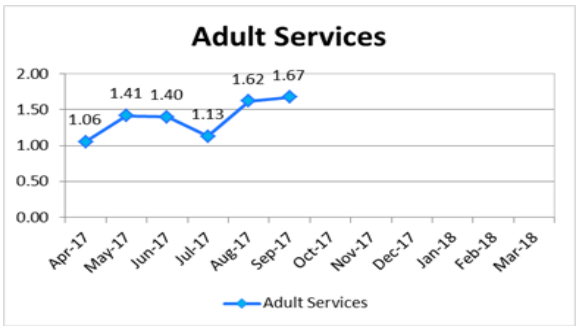
2.0 Incidents causing harm (LCH only)

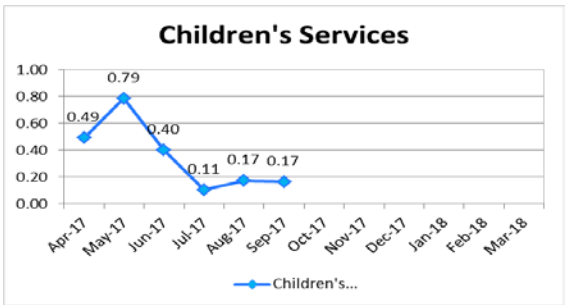
2.1 The number of **LCH *patient safety incidents causing harm per 1000 contacts*** remains within the variation limits at this time.

**data available to Sep 2017 only*

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

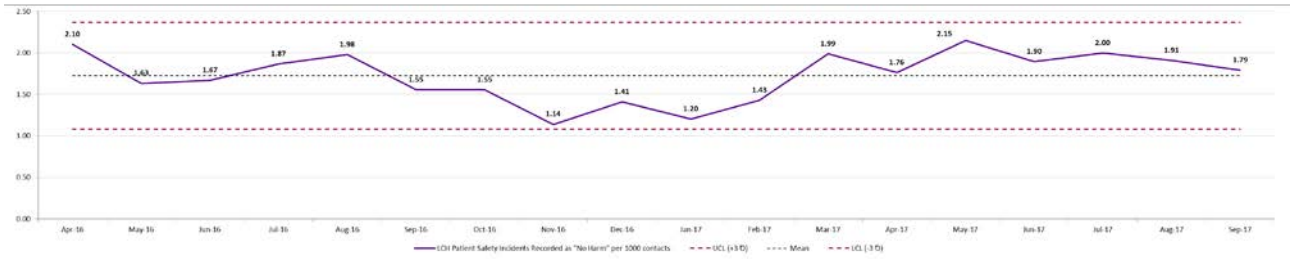
2.3 The number of LCH ***patient safety incidents causing harm per 1000 contacts*** broken down by business unit is demonstrated in the below run chart with associated monthly ratios. This is a new reporting feature and currently is presented in a run chart due to the small number of data points available. As reporting develops over time, this will be converted to an SPC chart in order to identify any statistical significance.





3.0 No Harm incidents

3.1 The number of LCH ***patient safety incidents causing no harm per 1000 contacts*** remains within the control limits. However, between March 2017 and our latest reporting month, there are now 7 data points above the mean which is statistically significant and indicates that there is something, other than normal process variation, affecting this system.



**data available to Sep 2017 only*

3.2 The ratio of moderate/major incidents to minimal/no harm incidents for LCH Patient Safety Incidents was 1:4.4 during October; the rolling year data is shown below. Whilst there have been fluctuations over the year, the lower ratio for October is consistent with other points in the rolling year.

The data will be monitored over the winter pressure period.

Safety Incidents by Degree of Harm

	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
No injury sustained	120	129	114	118	216	148	202	174	198	163	151	186
Minimal Harm	59	63	66	68	79	68	95	89	70	81	79	62
Moderate Harm	38	21	32	27	39	27	47	37	23	39	39	48
Major Harm	3	3	9	7	5	4	4	4	5	5	6	8
Death	1	4	5	3	5	6	4	2	11	5	9	9
Total	221	220	226	223	344	253	352	306	307	293	284	313
Ratio: (moderate/major incidents : minimal/no harm incidents for LCH Patient Safety Incidents)	1:4.4	1:8	1:4.4	1:5.5	1:6.7	1:7	1:5.8	1:6.4	1:9.6	1:5.5	1:5.1	1:4.4

4.0 Overdue Incidents

4.1 Figures and details of overdue incidents were scrutinised by the PSEGG on 26 October 2017. A number of historical incidents remain outstanding despite escalation and requests for closure:

- ID 35617 (SLIC) Reported 17 April 2016
  Awaiting mortality proforma to be up loaded from Mortality governance – to be actioned on 8/11/17 by AMD

- ID 41766 (Pudsey NT) Reported 27 February 2017
  Awaiting mortality proforma to be up loaded from Mortality governance – to be actioned on 8/11/17 by AMD

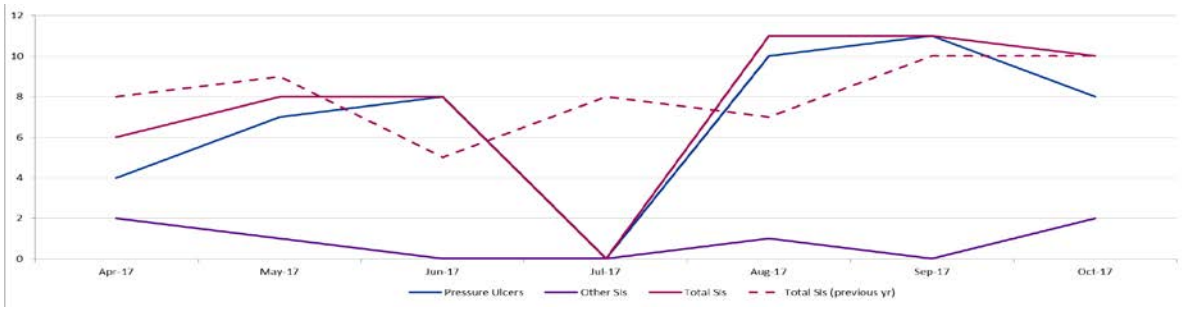
- ID 41754 (CLASS) Reported 27 February 2017
  Awaiting minor update to record and closure

All 3 incidents were highlighted in September's reports; however they still remain open. The Clinical Governance Team has escalated this to appropriate parties.

5.0 Serious Incidents

5.1 The pattern of reported SIs has changed but is consistent with the new process for reporting avoidable only pressure ulcers as SI's. The overall number of SI's is reflective of the pattern of Pressure Ulcers reported as SI's.

There were 10 SI's reported in October 70% of which related to unstageable pressure ulcers.



6.0 Protecting Patients from harm

6.1 Protecting patients from harm that happens in our care is a Quality Account quality improvement priority for 2017/18. Areas of focus are:
- reduce the number of patients who have a fall resulting in avoidable harm whilst in our care
- reduce the number of patients who develop an avoidable pressure ulcer

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

7.0 Never Events

There were no Never Events reported in October.

8.0 Safety Alerts (CAS)

There were no Safety Alert response breaches in October.

9.0 Duty of Candour

9.1 During October 47 incidents (closed) triggered duty of candour.

- 40 (85%) were identified as not being as a result of the healthcare intervention following a 3 day fact find or SI investigation.
- 3 (6.5% were classed as not being an LCH patient incident.
- 4 (8.5%) were verified as actual moderate + harm attributable to LCH where the patients received an appropriate apology

9.2 In conclusion, DoC was applicable in 4 incidents where 100% received an appropriate apology.

9.3 Note of process: it has been identified that some services have sent DoC letters without updating the Datix record. This has been picked up by the Quality Lead and the services have been reminded of the correct process in order to maintain accurate records of DoC compliance.

10.0 Infection Prevention Control (IPC)

10.1 **MRSA bacteraemia and C difficile Infection**
During October there were no reported cases of MRSA bacteraemia or C Difficile Infection assigned to LCH.

10.3 **Other contractual issues or Outbreaks**
There are no issues to report.

10.4 An infection control update was provided to the PSEGG on 26 October 2017; any actions, learning and assurance from this is included in the Quality Governance section of the Director of Nursing report.

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	July	Aug	Sept	Forecast
Compliance with Technology Appraisals Within 3 Months	2017/18	100%	-	0	0			●
	2016/17		-	100%	100%			
Compliance with Other NICE Guidance Within 1 Year	2017/18	No Target						-
Full Compliance			-	2	2			
Working Towards Compliance			-	1	1			
Under Review			-	5	8			
2016/17								
Full Compliance			-	4	3			
Working Towards Compliance			-	3	2			
Under Review			-	4	6			
Compliance with Other NICE Guidance Within 2 Years	2017/18	No Target						-
Full Compliance			-	2	5			
Working Towards Compliance			-	3	6			
Under Review			-	2	1			
Number of Clinical Audits Completed	2017/18	117 by year end	-	0	10			●
	2016/17		-	-	-			
Compliance with Clinical Supervision	2017/18	>=80%	-	80%	61.0%			●
	2016/17		-	65.0%	72.5%			
Increase the number of Services Centrally Reporting Outcome Measures	2017/18	>7	-	7	7			●
	2016/17		-	-	-			
Number of Unexpected Deaths in Bed Bases	2017/18	No Target		0	2			
	2016/17		-	4	0			
Number of Sudden Unexpected Deaths in Infants and Children on the LCH Caseload	2017/18	No Target		1	1			
	2016/17		-	3	1			

This section is presented again after first appearing in the September 2017 Performance Brief.

1. Compliance with NICE guidance

1.1. Technology appraisals

Twelve NICE Technology Appraisals were published in Q1 2017/18. None were relevant to the Trust.

1.2. Other NICE guidance

As agreed at the June 2017 Quality Committee, compliance is now reported by the number of services involved, rather than the number of NICE guidelines issued.

Twenty-one NICE guidelines were published during in Q2 2016/17. Six of these were relevant, to a total of eleven LCH services. Full compliance has been achieved by three services within the last twelve months:

- NG 49 Non alcoholic fatty liver disease – full compliance reported by the **Prison Healthcare HMYOI team**
- NG 50 cirrhosis in over 16s – full compliance reported by the **Prison Healthcare HMYOI team**
- NG 55 harmful sexual behaviour among children and young people – full compliance reported by the **Safeguarding team**

Work is ongoing to ensure compliance by two services/service areas:

- NG 48 oral health for adults in care homes
    - The **Community Dental Service** have reviewed the guidance and developed an action plan. Areas outstanding include labelling of dentures, development of oral health care plans for residents as required and appropriate recall of patients.

- NG 51 sepsis: recognition, diagnosis and early management. The 127 recommendations in this guideline cover identifying and assessing people with suspected sepsis; risk factors and risk stratification for sepsis and managing suspected sepsis (in acute hospitals and out of hospital care). The guidance is relevant to **all clinical services across LCH**.
- A range of work is underway across the Trust including:
    - Raising awareness of sepsis at mandatory clinical training sessions
    - Development of a sepsis algorithm for identification of potential cases
    - Sepsis study day held during 2016
    - Refinement of the management of the deteriorating patient policy (for both adults and children)

Guidance is under review by six services:

- CG 44 heavy menstrual bleeding: assessment and diagnosis
    - **Community Gynaecology Service** reviewing the impact on this updated guideline on the service

- NG 55 harmful sexual behaviour among children and young people. This guideline covers children and young people who display harmful sexual behaviour, including those on remand or serving community or custodial sentences. It aims to ensure these problems don't escalate and possibly lead to them being charged with a sexual offence. The 54 recommendations cover risk-assessment, engaging with families and carers, interventions for children and young people displaying harmful sexual behaviour and supporting a return to the community for 'accommodated' children and young people.
- Aimed primarily at social workers, social and residential care practitioners and foster carers, some recommendations are applicable to LCH services:
    - **Prison Healthcare YOI**
    - **Adel Beck Secure Children's Centre**
    - **Child & Adolescent Mental Health Service**
    - **Community Paediatrics**
    - **Sexual Health Service**

Fourteen NICE guidelines were published during in Q2 2015/16. Six of these were relevant, to a total of twelve LCH services. Full compliance has been achieved by five services within the last two years:

- NG 18 diabetes (type 1 and 2) in children and young people: diagnosis and management – full compliance reported by the **Prison Healthcare HMYOI** and **Adel Beck Secure Children's Centre teams**.

- NG 20 coeliac disease: recognition, assessment and management – full compliance reported by the **Prison Healthcare HMYOI, Nutrition & Dietetics** and **Community Paediatric teams**

Work is ongoing to ensure compliance by six services:

- NG 15 – antimicrobial stewardship: systems and processes for effective antimicrobial medicine use. This guideline covers the effective use of antimicrobials (including antibiotics) in children, young people & adults. It aims to change prescribing practice to help slow the emergence of antimicrobial resistance & ensure that antimicrobials remain an effective treatment for infection.
- The 51 recommendations cover antimicrobial stewardship programmes, antibiotic prescribing and the introduction of new antimicrobials. Aimed primarily at secondary care, some recommendations are applicable to LCH services:
    - The **Infection Prevention and Control Team** and the **Medicines Management Team** are involved in the multiagency strategic group that is taking forward this work across the health and social care economy. Work to date includes: topic covered in the IPC mandatory training programme, and in the annual Infection Prevention and Control week. Support of facilitated workshops ofr primary acre staff (autumn 2017) and review of LCH antimicrobial prescribing data for in-patient services.

- NG 17 type 1 diabetes in adults: diagnosis and management
    - The **Neighbourhood Teams** have reviewed the guidance and developed an action plan. Areas outstanding include identification of capacity to support patients to test their blood glucose levels four times a day during periods of illness (if the patient is unable to self-care).

- NG 19 diabetic foot problems: prevention and management
    - At the time of publication (August 2015), a specialist diabetic foot service was not commissioned in Leeds. Work with the **Podiatry Service, Community Diabetes Service** and commissioners have been trying to resolve the issue going forward.

- NG 21 home care: delivering personal care and practical support to older people living in their own homes. This guideline covers the planning and delivery of person-centred care for older people living in their own homes. It aims to promote older people's independence and to ensure safe and consistently high quality home care services. The 84 recommendations cover: person-centred care; delivering home care and joint working between health and social care.
- Aimed primarily at home care providers, social care practitioners, and home care workers, some recommendations are applicable to LCH services:
    - The key to the implementation of this guidance is the development of services across **Neighbourhood Teams.**

Guidance is under review by one service:

- NG 17 type 1 diabetes in adults: diagnosis and management
    - **Community Intermediate Care Unit**

Oversight of compliance at a service level is reported to the Quality Committee on a six monthly basis.

2. Clinical Audit Programme

Quality Committee approved and ratified the Trust Rolling Clinical Audit Programme 2017-18 on the 24 April 2017.

Ensuring that organisation have an ratified programme for each financial year is imperative as fulfils several functions which includes:

1. It allows the healthcare provider to meet the requirements for external monitoring
2. It allows the healthcare provider to monitor the progress made in completing the programme
3. It allows the healthcare provider to monitor the quality of clinical audit activity
4. It allows the healthcare provider to monitor the impact of the audit programme

The total numbers of clinical audits on the programme were:

Clinical Audit Summary 2017-2018				
Business Unit	**Number of Audits**			
	Priority 1	**Priority 2**	**Priority 3**	**Total (per business unit)**
Trustwide	4	0	0	4
Adults	4	24	22	50
Children's and Families	8	3	10	21
Specialist	10	11	10	31
Corporate	7	2	2	11
Audits per Priority	**33**	**40**	**44**	**117**

The position at the end of Quarter 2 against the number of clinical audits including on the Clinical Audit Database is shown below. The total number of clinical audits registered is 124 clinical audits.

Compliance against the Trust wide clinical audit database is the following:

Q2 Audit Status – All Business Units	
Started	**19.16%**
Not Started	**63.34%**
Completed	**8.34% ***
Abandoned	**9.16%**

*The above completed figure does not reflect the number of individual teams/business units documentation audit compliance. The individual data for these audits is recorded on a master spreadsheet held within the Clinical Governance Team.

The figure recorded for abandoned audit is higher than would be expected for the organisation but this is due to a number of service decommissioned.

3. Clinical Supervision

61% of LCH practitioners have received clinical supervision in the last quarter, in accordance with LCH policy. This is down from 80% in Q1 2017/18 and means the Trust is moving away from its end of year target after strong Q1 performance. Services continued to be supported to achieve the 80% target.

Service Area	% Clinical Supervision	Service Area Target
Adult	**64.91%**	80%
Children	**64.16%**	90%
SBU: Health and Justice excluding Police Custody	**59.47%**	90%
SBU: Police Custody	**22.00%**	80%
Corporate	**56.00%**	80%
LCH Target for end of 2017-18: 80%	**61.00%**	**80%**

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	Oct	Nov	Dec	Forecast
Patient Contacts - Variance from Profile	2017/18	0 to ±5%	-6.2%	-5.5%	-7.1%	-5.4%			●
	2016/17		0.0%	1.2%	1.2%	-2.2%	5.9%	-2.7%	
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	2017/18	>=92%	-	99.6%	99.5%	99.5%			●
	2016/17		-	100.0%	99.9%	100.0%	99.9%	99.9%	
Number of patients waiting more than 52 Weeks (Consultant-Led)	2017/18	0	0	0	0	0			●
	2016/17		0	0	0	0	0	0	
Percentage of patients waiting less than 6 weeks for a diagnostic test (DM01)	2017/18	>=99%	-	99.5%	100.0%	100.0%			●
	2016/17		-	100.0%	98.1%	98.4%	99.2%	100.0%	
% Patients waiting under 18 weeks (non reportable)	2017/18	>=95%	-	98.8%	98.8%	98.9%			●
	2016/17		-	98.8%	98.7%	98.0%	97.8%	97.6%	
IAPT - Percentage of people treated within 18 weeks of referral	2017/18	>=95%	-	100.0%	98.6%	99.6%			●
	2016/17		-	99.9%	98.9%	98.4%	99.8%	98.1%	
IAPT - Percentage of people treated within 6 weeks of referral	2017/18	>=75%	-	96.1%	94.4%	95.5%			●
	2016/17		-	98.3%	98.3%	99.8%	98.7%	97.7%	

At the end of October five patients were waiting more than 18 weeks for treatment in consultant-led services.

Three patients were waiting for the Paediatric Neuro Disability Service (PND), one for Child Development Centres (CDC) and one for CPC (CHICS) Children's Paediatric Clinic.

Two waits were attributed to parents cancelling due to the child being ill, one wait is attributable to the child being in hospital, one has subsequently attended an appointment and has been discharged.

Please see section 3.1 for narrative information on those measures relating to patient contacts and variance from profile.

Leeds Community Healthcare NHS Trust

Well Led Domain Report

Well Led - leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture		YTD Target	YTD	Q1	Q2	Oct	Nov	Dec	Forecast
Workforce Race Equality Standard	2017/18	>=14.7%	-	-					
	2016/17		-	-	-	-			
Staff Turnover	2017/18	<=15%	-	15.2%	14.4%	14.1%			
	2016/17		-	14.6%	13.9%	14.0%	14.8%	15.7%	
Executive Team Turnover	2017/18	<=15%	-	0.0%	0.0%	0.0%			
	2016/17		-	0.0%	0.0%	0.0%	0.0%	0.0%	
Stability Index	2017/18	>=85%	-	83.8%	82.5%	84.9%			
	2016/17		-	-	-	-	-	-	
Short term sickness absence rate (%)	2017/18	<=1.84%	-	1.8%	1.9%	2.3%			
	2016/17		-	1.3%	1.6%	2.4%	2.2%	2.3%	
Long term sickness absence rate (%)	2017/18	<=3.6%	-	3.5%	3.4%	3.5%			
	2016/17		-	4.5%	4.0%	3.5%	4.0%	4.0%	
Total sickness absence rate (%)	2017/18	<=5.44%	-	5.2%	5.4%	5.8%			
	2016/17		-	5.6%	5.1%	5.9%	6.2%	6.3%	
AfC Staff Appraisal Rate (12 Month Rolling - %)	2017/18	>=91.7%	-	86.6%	82.5%	81.3%			
	2016/17		-	89.1%	87.2%	86.4%	87.6%	85.7%	
Medical staff appraisal rate (%)	2017/18	100%	-	100.0%	100.0%				
	2016/17		-	86.4%	93.3%	98.0%			
6 universal Statutory and Mandatory training requirements	2017/18	>=92.7%	-	91.0%	90.5%	91.5%			
	2016/17		-	88.9%	87.5%	88.6%	89.8%	89.9%	
Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	2017/18	>52.0%	-	54.0%	53.0%	-			
	2016/17		-	49.0%	42.8%	-			
Percentage of staff who are satisfied with the support they received from their immediate line manager	2017/18	>52.0%	-	62.0%	60.0%	-			
	2016/17		-	-	-	-			
Response Rate for Staff FFT	2017/18	>23.0%	-	22.0%	18.0%	-			
	2016/17		-	22.2%	21.0%	-			
Sustain the time between placing adverts and filling vacancies									
Qualified Nurses		<= 112 Days	-	97	131	-	-	-	
Police Custody		<=145 Days	-	124	106				
Administration		<=83 Days	-	83	96				
Reduce the number of staff leaving the organisation within 12 months	2017/18	<=22%	-	16.3%	12.0%	12.0%			
	2016/17		-	-	-	-	-	-	
Category for Reason for Leaving in ESR Recorded as "other/unknown"	2017/18	<=10%		0.0%	0.0%	0.0%			
	2016/17		-	-	-	-	-	-	
Response Rate for Inpatient FFT	2017/18	>=23.1%	-	15.4%	11.8%	8.4%			
	2016/17		-	-	9.7%	8.0%	12.3%	3.5%	
Response Rate for Community FFT	2017/18	>=6.8%	-	6.9%	4.6%	5.5%			
	2016/17		-	-	5.1%	3.0%	3.2%	2.5%	
Total agency cap	2017/18	£4,082k	£3,632k	£1,544k	£3,123k	£509k			
	2016/17		£6,366k	1,926k	3,576k	382k	419k	419k	
Percentage Spend on Temporary Staff	2017/18	None	8.1%	8.1%	8.1%	8.0%			
	2016/17		7.5%	9.6%	8.5%	5.9%	6.7%	7.3%	

1. Appraisal

As at the end of October 2017, 81.3% of available staff were registered as having had an appraisal within the last 12 months. Training sessions continue to be offered to support appraisers gain the necessary skills to have a productive conversation.

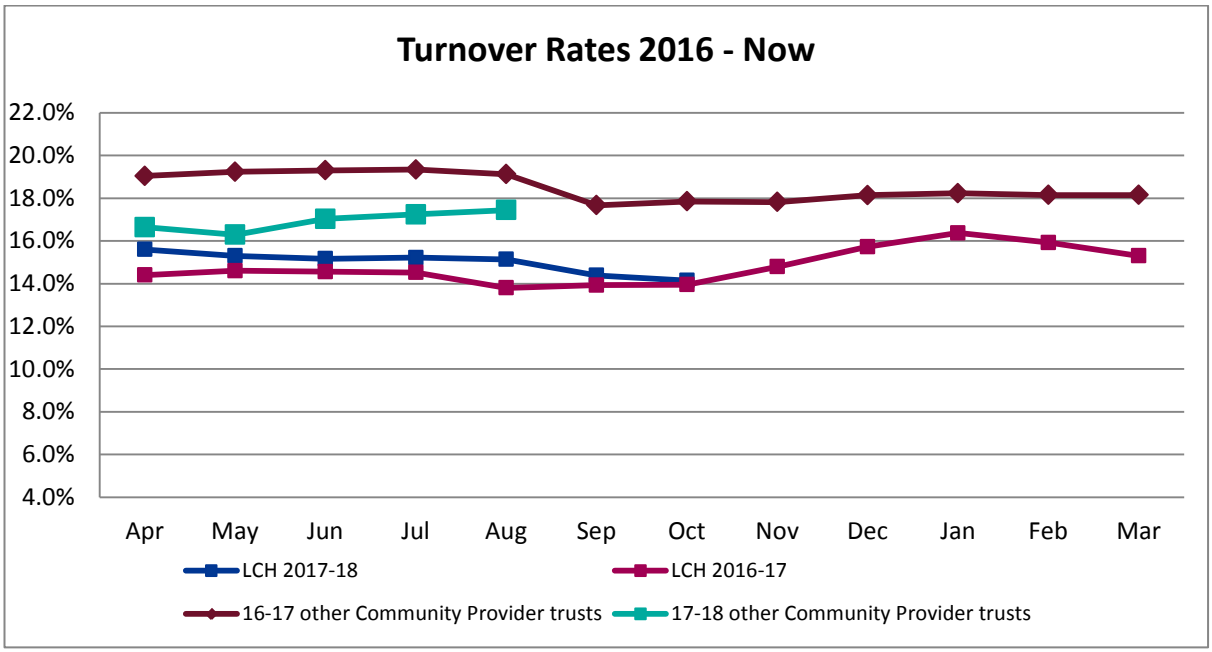
2. Statutory & Mandatory Training

It is pleasing to note that this month there has been an increase in the level of staff compliance across all of the universal statutory and mandatory training. The overall level of compliance now stands at 91.5%

The individual topics are as follows:-
Information Governance training – 95.3%
Equality and Diversity training – 96.8%
Health and Safety (Slips, Trips and Falls) training – 94.5%
Fire training – 87.4%
Infection Prevention and control – 87.4%
Moving and Handling – 87.8%

3. Turnover

The rate of turnover during the rolling year is steadily improving, with the latest figure standing at 14.1%. (The trust target is to be below 15%). This is comparable with last year's turnover rate at October 2016 and remains consistently lower than our comparator Community Provider trusts which last reported a 17.4% turnover at August 2017.



In October 2017 there were 31 leavers across the Trust as set out below:

Business Unit	Oct 2017 Leavers
833 Adult Business unit	7
833 Children's Business Unit	7
833 Corporate Directorate	7
833 Operations	4
833 Specialist Business Unit	6
Grand Total	**31**

Staff Groups	Oct 2017 Leavers
Add Prof Scientific and Technic	2
Additional Clinical Services	8
Administrative and Clerical	7
Allied Health Professionals	3
Estates and Ancillary	1
Medical and Dental	1
Nursing and Midwifery Registered	9
Grand Total	**31**

The top 3 reasons for leaving were:

- Retirement Age
- Voluntary Resignation - Relocation
- Voluntary Resignation – Promotion

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

4. Retention

The Interim Director of Workforce and Deputy Director of Nursing attended a workshop as the first step of NHS Improvement three year workforce retention programme, that the Trust was been given the opportunity to participate in. An output from the workshop is to refine our existing retention plan over a 90 day period, follow up telephone support and a site visit from NHS improvement (NHSi) to talk through the development of the retention plan. In addition, the OD and Resourcing Manager will be attending a Retention Improvement Masterclass which is designed to complement the above workshop, with the focus will be on staff engagement, development of plans and obtaining insight and feedback to drive actions.

Work continues on staff engagement and ‘Creating the Working Life we want’ and ‘Building the Workplace we want’ and remains the focus of our retention effort. Each of the Business unit plans also has a specific section about their focus on staff.

5. Recruitment

The trust continues to work with other Leeds health and social care employers to promote our trust at nursing career fairs. The trust has recently attended Liverpool and Nottingham RCN career fairs and Bradford University to promote newly qualified nursing positions to student nurses.

Within last month’s performance report, statistics were provided for Quarter 2 on the time taken between placing adverts and filling vacancies, for Prison Custody, administration and qualified nursing against trust targets. A commitment was given to provide clarity as to the reasons for delay. The reason for the delays to qualified nurse recruitment was due to inclusion of the newly qualified nurses who were recruited months prior to officially qualifying and commencing employment.

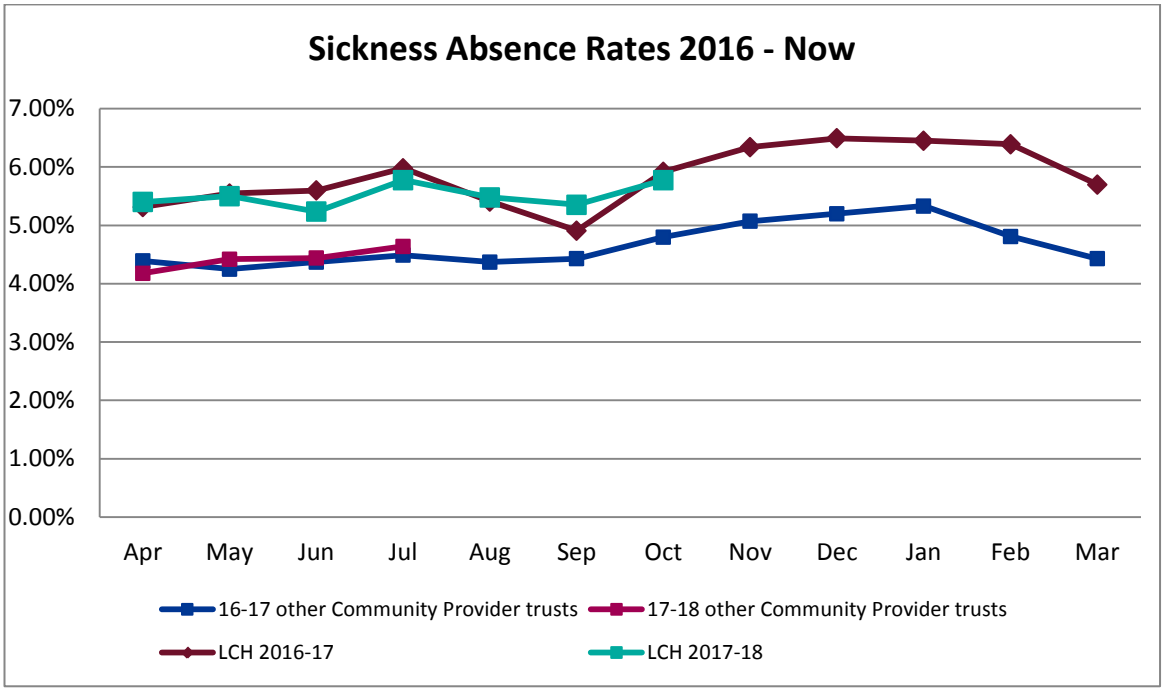
Administrative staffs time to recruit exceeded target due to inclusion of incorrect data which skewed the target. A full validation exercise will now be undertaken to cleanse this information.

Target is as follows:	Quarter 2 (Actual)
Qualified Nursing – 112 days	131 days
Administration –83 days	96 days
Policy Custody – 145 days	106 days

6. Sickness absence

Sickness absence rate for October was 5.8%, which is broken down into Long-term absence 3.5% and Short-term absence at 2.3%.

Business Unit	October 2017 absence rate
Adult	6.3%↑
Children	6.4%↑
Specialist	5.1%↑
Estates & Ancillary Staff (Operations)/Corporate	4.7%↓



Areas of HWB focus during November 2017 to include:-

- Support for National anti-harassment and bullying week, promoting range of support staff can access
- Advertise HWB post to encourage applicants from clinical background
- OH SLA signed for further year which encompasses Health and wellbeing checks
- Ideas generated by 50 voices – will be explored in more detail

Leeds Community Healthcare NHS Trust

Finance Report

Finance		YTD Target	YTD	Q1	Q2	Oct	Nov	Dec	Forecast
Net surplus (-)/Deficit (+) (£m) - YTD	2017/18	-£2.0m	-£2.4m	-£0.9m	-£2.1	-£2.4			●
	2016/17			-£0.1m	-£1.8m	-£0.2m	£0.2m	-£0.2m	
Net surplus (-)/Deficit (+) (£m) - Forecast	2017/18	-£3.0m	-£3.0m	-£3.0m	-£3.0m	-£3.0m			●
	2016/17		-	-£2.9m	-£2.9m	-£2.9m	-£2.9m	-£2.9m	
Forecast underlying surplus	2017/18	-£1.4m	-£1.4m	-£1.4m	-£1.4m	-£1.4m			●
	2016/17		-	-£1.5m	-£1.5m	-£1.5m	-£1.5m	-£1.5m	
Capital expenditure in comparison to plan (£k) - YTD	2017/18	£0.5m	£0.4m	£0.2m	£0.3m	£0.4k			
	2016/17		-	£354k	£510k	£624k	£676k	£740k	
Capital expenditure in comparison to plan (£m) - Forecast	2017/18	£1.8m	£1.5m	£1.8m	£1.8m	£1.5m			●
	2016/17		-	£3.2m	£3.2m	£2.1m	£2.1m	£2.1m	
CIP delivery (£m) - YTD	2017/18	£1.9m	£1.6m	£0.6m	£1.2m	£1.6m			
	2016/17		-	£0.2m	£0.4m	£0.4m	£0.7m	£1.1m	
CIP delivery (£m) - Forecast	2017/18	£3.4m	£2.9m	£3.4m	£2.9m	£2.9m			●
	2016/17			£0.7m	£0.7m	£0.7m	£1.4m	£1.8m	
Use of Resources Risk Rating (from Oct 2016)	2017/18	2	1	1	1	1			●
	2016/17		-	-	-	1	1	1	

1. Summary & KPIs

The Trust continues to be £0.3m ahead of its financial plan at the end of October. Pay expenditure was in line with budget in month and there has been a reduction in the level of vacancies. The year to date overspend on pay has been mitigated by the underspending on non-pay. The expenditure on agency staff continues below the agency cap at the end of October. Cost savings plans are 16% below expected levels year to date which is an improvement on last month; any shortfall has been included in the reported forecast expenditure outturn position. The Trust has spent £0.3m on capital assets for the year to date this is marginally more than planned. The forecast outturn for capital expenditure has been revised this month. Cash is running £2.9m ahead plan and the use of resources risk rating continues to be 1.

Table 1 Key Financial Data Statutory Duties	Year to Date	Variance from plan	Forecast Outturn	Performance
Income & Expenditure retained surplus	(£2.4m)	(£0.3m)	(£3.034m)	G
Remain with EFL of £2.941m			£2.941m	G
Remain within CRL of £1.816m	£0.4m	(£0.1m)	£1.200m	G
Capital Cost Absorption Duty 3.5%			3.5%	G
BPPC NHS Invoices Number 95%	98%	3%	95%	G
BPPC NHS Invoices Value 95%	99%	4%	95%	G
BPPC Non NHS Invoices Number 95%	96%	1%	95%	G
BPPC Non NHS Invoices Value 95%	97%	2%	95%	G
Trust Specific Financial Objectives				
Use of Resources Risk Rating	1	-	1	G
CIP Savings £3.0m recurrent in year	£1.4m	-12%	£2.6m	R
CIP Savings £0.5m planned non recurrent in year	£0.2m	-44%	£0.3m	R
CIP Savings other non recurrent in year	£0.3m	NA	£0.5m	G

2. Income & Expenditure

The Trust's contract income continues to be marginally behind plan at the end of October. The year to date expenditure is underspending by £0.3m; with pay costs £0.2m more than expected this overspending is being offset by underspending on non-pay. The Trust has 93 wte or 3.5% less staff in post than funded for October; this is after the planned vacancy factor reduction. Temporary staffing costs are £691k for the month.

Table 2 Income & Expenditure Summary	October Plan WTE	October Actual Contract WTE	YTD Plan £m	YTD Actual £m	Variance £m	Annual Plan £m	Forecast Outturn £m	This Month Variance £m	Forecast Variance last month £m
Income									
Contract Income			(79.8)	(79.7)	0.1	(134.8)	(134.7)	0.1	0.1
Other Income			(5.6)	(5.6)	0.0	(9.1)	(9.1)	0.0	0.0
Total Income			***(85.4)***	***(85.3)***	***0.1***	***(143.9)***	***(143.8)***	***0.2***	***0.2***
Expenditure									
Pay	2,635.5	2,542.8	60.4	60.6	0.2	102.1	103.1	0.9	1.3
Non pay			20.4	19.7	(0.7)	34.5	33.4	(1.1)	(0.9)
Reserves & Non Recurrent			1.0	1.2	0.2	1.8	1.9	0.1	(0.5)
Total Expenditure	***2,635.5***	***2,542.8***	***81.9***	***81.6***	***(0.3)***	***138.4***	***138.3***	***(0.1)***	***(0.1)***
EBITDA	**2,635.5**	**2,542.8**	**(3.5)**	**(3.7)**	**(0.2)**	**(5.5)**	**(5.4)**	**0.1**	**0.1**
Depreciation			1.0	1.0	(0.0)	1.7	1.8	0.0	0.0
Public Dividend Capital			0.5	0.5	0.0	0.8	0.8	0.0	0.0
Profit/Loss on Asset Disp			0.0	(0.1)	(0.1)	0.0	(0.1)	(0.1)	(0.1)
Interest Received			(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	0.0	0.0
Retained Net Surplus	**2,635.5**	**2,542.8**	**(2.0)**	**(2.4)**	**(0.3)**	**(3.0)**	**(3.0)**	**0.0**	**(0.0)**
	Variance =	**(92.7)**							

2.1 Income

Contract income continues to run less than planned due to penalties for missed shift and performance for the Police Custody service; non-contract income is running as expected. The income figures include assumed full CQUIN income; Quarter 1 CQUIN income has been agreed. The income figure assumes all the STF monies for 2017/18 will be achieved; the first tranche of this was paid at the end of September.

The forecast income is consistent with last month and assumes the Trust will deliver all the CQUINs agreed with commissioners; following the quarter 1 review of progress there could be a shortfall circa £250k. This is not included in the position reported at table 2. The forecast income assumes no income reduction in respect of a potential contract dispute with the CCG. The Trust is working closely with the CCG on this issue and fully expects to suffer no income reduction this year.

2.2 Pay

Table 3 below illustrates the total pay costs by category. Expenditure on substantive staff in post continues to underspend in September; the overall year to date position at the end of October is £0.2m overspent; the same as last month.

Table 3 Annual Pay Costs by Category	YTD Plan £k	YTD Actual £k	YTD Variance £k	Last Month YTD Variance £k	Forecast Outturn Variance £k
Cost of staff directly employed	59,476	55,097	(4,379)	(3,806)	
Seconded staff costs	562	598	36	15	
Vacancy Factor	(3,734)		3,734	3,297	
Sub-total Direct Pay	**56,303**	**55,695**	**(609)**	**(494)**	
Bank Staff	51	1,290	1,239	1,055	
Agency Staff	4,082	3,633	(449)	(376)	
Total Pay Costs	**60,436**	**60,618**	**181**	**185**	**934**

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

Table 4 Month on Month Pay Costs by Category	April £k	May £k	June £k	July £k	August £k	Sept £k	Oct £k	YTD Actuals £k
Directly employed staff	7,816	8,037	7,831	7,817	7,982	7,715	7,898	55,097
Seconded staff costs	72	111	117	92	-111	216	101	598
Bank staff	182	175	212	156	164	219	182	1,290
Agency staff	563	474	507	416	625	538	509	3,633
Total Pay Costs	**8,633**	**8,798**	**8,668**	**8,480**	**8,659**	**8,689**	**8,690**	**60,618**

Agency costs overall are £509k for October bringing the total for the year to £3.6m which is 11% less than the planned spend.

Overall there are 93 wte vacancies for October this is 42 less than last month. There are 11 new starters in the Neighbourhood Teams and 9 wte in the YOI and structured education diabetes services.

The Trust planned for agency expenditure of up to £7m for the year, the agency cap for 2017/18 set by NHS Improvement is £7.4m. Agency staff are recruited where it is proving difficult to recruit permanent staff, where a vacancy cannot be covered by our own bank staff or to cover other service gaps where it is deemed essential to do so.

2.3 Non Pay

Non pay expenditure continues to be less than planned. The main movement this month in in premises in respect of estates savings for Shaftsbury and a correction for HIV drugs which had been charged to the sexual health service provided in partnership with Leeds Teaching Hospitals in error. The overspending in other non-pay is as a result of the estates and course fees savings targets where the savings have yet to be identified.

Table 5 Year to Date Non Pay Costs by Category	YTD Plan £k	YTD Actual £k	YTD Variance £k	Last Month YTD Variance £k	Forecast Outturn Variance £k
Drugs	602	575	(27)	49	
Clinical Supplies & Services	5,316	5,432	116	96	
General Supplies & Services	1,468	1,407	(61)	(50)	
Establishment Expenses	3,870	3,621	(248)	(229)	
Premises	8,071	7,599	(472)	(354)	
Other non pay	1,085	1,105	19	76	
Total Non Pay Costs	**20,412**	**19,739**	**(673)**	**(411)**	**(1,110)**

3. Reserves & Non Recurrent

The Trust has £1.8m in reserve at the end of October all of this is committed.

4. Cost Improvement Plans

Table 6 has the Trust's performance against the cost savings plan for 2017/18. Overall the plan is £307k or 16% behind at month 7. This is an improved performance on last month as the drugs and procurement saving requirements are now being met. Any shortfall in the delivery of a recurrent CIP will be a cost pressure for 2018/19.

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	12	8	(4)	20	20	0	0%
Night Nursing	33	11	(23)	50	41	(9)	-18%
JCMT	117	0	(117)	200	7	(193)	-96%
Admin Review	42	42	0	250	250	0	0%
CAMHS	146	0	(146)	250	0	(250)	-100%
Corporate Support	88	88	0	150	150	0	0%
LSH	88	88	0	150	150	0	0%
Orthotics	12	12	0	20	20	0	0%
Child Health Continence Products	15	0	(15)	25	0	(25)	-100%
Geriatricians Overhead Charge	29	29	0	50	50	0	0%
Training	117	117	0	200	200	0	0%
Procurement	105	102	(3)	180	180	0	0%
Travel	88	88	0	150	150	0	0%
Drugs	29	29	0	50	50	0	0%
Non pay inflation	210	210	0	360	360	0	0%
Mobile/data line charges	58	58	0	100	100	0	0%
Rents	82	82	0	140	140	0	0%
Estates other	58	58	0	100	100	0	0%
Contribution to overheads/fixed costs	190	190	0	325	325	0	0%
IT kit	146	146	0	250	250	0	0%
Release of reserves	233	233	0	400	400	0	0%
Total Efficiency Savings Delivery	**1,895**	**1,588**	**(307)**	**3,420**	**2,943**	**(477)**	**-14%**

5. Capital Expenditure

NHS Improvement has confirmed the Trust's Capital Resource Limit as £1.816m.

Equipment and IT requirements have been reviewed and the forecast outturn has been amended to reflect revised expenditure plans. The Trust will underspend against IT by £100k and there will be £200k less expenditure on equipment. The position is being reviewed to see if it is appropriate to being forward any planned future capital spend. The resource is not lost if there is an in-year underspend. The overall forecast outturn on capital expenditure is now £1.5m. The charge against the Capital Resource Limit is forecast to be £1.2m as the capital receipts for Garforth are net off the expenditure.

Table 7 Scheme	YTD Plan £m	YTD Actual £m	YTD Variance £m	Annual Plan £m	Forecast Outturn £m	Forecast Variance £m
Estate maintenance	0.1	0.1	0.0	0.5	0.5	0.0
Equipment/IT	0.1	0.0	(0.1)	0.8	0.5	(0.3)
Electronic Patient Records	0.2	0.2	(0.0)	0.5	0.5	0.0
Totals	**0.5**	**0.4**	**(0.1)**	**1.8**	**1.5**	**(0.3)**

6. Statement of Financial Position

Table 8 has the statement of financial position as at the end of October. As a result of the net position on current assets and liabilities the cash position is £2.9m more than planned at £23.6m. There are no concerns about the statement of financial position.

Table 8 Statement of Financial Position	Plan 31/10/17 £m	Actual 31/10/17 £m	Variance 31/10/17 £m	*Opening 01/04/17 £m*	Planned Outturn 31/03/18 £m	Forecast Outturn 31/03/18 £m	Forecast Variance 31/03/18 £m
Property, Plant and Equipment	26.8	26.4	(0.4)	*27.1*	27.5	27.1	(0.3)
Intangible Assets	0.0	0.1	0.0	*0.1*	0.0	0.1	0.0
Total Non Current Assets	**26.8**	**26.5**	**(0.3)**	*27.2*	**27.5**	**27.2**	**(0.3)**
Current Assets							
Inventories	0.0	0.0	0.0	*0.0*	0.0	0.0	0.0
Trade and Other Receivables	6.3	8.1	1.8	*6.7*	6.6	6.6	0.0
Cash and Cash Equivalents	20.7	23.6	2.9	*19.1*	20.7	22.0	1.4
Sub-Total Current Assets	**27.1**	**31.7**	**4.7**	*25.8*	**27.3**	**28.7**	**1.4**
Non-Current Assets held for sale	0.0	0.0	0.0	*0.2*	0.0	0.0	0.0
Total Current Assets	**27.1**	**31.7**	**4.7**	*26.0*	**27.3**	**28.7**	**1.4**
TOTAL ASSETS	**53.9**	**58.2**	**4.3**	*53.2*	**54.8**	**55.8**	**1.1**
Current Liabilities							
Trade and Other Payables	(10.7)	(14.3)	(3.6)	*(11.1)*	(11.1)	(11.7)	(0.6)
Provisions	(0.8)	(1.2)	(0.4)	*(1.4)*	(0.4)	(0.4)	0.0
Total Current Liabilities	**(11.5)**	**(15.5)**	**(4.0)**	*(12.5)*	**(11.5)**	**(12.1)**	**(0.6)**
Net Current Assets/(Liabilities)	**15.5**	**16.2**	**0.7**	*13.5*	**15.8**	**16.6**	**0.8**
TOTAL ASSETS LESS CURRENT LIABILITIES	**42.3**	**42.7**	**0.3**	*40.7*	**43.2**	**43.7**	**0.5**
Non Current Provisions	0.0	0.0	0.0	*0.0*	0.0	0.0	0.0
Total Non Current Liabilities	**0.0**	**0.0**	**0.0**	*0.0*	**0.0**	**0.0**	**0.0**
TOTAL ASSETS LESS LIABILITIES	**42.3**	**42.7**	**0.3**	40.7	**43.2**	**43.7**	**0.5**
TAXPAYERS EQUITY							
Public Dividend Capital	0.3	0.3	0.0	*0.3*	0.3	0.3	0.0
Retained Earnings Reserve	14.7	14.7	0.0	*12.8*	15.6	16.1	0.5
General Fund	18.2	18.5	0.4	*18.2*	18.2	18.2	0.0
Revaluation Reserve	9.2	9.1	(0.0)	*9.5*	9.2	9.1	(0.0)
TOTAL EQUITY	**42.3**	**42.7**	**0.3**	40.7	**43.2**	**43.7**	**0.5**

Table 9 Measure	Performance This Month	Target	RAG
NHS Invoices			
By Number	98%	95%	G
By Value	99%	95%	G
Non NHS Invoices			
By Number	96%	95%	G
By Value	97%	95%	G

Table 9 demonstrates the Trust's performance in respect of the Better Payment Practice Code. The Trust continues to meet all targets.

7. 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.

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

Table 10 Criteria	Metric	Performance	Rating	Weighting	Score
Liquidity	Liquidity ratio (days without WCF)	28	1	20%	0.2
Balance Sheet sustainability	Capital servicing capacity (times)	7.2	1	20%	0.2
Underlying performance	I&E margin	2%	1	20%	0.2
Variance from plan	Distance from plan	0	1	20%	0.2
Agency spend above ceiling	Agency	-16%	1	20%	0.2
Overall Use of Resources Risk Rating					**1**

8. Conclusion on Financial Performance

The forecast outturn position demonstrates the Trust should be able to achieve the control total surplus of £3.034m. The forecast overspend is mitigated by underspending on non-pay. However there are further financial risks such as the non delivery of CQUINs, winter pressures, contract changes and redundancy costs that may have a negative impact as the year continues. Under the current NHS Improvement business rules the Trust has no contingency to mitigate these issues should they arise.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (64)

Meeting Trust Board 1 December 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 Quality Committee 20 November 2017	**For information**	

PURPOSE OF THE REPORT

This report provides the Trust Board with a six months update on the themes of patient experience and incidents within Leeds Community Healthcare NHS Trust between 1 April and 30 September 2017. 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 first six months of 2017/18. 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.

Appointments, clinical judgement/treatment, attitude, communication and access/availability have continued to feature within the top five themes of complaint and concern from April 2017 to September 2017 which is in keeping with the themes for the whole year 2016/17.

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 ongoing themes. These two subjects were also top themes identified in the previous two thematic reports. National data remains comparable with regards to top themes for both complaints and incidents.

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. 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 3.8 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 Clinical Leads and the Director of Nursing Report, are detailed in Appendix 1.

Analysis of negative comments received via the Friends and Family Test are detailed in Appendix 2.

RECOMMENDATIONS

Trust Board is requested to:

- Receive this report
- Note the themes identified and comparisons provided
- Receive assurance that actions and learning is in progress to address the themes identified

Patient Experience and Incidents: Thematic report

1. PURPOSE OF THIS REPORT

1.1 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 April 2017 and 30 September 2017. This information has been taken from reported complaints, concerns and incident data; and the Friends and Family Test.

2. BACKGROUND

2.1 The Patient Safety, Experience and Governance Group (PSEGG) will receive this six-monthly report on the quality of our services. This report includes a detailed consideration of incident, complaints and patient experience data.

Following discussion at PSEGG, the report will be shared with the Trust Board, which 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 Exception Report and a fuller analysis via the quarterly Patient Safety, Experience and Governance Group report, and Quality Governance report.

3. OVERARCHING THEMES

3.1 LCH Complaints and Concerns

3.1.1 This section provides an overview of themes during the first six months of 2017/18 alongside a national and LCH comparison year on year from 2015/16 and 2016/17 for the **top five subjects of complaint**. The data reported for 93 complaints and 90 concerns has been used. In total 296 subjects and 294 sub-subjects were recorded across the 183 pieces of patient feedback.

3.1.2 Subjects of the same theme are colour coded and all subjects recorded for complaints and concerns are included in this thematic analysis.

	Nationally 2015/16	LCH 2015/16	Nationally 2016/17	LCH 2016/17	LCH Apr 17- Sep 17
1	All aspects of clinical treatment	Appointments	Communication	Clinical Judgement / Poor Treatment	Clinical judgement / Poor treatment
2	Attitude of staff	Clinical judgement / Poor treatment	Patient Care including Nutrition and Hydration	Attitude, conduct, cultural and dignity issues	Appointments
3	Communication / information to patients (written and oral)	Access and availability	Values and Behaviours (Staff)	Appointments	Attitude, conduct, cultural and dignity issues including Staff attitude and communication
4	Appointments, delay / cancellation (outpatient)	Attitude, conduct, cultural and dignity issues including Staff attitude and communication	Appointments including delays and cancellations	Communication issues with the patient (verbal and written)	Connected with the management of operations / treatment
5	Admissions, discharge and transfer arrangements	Medication issues	Other	Access and availability	Communication issues with the patient (verbal and written)

3.1.3 **"Clinical judgement / Poor treatment"** was the theme in 35% of complaints received during April to September 2017, although it was not necessarily the primary subject. Within those complaints, this subject was recorded 57 times with the top three issues being 'Clinical Judgement', 'Clinical / Professional Opinion' and 'Poor Treatment'.

3.1.4 **"Appointments"** issues were a subject of 25% of the complaints received. The subject was reported 42 times with the top three issues being 'Unable to get an appointment', 'Waiting time for an appointment' and 'Other appointment issue'. Due to the increased number of appointment issues received, overall it is the area of most concern to patients and carers. The increase means the theme is now the second highest complaint theme for the first time since 2015/16. This will be discussed further in 3.8.1.1.

3.1.5 **"Attitude, conduct, cultural and dignity issues including Staff attitude and communication"** featured in 19% of complaints and was reported 28 times during April to September 2017. This was followed by "Connected with management of operations and treatment" (11% of complaints and 11 mentions) and "Communication issues with the patient" (6.5% of complaints and 9 mentions).

3.1.6 The Trust data aligns with the National picture from 2016/17 with four of the same top five themes, despite the national statistics including data submitted by acute Trusts. The main difference is the national use of the "Other" category. LCH discourages the use of this category in recording complaints, concerns and incidents wherever possible as it is vague and unhelpful when analysing themes and trends.

3.1.7 The subjects reported within complaints have remained stable over the first six months of the year when compared to the previous 18 months. The theme of **"management of operations and treatment"** has featured for the first time with the main sub-subjects being 'Delays' and 'Continuity of care'. A review of the teams involved has shown they are spread across the business units with no clusters or areas of concern to highlight.

3.2 Benchmarking with national comparison

3.2.1 The themes from **complaints** received during April to September 2017 are shown in the table below against the data from comparable community Trusts either for the same time period or for the whole year 2016/17. The overall themes for 2016/17 are generally in keeping with comparable organisations.

	LCH Apr - Sep 17	Birmingham Apr – Sep 17	Derbyshire Apr – Sep 17	Bridgewater 2016/17
1	Clinical judgement / Poor treatment	Standard of clinical care	Clinical judgement / Poor treatment	Aspects of clinical treatment
2	Appointments	Delayed or cancelled treatment or appointment	Values and behaviours	Attitude of staff
3	Attitude, conduct, cultural and dignity issues including Staff attitude and communication	Manner and Attitude	Communication issues	Failure to follow agreed procedures
4	Connected with the management of operations / treatment	Communication with patient (written and verbal)	Appointments	Aids & appliances, equipment, premises
5	Communication with patient (written and verbal)	Discharge	Access and availability	Patient's privacy and dignity

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 The **top five subjects relating to concerns** received in the April to September 2017 are consistent with the themes of complaints:

- Appointments (reported in 32% of concerns)
- Clinical judgement/Treatment (16%)
- Attitude, conduct, cultural and dignity issues (10%)
- Access and availability (12%)
- Communication issues with the patient (9%)

3.2.3 **Appointments** remain the top area concern for our patients and carers.

3.2.4 Of the concerns received within the reporting period, 26% had no subject and 25% had no sub-subject recorded. This is a change from Quarter 4 2016/17 when it was reported that "no concerns were recorded without both a subject and sub-subject." The Patient Experience Team has now rectified this and all records are complete. Weekly quality assurance checks of received concerns are being completed by the Patient Experience Team to ensure accurate and complete records are maintained. The PET will liaise closely with service staff if information is missing to offer advice and support. If it becomes necessary to escalate the issue, this will be done via the appropriate channels.

3.2.5 The concerns were recorded over the period 1 April – 31 August 2017 and were split over the business units with no clusters. All concerns recorded since 1 September 2017 have subjects and sub-subjects recorded.

3.2.6 Training for service staff on how to record concerns and update complaint and concern records is to be revised and updated, along with accompanying materials.

3.3 Incident themes

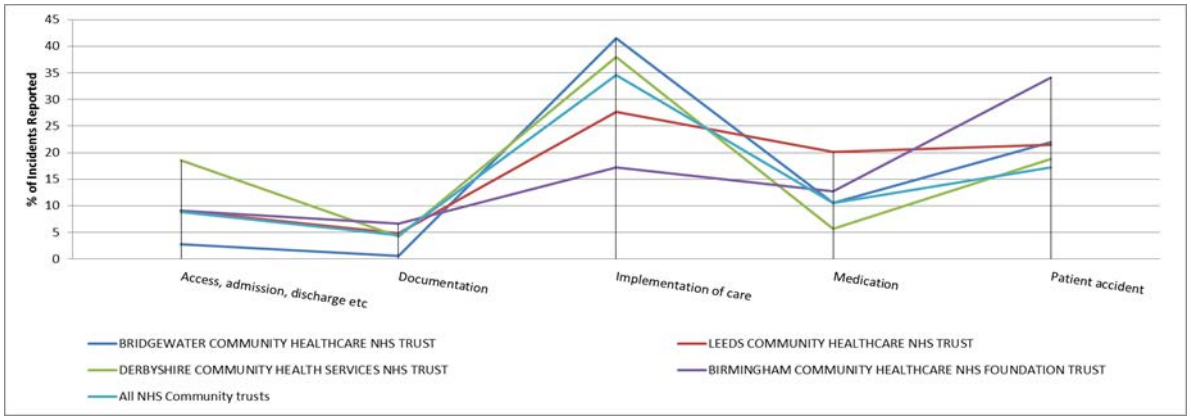
3.3.1 Incident themes for Leeds Community Healthcare have been consistent over the past 3 years and this trend has continued in the first half of 2017/18. The top four results are reflected by other Community Trusts that report via the NRLS as shown in the table below.

3.3.2 The fourth and fifth incident categories reflects only 9% (combined) of all incidents reported in this period and is subject to more fluctuation than the top 3 which account for 60% of all LCH PSI's reported:

	Incident Themes (LCH Patient Safety Incidents (PSI's) only)				
	2014/15	**2015/16**	**2016/17**	**2017/18 Q1/Q2**	**NRLS National Data Oct-Mar 17**
1	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	Implementation of care or ongoing monitoring /review
2	Medication	Implementation of care or ongoing monitoring /review	Accidents that may result in personal injury	Accidents that may result in personal injury	Accidents that may result in personal injury
3	Implementation of care or ongoing monitoring /review	Medication	Medication	Medication	Medication
4	Access, Appointment, Admission, Transfer, Discharge	Access, Appointment, Admission, Transfer, Discharge	Access, Appointment, Admission, Transfer, Discharge	Access, Appointment, Admission, Transfer, Discharge	Access, Appointment, Admission, Transfer, Discharge
5	Infrastructure or resources (staffing, facilities, environment)	Abusive, violent, disruptive or self-harming behaviour	Abusive, violent, disruptive or self-harming behaviour	Abusive, violent, disruptive or self-harming behaviour	Documentation (inc records)

3.3.3 Overarching themes exist across complaints and incidents as seen in the tables provided so far, particularly **access/appointments and clinical care**. Further analysis identifies any commonalities arising from these themes in section 3.8.

3.3.4 Themes from **incidents** are benchmarked against the comparable Community Trusts below using the latest published data from the National Reporting and Learning System **(October 2016 – March 2017)**. This shows the top five themes to be comparable to the national data.



3.3.5 A higher number of **medication incidents** are reported within the Trust in comparison to the benchmarked organisations. However this is not the highest reported incident category. **Implementation of Care** (which includes pressure ulcers) is the most reported category for the majority of organisations; reported LCH figures are mid-range against the other Trusts benchmarked against.

3.3.6 The Adult Nursing services report 73.8% of all medication incidents. A detailed medicines management section is provided in the quarterly Patient Safety, Experience and Governance Group 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 five SI's were reported in the first 6 months of 2017/18 with the primary theme being category 3 and 4 pressure ulcers. The themes for April – September 2017 are reflective of the previous year.

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 exception 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. How to address and prevent the recurrent themes will be a focus for discussion for the October PSEGG meeting.

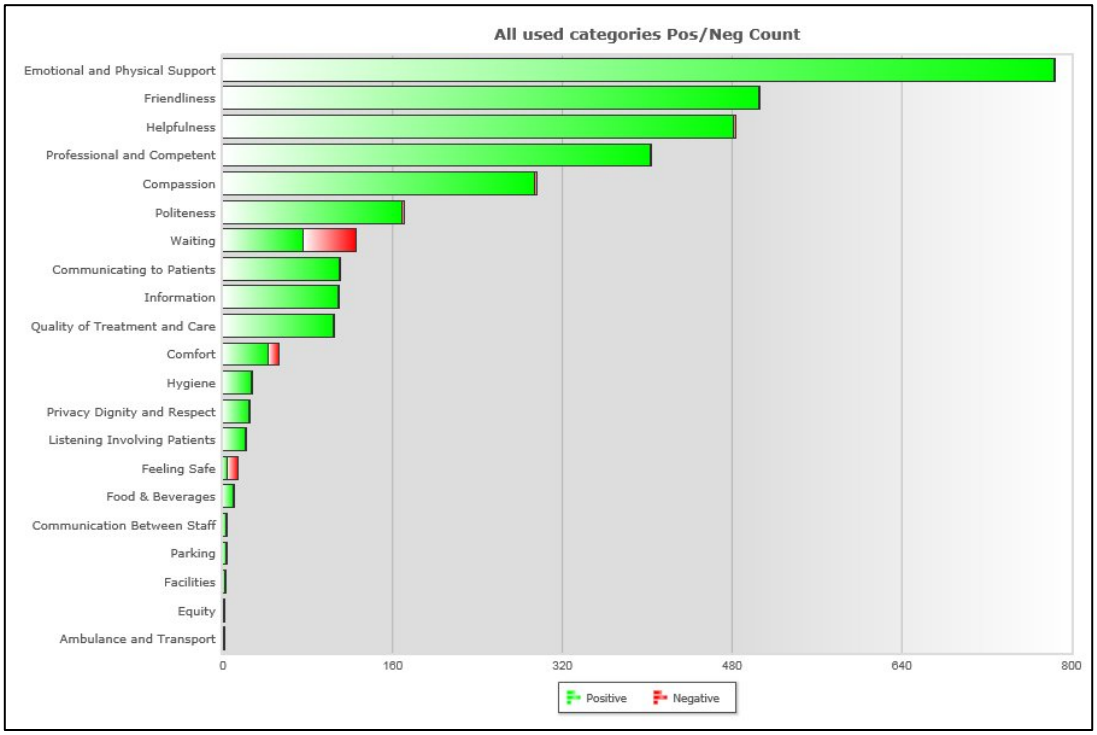
3.4.5 During Q2 2017/18 a refined process for reporting pressure ulcers as Serious Incidents was introduced following agreement with the CCG. The purpose of the change is to align LCH's practices with the other healthcare providers within the city to ensure a consistent approach in SI reporting. Under the new process avoidable cases only are recorded as SI's. This includes category 3, 4 and unstageable pressure ulcers.

3.4.6 The impact of this change has been a decrease in the numbers of category 3 pressure ulcer SI's (previously all category 3 would be included as an SI) and an increase in unstageable pressure ulcer SI's (these were not previously recorded as an SI).

Accurate data comparison is no longer available using previous data sets; however, the focus is now on cases where there is more opportunity for learning and improvement.

3.5 Friends and Family Test

3.5.1 The FFT results for Q1 & Q2 2017/18 demonstrate an overall positive response to the FFT question as highlighted in the comments detailed in the graph below.



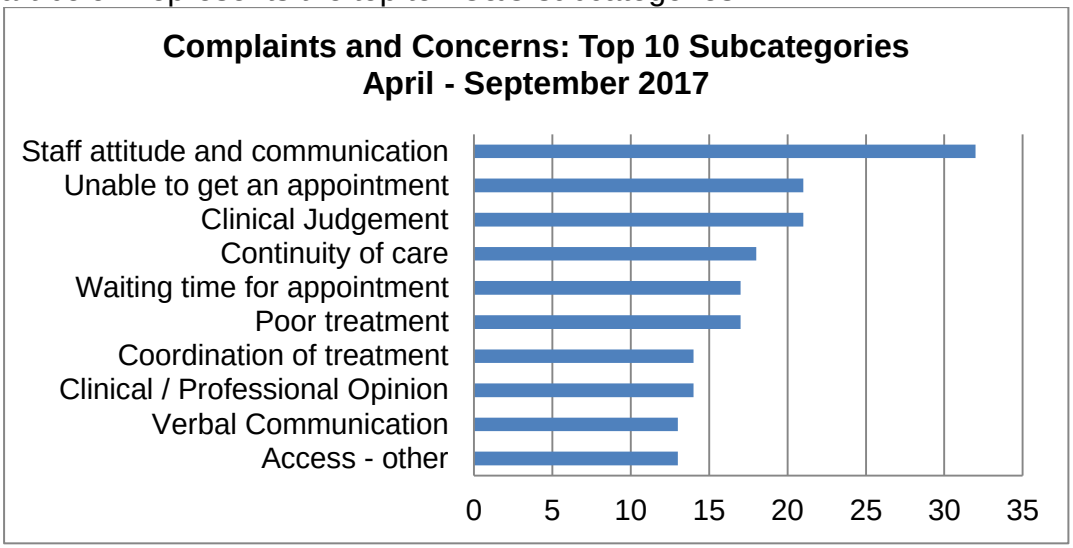
3.5.2 These comments are provided from 7506 FFT surveys, which represents an 8% response rate for the year. Negative responses recorded under the themes of Helpfulness, Compassion, Politeness, Waiting, Comfort and Feeling Safe are listed in Appendix 2.

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. Waiting continues to be a commonality with LCH FFT feedback.

3.6 Complaint & Concern Sub-Subjects

3.6.1 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.

3.6.2 The chart below represents the top ten C&C subcategories:



3.6.3 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.

3.6.4 The 'Access- Other' issues related primarily to Bramley Health Centre. During the reporting period there was an issue with the path leading to the main street requiring it to be closed for repair. The alternative entrance is more challenging to access, which led to an increase in the number of concerns reported. The issue has now been resolved.

3.6.5 As noted in the previous report, a full review of the Datix system and categorisation used is to be completed by year-end 2017/18.

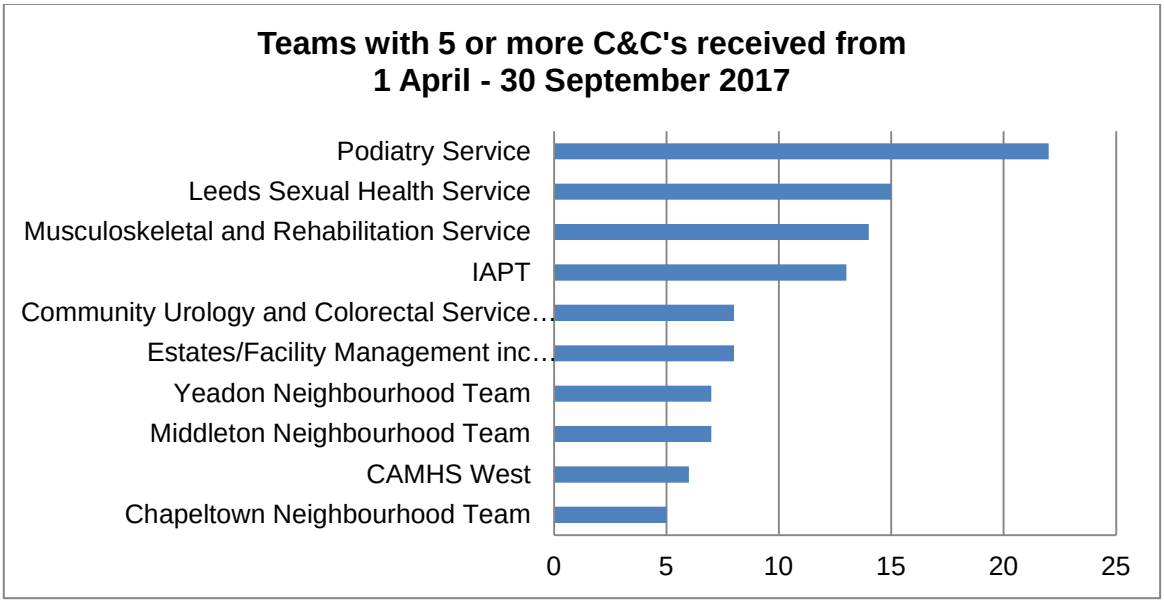
3.7 Teams with highest number of C&Cs

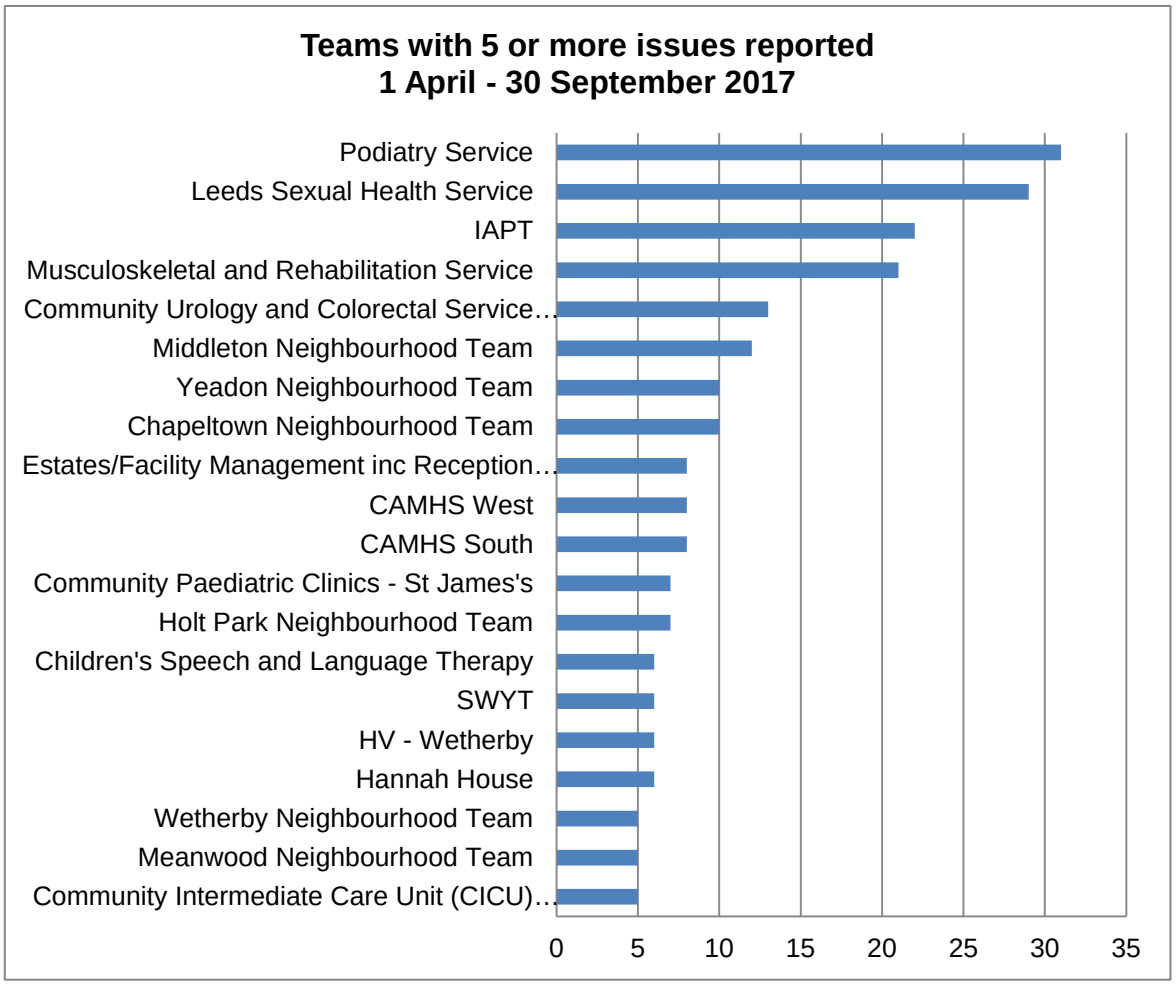
3.7.1 In the reporting period, the Trust has completed 790,385 patient contacts. The table below details how the contacts were split across the business units and the ratio of complaints per 10,000 contacts:

Business Unit	Number of contacts	Total Complaints and Concerns received	Ratio
Adult	395,419	42	1.06
Adults Other	11,672	9	7.71
Children's	167,873	48	2.86
Specialist	215,421	73	3.39

3.7.2 Based upon contact numbers alone, the Adult BU would be expected to feature more in the complaints and concerns received; the Neighbourhood Teams should be congratulated for their performance in this area.

3.7.3 The two charts below illustrate the teams with 5 or more concerns or complaints received and the teams with five or more issues within the reporting period:





3.7.4 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.

3.7.5 There are no unexpected complaint clusters identified within the reporting period.

3.7.6 The top four teams with the highest numbers of issues reported also receive the highest number of C&Cs. These are all services dealing with patients who may have chronic conditions or where there is high demand for the service.

3.7.7 When looking at the services with the highest numbers of C&Cs and reported issues, it is important to consider the number of patient contacts during the same period to give context to the data:

- Podiatry - 36827
- Leeds Sexual Health - 24163
- IAPT - 9458
- Musculoskeletal and Rehabilitation - 46886

3.8 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.

3.8.1 **Appointments remain a key issue within both concerns and complaints.**

3.8.1.1 As noted in 3.1.4, appointments remain the dominant theme within concerns and consistently represent a top theme within complaints.

3.8.1.2 The position of appointments will require further scrutiny over the next six month period.

3.8.1.3 Improved reporting capabilities allow all recorded subjects to be taken into account rather than just the primary subject as in previous reports. This has made appointments a more prominent theme in patient feedback in this reporting period.

3.8.1.4 Examples of <u>complaints</u> within this category are:

- Unable to get appointments for IAPT
- District nurses not attending home visits as often as required
- Waiting times for the Sexual Health Service
- Appointment recording errors in Children's Services

3.8.1.5 Examples of <u>concerns</u> within this category are:

- Patients at SWYT unable to get appoints as required
- Urgent appointments not available for the Diabetes Service
- Proposed changes to the Health Visiting service at Wetherby centre leading to reduced service for new mothers.

3.8.1.6 Whilst appointments remained a key theme within the organisation, when combining complaints and concerns (C&Cs) together there are few "hot spot" areas with most teams receiving only a small number of issues. The data collected covers 6 months, during which time the Trust completed 790,385 patient contacts; appointment issues were recorded 90 times across the Trust (a ratio of 1 per 8,782 contacts).

The top three services to have issues with appointments recorded are all in the Specialist Business Unit:

- Podiatry Service 21%
- Leeds Sexual Health Service 13%
- IAPT 7%

3.8.1.7 For all other services appointments were a minimal issue.

3.8.1.8 Over the next reporting period, further analysis will be applied to establish what impact the improved reporting capability is having on the themes and trends.

3.8.2 Experience Wall - Staff attitude and communication

3.8.2.1 As a theme, “Attitude, conduct, cultural and dignity issues including Staff attitude and communication” has featured in the LCH top five for complaints for the past two and a half years. This is comparable to other trusts and the national picture.

3.8.2.2 Due to improved reporting capabilities, a single sub-subject may be recorded more than once in the same piece of feedback. E.g. Staff attitude and communication has been recorded against more than one type of staff member. In the following paragraphs the term ‘mention’ has been used to illustrate when the theme was recorded in concerns or complaints.

3.8.2.3 Between 1 April - 30 September 2017 the individual sub-subject of “Staff attitude and communication” was the single most mentioned issue in complaints and concerns from patients and carers with 34 mentions across the business units.

3.8.2.4 Each block in the chart in 3.8.3 represents a C&C contact from a patient or their representative about their experiences in this area. The comments about experiences split broadly into three categories; the way a patient felt, the way a staff member spoke to the patient or the actions of the staff member involved.

3.8.2.5 The Specialist BU has the highest number of mentions in this area (17) with Adults and Children’s both receiving 8 mentions each and Operational Support Services having one mention during the reporting period.

3.8.2.6 Where staff type is recorded, the data demonstrates that a range of staff disciplines are identified. The recording of staff type is not compulsory. Over the next reporting period, this field will be completed for all complaints and concerns and analysis will be applied to this area to ascertain if there is any disproportionate reporting relating to staff group.

3.8.2.7 The theme of “Staff attitude and communication” is specifically categorised within the Datix system. There are also categories for issues with ‘verbal communication’ and ‘staff abuse of patient’. The review of Datix categories noted in 3.6.5 will consider whether these should be merged to improve the quality and clarity of the data collected by the Trust.

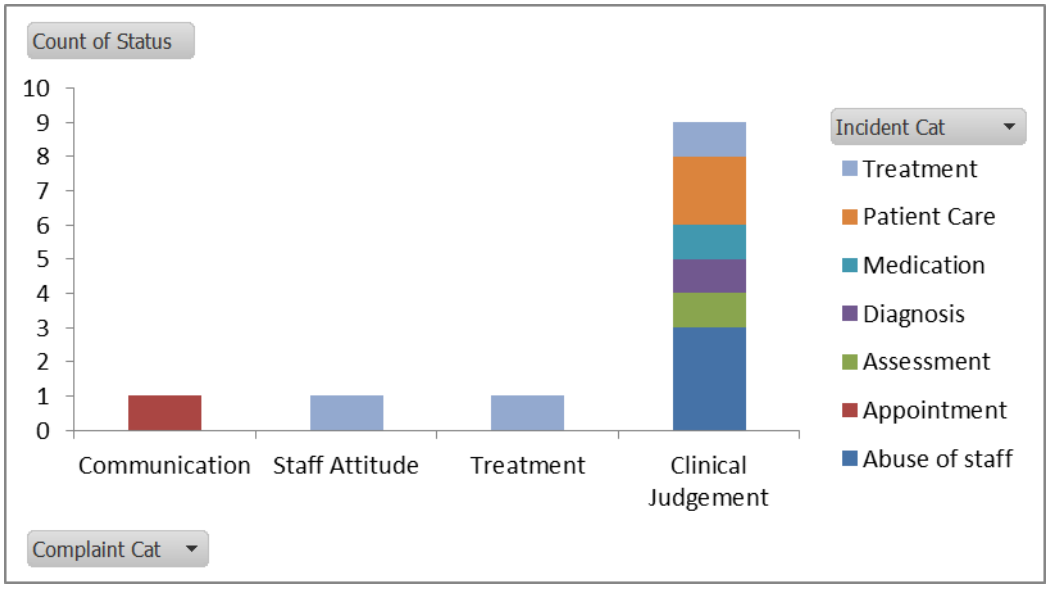
3.8.3 Experience Wall – ‘Staff attitude and Communication’

3.9 Incident and complaints and concerns data analysis

3.9.1 There were 13 records linked as Incidents/Complaints or Concerns in Datix; 1 was subsequently withdrawn by the complainant (not included in this analysis). Below is the breakdown of Business Units that have incidents linked to feedback and their status following investigation:

Business Unit	Linked Feedback/Incidents	Count of Feedback Upheld
Adult	5	5
Children's	1	Investigation ongoing
Inpatient	1	Investigation ongoing
Specialist	5	3

3.9.2 Eight of the twelve records had their complaint/concern upheld or partially upheld. Two were not upheld and two investigations are ongoing, we know the subject of these records but do not yet know the investigation outcome.



3.9.3 Seven records followed the Complaints process and 5 were recorded Concerns, for the purpose of this analysis, all will be treated equally as feedback.

3.9.4 The chart above shows that of the 12 records, 9 had the complaint category of 'Clinical Judgement' but when the incident was first recorded; various incident categories have been used.

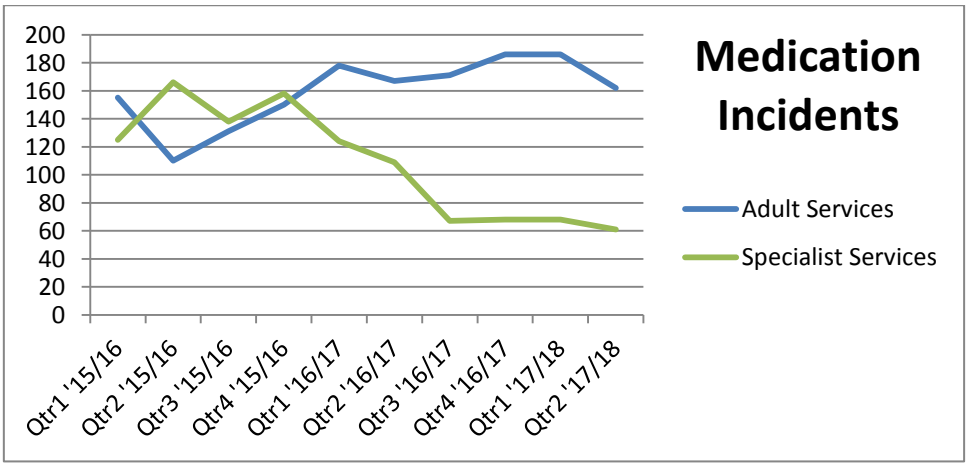
3.9.5 Three records linked Abuse of Staff (incident) to Clinical Judgement (Feedback). Further analysis of these 3 records identified that they were all reported by the MSK Service, and all highlighted a difference between the patient and clinician with regard to communication and treatment plans/expectations. There is evidence within the records that were upheld of steps being taken to reduce the risk of further similar reports.

3.9.6 Ten of the thirteen incidents that are linked to feedback records reported no harm to staff or patients. However, one reported minimum harm and another highlighted moderate harm. Both of these were reported as incidents by the Adult Neighbourhood Teams (although one is regarding a discharge from CICU) and both are Patient Safety Incidents.

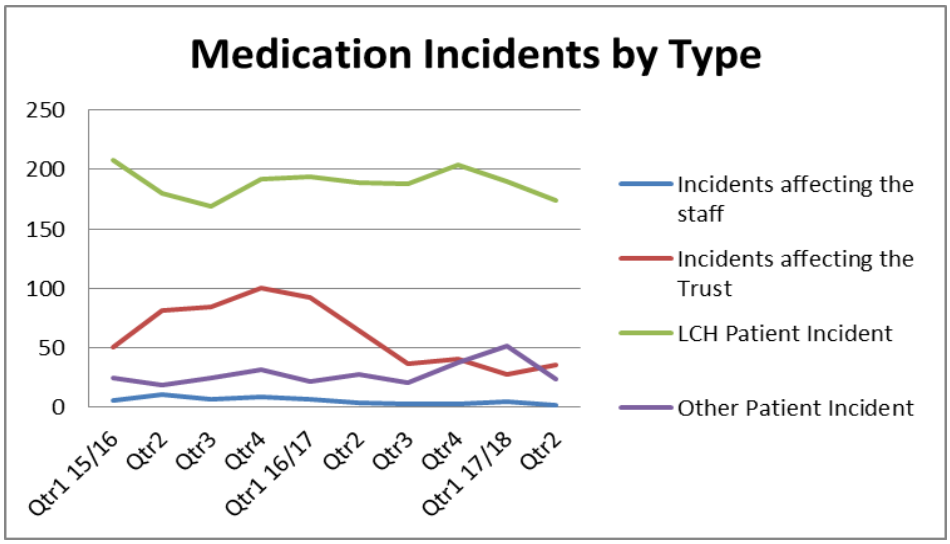
One remains under investigation and the other was upheld and evidence of learning from the incident is documented in the record

3.9.7 Whilst **Medication** complaints decreased overall in 2016/17, Medication remains the third top category for incident reporting. Numbers reported are decreasing quarter on quarter on 2017/18 for both Adult (including inpatient services) and Specialist Business Units. (Medication incidents in Children's Business unit are of small number with less than 30 reported in any quarter since 2015 so not included in this comparison).

The change to HMP healthcare provision in 2017 contributed to the decrease in medication related complaints and incidents in the Specialist Business Unit:



3.9.8 Further examination of the type of patient (LCH or Other NHS) or other incidents shows a decrease over recent quarters in the LCH medication incidents rather than those occurring with other NHS providers. There is also a significant decrease in Trust/Staff medication incidents as these earlier higher figures were mainly attributable to Prison Service counting errors of controlled drugs:



3.9.9 The actions and learning from this data are monitored by the medicines management team and via the quarterly Patient Safety, Experience and Governance 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	Clinical judgement / Treatment	Clinical judgement / Treatment	Slips, Trips & Falls (Patient Accidents)
	Attitude, conduct, cultural and dignity issues	Appointment	Pressure Damage (Implementation of Care)
	Appointment	Attitude, conduct, cultural and dignity issues	Medication (all)
Children's	Appointment	Appointment	Abusive, violent, disruptive or self-harming behaviour
	Clinical judgement / Treatment	Clinical judgement / Treatment	Appointment
	Attitude, conduct, cultural and dignity issues	Attitude, conduct, cultural and dignity issues	Medication (all)
Specialist	Appointment	Appointment	Slips, Trips & Falls (Patient Accidents)
	Attitude, conduct, cultural and dignity issues	Clinical judgement / Treatment	Medication (all)
	Clinical judgement / Treatment	Attitude, conduct, cultural and dignity issues	Appointment

5. ACTIONS AND LEARNING TO IMPROVE SERVICES

5.1 An update was requested from Business Unit Clinical Leads to evidence action and learning relating to 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 Exception Report and the quarterly Patient Safety, Experience and Governance Report.

6. RECOMMENDATIONS

6.1 Trust Board is requested to:

- Receive this report
- 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. Adult Business Unit

The Neighbourhood Team Clinical Leadership Team monitors service user feedback on a formal basis within the Monthly Quality Metric Meeting. This includes a review of the themes and any causative or contributory factors that have occurred as a response to service.

Learning from this analysis of complaints and concerns is shared directly to staff on either a 1:1 or group basis. The learning is also shared via the weekly Safety Huddles and Neighbourhood Team Quality Safety Briefings.

1.1 Clinical judgement / Treatment

- The theme related to clinical judgement and treatment when analysed mainly relates to delivery of care rather than the skills and experience of staff provided care to Neighbourhood Team patients.
- Despite the ongoing service pressures impacting upon staff availability for training, there is ongoing provision and attendance by registered staff at key clinical skills training sessions.
- The Neighbourhood Teams are developing a Clinical Delivery Framework Handbook to guide and support the quality of care being delivered and reducing any variation in clinical practice.
- Daily handover meetings are established at caseload cluster level led by senior clinician to support clinicians in their clinical decision making.
- The monthly case load review process is being established. They are peer reviewed to support reflection upon evidence based practise and clinical service delivery.
- The learning from 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 practise 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.

1.2 Appointments and access to services

- Issue related to appointments: a review of feedback from our service users has led to a further refinement of the Neighbourhood Team referral triage and allocation of clinical visit processes.
- The Neighbourhood Team Capacity and Demand Tool continues to be refined to support efficient and effective service delivery.
- This work along with the ongoing monthly audit held that reviews cancelled and unscheduled Neighbourhood Team Visits supports the analysis that is reported to the ABU Performance Meeting and is included in the Director of Nursing report to the Quality Committee. Access and waiting times to the Neighbourhood Team is monitored from the waiting list report and followed up with specific initiatives to reduce long waiters. Access to therapy is a growing issue that the leadership team are sighted on and developing new approaches to manage.

1.3 Attitude of staff / Communication issues with the patient

- Where patient feedback has described either a failure in effective communication by NT staff or staff behaviour having led to a negative impact on a patient or families experience of NT care this feedback is shared with individual staff members in order for them to understand and learn.
- Staff are supported by their Neighbourhood 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 the trust conflict resolution training.

2. Children's Business Unit

2.1 Appointments and Access to Services

- The CBU are sharing learning on how to manage waiting lists even better. One example is the CSaLT Summer Initiative which was a project with colleagues at LBU targeting children who had been waiting the longest.

- The new models of service that CAMHS is working on will also impact waiting times [this is not an immediate effect but will bring about more long term sustained change].

- A secondary theme within this category was the importance of clear information on service provision and prompt return of telephone calls – the continued move towards a single Children's Services SPA will support the development of consistent approaches and the one contact point for all services.

- The Children's Business unit is committed to ensuring effective and timely access to clinical services and is a priority domain within the Children's Strategy. Access and flow are being improved by developing further the Single Points of Access (SPA) for services within the business unit in parallel to supporting the organisational intention of establishing a SPA for the administration service. The benefit of the administration SPA will further improve access, increase efficiency and reduce costs.

- Ongoing continuous live management of waiting times in services allows teams to regularly review clinical complexity and acuity to determine risk with responsive and active management. The enhanced signposting function of the established SPA's (CAMHS, HV, SN)coupled with access to a wide range of self-help materials, apps and health and local authority platforms has enabled families to have increased connectivity with services whilst awaiting appointment.

- ICAN is one of the services actively addressing ongoing challenge with wait times. Strategically the service is being supported by the development of the ICAN Nursing Strategy which will extend and strengthen the nursing skill and competency set in order to deliver nurse led clinics within wider ICAN clinical pathways.

2.2 Clinical Judgement

- The overall theme was the importance of explaining the assessment process in meaningful ways. Each service discusses feedback and learning lessons from specific feedback including complaints at its professional meeting / team meetings for example the HV Professional Issues Meeting

- 2 of the complaints centred on the CAMHS service and management of autism assessment – this is being picked up with the new Models work the service is involved in, which includes users of the service. The BU is also looking at an Autism assessment and intervention pathway across services building on this work with a multi-disciplinary workshop is planned for January 2018.

- Clinical judgement within care delivery remains a priority for the Children's business unit. Services are engaged in further health coaching training. The business unit promote collaborative practice with children, young people and families in order that individuals' goals are identified by the young person and offered intervention seeks to enable goal achievement with positive impact.

- The use of Safety Huddles is being encouraged within services, particularly inpatient settings, allowing all staff to share awareness and understanding of clinical need with agreed decision making and priority setting with regarding intervention and care.

- The use of Clinical Supervision policies is being revisited to ensure that clinicians are supported by supervisors to make informed, safe and appropriate decision regarding care.

- Staff health and wellbeing is a priority with Children's services. Managers and leads are implementing strategies to support staff which are compatible with the organisation's Vision and Values to promote and maintain emotional health and wellbeing of staff. There is a recognised correlation between these factors and effective clinical decision making and high quality care delivery. Examples of support include access to coaching training, mindfulness, stress management awareness courses, staff counselling, fast track into access to IAPT, flexible working, bullying and harassment workshops and mediation.

- The business unit places importance on promoting and celebrate achievements by clinicians, teams and services, national awards and contribution to conferences. Children's Services are currently planning a business unit wide celebratory event to showcase service development and clinical expertise.

2.3 Attitude of Staff and Communication

- One of these complaints was about homophobia/heteronormative language used in a letter to a child's parent. This has resulted in all services reviewing their letters to parents to ensure that homophobia/heteronormative language is not used. This was a specific issue for health visiting only and the service is working with the complaints and wider services users, including fathers to look at alternative approaches.

- The second complaint was regarding care at Hannah House – the learning has been used as part of the QIP and Quality Challenge+ in place for the unit. The complainant has had long conversations with unit staff and is involved in suggested improvements.

- Staff are encouraged to access leadership training to improve and develop leadership and advanced communication skills. Services promote "better conversation" within on

going health coaching. The model has extended out to a communication style that is helpful with supervision and team meetings.

- Managers and leaders are supported in managing staff sickness, adopting a culture of being receptive to and hearing the staff voice and responding to this flexibly and appropriately. Learning from incidents and complaints has become an expected component of the culture within Children's Services.

- Teams discuss and share learning locally, report incidents and learning within the Quality and Performance framework and transferable learning is shared across the business unit.

- Staff are to undertake equality and diversity training and focused sessions are organised within teams to promote the importance of adhering to duty of candour standards of practice and developing a culture within teams that promotes empathy and unconditional positive regard. Focus has recently been offered to teams to raise awareness of unconscious bias and the impact of this on behaviour and communication.

2.4 Incidents

- Abusive, violent, disruptive or self-harming behaviour:

    - 94% of these incidents are from AIS which reflects the complexity and vulnerability of these young people. After every incident the young person's risk assessment is reviewed and updated, the care plan is updated and there is discussion by the MDT – looking at trends and learning. This informs plans for staff training and therapeutic interventions availability.

- Access, Appointment, Admission, Transfer, Discharge:

    - 53% of these are from health visiting. This service is moving towards a central SPA to organise appointments; this is causing teething problems. There are now weekly meetings focusing on learning from incidents – this has seen the development of new processes, rapid audit and change based on the outcomes of the meetings.

- Information Governance / Records:

    - During the reporting period, 41% of these incidents are from health visiting and thus the above is applicable. The work that Jo Sykes has done on these incidents has been shared with all teams – specific things services have been asked to focus on is ensuring that scanned documents are attached to the right clinical record. Another change that has helped is the Child Health team using password access printing/copying.

- Medication:

    - A lot of work has happened at Hannah House to improve medication management and this should be recognised. All staff have had additional training on medicines management including recording incidents and new SOPs have been introduced.

3. Specialist Business Unit

From monthly analysis it has been determined that from investigations of incidents and complaints that all were followed up with individual feedback and staff managed as appropriately within relevant clinical guidelines or the 'How We Work' framework. Additionally Quarterly learning sessions have been held at clinical forum whereby incidents and complaints learning shared across the business unit.

The total number of minimal and moderate harm incidents reported was within the normal range on a Standard process control chart where upper and lower control limits are set.

3.1 Appointments:

- A theme within this category has related to lack of prison staff escorts at Wetherby YOI, resulting in patients not accessing healthcare appointments (internal and external). This is an issue of concern and is currently on the risk register. Escorts and Bedwatch is a joint healthcare and prison CQUIN for 2017/18 which is being led by senior managers from both LCH and HMP.

- A range of measures have/ are being implemented as part of an ongoing action plan to ensure patient safety and reduce number of missed appointments. These include; Implementing a medical triage criteria for cancelled appointments with clear escalations processes to Head of Healthcare and Governor when there are potential patient safety issues.

- Weekly and monthly joint view of cancelled appointments, exploring reasons why and following up any identified issues and learning; and establishing an acute care pathway working group with YAS and Harrogate A&E with the intention of preventing external escorts as much as possible.

3.3 Attitude, conduct, cultural and dignity issues (including Staff attitude and communication):

- As identified above all incidents and/ or complaints relating to staff attitude have been followed up with the individuals concerned and managed appropriately. Additionally health coaching training is being rolled out across Long Term Conditions, MSK/ Spinefit and Podiatry services to support better conversations with patients.

3.4 Clinical judgement / Treatment:

- There were two pressure ulcer incidents in Police Custody in the last 6 months. Whilst these were found to be unavoidable to LCH it was found that staff did not know how to access Purpose T.

- Training is now being rolled out to all staff that includes the expectation that all patients should be screened for pressure ulcer risk factors and appropriate action taken when risk factors are identified.

- All teams have refreshed their clinical supervision models to ensure flexibility for supervision where appropriate, therefore enabling greater access to support for clinical practice.

3.5 Monitoring of medicine use:

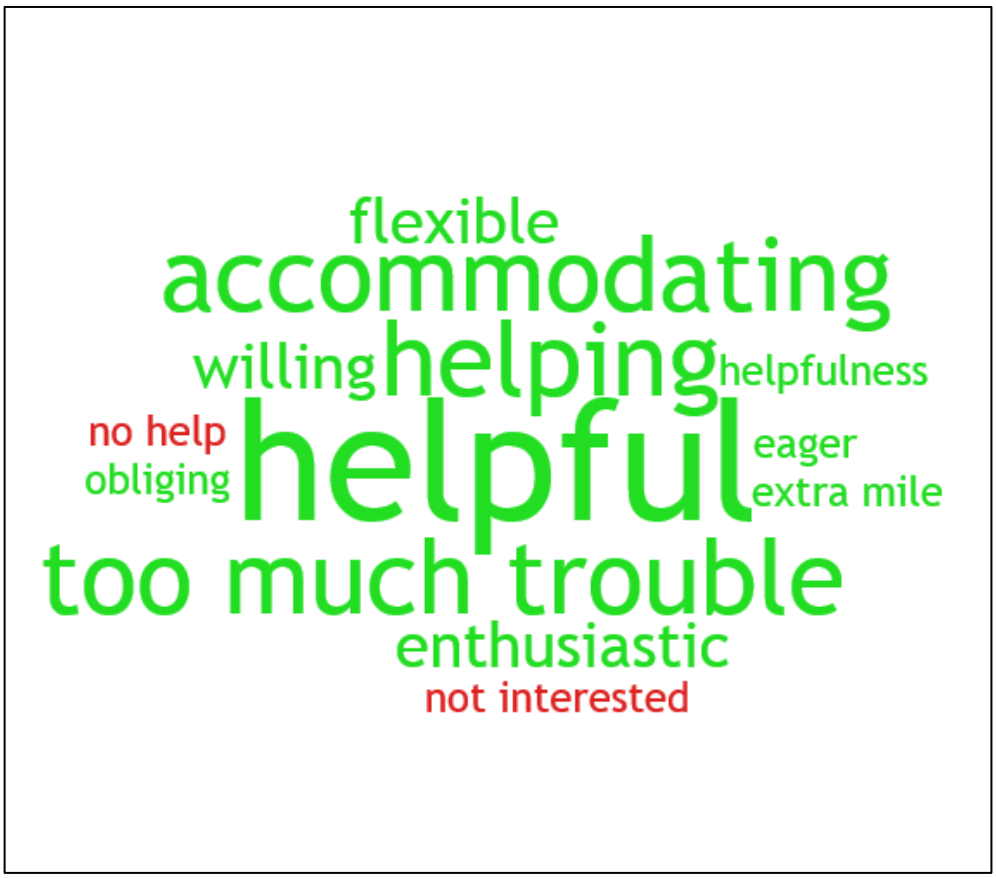
- Police Custody Suites have been implementing a reconciliation of drugs process since January that includes a stock check on each shift. This has significantly reduced the number of medicines incidents (50% decrease since August 2016).

3.6 Slips, trips, falls and collisions:

- Following advice from the Falls Team the reporting of unwitnessed falls on Datix by CNRS has been revisited with staff to ensure consistency. This is due to a number of falls incidents being reported that resulting in no harm which should not have been reported. Falls reporting has since reduced.

APPENDIX 2: FFT comments

Helpfulness



The negative comments in the word cloud are recorded in a negative sense listed in the table below. The 2 responses represent 0.41% of the total (483) of feedback under this theme and refer to 2 different services and locations.

THEME GROUP: 4 STAFF (HELPFULNESS - ALL)

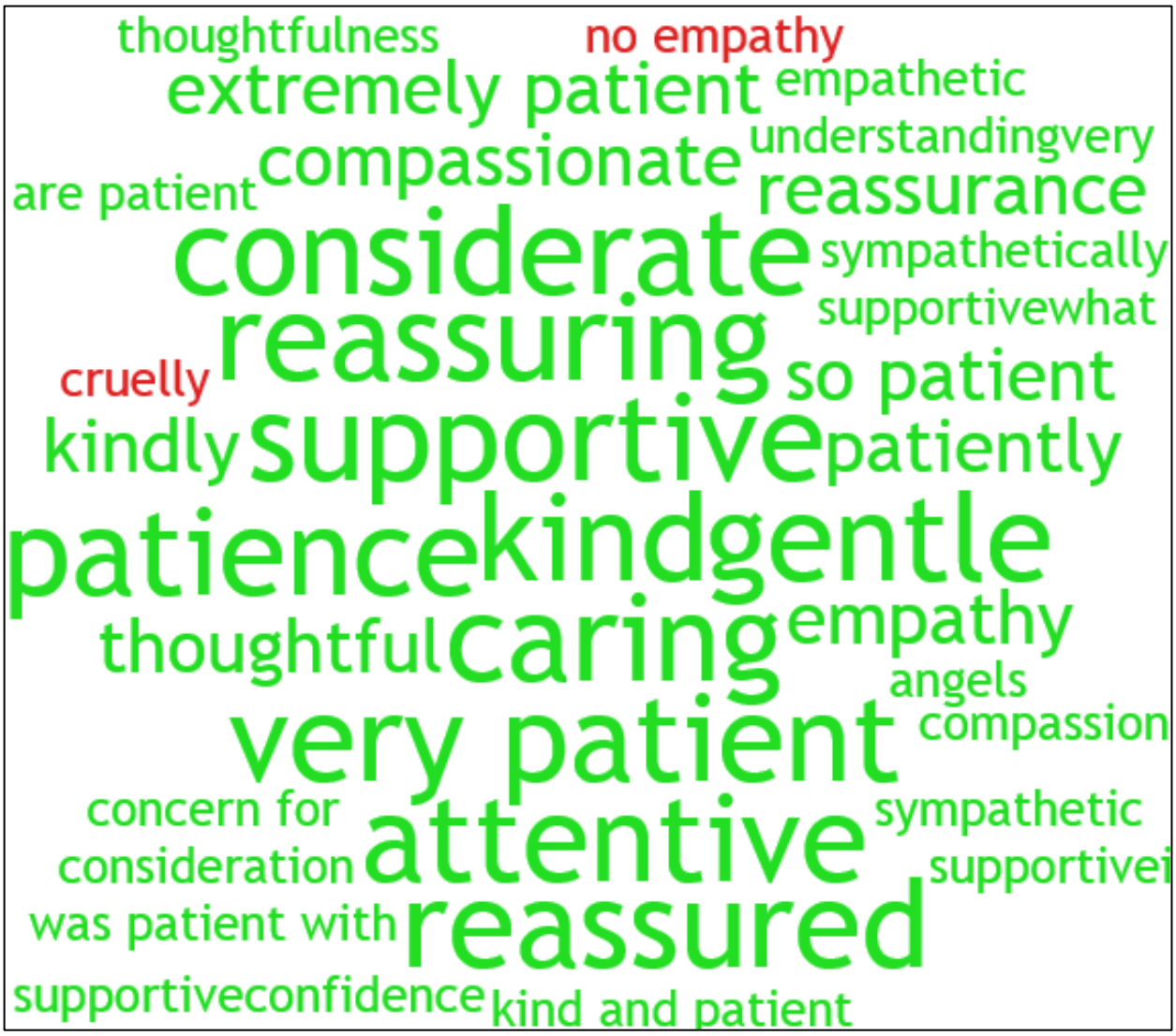
NEGATIVE COMMENTS FOR: *ALL KEYWORDS*

Page: 1

Perception	Date	FFT Response	Speciality Ward/Clinic	Keyword within comment
13706-1	2017-08-22	Likely	SP - St George's Centre ** ID='0' Not Found **	at present no help
11898-1	2017-06-01	Unlikely	South 2 - Middleton ** ID='0' Not Found **	stop. they have pushed and pushed to get his carers to do this. the social care. we are really not interested in lack of funds short staffed. such issues are not for sick patients to be told on a daily basis

Records: 2

Compassion



The negative comments in the word cloud are recorded in a negative sense listed in the table below. The 2 negative comments represent 0.68% of the total (296) of feedback under this theme and refer to 2 different services and locations.

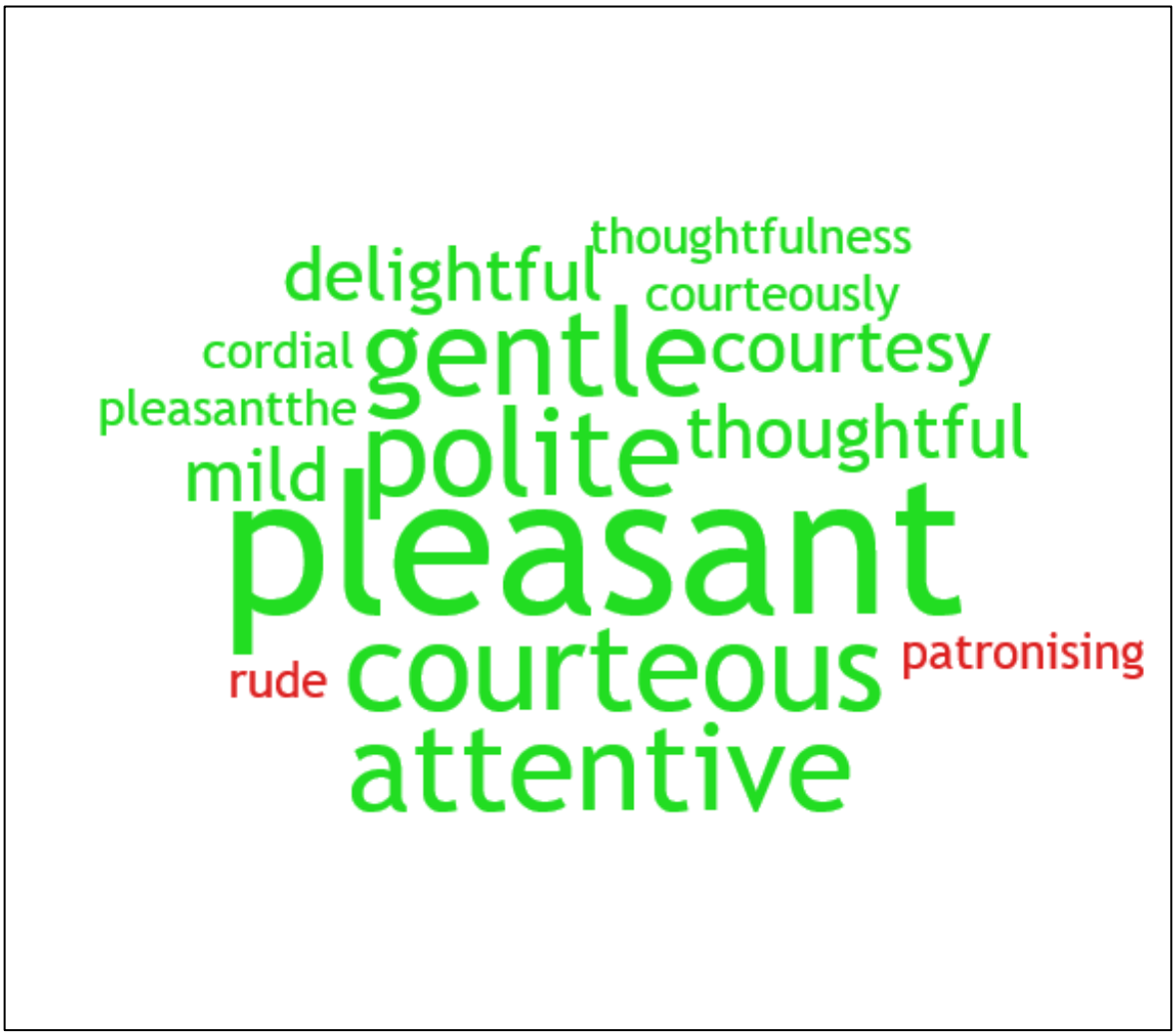
THEME GROUP: 4 STAFF (COMPASSION - ALL)

NEGATIVE COMMENTS FOR: *ALL KEYWORDS*

Page: 1

Perception	Date	FFT Response	Speciality Ward/Clinic	Keyword within comment
14398-1	2017-07-25	Likely	CS - Armley\Pudsey ** ID='0' Not Found **	and what they do to help him recover unlike some of the nurses in the hospital that treated him cruelly
14375-1	2017-07-21	Neither Likely or Unlikely	South 1 - Morley ** ID='0' Not Found **	the physio and ot were great. some of the carers had no empathy and meals and visits missed

Politeness



Of the negative comments in the word cloud only one is recorded in a negative sense listed in the table below. The 1 negative comment represents 0.58 % of the total (171) of feedback under this theme.

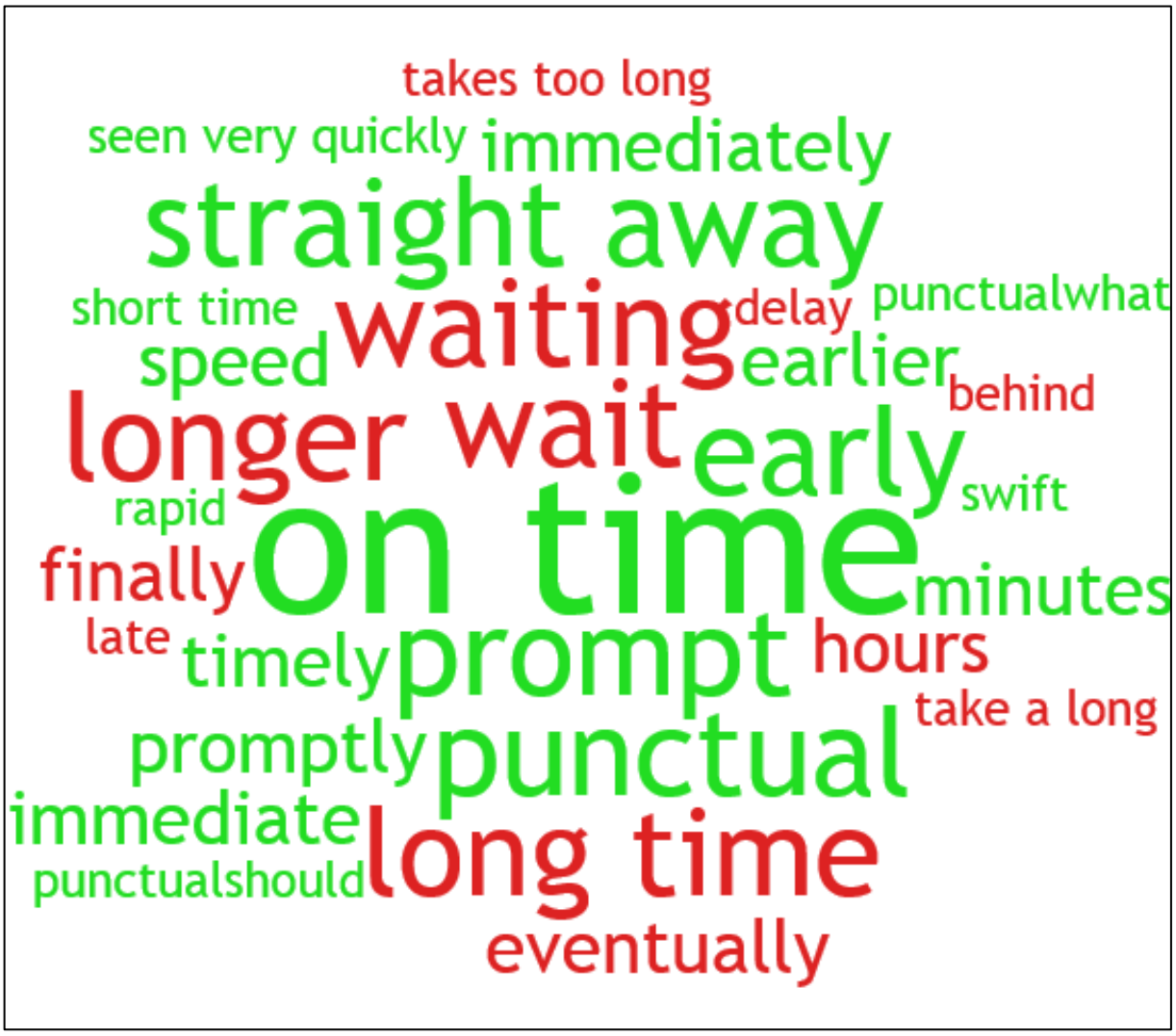
THEME GROUP: 4 STAFF (POLITENESS - ALL)

NEGATIVE COMMENTS FOR: *ALL KEYWORDS*

Page: 1

Perception	Date	FFT Response	Speciality Ward/Clinic	Keyword within comment
14411-1	2017-07-25	Extremely Likely	DS - Nurse, Dietitian, Doctor Clinic?- East Leeds ** ID='0' Not Found **	friendly group - informative without being patronising . tips and suggestions for healthy life-style and prevention strategies
12272-1	2017-06-27	Extremely Likely	POD - Clinic: Beeston Hill Health Centre ** ID='0' Not Found **	the podiatrist i see is very good. he`s the only one i see. one of the other podiatrists was very rude . at reception you can stand waiting and they are chatting

Waiting



Of the negative comments in the word cloud only 27 are recorded in a negative sense listed in the table below. The 27 negative comments represent 23 % of the total (125) of feedback under this theme.

FFT response	Service	Comment
Extremely Likely	MSK - Meanwood Health Centre	Back buttock leg pain. Physiotherapist was excellent. gave me a set of exercises and explained rationale behind them symptoms eased significantly over the 3 sessions and I have been pain free for the first time in
Extremely Likely	CNS - Stroke Pathway	Only thing I could mention is the delivering of equipment some of it arriving unexpectedly plus the delay in getting unrequired equipment taken back again. Other than that brilliant.
Extremely Likely	Civas - City Wide	Each was pleasant and very efficient. All process were explained to me as we went along. Eventually all members of the team dealt with me if I asked for special arrangements to fit in with

Extremely Likely	MSK - Sunfield Medical Centre	Only some backache. I believe that without the advice of the physiotherapist I would eventually have been unable to walk any real distance. Thank you
Extremely Likely	MSK - Wharfedale General Hospital	Timescale too long before I could see a physio paid to see private physio x 3 when I finally saw an NHS physio all the bruising from my injury had disappeared
Extremely Likely	MSK - Sunfield Medical Centre	I have been given advice and guidance relevant to me and my condition and its helped greatly. I finally feel on the road to recovery and know how to build strength in my joint. Thank you
Extremely Likely	Civas - City Wide	Care at home was excellent and all very helpful. They don't get the credit for what they do and the hours thy put int. They should all get a pay rise for this service
Extremely Likely	CS - Yeadon\Woodsley	Course very motivating especially when one`s been inactive physically for a long time. Personal health awareness has been very helpful advice on good bad good fats and the reason for
Extremely Likely	MSK - Wharfedale General Hospital	Exercise and follow up treatment were explained and demonstrated very well never had to wait a long time for appointments
Extremely Likely	MSK - St George`s Centre	Because I have been in pain that long struggling at work etc it`s gone on a long time. One visit and an injection advice etc. Absolutely fantastic. I`m doing everything advised and
Extremely Likely	CS - Kippax\Hunslet	All the help and advice from all the staff what can we do better? Make the course longer
Extremely Likely	POD - Clinic: Rothwell Health Centre	And the will to see difficult problems through. You have preserved my mum`s mobility for much longer than it otherwise would have been
Extremely Likely	CNS - Stroke Pathway	Being in a foreign world. The care I had helped me so much. I just wish the help could have been longer.
Extremely Likely	MSK - St George`s Centre	Has helped the pain in my lower back and made me think about my posture. Had to wait for a few months to see a physio but it was not a long wait for this class
Extremely Likely	MSK - St George`s Centre	Made me think about my posture. Had to wait for a few months to see a physio but it was not a long wait for this class
Extremely Likely	MSK - Wharfedale General Hospital	Into leeds quick referral listening staff good sound advice with exercise treatment not busy not had to wait
Extremely Likely	SST - Pudsey	Very friendly approachable immediate care not to wait months identified root cause of my issue couldn't ask for more excellent! thank you
Extremely Likely	MSK - Wharfedale General Hospital	I had to wait for several weeks for an appointment but I felt confident that I had the treatment and advice

Extremely Likely	MSK - Sunfield Medical Centre	Professional service not too long to wait for an appointment. Physio was very polite friendly and good examination and explanation
Extremely Likely	MSK - St George`s Centre	Very kind and patient. A trainee and a young man called it's just a shame that I had to wait so long to see someone almost 4 months from referral.
Extremely Likely	MSK - Sunfield Medical Centre	I have found the service very good. Never had to wait for appointments. Everyone I`ve met have been friendly and professional.
Extremely Likely	MSK - Wetherby Health Centre	Had physio in the past - nothing worked - saw new physio for 2 months and had great improvements - had to wait 15 years to find someone who knew what she was doing
Extremely Likely	MSK - Morley Health Centre	Excellent service advice. Unfortunately to wait a prolonged period of time between first assessment and treatment session however i understand
Extremely Likely	MSK - East Leeds Health Centre	I had to wait a few weeks for treatment but the exercises I have been given have been amazing
Extremely Likely	CAMHS - Community	Perhaps tea or coffee could be available in reception. I have to wait approx. 70mins
Extremely Likely	MSK - Wharfedale General Hospital	Was a good response to this. What can we do better? I now feel much better. I had a three month wait to be seen strained neck muscles can be painful. Is this due to a high demand for this service?
Extremely Likely	MSK - Meanwood Health Centre	To converse well fairly quick results from exercises only downside is limited appointments and long wait before hand
Extremely Likely	MSK - Wharfedale General Hospital	Exercise and follow up treatment were explained and demonstrated very well never had to wait a long time for appointments
Extremely Likely	CNS - Stroke Pathway	Talking brought me on however it would have been better I could have 10-12 weeks as i now have to wait for more therapy
Extremely Likely	CNS - Neurology Pathway	It was already in difficulties pre-stroke but now bad!! On a waiting list for some outstanding issues
Extremely Likely	MSK - Beeston Hill Community Health Centre	Follow up and making sure the problem was solved lovely staff always keeping to time. Waiting period is less none
Extremely Likely	MSK - St George`s Centre	Given good exercises to improve my knee which has really helped. Good communication and was only waiting about 4 weeks from having appointment with my doctor to see physio
Extremely Likely	POD - Clinic: Beeston Hill Health Centre	One of the other podiatrists was very rude. At reception you can stand waiting and they are chatting
Extremely Likely	CS - Armley\Pudsey	How I felt when her phone rang and she answered it. Then she was worried about the man still waiting outside. Then her phone rang again and she held a long conversation with a patient for about 20mins.

Extremely Likely	South 1 - Morley	I am very grateful for the nurses. I am waiting a hip replacement and will need your care again. I am very grateful for the care received.
Extremely Unlikely	CAMHS - Community	`In case of interference with what CAMHS is doing` even when all CAMHS is doing is keeping you on a waiting list for years at a time. Throughout this time my child`s problems have become steadily worse to
Extremely Unlikely	CAMHS - Community	Elsewhere and not getting involved in the quagmire of CAMHS because once your name is down on a waiting list no other support service will touch you `in case of interference with what CAMHS is doing`
Likely	CNS - Neurology Pathway	The information was well put over what can we do better? A longer time would be useful ie 3 hours the trainers should be more assertive with some people
Likely	CAMHS - Community	Keep appointments improve waiting list times more regular appointments out of hours service
Likely	MSK - Armley Moor Health Centre	I gave the above score is because the techniques and workout helped a lot but seems to take a long time. So you will need to motivate yourself
Likely	CNS - Neurology Pathway	The information was well put over what can we do better? A longer time would be useful ie 3 hours the trainers should be more assertive with some people
Likely	MSK - Armley Moor Health Centre	The reason I gave the above score is because the techniques and workout helped a lot but seems to take a long time. So you will need to motivate yourself
Likely	MSK - Meanwood Health Centre	Very helpful! Massive improvement however it was a long wait to get an appointment
Likely	MSK - Wharfedale General Hospital	Excellent service once I was seen felt like a long wait. I booked at Wharfedale because this had the shortest waiting list. It would be useful to know
Likely	CICU	Disorganised mornings. At times a very wait for alarm attention first class staff. Poor choice of menu
Likely	MSK ? Sunfield Medical Practice	Good service once you could get an appointment a wait of a couple of months for first appointment is too long.
Likely	POD - Clinic: Bramley Clinic	Are courteous and put you at ease. Also they do a good job. Minus side I think that three months wait between appointments is to long for some people as nails grow differently on people.
Likely	MSK - Meanwood Health Centre	The only reason I did not tick `extremely likely` was the length of time waiting for the initial appointment
Likely	MSK - St George`s Centre	Shoulder impingement staff helpful. Only fault 3 months waiting to see physio other than that all good thank you

Likely	North 2 - Seacroft ~	Cheerful in the most part and kind. The system behind them has holes in it leading to wasted days waiting for a visit and uncertainty on who was responsible for what
Likely	MSK - Wharfedale General Hospital	Once I was seen felt like a long wait. I booked at Wharfedale because this had the shortest waiting list. It would be useful to know in advance that wherever you book initially is where you have to
Likely	SLIC	100% respectful and courteous but Ihave had 2 accidents due to waiting
Likely	CAMHS - Community	Keep appointments improve waiting list times more regular appointments out of hours service
Neither Likely or Unlikely	MSK - Meanwood Health Centre	In time but I`d rather see and find out what`s causing it and how we can fix it rather than just wait for my body to heal itself
Unlikely	CAMHS - Community	Improve waiting lists - takes too long. More staff. Appointments outside of school times!
Unlikely	CICU	Too much waiting and hanging about

Comfort

Of the negative comments in the word cloud 4 are recorded in a negative sense listed in the table below. The 4 negative comments represent 7.5 % of the total (53) of feedback under this theme. All 4 negative comments are referring to 4 different services in 4 different locations.

THEME GROUP: 2 NON CLINICAL SERVICE QUALITY (COMFORT - ALL)

NEGATIVE COMMENTS FOR: *ALL KEYWORDS*

Page: 1

Perception	Date	FFT Response	Speciality Ward/Clinic	Keyword within comment
11453-1	2017-04-27	Extremely Likely	MSK - Wetherby Health Centre ** ID='0' Not Found **	the help and tuition i have received by the physio gill has relieved my stiff lumbar back and discomfort and has shown me how to maintain this improvement.
12228-1	2017-06-22	Extremely Likely	MSK - Sunfield Medical Centre ** ID='0' Not Found **	definite noticeable sustained improvement in reducing knee discomfort .
12290-1	2017-06-29	Extremely Likely	MSK - Wetherby Health Centre ** ID='0' Not Found **	because the exercises given have eased the pain and discomfort . the physio was very pleasant and helpful
12608-1	2017-05-09	Extremely Likely	MSK - Armley Moor Health Centre ** ID='0' Not Found **	i come here with bad head pain and after sessions of acupuncture i have reduced pain and discomfort from pain every day to virtually none
14381-1	2017-07-24	Extremely Likely	MSK - Wharfedale General Hospital ** ID='0' Not Found **	i attended with a shoulder problem which had been causing me discomfort for a long period of time & nothing was helping iti attended clinic who quickly identified the
12532-1	2017-05-08	Extremely Likely	MSK - Wharfedale General Hospital ** ID='0' Not Found **	but. physiotherapy consultation in large open ward - at least 5 conversations behind curtains - loud and difficult to concentrate clearly very un confidential. also people with hearing difficulties
11550-1	2017-04-06	Likely	OHC - SLIC ** ID='0' Not Found **	respected helpedhow can we do better?reduce the noise at night. meals are a bit repetitive
14111-1	2017-07-06	Neither Likely or Unlikely	CNS - Neurology Pathway ** ID='0' Not Found **	not judged on the condition of your home providing it is clean and reasonably tidy. i said i could not sleep very well. the reply on the telephone was - do you think you have bed bugs. simply no respect or
13759-1	2017-08-21	Did not answer	POD - Clinic: Yeadon Health Centre ** ID='0' Not Found **	i" d like to recommend this practice but it" s already overcrowded . podiatrist is great but i am very frustrated that i cannot get any more soles for my other shoes
11413-1	2017-04-18	Likely	CGS - Armley Moor Health Centre ** ID='0' Not Found **	doctor and nurse very friendly. doctor aware i found the larger speculum uncomfortable and was able to use a smaller instrument to make me feel relaxed.

Feeling Safe

After analysis of the information in the table below it was revealed that the negative comments in the word cloud none were mentioned in received FFT comment feedback in a negative sense.

THEME GROUP: 3 CLINICAL SERVICE QUALITY (FEELING SAFE - ALL)

NEGATIVE COMMENTS FOR: *ALL KEYWORDS*

Page: 1

Perception	Date	FFT Response	Speciality Ward/Clinic	Keyword within comment
14416-1	2017-07-25	Extremely Likely	DS - Nurse, Dietitian, Doctor Clinic?- East Leeds ** ID='0' Not Found **	education about the condition is very importanthalf the battlediet and controlling condition is very importantit is nice to be able to ask questions and speak freely in an
13707-1	2017-08-22	Extremely Likely	SP - St George's Centre ** ID='0' Not Found **	friendly and informative plenty in information and suggestions to take forward no stress to force you any one way - encouraged to find the one that works for you thank you to the team
11798-1	2017-04-06	Extremely Likely	CGS - East Leeds Health Centre ** ID='0' Not Found **	staff all friendly and helpful. feels less intimidating than a hospital out patient dept. good appointment service
11898-1	2017-06-01	Unlikely	South 2 - Middleton ** ID='0' Not Found **	see how shifting nursing care onto social care is appropriate. if i thought this was a one off isolated inident then that can be dealt with. but this is endemic. social carers say this is normal practice
12089-1	2017-06-15	Extremely Likely	CNS - Neurology Pathway ** ID='0' Not Found **	available and other useful referencesis there anything else you want to tell us? yes i desperately need help with managing a disintegrating marriage. it was already in difficultles pre-stroke but now bad!
11568-1	2017-04-18	Extremely Likely	CS - Beeston\Middleton ** ID='0' Not Found **	during all the sessions the staff have been very careful professional and helpful about health and safety of participants and have been frequently taking as much information as possible
13758-1	2017-08-21	Likely	CFS - Citywide ** ID='0' Not Found **	the nurse that came was very helpful. she made agreement to have additional safety which have me confidence on the stairs and in the shower and also was understanding about my
11757-1	2017-04-12	Extremely Likely	MSK - St George's Centre ** ID='0' Not Found **	feels like self harm but this is the best treatment i have had within the nhs
11553-1	2017-04-06	Extremely Likely	CS - Kippax\Hunslet ** ID='0' Not Found **	nurses were brilliant and so caring. they gave me so much reassurance when i felt so vulnerable after my heart attack
12592-1	2017-05-09	Extremely Likely	South 2 - Middleton ** ID='0' Not Found **	this form was completed by the daughter of the patient. my mother is vulnerable both mentally and physically

Records: 10

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (65)

Meeting Trust Board 1 December 2017	**Category of paper**	
Report title Quarterly Report of the Guardian of Safe Working Hours	**For approval**	
Responsible director Executive Medical Director **Report author** Guardian of Safe Working Hours	**For assurance**	√
Previously considered by Quality Committee 20 November 2017	**For information**	

Purpose of the report

This paper comprises a report on issues affecting trainee doctors and dentists in Leeds Community Healthcare NHS Trust, including matters such as morale, training and working hours.

Main issues for consideration

The report provides an opportunity to more fully nderstand the role of the guardian of safe working hours (GSWH) to highlight issues affecting the training and working lives of trainees and to note:

- The appointment of Dr Turlough Mills (20 October 2017) as Guardian of Safe Working Hours.
- Concerns highlighted in previous reports remain. These include concerns in relation to training for community paediatrics trainees: training may be being compromised by on-call responsibilities.

Recommendation

The Board is recommended to note the report

Quarterly Report of the Guardian of Safe Working Hours

1.0 Quarterly Report of Guardian of Safe Working Hours: Context

There are 25 junior doctors, of which, eleven have employment directly with Leeds Community Healthcare NHS Trust and the remainder have been issued with honorary contracts by the Trust across the four departments as outlined below. All but three of the employed trainees are employed on the 2016 contract.

Adults	3	GP Trainees	Employed
CAMHS	5	STs	Employed (fulltime)
	3	CTs	Honorary
	5	FYs	Honorary
Community Paediatrics	3	STs	Employed
	11	STs	Honorary – (3 at full time and 8 at less than full time)
Sexual Health	1	ST	Honorary

2.0 Implementing the Role of Guardian of Safe Working Hours

Dr Turlough Mills (Consultant Child Psychiatrist) was interviewed in September 2017 and appointed to the role in October 2017. This followed the resignation of his predecessor Dr Stephen Bradley.

2.1 Engagement

Since taking up his new role, Dr Turlough Mills has met with the CAMHS trainees to introduce himself and review exception reporting. He has also met with the HR Adviser with lead responsibility for medical and dental staffing and has attended the Local Negotiating Committee on 16 November 2017. The Junior Doctors' Forum is due to meet on the 7 December 2017.

3.0 Guardian of Safe Working Hours Data Report

3.1 Exception Reports

The Trust does not have records of any exception reports submitted since May 2017. However, anecdotal information would suggest that issues previously reported, especially around accessing training and meeting competencies for community paediatrics trainees, are ongoing.

3.2 Fines

No fines have been levied by the guardian of safe working hours.

3.3 Locum Usage

The Trust is filling gaps on the non-resident CAMHS on call rota using internal doctors who are registered on CLASS. Gaps are arising due to one maternity amongst the group and also due to capacity issues.

3.4 Rota Gaps and 'Fill' Rates

HR have reported there is a gap of 1 full time equivalent (FTE) in the trust, which is on the core psychiatry trainee rota in CAMHS. CAMHS trainees report that there is a gap of at least 1.4 FTE on the core psychiatry trainee rota and that on the higher trainee rota there are two days out of seven without trainee cover. These days are covered by consultant. Trainees are unsure if these days represent (an) unfilled post(s).

Supervisors have confirmed there are no rota gaps in any of the other departments.

4.0 Impact

4.1 Quality

This report has been informed by several discussions with trainees and supervisors in the Trust.

4.1 Risk

It is believed that the issues identified as being of concern in May 2017 continue to be problematic. These include trainees in community paediatrics struggling to achieve training competencies due to acute commitments. A general failure to meet competencies could threaten ongoing community paediatric placements within the Trust. Failure to fulfil the spirit of the 2016 contract by encouraging trainees to engage with the Junior Doctors Forum and exception reporting could pose reputational risk to the Trust as a high quality training organisation. The Trust's largest groups of trainees, paediatrics and psychiatry, are specialties with particular challenges with morale. The Trust should therefore make particular efforts to achieve engagement with its trainees.

5.0 Conclusions and Next Steps

5.1 No exception reports since May 2017 is likely to represent an ongoing challenge for engagement rather than an absence of contractual difficulties.

5.2 It is the opinion of the current guardian that issues reported in May 2017 continue to be of concern and that the Trust should:

- Support the guardian of safe working hours to become highly visible presence for trainees and prioritise 'face to face' engagement
- Develop adequate administrative support for the guardian of safe working hours
- Ensure adequate support for supervisors in preparation of generic work schedules
- Support supervisors in community paediatrics and director of medical education to advocate to increase proportion of time trainees spend with the Trust

6.0 Recommendation

6.1 The Board is recommended to note the report:

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (66)

Meeting Trust Board 1 December 2017	**Category of paper**	
Report title Approval of CAMHS New Care Model	**For approval**	✓
Responsible director Executive Director of Finance and Resources	**For assurance**	
Previously considered by Business Committee 27 November 2017	**For information**	

Purpose of the report

This report asks the Board to approve in principle a proposal to commence the New Care Model pilot for Children and Adolescent Mental Health Services (CAMHS) Tier 4 on 1 April 2018.

Main issues for consideration

In May 2017, Leeds Community Healthcare NHS Trust (LCH) submitted a successful proposal to NHS England to become a New Model of Care Children and Adolescent Mental Health Services Tier 4 pilot site as part of NHS England's 'Five Year Forward View for Mental Health'. The pilot includes a partnership of providers, South West Yorkshire Partnership NHS Foundation Trust, Bradford District Care NHS Foundation Trust and Leeds & York Partnership NHS Foundation Trust in additional to working closely with colleagues from the ten West Yorkshire CCGs and, vitally, NHS England Yorkshire & Humber specialised commissioning hub.

The Tier 4 New Model of Care will develop a revised pathway across West Yorkshire, the aim being to reduce the use of Tier 4 beds with more services being delivered in the community and closer to home. Any savings that arise from the new pathway will be invested in community mental health services for children and young people.

THe pilot is one of eight sites chosen by NHS England to be taking on new commissioning powers for tertiary mental health services for Wave 2.

There has been a period of gathering and validating information about the level of activity and costs that will be included in the contract and it is intended that LCH will take budget responsibility for from 1 April 2018.

This report presents an overview of the proposals and an assessment for LCH and its partners of the financial and other risks of running this pilot.

The Business Committee considered an updated business case for the pilot and a draft management agreement between LCH and NHS England at its meeting on 27

November 2017. These documents are available to Board members on request. The Business Committee was asked to recommend approval to undertake the pilot. The outcome of the Committee's consideration will be reported to the Board as part of this agenda item.

Recommendation

The Board is asked to:

- approve in principle LCH taking lead provider responsibility for the West Yorkshire NCM from 1 April 2018
- to recommend that the Board delegates final sign off to the Chief Executive, escalating back to Board in the event the business case anticipated savings change by more than £50,000 in advance of sign-off, that a risk share with other providers is not agreed, or that the draft management agreement changes materially before sign off.

Child and Adolescent Mental Health Services: New Care Model

1. BACKGROUND

1.1. In "Delivering the Forward View: NHS Planning Guidance 2016/17 to 2020/21" NHS England set out its intention to trial secondary mental health providers managing care budgets for tertiary mental health services. The two tertiary services selected for trialling the approach were Adult Secure and Tier 4 Child and Adolescent Mental Health Services ("CAMHS"). Following the first wave of the Programme, which went live on 1 April 2017, a second wave was developed. As part of this wave, an additional 9 sites will join the Programme in October 2017 and 2 further sites, including West Yorkshire CAMHS if approved by Boards, in April 2018.

1.2. In May 2017, Leeds Community Healthcare NHS Trust (LCH) submitted a successful proposal to NHS England to become a New Model of Care Child and Adolescent Mental Health Services Tier 4 pilot site as part of NHS England's 'Five Year Forward View for Mental Health'. The pilot includes a partnership of providers, South West Yorkshire Partnership NHS Foundation Trust (SWYPFT), Bradford District Care NHS Foundation Trust (BDCT) and Leeds & York Partnership NHS Foundation Trust (LYPFT) in additional to working closely with colleagues from the ten West Yorkshire CCGs and, vitally, NHS England Yorkshire & Humber (NHSEY&H) specialised commissioning hub.

2. PURPOSE

2.1. The Tier 4 New Care Model (NCM) will develop a revised pathway across West Yorkshire, the aim being to reduce the use of Tier 4 beds with more services being delivered in the community and closer to home. Any savings that arise from the new pathway will be invested in community mental health services for children and young people.

3. CURRENT POSITION

3.1. There has been a period of gathering and validating information about the level of activity and costs that will be included in the contract and it is intended that LCH will take budget responsibility for from 1 April 2018.

3.2. The business case that was submitted as our original proposal to NHS England has been continually revised and updates over the last five months. There has been a period of gathering and validating information about the level of activity and costs that will be included in the contract and it is intended that LCH will take formal budget responsibility for from 1 April 2018.

3.3. The proposed new clinical model and the financial model have been developed with all partners, clinical and managerial. Engagement work continues across West Yorkshire.

4. THE BUSINESS CASE

4.1. The business case sets out clearly:

- The case for a new care model
- The key components of the new clinical model
- The financial case for the new clinical model
- Governance arrangements

4.2. The financial case sets out that:

- At 2016/17 prices, a commissioning budget of £9.47m will become the responsibility of LCH, as the lead provider in the NCM
- The forecast spend against this budget after realising only the most easily attainable savings (see 4.3 below) is £8.78m
- It is planned to commit £0.39m to a new role of 'care navigators'
- Uncommitted funds of £0.3m are therefore available for initial investment in new community services. Any investment of these funds, if they were available as anticipated, would be subject to approval by the Programme Board.

4.3. The NCM plans to deliver savings as described in 2.1 above. To explain further, an in depth review of the 2016/17 patient cohort by the former Consultant Psychiatrist at Little Woodhouse Hall, supported by NCM project colleagues and finance colleagues from the West Yorkshire and Harrogate STP and the LCH finance team have assessed that:

a) Too many children and young people are being admitted to a Tier 4 bed when an alternative care package could have been put in place, some without additional investment in the community but especially *after* investment in the community
b) Too many children and young people are experiencing lengths of stay that could be shorter, some without additional investment in the community but especially *after* investment in the community
c) Too many children and young people are being admitted to a Tier 4 bed and experiencing lengths of stay that could be shorter in beds outside West Yorkshire ("out of area")

4.4. In addressing a) and b) above the NCM would expect to reduce the number of out of area admissions. Until the planned new CAMHS unit is built in Leeds, providing an estimated 22 beds, only 8 children and young people can be accommodated at any one time in Little Woodhouse Hall.

5. FINANCIAL RISK

5.1. The modelling that has been done suggests that a prudent assumption of £690k savings from reduced admissions and reduced bed days is possible.

5.2. The NCM has successfully bid for £219,500 "crisis" funds in 2017/18 to pump-prime in establishing the NCM

5.3. Set up funds of £100,000 are provided to every NCM pilot established.

5.4. The set up funds and the successful "crisis" bid provides a great opportunity to establish the NCM. However, there are financial risks attached to the pilot. These have been identified as:

a) The 2016/17 financial baseline is incorrect. This could be because:
   i. 2016/17 was an untypical year. Comparison with information from 2015/16, whilst not as detailed as 2016/17 data, suggest that this is not the case

ii. The 2016/17 data is incomplete. This is a concern from other NCM pilots elsewhere in the country but is not considered a material risk with the West Yorkshire data

iii. The costs associated with the 2016/17 patient information are incorrect. The costs are thought to be reasonable accurate with as much chance that the costs are overstated as they are understated. In either case, scrutiny of the 2016/17 data would suggest that any error either way would not be material

iv. The 2016/17 costs exclude CAMHS patients who were admitted to acute wards or other settings not captured by the 2016/17 baseline. This is a concern as we are aware of examples during 2016/17 of young people being admitted to wards at SWYPFT for which SWYPFT have not received payment from NHS England. As we would expect the WY NCM to provide alternatives to this, or to move patients from inappropriate settings if it has been necessary to admit them there in an emergency, this would, all other things being equal increase the charge to the NCM budget over and above that provided for. It is proposed to accept this risk but to ascertain how many young people were admitted to acute wards in 2016/17 in order to provide a negotiation point with NHS England in the event that costs cannot be constrained within the budget

b) There is insufficient recognition of inflationary or demographic cost increases in the 2018/19 budget uplift. This is a risk we will need to accept. NHS England have agreed that whatever uplift the budget would have received had it been retained by them will be passed to the NCM.

c) The NCM is unsuccessful in reducing bed usage as envisaged. This is a real risk but is somewhat mitigated by the prudent assessment of the savings that can be achieved. The financial plan has recurrently committed £390,000 of £690,000 planned savings to the care navigators role as these are considered vital to achieving the savings. No further investment in community services will be made without approval from the NCM Programme Board which includes the Director of Finance and Director of Operations from LCH.

5.5. Risk Share

5.5.1. The three provider partners providing community CAMHS service in the NCM programme, LCH, SWYPFT and BDCT have agreed, in principle to accept and share the financial risk associated with the NCM. The actual share of the risk is still to be agreed but, if agreed, would be LCH circa 33%, SWYPFT a few percentage points higher and BDCT a few percentage points lower based on the most appropriate assessment of populations served.

5.5.2. The rationale for risk share is that this was always, and remains, a West Yorkshire initiative. As the current provider of CAMHS Tier 4 services in West Yorkshire it made sense for LCH to be the lead provider for the NCM and having a lead provider was something NHS England were looking for in our bid. More importantly, the children and young people served by all three providers in West Yorkshire will benefit from investment in their services if the NCM is successful.

5.5.3. The nature of the NCM and the partners' approach is that the transferred commissioning budget is ring fenced for CAMHS services.

There is no financial upside for any of the Trusts in savings being diverted into other services they provide.

5.5.4. It is therefore accepted in principle that it would not be appropriate for LCH to take all the risk when the only upside to that risk is the potential for investment in the community services it provides. Both SWYPFT and BDCT have the same potential upside but, without a risk share, no financial risk. For this reason, and through a shared desire to improve services, they have accepted the principle of risk share.

5.5.5. If the NCM pilot is successful and runs beyond its two year pilot there is real opportunity to include West Yorkshire commissioners in the risk share. This would be part of what the partners in the NCM believe would be an exciting opportunity to bring together all CAMHS commissioning and provision in a partnership. Whilst there is no evidence whatsoever of any local CCG or Council commissioner planning to do this, there is a risk that local commissioners would regard any investment in community CAMHS from the NCM budget as an opportunity for an equivalent dis-investment from their own resources or an opportunity not to invest in the local core CAMHS service. Creating a CAMHS partnership across West Yorkshire should be a strategic aim of the NCM and the West Yorkshire and Harrogate STP.

6. THE MANAGEMENT AGREEMENT

6.1. In addition to the business case there is a draft management agreement between NHS England and Leeds Community Healthcare representing all the parties participating in the New Care Model. The management agreement sets out:

- The scope of the agreement – in simple terms, CAMHS Tier 4 in West Yorkshire, the patients included and those excluded
- The principles – the values, the accountability, and the behaviours parties to the agreement will exhibit
- The terms – essentially that LCH will manage the budget described in the business case for a two year pilot period, reviewable at six monthly periods
- How disputes will be settled
- The detailed commissioning functions delegated to LCH:
  - Exercise general duties in relation to the commissioning and/or provision
  - Ensure contracts and other arrangements are correctly monitored and governed including ensuring that all contractors sign NHS England's data confidentiality code of conduct and IT security policy where relevant.
  - Authorisation to investigate any complaint related to the provision of specialised commissioned services by any provider from whom NHS England commissions such services, either directly or indirectly.
- The roles of each party to the agreement. This is an important section and details what is expected of LCH, what NHS England retains accountability for and contract management arrangements:
  - NHS England (Yorkshire & Humber) remains accountable for all existing service contracts with providers in respect of the tertiary CAMHS services associated with NCM.
  - As NHSE remains the contract holder, LCH will not be able to negotiate its own sub-contracts to provide care for patients. LCH will be able to propose

sub-contracts in sufficient detail to enable NHS England to negotiate on their behalf, and to provide support during the negotiation process.

- LCH has a key role alongside NHSE in contract monitoring and management of the New Model of Care services for their population. This will include as necessary Tier 4 providers both locally in West Yorkshire and Out of Area providers. It is expected that NHSE will lead this work but the LCH will be involved by exception.
- LCH will be included in the membership for Contract and Quality Review Meetings for providers by exception from 1 April 2018
- By 1 April 2018 LCH will have access to details of provider contracts including KPIs, CQUIN and QIPP, and require performance reports from providers in advance of contract meetings.
- NHS England (Yorkshire & Humber) will discuss with LCH the reporting of data relating to the NCM area and reporting of any other pertinent issues such as unit safety and quality which LCH will have a role with NHSE in discussing with providers.
- NHSE will remain the link into contract meetings and quality reviews with providers for which there is a national contracting arrangement. They will report the need to make amendments to contracts on an exception basis.
- The monthly Programme Board will have oversight of the expenditure and monitoring against projections for the Tier 4 budget, with regards to budgetary oversight.

6.2 The rest of the agreement covers operational details including information sharing, invoicing arrangements, contract monitoring and contract review processes.

6.3 There is nothing in the management agreement that causes the NCM or LCH concern. There are remaining details to work through and this will be undertaken with NHS England.

7. SUMMARY

7.1. The CAMHS NCM presents a real opportunity to begin the transformation of CAMHS services across West Yorkshire. Together with the planned new CAMHS Unit over the next few years patients could expect to see investment in community CAMHS services, a reduction in unnecessary admissions, reduced lengths of stay, a significant reduction in the need for out of area admissions and the promotion of best practice ideas across the county.

7.2. The NCM is a two year pilot and it will be possible for LCH and its partners to walk away at any stage. However, there is a significant prize to be obtained in terms of improved services for patients. There is considerable and growing enthusiasm for the opportunities the NCM approach facilitates.

8. RECOMMENDATION

8.1. The Board is asked to approve LCH taking lead provider responsibility for the West Yorkshire NCM from 1 April 2018. The Board is also asked to recommend that the Board delegates final sign off to the Chief Executive, escalating back to Board in the event the Business Case anticipated savings change by more than £50,000 in advance of sign-off, that a risk share with other providers is not agreed, or that the draft Management Agreement changes materially before sign off.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (67)

Meeting Trust Board 1 December 2017	**Category of paper**	
Report title Professional strategy implementation update	**For approval**	
Responsible director Executive Director of Nursing **Report author** Professional lead for AHP	**For assurance**	√
Previously considered by Quality Committee 23 October 2017	**For information**	

Purpose of the report

This is the first report to Board providing an update on the progress of implementing the professional strategy. The purpose is to assure the Board that work to deliver the strategy is in progress.

Main issues for consideration

The Trust has a vision to provide the best possible care in every community, to achieve this it has four objectives one of which is to recruit and retain the best workforce. The aim of the professional strategy is to set out aspirations for the clinical workforce and how the Trust can best work together with patients and partners to ensure the professional competency and skills of the clinical workforce. This paper has previously been considered by the Quality Committee in October 2017 and amended to include this feedback.

Thirteen professional objectives have been identified to help achieve the four aspirations set out in the strategy. This paper updates the Board on progress so far in achieving the aspirations in the strategy.

Recommendation

The Board is recommended to:

- Note and accept the update of the implementation of the Professional Strategy.

Update report of the implantation of the Professional Strategy

1.0 Purpose of the report

1.1 The Professional Strategy was approved at the board meeting in October 2016. This is the first update to the board.

2.0 Background

2.1 The purpose of the Professional Strategy is to ensure that as an organisation we have a clinical workforce that is fit for practice and responsive to the changing context in which we are working.

2.2 The strategy details four aspirations that will guide and support the development of the professions to deliver quality services within Leeds Community Healthcare (LCH) NHS Trust. The aspirations are:

- Promoting health and well being
- Partnerships
- Satisfying careers
- Quality improvement

2.3 Underpinning each aspiration are objectives with measures of success. A number of the objectives are cross cutting and underpin more than one aspiration. The delivery of these is monitored through the senior management team meetings and relevant board sub committees.

3.0 Current Position

3.1 The NHS aspires to be a clinically led organisation, and here in LCH we are committed to supporting this aspiration by developing a Clinical Professional Council. The Clinical Professional Council offers LCH an opportunity to foster a culture of professional and clinical leadership and influence the development of services by clinicians advising on quality standards thus achieving evidence based patient centred care pathways.

3.2 A core function of the Professional Council will be to ensure a cohesive and coordinated approach to delivering the aspirations of the professional strategy. It provides an opportunity for health care professionals to come together from across the business units to share good practice, reduce variation and build professional relationships supporting LCH in the delivery of effective, high quality clinical services and care. The council also provides the opportunity for ground level staff to have their professional voice heard and develop their leadership skills.

4.0 Progress

4.1 Aspiration 1: Promoting health and wellbeing

LCH promotes 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 demonstrating the difference this makes to people's lives.

4.1.1 LCH is committed to developing a skilled workforce and ensuring all staff have the required competencies to deliver high quality, evidence based care to the people of Leeds. The formation of the business units has provided a model and leadership structure for integrated working across professional disciplines. This model is well established in the adult services with clinical and operational leads in post in the Neighbourhood Teams. Clinical leadership is also being further considered within specialist services and is also considered in the children's strategy. Following the formation of the integrated Neighbourhood Teams there has been substantial work developing competencies and appropriate training across all staffing levels. This has led to a significant improvement in staff satisfaction and our ability to offer care to patients by being able to deploy the appropriately skilled member of staff. Work taking place in the Children's ICAN hubs on the Nursing model and pathways is another example of how the trust is looking at the skills and competency of its Nursing staff. This exciting project is looking to develop a nursing model which maximises nursing potential, resulting in a highly skilled, competent workforce that is sustainable and fit for the future as well as an effective and efficient use of our resources. We value the importance of strong clinical leadership, and moving forward there have been lessons learned from the adult services, one of which was the conclusion that there needed to be more leadership support for therapists. Therefore, recently Therapy Leads have taken up posts in Neighbourhood teams. It is essential for all staff, at any level, to have access to support and advice for professional issues from a member of their profession, and this remains a key area for development. Additionally, as we continue to develop new roles and apprenticeships it is important to develop competency frameworks, ensuring that all interventions are being delivered by a well-trained clinically competent workforce.

4.1.2 The development of outcomes for all services will be a key part of our success in continuously improving the quality of the services we deliver and demonstrating the difference we make to people's lives. It is important that our interventions are evidence based and this has been challenging in relation to outcome measures as there are few existing frameworks which are appropriate for community services. As the board are aware there has been a programme of work over the last year progressing with reporting on outcome measures, this has resulted in a number of pilots across some services using key outcome measures:

- ICAN; goals, Measure of Process of Care (MPOC), Canadian Occupational Performance Measure (COPM)
- MSK – Patient Global Impression of Change (PGIC)
- Neighbourhood Teams – TOMs, EQ5D and FFT
- Podiatry – PGIC and TOMs

- Cardiac Services – EQ5D, PHQ9 and GAD7

The next stage of this work is to recruit a project manager who will be responsible for taking a cohesive approach to driving forward and leading on this work in the future. Outcome measures have been highlighted by the business units in their business plans for 2017/18 and will also continue to be a quality improvement priority in 2017/18.

4.1.3 Ensuring that LCH is delivering high quality, innovative care that is evidence based is the focus of many of our strategies, including the research strategy, clinical strategy and quality improvement plan. It is important that all staff are encouraged to showcase and publicise innovative work which has made a difference to the people and communities we serve. Recent examples of this include a Nursing Times award won by our team at Wetherby Young Offenders and Adel Beck for their partnership work with the local mental health trust. Also, fifteen services were able to find the time to submit entries into the Health Service Journal awards this year, with five being shortlisted for the awards ceremony in November. However, we need to strengthen our commitment to ensuring we are delivering evidence based interventions and this will form one of the main functions of the Professional Council. We also need to raise the profile of the innovative pieces of work which are happening in the trust, and more importantly support staff to have the time to apply for health awards and publicise their work.

4.2 Aspiration 2: Partnerships

Patients and carers are active partners in their care. 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.

4.2.1 As the board are aware the trust ethos is to view patients as active partners in their care, this is evident by our commitment to train staff in the health coaching approach. From a systems perspective, health coaching has also provided LCH with the opportunity to work alongside other provider organisations across the city of Leeds and influence the local STP and Wellbeing strategy. Over 170 staff members in LCH have been trained in using the health coaching approach, from across all services to include clinicians and also administration staff allowing everyone to hold better conversations. In addition to this the Long Term Conditions Service are currently progressing their work for CQUIN 5 on patient activation measures (PAMs) which is a measure of a patients ability to manage their own health and care. However, moving forward we will continue to train more staff, and we need to develop a means to ensure that the health coaching approach can be embedded within services and works in synergy with our other coaching programmes such as the 'Manager As Coach' which is offered as part of the Trust leadership and development programme.

4.2.2 LCH is committed to working in partnership with organisations across the city from health and social care to develop more integrated models of working. We are working in partnerships with other organisations to deliver high quality care in Leeds, working safely across organisational boundaries (where appropriate). An exciting example of this is the integrated Nursing group

which involves the provider organisations from across Leeds coming together to integrate Nursing care to create efficiencies, decrease duplication and variation. Linked in with this is further work on creating an integrated health and social care system that is financially sustainable and makes better use of our resources. The New Models of Care; a programme aimed at providing better care and experience for people, resulting in better outcomes and ultimately a better use of resources. Currently, LCH is also involved with the PAN Leeds Occupational Therapy directive which is working towards the development of one Occupational Therapy workforce across Leeds which spans health and social care. The next steps in both of these pieces of work are exploring the viability of a rotational workforce and the effects this would have on improving our staff recruitment and retention rates. We are also taking a more collaborative approach to workforce planning. LCH is part of a city wide workforce planning group, one strand of this is specifically looking at Nursing; how we attract Nursing students and retain our qualified Nurses in Leeds.

4.3 Aspiration 3: Satisfying careers
LCH is 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.

4.3.1 LCH is devising a robust professional development plan will be fully detailed in the education and developement strategy currently being developed. LCH recognises that in order to recruit and retain the best people it is essential that we invest in their development, through all stages of their careers and promote this as part of our offer of employment. We have made a commitment to developing the careers of our current workforce by offering a range of development opportunities through ‘Developing Your Working Life’. This provides staff, at all levels, with the opportunity to access training from IT skills, coaching skills and leadership training for those who aspire to a leadership role. Recently, the trust has launched new Preceptorship Sessions to staff across the organisation, but especially our new recruits. The Preceptorship Programme was evaluated in spring this year to ensure that it was inclusive and in line with the Health Education England Preceptorship Framework for Nurses, Midwives and Allied Healthcare Professionals. Comments from recent preceptorship sessions include "Empowering, enjoyed every minute". The preceptorship sessions are offered not only to newly qualified staff, but also to staff who are new to working in a community trust.

4.3.2 Additionally a forum for non-registered staff has been developed with the aim of providing an opportunity to drive forward some specific work streams within the non-registered workforce. These include frameworks for professional development along with some competency frameworks and formalising the contribution of our non-registered workforce to our care pathways ensuring they reach their full potential. With a focus remaining on the non-registered workforce, a conference for non-registered staff took place on the 2nd November 2017. This provided an opportunity for the trust to recognise the contribution this group of staff make and to share stories of

how non-registered staff have gone on to take more senior roles in the organisation.

4.3.3 As we develop new ways of working and partnerships with different services, as described above we need to maximise on the potential of training advanced practitioners, this offers a great opportunity for staff who want to develop whilst maintaining a clinical role. We need to ensure that our organisational development strategy considers how we value and retain our experienced workforce who may be in a position where they could consider retirement. A piece of work currently being undertaken by the Deputy Director of Nursing in partnership with the Organisational Development team and colleagues from QPD is the development of an education, training and personal development strategy for the organisation. The aim of the strategy is to support talent management, retention of staff including those experienced staff and those approaching retirement.

4.4 Aspiration 4: Quality Improvement

LCH is a centre for excellence for innovative community health care and education. We use business intelligence, benchmarking and data to demonstrate the impact of what we do. AHP's and Nurses in LCH are creative and solution focused in their response to the needs of the patients, carers, commissioners and educators sharing developments to shape future provision and the workforce.

4.4.1 LCH continues to work hard to meet the constant challenge of improving the quality of care in a time of constrained resources and increased demand for the services we provide. Patient safety and quality of clinical care remains the focus of everything we do. Reducing unavoidable harm remains our top priority. The board are aware that Quality Boards are well embedded within all the Neighbourhood Teams. The boards show information on staffing levels, clinical incidents, clinical supervision, appraisals, and infection prevention metrics and also offer the opportunity to display feedback for the team. Quality Boards are helping to make our care safer and improving the clinical outcomes for our patients. Daily cluster clinical handovers remain pivotal meetings to review service delivery. The Quality Boards have been well received by staff. Next steps include work to roll out safety huddles in all teams and the roll out of the approach across business units. A safety huddle is clinically led, held on a daily basis and is brief (usually five minutes). It has a focus on safety; particularly discussing areas where patients are most at risk, and where unavoidable harm could occur e.g. pressure ulcers and will they will pose the question 'what might stop us keeping our patients safe?'

4.4.2 Workforce planning is essential to maintaining our quality services ensuring we have appropriately trained staff delivery evidence based interventions. The education and training group are driving forward areas such as apprenticeships, associate roles and discussions around the future shape of the workforce. LCH was successful in becoming a national pilot site for the new Nursing Associate role. This role allows LCH to offer opportunities to our current support worker workforce, which is essential to us achieving our objective of retaining the best people. In September 2017 we welcomed our

first cohort of Nursing Associates. Moving forward LCH has also been accepted to be part of the trailblazing group for Dietetics apprenticeships and will be an active member of shaping this apprenticeship scheme moving forward, allowing us to offer more opportunities to the AHP support workers. The trust is also taking a lead national role in exploring the option of a District Nurse apprenticeship.

4.4.3 Reducing variation in healthcare offers not only the opportunity to improve patient care, but also the opportunity for a financial saving. As in many other NHS trusts across the country LCH is working hard to address unwarranted variation within the services we deliver. The Quality Improvement team continues to work with services across the trust to transform and develop existing pathways to ensure they are as effective and responsive as possible and reducing unwarranted variation, examples of these include the Adult Business unit developing the wound care pathway. The Quality Improvement team has been working with services such as CAMHS and also the sexual health service on reducing unwarranted variation. Using a capacity and demand model they have been working directly with practitioners to help them agree a service model and to develop and redesign pathways going forward. Moving forward LCH will support teams to work more systemically to quality improvement. The Quality Improvement team are currently developing a framework which gives clear and explicit guidance on quality improvement which teams can embed in their services.

5.0 Next Steps

5.1 The next steps involve establishing and developing the Clinical Professional Council which will take a collaborative approach to ensuring we meet the aspirations in the strategy. It is important for the board to note that the Professional Strategy supports other published LCH strategies and publications to include the Quality Strategy, the Education and Training Strategy, the Research Strategy and also the Quality Account. We also intend to develop a detailed action plan which will be presented to the board in six months providing an update on projects (including timescales) to meet the aspirations set out in the strategy.

6.0 IMPACT

6.1 Financial/Resource

6.1.1 It is important to drive forward all pieces of work which prove the worth and impact of the services which are delivered by LCH as more services enter a competitive tender process.

7.2 Risk

7.2.1 The professional strategy supports LCH's commitment to provide the best possible care to every community whilst also recruiting and retaining the best people. Failure to achieve the aspirations set out in the strategy risk LCH failing to meet its strategic objectives.

7.2.2 An action plan will be developed, in order to track progress. This will be presented to Quality Committee with an update in 6 months.

8.0 RECOMMENDATIONS

8.1 The Board is recommended to:

- Note and accept the update of the implementation of the Professional Strategy.

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (68)

Meeting Trust Board 1 December 2017	**Category of paper**	
Report title Organisational Development Strategy update	**For approval**	
Responsible director Interim Director of Workforce **Report author** Head of Organisational Development (OD)	**For assurance**	√
Previously considered by Business Committee	**For information**	

Purpose of the report

The organisational development (OD) strategy 2017-19 which was agreed at Board on 31 May 2017 describes the OD approach which the Trust will take over the next 2 years to promote and develop the organisation and the people who work for the Trust, so that the Trust delivers its vision of 'best possible care to every community we serve'. The purpose of the paper is to connect the OD strategy and action plan and show key areas of focus for 2017-18, and to outline progress being made with implementation of the strategy.

Main issues for consideration

This paper sets out the core area of work and particularly progress regarding:

- Development of leadership capacity through coaching and management development interventions
- Creating a culture of better conversations
- Approaches to attract, on-board and retain staff
- Building directly on staff feedback and launch of the feel good pledge
- Launching of staff networks
- Developing clinically rewarding careers
- Organisational structure that is fit for purpose

Following discussion at Business Committee, work is underway to produce more evidential measures on the positive outcomes contained within the report. These will be reported at the Business Committee, through the quarterly workforce and OD report

Recommendation

The Board is recommended to:

- note the six monthly update on OD strategy implementation and the subsequent action being taken.

Organisational Development Update

1. Background

1.1 The Organisational Development (OD) strategy describes the actions which Leeds Community Healthcare is taking to promote and develop our organisation and the people who work here over the next 2 years; so that we deliver our vison of best possible care to every community we serve.

1.2 The purpose of the 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 evaluations plan
- Outcomes and other key measures

1.3 This paper runs alongside our other documents, which are linked, to this: Detail about specific actions and detail of interventions can be found in these papers.

- OD strategy
- OD action plan
- OD strategy priorities - links to other strategies
- Quarterly report for quality accounts
- Quarterly workforce report

1.4 Our strategy, as people are aware is aimed at reducing sickness levels and turnover (increasing retention) whilst improving staff engagement and staff morale. In order to do this we are focused on five key actions we know have the biggest impact:

1. Creating and developing leadership capability
2. Creating a culture of “better conversations”
3. Attracting and on-boarding Nurses and AHP’s in particularly but ensuring all staff have a good entry to the organisation
4. Ensuring good quality training and development opportunities for all
5. Ensure our organisational structure meets our strategic vision and is fit for purpose

1.5 Work to ensure that all staff are aware of an follow, understand our policies and procedures is not the subject of the OD strategy but is part of management training. Ensuring good understanding and embedding of the managing absence policy has been a specific focus.

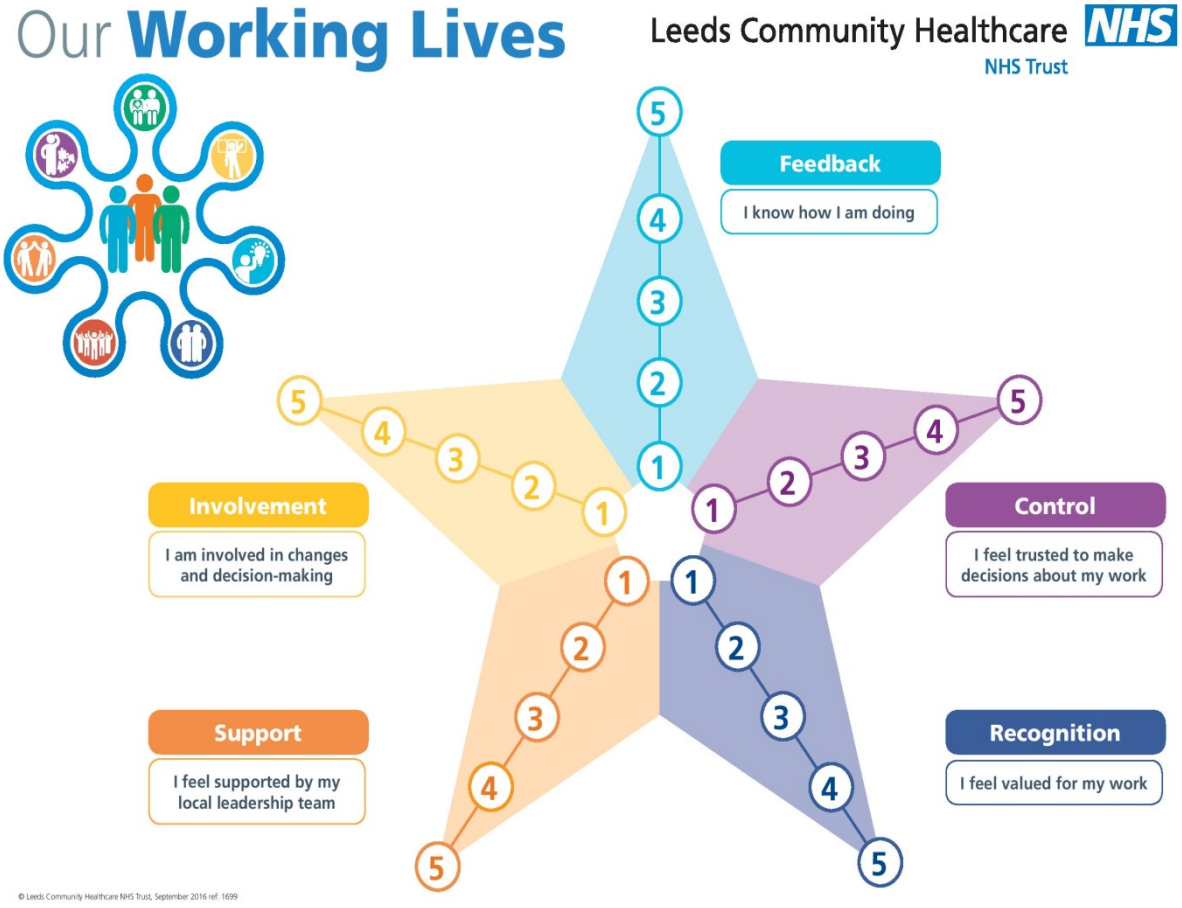
1.6 This paper provides an update on progress in particular on the first three areas of work.

2. Overall Context

2.1 Our approach aims to tackle the 6 main challenges which people face work and which form an organisation's culture. These are:

1. **Resources and communication** (Pressure from lack of resources/information)
2. **Control and autonomy** (Limitations on how the job is done, or freedom to make decisions)
3. **Balanced workload** (Peaks and troughs in workload, difficult deadlines, unsocial hours, work life balance challenges)
4. **Job security & change** (Pressure from change/uncertainty)
5. **Work relationships** (High pressure relationships with colleagues, patients, managers)
6. **Job conditions** (Pressure from working conditions/pay/benefits)

2.2 This understanding informed the development of our working lives star which all teams are using to look at how their teams are feeling and operating.



2.3 We know that individual teams are using this to look at their individual culture and to identify areas for development and change. Ideally we would have the ability to collate and analyse this information but currently there is not the capacity to do this centrally.

2.4 In the new year the intention is to have a new push on using the tool and some communication and promotion again on its use.

2.5 Appendix one outlines for Board how our OD strategy is represented pictorially

3. Key areas of work

(Further details was contained in the last quarterly workforce report)

3.1 Create and develop leadership capability

3.1.1 The Trust continues to develop its leadership capability through its Coaching Strategy which supports the development of staff via 4 areas, 1-1 coaching, team coaching, health coaching and manager as coach (M.A.C).

3.1.2 The M.A.C. programme is now moving into its 8th cohort with cohorts 9-11 planned in. The programme is 5 modules (evaluation session planned in 6 months after completion of the course) with a focus on developing core coaching skills for managers to support them in their roles. The programme is open to anyone who manages others. Feedback is currently being sought from the managers of participants to gauge what the difference has been for those attending back in practice.

3.1.3 The M.A.C. programme is the main element of our L.E.A.D. offer. Cohort 2 of LEAD commenced in October 2017. In addition to M.A.C, the programme includes peer coaching groups, 360 feedback, a personality assessment focused on potential, access to individual leadership modules, a reconnect event and a celebration event where participants can share their learning with the group and invited guests. To access the programme, nominations are taken from each business unit/corporate. The LEAD programme has supported 45 leaders to date.

3.1.4 Impact is seen through the staff survey results, informal feedback from staff and focussed surveys in particular areas of the business.

3.1.5 This is without doubt the area where we can make the biggest impact whether it is through the take up of specific training such as having a difficult conversation, implementing policies, broader leadership work or continuing to reward and celebrate good leadership at all levels.

3.1.6 All evidence (qualitative and quantitative) points to the start of success in this area but it is important to recognise this is not a quick fix and we need to continue to support and develop work over the coming years.

3.2 Create a culture of "Better Conversations"

3.2.1 Engagement events have taken place with 3 groups of staff – place based frontline multidisciplinary staff in Chapeltown, Armley and Beeston; senior and middle managers across Leeds City Council; the NHS and the Leeds Universities; and one session focussed on University staff engaged in pre-registration training.

3.2.2 These 'working with' and health coaching engagement sessions took place between November 2016 and June 2017. The aim of these sessions were to *work with* health and care staff to generate discussions around the 'working with' principal and the associated approaches that includes health coaching, collaborative care and support planning, strength based social care and making every contact count (MECC).

3.2.3 The events were attended by 300 staff working in health and care organisations across the city alongside NHSE who also attended one of the sessions. Feedback from all events was captured and will form part of the health coaching evaluation. Key emerging themes from the events included:

- The real support for a push forward with the 'working with' principal.
- The need for skills development at scale for health and care staff.
- The need to introduce 'working with' / health coaching into academia.
- The great opportunity to unite the health and care system in Leeds through a unified conversation with those accessing health and care in Leeds.
- The need for real organisational sign up to this approach.
- The requirement for significant resource to change the culture of conversations.

3.2.4 To date we have trained 240 staff in health coaching and we are currently biding for additional funds to take the Leeds "Working With" approach forward in a more integrated and coordinated way across the city.

3.2.5 LCH staff have reported that having greater staff satisfaction, building up relationships with patients and promoting self-management has been core for them. Being able to have adult to adult conversations with each other and this has featured strongly as part of one to ones, clinical supervision, appraisals, team meetings and staff really value being listened to.

3.2.6 All of these things are core to our strategy and are aligned to the development of a coaching mind set across our organisation. This together with our development of our leadership work adds to the impact on staff retention amongst the other interventions described in this update and also the quarterly workforce report.

3.3 Attract and on-boarding of staff - and staff retention approaches

3.3.1 We have done a significant amount of work to ensure we can attract and on board staff in an excellent manner. Research shows that this is extremely important especially in such a competitive market. Detail about success in recruitment and initial feedback from our new preceptor programmes is in the last quarterly workforce report.

3.3.2 There is significant future work planned to continue to develop our attraction to new recruits.

3.3.3 Our future attraction strategy will focus on the development of the trusts website to promote the full range of benefits on offer and the use of social and digital media.

3.3.4 The existing 'Work for Us' section of the website will be redesigned: to improve the look and feel of the section; to improve navigation and ease of finding information; and to better showcase the Trust's careers, development opportunities, the full range of employment benefits and the advantages of living and working in Leeds. Pages on the temporary staff bank and apprenticeship scheme will be included/updated. We will use social media (chiefly Facebook and Twitter) to share our offer with a wider audience, and to showcase the culture of the Trust and what it's like working here.

3.3.5 To further enhance this approach we are exploring other forms of media and see digital advertising as a more effective way of reaching our target audience.

3.3.6 To ensure that we continue to develop and retain our existing workforce, we are also updating the Trust's intranet site, to make it easier for staff to find and access the information they need, such as development opportunities and the benefits available.

3.3.7 Building directly on feedback from the staff survey we have launched our Feel Good pledge earlier this year. This aims to make it easier for staff to both understand and access all our staff benefits and support and also to ensure they are aware of how we are working with them to support their mental and physical well- being. Evidence shows that this is key in staff retention.

3.3.8 The BME staff network was launched during black history month following extensive consultation and involvement and so far this, and the work to develop it has been received positively by staff.

3.3.9 The disability and LGBTQ networks are also now established with informal champions. In particular work of the dyslexia champions working with the EPR team we are aware has impacted directly on the mental health and well-being of staff affected.

3.3.10 All of the work we are doing throughout the OD strategy is aimed at staff retention with focussed work in areas where there is highest turnover or concern. For example we have embedded team coaching and development working alongside all the NTs and currently in Hannah House.

3.4 Training and development - having a clinically rewarding career

3.4.1 We know that one of the key factors that retain clinical staff in particular is access to training and development opportunities. This is particularly important in organisations which have erased "grade drift" and where the opportunity of promotion to higher grades is less open. The work to ensure this forms part of the nursing and AHPS strategy, the training and development work and work to develop Band 4s and the non- registered workforce all of which is overseen by the Quality committee and is nested in specific strategies and reports. They do, however, form a key plank of our approach to retention.

3.5 Ensure our organisational is fit for purpose

3.5.1 Work is progressing with a review of business unit structures and the triumvirate structure within the context of our overall strategy. This will be discussed at the private session of the December 2017 Board.

3.5.2 Work on individual team form, who reports to whom, how many line reports, span of control etc., does not form a part of this strategic update and takes place operationally and in essence is fit for current organisational function.

4. Conclusion

4.1 We have made significant improvements in attraction, recruitment and retention over the last quarter, and will continue to gather evidential measures on the positive outcomes contained within this report. Our continuing focus on leadership and developing our coaching culture has also had seen a positive impact. Also significant improvements have been made with onboarding (Perceptorship) and supporting the development of new employees into the organisation.

4.2 Whilst we have seen improvements in these areas the next quarter's work focus continues to be:

- Leadership development
- Embedding of a coaching approach
- Attraction of key staff and excellent on boarding
- Analysis of the reasons for leaving and focussed work on retention

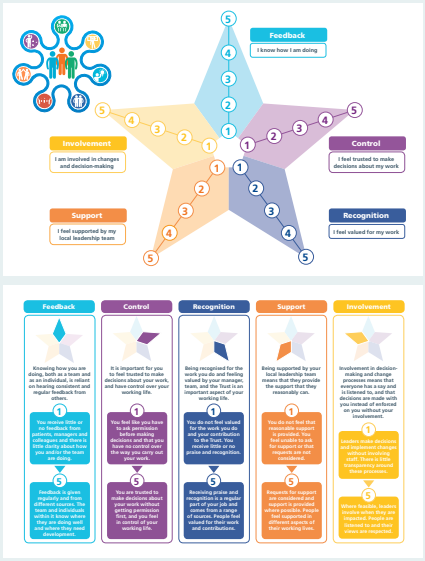
4.3 Finally we are continuing to encourage a high return on this year's staff survey.

How we build the **working lives we want**

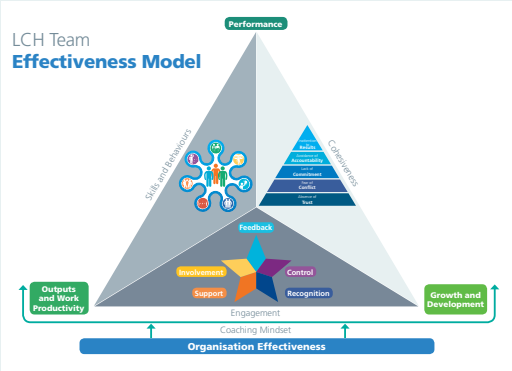
NHS
Leeds Community Healthcare
NHS Trust

Our Eleven: Shared Vision, Values and Behaviours

Individuals

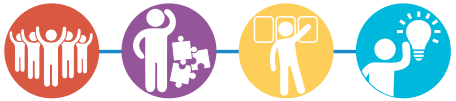


Teams



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?**

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (69)

Meeting: Trust Board 1 December 2017	**Category of paper**	
Report title: Annual Equality and Diversity Report	**For approval**	
Responsible director: Executive Director of Nursing **Report author:** Equality and Diversity Manager	**For assurance**	√
Previously considered by: Patient Safety and Experience Governance Group 26 October 2017	**For information**	

PURPOSE OF THE REPORT

This report identifies the activity and progress made by Leeds Community Healthcare NHS Trust in order that the Trust Board can be assured that the requirements of the Equality Act 2010 Public Sector Equality Duties (PSED) and the NHS Standard Contract are being met.

MAIN ISSUES FOR CONSIDERATION

The report has been previously considered and reviewed by Patient Safety and Experience Governance Group (PSEGG).The Workplace Race Equality Standard (WRES) update has been previously considered, reviewed and direction provided by the SMT.

The report highlights areas of achievement. In particular the Board's attention is drawn to the following areas:

- The current LCH EDS2 grades
- Acknowledge the progress and positive feedback received on LCH WRES performance
- The Trust Equality objectives for 2018-20:
  - Create and implement an improvement plan for the collection, analysis and use of patient and staff equality data for protected groups
  - Create and implement a Workplace Disability Equality Scheme action plan
  - Achieve the Disability confident Level three (Leaders) accreditation

RECOMMENDATION

The Board is recommended to:

- Note the progress made
- Confirm that the Board is assured that the requirements of the Equality Act 2010 Public Sector Equality Duties (PSED) and the NHS Standard Contract are being met.

1.0 PURPOSE OF THE REPORT

1.1 This report identifies the activity and progress that Leeds Community Healthcare NHS Trust (Trust) has achieved in meeting the requirements of the Equality Act 2010 Public Sector Equality Duties (PSED) the NHS standard contract.

2.0 BACKGROUND

2.1 At the December 2015 Trust Board meeting, in order to meet the statutory and contractual reporting requirements, it was agreed that an annual update the Trust Board would be provided at the December formal Board meeting. The report to the Trust Board would contain progress on the NHS Equality Delivery System2 (EDS2) and equality objectives.

2.2 This process (2.1 refers) enables the sharing of the ratified equality annual report with Commissioners as part of scheduled contract monitoring arrangements, and meets the requirement of the Equality Act Public Sector Equality Duty (PSED) to share progress with the public on the 31January 2016.

2.3 As a result of feedback from local authority and NHS partners, Voluntary Action Leeds and Leeds Involving people, the local EDS2 assessment process was amended and now takes the form of a *year to year* rolling programme of assessment;

- September - Goal 1 "*Better health outcomes"*
- November - Goal 2 "*Improved patient access and experience"*
- February - Goal 3 "*A representative and supported workforce"*
  Goal 4 *"Inclusive leadership"*

This provides a more palatable approach which does not exceed organisations understanding of, their appetites and capacity to be fully engaged in the EDS2 assessment process.

3.0 CURRENT POSITION

3.1 Equality Delivery System2 (EDS2)

3.1.1 In April 2015, the use and reporting of the EDS2 became mandatory as part of the standard contract, progress is reported to the Commissioner in February of each year. The NHS EDS2 is significant in ensuring that equalities continue to enjoy a high priority within the Trust.

3.1.2 As a public body, the Trust under the Equality Act 2010 has a legal duty to:

- Promote equality of opportunity,
- Good relations between different groups
- Eliminate harassment and unlawful discrimination under the Equality Act (2010)

3.1.3 NHS EDS2 currently helps the Trust;

- Deliver on the Government's commitment to fairness and personalisation, including the equality pledges of the NHS Constitution.
- Deliver improved and more consistent performance on equality

- Respond more readily to the Equality Act duty, CQC and contractual requirements.

3.1.4 The four NHS EDS2 grades that are awarded, dependent on how many protected groups "*fare well"* are:

- **Excelling** - all nine protected groups
- **Achieving** - six to eight protected groups
- **Developing** - three to five protected groups
- **Underdeveloped** - one or two protected groups

3.1.5 The EDS2 goals are self-assessed and presented to the Leeds NHS EDS2 assessment panel which comprises of one or more representatives from:

- Leeds South and East CCG
- Leeds North CCG
- Leeds West CCG
- Leeds City Council
- Leeds Healthwatch
- Volition
- Voluntary Action Leeds
- Leeds Involving People
- Forum Central

3.1.6 The current EDS2 individual grading's for the Trusts 18 EDS2 goals includes 3 "Excelling" grades for goals;

1.5 Screening, vaccinations and other health promotion services reach and benefit all local communities

2.1 People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds

2.2 People are informed and supported to be as involved as they wish to be in decisions about their care

The remaining 15 goals are all graded as Achieving; a table of the Trusts current EDS2 grades is contained in Appendix A.

3.2 Workplace Race Equality Standard (WRES)

3.2.1 Since April 2015 the WRES has been part of the NHS standard contract, the Trust produced and published the WRES baseline data on 1 July 2015 and the first WRES report, providing analysis and an overview of our data returns, was published in July 2016.

3.2.2 The WRES update and the action plan, drafted by the Chief Executive, Trust Chair and members of the BME staff network, was tabled and agreed at the SMT and Business Committee meetings in July and August 2017 (see Appendix B).

3.2.3 A recent visit by Yvonne Coghill OBE, lead for the Workforce Race Equality Standard and Dr Habib Naqvi, NHS England's Equality Lead WRES team was positive; and

assurance was forthcoming that that the Trust is progressing well in fully meeting the requirements of the WRES.

3.3 Black, Asian & Minority Ethnic (BAME) staff network

3.3.1 Taking the views from consultation events with BAME staff held during three open events in 2016, the Trust took the informed step of commissioning the NHS Leadership Academy to develop and facilitate workshops specifically aimed at Black, Asian and Minority Ethnic (BAME) staff in the Trust, to understand and address:

- The outcomes from the recent staff survey,
- The Trusts WRES data
- To discuss the development of a BAME Staff Network.

3.3.2 In June 2017, the Trust provided BAME staff the opportunity to attend two half day workshops, facilitated by the NHS Leadership Academy to develop a Staff Network for the Trusts BAME workforce.

3.3.3 Both sessions were a success; Trust BAME staff looked at a Trust BAME strategy and development of a BAME Staff Network.

3.3.4 Following the two facilitated sessions a BAME Staff Network meeting took place, on the11th October 2017, facilitated by the Development Lead for leadership and team effectiveness

3.3.5 The BAME Staff Network agreed the draft Terms of Reference for the Network, roles, responsibilities, appointment of the Chair.

3.4 Accessible information

3.4.1 The Trust patient recording systems and process are compliant with the accessible information requirements listed below:

3.4.2 All patients, accessing Trust services, access requirements are sought and recorded as part of the initial assessment.

3.5 Interpretation and Translation

3.5.1 On 3 March 2017, Pearl Linguistics declared bankruptcy leaving the Trust without a provider of interpretation and translation services.

3.5.2 The Trust was able to mitigate this unforeseen event's impact on patient care through interim arrangements with a number of organisations (Section 3.1).

3.5.3 A number of appointments were re arranged; there were no patient care incidents attributable to the unavailability of interpreters.

3.5.4 No complaints or concerns were recorded regarding 'appointments/treatment delayed' because of the unavailability of interpreters as a result of the described event

3.5.6 The SMT discussed the interpretation and translation provision on 16 August 2017 and agreed:

- Face to Face interpretation to be provided by the Leeds City Council Interpretation and Translation team (LCCITT)
- Translation of documents, including Braille, to be provided by LCCITT
- Telephone interpretation to be provided by Language Line Solutions (LLS)
- British Sign Language (BSL) to be provided by two organisations, Leeds Society for Deaf and Blind People and Topp Language Solutions to provide a cultural and timely service.

3.5.7 As an organisational requirement, the Trust staff continues to report all incidents involving interpreters or an interpretation need via DATIX to provide management information to inform contract meetings and provide evidence of compliance in regards to the Accessible Information Standard.

3.6 Statutory E&D Training

3.6.1 The statutory requirements of the Equality Act 2010 are met by staff attendance at the Trust Corporate induction E&D session which provides staff with direction on their responsibilities regarding the three general duties

- Promote equality of opportunity,
- Good relations between different groups
- Eliminate harassment and unlawful discrimination under the Equality Act (2010)

3.6.2 The statutory requirements (Equality) of the Health and Social Care Act 2012 are met by staff completion of the Equality, Diversity and Human Rights e-learning within 3 months of commencing employment with the Trust.

3.7 Unconscious Bias awareness

3.7.1 Unconscious Bias awareness sessions have been provided to staff through interactive scenario based facilitated sessions. The sessions last between 30 and 90 minutes and are now being delivered by the Clinical Governance Team (CGT) in team/service meeting settings and monthly at Shine as part of the staff development programme.

3.7.2 The adoption of the delivery of Unconscious Bias awareness in situ with services and teams has had a significant impact on training with an increase from 47 delegates in the same reporting period last year compared to 112 delegates this reporting period.

3.8 Stonewall Diversity Champions

3.8.1 The Trust continues to allocate annual resource to ensure the organisation remains part of the Stonewall Diversity Champions programme.

3.8.2 During the reporting period the Trust has been involved in city wide working with the following Stonewall Diversity Champions:

- Leeds Teaching Hospital Trust
- Leeds City Council
- St Anne’s Community Services
- DWP

3.8.3 The city wide working has included but is not restricted to:

- A review and comment on the Stonewall Unhealthy Attitudes report prior to a tabled paper by LCC at the Health and Wellbeing Board
- The organisation of the pre pride event in July held at the Civic Centre which provided NHS colleagues in Leeds with an opportunity to network and celebrate the 50th anniversary f the Sexual Offences Act 1967 which decriminalised homosexuality ahead of the Leeds Pride event
- Trust staff of all levels taking part in Leeds Pride as part of the NHS Employers open- top bus.
- Delivery of two LGBT awareness sessions to the staff of Bellbrooke Group of GP Practices by the CGT (E&D) Team
- Support in the dissemination of the Leeds LGBT+ mapping project survey
- Attendance and contribution to a Leeds LGBT+ mapping project workshop to discuss findings of the project, in particular mental health concerns within the LGBT+ community.

3.10 Stonewall WEI18

3.10.1 The Stonewall Workplace Equality Index (SWEI) is the definitive benchmarking tool to measure progress on lesbian, gay, bi and trans inclusion in the workplace.

3.10.2 In light of the LCH SWEI performance in 2017 which was awarded 32 points scored out of 200, placed 360 out of 439 WEI submissions and ranked 39 out of 48 in the Health and Social care category, a SWEI18 delivery plan was developed, with progress reported to the LCH SMT, which concentrated on five areas:

1 - Employee policy
2 - Training
3 - Staff Network Group
4 - All staff engagement,
5 - Community engagement

3.10.4 Staff from across LCH was provided with the opportunity to complete an anonymous survey about their experiences of diversity and inclusion at work. The findings of this survey will be included in the SWEI feedback (see 3.10.5)

3.10.5 The SWEI18 was submitted electronically on 8 September 2017; feedback from Stonewall will be provided in January 2018.

3.11 Workplace Disability Equality Standard

3.12.1 The Workforce Disability Equality Standard (WDES) will be mandated via the NHS Standard Contract in England from April 2018.

3.12.2 It is anticipated that the metrics of the WDES will be shared in Q4 2017/18.

3.13 Disability Confident

3.13.1 The Disability Confident scheme replaced the Job Centre *Two Ticks Scheme* and aims to support LCH and other employers to make the most of the talents disabled people can bring to the workplace.

3.13.2 The Trust has committed to the Disability Confident promise to:

- Actively look to attract and recruit disabled people
- Provide a fully inclusive and accessible recruitment process
- Offer an interview to all disabled people who meet the minimum criteria for the role they have applied for
- Demonstrate flexibility when assessing applicants so disabled people have the best opportunity to demonstrate that they can do the job they have applied for.

3.13.3 The Disability Confident scheme consists of three levels:

- Level 1: Disability Confident Committed
- Level 2: Disability Confident Employer
- Level 3: Disability Confident Leader

3.13.4 The Trusts current assessment is Level 2 Disability Confident Employer.

3.14 Dyslexia in the workforce

3.14.1 As the implementation of the EPR progressed it became apparent that a significant number of the workforce is dyslexic.

3.14.2 As part of the staff Disability Champions initiative two members of staff, have been pivotal in highlighting dyslexia in the workforce, providing advice and bespoke EPR training.

3.14.3 In September 2017 the Dyslexia survey was shared with staff and attracted 47 responses. These have directed the creation of a draft Dyslexic staff survey action plan, which will be shared with staff once agreed.

3.14.4 Themes identified in the survey have been shared with staff via Community Talk on 5 October 2017.

3.15 FFT equality data

3.15.1 The NHS Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use Trust services should have the opportunity to provide feedback on their experience.

3.15.2 Since 2014 the Trust has been asking people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up question, the FFT provides a mechanism to highlight both good and poor patient experience.

3.15.3 Analysis of the FFT data revealed the following levels of equality data recorded on the database, there were a total of 13046 completed FFT surveys received and recoded in 2016/17

Protected Characteristic	Percentage of data held of total responses	Actual number of responses)
Age	69.11%	9002
Disability	65.02%	8480
Gender	58.37%	7566
Ethnicity	54.77%	7175
Religion	46.35%	6001
Sexuality	58.37%	7567

3.15.4 The analysis of the equality data resulted in the FFT action:

- Ensure FFT equality data is reflective of the patient population, through promotion, in order to identify and better understand health inequalities; and bring about improvements in patient care

The action is included in the Quality Account Improvement Plan which is present to the LCH Quality Committee on a quarterly basis.

4.0 NEXT STEPS

4.1 **Equality Objectives** – As a Public authority, listed in Schedule 1 and 2 of the Equality Act 2010 (Specific Duties) Regulations 2011 (the specific duties) the Trust must:

- Prepare and publish one or more objectives that the Trust thinks we should achieve to do any of the things mentioned in the aims of the general equality duty. This had to be done for the first time by 6 April 2012, and then at least every four years thereafter.

4.1.1 In addition to the outcomes delivered as part of the WRES action plan, including the BAME staff network, the Stonewall Workplace Equality Index delivery plan and staff disability champions it was agreed, at the SMT meeting on the 15th November 2017 the Trust would implement the following equality objectives to assist delivery of the Equality Act General Duties;

- Create and implement an improvement plan for the collection, analysis and use of patient and staff equality data for protected groups
- Create and implement a Workplace Disability Equality Scheme action plan
- Achieve the Disability confident Level three (Leaders) accreditation

4.1.2 Progress of the equality objectives will be reported quarterly at the PSEGG meeting and to the Trust Board in the annual equality and diversity report.

4.2 EDS2 - The timetable in 3.1.6 provides the EDS2 self-assessment dates for delivery for all EDS2 goals on an annual basis. Evidence will be sought and gathered from services and presented to SMT prior to the Leeds NHS EDS2 assessment panel.

4.2.1 During Q4 2017/18 it is planned to deliver a concerted awareness raising of the NHS EDS2 to all staff through internal Comms channels to improve understanding and acknowledgment of the benefits of the EDS2 for services, staff and LCH.

4.3 **WRES** - The WRES will be reviewed, revised and published once the results of the NHS National Staff Survey 2017 for the Trust have been received.

4.4 **BAME Staff Network** – The BAME staff network project officer role and job description will be confirmed and shared with the BAME staff network in Quarter 4 2017/18.

4.5 **Accessible information standard** - Plans are in place to raise the awareness of staff regarding their responsibilities as a requirement of the Accessible information in Q1 2017/18 through the internal Comms process and the Corporate Induction E&D session.

4.5.1 The E&D manager will liaise with NHS partners in Leeds together with Leeds City Council to identify a cross city process for the audit and effectiveness of the Accessible Information Standard implementation in organisations.

4.6 **Interpretation and Translation** - DATIX incidents, complaints and concerns will continue to be monitored for interpretation issues by the CGT and together with data on interpretation usage by Service/location/language will be included in the PSEGG quarterly E&D reports.

4.7 **Statutory E&D Training** – the content and delivery of the Corporate Induction E&D Session and Equality, Diversity & Human Rights e-learning will be reviewed in Q1 guided by delegate feedback and legislation requirements in force at that time.

4.8 **Unconscious Bias** – monthly Unconscious Bias sessions for the next 12 months have been identified and are available for staff to book via ESR.

4.8.1 The CGT will promote the offer of bespoke Unconscious Bias sessions for teams/services to access through Community Talk, Elsie Latest Trust News and Features and QPD Quality Leads.

4.8.1 During Q2 2017/18 the CGT will review the current delivery of the Unconscious Bias awareness session guided by delegate's feedback and current societal thinking.

4.9 **Stonewall Diversity Champions** – the Trust will continue to be part of the Stonewall Diversity Champions programme throughout 2017/18.

4.9.1 This will support any proposed cross city action plan devised by the Leeds Health and Wellbeing Board to help address relevant issues identified in the Stonewall Unhealthy Attitudes report.

4.9.2 The Trust will provide opportunities for staff to take part in Leeds Pride in August 2018.

4.9.3 The Trust CGT (E&D) will deliver a LGBT awareness session to the staff of Bellbrooke Group of GP Practices on 6 February 2018 as part of LGBT History month.

4.9.4 IAPT and LSH services will work to strengthen their relationship with the LGBT+ mapping project to inform service delivery and design to meet the needs of the LGBT+ community.

4.10 **Stonewall WEI** - The SWEI18 delivery plan has been reviewed, revised and renamed the SWEI19 delivery plan and will now provide evidence to support following areas of the submission:

- Employee Policy
- Employee Lifecycle
- LGBT Staff Network Group
- Allies & Role Models
- Senior Leadership
- Monitoring
- Procurement
- Community Engagement
- Clients, Customers and Service Users
- Additional Work

4.10.1 An update of the SWEI19 delivery plan will be provided to the SMT in April 2018 following Stonewalls notification of the WEI score in January and full feedback on performance in March 2018. This will provide an understanding of what is going well and where the focus needs to be going forward in the form of additional actions, to be incorporated into the SWEI19.

4.10.2 The E&D manager will table a paper to the SMT in November proposing that the annual SWEI submission in 2019 and 2020 become a two year equality objective

4.11 Sexual orientation monitoring information standard (SOM) – The Trust has been routinely asking and recording the sexual orientation of people accessing services (over the age of 16 years) since 2013.

4.11.1Future PSEGG quarterly reports will contain a section on recorded equality data and a light touch analysis of the following protected characteristics:

- Age
- Disability
- Ethnicity
- Gender
- Sexual orientation
- Religion and or belief

4.12 Workplace Disability Equality Standard (WDES) - Following the release of the WDES metrics in Q4 2017/18 the information will be shared with stakeholders for information and involvement in the creation of an action plan to deliver the outcomes required by the WDES.

4.13 Disability Confident – In November 2017, the E&D manager will table a report to SMT proposing that a 2 year equality objective of LCH achieving Disability Confident Leader is agreed.

4.13.1 If agreed, the Disability Confident Leader delivery plan will form part of the quarterly PSSEG E&D report

4.15 FFT equality data – the E&D Manager will table a paper to the SMT proposing that a FFT equality data action is adopted as a 2 year equality objective to support the current FFT equality data action in the Quality Account Improvement Plan

4.16 Sensory awareness sessions – LCH has recently secured resource to provide staff with opportunity to attend quarterly sensory awareness sessions provided by the Leeds Society for Deaf & Blind People at Shine.

4.16.1 The sessions will be added to the course catalogue on ESR and promoted through Community Talk and Elsie's Latest Trust News and Features.

5. IMPACT

5.1 **Risk**

The key risk in failing to deliver the equality objectives is the potential for legal challenge if the Trust failed to meet it duties under equality legislation or if knowingly or unknowingly allowed discrimination to occur. The equality objectives are consistent with the Trusts risk tolerance with an aim to reduce to a minimum level.

5.2 **Legal/Regulatory**

The equality objectives will meet the legal requirements of the Equality Act 2010, Human Rights Act 1998 and the CQC regulatory requirements.

6.0 RECOMMENDATIONS

The Board is recommended to:

- Note the progress made
- Confirm that the Board is assured that the requirements of the Equality Act 2010 Public Sector Equality Duties (PSED) and the NHS Standard Contract are being met.

Appendix A

Goal 1 – Better health outcomes for all		Assessment
1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities	Achieving
1.2	Individual people's health needs are assessed and met in appropriate and effective ways	Achieving
1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed	Achieving
1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse	Achieving
1.5	Screening, vaccinations and other health promotion services reach and benefit all local communities	Excelling

GOAL 2 – Improved patient access and experience		Assessment
2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds	Excelling
2.2	People are informed and supported to be as involved as they wish to be in decisions about their care	Excelling
2.3	People report positive experiences of the NHS	Achieving
2.4	People's complaints about services are handled respectfully and efficiently	Achieving

GOAL 3 – Empowered, engaged and well-supported staff		Assessment
3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels	Achieving
3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations	Achieving
3.3	Training and development opportunities are taken up and positively evaluated by all staff	Achieving
3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source	Achieving
3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives	Achieving
3.6	Staff report positive experiences of their membership of the workforce	Achieving

GOAL 4 – Inclusive leadership at all levels		Assessment
4.1	Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond	Achieving
4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed	Achieving
4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination	Achieving

Appendix B

Main findings from WRES 2016/17

There are a number of positive comparisons to report but some of the data needs to be treated with caution due to the small sample size available e.g. number of formal disciplinary processes reported.

The overall percentage of BME staff has decreased from 12% to 9.45%.

Relative likelihood of BME staff being appointed from shortlisting across all posts has decreased from 19.22% to 18.21%

Relative likelihood of staff accessing non-mandatory training and CPD for BME staff has risen from 13.28% to 14.61%.

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months has seen a slight decrease from 25.6% to 25%. White staff have reported a significant decrease from 34% to 27%.

There is also a significant difference between White and BME staff believing that the Trust provides equal opportunities for career progression or promotion. 78% of BME staff believes the trust provides equal opportunities as opposed to 94% of White staff. This is a decrease of 2% for BME staff.

Percentage of BME staff personally experiencing discrimination at work from a manager, team leader or other colleagues has seen a significant decrease from 12% to 9%.This has reduced significantly for both White and BME staff. White staff has reduced from 6% to 4%.

BME have seen a significant reduction over 3 years reducing from 31.3% in 2013/14 to 9% this reporting year.

The likelihood of staff entering the formal disciplinary process has reported a slight increase from 1.3% to 1.49% for BME staff.

WRES indicator 9 now requires the percentage difference between the organisation BME board voting membership and its overall BME workforce. This indicator has remained static at 0% against an overall BME workforce of 9.45%.

WRES action plan

Planned Actions	Progress update
Establish Leaders BME Network by January 2016	Established and first meeting held April 2016- follow up actions are being pursued: • *reconsider for role models from BME backgrounds at board or equivalent levels* • *create network of BME individuals prepared to be a listening ear* • *publicise Staff support and intervention feedback in event of difficulty with families/patients* • *developing more open culture, and to sustain communication regarding cultural observances* • *training and support on diversity for all* • *publicise access and feedback to BME staff on development options*
Conduct an Equality Analysis of the Recruitment process (end of Q2 report to SMT)	Completed and reported to SMT in October 2015
Monitor Employee Relations data	This is an ongoing activity within HR. Reviewed monthly and recorded on ESR
Monitor Unconscious Bias session	Attendance reviewed. Development session held with Leaders Network
Appoint to NED Associate role to expand diversity in potential Board members by end January 2016	Not progressed

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2017-18 (70)

Meeting Trust Board 1 December 2017	**Category of paper**	
Report title Major Incident Plan	**For approval**	X
Responsible director Executive Director of Operations **Report author** Resilience Manager	**For assurance**	
Previously considered by SMT 22 November 2017	**For information**	

Purpose of the report

The Trust is required to have a major incident plan in place which is signed off and agreed at Board level. Following the desk-top exercises which have taken place this year, the plan has undergone a full review and update and review by the senior Management Team.

Main issues for consideration

The NHS has a duty to protect and promote the health of the community. It is essential that the Trust is involved in planning for and response to any incident which may impact on the health of the community. The Trust has a statutory requirement under the Civil Contingencies Act 2004 (CCA) to ensure such planning is undertaken.

The Trust's emergency planning arrangements, including this major incident plan (MIP), are embedded within local, regional and national emergency planning arrangements. NHS England will coordinate the NHS response to major incidents and emergencies for the local and regional area. This will be done locally by NHS England working closely with Clinical Commissioning Groups. Leeds City Council, in conjunction with Public Health England, will coordinate the local response to public health outbreaks, incidents and emergencies. All local provider plans have been produced to be cohesive, flexible and follow the same regional and national guidelines.

In this context, the Trust's plan provides an agreed framework for the Trust to be able to respond to the impact of a major incident in its capacity as a provider of healthcare in Leeds. This plan is intended to be flexible enough to meet the demands of a range of circumstances but regardless of the nature of the incident, the basic principles and procedures set out in this plan are to be followed

Recommendation

The Board is recommended to:

- Approve the major incident plan

Leeds Community Healthcare NHS Trust

Leeds Community Healthcare

Major Incident Plan

Version 5.1
November 2017

Document Control:

Author	Emma Lydon Resilience Manager
Director Lead	Sam Prince Executive Director of Operations
Date Issued	
Ratified by	
Date Approved	
Status	Draft
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Change History

Version	Changes Applied	By	Date
1.0	Initial Draft	Emma Lydon	05/01/2011
1.1	Further development	Emma Lydon	14/01/2011
1.2	Further development	Emma Lydon	21/01/2011
1.3	Further development following consultation with Denise Gibson	Emma Lydon	25/01/2011
1.4	Acronyms and minor amendments	Emma Lydon	04/02/2011
1.5	Amendments made	Emma Lydon	14/02/2011
1.6	Further development following consultation with Denise Gibson	Emma Lydon	18.02.2011
1.7	Amendments made	Nicola Annakin	11/04/2011
1.8	Amendments & update	Emma Lydon	25/07/2011
1.9	Updated Control Centre details	Emma Lydon	15/08/2011
1.10	Updated WY Contact Details	Emma Lydon	29/09/2011
1.11	Update following QGRC meeting	Emma Lydon	
1.12	Updated contacts	Emma Lydon	04/11/2011
1.13	Updated Liaison Officer section	Emma Lydon	14/11/2011
1.14	Mass Casualties Appendix added & Board comments	Emma Lydon	23/11/2011
1.15	Annual Review	Emma Lydon	03/10/2012
1.16	Minor update following consultation with Sam Prince	Emma Lydon	04/01/2013
2	Review following NHS Organisational change	Emma Lydon	April 2013
3	Annual review & update	Emma Lydon	May 2014
4	Annual review and update	Emma Lydon	February 2016
5	Complete review and refresh of plan including new How To Guides and Action Cards	Emma Lydon	June 2017
5.1	Minor updates following review	Emma Lydon	Nov 2017

MIP Review Schedule

The Major Incident Plan will be updated on a continual basis with a major re-issuing of the document every year.

As an electronically distributed file any amendments will be notified by the complete replacement of the file that are held by plan holders rather than by the issuing of incremental paper amendments.

The next review of the Leeds Community Healthcare Major Incident Plan is scheduled for November 2018

Major Incident Plan Sign-off

The Major Incident Plan for Leeds Community Healthcare NHS Trust has been formally signed-off by the Leeds Community Healthcare NHS Trust Board as fit for purpose

_____

Chief Executive

_____

Date

_____

Chair of the Board

_____

Date

Please familiarise yourself with this plan prior to the management of an incident.

If you are using this plan in response to an on-going incident, please refer to the How To Guides and Action Cards found at the back of this plan.

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1. Introduction

The NHS has a duty to protect and promote the health of the community. It is therefore essential that Leeds Community Healthcare NHS Trust (LCH) is involved in planning for and response to any incident which may impact on the health of the community, regardless of size, nature, locality or duration. LCH has a statutory requirement under the Civil Contingencies Act 2004 (CCA) to ensure such planning is undertaken.

LCH's emergency planning arrangements, including this Major Incident Plan (MIP), are embedded within local, regional and national emergency planning arrangements. NHS England will coordinate the NHS response to major incidents and emergencies for the local and regional area. This will be done locally by NHS England working closely with Clinical Commissioning Groups. Leeds City Council, in conjunction with Public Health England, will coordinate the local response to public health outbreaks, incidents and emergencies. All local provider plans have been produced to be cohesive, flexible and follow the same regional and national guidelines.

2. Aim

To provide an agreed framework for the Trust to be able to respond to the impact of a major incident in its capacity as a provider of healthcare in Leeds. This plan is intended to be flexible enough to meet the demands of a range of circumstances but regardless of the nature of the incident, the basic principles and procedures set out in this plan should be followed.

3. Scope

The LCH Major Incident Plan (MIP) is a generic plan and can be applied to all types of major incident and all LCH staff with a role within the Emergency Management Team (EMT) should familiarise themselves with it. In the event of a major incident, the actions cards and guidance documents should be used as a guide to managing the incident, rather than using the plan in its entirety.

This plan should be used in conjunction with the Trust's On-Call Procedures. The Trust has both a 1st (senior manager) and 2nd (executive director) On-Call Manager available 24/7 and this process is supported by a comprehensive on-call manual. The 2nd On-Call Manager will act as Incident Manager in the event of a major incident.

4. Training and Exercising

It is a requirement under the CCA that the following exercising schedule is adhered to in order to ensure that the plan is fit for purpose.

- A communications test of the EMT at least once every six months
- An annual desk-top exercise of the MIP
- A live exercise of the plan at least once every three years (unless the plan has been activated during this period)

5. Contacts

PLEASE NOTE, IN RESPECT OF SECTION 5, CONTACTS:

- **CONTENT IS AVAILABLE IN THE INTERNAL DOCUMENT ONLY**
- **CONTENT HAS BEEN REMOVED IN THE DOCUMENT RECEIVED BY THE TRUST BOARD IN PUBLIC SESSION**

5.1 Emergency Management Team

Name	Contact Number	Note
LCH Switchboard	0113 2208500	
LCH On-Call Manager	0845 2657599	Available 24/7 – both Director on-call and Operational Manager on-call

Role	Name	Work	Mobile	Home Number (if happy to be contacted OOH)
Incident Manager				
Loggist				
Operational Manager				
Emergency Management Support Team				

Communications Manager				
IT Manager				
Resilience Manager				

5.2 Partner Organisations – In-Hours

Local Police	Emergency	
NHS	Medical advice	
Environment Agency	Reporting environmental emergencies and incidents	
Transco/Gas	Emergency contact i.e. leaks etc.	
Northern Power Grid	Emergency contact i.e. power outage etc.	
Yorkshire Water	Emergency contact i.e. burst pipes etc.	
Leeds City Council	Reporting emergencies	
Leeds City Council	Reporting flooding	
NHS Leeds West CCG	Commissioning of Acute and Planned Care Services	
NHS Leeds North CCG	Commissioning of Mental Health, L&D and Urgent Care Services	
NHS Leeds South & East CCG	Commissioning of Community Services, Children's and Maternity Services, Continuing Health Care and	
Leeds Teaching Hospitals NHS Trust	Provider of Acute Services	
Leeds Community Healthcare NHS Trust	Provider of Community Services	
Leeds & York Partnership NHS Foundation Trust	Provider of Mental Health Services	

5.3 Partner Organisations – Out of Hours

Organisation	On-call arrangements	Contact details
Leeds Teaching Hospital Trust	On Call	
	Clinical Site Manager	
	Switchboard	
Local Care Direct	Duty manager (from 18:30 -08.30 weekdays and all day weekends and Bank Holidays)	
	Minor Injury Unit (MIU) - Wharfedale (08:00 – 23:00 except Christmas Day)	
	Minor Injury Unit (MIU) – St Georges(08:00 – 23:00 except Christmas Day)	
YAS	ROC (Regional Operations Centre)	
111	24/7 Supervisor Line	
One Medical Group	Shakespeare Walk In Centre(08:00 - 20:00)	
Leeds City Council	LCC Contact Centre	
	Adult Social Care Emergency Duty Team	
Leeds Community Healthcare	On-call manager	
Leeds and York Partnership	On-call manager	
Age UK	Hospital to Home scheme (10:00 – 19:00 every day	
NHS England	Director on-call	
Public Health England	Ask for the duty public health specialist for West	
Clinical Commissioning Groups (CCGs) on call	Bradford & Airedale, Calderdale & G. Huddersfield, Leeds, Wakefield & North Kirklees	

6. Roles and Responsibilities in a Major Incident

6.1 Leeds Community Healthcare

- Maintain Business Continuity with a focus on admission avoidance and early discharge from hospital.
- If required, meet health care needs in evacuation centres
- If required, provide mass treatment/vaccination
- Co-ordinate and meet the health care needs of patients discharged early from hospital
- Provide community hospital bed capacity if required
- Utilise psychological support (either own Trust or contracted service) – Primary Care Mental Health Services
- Support Public Health England (PHE)/Local Authority in implementing health protection measures
- Ensure continuation of essential routine health care of the general population (affected or not by the incident)

6.2 NHS England

- Lead the mobilisation of the NHS in the event of an emergency
- Work together with PHE and DH, where appropriate, to develop joint response arrangements
- Ensure integration of plans across the region to deliver a unified NHS response to incidents, including ensuring the provision of surge capacity
- Maintain capacity and capability to coordinate the regional NHS response to an incident 24/7

6.3 Clinical Commissioning Groups (CCGs)

- Support NHS England in discharging its EPRR functions and duties locally, including supporting health economy tactical coordination during incidents
- Maintain service delivery across the local health economy to prevent business as usual pressures and minor incidents within individual providers from becoming significant or major incidents. This could include the management of commissioned providers to effectively coordinate increases in activity across their health economy which may include support with surge in emergency pressures

6.4 Public Health England (PHE)

- Deliver public health services including, but not limited to, surveillance, intelligence gathering, risk assessment, scientific and technical advice, and microbiology services to emergency responders, Government and the public during emergencies at all levels
- Participate in and provide specialist expert public health input to national, sub-national and LHRP planning for emergencies
- Maintain PHE's capacity and capability to coordinate regional public health responses to emergencies 24/7

6.5 Leeds Teaching Hospitals Trust

- Treat incoming patients affected by the major incident
- Plan for the rapid expansion of capacity of A&E facilities and supplement staffing
- Consider the need to remodel triage and increase treatment capacity at the scene
- Maximise bed availability and free up capacity with primary and community care partners
- Suspend elective surgery (if necessary)
- Plan for accelerated and temporary discharge of patients from acute beds
- Trigger security measures to control and reduce access to protect capacity
- Activate command and control procedures

6.6 Leeds & York Partnership NHS Foundation Trust (LYPFT)

- Support to victims of an incident including NHS staff
- Provision of staff
- Provision of facilities
- Provision of capacity
- Provision of equipment

As a Mental Health and Learning Disability Trust, LYPFT also have specific responsibilities in the event of a major incident including:

- Link with partner organisations locally in co-ordinating services
- Support the provision of psychological and mental health care in conjunction with partner organisations
- Advise on the long term effects of trauma on the casualties associated with the incident
- Ensure that mental health patients caught up in an incident are discharged home with appropriate support in the community

6.7 Yorkshire Ambulance Service (YAS)

The Ambulance Service is primarily responsible for the alerting, mobilising and coordinating at the scene all primary NHS resources necessary to deal with any incident, unless the incident is an internal health service incident.

Ambulance trusts have specific responsibilities in terms of alerting NHS organisations in the event of a civil emergency and/or major incident. These are:

- Immediately notify, or confirm with police and fire controls, the location and nature of the incident, including identification of specific hazards, for example, chemical, radiation or other known hazards
- Alert the most appropriate receiving hospital(s) based on local circumstances at the time
- Alert the wider health community as the incident dictates.

In addition, YAS are also responsible for:

- Providing clinical decontamination of casualties and to support mass decontamination
- Making provision for the transport of the Medical Emergency Response Incident Team (MERIT) if this is an agreed function for that Ambulance Service

6.8 General Practitioners (GPs)

- Voluntary involvement in the treatment of minor injuries and general health treatment
- Keeping up to date with locally or nationally issued public health advice
- Awareness of disease presentations associated with biological release
- Ensuring the PHE is informed when a disease presentation is suspected
- Provide medical assistance at rest centres, vaccination centres and other treatment areas
- Assist with service provision of patients from practices directly affected
- Assist colleagues from affected practices
- Balance major incident role with the business continuity of the practice

7. Terms and Definitions

7.1. Types of Incident

For the NHS, incidents are classed as either:

- ***Business Continuity Incident***

A business continuity incident is an event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, below acceptable predefined levels, where special arrangements are required to be implemented until services can return to an acceptable level. (This could be a surge in demand requiring resources to be temporarily redeployed)

- ***Critical Incident***

A critical incident is any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions.

- ***Major Incident***

A major incident is any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented.

Each will impact upon service delivery within the NHS, may undermine public confidence and require contingency plans to be implemented. NHS organisations should be confident of the severity of any incident that may warrant a major incident declaration, particularly where this may be due to internal capacity pressures, if a critical incident has not been raised previously through the appropriate local escalation procedure.

There are a number of types of incident including:

- **Business continuity/internal incidents** – fire, breakdown of utilities, significant equipment failure, hospital acquired infections, violent crime
- **Big bang** – a serious transport accident, explosion, or series of smaller incidents
- **Rising tide** – a developing infectious disease epidemic, or a capacity/staffing crisis or industrial action
- **Cloud on the horizon** – a serious threat such as a significant chemical or nuclear release developing elsewhere and needing preparatory action
- **Headline news** – public or media alarm about an impending situation, reputation management issues
- **Chemical, biological, radiological, nuclear and explosives (CBRNE)** – CBRNE terrorism is the actual or threatened dispersal of CBRN material (either on their own or in combination with each other or with explosives), with deliberate criminal, malicious or murderous intent
- **Hazardous materials (HAZMAT)** – accidental incident involving hazardous materials
- **Cyber attacks** – attacks on systems to cause disruption and reputational and financial damage. Attacks may be on infrastructure or data confidentiality
- **Mass casualty** – typically events with casualties in the 100s where the normal major incident response must be augmented with extraordinary measures

7.2. Activation

To avoid confusion about the different stages of activation, all NHS organisations should use the following standard messages in relation to both critical and major incidents:

- ***Major incident – standby***
  This alerts the NHS that a significant incident/major incident may need to be declared. Significant incident/Major incident standby is likely to involve the participating NHS funded organisations in making preparatory arrangements appropriate to the incident, whether it is a 'big bang' , a 'rising tide' or a pre-planned event
- ***Major incident declared***
  This alerts NHS funded organisations that they need to activate their plan and mobilise additional resources
- ***Major incident cancelled***
  This message cancels either of the first two messages at any time
- ***Major incident stand down***
  All receiving hospitals are alerted as soon as all live casualties have been removed from the site. Where possible, the Ambulance Incident Commander will make it clear whether any casualties are still en-route while ambulance services will notify the receiving hospital(s) that the scene is clear of live casualties, it is the responsibility of each NHS funded organisation to assess when it is appropriate for them to stand down

7.3. Command and Control

There are a number of different terms used when describing the levels of command and control. These are:

- ***Operational or Bronze Command***

Those responsible for carrying out the actions and tasks agreed at Tactical/Silver level of command. Locality-based, dealing directly with either the incident itself or the effects of the incident on the organisation.

- ***Tactical or Silver Command***

Those responsible for directly managing an organisation's response to an incident. To set priorities in line with Strategic/Gold command, allocation of resources and coordination of tasks. Tactical command should oversee and support, but not be directly involved in the operational response.

- ***Strategic or Gold Command***

Multi-agency Executive-level management of an incident affecting more than one organisation. Sets strategic priorities to be delivered by individual organisational silver command.

8. Procedures

8.1. Activating and Alerting Mechanisms

In most cases, LCH along with the rest of the health community, will be informed of a major incident in Leeds via the Ambulance Service. This will usually be via the LCH on-call number. However there are a number of alternative channels through which information could be received. These include media reports, emergency messaging systems (such as Leeds Alert), emails or other responding agencies.

Regardless of how the information is received into the Trust, the activation of the LCH MIP will take place when an incident has occurred that has the potential to compromise the Trust's ability to maintain its essential services and critical functions and requires the establishment of additional command and control arrangements to oversee the management of the incident and its recovery.

If the 1st On-Call Manager is notified of a major incident, or an issue which has the potential to become a major incident, this should be immediately escalated to the 2nd On-Call manager.

The decision to activate this plan and/or declare a major incident will be taken by the Chief Executive or Incident Manager who will also decide if it is necessary to establish an Emergency Management Team (EMT) and/or open a control centre. Please see How To: Establish an EMT guide in Appendix A. If the decision is taken to declare a Major Incident, the Chief Executive or Incident Manager should ensure that the Chair of the Board is alerted and informed.

The 2nd on-call manager has full authority to respond to an incident on behalf of the Chief Executive. The 2nd on-call manager may be required to prioritise or cancel some services and redeploy staff. They may also be required to approve financial payments to cover immediate needs. In the event of a declared major incident, this command and control arrangement supersedes normal management structures and reporting arrangements.

If another organisation(s) declare a major incident but the impact of the incident is not significant enough to warrant LCH declaring a major incident, the Chief Executive or Incident Manager should put the Trust on standby and monitor the situation as it develops. If the decision is taken to declare a major incident for LCH, this must be communicated to our partner organisations. See How To: Declare a Major Incident guide in Appendix B.

8.2. Liaison Officer

The Incident Manager should give consideration to deploying a Liaison Officer to attend another organisation's control centre where appropriate. This would enable and enhance joint working between key organisations and improve information flows. As many Liaison Officers as required should be deployed.

A request to join LTHT command and control must be made via the LCH Director leading the incident response direct to LTHT Silver Commander/Director on Call. Access to the LTHT Control Centres will not be granted without production of an LCH photo identification card.

8.3. Emergency Control Centres

Leeds Community Healthcare has two pre-identified control centres that may be used for the co-ordination and control of any incident, although any facility may be used that meet the space and communication requirements. The decision to open a control centre rests with the Trust's Incident Manager. In most circumstances the secondary control centre will only be utilised if the primary control centre is unavailable (largely where access to the primary control centre is denied due to the incident itself).

If required, the Emergency Control Centre (ECC) may operate across two adjacent areas. This will allow the EMT to remain focused on managing the incident without the distraction of mobile phones, emails etc. The two areas are:

- Incident Management: The Emergency Management Team (Incident and Operational Managers) will sit here alongside a Loggist and any specialist roles.
- Communications & Support: The Emergency Management Support Team will be based here (including communications and telephone/message handlers). This team should be in close proximity to the Incident Management team.

The primary control centre is Stockdale House, as this is the Trust's Headquarters. Depending on the location, scale and nature of the incident it may be necessary to use the secondary control centre which is Hunslet Health Centre. Other locations may be used as required. Please see How To Guide: How to Establish an Emergency Control Centre in Appendix C.

8.4. EMT Agenda

The aims and objectives of the Emergency Management Team will differ depending upon the scale and nature of the incident being managed. Regardless of this, these meetings should be regular in occurrence and have a Loggist in attendance where possible.

A suggested agenda for the EMT to follow can be found in Appendix D Emergency Management Team Agenda.

Regardless of whether an EMT is running continuously, regular meetings should still be set to work through the agenda. It is easy to become engrossed in the response to an incident and to lose sight of the overview. It is also important to ensure that there is a common understanding of what is happening between all team members.

8.5. Recovery

Depending upon the nature and impact of the incident, the Incident Manager should consider establishing a Recovery Team. The function of this team is to coordinate the recovery effort and restore full service capability of the Trust. The list of essential services should be used to guide the priorities for the order of service recovery. Please see Appendix E LCH Essential Services. More detailed information regarding LCH essential services can be obtained from the Trust Resilience Manager.

The membership of the Recovery Team will depend upon the specific incident but staff can be drawn from the list of Emergency Management Team who are not required to respond to the on-going incident.

8.6. Legal Advice

During the response to any major incident, there may be actions and policy decisions made that have potential legal consequences. Advice can be provided to the Incident Manager on those aspects of the incident and the response that may create legal liabilities for the Trust. This advice should be considered as part of the decision-making of the EMT during the management of the incident.

However, engaging solicitors can be an expensive budgetary commitment and therefore LCH needs to ensure that solicitors are contacted for specific purposes only by designated people after exhausting LCH knowledge and expertise.

The need for legal advice out of hours is rare and staff that require legal advice should, in the first instance, use the on-call procedure. The Senior Manager on-call or Incident Manager will authorise and seek legal advice where deemed appropriate.

Leeds Community Healthcare contract Hempsons for all legal advice. Contact details as below:

Hempsons: 01423 522 331

If the solicitor advises that they cannot supply services due to a conflict of interest then please contact the Procurement Manager on 07957 411193, who can advise on alternative providers.

8.7. Communications

In the event of a major incident, it is vital that clear and effective communication is maintained with staff service users, the general public, other responding agencies and the media.

The media and general public may contact the Trust for information about the incident and social media will be used instantaneously to broadcast messages and share information in an emerging situation. It is therefore important to ensure an accurate and appropriate response is provided.

To assist in the operational duties associated with good external and internal communications handling during a major incident a pack of Communications Action cards has been developed and is available both in the Supporting Information folder on the H:Drive On-Call and a paper copy in the Boardroom at Stockdale House.

9. Appendix A: How to Establish an Emergency Management Team (EMT)

What is an EMT?

- A team called together to manage the LCH reponse to an incident
- Roles fulfilled by LCH staff

When to call an EMT

- Decision to be made by Incident Mgr or Deputy Incident Mgr
- When the response required to manage the incident is greater than can be managed by the on-call manager and/or specialist advice is required
- When an ECC has been set up to manage the response to an incident

Roles within an EMT

- Incident Manager (usually 2nd On-Call Manager)
- Operational Manager/Deputy Incident Manager (usually 1st On-Call Manager)
- Loggist
- Support Team
- Comms Manager
- IT Manager
- Resilience Manager

How to establish an EMT

- Incident Manager to decide what roles/representatives are required depending on scale and nature of incident
- If decision is made to call an EMT, a loggist should attend
- Use contact list in Major Incident Plan (MIP) to call relevant team together or delegate this responsibility to 1st On-Call Manager

10.Appendix B: How to Declare a Major Incident

What is a Major Incident?

- Any occurence that presents serious threat to the health of the community, disruption to the service or causes (or is likely to cause) such numbers or types of casualties as to require special arrangements to be implemented by hosptials, ambulance trusts or primary care organisations

Major Incident Standby

- Decision to be made by Incident Manager
- This alerts partners that a Major Incident may need to be declared
- Involves making preparatory arrangements appropriate to the incident

Major Incident Declared

- Decision to be made by Incident Manager
- This alerts partners that the Major Incident Plan has been activated and LCH response has been triggered
- NHSE to be informed: 0113 8252700 / 0333 0124267
- CCG Director On-Call to be informed: 0844 8707937

Major Incident Stand Down

- Decision to be made by Incident Manager
- This alerts partners that LCH is no longer operating under Major Incident status

Action Required

- Escalate/De-escalate using normal escalation channel via CCG
- Ensure staff are informed where appropriate
- Inform NHSE/CCG of change to Major Incident status

11.Appendix C: How To Establish an Emergency Control Centre (ECC)

What is an ECC?

- A location used for the coordination and management of LCH's response to an incident

When to open an ECC

- Decision to be made by Incident Mgr or Deputy Incident Mgr
- When the response cannot be managed via remote communications

Primary Control Centre

- Stockdale House Boardroom
- Reception: 0113 220 8500
- Boardroom Landline: 0113 2208570 (ext. 33570)
- Security Office: 0113 2784971 - to open gate OOH
- Side Door Access code: 4323 to access building OOH
- Supplies Cupboard: key in blue key box at Reception

Secondary Control Centre

- Hunslet HC Health Education Room
- Reception: 0113 2771811
- Health Ed Room Landline: Side room to Health Ed ext number: 28605
- OOH Access: (outside 7am-10pm) contact Profile Security 0113 3839036
- Outside door code: 1352

Alternative Locations

- Any location which meets the space and communications required to manage response
- Any of the locations below can be accessed out of hours:
- Bramley Clinic
- Burmantofts HC
- Halton Clinic
- Holt Park HC
- Hunslet HC
- Horsforth Clinic
- Kirkstall Clinic
- Morley HC
- Otley Clinic
- Pudsey HC
- Rothwell HC
- Seacroft Clinic
- Woodsley Road HC
- Meanwood HC
- To access call Profile Security on 0113 3839036 and use the password 'Golfball'

12.Appendix D: Emergency Management Team Agenda

Current Situation Report

- What has happened, what is currently being done, what needs to be done?
- Which organisation is leading on the incident?
- What command and control arrangements are in place?
- What requests have been made of LCH?

Liaison and Communications

- How will communications be maintained between LCH and other responding organisation?
- What, if any, communications are required for our staff, patients, partners?
- Have the WY Emergency Media Arrangements been invoked?
- Who is the lead organisation for public information?
- What arrangements are being made for Helplines?

Impact on the Trust - Service Continuity

- How will the functions of the Trust be affected by the incident?
- What interim arrangements/resources are needed?
- Have any services been reduced/suspended to manage the impact of the incident?
- Are all essential services maintained?

Staff and Resources

- How can the Trust's resources be used to help mitigate the impact of the incident?
- Can external agencies assist in the Trust's response?
- What are the implications of using these resources?
- Are all health and safety and welfare arrangements for staff in place?

Reporting Arrangements

- Who needs to be kept informed of the incident?
- Who needs to be briefed and how often?
- What reporting requirements are expected of LCH - how often, by who, what information?

Horizon Scanning

- How long is the incident likely to last?
- In the impact of the incident likely to increase?
- Are arrangements in place to sustain LCH's response over the next period?

Any Other Business

Time and Date of Next Meeting

- Who should attend?
- Who will lead?

13.Appendix G: Incident Manager Action Card

Role:

- To establish and maintain overall control and coordination of the Trust's response to an incident
- To determine the strategy and tactical actions for how the Trust will manage the incident

Responsibilities:

- Gather as much information about the incident as possible to determine scale and nature
- Establish if any other responding organisation has declared a major incident
- Determine impact on LCH
- Set response priorities for LCH

Actions (if appropriate):

- Start and maintain an Incident Log of any actions considered and/or taken (until EMT and Loggist in place if appropriate)
- Declare Major Incident (see How To: Declare a Major Incident)
- Establish an ECC (see How To: Establish an ECC)
- Establish an EMT (see How To: Establish an EMT)
- Prepare a situation briefing for the EMT
- Inform the Chief Executive, Chair and NEDs of the incident
- Consider establishing a Recovery Team to support business continuity and manage the restoration of normality
- Declare Major Incident Stand Down

14.Appendix H: Loggist Action Card

Role:

- To maintain a timely and accurate record of:
- all key decisions made by the Emergency Management Team (EMT)
- all actions taken by the EMT
- all actions considered and rejected by the EMT
- all requests for information

Responsibilities:

- To attend the Emergency Control Centre (ECC) as required
- To use the log books provided in the ECC (if available) or create a log as appropriate
- Ensure that the log records all present and roles fulfilled
- Include named responsibility for specific actions
- Include rationale for decisions made/rejected

Actions at the end of your shift:

- Review documentation and liaise with the Incident Manager to ensure accuracy of records
- Ensure log book and any other paperwork is handed to Incident Manager or nominated representative
- Provide a handover to new loggist if required

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2017-18 (71)

Meeting: Trust Board 1 December 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: N/A	**For information**	

Purpose of the report:

This summary report is part of the governance processes supporting risk management in that it provides the Board with updated information about the effectiveness of the risk management processes and that adequate controls are in place to manage risks.

The summary report provides The Board with information about risks currently scoring 15 or above, after the application of controls and mitigation measures. It also provides a description of any movement of risks scoring 12 (high risks) since the last report was received by the Board on 6 October 2017.

The Board Assurance Framework (BAF) summary advises on the current assurance level determined for each of the Trust's strategic risks.

Main issues for consideration:

This summary report shows changes to the risk register (for risks scoring 15 or above) since October 2017:

- There are three risks scored as 'extreme' risks.
- No new risks scoring 15 or above
- One deescalated risk, which previously scored 15 or above
- One new risk scoring 12
- Four deescalated risks previously scoring 12
- Two risks, which previously scored 12 have been closed

The BAF summary gives an indication of the current assurance level for each strategic risk, based on sources of assurance received and evaluated by SMT, committees, and the Board.

Recommendations

The Board is recommended to:

- Note the revisions to the risk register
- Note the current assurance levels provided in the revised BAF summary

SIGNIFICANT RISKS AND BOARD ASSURANCE FRAMEWORK (BAF) REPORT

1.0 Introduction

1.1 This report, which is presented at Senior Management Team (SMT) monthly, and every two months to the Board provides an overview of the Trust's risks currently scoring 15 or above after the application of controls and mitigation measures.

1.2 The Board's role in scrutinising risk is to maintain a focus on those risks scoring 15 or above (extreme risks) and to be aware of risks currently scoring 12 (high risks). This report provides a description of risk movement since the last register report was received by the Board (6 October 2017), including any new risks, risks with increased or decreased scores and newly closed risks. The report seeks to provide assurance to the Board that there is a robust process in place for managing risk.

1.3 Summary reports (such as this one) are produced on a frequent basis and alert the senior governance structure (SMT, committees, and Trust Board) to important changes in the risk register. An in-depth (full) report is produced for the Board on a less frequent basis (three times each year) , and describes and analyses all risk movement, the risk profile, themes and risk activity.

1.4 This paper also provides a summary of the current Board Assurance Framework (BAF) and an indication of the assurance level that has been determined for each strategic risk.

2.0 Summary of current risks scoring 15 or above

2.1 There are three risks with a current score of 15 (extreme) or above on the Trust's risk register as at 7 November 2017. These are as follows:

Risk ID	Risk description	Risk score	Risk movement
Risk 906	*Reduction in funding for Neighbourhood Teams as a result of CIC retender*	16 (extreme)	
Risk 224	*Reduced level of care due to the prevalence of staff sickness in particular services and or across the Trust.*	16 (extreme)	
Risk 872	*Difficulties recruiting to and retaining staff within neighbourhood teams.*	16 (extreme)	

2.2 There are no new risks scoring 15 (extreme) or above.

2.3 There are no escalated risks now scoring 15 or above.

2.4 There is one deescalated risk, which previously scored 15 (extreme) or above:

Risk: 862	Risk title: ***Clinical capacity in Adult Speech and Swallow Team.***	Current risk score **12**	Previous risk score **15**
Risk description: Due to sickness, vacancies and difficulty in recruiting there is reduced capacity in the adult speech and swallow team, which has resulted in breaching 18 weeks and urgent two weeks waiting time. This could have an impact on patient safety and care and the organisations reputation if contractual requirements are not met. **Reason for de-escalation:** As of end of September 2017, there were 246 patients on waiting list. No urgent referrals breaching two weeks wait. Minimal annual leave booked for September 2017 so increased staffing availability. Extra hours being worked in stroke team until mid-November 2017. Clinics increased to try to offer increased number of appointments. **Action being taken to mitigate the risk:** Plan for increased staffing to allow for neighbourhood working so reduced travel time. Also new referral form launched which is anticipated to reduce triage time. Recruitment process ongoing.			

3.0 Risks scoring 12 (high)

3.1 There is one new risk scoring 12 reported since October 2017:

Risk: 918	Risk title: ***Reduced staff capacity at Hannah House***	Current risk score **12**
Risk description: As a result of very low staff capacity at Hannah House (children's respite unit) due to sickness absence, maternity leave and vacancies, there is a risk of children's stays being cancelled causing distress and dissatisfaction amongst parents, a risk of the unit operating with less beds and not meeting commissioning obligations, and a risk of remaining staff feeling pressure. The impact will be an adverse effect on staff wellbeing, reputational damage and financial loss. **Controls in place:** Successful recruitment Agency staff cover and existing staff offering additional shifts Cross-service working (extra capacity from community continuing care staff) Communication with parents Trust management is liaising with commissioners Interim manager in post and additional management support to unit Sickness absence management processes Involvement of staff regarding decisions to reduce bed numbers Involvement of freedom to speak up guardian Coaching and support for staff **Action being taken to mitigate the risk:** Additional communication with parents Expedite recruitment process for vacancies Further communiaction of improvement plan Staff time-out session to be arranged		

4.0 Risks escalated to a score of 12 (high)

4.1 No risks have been escalated to a score of 12 since October 2017.

5.0 Risks deescalated from a score of 12 (high)

5.1 Four risks have been deescalated from a score of 12 since October 2017.

Risk: 259	Risk title: ***Maintenance of children's equipment is not commissioned***	Current risk score **8**	Previous risk score **12**
Reason for de-escalation: PAT testing of equipment has taken place. Integrated Children's Equipment Working Group to meet September 2017 where this risk will be reviewed. To be discussed with Executive Director of Operations. Risk score reduced as no evidence of issues arising directly as a result of this risk since it was recorded on Datix in 2011.			
Risk: 675	Risk title: ***IAPT Access target is not being met***	Current risk score **6**	Previous risk score **12**
Reason for de-escalation: Currently testing direct access model. Working with LYPFT to receive referrals in more streamlined way. Service is researching other organisations' models as commissioners have requested this to provide clearer direction on future models. Risk score reduced as commissioners recognise that existing model needs amending.			
Risk: 865	Risk title: ***Lack of service specification in the Community Sickle Cell & Thalassaemia Service***	Current risk score **6**	Previous risk score **12**
Reason for de-escalation: Service continues to be affected by sickness absence. A small part of the service is to be decommissioned. The draft specification was sent to the commissioners and a meeting arranged for the end of September 2017. Risk has been reviewed by SMT and risk score reduced to moderate, as this is a small service and service will transfer to LTHT shortly**.**			
Risk: 905	Risk title: ***Risk of lack of child and adolescent mental health services (CAMHS) bed availability within shortened timescale following a detention of a patient in a 'place of safety'***	Current risk score **8**	Previous risk score **12**
Reason for de-escalation: A meeting has been arranged with LYPFT and LTHT to review section 136 provision. Risk score reduced as there have been very few previous occurrences of this type of situation.			

6.0 Closed risks previously scoring 12

Two risks have been closed, which previously scored 12:

Risk ID	Risk description and reason for closure
Risk 895	***Staff capacity in children's speech and language therapy (SLT) school age learning disability (SALD) service.*** Reason for closure: The SALD SLT team operates at full establishment with support of highly specialised SLTs on a bank basis to supplement staffing levels to cover the core and traded offer. Changes being made to the traded sessions for East specialist inclusive learning centres (SILCs), which will provide additional staffing in the SALD team from January 2018. SLT bank time continues to be cost neutral. Regular meetings to look at capacity and demand alongside waiting lists and staffing. SALD waiting lists continue to be prioritised.
Risk 911	***Insufficient registered nurses on Community Intermediate Care Unit (CICU) and South Leeds Independence Centre (SLIC).*** Reason for closure: New contractual arrangements for this service are in place. Staff capacity is at a reasonable level due to temporary arrangements with recruitment agency and the movement of staff from CICU to the new service.

7.0 Risks with an out of date review date

7.1 Risk owners are asked to update their risks where a review date had passed. If risks review dates remain outstanding, further reminders are sent and any risks remaining out of date by more than a month are escalated to the relevant director for intervention.

8.0 Board Assurance Framework Summary

8.1 The purpose of the Board Assurance Framework (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.

8.2 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)

8.3 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.

8.4 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.

8.5 The BAF summary (appendix 1) 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 2 (BAF risk assurance levels).

8.6 Since the last BAF report in October 2017, the current level of assurance for the following BAF risks has been adjusted as follows:

Positive assurance movement

- BAF risk 1.2 (risk of not implementing and embedding lessons from reviews and reports) has moved further into 'reasonable' as the whistle-blowing report to Quality Committee received 'substantial' assurance and reasonable assurance had been provided regarding complaints and incidents management
- BAF risk 2.4 (retain existing viable business and/or win new financially beneficial business tenders), has moved further into reasonable as the business development strategy received 'reasonable' assurance from Business Committee
- BAF risk 2.5 (risk of not delivering the agreed income and expenditure position) is moving towards 'substantial' as monthly finance reports to Business Committee (September and October 2017) received 'reasonable' assurance. The internal audit of bank and agency spend received 'reasonable' assurance and the reference costs submission internal audit received 'substantial' assurance
- BAF risk 4.1 (responding to the changes in commissioning, contracting and planning landscape (STP implementation) and scale and pace of change) is moving further into 'reasonable' because of the assurance received about the intermediate care procurement model and the growing number of formal and informal partnerships
- BAF risk 4.3 (risk of not engaging patients and the public in Trust decisions) has moved from 'limited' to the low end of 'reasonable' as the patient and public engagement paper, whilst in its early stages, provided 'reasonable' assurance. The number of responses to the friends and family test continues to provide 'limited' assurance.

Negative assurance movement

- BAF risk 2.2 (risk of not delivering contracted activity requirements). The assurance level is moving from 'reasonable' towards 'limited' as activity reports received by the Business Committee in September and October 2017 provided limited assurance

8.9 ***Escalated BAF risk scores***

8.9.1 The BAF was reviewed by SMT in detail on 11 October 2017. SMT considered each of the strategic risks in terms of key controls, gaps in controls, sources of assurance and gaps in sources of assurance and these have now been amended as required. SMT also agreed that the following BAF risk scores should be increased:

BAF risk 1.1 (relating to the assessment of quality) is now scoring 16 (was 12)
BAF risk 2.1 (achieving principal projects) is now scoring 12 (was 8)
BAF risk 2.2 (risk of not delivering contracted activity requirement) is now scoring 12 (was 6)
BAF risk 3.1 (risk of not having suitable and sufficient staff capacity) is now scoring 16 (was 12)

8.9.2 The attached BAF summary reflects the amended risk scores.

9.0 Recommendation

9.1 The Board is recommended to:

- Note the revisions to the risk register
- Note the current assurance levels provided in the revised BAF summary

Appendix One: Board Assurance Framework summary

Details of strategic risks (description, ownership, scores)								Level of Assurance					
Risk		Risk ownership		Risk score									
Corporate Objective	Risk	Responsible Director	Responsible Committee	Likelihood	Consequence	Risk Score	Risk score movement	Current Level of Assurance (denoted by ◆). No	Limited	Reasonable	Substantial	Assurance - additional Information	Assurance Movement
Ensure consistent delivery of high quality care	**RISK 1.1** If the Trust does not have effective systems and processes for assessing the quality of service delivery and compliance with regulatory standards then it may have services that are not safe or clinically effective.	MP	QC	4	4	16 (was 12)	↑			◆			
	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	↔			◆		Whistle-blowing report received 'substantial' assurance. Reasonable assurance had been provided regarding complaints and incidents management.	→
	RISK 1.3 If the Trust does not maintain and continue to improve service quality, then it may not maintain a 'Good' CQC rating and will not achieve 'Outstanding'. This will have an impact on the Trust's reputation and it will receive a greater degree of oversight and scrutiny	AT	QC	2	3	6	↔			◆			
	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	↔			◆			
Create sustainable services	**RISK 2.1** If the Trust does not achieve principal internal projects (integrated neighbourhood teams, EPR, E-rostering) then it will fail to effectively transform services and the positive impact on quality and financial benefits may not be realised.	SP	BC	3	4	12 (was 8)	↑		◆			To note: E-rostering received 'no' assurance. EPR received 'substantial' assurance hence assurance level remains the same.	
	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	4	3	12 (was 6)	↑			◆		Activity levels report received 'limited' assurance from Business Committee in September and October 2017.	←
	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	↔			◆		Business development strategy received 'reasonable' assurance.	→
	RISK 2.5 If the Trust does not deliver the income and expenditure position agreed with NHS Improvement then this will cause reputational damage and raise questions of organisational governance.	BM	BC	2	4	8	↔				◆	Monthly finance report to Business Committee (September and October 2017) received 'reasonable' assurance. Bank and agency spend internal audit received 'reasonable' assurance. Reference costs submission internal audit received 'substantial' assurance	→

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	4	4	16 (was 12)							
	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							
	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							
	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						Intermediate care procurement model and growing number of formal and informal partnerships provided reasonable assurance.	
	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							
	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						Patient and public engagement paper - Business Committee recognised it is in early stages but provided 'reasonable' assurance. Friends and family test response levels continue to provide 'limited' assurance.	
	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							

Appendix Two: 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 (72)

Trust Board public workplan 2017-18
Version 7 27 October 2017

Topic	Frequency	Lead officer	6 October 2017	1 December 2017	2 February 2018	29 March 2018	25 May 2018 (revised from 1 June 2018)	3 August 2018
Preliminary business								
Minutes of previous meeting	every meeting	CS	X	X	X	X	X	X
Action log	every meeting	CS	X	X	X	X	X	X
Committee's assurance reports	every meeting	CELs	X	X	X	X	X	X
Patient story	every meeting	EDN	X ICAN	X CAMHS	X	X	X	X
Quality and delivery								
Chief Executive's report	every meeting	CE	X	X	X	X	X	X
Performance Brief	every meeting	EDFR	X	X	X	X	X	X
Care Quality Commission inspection reports	as required	EMD	X					
Quality account	annual	EDN			X			
Staff survey	annual	DW				X		
Safe staffing report	2 x year	EDN			X			X
Seasonal resilience	annual	EDO	X CE's report	X CE's report				
Serious incidents report	4 x year	EDN	X		X	X		X
Patient experience: complaints and incidents report	2 x year	EDN		X			X	
Freedom to speak up annual report	annual	CE						X
Guardian for safe working hours report	4 x year	EMD		X	X	X		X Annual report
Strategy and planning								
Operational plan including financial plan	2 x year	EDFR	X			X		
Service strategy	as required	EDFR						
Quality strategy	annual	EDN			X			
Professional strategy	annual	EDN	X	X				
OD strategy	2 x year	DW		X			X	
Research and development strategy	annual	EMD						X
Other strategic service developments	as required	EDO		X CAMHS tier 4	X Children's strategy			
Reports								
Equality and diversity report	annual	EDN		X				
Safeguarding annual report	annual	EDN	X					
Infection prevention control annual report	annual	EDN	X					
Emergency preparedness and resilience report and major incident plan annual report	annual	EDO	X	X Major incident plan				
Governance								
Medical Director's report: doctors' revalidation	annual	EMD						X
Nurse revalidation	annual	EDN						X
Well-led framework (in CE's report)	2x year	CS		X			X	
Annual report	annual	EDFR					X	
Annual accounts	annual	EDFR					X	
Letter of representation	annual	EDFR					X	
Audit opinion	annual	EDFR					X	
Audit Committee annual report	annual	CS					X	
Standing orders/standing financial instructions review	annual	CS				X		
Annual governance statement	annual	CS				X		
Going concern statement	annual	EDFR				X		
Committee terms of reference	annual	CS					X	
Board and sub-committee effectiveness	annual	CS					X	
Register of sealings	annual	CS					X	
Declarations of interest/fit and proper persons test	annual	CS				X		
Significant risks and risk assurance report	every meeting	CS	X	X	X	X	X	X
Corporate governance update	as required	CS						
Decisions for ratification	as required	CS						
Board workplan	every meeting	CS	X	X	X	X	X	X
Minutes (for noting)								
Approved minutes of committees, Safeguarding Boards, Health and Wellbeing Board, Children's Trust Board (for noting)	every meeting	CS	X	X	X	X	X	X

Key

CE	Chief Executive
EDFR	Executive Director of Finance and Resources
EDN	Executive Director of Nursing
EDO	Executive Director of Operations
EMD	Executive Medical Director
DW	Director of Workforce
CELs	Committees' Executive Leads
CS	Company Secretary

= received
= deferred to another meeting
= not required

Leeds Community Healthcare NHS Trust

Audit Committee

Boardroom, Stockdale House, Headingley Office Park,
Victoria Road, Leeds, LS6 1PF
Friday 21 July 2017
9.00 am – 11.30 am

AGENDA ITEM 2017-18 (73a)

Present:	Jane Madeley (JM)	Chair
	Richard Gladman (RG)	Non-Executive Director
	Professor Ian Lewis (IL)	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	Local Counter Fraud Specialist (TiAA Limited)
	Gareth Robins	Counter Fraud Manager (TiAA Limited)
	Sue Ellis	Director of Workforce (for item 25c)
	Dominic Mullan	Local Security Management Specialist (for item 28c)
Apologies:	Clare Partridge	External Audit Partner (KPMG)
Minutes:	Liz Thornton	Board Administrator
Observer:	Tina Gill	Corporate Assurance Lead, NHS Digital

Item	Discussion Points	Action
2017-18 (24)	**Welcome, introductions and preliminary business** The Chair of the Committee welcomed Non-Executive Director Professor Ian Lewis (IL) to his first meeting as a new member, others in attendance and observing.	
2017-18 (24a)	**Apologies** Apologies were received from Clare Partridge, External Audit Partner (KPMG).	
2017-18 (24b)	**Declarations of interest** The Chair of the Committee and a Non-Executive Director (RG) declared an interest in agenda item 31d related to the contents of the Trust's register of gifts hospitality or sponsorship for 2016-17.	
2017-18 (24c)	**Minutes of the previous meeting 26 May 2017** The minutes of the meeting held on 26 May 2017 were reviewed and agreed as an accurate record. **Outcome:** The Committee approved the minutes of the previous meeting held on 26 May 2017.	
2017-18 (24d)	**Matters arising and actions' log** The following outstanding action was discussed and an update provided: *Item 2017-18(23): Cybersecurity incident* A copy of a presentation made to the Senior Management Team (SMT) reflecting on the lessons learnt from the cybersecurity incident that the NHS experienced on 12 May 2017 was shared with the Committee.	

	Referring to a slide which reflected on communications during and following the incident, the Chair of the Committee said that a robust system of cascading communications in the event of future incidents should be developed as soon as possible. The Executive Director of Finance and Resources advised that the Trust's Head of Communications and the Assistant Director of Business Intelligence, Systems and IT were working in partnership to draft a communication plan for approval by the SMT. The Chair of the Committee also observed that relevant future audits and cyber security test exercises should consider whether learning from the cybersecurity attack had been implemented where appropriate. She added that team based business continuity plans should be updated in light of the 'lessons learnt'. The completion of actions from previous meetings was noted and there were no further matters arising.	
2017-18 (25a)	**Internal Audit** **Summary of internal controls assurance report** The Internal Audit Manager introduced the report and advised that the first two audits for 2017-18 had been completed namely: neighbourhood teams (demand and capacity management) and board and committee effectiveness; both audits had received a reasonable assurance opinion. **Progress against the annual plan for 2017-18** The Internal Audit Manager introduced the report; particularly noting that good progress had been made on the remaining audits due for quarter one and he was confident that the audits for quarter two were on target for completion by their due date. The Committee discussed the executive summary and management action plans for the two completed audits. *Assurance review of the neighbourhood teams* The Chair of the Committee observed that the development of the demand and capacity tool was crucial to the management of demand and capacity within the neighbourhood teams, noting that roll out of revisions to the tool were scheduled for completion by the end of August 2017 and she asked for a piece work to be undertaken in quarter 2 to gauge its impact. A further report should be brought to the Committee in December 2017. **Action:** A further audit to be undertaken in quarter 4 of 2017/18 to assess the impact of the implementation of the demand and capacity toolkit in the neighbourhood teams. *Board and committees effectiveness* The audit field work had included attendance at committees and discussions with committees' chairs. It was noted that an erroneous date in the report required amendment. **Action:** An erroneous date under recommendation two in the finalised report in appendix B to be amended.	**Internal Audit Manager** **Internal Audit Manager**

	The Chair of the Committee asked about the scheduling of the reporting of internal audit reports and whether the appropriate sub committees of the Trust Board had been sighted on the recently completed audits prior to discussion at Audit Committee. 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 would be seen by the Audit Committee prior to scrutiny by the Business or Quality Committees.	
2017-18 (25b)	**Outcome:** The Committee noted the contents of the summary internal controls assurance report, including progress on the internal audit plan for 2017-18. **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 30 June 2017 and the more detailed report on the outstanding actions. He advised that SMT was using the TiAA tracker to review progress against the recommendations. He noted that there were seven recommendations to report this month that had not been completed by the due date. **Action:** It was agreed that the recommendations related to stakeholder engagement systems and the contract bid process needed to be revised.	**Executive Director of Finance and Resources**
2017-18 (25c)	**Outcome:** The internal audit actions update report was received and progress against the internal audit recommendations noted. **Internal audit follow-up: statutory and mandatory training** The Director of Workforce presented a follow up report on an audit completed as part of the 2016-17 internal audit plan. She reminded the Committee that the audit had covered statutory and mandatory training and had received a limited assurance opinion. The Director of Workforce advised that all the urgent recommendations had been addressed, including: access to e-learning modules through the electronic staff record (ESR); the reporting of compliance by training topic; and the expansion of the role of subject matter experts. She explained that future performance against the compliance target would be included in the workforce reports to the Business Committee. A Non-Executive Director (IL) asked about the training topics which comprised the statutory and mandatory training indicator and particularly whether safeguarding was included. The Director of Workforce explained that there were six 'universal' topics whereby training was essential for all staff and a further tranche of topics (including safeguarding) that were requirements for staff in certain staff groups. She added that information about compliance with safeguarding training was reported and discussed in a number of ways. Compliance figures were incorporated into the quarterly workforce report to Business Committee and the Safeguarding Committee considered training compliance in detail and this was reported in minutes to Quality Committee. The Chair of the Committee noted that e-learning access to fire training remained a problem and asked what steps were being taken to find a solution.	

	The Director of Workforce advised that face to face fire training continued to be offered and a suitable e-learning package had been identified and would be made available through ESR as quickly as possible. The Chair of the Committee also asked whether essential fire checks had been completed on the Trust's estate following the Grenfell Tower incident. The Executive Director of Finance and Resources advised that action had been taken within the Trust to complete essential fire safety checks on the Trust's buildings and a process of ongoing inspection was in place. **Outcome:** The Committee received and noted the update report.	
2017-18 (26a) **2017-18 (26b)**	**External audit** **Annual audit letter** The External Audit Manager presented KPMG's annual audit letter for 2016-17. It stated that the auditors' had issued an unqualified opinion on the Trust's 2016-17 financial statements and concluded that there were no matters arising from KPMG's 2016-17 audit work. **Action:** The annual audit letter for 2016-17 to be placed on the Trust's website along with the Trust's annual report and accounts for 2016/17. **Outcome:** The Committee noted receipt of the annual audit letter 2016-17. **External audit technical update** The External Audit Manager presented the technical update paper. **Outcome:** The Committee received and noted the update.	**Board Administrator**
2017-18 (27a-c)	**Charitable funds accounts** **Annual report and accounts 2016-17** **Letter of representation** **ISA260 external audit opinion** The Executive Director of Finance and Resources introduced the annual report and accounts for 2016-17 prepared in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) and the Charities Act 2011 and UK generally accepted practice as it applies from 1 January 2015. He reminded the Committee that the aim of the charity is to raise funds and attract donations that can be used to benefit community health care services. He confirmed that the legal duty to ensure that funds are spent in accordance with the objectives of the fund had been met. Levels of income and expenditure remained low. It was noted that the accounts had been audited. The External Audit Manager explained that the ISA 260 report gave audit highlights and gave an unqualified audit opinion on the financial statements. In reply to the Chair of the Committee, the Executive Director of Finance and Resources confirmed that the necessary declarations were sought from the charity's trustees in relation to disclosure of information. The letter of representation from the Trust to the external auditors was noted.	

	Outcome: The annual report and accounts for the Trust's charitable funds for 2016-17 were received and approved with a recommendation to the Charitable Funds Committee to adopt the accounts at its meeting on 22 September 2017 (subsequently re-arranged to 19 October 2017).	
2017-18 (28a)	**Counter fraud and security management** **Counter fraud annual report 2016-17** The Local Counter Fraud Specialist (LCFS) introduced the annual report for 2016-17; the report included an analysis of counter fraud activity for the year. The Committee discussed the report. Referring to the section on raising staff awareness of fraud in the workplace the Chair of the Committee expressed concern about the low response rate to the online staff survey which she said gave the Committee limited assurance. She asked the LCFS to consider what additional measures could be introduced to raise the profile of fraud in the workplace across all staff groups. **Action:** The LCFS to consider options for raising fraud awareness across all staff groups and provide an update report in October 2017. **Outcome:** The counter fraud annual report for 2016-17 was received and its contents noted.	**Local Counter Fraud Specialist**
2017-18 28(b)	**Quality assessment against NHS Protect standards** The LCFS introduced NHS Protect's focused quality assessment of compliance against NHS Protect's standards for NHS Provider organisations. He reported that the Trust had been identified by NHS Protect as being non-compliant and rated as 'red' related to the 'hold to account' standards. This covered aspects including: implementation and publication of anti-fraud, bribery and corruption policy; full use of the national fraud, bribery and corruption reporting tool; use of the national toolkit to support investigations and reporting timescales; and application of appropriate sanctions. The Chair of the Committee noted that the self-review tool for the Trust had been submitted to NHS Protect in March 2017 with an overall assessment of 'green' including the assessment related to the 'hold to account' standards. The Committee discussed the subsequent 'red' rating related to the 'hold to account standards' following the NHS Protect inspection on 12 June 2017 to which the Trust was required to provide a response by the 7 August 2017. The Committee asked for a further report in October 2017. The paper would serve to: • show self-assessment against all four standards • provide evidence to support self-assessment across all four standards • provide a progress report against the actions to address those areas rated as 'red' by NHS Protect (in the 'hold to account' standard) **Action:** The LCFS to provide a detailed report on the self-assessment of compliance against the four standards and a progress report and current action plan. **Outcome:** The Committee received and noted the report.	**Local Counter Fraud Specialist**

2017-18 (28c)	**Security management annual report 2016-17** The Local Security Management Specialist joined the meeting to present the annual report for 2016-17. He referred to activity and achievements during 2016-17 as set out in the report. The Chair of the Committee noted the thematic analysis of security-related incidents for the year and in particular the significant increase in the number of security incidents reported during 2016-17. The Local Security Management Specialist said he believed that the increase was a result of improvements in reporting procedures and an increased awareness amongst staff about the importance of reporting incidents. The Committee asked about how the resolution of incidents and outcomes from investigations were shared with staff. The Executive Director of Finance and Resources advised that individual members of staff were routinely notified in person about the resolution of incidents. He agreed to consider how information relating to the resolution of incidents, outcomes and learning from investigations could be shared more widely with all staff where appropriate. **Action:** Consideration to be given on how information relating to the resolution of incidents, outcomes and learning from investigations could be shared more widely with all staff where appropriate. **Outcome:** The Committee received and noted the annual security management report for 2016-17.	**Executive Director of Finance and Resources**
2017-18 (29a)	**Information governance update** The Executive Director of Finance and Resources presented the report which contained information about the status of serious information governance incidents reported to the Information Commissioners Office (ICO) between December 2016 and June 2017. He advised that two new incidents had been reported as meeting the threshold for external reporting under current requirements. One incident had been closed requiring no further action. The other incident remained under investigation by the ICO and could result in enforcement action or a fine. The Committee noted that new guidance following the commencement of the General Data Protection Regulations EU Directive in May 2018 was to be published. The Committee also noted that the Trust would need to ensure that the implications were thoroughly considered and necessary changes made to reflect the new arrangements. **Action:** An update on General Data Protection Regulations would be provided to the Committee with the information governance report in December 2017. **Outcome:** The report on reportable incidents was received and the contents noted.	**Executive Director of Finance and Resources**

2017-18 (29b)	**Cybersecurity exercise** The Executive Director of Finance and Resources introduced the debrief report from a cybersecurity emergency planning exercise which had been run in the neighbourhood teams during June and July 2017. He said that overall the teams had felt confident that they would be able to maintain essential service delivery but consideration needed to be given to the time required to recover from the impact of an incident and the time to return to full service delivery. The Chair of the Committee said it was important that the learning from the exercise was shared with other teams to ensure that all team level business continuity plans were updated and remained fit for purpose. She also observed that as the Trust moved towards more electronic based systems to manage the day-to-day delivery of services it would be sensible for the Trust to repeat this type of exercise regularly and test the resilience of the system. The Executive Director of Finance and Resources reported that the SMT would continue to test periodically the business continuity plans. **Outcome:** The Committee received and noted the report.	
2017-18 (30a)	**Governance** **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 February 2017 and the responsibilities and 'flow' of Business through SMT, sub-committees and the Board. The BAF 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 key points made were: • Risk 1.1: Gaps in control - actions in relation to use of quality boards to be more directive • Risk 1.2: Gaps in control - completion dates for actions to be reviewed particularly those due for completion in December 2017 and March 2018 • Risk 1.4: Gaps in control - actions and processes in place to evidence progress to be further considered • Risk 2.1: Risk score - to be reviewed in the light of current progress with projects • Risk 2.1: Gaps in control - lack of clarity of project plans felt to be a gap • Risk 2.3: Gaps in controls - completion dates for actions to be reviewed particularly those due for completion in March 2018 • Risk 2.4: Risk score – target score to be reviewed • Risk 3.2: Gaps in control - more narrative on progress required and whether sufficient controls are in place to be reviewed • Risk 3.4: Gaps in control: *'Talent management approach requires development'* completion date of March 2019 to be reviewed • Risk 4.1: Gaps in sources of assurance – robustness of assurances to be reviewed The Committee encouraged further work to be done to ensure that adequate controls were in place particularly where strategic risks were significant and assurance was limited.	

	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. Risk owners (executive leads) to be advised of the comments made by the Committee. **Action:** The Company Secretary to ensure that the BAF is updated in response to the Committee's comments. **Outcome:** The latest draft of the BAF was reviewed and noted.	
2017-18 (30b)	**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 February 2017. 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, including: improvements to the Trust's electronic risk management system (Datix), support to complete extensive risk assessments for specific aspects of various services and bespoke training (by team, service or location). The recent developments were noted particularly the developments to strengthen the risk management process. **Outcome:** The Committee received and noted the report.	
2017-18 (31a) **2017-18 (31b)**	**Financial controls** **Reference costs submission process 2016-17** The Executive Director of Finance and Resources introduced the report. He advised that the report provided the Committee with assurance that the national guidance was being followed for the collection and processing of reference cost data. He reminded members that the reference costing process was an annual mandatory return required by the Department of Health for all NHS trusts. Referring to the confirmations required of the Committee, the Chair asked that paragraph 6.1(b) be amended to read: *'to the best of our knowledge the information, data and systems underpinning the reference cost return is reliable and accurate.'* **Outcome:** Subject to the above amendment the report was received and noted and the Committee was content to sign off compliance with the guidance. **Tender and quotations waiver report** The Executive Director of Finance and Resources introduced the report. He advised that the report presented an extract from the 2017-18 register of waivers that had been completed during the financial year. He noted that there had been eight waivers since the beginning of April 2017: the report contained details of the supplier, the rationale for the waiver and the processes within the Trust. The Chair of the Committee asked whether the Official Journal of the European Union (OJEU) rules on procurement should apply to the £210,000 waiver for delivery of nursing support in residential care homes. **Action:** The Executive Director of Finance and Resources agreed to provide clarification following the meeting.	**Executive Director of Finance and Resources**

	The Chair of the Committee asked whether the Trust kept a list of declined tender waivers. **Action:** The Executive Director of Finance and Resources agreed to share a copy of the declined waiver register with members following the meeting as appropriate. **Outcome:** The Committee received the report and the content was noted.	**Executive Director of Finance and Resources**
2017-18 (31c)	**Losses, compensation and special payments report** The report and register were presented by the Executive Director of Finance and Resources. The report covered payments made for the period April 2017 to June 2017, containing three items as bookkeeping losses. Referring to the bookkeeping losses the Chair of the Committee asked for more information on item number 2018-3 for £1,500 which related to the re-imbursement of costs incurred for caring for a patient at home. The Executive Director of Finance and Resources explained that the payment had reimbursed a patient who had purchased a bed in advance of the bed being provided by the Trust. **Outcome:** The losses, compensation and special payments report containing three payments was received by the Committee.	
2017-18 (31d)	**Register of gifts, hospitality and sponsorship** The Company Secretary presented the report which contained eight items. The Chair of the Committee observed that the number of items on the register was always low and suggested that staff should be reminded about the policy on registering gifts and hospitality. A Non-Executive Director (IL) thought it might be also be helpful to include a reference to the professional codes of conduct if the Executive Medical Director and Executive Director of Nursing thought it appropriate. The Company Secretary indicated that gifts and hospitality were to be included in a revised conflicts of interest policy and said it would be timely to remind staff about the gifts and hospitality policy and any responsibilities they have under the various professional codes of conduct when the new document was launched. **Action:** The Company Secretary to remind staff about the gifts and hospitality policy and the related responsibilities after the launch of the new conflicts of interest policy. **Outcome:** The report on gifts, hospitality and sponsorship was received and noted.	**Company Secretary**
2017-18 (32)	**Charitable funds: audit arrangements** The Executive Director of Finance and Resources introduced the paper. He explained that since the Audit Commission had been disestablished all NHS trusts had become responsible for appointing its external audit function. The Trust had appointed KPMG as its external auditor for 2017-18 but they had indicated that it may not be the most cost effective solution for them to continue this work in future given the low value of the Chartable Funds annual income. The Committee considered the range of external scrutiny options with a view to minimising the cost.	

	Referring to the financial limits for audit and 'independent examination' quoted in the paper, the Chair of the Committee asked for more clarity on the precise requirements under the Charities Act. **Action:** The Executive Director of Finance and Resources to clarify the financial requirements under the Charities Act. **Outcome:** Subject to the clarification requested above the Committee approved that option of an independent examination of the 2017/18 Charitable Funds accounts to recommend to the Charitable Funds Committee.	**Executive Director of Finance and Resources**
2017-18 (33)	**Minutes for noting** The draft minutes of the Information Governance Group meeting held on 20 June 2017 were received and noted.	
2017-18 (34)	**Audit Committee work plan** There were no matters removed from or changes made to the work plan.	
2017-18 (35)	**Matters for the Board and other committees** The Chair of the Committee noted the following items to referred to Board colleagues: • Progress on internal audits • Charitable funds: annual report and accounts 2016-17 • Counter fraud • Security management • Information governance update • Risk management and Board assurance framework	
2017-18 (36)	**Any other business** There were no matters of any other business raised.	
	Date and time of next meeting Friday 13 October 2017 9.00 am – 11.30 am, Boardroom, Stockdale House, Leeds LS6 1PF	

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2017-18 (73b)

Quality Committee
Monday 25 September 2017
Boardroom, Stockdale House, Leeds
09:30 – 12:30

Present	Dr Tony Dearden	Committee Chair / Non-Executive Director
	Thea Stein	Chief Executive (joined at 10:15)
	Professor Ian Lewis	Non-Executive Director
	Marcia Perry	Executive Director of Nursing
In Attendance	Sam Prince	Executive Director of Operations
	Vanessa Manning	Company Secretary
	Karen Worton	Clinical Lead for Children's Services
	Vanessa Hunt	Professional Lead for Allied Health Professionals (AHP) and Head of Patient Experience
	Carolyn Nelson	Head of Medicines Management
	Rebecca Le-Hair	Clinical Governance Manager
	Gill Armstrong	Quality Lead Adult Business Unit *deputising for Caroline McNamara*
	Sue Lawrenson	Pathway Lead for Dietetics *deputising for Elaine Goodwin*
	Sarah Hellewell	Service Manager ICAN (Item 35)
	Sue Ellis	Director of Workforce (Item 36e)
Minutes	Nicola Wood	PA to Executive Director of Nursing
Apologies	Neil Franklin	Trust Chair
	Dr Amanda Thomas	Executive Medical Director
	Stephanie Lawrence	Deputy Director of Nursing
	Elaine Goodwin	Clinical Lead for Specialist Services
	Caroline McNamara	Clinical Lead for Adult Services

Item no	Discussion item	Actions
Welcome and introductions		
2017-18 (34a)	**Welcome and Apologies** The Chair opened the meeting. Apologies were noted from Neil Franklin, Dr Amanda Thomas, Stephanie Lawrence, Caroline McNamara and Elaine Goodwin.	
2017-18 (34b)	**Declarations of Interest** There were no declarations of interest received.	
2017-18 (34c)	**Minutes of meeting held on 24 August 2017** The minutes were reviewed for accuracy and agreed as a true record of the meeting.	
2017-18 (34d)	**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: 2016-17 (74) Service Spotlight: Dietetics The Pathway Lead for Dietetics provided an update on the recruitment issues and suitability of the structure of the service following the service spotlight presentation to the Committee in February 2017. *Action closed.* 2016-17 (83ii) Director of Nursing quality and safety report The Clinical Governance Manager stated that the Quality Lead for Specialist Services would provide the full report on Duty of Candour at the October 2017 meeting. *Action log to be amended.* 2017-18 (28a) Director of Nursing quality and safety report The Executive Director of Nursing provided an update on the podiatry service deep dive that was discussed at Quality Committee in July 2017, and provided assurance to the Committee that there were no significant levels of concern. Executive Director of Nursing to feedback findings to the Trust Chair. *Action closed.* 2017-18 (30a) Board members service visits The Clinical Lead for Children's Services confirmed that the response was sent to Non-executive Director (BC) on 11 September 2017. *Action closed.*	
Service spotlight		
2017-18 (35)	The Executive Director of Nursing welcomed Sarah Hellewell, Service Manager for the Integrated Children's Additional Needs (ICAN) Service to the meeting. The Service Manager provided an overview of the presentation and provided an outline of the service. The ICAN service is delivered from three bases across the city; St Georges Centre in the South, Wortley Beck in the West and St James' Hospital in the East. There are a variety of clinics to meet the needs of children with complex and additional needs; these are paediatric neurodisability clinics, community paediatric clinics, physiotherapy, occupational therapy and the community disability team for under-fives. The Service Manager highlighted what was going well in the service, this included the success of the rapid access clinics, with children being seen within two weeks; above average returns of the Friends and Family Test, with a 97-100% recommendation rate; and successful hub meetings where staff were sharing and learning from incidents. The Service Manager also highlighted what was not going so well in the service; this included difficulties in covering the child protection rota due to capacity within the medical team. The Executive Director of Operations highlighted that the unplanned sickness absence experienced recently within the service was unprecedented and was due to a series of extraordinary events. The majority of sickness absence reported was long term. Short term sickness within the team was generally below the Trust's target. Locums had been successfully attained to support the medical team during this period. Non-executive Director (IL) raised a query around the individual pathways available to children and families and how they are accessed. The Service Manager advised that there was one referral into the service; which was	

	clinically triaged to determine where the child would be referred to within the service. The Service Manager highlighted that a lot of work was underway to integrate services, identify pathways and assist in the transition between agencies. The Service Manager suggested a visit to one of the ICAN hubs would be helpful in understanding how the service operates. Non-executive Director (IL) welcomed this proposal. The Executive Director of Operations agreed to facilitate arrangements. **Action: A service visit to one of the ICAN hubs to be arranged for Non-executive Director (IL)** The Committee Chair asked if there was a vision for the ICAN service and a strategy to achieve the vision. The Service Manager responded that the vision was for children with complex needs and disabilities to have all their needs met in one place, where appropriate. The Service Manager assured the Committee that staff were behind the vision. The Service Manager added that there was medical representation on all pathways and ongoing work, and they were fully embedded in contributing to hub management meetings. The Executive Director of Nursing stated that the strategy for nursing aimed to maximise the capacity and potential of the workforce. The Clinical Lead for Children's Services advised that there had recently been a valuable visit to Greater Manchester and Oldham Community Trusts to look at their nursing strategy and how this is rolled out in the multi-disciplinary team. The Service Manager highlighted the positive feedback that had been received from families accessing the service at St Georges Centre through one telephone number rather than individual numbers for each service. The Committee Chair asked when an upturn in waiting list and sickness absence performance measures would be seen. The Service Manager responded that some challenge would remain for the foreseeable future with regards to the medical clinics; however, this position would improve once the nursing strategy was embedded. The Executive Director of Operations agreed to report a trajectory of improvement at the October 2017 meeting. **Action: The Executive Director of Operations to report a trajectory of improvement at the October 2017 meeting.**	**Company Secretary** **Executive Director of Operations**
Quality governance		
2017-18 (36a)	**Director of nursing and quality governance report** The Executive Director of Nursing presented the full quarterly report and highlighted the following as the main areas of focus within the performance brief and director of nursing and quality governance report: • An initial early report on the new frailty unit • Update on children's services • Update on neighbourhood teams • Updated SEND action plans	

Update on Neighbourhood Teams

Clinical supervision

Positive progress had been made regarding clinical supervision rates. There remained some inconsistency across the teams, with the highest level at 95% and the lowest at 62%. Processes to record the sessions had been reviewed and good practice shared.

Safe staffing

Safe staffing remained a challenge in neighbourhood teams. There were a number of ongoing actions including: increasing the number of non-registered staff in order to meet capacity, new pharmacy technician roles managing patients' medication requirements more effectively and additional clinical posts to progress the clinical staff competency sign off process.

The first cohort of newly appointed Band 5 staff had commenced their preceptorship and early positive feedback had been received.

Training

The Executive Director of Nursing provided a brief update on the progress of the skills and competencies of non-registered Band 3 and Band 5 clinical staff.

Activity

The Committee Chair queried why there had been an increase in unallocated visits when there had been a reported reduction in staff vacancies and activity. The Executive Director of Nursing responded that although August 2017 had been a challenging month due to staffing issues, there was assurance that the visits moved had been carried out in a safer and more managed way. The Executive Director of Nursing added that the performance team was assisting in collating data from the last six months, to further analyse activity, unallocated work and the identification of possible trends.

Non-executive Director (IL) suggested that a denominator would be helpful when analysing moved or cancelled visits.

Patient Safety and Experience Governance Group

The Executive Director of Nursing thanked the Patient Safety and Experience Governance Group (PSEGG) for their work on the revised terms of reference and workplan.

The Committee Chair raised a query regarding the reporting flow chart. The Clinical Governance Manager clarified that some reports would go to Trust Board via Quality Committee and some would go direct in order to avoid any unnecessary duplication.

Outcome: The Committee approved the PSEGG terms of reference and workplan.

Overdue incidents

The Executive Director of Nursing highlighted that a focus on reporting remained and the Trust continued to be a high reporter of incidents.

Pressure ulcers

Work to deliver the pressure ulcer improvement plan continued. There was some concern regarding the re-emergence of past themes in the management of avoidable pressure ulcers. The first avoidable category four pressure ulcer had been reported this month and there had been an increase in category three

	pressure ulcers reported. The Executive Director of Nursing advised the Committee that there would be a three month focus on avoidable harm; October 2017 would focus on falls, November 2017 on pressure ulcers and December 2017 on medication incidents. The Chief Executive asked if there was a specific reason why former patterns were re-emerging. The Executive Director of Nursing advised that a recent change in the leadership team had left a gap in a previously high performing team. The Committee were assured that this was not due to the staffing issues experienced in August 2017. The Committee Chair queried what was meant by 'a comprehensive action plan is in place to address the areas of substandard practice' stated in the Clinical Lead's quality report. The Executive Director of Nursing responded that a satisfactory explanation had not been identified and that an action plan had been put in place. Non-executive Director (IL) queried why the Trust did not present the reported incidents as a ratio chart. The Executive Director of Nursing welcomed the suggestion. The Clinical Governance Manager asked the Committee to note that the detailed data was now scrutinised in PSEGG. **Action: Consideration to be given as to the use of ratio charts in relation to serious incidents.** **Medication focus** The Executive Director of Nursing highlighted that five neighbourhood teams had not reported any incidents involving insulin administration errors during the period. **Friends and Family Test** It was noted that no data had been reported for Little Woodhouse Hall. The Executive Director of Nursing agreed to discuss with the Clinical Lead for Children's Services. **Action: Executive Director of Nursing to look into absence of data from Little Woodhouse Hall with Clinical Lead for Children's Services.** **Clinical Leads' quality reports** A summary of the reports appended to the Director of Nursing and quality governance report was provided by each business unit representative. *Adults Services* The Executive Director of Nursing highlighted the following areas to the Committee*:* • Focus remained on supporting Band 6 leaders in neighbourhood teams, with the third clinical Band 6 leadership training course scheduled for October 2017. • A winter pressure preparation workshop was held in September 2017 for the full leadership team and community matrons. • Immunisation and vaccination training was being delivered across neighbourhood teams to ensure there are adequate numbers of trained staff to deliver the flu vaccine. Therapists will be included in the programme, by delivering flu vaccinations when providing therapy to patients. • Good progress was being made with the development of the wound care framework to standardise delivery of care and reduce variation across the neighbourhood teams.	**Executive Director of nursing** **Executive Director of nursing**

	Children's Services: The Clinical Lead for Children's Services highlighted the following areas to the Committee: • There had been successful recruitment into the school nursing service. • The school immunisation team remain on track to achieve their targets. • Concerns around activity in child and adolescent mental health services remained. • Concerns about catering in Little Woodhouse Hall were being addressed with the provider. • There had been a reduction in the speech and language therapy waiting list over the summer months. • There had been a focus on the quality improvement plan following the CQC report. *Specialist Services* The Pathway Lead for Dietetics highlighted the following areas to the Committee: • The Trust had been successful in the bid for the respiratory virtual ward from spring budget monies. • The healthy living service would transfer to a new provider on 30 September 2017. The Committee was asked to note the level of quality care that had been delivered over the decommissioning period. • The dietetics service was now receiving outcome measure data. This enabled the service to compare the outcomes of those patients' completing their treatment with those who do not. • There were concerns over staffing in community neurological rehabilitation service due to a number of pending maternity leaves over the coming months. There may be scope to backfill with staff in the wider organisation. • Activity does not match the profile for the redesigned early stroke discharge service. The Trust was working with commissioners to resolve this issue. • There had been an issue with staff in the sexual health service accessing training from other bases. This had been escalated to the LTHT IT department and an action plan was in development. • Staff shortages and waiting list breaches were a concern in the speech and swallowing team. The Clinical Lead for Specialist Services was working with the team to review processes and look at new ways of working. The Chief Executive requested clarity on the issues being experienced in the speech and swallowing team around staffing. The Executive Director of Operations confirmed that there were currently three vacancies within the service. The Executive Director of Nursing highlighted that it had been difficult to recruit to this small highly specialised service. The Executive Director of Nursing added that a greater number of more complex patients needed to be seen in a shorter timescale, which was further impacting the service. The Executive Director of Nursing agreed to look at this in more depth with the Chief Executive. **Action: Executive Director of Nursing to look at the staffing issues experienced in the speech and swallowing team in more depth with the Chief Executive.** The Chief Executive queried the clinical quality consequences of the 13 patients who had breached the two weeks urgent waiting time. The Executive Director of Operations informed the Committee that assurance of no harm had been received in July 2017.	**Executive Director of Nursing**

	Outcome: The Committee: • Noted the contents of the report • Approved the PSEGG terms of reference and work plan • Agreed **reasonable assurance** had been provided regarding pressure ulcers • Agreed **reasonable assurance** had been provided regarding duty of candour • Agreed **reasonable assurance** had been provided regarding friends and family test • Agreed **reasonable assurance** had been provided regarding complaints and incidents management	
2017-18 (36b)	**Performance brief and domain reports** The Committee reviewed the document and focused on the safe, caring, responsive and well led domains. *Safe* The Executive Director of Nursing highlighted to the Committee that the Trust had achieved all but one of its targets within the safe domain for the year to date. The exception was one avoidable category four pressure ulcer in August 2017, resulting in a red rating. *Caring* All measures in the caring domain were rated green. *Responsive* The Trust was 10% below its activity profile for August 2017. The Committee Chair noted that the responsive domain was primarily reviewed by the Business Committee and asked if there were any quality concerns. The Executive Director of Operations advised that there was an ongoing piece of work analysing activity numbers to explore the extent of reduction. *Well Led* Sickness absence rates had fallen in August 2017 and had returned to a green rating. The Committee Chair asked for confirmation that the recent staffing levels experienced in South Leeds Independence Centre, due to sickness absence, had improved to enable the delivery of safe and complete care. The Executive Director of Nursing responded by providing a brief update on the position regarding community intermediate care beds following the recent tender. Ward J31 at St James' Hospital would close on 31 October 2017 and there was a decommissioning plan in place, and a consultation with staff. Although safe staffing remained a challenge, the service had now ceased taking new referrals. The old model at South Leeds Independence Centre will close on 31 October 2017 and the new model will be mobilised on 1 November 2017. Recruitment to the new model was underway. The Committee Chair asked for clarification that the service would not close early for reasons of safety. The Executive Director of Nursing provided assurance that the service would close on 31 October 2017 as planned. There was a discussion around the effectiveness of the heat maps. The Executive Director of Operations stated that the 12 indicators were not 'smart' for each service and lacked granular detail. The Executive Director of Nursing was conducting some broader analysis, looking at how issues relating to small services and isolated workers can be picked up through the heat map.	

	Outcome: The Committee: • Noted present levels of performance	
2017-18 (36c)	**Care Quality Commission (CQC) inspection report** The Executive Director of Nursing presented the report for discussion. The report provided an overview of the CQC inspection findings following the announced inspection of the Trust on 31 January – 2 February 2017, and a progress report on the development and delivery of the organisational response. The Executive Director of Nursing advised the Committee that the CQC had proposed a meeting on 12 October 2017 with members of the Trust and representatives from commissioners to discuss the inspection report findings. The Trust was required to submit the written report of actions to the CQC by 30 October 2017. The Executive Director of Nursing confirmed that the quality improvement plan was being refined and finalised. This would be presented to Quality Committee in October 2017 ahead of final submission. The Committee Chair emphasised that the Trust now required a plan to achieve 'good' across all areas of the Trust. **Outcome:** The Committee: • Received the information with regard to the CQC inspection and ratings published on 29 August 2017 • Approved the proposed monitoring and reporting arrangements through the Senior Management Team and Quality Committee to Board • Agreed the proposal for consideration of the new key lines of enquiry. Three of these domains will be assigned to Quality Committee and the remaining two to the Business Committee • Agreed **reasonable assurance** had been provided by the report	
2017-18 (36d)	**Risk register: operational and clinical risks** The Company Secretary presented an in depth report which outlined risk movement since the last report in July 2017. The Committee agreed that the escalated risk ID862 *clinical capacity in adult speech and swallowing team* had been covered in earlier discussions. The Chief Executive queried why increased waiting times had been experienced in the child and adolescent mental health services when there had been a reduction in referrals received. The Executive Director of Operations assured the Committee that the management team had a plan in place to rectify this position. The Executive Director of Operations advised the Committee that risk ID906 *reduction in funding for neighbourhood teams as a result of community intermediate care beds retender* had been de-escalated following confirmation from commissioners that funding would be maintained during the financial year 2017/18. The risk has not been removed as funding had not been secured beyond 2018.	

	The Committee noted risk ID911 *insufficient registered nurses on Community Intermediate Care Unit and South Leeds Independence Centre* would be closed on 31 October 2017. The Executive Director of Operations agreed to reinforce the importance of updating overdue risks with individual team leads following a request from the Company Secretary. **Action: The Executive Director of Operations agreed to reinforce the importance of updating overdue risks with individual team leads.** **Outcome:** The Committee: • Noted the contents of the risk register	**Executive Director of Nursing**
2017-18 (36e)	**Whistleblowing report** The Director of Workforce presented the report and highlighted key areas. The Committee Chair requested that he be made aware of any ongoing whistleblowing reports prior to them being presented at Quality Committee. The Director of Workforce informed the Committee that the whistleblower had received the findings following the investigation which had partially upheld some of the concerns. There had been an initial meeting with the Specialist Business Unit and it was felt that a change to the staffing rota was not required when balanced against other risks. This was supported by The Executive Medical Director and Executive Director of Operations. In response to a query from Non-executive Director (IL), the Director of Workforce confirmed that there were no triggering incidents for the enquiry and the whistleblower was a participant on the rota. Non-executive Director (IL) raised a concern that information in the report may have identified the whistleblower. The Director of Workforce noted the concern and said that anonymity in reports would be maintained. The Committee was substantially assured that the matter had been thoroughly investigated in line with the Trust's policy. It was agreed the final decision was operational. **Outcome:** The Committee: • Noted the report • Agreed **substantial assurance** has been provided from the investigation	
Clinical Effectiveness		
2017-18 (37a)	**Outcome measures** The Executive Director of Nursing presented the report and provided an overview of the history of reporting outcome measures as a Trust. A recent pilot project led by the Head of Business Intelligence and the Clinical Leads' from the three business units looked at current outcome measures and propositions for further implementation across multiple services.	

	The Senior Management Team meeting had agreed that a project manager would be appointed to drive this work forward and predominantly continue to develop the use of Therapy Outcome Measures (TOMs) and EQ-5D-DL across a portfolio of services. The Committee noted the priority areas for 2017/18. Five services had been identified by the CCG, for which they sought progress with reporting on clinical outcome measures. These services are: ICAN, musculo-skeletal services, neighbourhood teams, podiatry and cardiac services. Non-executive Director (IL) welcomed the focus on outcome measures and asked how patient centred outcome measures fitted into the Trust's framework, and where this featured in the context of the national outcomes framework. The Executive Director of Nursing responded that benchmarking was ongoing and agreed to provide a comparison update at the January 2018 meeting. **Action: The Executive Medical Director to provide an update on comparison at January 2018 meeting.** The Executive Director of Operations commented that ideally the Trust would be commissioned on outcomes rather than activity. The Chief Executive responded to a query from the Committee Chair that this was an ongoing programme and there was no agreed timeline at this stage. **Outcome:** The Committee: • Noted progress to date • Agreed **reasonable assurance** had been provided	**Executive Medical Director**
2017-18 (37b)	**Patient group directions (PGDs)** The Executive Director of Nursing confirmed that all PGDs had been through the correct processes and recommended all for ratification. **Outcome:** The Committee ratified the five approved PGDs: • 060-08 Patient Group Direction for administration of Diphtheria (low dose), Tetanus and Inactivated Polio Vaccine (adsorbed) (Td/IPV) • 024-10 Patient Group Direction for administration or supply of Progestogen Only EC • 104-05 Patient Group Direction for administration or supply of Ulipristal • 112-02 Patient Group Direction for administration or supply of Metronidazole • 113-02 Patient Group Direction for administration of Ceftriaxone in Lidocaine	
Reports for approval		
2017-18 (38a)	**Safeguarding annual report 2016/17** The Executive Director of Nursing presented the report and commended the team for their hard work. The Executive Director of Nursing highlighted that there had been a percentage increase in the target to attend PREVENT training. The Committee Chair requested clarification on the Wood Review. The Executive Director of Nursing advised that this was the national review into the safeguarding boards. The Trust was working through the implications for Leeds with the Leeds Safeguarding Adults Board and Leeds Safeguarding Children's Board.	

	Outcome: The Committee: • Recommended the report for approval by the Trust Board	
2017-18 (38b)	**Infection prevention and control annual report 2016/17** The Executive Director of Nursing presented the report and commended the team for their hard work. Training remained the key focus and the Executive Director of Nursing indicated that the team was happy to deliver group training where appropriate. The Executive Director of Nursing informed the Committee that the launch of the flu vaccination was on 29 September 2017, with a target of 75% of staff to be vaccinated. The Trust was the highest performing community trust in 2016/17. **Outcome:** The Committee: • Recommended the report for approval by the Trust Board	
2017-18 (38c)	**Sub-groups: review of effectiveness and internal audit committee effectiveness report** The Company Secretary presented the report and highlighted key themes. The Committee noted the key areas for development in the effectiveness of Quality Committee sub-groups as follows: clarity of functions, clarity of membership and consistency of attendance, widest participation of members, consistency of decision making, recording and following up on actions and improved administration. The Committee Chair asked if the results had been fed back to the sub-groups. The Company Secretary agreed to work with the chair of each sub-group to agree pertinent actions for the group to take forward. **Action: Improvement actions to be agreed with chairs of sub-groups** The Committee Chair raised a query about the relationship of each sub-group with the Quality Committee and how information was fed up and fed down. The Company Secretary advised that this was episodic with stand-alone papers or minutes presented for consideration. The Clinical Governance Manager advised the Committee that recent changes to the PSEGG meeting had enabled productive discussions and assisted in the production of this month's Director of Nursing Report. The key themes from the internal audit committee review of effectiveness report were; regular attendance, topicality of key issues and the regularity of reviewing the effectiveness by way of six monthly and end of year reports. The Committee Chair highlighted that the terms of reference stated that the business unit membership should be the Clinical Lead, deputised by the Associate Medical Director, however attendance by the Associate Medical Director was rare. Non-executive Director (IL) stated that the reflection had been helpful. He made a recommendation that the meetings be more thematic and topic led rather than report led. The Committee Chair welcomed the recommendation and suggested a self-reflective review of the committee in November 2017.	**Company Secretary**

	Action: The Chair to lead a self-reflective review of the Quality Committee at its meeting in November 2018. **Outcome:** The Committee: • Noted the outcome of the review of Quality Committee's sub-groups effectiveness • Received the internal audit report on Business Committee's and Quality Committee's effectiveness	
2017-18 (38d)	**Board members' service visits** The Executive Director of Nursing presented the report which detailed the recent visit to the speech and language therapy service by the Non-executive Director (BC) and the visit to Hannah House by the Trust Chair. The reports were received and noted by the Committee. The Director of Operations confirmed that it had been agreed at the Senior Management Team meeting who would provide the final feedback following the visits. **Outcome:** The Committee: • Received the report on non-executive directors' service visits July 2017 – December 2017	
Minutes for noting and concluding business		
2017-18 (39a)	**Patient Safety and Experience Governance Group: 27 July 2017** **Outcome** • The draft minutes were received.	
2017-18 (39b)	**Mortality Surveillance Group: 3 August 2017** **Outcome** • The draft minutes were received.	
2017-18 (39c)	**Clinical Effectiveness Group: 17 August 2017** **Outcome** • The draft minutes were received.	
2017-18 (39d)	**Safeguarding Committee: 25 August 2017** **Outcome** • The draft minutes were received.	
2017-18 (40a)	**Quality Committee future work plan** The future work plan was received for information. The team from Little Woodhouse Hall had been scheduled to provide the service spotlight presentation at the October 2017 meeting of the Quality Committee. This would coincide with the CQC QIP report.	
2017-18 (41)	**Matters for the Board and other committees** It was agreed that the Committee's Chair would provide a verbal update to the Board at the meeting on 6 October 2017. Items to be reported include: • Service spotlight: ICAN • Incident reporting • Pressure ulcers • Outcome measures • Whistleblowing • CQC inspection report	

2017-18 (42)	**Any other business** The Chief Executive highlighted that there had recently been a serious incident at Little Woodhouse Hall. This was a no harm incident. Assurance was provided to the Committee that all necessary actions had been carried out and a full root cause analysis would be completed. The Committee Chair offered his apologies for the next meeting. Non-executive Director (IL) agreed to Chair the meeting.	
	Dates and times of next meetings (09:30 – 12:30) Monday 23 October 2017 Monday 20 November 2017 Monday 22 January 2018 Monday 19 February 2018 Monday 19 March 2018	

NHS
Leeds Community Healthcare
NHS Trust

AGENDA ITEM 2017-18 (73b)

Quality Committee
Monday 23 October 2017
Boardroom, Stockdale House, Leeds
09:30 – 12:30

Present	Professor Ian Lewis	Non-Executive Director, *deputising for Non-executive Director and Committee Chair Tony Dearden*
	Brodie Clark	Non-Executive Director, *deputising for Trust Chair Neil Franklin*
	Dr Amanda Thomas	Executive Medical Director
	Marcia Perry	Executive Director of Nursing
In Attendance	Sam Prince	Executive Director of Operations *(joined at 10:15)*
	Vanessa Manning	Company Secretary
	Stephanie Lawrence	Deputy Director of Nursing
	Vanessa Hunt	Professional Lead for Allied Health Professionals (AHP)
	Karen Worton	Clinical Lead for Children's Services
	Philip Boynes	Quality Lead for Specialist Services, *deputising for Clinical Lead for Specialist Services Elaine Goodwin*
	Caroline McNamara	Clinical Lead for Adult Services
	Carolyn Nelson	Head of Medicines Management
	Emma Sutcliffe	Team Manager, Little Woodhouse Hall *(item 44)*
	Dr Turlough Mills	Consultant Psychiatrist *(item 44)*
Minutes	Nicola Wood	PA to Executive Director of Nursing
Apologies	Neil Franklin	Trust Chair
	Dr Tony Dearden	Committee Chair / Non-Executive Director
	Elaine Goodwin	Clinical Lead for Specialist Services
	Thea Stein	Chief Executive

Item no	Discussion item	Actions
Welcome and introductions		
2017-18 (43a)	**Welcome and Apologies** Non-executive Director (IL) welcomed members to the meeting and informed the committee that he was deputising for Non-executive Director and Committee Chair (TD) and would act as Committee Chair for this meeting. Apologies were noted from Neil Franklin, Dr Tony Dearden, Thea Stein and Elaine Goodwin.	
2017-18 (43b)	**Declarations of Interest** There were no declarations of interest received.	
2017-18 (43c)	**Minutes of meeting held on 25 September 2017** The minutes were reviewed for accuracy and agreed as a true record of the meeting.	

2017-18 (43d)	**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>2017-18 (27i) Service spotlight: Leeds Integrated Sexual Health Service</u> Due to capacity issues and the need for more scoping work to be done, it was agreed this action in relation to benchmarking data would be postponed until January 2018. <u>2017-18 (27ii) Service spotlight: Leeds Integrated Sexual Health Service</u> The use of an electronic option for the friends and family test had been explored and was not possible at that time. The use of the four tubes approach had been implemented. Action complete. <u>2017-18 (36a) Director of nursing and quality report</u> The clinical governance team and performance team were looking into the use of ratio charts in relation to serious incidents. <u>2017-18 (36d) Risk register: operational and clinical risks</u> All overdue risks had been updated. Action completed.	
Service spotlight: CAMHS inpatient unit		
2017-18 (44)	The Executive Director of Nursing introduced colleagues from the Child and Adolescent Mental Health Service (CAMHS) inpatient unit at Little Woodhouse Hall to the meeting. The Consultant Psychiatrist provided an overview of the presentation and provided an outline of the service. The CAMHS inpatient unit is regionally commissioned by NHS England (NHSE) to provide service to the West Yorkshire region. There are eight beds for male and female patients aged 12-18 years. The multidisciplinary team includes a team manager, psychiatry team, nursing team, therapy team, social worker, dietician and teaching team. The team is staffed to Quality Network for Inpatient CAMHS (QNIC) standards. Clinical cases referred to the service include eating disorders, psychosis, depression and high risk self-harm. The Consultant Psychiatrist and the Unit Team Manager highlighted what was working well in the service, this included staff sickness rates below Trust average, 95% appraisal rates, the effective use of quality boards and daily handovers, incident reporting, outcome monitoring, patient involvement and the use of animal therapy. The main challenges faced by the unit were estate issues. The Consultant Psychiatrist concluded by highlighting to the Committee NHSE's commissioning intentions of new care models. He explained that there is a regional population of 2.2 million with only eight commissioned inpatient beds. This is an extremely low provision in comparison to Sheffield which has fifty beds. The Trust is the lead provider for new models of care and a working group has been set up in Leeds with regional attendance, looking at this piece of work. The Executive Medical Director indicated that supervision rates were lower than expected; the Team Manager advised the main issue was recording that supervision had taken place. The Clinical Lead for childrens services added there was work ongoing with the workforce directorate to look at this in more depth, and further added that as the inpatient unit was a small team slight shifts in staffing levels for example episodes of sickness absence could have a	

	substantial impact on the rates. The Executive Medical Director asked how much the team had been involved in looking at the Care Quality Commission (CQC) action plan; the Consultant Psychiatrist advised the Committee that at the time of the inspection there was significant staff absence which had impacted on the report, particularly around effective care. He stated that the action plan was discussed at weekly team meetings and implementation of the plan would involve the whole team. Non-executive Director (BC) commended the Consultant Psychiatrist and Team Manager on the comprehensive presentation and indicated that he was particularly impressed by the key performance indicator levels, quality board, education department and the use of animal therapy. Non-executive Director (BC) asked if the comprehensive CQC action plan could be delivered; the Clinical Lead for childrens services responded that the Clinical Team Manager at Little Woodhouse Hall had been instrumental in developing the quality improvement plan, and there was a defined action plan being taken forward within the team, she further added that the action plan felt achievable. The Team Manager and Consultant Psychiatrist stated that the team were extremely receptive and although the action plan was intensive, it would be incremental, and they assured the Committee it felt achievable. Non-executive Director (BC) requested assurance that the ligature issue raised following a recent service visit had been resolved; the Team Manager confirmed that the work had been scheduled week commencing 30 October 2017. The Committee Chair (IL) asked if there was a way of recognising how this service performed in comparison to other inpatient units around the country; the Consultant Psychiatrist responded that this was undertaken by the use of outcome measures. Clinical data was collected for every individual on admission and on discharge. Current analysis of clinical measures showed improved outcomes for young people. The Team Manager presented to the Committee a leaflet designed by the young people on the unit, for patients to receive prior to or on admission.	
Quality governance and safety		
2017-18 (45a)	**Quality improvement plan including CQC action plan** The Executive Medical Director presented the report which outlined the Trust's action plan to address the 'must-do' and 'should-do' improvement actions set out in the CQC's inspection report. 'Could-do's' were also included in the quality improvement plan (QIP) but would not be submitted to the CQC. The Executive Medical Director stated that there was some further updates and clarifications required in advance of submission to the CQC on 31 October 2017. The Committee Chair (IL) asked if there were any specific issues around the Little Woodhouse Hall recommendations; the Executive Director of Nursing stated that the Clinical Lead for childrens services planned to meet with the team on the unit to review the document and gain ownership by team members. The Executive Medical Director highlighted that progress had been made at Hannah House. The Executive Director of Nursing added that the team were working on updating the amber rated actions prior to submission.	

	In response to a query from the Committee Chair (IL), the Executive Director of Nursing informed the Committee that there had been some confusion over completion of the action plan and due to the late submission the dates had not been reviewed and amended prior to Quality Committee. Assurance was provided that this would be completed prior to submission to the CQC. In response to a query from the Committee Chair (IL), the Executive Medical Director stated that services within the Trust had set their own action timescales. There was an expectation from the CQC that the timeline was reasonable and progress would be achieved, however this had to be balanced with a realistic timeframe. Non-executive Director (BC) queried if the 'should-do's' and 'must-do's' would be dealt with equally; the Executive Medical Director provided assurance that that would be the case. Non-executive Director (BC) raised a concern around culture and oversight, particularly in small units, as reflected in the findings of the CQC inspection report, and reiterated the importance of avoiding reoccurrence. The Executive Medical Director responded that there was a separate piece of work looking at quality in small services. The Committee Chair (IL) further added that cultural change appeared to be one of the key issues, which could be particularly difficult to document as an action, but was a key objective for the organisation. **Action: work on quality in small services was to be completed for consideration at Senior Management Team prior to receipt at Quality Committee in January 2018.** Non-executive Director (BC) indicated that it would be helpful to have deeper narrative around the amber actions; the Executive Medical Director responded that the timeframes would be reviewed with the Executive Director of Nursing as it was agreed there would be no amber rated actions at this stage of the plan. Non-executive Director (BC) reiterated his concerns around being able to deliver the extensive action plan within the required timeframe. In response to a query from the Committee Chair (IL), The Executive Medical Director assured the Committee that all actions at Hannah House were achievable, although the cultural and learning actions may take slightly longer to embed. The Executive Director of Nursing further added that in response to the issues identified by the CQC a programme of internal work was ongoing and an update would be provided to subsequent Quality Committee meetings. Non-executive Director (BC) proposed the spot checks be carried out monthly rather than three in three months. The Executive Medical Director accepted this proposal for consideration. The Executive Director of Nursing informed the Committee that as a new approach, the CQC would like to spend some informal time with services. The Executive Director of Nursing and Executive Medical Director were working with the CQC to agree arrangements. The Company Secretary indicated that the Trust must be mindful of significant risks arising from the plan.	**Executive Medical Director**

	Outcome: The Committee: • Considered whether the QIP adequately addressed the CQC's 'must-do' and 'should-do' improvement actions. • Approved submission of the QIP to the CQC by 31 October 2017 subject to updating, as indicated, in advance of submission • Agreed the provision of monthly monitoring reports to Quality Committee • Agreed **reasonable assurance** subject to updating, as indicated, in advance of submission.	
2017-18 (45b)	**Performance brief and domain reports** The Committee reviewed the document and focused on the safe, caring, effective, responsive and well led domains. ***Safe*** The Executive Director of Nursing informed the Committee that there was some disparity between the data in the performance brief and the director of nursing report. The Executive Director of Nursing informed the Committee that the VTE report was not 77.8% as reported. She further added that VTE would not be reported on from November 2017 as the Trust was no longer the provider for community intermediate care beds. The Executive Director of Nursing stated that the falls figure appeared to be incorrect; however the investigation reporting process had not yet been carried out, so assurance could not be provided to the Committee. The Executive Director of Nursing agreed to work with the falls team and performance team to review the reports and figures. **Action: Executive Director of Nursing agreed to work with the falls team and performance team to review the reports and figures.** In response a point raised by Non-executive Director (BC), the Committee Chair (IL) reiterated his suggestion of the use of ratio charts when reporting harm and no-harm incidents, to show any changes more clearly. ***Caring*** There was a small reduction in the percentage of inpatients recommending care, resulting in the amber rating; all other measures were rated green. All indicators were expected to be green at the end of 2017/18. ***Effective*** 61% of practitioners had received clinical supervision in the last quarter, in accordance with policy. This was down from 80% in Q1 2017/18 and meant the Trust was moving away from its end of year target after strong Q1 performance. Services continued to be supported to achieve the 80% target. It was agreed the decrease could be due to recording issues. ***Responsive*** The Trust continued to perform well in its indicators relating to waiting lists, of which there were six. All were rated as green for September 2017. The Trust was 5.8% below its activity profile in September 2017 resulting in an amber rating in month and an amber rating year to date. September 2017 had seen a recovery against the Trust activity profile from 10% below to 5.8% below. The forecast for activity remained amber.	**Executive Director of Nursing**

	Well Led The total sickness absence rate (5.35%) had improved slightly again in September 2017 for the third month in succession and remained as a green rating. The staff appraisal rate (82.5%) remained rated red in September 2017. Also rated red were the response rates for the three friends and family test measures despite work to improve response rates. The targets for number of days between placing advertisements and filling vacancies had increased to 131 days for qualified nurses and to 96 for administration staff and were rated red but police custody was rated green at 106 days and well within target. **Outcome:** The Committee: • Noted present levels of performance	
2017-18 (45c)	**Director of Nursing quality and safety report** The Executive Director of Nursing presented the report and highlighted the following as the main areas of focus: • Pressure ulcers • Hannah House • Complexity in neighbourhood teams • Duty of candour • Friends and family test response rates **Pressure ulcers** The Executive Director of Nursing informed the Committee that following discussions at the September 2017 meeting, some reflective work had been carried out with the Clinical Lead of adult services, looking at gaps in leadership, capacity in teams and the incidence of pressure ulcers; she further added that there would be a focus on falls in October 2017 and pressure ulcers in November 2017, leading to a Patient Safety and Experience Governance Group (PSEGG) workshop on pressure ulcers in December 2017. In response to a query from Non-executive Director (BC), the Executive Director of Nursing informed the Committee that the issues around the re-emergence of avoidable pressure ulcers were multifactorial. There had been a small number of issues relating to the clinical practice of individuals and these had been dealt with on an informal level. The new format for the review process meant that staff directly involved in cases would attend panel. The Executive Director of Nursing further added that a review of the functionality of care plans may be required as it did not differentiate between registered and non-registered staff. Non-executive Director (BC) asked if anything had been identified from existing cases; the Deputy Director of Nursing and Clinical Lead for adult services assured the Committee that the issue was not related to training, and added that a deeper review into what the issues were, would be finalised for the PSEGG workshop on 14 December 2017, and an action plan resulting from this would be developed. The Clinical Lead for adult services informed the Committee that knowledge within the teams was much greater than eighteen months ago. There remained some variability across the teams, however this was reducing. She further added that the woundcare framework, which included input from the pressure ulcer	

	steering group, had been finalised. The Deputy Director of Nursing informed the Committee that a meeting with Bradford District Care NHS Foundation Trust had recently taken place, and work with partners was ongoing to share learning. The Committee Chair (IL) asked if the reduction in the number of pressure ulcer cases being reviewed was to focus on categories three and four; the Deputy Director of Nursing responded that all categories were reviewed; however the focus was on greater scrutiny of avoidable pressure ulcers rather than reviewing clearly unavoidable cases. The Clinical Lead for adult services added that the clinical framework on wound care was to ensure evidence based practice. The Committee Chair (IL) stated that he felt assured that this review was underway following the discussions at the September 2017 meeting. **Action: Executive Director of Nursing to provide an update on pressure ulcers at the January 2018 meeting following the PSEGG workshop in December 2017.** **Hannah House** The Executive Director of Nursing informed the Committee that work to review safe staffing was continuing at Hannah House, and added that staffing levels were at 50% of establishment; this had been a complicated piece of work due to a combination of factors, including maternity leave, staff sickness absence (currently 27%), vacancies and the wait for staff to take up post. This was further compounded by the use of a transitional bed; additional staffing was necessary to provide the level of care required. The Executive Director of Nursing advised that a proposal to reduce capacity by two beds for a three months period had been agreed at the Senior Management Team meeting. The Executive Medical Director highlighted that recent cancellations on the unit due to staffing issues meant there would not be an increased impact; however the change would be better planned. The Executive Director of Operations highlighted that findings from the CQC inspection report had caused some uncertainty amongst staff and this had taken time to settle down, although this had felt more positive over recent weeks. The Executive Director of Nursing continued to say that recruitment at the unit had progressed and a number of staff were going through the appointment process. Additional bank staff had been identified to provide support to the service. The Executive Director of Nursing highlighted to the Committee that work had been progressing to complete the final draft of the quality improvement plan for submission to the CQC, alongside the action plan and organisational development work. Good progress had also been made with statutory and mandatory training. The Executive Director of Nursing agreed to provide an update to Quality Committee at the November 2017 meeting. **Action: Executive Director of Nursing to provide an update of progress made at Hannah House to Quality Committee at the November 2017 meeting.** Non-executive Director (BC) felt assured that positive steps were being taken to address the issues identified.	**Executive Director of Nursing** **Executive Director of Nursing**

	The Committee Chair (IL) asked about the impact on families who no longer accessed the service; the Executive Director of Nursing responded that cancellations were reviewed on allocation to look at other support available to families. The Executive Director of Operations added that a summit was planned with commissioners, and following that there could be changes to the current service model. The Committee Chair (IL) queried if the defined action plan sat alongside the CQC action plan. The Executive Director of Nursing confirmed that a summary of all the work was being combined by the Head of Service; this included a presentation that had been developed showing, in detail, the ongoing work and progress made in the service. The Executive Director of Nursing agreed to share the presentation with Committee members at the November 2017 meeting.	
	Action: Executive Director of nursing to share the presentation of ongoing work at Hannah House with Committee members at the November 2017 meeting.	**Executive Director of Nursing**
	Caseload complexity The Executive Director of Nursing highlighted the recent work around demonstrating caseload complexity and intensity, and the review of available tools and models to identify if there was a tool suitable for use in neighbourhood teams. Following the review, discussions had been ongoing with a number of organisations who had implemented or were in the process of implementing a caseload dependency tool. The Committee Chair (IL) stated that it felt more research than development and queried if there had been any interaction with the university nursing teams. The Head of Medicines Management agreed to discuss this further with the research team.	
	Action: Head of Medicines Management to discuss caseload dependency tool further with the research team.	**Head of Medicines Management**
	The Clinical Lead for adult services informed the Committee of a small audit of highly complex patients, whereby a case that was allocated two units per week, could actually take between 20-30 units per week, due to the complexity of the case. **Duty of Candour** Non-executive Director (BC) queried the length of time taken to identify whether the incident was due to healthcare intervention, and asked if this could be resolved at an earlier stage; the Executive Director of Nursing stated that pressure ulcer issues were having an impact on the time taken. The Committee Chair (IL) stated that it was important to reinforce duty of candour and the need to promptly and clearly 'say sorry' when something had gone wrong. **Friends and family test** The Executive Director of Nursing said that focus remained on the friends and family response rates and that teams were looking to see how administration staff could be used more effectively. The Head of Medicines Management advised that the research team had offered support in this area. In response to a query from Non-executive Director (BC), the Executive Director of Nursing advised that she was working with the quality leads to see how support could be	

provided to teams and developments from IT were being explored.
The Executive Director of Operations queried if the denominator was correct, and proposed that it be 'per episode of care' rather than 'per visit' to avoid repeat requests to patients.

The Clinical Lead for adult services suggested it would be more effective if there was a targeted approach quarterly rather than monthly data returns, this would allow for more scrutiny and deeper analysis of the information.

Serious incidents
Non-executive Director (BC) highlighted that 'actions closed within timescale' seemed particularly low; the Executive Director of Nursing responded that there had been significant improvement over recent months and she informed the Committee that teams were being encouraged to close incidents in a timely manner. In response to a query from Non-executive Director (BC), the Clinical Lead for adult services advised that teams set their own actions and timescales.

Clinical Leads' quality reports
A summary of the reports appended to the director of nursing and quality and safety report was provided by each business unit representative.

Adult services:

- Training for clinical staff around nutrition and hydration needs in the frailer older adult, and its impact upon tissue healing and pressure ulcer healing rates was being rolled out across neighbourhood teams.
- Spring budget monies allocated for falls prevention were being progressed with the appointment of a Safety Huddle Coach (seconded until March 2018) to work with a specific neighbourhood team to establish the safety huddle approach; this would then be rolled out across all neighbourhood teams.
- The nomination of the palliative care team and neighbourhood teams has been shortlisted for a Health Service Journal award.
- The neighbourhood teams' leadership team delivered the third clinical Band 6 leadership training course in October 2017 as it continued to evaluate well.

Specialist services

- Speech and Language Therapy: there had been a review of all patients who had waiting times of over two weeks, and it was confirmed that none had come to harm. The numbers had now been reduced.
- Podiatry: four out of the six new foot protection posts had been secured from the existing community podiatry workforce resulting in further vacancies to fill, which would have some impact upon delivery of the service. Commissioners were aware of this factor.

Childrens services

- Speech and Language Therapy: the service had engaged in a waiting list initiative over summer 2017 and was successful in reducing all follow on waiting times to 27 weeks.
- Child and Adolescent Mental Health Service: Autistic Spectrum Condition waiting times remained a concern. The service was working actively with external community services.
- Tendering process in the school nursing and health visiting teams was having an impact on staff; the leadership team were working to support the teams.
- The childrens nursing strategy was progressing well.

	Outcome: The Committee: • Agreed **limited assurance** on the pressure ulcer work • Agreed **reasonable assurance** on the work at Hannah House	
2017-18 (45d)	**Falls prevention and management action plan** The Executive Director of Nursing presented the report which outlined the action plan for falls prevention and management within the Trust, overseen by the falls steering committee. Following a discussion around the amber rated actions, the Deputy Director of Nursing assured the Committee that all actions were on track and none were at risk. **Outcome:** The Committee: • Noted the action plan and dates for completion. • Agreed **reasonable assurance** had been provided by the report.	
2017-18 (45e)	**ICAN: capacity and waiting times improvement trajectory** The Executive Director of Operations provided a verbal update on the capacity and waiting times improvement trajectory for the ICAN Service. Recruitment to two Consultant Paediatrician posts had been successful and recruitment was underway for the nursing staff posts. Due to locums joining the service all clinics were now being covered, although this remained tight, particularly in the child protection medical services. First appointment waiting times were on track; however some concern remained around follow up appointments. The Executive Director of Operations assured the Committee that overall it was an improved position on last month.	
2017-18 (45f)	**Risk register: operational and clinical risks** The Company Secretary presented the report which outlined risk movement since the last report in September 2017. The Committee noted there were two new clinical or operational risks, one risk with an increased score, eight risks with a decreased score and no closed risks. There are three extreme risks in total. In response to a query from the Executive Medical Director, the Company Secretary assured the Committee that the correct risks had been identified and that changes within the risk register represented active management of clinical risks in the Trust. **Outcome:** The Committee: • Noted the recent revisions made to the risk register. • Agreed **reasonable assurance** had been provided by the report**.**	
2017-18 (45g)	**Midyear review of Board Assurance Framework** The Company Secretary presented the report which provided a revised copy of the Board Assurance Framework (BAF) strategic risks assigned to the Committee following the Senior Management Team (SMT) mid-year review.	

	In response to a query from Non-executive Director (IL), the Company Secretary informed the Committee the risk around effective systems and processes for assessing quality had been deemed more uncertain than in April 2017 by the Senior Management Team; looking at safety in smaller units and the CQC inspection report may had increased the risk score. **Outcome:** The Committee: • Noted the revised BAF strategic risks assigned to Quality Committee • Noted the risk scores, controls and sources of assurance for these strategic risks	
2017-18 (45h)	**Professional strategy: annual update** The Executive Director of Nursing presented the report which provided an update on progress of actions relating to the professional strategy for clinical staff and its implementation. The Executive Director of Nursing advised the Committee that the first clinical professional council had been scheduled for December 2017. Non-executive Director (BC) stated that the statements and evidence did not consistently present a strong case. He pointed out that the statements in relation to aspiration 4 'quality improvements' did not present evidence of improved quality of care. In response to a point made by Non-executive Director (IL) around promoting health and wellbeing, satisfying careers and development opportunities, the Executive Director of Nursing highlighted to the Committee that following the professional council in December 2017, the professional strategy would be aligned with the organisational development and training strategies. The Professional Lead for Allied Health Professionals (AHP) informed the Committee that a variety of work was underway with non-registered staff. Non-executive Director (IL) suggested that the ageing workforce be encompassed in the strategy. In response to a point made by the Executive Medical Director, Non-executive Director (BC) suggested the report be sharper about what the Trust was hoping to achieve, to help focus training initiatives and funding. The Committee agreed that the report required additional work before being recommended for Board in December 2017. **Outcome:** The Committee: • Received the report • Commented on progress to date • Agreed **limited assurance** had been provided by the report	
Clinical Effectiveness		
2017-18 (46a)	**NICE guidance compliance update** The Executive Medical Director presented the report and highlighted to the Committee the key items for note. NICE issued 409 pieces of guidance in the period January 2015 to April 2017, of which 71 were relevant to at least one service within the Trust and had been circulated for implementation, 49 pieces had been circulated for information only	

	and 289 were not applicable to services within the Trust. Non-executive Director (BC) asked how the Committee knew what progress had been made; the Head of Medicines Management responded that evidence that the guidance had been embedded, had been received from services and these were all displayed as green rated on the chart. The Clinical Lead for adult services added that compliance was monitored and reviewed in the neighbourhood team quality meeting; any issues were raised on an individual basis. Non-executive Director (IL) asked if evidence was provided by audits; the Head of Medicines Management stated that this was sometimes the case. Non-executive Director (BC) queried what was meant by 'under review'; the Head of Medicines Management responded that services were still working on embedding that guidance; and further added that this was regularly reviewed. Non-executive Director (IL) pointed out that focus was required from services in relation to the outstanding guidance. The Committee noted that five pieces of guidance would be removed from the report in November 2017 as they related to community intermediate care beds. In response to a query from Non-executive Director (BC), the Head of Medicines Management responded that more work could be done to improve guidance being embedded in a timely manner within services. In response to a suggestion by Non-executive Director (IL), the Executive Medical Director agreed to review the outstanding guidance from 2015 with the Head of Medicines Management and provide an update to Quality Committee in the next report in May 2018. **Action: Executive Medical Director to review the outstanding guidance from 2015 with the Head of Medicines Management and provide an update to Quality Committee in May 2018.** **Outcome:** The Committee: • Received the report and noted the progress to date with implementation of NICE Guidance • Agreed **reasonable assurance** on process, reporting and monitoring had been provided by the report • Agreed **limited assurance** on implementing the guidance had been provided by the report	**Executive Medical Director**
Patient experience		
2017-18 (47a)	**Patient and public engagement** The Executive Director of Nursing presented the report which provided an update on patient and public engagement; drawing together various strands of work that demonstrated the systems in place to ensure the Trust engaged with patients and the public. The Executive Director of Nursing informed the Committee that the key priorities for the Membership and Involvement Officer, once in post, was to ensure a strategic plan was in place. Non-executive Director (BC) stated that there was impressive work going on in the services; however it felt, as a Trust, that it lacked overview, vision and statement of purpose. Non-executive Director (IL) noted that there did not appear to be much	

	emphasis around 'listening' and it felt more 'ask and collect' rather than listen directly. The Clinical Lead for adult services responded that although it was not evidenced in the report the teams were encouraging staff to maximise opportunities to involve patients and their families. The Committee was supportive of the systematic approach and agreed this was a fore runner across the organisation. The Company Secretary pointed out that the patient and public engagement report was on the workplan 'as and when required', and proposed this be reviewed six-monthly. The Executive Director of Nursing suggested this be reviewed once the post holder was in place. Non-executive Director (IL) stated that it was evident since joining the Trust that staff were exceptionally patient and community focused. The Clinical Lead for childrens services requested that the nomination for health coaching at the Health Service Journal awards was an excellent example of patient involvement. **Outcome:** The Committee: • Noted the content of the report • Noted the further areas of work identified • Agreed **reasonable assurance** had been provided by the report	
Reports and minutes for approval and noting		
2017-18 (48a)	**Board members' service visits** The Executive Director of Nursing presented the report which detailed the recent visit to the CAMHS inpatient unit at Little Woodhouse Hall by Non-executive Director (IL) The reports were received and noted by the Committee. Non-executive Director (BC) suggested it would be helpful to provide the authors of reports with feedback following a service visit. The Executive Medical Director advised that a process had been designed, including feedback to Non-executive Directors. Non-executive Director (BC) stated that the issue raised following the visit to Little Woodhouse Hall was the food and not the building as was stated in the report. **Outcome:** The Committee: • Received the report on non-executive directors' service visits April 2017 – December 2017	
2017-18 (48b)	**Mental Health Act Governance Group: 22 September 2017** **Outcome** • The draft minutes were received.	
2017-18 (49a)	**Quality Committee future work plan** The future work plan was received for information. The team from infection prevention control had been scheduled to provide the service spotlight presentation at the November 2017 meeting of the Quality Committee.	

2017-18 (50)	**Matters for the Board and other committees** It was agreed that the Committee's Chair would provide a verbal update to the Board at the meeting on 6 October 2017. Items to be reported include: • Service spotlight: Little Woodhouse Hall • CQC inspection: action plan • Pressure ulcers • Hannah House • Falls • Professional strategy • NICE guidance • Patient and public engagement	
2017-18 (51)	**Any other business** There was no any other business.	
	Dates and times of next meetings (09:30 – 12:30) Monday 20 November 2017 Monday 22 January 2018 Monday 19 February 2018 Monday 19 March 2018	

Leeds Community Healthcare NHS Trust

AGENDA ITEM 2017-18 (73c)

MINUTES

Business Committee Meeting
Boardroom, Stockdale House
Wednesday 27 September 2017 (9.00 – 12.00 noon)

Present:	Brodie Clark (Chair)	Non-Executive Director (BC)
	Tony Dearden	Non-Executive Director (TD
	Richard Gladman	Non-Executive Director (RG)
	Thea Stein	Chief Executive
	Bryan Machin	Executive Director of Finance & Resources
	Sue Ellis	Director of Workforce
Attendance:	Sam Prince	Executive Director of Operations
	Vanessa Manning	Company Secretary
	Ann Hobson	Assistant Director of Workforce
	Steve Callaghan	IAPT Service Manager (for item 43 only)
	Janet Addison	Head of Service (for item 45 only)
Apologies:	None recorded	
Note Taker:	Ranjit Lall	PA to Executive Director of Finance & Resources

Item	Discussion Points	Action
2017/18 **(42)**	The Chair welcomed the Service Manager to the meeting. **42a - Apologies**: None recorded. **42b - Declarations of Interest**: None recorded. **42c - Minutes of last meeting:** The public and private minutes of the meeting dated 26 July 2017 were approved by the Committee. **42d - Matters arising from the minutes and review of actions:** No further actions were noted; all actions on the action log due for completion by September 2017 were completed.	
2017/18 **(43)**	**Improving access to psychological therapy service presentation (IAPT)** The Service Manager gave a brief background of his experience of working within a mental health setting. The presentation reflected on issues, challenges and successes in the IAPT service. The Trust and three other third sector organisations provided the service which comprised psychological interventions for people with common mental health problems. The Committee heard about the challenges presented by access and waiting times' targets and the achievements in relation to the recovery rate target whereby the 50% recovery rate for those completing treatment had been exceeded over the past two quarters.	

	The Committee noted the current commissioning and contractual discussions, the level of resource committed to frontline clinical staff and the likely requirement to operate shadow 'payment by results' from 2018/19. The Chair thanked the Service Manager for the presentation and said that it had been very useful and had raised some important questions, challenges and points of clarification, particularly around meeting service targets. The Executive Director of Finance & Resources noted that the 15% access target of the prevalent population seemed to be extremely high; relating to mental stress, depression or anxiety. The Service Manager explained that the 15% prevalence rate was further broken down into each of the three Clinical Commissioning Group (CCG) areas and that the overall figure was 15,000. A Non-Executive Director (TD) said that he was pleased with the overview of the service and its achievements. He noted two areas: firstly, pathway development in light of the capacity and demand issues and the requirement to achieve a 50% recovery rate for those completing treatment, and secondly, the investment in clinical staff as a proportion of contractual income. The Service Manager said that there was a direct budget of £3.5m for the service. The Executive Director of Finance & Resources agreed to issue a briefing note to clarify the funding and budget position. A Non-Executive Director (RG) asked if there was any benchmarking data to compare the Trust with other trusts. The Service Manager said that the IAPT service worked and delivered in a unique way and because of its complexity there were no other services 'like for like' with which to benchmark. The Chair noted a significant amount of under spend in the year to date. The Service Manager responded to say that the under spend of £29k had since been allocated to cognitive behavioural therapists posts. It was noted that about 70% of the referrals were self-referred. A website called 'MindWell' had an entry point into the service which sign posted patients appropriately. The Service Manager said that this was a complicated system in terms of how to access services. There were two single points of access into mental health service in Leeds through Leeds Community Healthcare NHS Trust (LCH) and Leeds and York Partnership NHS Foundation Trust (LYPFT). He said there was a considerable work underway in the city for LCH and LYPFT working together with Commissioners. There was a mental health framework for the city and a number of different work streams looking to address pathway issues and piloting different mental health liaison work. In response to the Chair asking about the generation of initiatives and ideas to address issues, the Service Manager said that the three key working groups in the service linked into the different targets; access, waiting times and recovery rate. The Service Manager said that there were some issues still to be addressed in terms of contractual arrangements relating to payment by results (PBR). There was a proposal to set up a meeting with the directors of finance across the CCGs and mental health providers to discuss PBR for Leeds. The Chair thanked the Service Manager for the presentation and for providing a helpful insight into service challenges and achievements.	

	Action: The Executive Director of Finance & Resources to issue a briefing note on the budget and financial position of the service, particularly the staffing costs. **Outcome:** The presentation on the IAPT service area was well received by the Committee.	BM
2017/18 (44)	**Project management** **44a – Projects' highlight reports** The Executive Director of Finance & Resources introduced the projects' highlight report and noted that only the e-rostering flash report had been included in the report. The Chair said that, as agreed previously, he expected all three flash reports so that the Committee could note the progress against the project plan for e-rostering, electronic patient record and patient administration review. **44b – E-rostering project update** (Please see private minutes). **44c - Electronic patient record (EPR)** The Executive Director of Operations provided a verbal update on the project plan for EPR and offered to email a flash report to the Committee members. The Executive Director of Operations said that the headline position was that the final neighbourhood team 'go live' was scheduled for 9 October 2017 in Wetherby and the neighbourhood would be continuing to implement new ways of working up to the end of March 2018. She said that work was still continuing in the community intravenous antibiotic service team and health case management team, and the next part of the project was the full implementation in integrated children's additional needs (ICAN) service. **Action:** The Executive Director of Operations to provide the flash report on EPR to the Committee members. **Outcome:** A more detailed focus to be provided in the presentation for EPR for the next Business Committee meeting in October 2017. **44d - Patient administration review** The Committee was briefed on the commencement of the review of patient administration services across the Trust with the aim of providing a modern and consistent service that made best use of digital approaches. The Executive Director of Operations said that the patient administration review plan was looking at two aspects of administration: centralised booking for patient administration and service related administration. She said that, at the moment, there were different models across the organisation in the different services. The plan was to standardise an approach for staff and have one clear offer for patient referrals into the Trust. The Executive Director of Operations explained that a single point of access (SPA) for neighbourhood teams already existed jointly with social services and would be the core of the solution for adult services. In terms of children services, a business case for setting up a children's SPA was to be presented to the senior management team meeting (SMT) in October 2017. Work around the scoping for specialist services was underway.	SP

	A monthly project board was to be established and a flash report for the Business Committee was to be generated. The project initiation document was to be circulated in readiness for an in depth review of the project in November 2017. A Non-Executive Director (RG) asked about e-referrals and its impact across the system in terms of administration. The Executive Director of Operations said that there were a number of services that were fully compliant with an e-referral system, for example musculoskeletal service, and, over the years, the Trust had worked towards e-booking targets set by the Commissioners. The Executive Director of Operations said that e-referrals could impact on waiting times because the Trust could breach waiting times if patients are given an e-referral and do not complete the booking process in a timely manner. **Action:** The Executive Director of Operations to circulate the project initiation document. **Outcome:** The Committee received progress reports on the Trust's three key projects.	SP
2017/18 **(45)**	**Strategy development and implementation** **Children's strategy update** The Executive Director of Operations introduced the first draft of the children's services strategy for initial comments. She said the strategy document aimed to draw out the following: • key national and local policy that will influence the children's services strategy • an overview of current service provision • the strategic objectives for the service • the next steps in the current year to support the achievement of the objectives whilst allowing time for the completion and consultation on the strategy itself The Chair acknowledged that it was a comprehensive document pulling together a number of key issues. **Comments noted:** • Reference to the children's nursing strategy was missing within the document • The role of parents and guardians • The strategy to be more patient centric; clarity as to what is expected for children and families • Relationship with commissioners of services • More explicit in terms of key changes and differences that will result from the strategy • An opportunity to utilise national health programmes around child health. • More detail on implementation and resourcing A Non-Executive Director (RG) was in favour of learning from other parts of the country and encouraged inclusion of benchmarked information. The Chief Executive said that the strategy lacked wider context and noted that it had been written primarily for an internal audience and should also be utilised externally with Commissioners. She said that she would welcome the possibility of integrating pathways across the Trust, hospital services and primary care.	

	The Director of Workforce added that this strategy would be used to build a workforce plan for children's services. The Head of Service was asked to contact the Head of Workforce Intelligence. The Head of Service said she was pleased with the feedback received from the Committee. She agreed that the document in terms of audience, would influence the content if were to be used with the city wide partners. The Executive Director of Operations said she proposed to launch the children's services strategy at a celebratory event on 6 December 2017. An opportunity to present the work of the children's services business unit. A two pages summary document would also be produced for staff. **Actions:** • Further work on the strategy was to be continued. A second draft to be brought back to the Committee after further development and no later than November 2017. • A workforce plan be developed to support the strategy **Outcome:** The Committee noted the strategy in its early stage of progress.	SP AH
2017/18 **(46)**	**Business planning and commercial development** **46a - Operational plan 2017/18: in year progress report** The Committee received an overview of progress towards achieving the corporate objectives and priorities set out in the 2017/18 operational plan at the end of month five and a forecast for the year-end. The RAG rating reflected an overall assessment of progress and performance in relation to the priorities. The Executive Director of Finance & Resources said that there were some issues with the rating of individual priorities at end of month five and year end forecast. He welcomed the Committee's views on whether the current overall sense of each of the priorities and success measures were accurately reflected in the paper before submission to the Trust Board on 6 October 2017. The Committee was asked to review the amber rating for e-rostering and the Chair invited further individual comments on the detail to be provided to the Executive Director of Finance & Resources by midday 28 September 2017. The Chair said that it would be desirable for the tools and provision of information supporting quality improvement, eg. quality boards and safety huddles to be in place by the end of the year. The Chair asked about changes to success measures for corporate objectives. The Executive Director of Operations explained that SMT had concluded that the requirement for service self-assessments should relate to those services being tendered in 2017/18 only; with the aim of removing duplication in assessment processes. **Action:** The progress against objectives and the RAG rating were to be further reviewed before the paper was submitted to the Trust Board meeting on 6 October 2017.	BM

	Outcome: The Committee noted the assessment of progress at the end of month five and the forecast for the year-end. It was agreed that the report would be amended in advance of going to the Trust Board. **46b - Business and commercial developments report** (Please see private minutes). **46c – Alliance: GP Streaming into A&E** The Executive Director of Finance & Resources reported that the work with GP streaming into A&E was progressing well; working in partnership with commissioners and providers. The Chief Executive said a workshop was being arranged for alliance members around risk share relating to quality, looking at legal advice and to standardise contractual framework.	
2017/18 **(47)**	**47a – Performance brief and domain reports** The Executive Director of Finance & Resources introduced the performance brief and domain reports. *Safe domain* A Non-Executive Director (TD) provided a brief update following discussions at the Quality Committee meeting on 25 September 2017. He said that the most significant variance from target arose from the avoidable category four pressure ulcer target. Further narrative was required to support the performance brief for the Trust Board meeting on 6 October 2017. *Caring domain* No further comments were noted. The caring domain measures were rated green. *Responsive domain* The responsive domain measures with the exception of activity levels were rated green. The Executive Director of Finance & Resources said that the key area of focus was related to neighbourhood team activity levels and whilst the Trust generally continued to perform well in respect of its responsive indicators, some areas needed further work to understand the variance from profile and service profiles were being reviewed with Commissioners to understand current and identify correct activity profiles. The Executive Director of Operations said that, at the performance panel it had been agreed that it would be useful for the fortnightly activity and monitoring group to have a summit with SMT members. The Executive Director of Operations said that the health visiting service's activity levels had been above profile at the end of 2016/17 but were behind profile for the year to date. The early start service commissioners do not assess the number of contacts in relation to profile and hence there was little focus on outcome. She said that the service was due to be re-procured later this year. *Well led domain* It was noted that the sickness absence rate had fallen slightly in August 2017. Staff turnover, staff appraisals rate and statutory and mandatory training remained below target.	

	The Director of Workforce said that, in addition to rolling recruitment for community staff nursing, nine newly qualified staff had started in September 2017 and fourteen were due to start in October 2017 and she said that the workforce team was promoting the Care Quality Commission results to applicants. Friends and family test response rates; there had been further deterioration in the response rates and both indicators were rated as red. Inclusion of further explanation in future reports was sought. *Heat map* The Chair noted that Pudsey and Middleton neighbourhood teams had a significant number of red rated measures. The Executive Director of Operations assured the Committee that this related to the position in June 2017. She said that there had been a positive change in the current position. **Outcome** The Committee noted areas of satisfactory performance and some improvements across areas of previous challenge. The Chair said that pending further investigation he drew only limited assurance in relation to activity levels, friends and family test response rates and workforce indicators. **Finance** The Executive Director of Finance & Resources said that in month five the Trust was meeting its financial targets for most of the indicators with the exception of cost improvement plan delivery and he was confident in achieving the control total. The Executive Director of Finance & Resources said that the Trust had to hold £0.5m of CQUIN income in a risk reserve until the wider health system had achieved its control total at year end. He said that each of the measures was forecasting to achieve its targets by year end with the exception of delivery of cost improvement plans. The Executive Director of Finance & Resources said that the contract settlement for CAMHS this year included a reserve to mitigate a CAMHS CIP. He said that the report was showing that CAMHS was not delivering the CIP. The Executive Director of Finance & Resources said that the Trust's financial performance at the end of August 2017 continued to run slightly ahead of the planned control total surplus. Apart from CAMHS, other services are on track to deliver recurrently and pay overspending had been mitigated by the release of reserves. **Outcome:** The Committee took reasonable assurance from the finance report. **47b - Neighbourhood teams report** The report provided the Committee with an update on the performance position across the neighbourhoods in the adult business unit. The Executive Director of Operations said that there had been significant pressure in August 2017 due to lack of availability of agency and bank staff and that the situation in September 2017 had not significantly improved. **47c – CAMHS community team** The Executive Director of Operations advised the Committee that during the visit to the West CAMHS team by the Chair of the Trust; he had learnt that access times were being compromised.	

	The Executive Director of Operations confirmed that this was due to the specification being reviewed by the Commissioners relating to increased thresholds for accepting referrals. In terms of activity levels for autism, productivity improvement work was ongoing ensuring that clinicians continued to see a consistent number of patients per day. It was noted that external resource had been commissioned to work with clinicians about expectations and to review referral management, appointment allocation and productivity. The Committee noted the waiting times challenges within this service and actions to understand and manage referrals and the onward impact that the volume and complexity of referrals had on waiting times and activity. A focus on consistent assessment and allocation processes was felt to be essential to maximising productivity to meet demand. **Action:** The Chair of the Trust and the Executive Director of Operations to arrange a joint follow up service visit to CAMHS. **Outcome:** The Committee noted the update on community CAMHS. **47d - Agency cap breach** The Director of Workforce presented a brief paper for information for the Committee to note that payment to a locum consultant in paediatrics had been above the agency cap and would be reported in the NHSI weekly return. **Outcome:** The Committee noted the engagement of the consultant and the breach in the agency cap. **47e – Operational and non-clinical risk register** The risk register report provided the Committee with an in-depth description of risk movement since the last register report received in July 2017. The main issues considered were the four new non-clinical risks scoring 8 or above as follows: • Risk 909 E-rostering project behind schedule. • Risk 911 Insufficient registered nurses on Community Intermediate Care Unit (CICU) and South Leeds Independence Centre (SLIC). • Risk 913 Increasing numbers of referrals for complex communication assessments in ICAN service and risk of breaching waiting time target. • Risk 914 Risk of failure to achieve CQUIN 2 (improving discharge arrangements) requirements in 2017/18. The Company Secretary said that the report included non-clinical risks where a review date had passed and remained overdue. An appendix to the report grouped the risks scoring 8 or above. **Outcome:** The Committee noted the revisions made to the risk register. **47f - Internal audit reports** The internal audit report provided a summary of the outcomes from completed internal audits where the report related directly to the role and functions of the Business Committee.	SP

	The paper covered completed audits from the 2017/18 plan and the audit opinion related to bank and agency staffing providing reasonable assurance and reference costs submission providing substantial assurance. **Outcome:** The Committee noted the audits completed as part of the approved 2017/18 plan. **47g – Care quality commission (CQC)** The Committee was advised of the new key lines enquiry introduced in June 2017. It was noted that the CQC would measure the organisation against 162 statements for which evidence of compliance would be sought. The Company Secretary said that there was a need to consider whether to realign some of the content reported to Business Committee and Quality Committee and the content of the performance brief to assure that they are aligned to the key lines of enquiry. Further conversation to take place at SMT to assure that the Trust was robustly aligned with key lines of enquiry. **Outcome:** The Committee noted the introduction of revised CQC key lines of enquiry.	
2017/18 **(48)**	**Business Committee's work plan** **Future work plan** The work plan was reviewed by the Committee and no changes were requested.	
2017/18 **(49)**	**Matters for the Board and other Committees** • IAPT presentation • E-rostering project • Children's strategy update • Operational plan 2017/18 • Activity levels • Finance	
2017/18 **(50)**	**Any other business** None discussed.	

AGENDA ITEM 2017-18 (73d)

HEALTH AND WELLBEING BOARD

TUESDAY, 20TH JUNE, 2017

PRESENT: Councillor R Charlwood in the Chair

Councillors D Coupar, B Flynn, S Golton, and L Mulherin

Representatives of Clinical Commissioning Groups
Nigel Gray NHS Leeds North CCG

Directors of Leeds City Council
Dr Ian Cameron – Director of Public Health
Steve Hume – LCC Adults and Health
Sue Rumbold – LCC Children and Families

Representative of NHS (England)
Louise Auger - NHS England

Third Sector Representative
Kerry Jackson – St Gemma's Hospice

Representative of Local Health Watch Organisation
Lesley Sterling-Baxter – Healthwatch Leeds
Tanya Matilainen – Healthwatch Leeds

Representatives of NHS providers
Sara Munro - Leeds and York Partnership NHS Foundation Trust
Dean Royles - Leeds Teaching Hospitals NHS Trust
Thea Stein - Leeds Community Healthcare NHS Trust

1 Welcome and introductions
The Chair welcomed all present and brief introductions were made.

Additionally, Councillor Charlwood noted that Dr Alistair Walling had been appointed to represent NHS Leeds South and East Clinical Commissioning Group by Annual Council on 25th May 2017.

2 Appeals against refusal of inspection of documents
There were no appeals against the refusal of inspection of documents.

3 Exempt Information - Possible Exclusion of the Press and Public
The agenda contained no exempt information.

4 Late Items
No late of business were added to the agenda.

5 Declarations of Disclosable Pecuniary Interests

No declarations of disclosable pecuniary interests were made

6 Apologies for Absence

Apologies for absence were received from Councillor G Latty, Gordon Sinclair, Phil Corrigan, Julian Hartley, Cath Roff, Steve Walker, Moira Dumma and Julian Hartley. The Board welcomed Councillor Flynn, Dean Royles, Steve Hume, Sue Rumbold and Louise Auger as substitutes to the meeting.

7 Open Forum

No matters were raised by members of the public under the Open Forum.

8 Minutes

RESOLVED – The minutes of the previous meeting held 20th April 2017 were agreed as a correct record.

9 Leeds Health and Care Plan: Progressing a conversation with citizens

The Board considered an overview of the emerging Leeds Health and Care Plan – Leeds' description of what it envisaged health and care will look like in the future and how it will contribute to the delivery of the vision and objectives of the Leeds Health and Wellbeing Strategy 2016-21.

Paul Bollom, Interim Executive Lead for the Leeds Health and Care Plan, presented the report seeking support from the Board for the draft narrative of the Plan to be published in order to develop a citywide conversation with citizens. Stuart Barnes, NHS Leeds North CCG was also in attendance.

The draft narrative set the Leeds Plan in context with the West Yorkshire Sustainability and Transformation Plan. To achieve the maximum chance of engaging the public and delivering change; the Plan was user friendly and accessible reflecting the core value of working with the population. Discussion would be held alongside the wider future discussion on provision of public services – 'changing Leeds' discussions.

A copy of the draft 'Leeds Health and Care Plan' narrative document was attached as Appendix A along with a copy of the 'Changing Leeds' document at Appendix B

During discussions the following matters were raised:

- Acknowledged and welcomed the opportunity for the Community Committees to have had early discussions on the Leeds Plan during the Spring 2017. A request for an update to the community committees was noted
- The need to realise the value of the collective Leeds Pound and emphasise this within the health economy and beyond; acknowledging that service users may be buyers as well as consumers who could form co-operatives or social enterprises. This was also an opportunity to engage businesses in the ambitions of the Leeds Health and Care Plan; to interact with inclusive growth alongside Leeds Growth Strategy and with the Leeds Academic Health Partnership

- A request for the draft Plan to include a foreword emphasising the role of feedback in shaping a live document that will evolve. Associated to this, a review of the language and phrasing to ensure a plain English approach and to avoid inadvertently suggesting that areas of change have already been decided. The narrative to also clarify who will make decisions in the future
- The Plan to include case studies
- Acknowledged the need to broaden the scope of the Plan in order to *"if we do this, then this how good our health and care services could be"* and to provide more detail on what provision may look like in the future
- Noted the request for the Plan to provide more focus on some of the options from the Joint Health and Wellbeing Strategy
- References to taking self-responsibility for health should also include urgent care/out of hospital health
- References to the role of the Leeds Health and Wellbeing Board and the Joint Health and Wellbeing Strategy to be strengthened and appear earlier in the Plan
- Assurance was sought that the Plan would be co-produced as part of the ongoing conversation
- A focus on Leeds figures rather than national
- Requested that a follow up paper with more detail, including the extended primary care model, be brought back in September.

In conclusion, the Chair noted that the Board was supportive of the draft Plan being released for consultation, subject to the amendments suggested being made. Additionally, she expressed her support for the 'plan on a page' approach but noted that a decision needed to be made on whether to have a generic approach or provide specific information within the Plan i.e. detail had been provided on some health issues but not others such as Primary Care. In response, it was agreed that the SRO's, the Interim Executive Lead for the Leeds Plan, a representative of Healthwatch and the Health Partnership Team would review the draft Plan narrative, including the 'plain English' request and report back to the Board in September 2017.

RESOLVED

a) To note the contents of the report and the comments made during discussions;

b) That having considered the draft narrative for the 'Leeds Plan', the feedback provided on whether it provides appropriate information to progress our conversation with citizens about the future of health and care in Leeds be noted.

c) To note the intention for the SRO's, the Interim Executive Lead, a representative of Healthwatch for the Leeds Plan and the Health Partnership Team to review the draft Plan narrative, including the 'plain English' request; and would report back to the Board in September 2017.

d) To approve plans to progress a conversation with the public, based around the content of the summary report, and delivered in conjunction with the 'Changing Leeds' discussion.

10 Leeds Health and Care Quarterly Financial Reporting

The Board considered the report of the Leeds Health and Care Partnership Executive Group (PEG) which provided an overview of the financial positions of the health and care organisations in Leeds, brought together as one single citywide quarterly financial report.

The report provided a financial 'health check' to clarify where the current and expected financial pressures were in the local health and care system. This gave the Board an opportunity to direct action to support an appropriate and effective response as part of the Boards role in having strategic oversight of both the financial sustainability of the Leeds health and care system; and of the executive function carried out by the Leeds Health and Care Partnership Executive Group.

Bryan Machin, Chair of the Citywide Directors of Finance Group, presented the report. He highlighted key headlines from the report including:

- The Leeds health & care system ended 2016/17 in a more favourable position than that predicted at quarter 3.
- The plans for health and care services within Leeds City Council and for the Leeds CCGs demonstrated the delivery of a breakeven position across the future 4-year planning period. However, this was reliant on the assumed delivery of significant levels of recurrent savings and the CCGs being able to access some of their previously accumulated surpluses.
- The aggregate 4-year plans of the three NHS Trusts would not achieve breakeven across the whole period without receipt of additional national funding, better management of demand, and delivery of significant levels of savings.
- The significant financial risk associated with the plans of all partners and that further citywide action is required to mitigate the risks in single organisation plans.

A question was raised over whether budget sharing to further the 'one approach' to health and care would be supported by the Directors of Finance. It was noted that although this approach may be viewed favourably, consideration would have to be given to the evidence required to support this approach. Members recognised that statutory and regulatory responsibilities may impact on collaboration but felt that this approach should be explored.

Further discussions noted the continuing austerity measures and the challenge of finding money upfront to invest in collaborative working. Concern was expressed that CCGs may not be able to draw down any previously accumulated surplus funds, as suggested in the report, due to Treasury restrictions and national funding pressures. An approach to PEG was suggested in the first instance to consider the opportunities for collaboration and budget sharing.

RESOLVED –

a) Having reviewed the Leeds health & care quarterly financial report, the Board noted its contents and the comments made during discussions;
b) To note the extent of the financial challenge over the next year and until 2021 and the need to further develop a shared system-wide response and assurance that this challenge will be met;
c) As part of the Boards' role to provide clear guidance to the Leeds Health and Care Partnership Executive Group on the possible actions required to achieve financial sustainability, the Board asked that PEG
    i) Convene a workshop to consider and identify the opportunities for collaboration and budget sharing
    ii) Undertake a piece of work to gather and understand savings and Return on Investment.

11 Being the Best City For Health Requires the Best Workforce

Tony Cooke, Chief Officer Health Partnerships Team, presented a report summarising the city's challenges relating to workforce and three potential and developing solutions. The Board was asked to consider it's' role in progressing, steering and directing future work to address the challenges, in the short term these were identified as:

- The impact of nursing bursaries (25% drop in applications)
- The impact of Brexit (96%fall in people coming to the UK to work)
- The number of health and care practitioners due to retire within the next 5 years (600,000)

The challenges ahead had highlighted the need to systematically "Grow your own workforce" with a focus on the establishment of a Health and Care Academy for Leeds, promotion of the living wage and supporting disabled people into employment.

Health & Care Academy – The Health and Social Care Academy would support a better targeting of employment opportunities in the city's more deprived areas. In answer to a query the Board received assurance that the Health Academy would focus on business as well as clinical skills, recognising the role of small and medium businesses in the health and care sector.

Work Related Long Term Illness - 32,000 people in Leeds received Employment & Support Allowance (ESA) - financial support for those who were unable to work through disability or illness. Of these, it was suggested that a large number had work related anxiety or musculoskeletal issues; and with the right support available to employers, that skilled and/or experienced workforce could be retained.

Dave Roberts, LCC Financial Inclusion Manager, provided the Board with information on the 'Living Wage', in particular:

- The influence the public sector had on the private sector
- 60% of children living in poverty are from working households
- The proven link between poverty and ill-health

Discussion followed on the proposal for public services to collaborate and develop a strategy to encourage momentum within the private sector for the Living Wage, noting a seminar had been proposed by the Integrated

Commissioning Executive (ICE) as an initial focus for the strategy. Comments included:

- Quality Care work – Paying appropriate wages will encourage staff retention, boost health and care outcomes and alleviate child poverty
- One approach to training - 57,000 people in Leeds work in the health and care sector and were largely trained within the organisation they work for. 'One approach' to training would encourage rotation throughout the health and care sector settings and break down barriers between the health and care settings in the public/private sector.
- The opportunities for joined up learning and training, recognising that there were issues across the public and private sectors which required the same training – such as moving/handling technique
- Awareness that many working in the health and care sector do so whilst they gain non-health and care related qualifications and/or language skills. Once complete, they often move out of the health and care sector
- The impact of the Apprenticeship Levy and whether this could be invested in health and care apprenticeships

RESOLVED -

a) That, having considered the role of the Health and Wellbeing Board in overcoming challenges relating to workforce; the comments made during discussions be used to provide direction for progress towards the priorities of the Leeds Health and Wellbeing Strategy 2016-21.
b) To support the engagement of members in discussions about the Living Wage and attend the Low Pay Seminar when arranged.
c) To oversee/raise the profile of the Supporting Disabled People into Employment Project to ensure it remains consistent with the city's health and wellbeing priorities and participate in a 'health, wellbeing and employment workshop' in October 2017.
d) To continue to note and support the development of Leeds Health and Social Care Academy and to receive regular updates on progress.
e) To note that the City Workforce Work stream should be used to understand and plan responses to these challenges and keep the Board up to date with progress.

12 For information: Better Care Fund Quarterly Reports

Steve Hume, Chief Officer, Resources & Strategy (LCC Adults & Health) presented a report for information on the completed Better Care Fund (BCF) reporting templates for quarters 2, 3 and 4 for 2016-17. The report noted that a requirement of the BCF is that completed reporting templates are submitted quarterly to NHS England to provide assurance that the conditions of the BCF are being met.

RESOLVED – That the completed BCF reporting templates for quarters 2, 3 and 4 for 2016-17 be noted for information.

13 Date and Time of Next Meeting

RESOLVED – To note the date and time of the next formal Board meeting as Thursday 28th September 2017 at 10.00am (with a pre-meeting for Board members at 9.30am).